NHS Employers’ evidence to the Pay Review Body on Doctors’ and Dentists’ Remuneration 2007/08

September 2006
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ANNEX

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### NHS EMPLOYERS KEY MESSAGES TO THE REVIEW BODY

#### Affordability
- A pay award in line with the Consumer Price Index (CPI) inflation target is the most that could be afforded by NHS employers.
- Affordability is dependent upon an appropriate increase in the pay element in tariff.

#### Equity
- Equity is particularly important and employers want a generic pay uplift across all staff groups.
- Given that the spending plans for the NHS in forthcoming years are subject to the outcome of the 2007 Comprehensive Spending Review, a multi year pay award would be undesirable at this time.

#### Stability
- All hospital doctors and salaried dentists have access to incremental pay scales which range from an average of 4 per cent for consultants, between 5 and 9 per cent for NCCG grades and 4 and 6 per cent for doctors in training. These increases need to be factored into decisions about the recommended level of uplift.
- Employers report that recruitment and retention has generally improved or remained stable and has been helped by a fall in staff turnover in most areas.
- Negotiations are continuing for GMS and salaried dentists and we will keep the Review Body informed of progress.
1. NHS Employers

Who we are

1.1 NHS Employers represents employers in the NHS and gives them an independent voice on workforce issues. Nationally NHS Employers provides advice and support to employers and shares information and good practice. Over the last 12 months we have been listening to employers. Our approach has been to gather information about priorities and concerns about how we can work more effectively together.

1.2 Our aim is to help employers improve the working lives of staff who work in the NHS and, through them, to provide better care for patients. NHS Employers is part of the NHS Confederation but we have our own director, policy board and assembly. We have four key roles:

- negotiating on behalf of employers
- representing employers
- supporting employers
- promoting the NHS as an employer.

1.3 The Department of Health, which remains responsible for developing policy standards for the health and social care workforce, has set the broad policy framework within which NHS Employers operates. However, it is the employers themselves who drive the agenda that NHS Employers follows.

1.4 NHS Employers is an England-only initiative. The Department of Health in England may have an observer at pay negotiations while the Devolved Administrations and Northern Ireland each attend as negotiating members. However, NHS Employers provides the ‘machinery’ for on-going negotiations on a UK basis by way of a secretariat.

About our evidence

1.5 Last year was a significant milestone as it was the first time that all employers from across the NHS in England were able to put forward their particular views on pay awards for their staff directly to the review bodies. The review bodies acknowledged the importance of NHS Employers’ evidence and we were very pleased that the final recommendations for uplifts in 2006/07 clearly took account of employer views.

1.6 As last year, our aim is to provide comprehensive evidence on issues related to the remit of the Doctors’ and Dentists’ Review Body (DDRB), the Nurses and Other Health Professions Review Body (NOHPRB) and the Pay Negotiating Council (PNC). Our
evidence is based primarily on information collected from employers by way of a questionnaire which has been specifically designed to provide sound evidence based argument to support the pay review for 2007/08. The views of NHS organisations have also been received during many other contacts with the NHS through meetings, working groups, dealing with queries and giving advice.

1.7 A copy of our letter seeking information and the questionnaire is at Annex A. Over 80 replies were received from the NHS, more responses than last year. The chart below shows the proportion of responses we have received, broken down by type of NHS organisation.

Chart 1: Type of organisation

1.8 The evidence which represents the views of NHS employers in England only, has been approved by the NHS Employers policy board.

Foundation trusts

1.9 NHS Employers’ role is to represent the interests of all employing organisations in the NHS in England. The views of NHS foundation trusts (NHS FTs) have been taken into account in this evidence.

1.10 Our questionnaire invited NHS FTs to raise issues specific to them but there were no special issues to highlight for the Review Body.
2. The economic context

Background

2.1 We recognise that the definitive sources of evidence on the economic context and affordability will be the Treasury and the Health Departments. However, in advance of trusts and foundation trusts receiving notification of Primary Care Trusts (PCT) allocations for 2007/08, and their likely income from contracts, employers will have to take a view on the affordability of their workforce. The following indicators, which are publicly available, together with the current financial positions indicated by the returns to our questionnaire, have helped us form a view on affordability for the sector.

2.2 Recent evidence suggests there has been a strengthening of the UK economy. Data from the Office for National Statistics showed that Gross Domestic Product (GDP) grew 0.8 per cent in the second quarter of 2006, an increase from 0.7 per cent in the first quarter. As a result, year-on-year growth stood at 2.6 per cent.

2.3 Labour market statistics published in September 2006 showed that the trend in the employment rate is broadly flat. The number in employment increased slightly on the previous quarter, and the previous year but the employment rate fell 0.1 per cent from the previous quarter to 74.6 per cent, and down 0.2 percentage points from a year earlier. The number of people in public sector employment was 5.84 million, down by 9,000 in the year to June. This decrease is the first fall in public sector employment since 1998. Over the same period, private sector employment increased by 236,000 to 23.13 million.

2.4 The number of unemployed increased over the previous quarter and year to reach 1.70 million. The unemployment rate stood at 5.5 per cent, up 0.3 percentage points over the quarter and 0.8 on the previous year. The claimant count level was 950,100, down 3,900 on the previous month but up 80,800 on the previous year. The number of vacancies for the three months to August was up 14,800 on the previous quarter to reach 608,800 but down 7,400 over the year. The redundancy rate for the three months to July 2006 was 5.7 per 1,000 employees, down 0.3 over the previous quarter.

2.5 In addition, UK house prices increased by 0.8 per cent in August according to the Nationwide Building Society, while annual house price growth increased to 6.6 per cent, more than double the rate of growth at this time last year.\footnote{Nationwide, August 2006, Nationwide House Price Index – \url{www.nationwide.co.uk/hpi}} The Halifax indicated
that house prices increased by 1 per cent in August. However, the overall increase in house prices from May to August is only 0.2 per cent compared with a 2.9 per cent rise in the previous three months. They suggest that this mixed pattern of monthly price rises and falls is a typical feature of a more stable housing market. Both sources have slightly increased their forecast for house price growth in 2006 to 5 per cent but increases in 2007 are expected to be slower.²

2.6 The increased pace of economic activity has resulted in the Bank of England raising interest rates by 0.25 percentage points to 4.75 per cent in an attempt to bring Consumer Price Index (CPI) inflation back towards the 2 per cent target.

2.7 The evidence paints a mixed picture of the economy with strong growth in GDP and house prices combined with increasing unemployment and a recent decline in employment. As the recent rise in interest rates takes effect demand should ease, allowing the economy to return to a more stable position.

Pay settlements

2.8 Evidence from the latest Income Data Services (IDS) Pay Report (September 2006) shows that the median pay settlement level for the three months to July was unchanged at 3 per cent. The median has now been steady at 3 per cent since the start of the year.³

2.9 There has been a slight increase in the range of settlements with the inter-quartile range now standing at 2.7 - 3.5 per cent in the three months to the end of July, up from 2.6 - 3.3 per cent in their previous analysis.

2.10 The public sector median for the three months to July was 3 per cent, comparable with the private sector median. The public sector pay settlement figures cover a number of new public sector deals including three of the largest government departments; Department for Work and Pensions, HM Revenue & Customs and the Home Office.

2.11 The largest bargaining units: teachers, NHS employees and local government workers have received increases below 3 per cent for 2006. Where large groups of public sector employees have received pay rises this year above 3 per cent they have been the result of previously agreed long term deals.

² HBOS plc, August 2006, Halifax House Price Index
³ Income Data Services Ltd, September 2006: IDS Pay Report 960
Average earnings  

2.12 Average earnings (seasonally adjusted, excluding bonuses), as measured by the Average Earnings Index three-month average, rose by 3.7 per cent in the year to July 2006, down from 3.8 per cent in June. Including bonuses, average earnings rose by 4.4 per cent in the year to July, up from 4.3 per cent in June.

Chart 1: Average Earnings Index – comparison of pay growth

2.13 Looking at the private and public sectors separately, the annual average earnings growth (excluding bonuses) shows that both public and private sector earnings growth remain above current inflation rates. In the three months to July 2006, pay growth (excluding bonuses) in the private sector was 3.9 per cent, down 0.3 percentage points on the previous month. Over the same period, public sector pay growth increased 0.3 percentage points to 3 per cent. Including bonus payments, private sector growth stood at 4.6 per cent, compared with 3.8 per cent for the public sector. Within the public sector, average earnings grew by 4.1 per cent in health and social work, by 3.5 per cent in education and 5.8 per cent in public administration.  

2.14 The evidence shows that since March 2006 private sector earnings growth has been higher than public sector earnings.

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Office for National Statistics

5 Office for National Statistics (includes public and private sector earnings)

6 Public administration includes staff employed in civil service, defence activities, the judiciary, fire service and law and order
growth. This indicates that we may be witnessing a reversal of the more recent trend for public sector earnings to run ahead of the private sector, particularly with lower basic increases in the public sector this year. This is partly due to the reversal of strong earnings growth in the health and social work sector, evident during 2005.

**Inflation**

2.15 In addition to the figures on average earnings growth, it is important to consider the impact of both current and future inflation levels.

2.16 According to the Office for National Statistics, the CPI annual inflation, the Government’s target measure, rose to 2.5 per cent in August, up from 2.4 per cent in July. The largest upward effects came from recreation and culture, furniture and furnishings and clothing and footwear. The only large downward contribution came from transport costs.

2.17 As an internationally comparable measure of inflation, the CPI shows that the UK inflation rate is around the average for the European Union (EU) as a whole. The provisional figure for the inflation rate for the EU in June was 2.4 per cent, the same as the corresponding UK figure. The Bank of England target for CPI remains 2 per cent.

2.18 The Retail Price Index (RPI) inflation rate and RPIX inflation, (the all items RPI excluding mortgage interest payments), also rose in August to 3.4 per cent and 3.3 per cent respectively.

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7 Office for National Statistics
Evidence from the August IDS pay report shows that RPI inflation is forecast to slow down towards 2.4 per cent by the second quarter of 2007 as recent rises in energy prices drop out of the calculation.

Evidence from the Bank of England’s latest inflation report suggests that higher domestic energy prices and university tuition fees will raise the central projection further above the 2 per cent target over the next few months. However, in the later part of the projection, CPI moves gradually back towards target, as energy and import prices moderate.

Financial situation in the NHS

The 2004 Comprehensive Spending Review set spending plans for the period up to 2007/08 that protected the increased resources delivered by previous Comprehensive Spending Reviews. The expenditure plans as set out in Table 1 represent an annual average increase of 7.1 per cent in real terms between 2005/06 and 2007/08 - a total increase of 23 per cent in real terms over the period.

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8 Office for National Statistics
Table 1: Planned net NHS expenditure (England)\textsuperscript{10}

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<thead>
<tr>
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<th>Net NHS Spending (£billion)</th>
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<tr>
<td>2005/06</td>
<td>76.4</td>
</tr>
<tr>
<td>2006/07</td>
<td>83.8</td>
</tr>
<tr>
<td>2007/08</td>
<td>92.1</td>
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2.22 Despite these record increases in funding the NHS recorded a net overspend of £250 million in 2004/05 and a substantial overspend, equivalent to around £512 million net for the 2005/06 financial year.\textsuperscript{11} This net overspend represents less than 1 per cent of the total NHS spend and affects a minority of organisations but signifies a gradual deterioration in the position over the last few years. The latest figures from Monitor, the Independent Regulator of NHS Foundation Trusts, report a £24 million net deficit across foundation trusts.\textsuperscript{12}

2.23 The figures show that 174 NHS organisations are in deficit compared to 159 the previous year. Fifteen organisations had deficits amounting to more than 10 per cent of their turnover. In 2004/05 there were only three reporting deficits on that scale, and the previous year there were none. The gross deficit in the 102 organisations subject to ‘turnaround’ programmes has doubled from a combined gross deficit of £476 million in 2004/05 to £915 million in 2005/06.\textsuperscript{13}

2.24 Evidence suggests that the main causes of NHS deficits are inherited debt, failure to manage excess capacity through reconfiguration, and in a few cases a loss of financial control and poor governance. Staffing issues have not been a major factor except in a few organisations where expenditure on temporary staffing has run over budget.

2.25 The financial difficulties some NHS organisations are facing have resulted in them reviewing their workforce numbers in an attempt to save money. According to information gathered between late March and early May 2006 by NHS Employers, a significant minority of organisations say they are planning reductions in posts. A small number of organisations with the largest deficits have outlined plans for actual redundancies.\textsuperscript{14}

2.26 The next Comprehensive Spending Review in 2007 is predicted to announce increases of between 3.0 to 4.4 per cent in real

\textsuperscript{10} Department of Health: Departmental Report 2006.
\textsuperscript{11} Department of Health, June 2006, NHS organisations forecast surplus and deficits 2005/06: Month 12
\textsuperscript{13} King’s Fund, June 2006, Deficits in the NHS
\textsuperscript{14} NHS Employers, May 2006, Briefing: What’s happening with the NHS workforce?
terms for the NHS from 2008/09 up to 2011/12. This is roughly half the annual increase the NHS has received every year since 2000.  

2.27 Money within the NHS budget is not specifically allocated to spend on annual pay increases. The pay bill at PCT level is met from the overall allocation of funding for PCTs. Resources for trusts come to them via contract income. Therefore, any large increases in pay will have an effect on the capacity of PCTs to secure additional services for their populations.

2.28 Analysis of spending in 2004/05 suggests that 50 per cent of new investment was spent on new staff and increased salaries. £1.4 billion (20 per cent of the increase) was spent on additional staff and £2 billion (30 per cent) was spent on increased salaries.  

2.29 Given the evidence above, we would ask the Review Body to consider carefully the impact that any pay increase deemed unaffordable by NHS employers would have on an already difficult financial position. Employers stressed that affordability was dependant on an appropriate increase in the pay element in tariff reference prices for 2007/08. Tariff income is not yet known for next year but it is unlikely to exceed the target rate for CPI.

Conclusion  

2.30 The 2006/07 public sector pay bargaining round is taking place in the context of a government policy of greater centralised control over pay decisions and the Treasury’s aim to limit pay uplifts to an average of 2 per cent. To achieve this, the government has established a new Public Sector Pay Committee to oversee all public sector pay rises. The Chancellor has specifically asked that increases for 2006 should take account of the Government’s CPI inflation target of 2 per cent.

2.31 The remit of the Review Body explicitly requires that in reaching recommendations, regard is given to ‘the Government’s inflation target’. We note that the Chancellor has written to the pay review bodies specifically asking that the increases for 2007 should take account of the Government’s CPI inflation target of 2 per cent.

2.32 The evidence paints a mixed picture of the economy with strong growth in GDP and moderate growth in house prices combined

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15 King’s Fund, May 2006, ‘Health summit outlines four key challenges for NHS ahead of lower growth in funding’  
16 The NHS Confederation, March 2006, Briefing: Debate on Deficits in the NHS
with increasing unemployment and a recent downward trend in employment. This increase in unemployment, combined with steady pay growth, lower pay settlements and few reports of recruitment difficulties suggests that there are few signs of tighter conditions in the labour market. The Bank of England projects that this margin of slack in the labour market is projected to continue, acting as a restraint on pay growth and pushing down the inflation projection over the forecast period.\textsuperscript{17}

\textsuperscript{17} Bank of England, August 2006, \textit{Inflation Report}
3. Employer pay proposals for 2007/08

Results from our questionnaire

3.1 Responses to the questionnaire issued by NHS Employers indicate that the majority view was that a pay award that does not exceed inflation targets was the most that could be afforded.

Chart 1: Level of pay uplift: what level of pay uplift could be deemed affordable for 2007/08?

- 78% in line with inflation
- 21% below inflation
- 1% above inflation

3.2 Employers were very clear that any further cost pressure through unfunded pay increases would almost certainly impact on the patient experience. A significant minority of respondents indicated that in the current climate no pay award would be affordable. Some have mentioned figures below inflation such as 1 per cent and others stressed that affordability was dependant on an appropriate increase in the pay element in tariff reference prices for 2007/08. Tariff income is not yet known for next year but it is unlikely to exceed the target rate for CPI.

3.3 Whilst some employers will be making redundancies whatever the level of settlement, most respondents indicated that a pay award higher than inflation would lead to further reductions in posts, possible redundancies, vacancy freezes, reduction in capacity/growth, and failure to meet health care and financial targets. Despite this, many employers acknowledged that a below inflation award would be detrimental for staff morale and motivation. Most organisations with deficits are already working towards driving out inefficiencies and have recovery plans and cost improvement programmes in place.
Chart 2: Impact on services: What would be the impact of a higher pay uplift than was deemed affordable?

3.4 The common view from employers in the NHS is that the review bodies should be asked to place most emphasis on a generic pay award for all NHS staff. Employers are almost unanimous in their agreement that both medical and non-medical staff should receive the same level of award to avoid undermining the Agenda for Change pay structure or prompting a number of equal pay claims. Employers believe that unless there is an absolutely clear recruitment and retention problem, differential pay awards are divisive and have a detrimental effect on morale and team working.

London weighting

3.5 In relation to more targeted awards, the majority of employers feel that the payments for London weighting should be uplifted in line with the general award.

Chart 3: London weighting: Do you think that the London weighting payment should be uplifted in line with the general award?

Recruitment and retention

3.6 Employers report that recruitment and retention for doctors is improving or remaining stable, with a few suggesting that they had difficulty in particular specialties. Despite this, very few
employers felt it necessary to pay recruitment and retention premia to consultants. The latest vacancy survey figures from the Health and Social Care Information Centre (HSCIC) show encouraging decreases. More information on the survey results and wider recruitment and retention issues is contained in Chapter 4.

Chart 4: Are you paying recruitment and retention payments to consultants?

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<tbody>
<tr>
<td>Yes</td>
<td>12%</td>
</tr>
<tr>
<td>No</td>
<td>88%</td>
</tr>
</tbody>
</table>

3.7 A small number of employers indicated that a premia is being paid in the following specialties:
- Psychiatry
- Forensic Psychiatry (special hospital)
- Paediatric Neurosurgery
- Paediatric Radiology – Pathology.

Temporary staffing

3.8 There has been substantial growth in directly employed NHS staff over a period of several years, while the trend in growth of temporary staff has now reversed with spending reduced significantly in the past two financial years. Many employers reported that the use of locum and agency staff over the last 12 months has remained the same due to better management of agency framework agreements and competition generated by NHS Professionals. Over half of respondents indicated that they were using less agency staff than 12 months ago.

3.9 With a major focus now on productivity, better management of temporary staffing is a key priority. The National Temporary Staffing Forum is a newly established employer interest group facilitated by NHS Employers and will be key to sharing ideas and ensuring employer input to emerging national policies.
Chart 5: Temporary staffing: Has your use of locums and agency staff changed over the last 12 months?

<table>
<thead>
<tr>
<th>Less Use</th>
<th>About the Same</th>
<th>Increased Use</th>
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<tr>
<td>13%</td>
<td>38%</td>
<td>49%</td>
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Conclusion

3.10 All hospital doctors and salaried dentists have access to incremental pay scales. For newly appointed consultants these increments are worth an average of 4 per cent of basic pay, excluding any clinical excellence awards. Consultants on the 2003 contract also benefit from a much higher maximum basic salary at £94,706 compared to £75,404 (figures increase to £95,831 and £76,300 respectively from 1 November 2006) on the pre 2003 contract.

3.11 In addition, doctors in the NCCG grades benefit from average increments of between 5 and 9 per cent of basic pay. Doctors in the training grades receive incremental increases of between 4 and 6 per cent of basic pay. It is important that these additional increases in basic pay are factored into decisions about the recommended level of uplift.

3.12 Negotiations for a new contract for NCCG doctors continued up to mid July, when the BMA rejected the proposals by NHS Employers. However, the offer of this new contract has remained on the table and at the deadline for submission of written evidence the BMA has indicated that they now wish to submit joint proposals to the four Health Departments for ratification. The proposals are expected to add approximately 10 per cent to the pay bill for this group of staff and any Review Body recommendation for a substantial uplift for this group of doctors would undermine the current position.

3.13 Given that spending plans for the NHS in forthcoming years are subject to the outcome of the 2007 Comprehensive Spending Review, we believe that a multi-year pay award at this time would be undesirable.

3.14 Employers have stressed that affordable pay settlements are necessary to ensure that the current financial position in the
NHS does not worsen. They have also emphasised the importance of a generic pay uplift across all staff groups.

3.15 Taking all this into account, a pay award in line with the CPI inflation target is the most that could be afforded by employers in the NHS.
4. Recruitment and retention

4.1 Employers reported that recruitment and retention was generally improving or remaining stable. There were, however some concerns at consultant level in particular specialties. These include pressures in accident and emergency, psychiatry, radiology and histopathology in which planned increases in training have yet to work through to consultant level. Overall it was thought that as these are attributable to an overall delay in supply, payment of recruitment and retention premia are not appropriate, and this is evidenced by the fact that only a minority of NHS organisations are paying them.

4.2 Initiatives under the Improving Working Lives (IWL) banner have been positively received and many trusts cited non-pay solutions as important as pay in improving recruitment and retention – especially the introduction of flexible working practices, for example the flexible training, flexible career and flexible retirement schemes. In addition, learning and development opportunities and childcare provisions are the areas of IWL which appear to have had the most significant positive effects on staff.

4.3 A major new development in assisting the recruitment and retention of staff into the NHS has been NHS Jobs. NHS Jobs is the electronic recruitment service for the NHS. It is managed by NHS Employers through the NHS team. A summary of NHS Jobs is at Annex B. At the deadline for submission of written evidence the service was actively being used for consultant, associate specialist, staff grade and salaried general practitioner vacancies.

**Headline Information**

4.4 Vacancy survey figures for consultants from the HSCIC show an encouraging decrease from 3.3 per cent in March 2005 to 1.9 per cent in March 2006. This is down from 4.4 per cent in March 2004. We regard this as a significant and very pleasing reduction. Furthermore, there were 31,993 consultants in September 2005, an increase of 1,343 or 4.4 per cent since September 2004.

4.5 At the end of September 2005, there were 32,738 general medical practitioners (excluding retainers and registrars). This represents an increase of 1,215 or 3.9 per cent since September 2004.

4.6 The second annual survey of GP Practice Vacancies in its current format was conducted at the end of March 2006. It
should be noted that all rates and figures quoted are estimated and based on sample data. As at March 2006, the HSCIC provided an estimated 3 month GP vacancy rate of 1.1 per cent for England, a decrease from 2.4 per cent for March 2005.

4.7 Employers indicate that in the current climate of challenging recovery plans, a higher than expected and unfunded pay award would lead to extended vacancies, possible redundancies and freezing of posts with a subsequent reduction of services and developments. Indeed in a recent recruitment and retention survey by NHS Employers, 10 per cent of respondents were anticipating redundancies in the next 12 months and a further 25 per cent indicated the potential for redundancies. This is against the backdrop of 39 per cent of respondents indicating that they had had recruitment freezes in the last 12 months.

Morale and job satisfaction

4.8 Overall, employers indicate that morale for medical staff has stayed the same over the last year. However, in some areas employers indicate that morale has deteriorated as a result of uncertainty due to perceived threats of job losses. The financial position of some employing organisations, NHS reconfiguration and the negative publicity surrounding the NHS are cited as the cause of deterioration in morale. Some employers indicate that service developments have already been curtailed to meet the costs of achieving financial balance.

4.9 Clearly these morale problems will not be addressed by additional pay. Indeed high pay awards that cause continuing financial problems for trusts will only exacerbate the difficulties and uncertainties for staff. These problems will be overcome when trusts achieve financial balance.

4.10 Judgments on morale and job satisfaction are always difficult. The national survey of NHS staff conducted by the Healthcare Commission between October and December 2005 asked a series of questions about how satisfied staff were with different aspects of their jobs, including: recognition for good work; support from their immediate manager and colleagues; freedom to choose methods of working; amount of responsibility; opportunities to use their abilities; and the extent to which the trust values their work.

4.11 Possible scores range from one to five, with one representing staff who were very dissatisfied and five representing staff who were very satisfied. High satisfaction is known to be associated with good performance, satisfaction of patients, wellbeing of staff and low levels of absenteeism and turnover.
4.12 The average score for job satisfaction was 3.44, indicating that staff in the NHS are generally fairly satisfied. However, this compares with scores of 3.55 and 3.50 in 2004 and 2003 respectively, suggesting a drop in the overall level of satisfaction since 2004.

4.13 Some employers would argue that turnover figures are probably a better measure of morale than the national staff survey. Turnover varies considerably, one trust quoting their own figures reported an actual turnover rate of 10 per cent which is much lower than the national staff survey figure which suggested that 20 per cent of people were looking for other jobs.

Developments in the NHS workforce

4.14 It is not unusual for employers to continually review and amend the number of posts in their organisations to keep pace with the way services are delivered, including new treatments and new roles for staff. Rather, it is good practice to do so. However, media reports of job losses and the perceived complexity of the factors at work prompted NHS Employers to look further into the situation.

4.15 Information gathered by NHS Employers from nearly 200 employers in the NHS in March and April 2006 indicated that where trusts are making reductions in their workforce, they are typically doing so by freezing vacancies, director level scrutiny of new appointments, reducing the use of agency and temporary staff, as well as redeploying staff in different ways. Uncertainty about post reductions was widespread and is attributed to a combination of factors including the impact of:

- Commissioning a Patient Led NHS (CPLNHS) and future PCT configurations
- Payment by Results and the tariff
- the emergence of other providers
- the white paper ‘Our Health, Our Care, Our Say’
- continued local service redesign as a result of new ways of providing care
- implementing Agenda for Change and the consultant contract.

4.16 There will be redundancies, both voluntary and compulsory, in a number of trusts where all the other processes, freezing, etc have not brought sufficient savings. Some organisations have indicated that they are planning reductions in posts over an extended period of time through a range of measures – actual redundancies, not replacing staff who leave, redeployment and changing roles. A number of respondents said that a local review of staffing is underway. Efforts are being made to protect clinical posts although we are aware of a limited number of
medical redundancies at Sandwell, Nottingham and North Staffordshire. This situation will continue to be monitored and will be updated at the oral evidence session in December.

4.17 CPLNHS was cited by PCTs as well as a number of other trusts as one of the factors contributing to workforce reductions. Only a minority were able to give definitive answers as to the effect on posts.

4.18 Management, administrative and clerical posts are significantly affected, not just in PCTs but also in acute and mental health trusts. This situation is also replicated in ambulance trusts, particularly due to organisational change as a result of ‘Taking Healthcare to the Patient: Transforming NHS Ambulance Services’.

4.19 NHS organisations report that efforts are being made to protect clinical posts, where possible, but where clinical posts are being actively reduced redeployment of staff and redesign of roles and ways of working are important features. In some cases this is due to the current financial situation, in others it is part of planned changes to services, such as providing more care outside hospitals, introducing shared services or new ways of working. What stood out from the responses obtained is just how challenging workforce planning is at present and how much effort is going into balancing workforce numbers and delivery of a high quality service with finances and system change. NHS Employers will continue reviewing the position in trusts and may be able to provide an update at the oral evidence session in December.

Opportunities for newly qualified clinical staff

4.20 Against this background is the fact that there are more clinical staff graduating from UK medical schools than in recent years. This means increased competition and as such greater mobility and flexibility is required of job applicants. Indeed the Home Office has acted to try to redress the balance by changing the immigration rules such that employers will need to demonstrate the inability to recruit to specialist training positions from the resident labour market before appointing an international medical graduate. The Home Office is currently reviewing the entire health sector shortage occupation list, including medical consultant roles to ensure the list reflects the current UK skill shortage.
5. Consultant contract

5.1 In our evidence to you last year we estimated that some nine out of ten consultants had moved to the 2003 consultant contract. This estimate has proven to be correct. A Department of Health survey, *New Consultant Contract Implementation Survey*, published by the HSCIC in July 2006, indicated that as at October 2005, 87.1 per cent of consultants had moved to the contract (up from 76.9 per cent in October 2005). We believe the uptake figure will have continued to increase since last year, with over 90 per cent of consultants now on the 2003 contract.

5.2 The Department of Health survey showed that uptake varied by type of NHS organisation, geographical location and specialty; 98.1 per cent of consultants employed by SHAs having moved to the contract compared with 74.8 to 97.5 per cent of consultants in other NHS organisations. Uptake, when broken down by specialty ranged from 76.8 per cent in the surgical group to 100 per cent for specialties in the public health medicine group. Having said that, the response rate to the latest survey was 71.3 per cent (following checking and amendment) compared with 95 per cent the previous year. This more limited coverage means we would not wish to rely too heavily upon some of the more detailed findings.

5.3 Numbers on the pre 2003 contract will continue to decline as non-transferees diminish as a group, through, for example, retirement. However, there was never an intention to compel existing consultants to change contracts (except in specified and agreed circumstances) and the pre-existing contract and its terms and conditions will need to remain available and be maintained for the immediate future.

5.4 Over the last three years significant focus has been placed on the introduction of new pay arrangements across the NHS with the explicit expectation that improvements will be made in service delivery and productivity. In the 2003 consultant contract the main vehicle for delivering flexibility in service delivery is the job planning process.
Illustrative examples of benefits realisation

Hampshire Partnership NHS

Has delivered effective job planning and found:
- consultants – better supported to work differently, review job descriptions, inform appraisals and develop professionally
- clinical managers – used job plans to inform manpower planning and service redesign
- general managers – better able to track funding, focus upon service needs and understand consultant activities
- service users – benefited from access to consultant delivered services during the evening.

Leeds Teaching Hospitals NHS Trust

Has developed team based job planning to support the delivery of a neonatal service across two sites. The resultant benefit being provision of an effective mechanism to clarify the roles of consultants which contributed to the efficient delivery of care.

Barts and the London NHS Trust

Has introduced team job planning and objective setting in A&E and found this was key to achieving A&E targets, providing:
- enhanced cover at busy times
- objectives related to service needs
- clarity over educational activities
- structured research activities that allow non approved work to be excluded from NHS Programmed Activities.

Plymouth Hospitals NHS Trust

Has introduced annualised and team based job plans for their colorectal team and found:
- Cancellations due to consultants annual leave have been eradicated
- Session utilisation is now running at nearly 100 per cent.

5.5 With regard to the number of Programmed Activities (PAs) worked, the Department of Health survey suggests the overall national average had decreased from 11.17 per consultant in October 2004 to 10.83 in October 2005. A change such as this would not be unexpected. The number of additional PAs

18 NHS oral evidence submission to the Health Select Committee. Further details are available on request
contracted for (if any) is subject to change, on at least an annual basis, when job plans are reviewed and the job planning process becomes more effective. The transitional phase from the pre to the post 2003 contract has effectively ended and whereas in some cases the numbers of PAs may have been based upon retrospective diary exercises, they are now more accurately reflecting the prospective needs of the employing organisation and the wider NHS as well as the preferences and needs of individual consultants. Furthermore, employers and consultants are generally becoming more skilled at tailoring job plans.

5.6 The survey also suggests that the proportion of PAs allocated to direct clinical care (DCC) has diminished from an average of 8.27 per consultant in October 2004 to an average of 7.93 in October 2005. This is to be expected as additional contractual consultant work reduces towards an average working week of 10 PAs per doctor.

5.7 The Department of Health has asked NHS Employers to develop ‘best practice advice’ on improving productivity and NHS Employers is supporting the use of productivity data such as Finished Consultant Episodes to help improve productivity.

5.8 NHS Employers is involved with a number of projects that are aligned to the productivity and efficiency agenda. These include: The establishment of a joint project with the National Institute of Mental Health for England to address issues associated with the utilisation and deployment of locum psychiatrists and sharing the learning from Mental Health Trusts within the north west of England.

5.9 It may be seen from data in the recruitment and retention section of this report that recruitment and retention challenges continue to diminish and employers report that non pay solutions to any remaining localised challenges continue to be as effective or more effective, than increases in levels of pay. Whilst provision exists within the contract for the payment of recruitment and retention premia, employers overwhelmingly report this is not used. Exceptions comprise specialties where it is acknowledged shortages may exist e.g. psychiatry, paediatrics, radiology and histopathology. Some employers report such payments are not only time limited (as intended) but so short term they are soon to be discontinued i.e. three years after which they could first have been introduced.

5.10 We note from the Department of Health implementation survey, cited previously, that SHAs and trusts in London have taken a strategic decision not to pay such premia, with this arrangement to be reviewed not less than annually.

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5.11 The current provisions for the local level design and payment of premia are deemed by employers to be satisfactory. No change is sought to these arrangements.

5.12 During 2006, NHS Employers has been working in partnership with the BMA to produce for the Department of Health a report on the operation of the first two years of the clinical excellence awards scheme (CEA) in England.

5.13 A report on the operation of the CEA scheme in England has been agreed with the BMA and, as intended, submitted to the Department of Health. The focus of the report is upon operational issues; it does not seek to question or amend the underpinning Department of Health policy.

5.14 The report comments in detail upon how the scheme is viewed by NHS managers and consultants and makes a series of recommendations as to how its operation could be improved. The Department of Health is currently considering the report and is expected to announce its response to the recommendations and when and how the report is to be made available shortly. We will comment further on this at the oral evidence session if appropriate.

5.15 NHS Employers has published, so far during 2006, three pay circulars related to consultants. A number of issues have been promulgated including amendments to the contract itself (for the purposes of certainty and clarity) and consequential changes made to the terms and conditions. As a result, the contract is now in its third version. In addition we have published guidance on contracting for PAs allocated to supporting professional activities and agreed with the BMA a comprehensive set of frequently asked questions on the 2003 contract and its interpretation.

5.16 We have been asked by the Department of Health to examine whether the on call availability supplement arrangements as provided for by Schedule 16, paragraphs 1 to 7, of the terms and conditions could be amended (on a cost neutral basis) to more accurately reflect and reward the variable contributions of consultant on-call rotas. We are engaged in discussions with the BMA on this and will advise the DDRB as and when the matter is resolved.

5.17 In summary we are content that the 2003 contract, in its most recently revised form, is working well and see no current need, with the exception noted above, to revise its content further. However, we are mindful of the implication for contracts of the recent opinion of the Advocate General in the case of
Cadman v the HSE. We plan to discuss this further with the BMA.

5.18 With regard to the DDRB’s recommendations for 2007/08, it continues to be NHS Employers position that we seek no difference in the increase awarded to those on the pre and post 2003 consultant contracts.

5.19 We would also ask that the pay award for consultants should be in line with the awards made to other health workers.
6. **Staff and associate specialists/non consultant career grade doctors and dentists**

6.1 In May 2005 negotiations began between NHS Employers and the BMA to negotiate a new contract of employment for staff and associate specialist grade doctors and dentists. Following a year of frequent negotiating meetings NHS Employers made a formal proposal to the full UK Staff and Associate Specialists Committee of the BMA (SASC) on 19 May 2006 which it was believed would meet the aspirations of both teams, taking into consideration the objectives laid out by Modernising Medical Careers (MMC) and also the mandate given by the Health Departments in April 2005.

6.2 The proposal was jointly developed and, whilst only the main elements of the deal were outlined to SASC in a summary document it was felt that the detailed terms and conditions of service could have been developed to support this documentation. Similarly, a joint cost model was developed and the formal proposal made was the maximum deliverable within the funding envelope provided by the Health Departments.

6.3 The main elements of the proposal are outlined below:

6.4 The proposal was for a new grade for these doctors which we suggested could be called 'specialty doctor'. This grade would have provided an opportunity for doctors to have a rewarding career with progression to the top of the grade over a number of years whilst gaining experience and extending and developing their skills base. Fundamental to the contract was that doctors would have been required to undertake job planning and appraisal whilst developing a portfolio to record their progress in the job. Commencing with a number of annual increments, doctors would have progressed through two thresholds by evidencing that they have participated in job planning and appraisal and have developed whilst in the role. Incremental progression between threshold one and threshold two would have been at two yearly intervals and then at three yearly intervals post threshold two. We proposed that the salary range for the specialty doctor grade would have been £34,131 to £64,512 (at 2006/07 rates).

6.5 Once the new grade was introduced we proposed that there would be a limited opportunity for eligible doctors to apply for re-grading to associate specialist (AS). Those who were eligible based on the existing criteria including the relevant service requirements by 1 April 2007, would have been able to submit an application by 1 April 2007 to be considered for re-grading. It would have been for each trust to determine whether there was
a service need for an AS post and if the doctor meets the requirements. Thereafter, we proposed that the AS grade would be closed to new entrants.

6.6 The proposal to close the AS grade recognised that historically this grade had not provided a rewarding career pathway. The proposal is that, in future, the new grade would have provided the opportunity to choose to continue to make a valued contribution to service delivery or to seek to re-enter the training grades. Alternatively, either specialty or AS doctors who wish to progress may choose to apply for entry to the Specialist Register via Article 14 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order, 2003.

6.7 We proposed to reward those doctors currently in the AS grade through similar arrangements to specialty doctors. The structure of the grade would have been the same as specialty doctors and discretionary points assimilated into a main scale. On entry to the grade there would be a number of annual increments. Provided doctors have participated in job planning and appraisal meetings they would initially progress through these increments. They would then progress through two thresholds by continuing to participate in job planning and appraisal and evidencing that they have developed in their role.

6.8 Incremental progression between threshold one and threshold two would be at two yearly intervals and then three yearly intervals post threshold two. In developing these proposals we have given consideration to the implications of the recent opinion of the Advocate General in the case of Cadman v the HSE. We proposed that the salary range for the AS grade would have been £48,217 to £80,040 (at 2006/07 rates).

6.9 In the event of there being any disagreements over either salary progression or career development processes there would have been a mediation and appeals process in place to ensure that these issues were dealt with quickly, fairly and transparently.

6.10 In relation to the general terms and conditions the working week would have comprised of a basic 40 hour week made up of ten programmed activities of four hours. For full time doctors this would have been based on nine programmed activities for direct clinical care and a minimum of one for supporting activities. There would be arrangements for those working part-time.

6.11 Outside the hours of 7am to 7pm (weekdays) and for work at weekends there would have been extra recognition at the rate of time and a third of whole time basic pay. Where doctors were on-call to be available to work they would have been paid a
percentage of basic pay depending on the frequency of on call duties:

More frequent or equal to 1 in 4             6 per cent
Less frequent than 1 in 4 and more frequent or equal to 1 in 8 4 per cent
Less frequent than 1 in 8 2 per cent

In addition to these provisions, arrangements would also have been made for:

- assimilation to the new grade from all existing non consultant career grades except AS
- pay protection on return to training which would protect but not enhance pay. This would require the agreement of all crafts to a change to paragraphs 134 and 135 of current (2002) terms and conditions for Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Services in England and the equivalent in Scotland, Wales and Northern Ireland.

6.12 NHS Employers believes this proposal would have had benefits for both staff grade and AS doctors who would have received average increases of between 9 per cent and 12 per cent for the new specialty doctors and 6 per cent and 13 per cent for associate specialists.

6.13 Additionally, whilst the mandate did not include trust grade doctors we were hoping that the package would prove sufficiently attractive to both employers and these doctors that employers would choose to offer the contract to them. In the last DDRB report a request was made for clarification of numbers of doctors in this group but we believe that as these doctors are on local individual contractual arrangements rather than national conditions of service neither the BMA, or ourselves have any specific information relating to these doctors.

6.14 The SASC negotiating committee took the proposal to their SASC UK Committee on 14 June where negotiators were mandated to continue talking to NHS Employers as SASC UK were unhappy with a number of aspects of the deal. Further joint meetings were then held to explore the issues raised which related to: the length of the window of opportunity; the mechanism for re-grading to associate specialist; the number of programmed activities and the name for the new grade.
6.15 Resulting from this was a supplementary proposal, given to SASC on 17 July which was then considered by the SASC UK Committee on 20 July 2006. At this meeting SASC UK decided that the package was insufficiently attractive to put to a vote of SAS doctors and dentists. The key issues for SASC UK in deciding not to take the deal to vote were:

- that they believed that a minimum of two programmed activities per week were necessary for development purposes
- that they did not feel the window of opportunity was long enough and expressed concern that the existing criteria, giving local trusts discretion, would continue to apply; and
- that on call work should be paid at 3 per cent, 5 per cent or 8 per cent in line with consultant arrangements. Additionally, SASC also felt that separate funding for training and development should be made available.

6.16 This response was fed back to the Health Departments who were all in agreement that the proposal was the optimum that could be offered under the terms of the mandate and in light of feedback from employers during the progress of the negotiations. The outstanding issues are concerned with governance, affordability and productivity, all of which are areas where employers across the NHS have urged that the negotiators demonstrate care and restraint.

6.17 NHS Employers strongly believes that the proposal would be a good deal for both doctors and employers. It would provide a significant pay increase in return for benefits for employers.

6.18 A further SASC UK Committee was held on 25 September 2006 and at the date of submission of evidence SASC have now advised that they intend to submit joint proposals on the new contract to the four Health Departments for ratification.

6.19 Work on the final details is still ongoing and in these circumstances, it would be counter productive for this group of doctors to be awarded a significant pay increase. There would be no incentive for SASC to progress pay modernisation or any benefit realisation for employers. We would therefore propose that the pay uplift for SAS doctors should be in line with other staff.

6.20 It should be noted that before any ballot by the doctors concerned can take place the proposals are subject to scrutiny.

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19 See para 6.20 for process of ratification prior to any vote of BMA membership
by the Public Sector Pay Committee and ratification by the four Health Departments.

6.21 A further update on progress will be given at the oral evidence session.
7. Doctors in training

Modernising medical careers

7.1 As was outlined in last year’s Report, the MMC strategy is now in the implementation stage. Pilots of the foundation programme for doctors in training began in August 2005, and the full two year programme has been in place since August 2006. Doctors in their second year will be able to apply for entry to the newly structured specialty training programmes, in which they will continue their formal training after graduation from the foundation programme in August 2007.

7.2 The implementation of this major reform will have significant implications for employers, who must understand the impending changes to post graduate medical training, their effect on the structure of the junior medical workforce, and how these changes might impact upon service delivery.

7.3 The centralised nature of MMC means that it provides an opportunity to streamline recruitment into training posts. Up to now the process has frequently been both time-consuming for candidates and resource-intensive for trust medical staffing departments, dealing with large numbers of applications for each post.

7.4 The UK Postgraduate Deans have now agreed to introduce a national web-based electronic recruitment and selection service as a more efficient approach to the filling of medical training posts in the NHS. The new service aims to:

- provide a fair and transparent system for appointment to foundation and specialty training places
- support the introduction of new MMC training arrangements by providing nationally agreed job descriptions and person specifications for each training vacancy
- enable the NHS to streamline their application processes and reduce related administration and advertising costs
- applicants complete a single universal application form, choosing their preferred programme and location from a range of web-advertised vacancies
- maximise the filling of all posts with suitable candidates – with a full audit trail and quality monitoring of the process.

7.5 Applications from medical students for foundation posts will open in October 2006, to start in post in August 2007. Applications to the new specialty training programmes (which will be open to both foundation graduates and qualified doctors with experience at appropriate levels) will begin in January 2007, again with start
dates from August 2007. Applicants not matched to their initial preferred placements will have the option of re-applying in subsequent rounds, or may elect instead to enter fixed-term specialty training.

7.6 During 2005/06, a similar application process was piloted for medical graduates in England. Around 90 per cent achieved success in the first round and were matched to their preferred foundation school, thereby filling the majority of training vacancies on offer at that stage. Others were successfully placed elsewhere in a second round of matching.

The effect of modernising medical careers on pay scales

7.7 The introduction of a foundation programme followed by a single specialist training grade has necessitated the introduction of new pay scales which facilitate payment on the new grades.

7.8 Our approach to this has been to utilise existing pay points and to formulate scales that enabled the new trajectory through training without: significant change to the rate of pay at any point; neither adding to employer costs; or creating any disincentive for junior doctors.

7.9 Employers have reached agreement with the Junior Doctors Committee of the BMA on pay scales and grade names for the Foundation Programme; trainees in the two years of the programme will be known as Foundation House officers 1 and 2 (FHO1, 2) respectively. While the pay scale for the ‘run-through’ grade has yet to be finalised, the parties have agreed that doctors in the grade will be known as Specialty Registrars (StR).

7.10 Table 7.1 below shows the agreed scales (at 2006/07 levels) for the Foundation Programme, and the proposed scale for the ‘run through’ grade alongside existing scales. The Specialist Registrar (SpR) grade will be closed from the end of 2006 and the Senior House Officer (SHO) grade from August 2007; nevertheless we expect that both scales will be used in parallel for some time. The figures in red in the table indicate an optimum transit through training.

7.11 To maintain parity with current arrangements the point at which the leave allowance increases from five to six weeks is shown on the table for information. Also shown is an objective threshold, provisionally titled the ‘curriculum threshold’, which is necessary to ‘proof’ the scale in respect of the forthcoming legislation on age discrimination. To access the pay points above this threshold it is proposed that doctors must be on a specialty training programme leading to the award of CST and hold a National Training Number (NTN).
### Flexible training

#### 7.12
In earlier rounds of evidence we reported on the changes to the arrangements for flexible training introduced in June 2005. While we anticipated an increased take up of flexible training following that step it would appear that this has not happened on the scale that either we expected or the BMA hoped.

#### 7.13
We have no evidence to indicate why this should be the case, but anecdotal reports suggest that while the number of flexible trainees has not increased, fewer are waiting for places. This might suggest a reduced demand for such training and we await with interest the result of the September deanery data gathering exercise for flexible trainees.
Pay protection

7.14 Pay protection and its costs has been a constant theme raised by employing organisations, since the contract was updated in December 2000. The provisions are generous by comparison with those of other NHS staff groups, and can significantly affect trust pay bills for several years.

7.15 The protection arrangements were formulated to provide an incentive for junior doctors to work with their employers to bring their hours down.

7.16 However, the value of pay protection to the doctor and the extended period over which it can apply have not only provided a disincentive for some doctors to eliminate the long hours culture and maintain their level of income, they have also not provided an incentive for trusts to reduce working hours. Although the work available from junior doctors has reduced significantly because of the European Working Time Directive (EWTD), the effect of pay protection means that salary costs have been seen to reduce by little, if at all, in both the short and medium term. This can be exacerbated if the provisions are poorly applied.

7.17 The chart shows the reducing weekly hours of doctors in training required as a result of the staged introduction of the EWTD – in many cases this has not so far been accompanied by a corresponding reduction in costs.

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<tr>
<th>Maximum Weekly Hours of Resident Duty</th>
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<tr>
<td>Hours</td>
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<td>75</td>
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<td>40</td>
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<td>2001</td>
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7.18 A sense of the scale of change going through pay bands can be drawn from the chart below.
7.19 The service has seen an almost complete elimination of Band 3 posts since banding was introduced. This is encouraging, as this band is the most expensive for trusts in pay terms. But the move to compliance to meet the European Working Time Directive (EWTD) may have left a significant number of doctors pay protected which will then take time before the financial impact of this is felt by trusts. NHS Employers has issued an interpretation of the arrangements for pay protection to assist trusts.  

7.20 We expect that by 2009, the date for full implementation of the 48 hour week for doctors in training, the majority will fall into Bands 1A and 1B. Movement to these bands from 2A and 2B will be less costly in terms of pay protection, and as posts stabilise in Band 1 pay protection will cease to be the major issue it is now. However, the impact of the current and impending EWTD restrictions and the New Deal are changing working practices and reducing bands; these changes will continue beyond 2009.

7.21 Regardless of the problems it generates, pay protection exists as part of the collective agreement on the contract for doctors in training, and may not be ignored. The provisions are complex, implementation even more so, and we are aware that some employers may still be applying protection in ways aimed more at expedience than adherence to the letter of the agreement, which can prove rather less than cost effective.

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20 NHS Employers website – [http://www.nhsemployers.org/pay-conditions/pay-conditions-357.cfm](http://www.nhsemployers.org/pay-conditions/pay-conditions-357.cfm)
7.22 NHS Employers has developed and published its interpretation of the provisions of pay protection in the hope of achieving a better common understanding of the issues. We regret that the BMA felt unable to agree with the views expressed in the paper; nevertheless it is important that the subject is well understood by employers, and we believe that this paper has helped in this process.

Banding supplements

7.23 We have proposed in previous evidence that the pay supplements currently in place properly reflect the amount of work done and appropriately reflected the unsocial elements of the work; and the Review Body has concurred with this view. The changes to working arrangements made since our last report have not had a major impact on the proportion of trainees in each band, and we see no reason to revisit the general value of banding supplements at this time.

7.24 Overall compliance with the New Deal is now running at about 98 per cent. Given the rigour with which the New Deal parameters are enforced in some quarters we consider it inevitable that some posts will fall into Band 3 on occasion. We would be concerned if the same posts remained non-compliant for long periods but expect that posts reported as band 3 would be there for transient reasons, dealt with in an on-going process. So long as compliance remains at this level we see no reason to pay specific attention to non-compliance.

7.25 Average pay supplements reached a peak of almost 75 per cent in 2003 after banding supplements, introduced in three stages, had reached their full values. Despite action to reduce hours, by March 2006 the average hospital training supplement for compliant posts in England was still higher than the average in the months immediately following the introduction of the contract.

7.26 The average supplement for compliant posts is now 56 per cent, and has remained at that level for two consecutive six monthly rounds of monitoring. With the planned reduction in hours and the clear intended link between hours of work and actual pay, it is expected that average take home pay will reduce further.
7.27 We expect the average supplement to slowly reduce as we approach 2009, but do not expect it to fall significantly below 50 per cent. This inevitable fall in overall salary must, however, be taken in context. Pay is one factor of the overall reward for undertaking work. Just as important is work-life balance, and reduced hours and less onerous working arrangements as demonstrated by reduced bandings should be reflected by a reduction in pay. It would be inappropriate to maintain overall pay at existing levels while reducing hours – this would be to increase effective pay rates without service benefits.

7.28 An increase in pay relative to other professions might be appropriate in circumstances where there was difficulty in recruiting to the profession. However, there continues to be no shortage of applications to enter medical school, and increasing competition for posts at all levels of training thereafter, even though the number of occupied training places has expanded significantly.

7.29 We consider that the banding supplements continue to represent fair reward for work undertaken and see no reason to move from the negotiated position and current rates. From a similar perspective, medical and dental salaries, particularly salaries on graduation, remain very competitive and there appears to be no shortage of qualified applicants to vacancies at all levels of training.

7.30 Given that annual increments already add around 4 - 6 per cent to basic pay, we would suggest that any uplift for doctors in training for 2007/08 should be limited to no more than inflation
and that it should be in line with awards made to other health workers.

**GP registrars (GPRs)**

7.31 The supplement for GP registrars (GPRs) was originally set at 65 per cent of basic salary to reflect the average supplement then payable in a hospital training post so as not to provide a disincentive to hospital trainees considering a move into general practice, particularly at a time when GP recruitment was weak. Currently recruitment to GP Registrar training programmes is strong, with some four applicants for each vacancy. The average hospital supplement is now 56 per cent in England and approaching that in the other Administrations.

7.32 We believe it is now time to revisit the level of the GPR supplement; indeed in its report last year the Review Body recognised this possibility. In the current environment of strong recruitment and reducing hospital supplements we consider that it is now appropriate to reduce the GPR supplement to the average level payable in hospital posts. The hospital supplement is now at 56 per cent and reducing, any changes made would not be implemented until mid 2007 by which time we anticipate the average hospital supplement to have fallen further.

7.33 We would therefore ask that the GPR supplement be reduced to 55 per cent for those entering GPR training after April 2007.
8. Salaried general medical practitioners

8.1 The salary range for salaried general medical practitioners (GMPs) employed in primary care organisations is between £50,332 to £76,462, with starting pay, progression and review determined locally. Demand for this group of staff continues to be high; the majority of employers have reported that the pay range is appropriate.

8.2 Discussions with the BMA’s General Practitioners Committee have begun on updating the Salaried GMP’s model offer letter and terms and conditions of service.

8.3 We are seeking an uplift to the pay range in line with that of other directly employed doctors.

9. General medical services

9.1 NHS Employers is currently in negotiations with the BMA’s General Practitioners Committee regarding the arrangements for independent GMPs throughout the UK under the GMS contract for 2007/08. The negotiating parties will provide an update for the review body as part of supplementary evidence.
10. Salaried primary care dental services

10.1 NHS Employers has been mandated by the Department of Health to negotiate new terms and conditions for salaried primary care dental services (SPCDS) in England with the British Dental Association (BDA). The aims of these negotiations are to agree a new pay and career structure which will lead to an enhanced patient experience through the:

- more efficient deployment of skills
- encouragement of higher levels of competence
- better integration of salaried dentists into the wider dental workforce, both generalist and specialist
- recruitment and retention of dentists into salaried employment
- improvement of the quality of clinical leadership.

10.2 Specifically we have been mandated to agree terms and conditions which will reflect the following specific proposals outlined in 'Creating the Future – Modernising Careers for Salaried Dentists in Primary Care':

- Proposal 2: Career pathways for salaried primary care generalists should be designed to distinctively acknowledge, develop and reward their crucial role.
- Proposal 3: Salaried generalists wishing to develop themselves as Dentists with Special Interest (DwSI) should be supported through a clear framework of development and reward within the generalist career pathway.
- Proposal 4: A new single pay spine should be developed for all salaried primary care generalists, including those with a special interest.
- Proposal 5: Future career pathways for salaried primary care based specialists should be designed to acknowledge, develop and properly reward these important clinicians.
- Proposal 6: Those adopting a career as a salaried primary care-based specialist should be rewarded comparably with hospital based colleagues by utilising existing medical and dental specialist grades.
- Proposal 7: Career development should be facilitated by the implementation of personal annual appraisal and personal development plans linked to General Dental Council re-certification for all salaried generalists and specialists.
- Proposal 11: Leadership roles should be open to all salaried dentists, generalist or specialist, for defined periods, with an ability to return to full time clinical practice.
• Proposal 13: PCTs should seek the benefits of integrating clinical leadership of the SPCDS with that of wider primary dental care services.

10.3 Negotiations commenced on 9 June 2006 and to date we have met on three occasions. Negotiations are progressing well and we intend to submit joint evidence with the BDA as supplementary evidence. We expect this to take the form of a separate letter to the Review Body.

11. Commissioning general dental practice services

11.1 The NHS Confederation surveyed PCTs about dental services in March just prior to their new responsibilities for the GDS contract. The survey painted a mixed picture of NHS dental provision across England. Whilst it was clear that headlines current at the time predicting the end of NHS dentistry were wrong, there were still felt to be significant problems when the new contract came into force. PCTs felt they needed support to help them persuade dentists to stay within the NHS family.

11.2 The survey of 124 PCT chief executives showed that the majority of trusts were confident that they had secured enough NHS provision to meet the needs of their local population by the time the new contract came into force. 93 per cent of chief executives also reported good working relationships with their local dental committee.

11.3 Whilst the vast majority of PCTs surveyed had open NHS lists for both children and adults, the survey showed that there were significant challenges in maintaining this. 15 per cent did not have open lists for children.

11.4 Actions that PCT chief executives identified as having been taken to ensure access to provision of NHS dental care included:

- New General Dental Services providers (54%)
- Personal dental services (54%)
- Increased PCT provision (33%)

11.5 OME asked NHS Employers to gather information from PCTs about the commissioning and provision of NHS dental care.
11.6 PCTs have been responsible for commissioning NHS dental care services since April 2006. When asked how they felt they were coping with this new responsibility, nearly three quarters of respondents believed they were coping satisfactorily and just over a quarter thought they were coping well. No PCTs thought they were not coping well.

11.7 PCTs were also asked how they rated access to NHS dental care in their areas. Although half rated access as either good or satisfactory, half rated access as poor.
12. Collaborative fees

12.1 In 2006 the Review Body recommended that doctors should set their own fees for carrying out sessional work in the community health service and work under the collaborative arrangements.

12.2 We believe that it is particularly important that the provision of these services is maintained, particularly in relation to looked after and adopted children, disabled people and people with mental health issues.

12.3 PCTs have overwhelmingly commented that the fees and allowances should be centrally determined and have expressed concern that allowing doctors to set their own fees would make it difficult to monitor and manage the level of fees and the amount of expenditure.

12.4 We would ask that the uplift for these fees is once again recommended by the Review Body, and that the uplift for 2007/08, should not exceed the target for inflation.
13. Pensions

NHS pension scheme review

13.1 NHS Employers and the NHS trade unions announced jointly the proposals for changes to the NHS pension scheme on 1 August 2006. The formal consultation will run from 1 September to 30 November 2006. A copy of the consultation document ‘Moving to the future: the NHS pension scheme review’ can be found at www.nhsemployers.org/pay-conditions/pension-review.cfm

Background

13.2 The review of the NHS pension scheme in England and Wales began in 2003 and has been taken forward on a partnership basis between NHS Employers and the NHS trade unions. The review was set up in the light of changes to public service pensions proposed by the government.

13.3 The joint proposals have been developed following the Public Sector Forum (PSF) agreement between the public service trade unions and the government last October. The PSF agreed that current pension scheme members would keep their current normal pension age (60 for most members, 55 for members of the special classes). New entrants to the pension scheme would have a normal pension age of 65.

13.4 Negotiations since then have considered all aspects of pension provision for NHS staff in England and Wales. The changes that we are proposing are intended to increase the flexibility of the scheme for staff whilst ensuring the long term financial stability of the scheme. The review partners have also carefully considered the equality dimension in developing these proposals.

The proposals

13.5 The consultation document sets out proposals for two ongoing schemes: a new scheme for new entrants and the current scheme with improvements for existing members. The new scheme will be much more flexible, reflecting likely changes in work patterns that will accompany the increase in the pension age to 65. An existing scheme member will be able to choose to join the new scheme at a date to be agreed after the new scheme is set up.

13.6 A new tiered contribution rate structure will be introduced for both schemes. This is intended to be fairer as it relates contributions more closely to the benefits received. The new
contribution structure recognises that those on low salaries may be able to afford less in contributions but are still in need of a high quality pension scheme. It also increases the overall level of member contributions to pay for benefit improvements and helps the long-term sustainability of the scheme. Existing staff will move to the new contributions structure by April 2008 when the changes are introduced. New entrants will pay the new contribution rates when the new scheme is set up.

Funding issues

13.7 As part of the overall package, a new basis for dealing with future increases in scheme costs has been agreed. The Government Actuary is currently undertaking a valuation of the NHS pension scheme and the recommendations are likely to be implemented in 2008. The Government Actuary makes the funding valuation report independently and it is too early to say what the recommendations will be. However, our analysis suggests that the employer contribution rate in 2008 should not vary markedly from 14 per cent. It has been agreed that there will be a cap on employer contributions in 2004 and 2008 when the valuation result are implemented in 2008 and 2012 of 14.2 per cent. From the 2012 valuation to be implemented in 2016, the employer contribution rate will be capped at 14 per cent. A further agreed aim is to maintain employer contributions at or just above the 14 per cent level and employee contributions at the levels proposed until 2016. Reductions in the employer or employee contribution rate would therefore not arise. Any surplus as a result of this will be used to reduce any upward pressure on the member contribution rate.

13.8 When identifying the costs in the scheme that would be subject to the employer contribution rate cap, the basic principle would be that changes that increase the value of members’ pensions should be taken into account, but changes that do not directly affect the value of members’ benefits should not be. Risk factors relating to the way the scheme benefits are calculated under scheme rules demographic factors such as longevity, retention, pay progression, average retirement age, incidence of ill health retirement, all affect the value of the scheme to the membership and would be subject to the employer cap.

13.9 It is possible that in the future, the costs of the pension scheme might reduce. If this was to happen any reductions in the costs of the scheme would go to the member until the overall contribution rate returned to 20.4 per cent. Any subsequent reductions below 20.4 per cent would be shared on a 50 per cent employee 50 per cent employer basis as would any subsequent cost increases back to 20.4 per cent and the employer 14 per cent cap.
Next steps

13.10 The consultation period runs from 1 September to 30 November 2006. The review partners will consider responses before making recommendations to health ministers, who will make the final decision. After that, regulations will be laid to implement the new arrangements.

Pensions as a component of pay

13.11 NHS Employers agrees with trade unions that pensions are deferred pay. It is important that when considering appropriate levels of remuneration to look at both current and deferred pay. The proportion of pay currently deferred to pay for pensions is 20 per cent of pensionable payroll of which staff pay 6 per cent and employers 14 per cent.

13.12 The joint proposals on pensions are that employee contributions for most staff will rise from April 2008. However, the employer contribution is expected to continue at 14 per cent. The proposals provide that employee contributions will only increase to pay for increases in the value of members’ pensions. NHS Employers believe that increases in the proportion of employees’ deferred pay should not be taken into account when considering levels of pay increases.
14. Redundancy and early retirement compensation review

14.1 NHS Employers, in partnership with NHS trade unions, are carrying out the review on behalf of the Department of Health and the National Assembly for Wales. Subsequently NHS Scotland joined the review. Northern Ireland is conducting a separate consultation of the review proposals.

Current scheme

14.2 Current redundancy retirement arrangements are based on age thresholds; this means that staff will receive very different benefits according to their age.

14.3 The redundancy compensation regulations currently provide for employees between the ages of 50 and 65 to take early retirement and receive an enhancement of their pensionable service of up to 10 years (or what they could have achieved by working to the age of 65). This package can be worth nearly six times the annual salary to a member of staff. This does not apply to those aged under 50.

Proposed new arrangements

14.4 The review group are proposing one month’s pay per year of service up to a maximum of 24 months for all employees with at least two years qualifying service. This will avoid direct discrimination as the payment is related only to service not to age. It is our view that a priority for the NHS is to offer a package that recruits and retains staff. It was therefore felt appropriate to have a qualifying limit of 24 years.

14.5 The review group are also proposing an additional provision that enables staff over the minimum pension age, to opt to take early retirement on the grounds of redundancy without actuarial reduction in their pension, as an alternative to redundancy payment. This means the employer would pay the Pension Agency the cost of this from their redundancy payment and if any cash were left over it would be paid to the redundant employee.

Transitional period

14.6 The purpose of transitional arrangements is to provide a period of adjustment for staff potentially disadvantaged by the change in arrangements. The aim is to phase in any changes to redundancy packages over a period of time, so staff do not face a ‘cliff edge’ where entitlements suddenly vary and so the NHS
does not face increased costs in the transitional period between schemes.

14.7 Existing staff who are over the age of 50 and members of the NHS pension scheme will be entitled to keep existing redundancy arrangements, with the following amendments:

- Existing staff in the NHS pension scheme would have the choice to take the transitional protection or take the new redundancy arrangements.
- A five year transitional period

14.8 The total effect of the transition period means that after each year of the transition the maximum enhancement will have reduced by two years until no enhancement is available after 1 October 2011.

14.9 Additionally, the Department of Health announced an ‘underpinning guarantee’ that no member of staff made redundant before 30 June 2007 would receive less than they would have done if they had been made redundant on 30 September 2006. This existing protection must underpin any transitional arrangements agreed.

**Next steps**

14.10 Consultation ended on 11 September 2006. The proposed agreement is currently with the Department of Health. An update will be provided in due course.
ANNEX A

Evidence to Pay Review Bodies and Pay Negotiating Council 2007/08 Questionnaire
Seeking Views from Employers

This questionnaire is directed to Chief Executives and HR Directors of NHS organisations.

NHS Employers will be making submissions on the pay review process to the Doctors and Dentists Review Body (DDRB), the Review Body for Nursing and Other Health Professions (NOHPRB) in September 2006 for the 2007/08 pay round. We are also gathering material to support the Pay Negotiating Council process for 2007/08.

Last year was the first time that the views of employers across the NHS in England were represented to the pay review bodies by NHS Employers from a ‘whole workforce’ perspective. We were very pleased that the views of employers were reflected in the recommendations for the uplifts in 2006/07.

We received positive feedback from the review bodies on the written and oral evidence we presented. Review body members were particularly pleased to receive direct input from employers which provided a comprehensive picture, supported by evidence rather than assertion.

We envisage that employers’ evidence this year will take a similar shape to last year. In presenting an employer view on the general level of pay uplift, it will need to reflect the financial position facing NHS organisations. It will also contain updates on the impact of Agenda for Change, progress with contract negotiations on non-consultant career grades and other developments in medical pay. It will cover employer views on pay and workforce issues such as recruitment, retention and return. This evidence will be submitted on behalf of employers in England only.

This year we have included a separate section on issues which are specific only to PCTs, which includes questions on dentistry and salaried GPs.

The questionnaire gives service managers the opportunity to make their views known and to help us to provide sound evidence based argument. When responding we would ask that your responses reflect what the likely position for your organisation will be by April 2007 when the new rates of pay will become operational. We will collate responses received into a representative report that will be agreed by the NHS Employers Policy Board. We are required to make representations to the pay Review Body and the PNC in early autumn.

Your views are very important. Please consult with your networks locally to obtain as broad a consensus as possible. Please indicate on the questionnaire which organisation(s) the evidence has been submitted on behalf of:

Please complete this questionnaire on line by 21 July 2006

JUNE 2006
NHS EMPLOYERS EVIDENCE FOR THE PAY REVIEW
2007/2008

QUESTIONNAIRE SEEKING NHS EMPLOYER VIEWS

SECTION A

PRIORITIES FOR THE 2007/08 PAY ROUND

1. AFFORDABILITY/FINANCE

1.1. What level of pay uplift (excluding incremental steps) could be deemed affordable for 2007/08.

Percentage uplift  
(Please put % in comments box below)

or

Above inflation

In line with inflation

Below inflation

Please put your comments here

1.2. What would be the impact on services of a higher pay uplift than was deemed affordable? Please tick the top three examples below or specify others:

Reduction in capacity/growth

Impact on bed capacity

Reduction in quality of care

Reduction in posts

Vacancy freezes

Failure to meet targets

No impact

Please comment on the examples you have specified

2. DISTRIBUTION OF AWARDS

2.1. Do you think that the same level of uplift is desirable for both Medical and Dental and Agenda for Change staff?

Yes  Please go to Section B

No  Please go to question 2.2
2.2 If no, what value of award would you like to see?

- Consultants %
- Doctors in Training %
- Staff and Associate Specialists %
- Agenda for Change (Non-medical staff) %

SECTION B

AGENDA FOR CHANGE (non medical staff)

3. RECRUITMENT AND RETENTION

3.1 Has the recruitment situation improved or deteriorated over the last 12 months in your trust and what is the evidence of this?

- Improved
- Deteriorated
- Stayed the same

Comments/evidence

3.2 Which staff groups do you have the most difficulty in recruiting and retaining?

<table>
<thead>
<tr>
<th></th>
<th>No problem</th>
<th>Low Problem</th>
<th>Quite a problem</th>
<th>Major problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses, midwives &amp; health visitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td></td>
<td></td>
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<tr>
<td>Ambulance staff</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical support workers</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

3.3 If you indicated at 3.2 that your recruitment situation is ‘quite a problem’ or a ‘major problem’ for some staff groups please indicate any specific roles where there are problems.

3.4 Of the groups in 3.3 where you have indicated there is a problem what local Recruitment and Retention Premia (RRPs) or any other initiatives are you using to address this?

3.5 Is there a need to expand or reduce the categories of national recruitment and retention premia.

- Yes
- No

If yes please specify which ones.
3.6 We have a specific commitment to take a further look at the need for RRP\s for Building Craft Workers (i.e. Carpenters & Joiners, Painters & Decorators and Bricklayers)

Do you employ any of these staff groups?

Yes □
No □ - If no please move on to question 3.7

If yes are you paying local RRP\s?

Yes □
No □

If you are not paying local RRP\s are you having problems recruiting these groups of staff?

Yes □
No □

Please put your comments here.

3.7 Do you employ qualified maintenance craftspersons and/or technicians with full electrical, plumbing or mechanical craft\s qualifications?

Yes □
No □

If so has the addition of a National RRP made a difference to recruitment?

Yes □
No □

Please put your comments here.

3.8 Would you be willing to provide additional information to help with a review of national RRP\s?

Yes □
No □

3.9 Retention problems – what are reasons for staff leaving the service? Please indicate the three most common reasons.

Other NHS employers □
Retirement □
Work in private health sector □
Reconfiguration □
4. AGENCY STAFF

4.1 Has your use of bank and/or agency staff changed over the last 12 months?

<table>
<thead>
<tr>
<th></th>
<th>Less Use</th>
<th>About the Same</th>
<th>Increased Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2 If at question 4.2 you indicated an ‘increased use’ of bank and agency staff, please indicate which staff groups this applied to?

5. HIGH COST AREA SUPPLEMENTS

5.1 Do you think the existing High Cost Area supplements are set at the correct level?

<table>
<thead>
<tr>
<th></th>
<th>Too low</th>
<th>About right</th>
<th>Too High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner London – (20%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer London – (15%)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fringe – (5%)</td>
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</tbody>
</table>

5.2 Do you feel that there is a need to extend the geographical coverage of High Cost Area payments?

Yes □

If yes please state what areas you feel should be included and why

No □

6. MORALE/MOTIVATION ISSUES

6.1 Has morale improved or deteriorated over the last 12 months? What evidence of this is there?

6.2 Is there evidence of improvements from the Improving Working Lives initiative? Please describe the initiative and the effect on staff.
6.3 What other non-pay solutions are working? E.g. changes to terms and conditions of service such as reduced hours or extended leave.

SECTION C:

MEDICAL AND DENTAL

7 RECRUITMENT AND RETENTION

7.1 Do you have any difficulties recruiting and retaining doctors?

Yes [ ]
No [ ]

If yes, in which speciality and grade.

7.2 Are you paying any recruitment and retention premia to Consultants?

Yes [ ]
No [ ]

If yes, in which speciality (ties).

8 TEMPORARY MEDICAL STAFF

8.1 Has your use of locums and agency staff changed over the last 12 months?

<table>
<thead>
<tr>
<th></th>
<th>Less Use</th>
<th>About the Same</th>
<th>Increased Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locum Agency</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

9. LONDON WEIGHTING

9.1 Do you think that the London Weighting payment should be uplifted in line with the general award?

Yes [ ]
No [ ]

10. MORALE/MOTIVATION ISSUES

10.1 Has morale improved or deteriorated over the last 12 months? What evidence of there is this?


10.2 Is there evidence of improvements from the improving Working Lives Initiatives, for GP flexible levers and returners scheme?

10.3 What other non-pay solutions are working? E.g. changes to terms and conditions of service such as reduced hours or extended leave.

SECTION D

OTHER ISSUES

11. EVIDENCE OF BENEFITS FROM PAY MODERNISATION

11.1 Have you been able to introduce new working practices as a result of pay modernisations?

Yes ☐
No ☐

If yes please provide examples and a contact name for more information

11.2 Have you noted any improvement in productivity/service quality as a result of pay reform?

Yes ☐
No ☐

If yes please provide examples and a contact name for more information

12. ORGANISATION TYPE

12.1 Please indicate type of organisation

Acute ☐
Ambulance ☐
Care ☐
Combination of organisation e.g. HR network ☐
Mental Health ☐
PCT ☐
SHA ☐

12.2 Are there any specific issues for Foundation Trusts?

Please add your comments here
12.3 Are you a Foundation Trust?

Yes ☐
No ☐

13. OTHER COMMENTS

13.1 Please add below any other comments

__________________________________________________________________________
__________________________________________________________________________

Thank you for taking time to fill in the questionnaire, would you be happy to be contacted for further research?

Yes ☐
No ☐

This evidence is submitted on behalf of:……………………………………………….
………………………………………………………………………NHS Trust/SHA or network

Contact Name: Position:

Telephone Number: email:

For PCTs only please continue at Section E
SECTION E

PCT SPECIFIC QUESTIONS

14. EMPLOYED GPs

14.1 Pay range for employed GPs – is the current range adequate/appropriate?

Yes [ ]

No [ ]

Can you provide evidence to support its use?

15. GP RECRUITMENT

15.1 What is the effect of the Primary Care development scheme on GP recruitment?

16. COLLABORATIVE FEES

16.1 In its 2006 report, the DDRB recommended that Doctors should set their own fees for carrying out sessional work in the community health service and work under the collaborative arrangements. The Department of Health has not yet responded to the recommendation.

Have you any comments to make on the practical effects of this recommendation for your PCT?

17. DENTISTRY QUESTIONS

ON PREPAREDNESS

17.1 PCTs have been responsible for commissioning NHS dental care services since April 2006. How do you feel you are coping with this new responsibility?

(Please √ one category)

Well (the commissioning role is going well, and there have been no major issues or areas where information is lacking to allow the role to be performed effectively)

Satisfactorily (the commissioning role is being performed, but there are some issues or areas where information is lacking and these are being overcome)
Not so well (significant help is needed to do with the commissioning role)

☐

ON ACCESS

17.2 We are interested in the views on the level of access to NHS dentistry in your area, ie how easily can patients access NHS dental care. How would you rate access to NHS dental care in your area?

(Please √ one category

Good (there are enough NHS practices in the area for the demand, and patients can access a NHS dentist easily)

☐

Satisfactory (there are enough NHS practices, but some expansion may be needed in areas)

☐

Poor (there are not enough NHS practices in the area for demand, and it is difficult to find a NHS dentist)

☐

Thank you for taking time to fill in the questionnaire, would you be happy to be contacted for further research?

Yes ☐

No ☐

This evidence is submitted on behalf of:.................................................................

.................................................................NHS Trust/SHA or network

Contact Name: Position:

Telephone Number: email:
NHS Jobs

Background

A major new development in assisting the recruitment of staff into the NHS has been NHS Jobs. NHS Jobs is the electronic recruitment service for the NHS. It is managed by NHS Employers through the NHS Jobs team.

Over 80 per cent of the 648 employers registered use NHS Jobs as their primary source for candidate attraction. Popularity of the service is increasing daily as trust realise the benefits that can be derived through using NHS Jobs. It is now one of the UK’s top five internet recruitment sites, attracting over 50,000 visitors every day.

The Benefits Realisation Survey – January 2006

During January 2006, the NHS Jobs team conducted a benefits realisation survey. Key financial savings and productivity gains were identified for trusts using NHS Jobs:

It found that one-third of NHS Jobs users (approximately 200) in this group, showed half-yearly savings of £6.8 million.

Recruitment advertising spend was the largest saving area with an estimated £5.7 million saved, recruitment administration and temporary staffing spend estimated savings were £0.5 million each.

If such success was replicated across all registered users, the NHS could save an estimated £40 million per year for the effective use of the online recruitment service.

Trusts have made significant achievements through NHS Jobs:

- Savings made have been directed and spent on patient care and used towards the trust’s financial recovery plans.
- Trusts have demonstrated that they are able to attract a wider audience compared to traditional media solutions and it provides quality candidates.
- Examples of the source of these savings are: no longer needing to operate 24-hour recruitment lines, print and mail application packs and photocopy information.
- A trust reported; “it has been quicker for us to advertise posts, producing a time benefit in preparing and mailing out application packs. Savings have been used to offset the PCT’s overall cost deficit”. A further trust reported; “Savings made will have gone back into the front line to spend on patient care”.

63
Benefits for employers

Employers reported a number of benefits as a result of using NHS Jobs:

Showcasing the NHS as a modern, model employer, adopting best practice in line with NHS values, a trust reported; “NHS Jobs enables the trust to create a profile as an employer of choice”.

- Wider pool of potential applicants; “The e-recruitment facility increases the pool of applicants and competencies to choose from for each post”.
- Linking local vacancies to national recruitment advertising campaigns; a trust reported; “It has been useful to be able to promote the website at our local Job Shop and encourage applicants to search and apply for appropriate jobs online”.
- Reduces the resources needed locally to support recruitment and speed up the process; a trust reported; “The process has been speeded up as a result of not having to use advertising agencies, which has significantly reduced the amount of administration time spent. For example, it is quicker to post jobs on NHS Jobs than to liaise with advertising agencies, which can sometimes take weeks when negotiating fees and publication cut-off dates”.
- Improve the quality and quantity of management information to aid decision making and planning. A trust reported; “Information from the service has allowed us to effectively monitor and issue reports on equal opportunities and report current recruitment activity in requested areas”.

High employer satisfaction

In a separate survey conducted during February and March 2006, employers were asked for their opinions on the effectiveness of NHS jobs and their satisfaction with it. Key findings were:

- Overall feedback was overwhelmingly positive with 92 per cent out of 200 respondents in a recent user survey reported that they were highly satisfied with the service.
- A significant measure of success of NHS Jobs is the volume and quality of candidates attracted to the site (three quarters of respondent said they were very pleased with both) and cost savings.
Benefits to candidates:

With currently nearly 1 million candidates now registered on NHS Jobs, its profile and popularity is ever increasing.

- It was voted by candidates as the ‘best employer website’ in the 2005 National Online Recruitment Awards.
- It provides a ‘one-stop shop’ for information about jobs in the NHS.
- Candidates have the ability to ‘drill down’ to local web sites for further, more detailed and specific information;
- Candidates can complete one job application form, on-line and be tailored to suit multiple job applications.
- Candidates can also set up optional daily email job alerts notifying them of new vacancies matching their search criteria.

Service improvements

NHS Employers has overseen a number of enhancements to the service designed to address the everyday issues faced by those trying to recruit frontline NHS staff, including improvements to the application form, devolved recruitment and filtering questions. One of the main changes is the creation of an innovative restricted jobs and accounts package, which provides a robust technical solution to manage organisational change and restructuring projects. This is currently being utilised for the reconfiguration of the NHS through Commissioning a Patient Led NHS and Taking Healthcare to the Patient: Transforming the NHS Ambulance Services. All of these were developed in response to feedback and consultation with the user community and NHS Jobs will continue to develop the service through this mechanism.

NHS Jobs is also working closely with the NHS Electronic Staff Record team to ensure that the technical interface of the two system work together to provide a full recruitment cycle to the NHS.