NHS EMPLOYERS’ SUBMISSION TO THE DOCTORS’ AND DENTISTS’ PAY REVIEW BODY 2019/20

7 January 2019
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Key messages

Introduction

- The view of employers remains that pay must always be considered in the context of long-term objectives; the future system and service operating model; and the reward and workforce strategies required to support this. Future annual changes in pay can therefore be used to support the long-term vision.

- In our response to the government’s announcement on medical and dental pay for 2018/19, we said that while we welcomed the steady progress towards ending the cap on earnings for NHS staff, employers would need assurances around how such awards could be fully funded in future.

- Without those assurances, employers will be faced with finding ways of meeting a significant increase in their pay costs through other means, which could ultimately compromise the level and quality of care that they are able to provide to their patients.

The financial challenge

- We continue to experience one of the most challenging periods for the health and care systems in the UK.

- We have just gone through the most significant squeeze on NHS funding since the NHS was formed 70 years ago. Those who are running these services, and those who are having to deliver on the front line, are being called upon to meet unprecedented levels of demand, not only with constrained funding but with significant and growing staff shortages.

- The NHS can only succeed if it is given sufficient resources and, just as importantly, if it is able to transform the way services are delivered. This transformation does also rely on investment in other public services, particularly social care. The deteriorating financial position of these services, and the failure to publish the long-awaited green paper for social care, present significant strategic risks for the NHS and our communities.

- The financial outlook remains challenging, even with the confirmation announced by the government on the long-term financial settlement. While the
additional investment is welcomed, it is not enough. It falls short of what is required and will restrict the ability of the NHS to invest in the real transformation of NHS services.

- *Securing the future*, a report by the Institute of Fiscal Studies and the Health Foundation (commissioned by the NHS Confederation) said that spending on healthcare will have to rise by an average of 3.3 per cent over the next 15 years just to maintain current service provision and by at least 4 per cent if services are to be improved. At the same time, social care funding will need to increase by 3.9 per cent each year to meet the growing needs of an ageing population and the increasing number of younger adults living with disabilities.

- The restrictions on funding in social care have a negative impact on NHS services, for example in the number of admissions to hospital.

### The workforce challenge

- Workforce shortages are the biggest challenge the NHS faces.

- The recently published summary report from the Health Foundation *The healthcare workforce in England - make or break*, sets out the issues being faced by employers in the face of mounting pressures associated with the workforce. It is now accepted that that the workforce challenges in the NHS represent an even greater threat to the delivery of health services than funding challenges.

- A new and coherent workforce strategy is required, but it must be fully funded. The current gaps in clinical staffing remain significant impediments to employers in the NHS in terms of their ability to deliver improved quality and transformation of patient care in a system facing significant rises in demand for services.

- It is essential that workforce costs are sustainable to enable employers to meet the quality and transformation challenges that the NHS faces. The cost of staff will remain central to efforts to manage budgets, further improve efficiency and transform services.

- If we are to develop a sustainable workforce with the right skills, long-term workforce planning and talent management must be a priority. This planning

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1 Local clinical excellence awards guidance 2018-21. NHS Employer, July 2018

2 Securing the future: funding health and social care to the 2030s. NHS Confederation, May 2018
must take place at a larger scale than individual organisations to better plan and develop the talent in the system.

- The current direction is towards more services being provided through better integrated out-of-hospital care, based on primary, community and acute care systems working more closely together with partners in other public services and, most especially, social care.

- Our members support this strategic direction, but there is a concern to ensure that the roles in these community settings are equally valued and recognised.

- Employers recognise and are working to address generational challenges in the workforce linked to changing attitudes to work, by providing more opportunities for flexible working and portfolio careers.

The transformation challenge

- NHS leaders recognise the challenge in changing how care is delivered to ensure patients receive the right care, in the right place, first time.

- NHS services will also need to change if we are to make the best use of new technology.

- Some new technologies will fundamentally change the way NHS staff work and will require the creation of new roles, for example in genomics, precision medicine, the provision of hospital-level diagnostics in the patient’s home and technology-supported self-management. Data can provide new ways for the NHS to learn, improve and generate new research. Artificial intelligence is already providing new analytical capacity for diagnosing patients, effective triage and logistics. We await with interest the report commissioned from Dr Eric Topol, which is due in February 2019.

- Successful transformation will depend on how we treat and involve staff. Change will be more likely to happen if staff understand and have ownership, and that they feel an integral part of the process.

- Transformation of NHS services will require NHS organisations to operate increasingly at a more system-wide level, working more closely with other public service providers. We expect this approach to service delivery to be re-enforced as part of the direction set out in the long-term plan.
Contract reform

Doctors in training

- Good progress has been made in implementing the 2016 contract.
- We are now in discussions with stakeholders to review the contract in line with the commitment made in the 2016 Acas agreement.
- Under the auspices of Acas, the British Medical Association (BMA) and NHS Employers have agreed to enter into a formal collaborative bargaining process to jointly review the efficacy of the contract and negotiate any changes necessary to address areas for improvement identified as part of that process.
- The review sub groups will deliver reports to the Joint Negotiating Committee (Juniors) early in the new year to inform negotiations between January and April 2019 on changes to the contract, with a view to reaching a collective agreement with the BMA after consultation with its members.
- We will provide updates on the progress of this activity in advance of and during our oral evidence session.
- The BMA remains formally in dispute with government over the way that the new contract was introduced, and so has not collectively agreed the terms under which most doctors in training are now employed. However, NHS Employers and the BMA have entered into constructive discussions to ensure a smooth implementation of the new contract in the interests of both trainees and employers.

Consultants

- In the latter half of 2017, the negotiation parties agreed to prioritise activity on contract reform to focus on reaching an interim agreement on arrangements covering employer-based local clinical excellence awards.³

³ Local clinical excellence awards guidance 2018-21. NHS Employer, July 2018
Negotiations on the wider aspects of contract reform were deferred until the government’s response to the review body’s 46th report (July 2018) was known. The government’s response to the recommendations on pay was not well received by the medical trade unions.

As a result, the medical trade unions have been considering their approaches to any future engagement in a negotiations process, as well as their approach to and participation in future pay review body annual pay rounds.

We remained optimistic that with the government’s response and commitment to future negotiations on a multi-year pay deal from 2019/20, this would provide the basis on which to formally re-enter negotiations with the medical trade unions on delivering wider contract reform.

In October, the Department of Health and Social Care (DHSC) confirmed the pay settlement envelope available to support negotiations for reform of the consultant contract over the next three years.

The BMA’s response is that it is not in the best interests of its members to continue contract negotiations within that pay envelope position.

The BMA will now be consulting its members to explore other options to attempt to secure an improved offer.

This decision by government on the pay envelope has effectively stalled any further negotiations on consultant contract reform.

Specialty and associate specialist (SAS) doctors

Health Education England (HEE) has been developing a strategic approach to SAS development. The strategy will include recommendations to raise awareness of SAS doctors and mechanisms to ensure they are effectively developed, supported and deployed to deliver high quality patient care.

One of the key recommendations within the strategy is for HEE and NHS Improvement (NHSI) to work with NHS Employers to help support providers to implement the SAS Charter and gain a greater understanding of the barriers that prevent providers from being able to do so.

The Secretary of State wrote to the BMA in September 2018 to say that he wanted to see the valuable role of SAS doctors recognised in their contract arrangements, and in the development and support they receive. He also made a commitment to look at introducing new contract arrangements for a
new ‘associate specialist’ grade soon. This reflects a shared aim across the parties to establish SAS as a positive career choice and maximise the role of this group within the medical workforce.

- NHS Employers is planning to undertake scoping work with employers early in the new year to see how this direction links to the long-term plan, SAS strategy and any wider reform agenda for the SAS grade. We are awaiting confirmation of a formal negotiating remit from the DHSC and any negotiation process is likely to commence at the earliest from March 2019.

**Targeting pay**

- The review body has been asked to consider targeting pay for the medical workforce staff groups.

- In respect of doctors in training, this would mean either extending the current flexible pay premia or establishing new premia to address geographical challenges.

- We are not convinced that there is a sufficiently well-developed evidence base to justify targeting pay in this way at this point in time, particularly within the limitations of the current pay envelope. Our survey of employers showed that 74 per cent of those who replied favoured a flat-rate pay increase for all staff.

- We believe that further and more comprehensive work is needed to understand the full range of factors that influence the career decisions of doctors in training. This would include reviewing the historic position and seeking the views of employers, staff and others to develop sustainable, long-term solutions that might include options other than simply targeting additional pay. We will work proactively with other stakeholders including HEE and NHSI to better understand key issues for this group of medical staff and we will share these with the review body in due course, including any views on whether options around a targeted approach to pay are supported by evidence.

- Following the remit set by the Secretary of State, it was asked that evidence should address the issue and option of targeting pay in respect of consultants, particularly to support increased productivity. Since discussions on contract reform, and the role of pay in supporting reform, have stalled, we do not believe that there is evidence currently available to justify any specific targeting of pay for consultants at a time when retaining engagement of this
key staff group remains a priority in supporting service delivery and transformation.

- In view of the 3 per cent pay award from October 2018, and the proposal to open a new specialty doctor grade, we do not believe that any additional targeting of pay within specialty doctor and associate specialist grade is required. The future approach to pay for this staff group will be part of the planned discussions, and any future negotiations process, and not treated in isolation.

- There is also no evidence to support targeting pay for salaried primary care dentists.

- Salaried GPs are paid within a range set by the review body at an amount determined by the employer considering criteria set out in the salaried GP terms and conditions. We have no evidence to suggest that pay should be specifically targeted at salaried GPs.
Informing our evidence

Introduction

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England for the 2019/20 pay review. We continue to value the role of the Doctors’ and Dentists’ Pay Review Body in bringing an independent and expert view on remuneration issues in relation to the medical and dental workforce.

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

   - had direct discussions at one-to-one meetings with NHS chief executives
   - maintained regular contact with HR directors
   - attended regional network meetings of human resources directors, the NHS Confederation and other employer networks
   - engaged the NHS Employers’ medical workforce forum
   - carried out a brief survey of employers
   - undertaken detailed engagement work with employers on matters including SAS development, the role of the medical associate professions, the 2018 junior doctor contract review, and the consultant contract.

3. In his letter of 21 November 2018, the Secretary of State for Health and Social Care asked the review body to consider targeting awards to support recruitment and retention to support productivity and we have addressed those issues in this submission.

The financial challenge

4. In our response to the government’s announcement on medical and dental pay for 2018/19, we said that while we welcomed the steady progress towards ending the cap on earnings for NHS staff, employers would need assurances around how such awards could be fully funded in future.

5. Without those assurances, employers will be faced with finding alternative ways of meeting a significant increase in their pay costs, which will ultimately compromise the level and quality of investment in services that provide care to patients.

6. The government’s funding settlement for the NHS was also broadly welcomed, with independent commentators noting that it was a lot more than had been
provided in recent years and that it formed the foundation of a five-year deal that would help to provide a degree of medium-term stability on which to base future plans.

7. Importantly, however, the increases proposed for the NHS fall below the minimum that many have argued is necessary to modernise and improve services in the future. The Health Foundation has estimated that the provider sector started this financial year about £4 billion behind in underlying terms - that is, their predictable recurrent income is £4 billion less than their predictable recurrent costs. They also point out that while the cash increase for the new settlement is worth 5 per cent in cash terms, NHS inflation is running at around 3 per cent. Factor in an increase in demand of 3 per cent and the result is a 6 per cent pressure against a 5 per cent cash increase each year.

8. NHS Improvement (NHSI) confirmed the extent of the underlying deficit in its report on the performance of NHS providers to the quarter ended 30 June 2018, including with a planned deficit of £519 million for the year 2018/19. They acknowledge that operational and financial performance is under severe pressure but that the long-term plan for the NHS is an opportunity to build a system response to the challenges ahead. However, they also warn that this would need to be based on strong delivery in the current year.

9. Despite the sustained hard work of staff, the provider sector ended 2017/18 with a deficit of £960 million. In its report on the performance of the NHS provider sector for the year, NHSI concluded that providers would need to move away from a reliance on non-recurrent efficiency savings to identify savings that were recurrent and long term.

10. Additionally, NHSI pointed out that significant opportunities remain for improving efficiency and quality and that providers and local health systems will need to tackle this in 2018/19 and beyond. However, as we discuss later in this submission, the capacity for organisations to do so is constrained by the pressing workforce and service delivery challenges they also face.

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5 Performance of the provider sector for the month ended 30 June, NHS Improvement. July 2018

11. The financial position is more acute when adjustments are made for rising demand from a growing and ageing population. Overall increases in funding are offset when population growth and the impact of an ageing population with complex health needs are considered. The Health Foundation has estimated that the 3.4 per cent average increase in NHS funding falls to 2.8 per cent on average when taking into account the impact of an ageing population, who use approximately four times as much acute hospital care as those of working age.\(^7\) The National Audit Office has estimated that funding per person, once adjusted for age, will fall by 0.3 per cent in 2019/20.\(^8\)

12. Additional cost pressures also arise as the result of rising expectation and the demand for quicker and better-quality services, including new technology and drugs. And, of course, NHS pay itself can exert additional pressure if any unfunded pay increase is not linked to productivity improvements.

13. Instead of providing the assurances that employers require around additional funding for pay, the current financial position suggests that employers will once again be forced into making difficult choices as they strive to attract, recruit, retain and engage the staff necessary to deliver the services that patients need.

14. We therefore firmly reiterate our strong views that that all pay award investment must be fully funded.

**The transformation challenge**

15. As part of the funding settlement, the government has set several financial tests to ensure that the NHS is doing its part to put the service onto a more sustainable financial footing. These include:

- improving productivity and efficiency
- eliminating provider deficits
- reducing unwarranted variation in the system to ensure consistently high standards
- improving management of demand
- making use of capital investment

16. However, this needs to happen within a service that is already under considerable strain. Productivity in the NHS has grown by an average of around 1.4 per cent a year since 2009, and at a better rate than the economy in general. One of the assumptions within the productivity test above is that productivity should continue to grow at a similar rate over the next five years.

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\(^7\) Health and Social Care Committee. Health Foundation written evidence, 19 July 2018.

\(^8\) National Audit Office. Sustainability and transformation in the NHS, January 2018.
This will be particularly challenging as, up to now, considerable savings have been made as the result of a sustained period of pay restraint.  

17. Employers are continually looking at the most effective way of delivering services given the financial and workforce pressures they currently face. The NHS Confederation’s report *System under strain – why demand pressures are more than a winter phenomenon* describes how some employers have looked to change how they provide services to increase efficiency. This demonstrates what health and social care providers can achieve when they work across traditional organisational boundaries to tackle demand pressures. Additionally, sustainability and transformation partnerships and integrated care systems can enable such innovations across health economies.

18. However, implementing such improvement initiatives at scale and pace requires staff to have the time and space to do so, and often pressing financial or service demands prevent them from doing this. This can be exacerbated further by workforce shortages which limit the ability of staff to lead and implement transformation and improvement initiatives – particularly the clinical engagement which is so important in securing effective change.

19. At the same time, concentrating on improving productivity while not focusing on the needs of staff can result in reduced morale and problems with retention. Yet, too much flexibility in a seven-day NHS can mean that patient care is inconsistent.

20. The National Audit Office (NAO) found that some of the measures the NHS took to rebalance its finances in 2016/17 restricted the money available for longer-term transformation. The NAO pointed out that local transformation of care was hampered by lack of resources and that it was difficult for local partnerships to shift focus from day-to-day pressures. It concluded that extra funding in 2016/17, that was intended to give the NHS breathing space to manage on significantly less resources, had been spent largely on coping with current pressures rather than the transformation needed to put the health system on a sustainable footing.

21. Speaking after the announcement on NHS funding, the then Secretary of State said that he was sympathetic to the potential of ring fencing transformation funding. He said:

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9 *The NHS ten-year plan: how should the money be spent. The Kings Fund, July 2018.*

10 *System Under Strain. NHS Confederation. June 2018*

11 *National Audit Office. Sustainability and transformation in the NHS, January 2018.*
“Transformation funding is also important because when the five-year forward view was published, pressures in secondary care and the acute sector meant that a lot of transformation funding was sucked into the hospital sector and we were not able to focus on the really important prevention work that can transform services in the long run.”

22. With NHS organisations facing almost year-round pressure to deliver the services that patients need, the time, space and resources required for service transformation are becoming much harder to find. As NHS England and NHS Improvement commented in a recent joint board paper: ‘The operational pressures in the provider sector combined with a high level of vacancies have impacted on the provider sector’s ability to deliver the planned level of efficiencies.’

The workforce challenge

23. The current Secretary of State has said that, along with technology and prevention, workforce is one of his top priorities.

24. We also know that workforce issues are foremost in the minds of employers in the NHS. However, as NHSI has acknowledged, even if additional money is made available, if the NHS cannot recruit and retain the doctors and other staff that are needed then it will not be able to deliver the improvements in care that everyone would wish to see. The NHS Confederation surveyed chief executives and chairs across member organisations. Staff recruitment and retention was the issue most frequently selected as an immediate pressure facing the NHS, with 80 per cent of leaders citing it. The second most significant issue was increasing demand (67 per cent), followed by provider deficits (47 per cent).

25. NHSI data reflects the scale of the challenge that employers face. At the time of reporting, the NHS has around 103,000 vacancies and this number is forecast to increase during 2018/19. As at 30 September 2018, there were over 9,000 whole-time equivalent (WTE) medical posts vacant, with 85 per cent of these filled by a combination of bank and agency locum staff. This has contributed to a significant year-to-date overspend on pay in the acute sector of £483 million. This reflects operational pressure and has resulted in increased spend on agency and locum bank staff so that trusts can manage workload in the face of increasing demand, high vacancy levels and high levels of sickness and staff

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12 NHS England board meeting papers, July 2018

13 Letting local systems lead, NHS Confederation, November 2018.
turnover. 14

26. The impact of unfilled vacancies at this level is felt in different ways, each of which present their own challenges. These include:
   - the impact on services and patients
   - the additional pressure on existing staff and the subsequent impact on morale, health and wellbeing
   - the additional unplanned expenditure on agency and locum staff.

27. There are a similar number of unfilled vacancies in the social care sector, which is also facing the twin challenges of funding and workforce. Around 11 per cent or £13 billion of the health budget is spent on non-NHS providers, including services delivered by local authorities. The long-term plan for the NHS must recognise the critical interdependencies between the health and social care sectors and promote and support integration.

28. The workforce pressures that the NHS currently faces require a long-term and sustainable workforce strategy, and we welcome the imminent arrival of the ten-year workforce plan which, combined with a longer-term funding settlement, will help employers make longer-term plans. This should also ensure that there is a clear link between any future service priorities and the workforce needed to deliver them.

29. The workforce will remain an important enabler of improvement. The plan provides an opportunity for the NHS to think about how it makes the best use of the skills and experience of its workforce to deliver care in a better way for patients. It is a chance to look at how we make the NHS a better, more inclusive place to work, which attracts and retains more staff.15

30. Recent research by the General Medical Council found that 56 per cent of doctors were examining other career options and 25 per cent had already cut their hours or had gone part time. A further 21 per cent were considering going part time, 15 per cent were thinking about taking retirement and 12 per cent considering practising abroad16. Pressure on doctors resulted mainly from staff shortages and a rising number of patients.

31. We welcomed the government’s commitment to a 25 per cent increase in the number of medical school places, although we acknowledge that it will take some time before these new doctors are in place. The NHS therefore needs to

14 Performance of the provider sector for the quarter ended 30 September 2018. NHS Improvement, 2018
15 Developing the long-term plan for the NHS in England. NHS England, August 2018
16 The state of medical education and practice in the UK. General Medical Council, November 2018
do more to attract and retain the existing workforce and develop new roles and professions to help meet the current workforce challenges.

32. While there is pressure on domestic workforce, both in terms of the unfilled vacancies that currently exist and the resultant pressure that falls upon the existing workforce, it is imperative that employers remain able to recruit staff from overseas to continue to provide high-quality care for patients. The risk is that without the staff to deliver it, some of the additional money to support NHS frontline activity will go unspent.17

33. Despite this, we note that medicine remains a popular career choice. Data supplied by the University and Colleges Admissions Service (UCAS) shows that applications for courses in medicine are up by 8 per cent overall, with a 12 per cent increase in applications from candidates based in England.18

34. The Nuffield Trust’s report *Caring for acute medical patients in smaller hospitals* revealed that the most immediate and visible challenge to acute medical care is that of staffing. Nearly all the hospitals surveyed were dependent on locum staff to support senior medical rota, although there was some variation. In acute medicine some sites are totally reliant on locum acute physicians, whereas others had no vacant posts. The report also notes that in some trusts some specialties have started to withdraw from the on-call rota, thus increasing the pressure on existing staff and increasing the incentive to leave the rota.

35. As a divisional director of medicine commented in the report: ‘There are challenges in using so many locums because when you’re wanting to embed improvements, it becomes quite a challenge if the majority of your consultant staff are transient.’19

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17 *The healthcare workforce in England. The King's Fund, Health Foundation and Nuffield Trust, November 2018*


19 *Acute Medical Care in England. The Nuffield Trust, 2018*
Workforce supply

36. Despite the easing of pay restraint and the efforts to increase supply and improve retention in core areas of the NHS workforce, there are clearly other issues in the health and social care sector that need to be addressed.

37. Providers of care and services are continuing to experience increased demand combined with challenging workforce shortages. Often this demand can change faster than employers are able to increase supply and it is not possible to respond in a timely way to workforce gaps through training more people.

38. It is also worth noting that we only expect this demand to increase. The draft workforce strategy highlights that if no action/no service redesign takes place, the NHS will need to grow by 190,000 clinical posts by 2027 to meet expected demand.20

39. The Migration Advisory Committee’s (MAC) shortage occupation list, which is currently under review21, published by UK Visas and Immigration (UKVI)22, reflects some of the professional supply shortages in the NHS and includes medical practitioners in consultant radiology, emergency medicine and old-age psychiatry.

International recruitment

40. Alongside the need to increase the skills base within the UK’s domestic labour market, the political narrative around managing and reducing migration continues to intensify, particularly in relation to Brexit and what this means for EU citizens wishing to remain living and working in the UK.

41. The change to the immigration rules in June 2018, so that applications for doctors and nurses can now be managed outside of the immigration cap, was greatly welcomed by the NHS. Between December 2017 and June 2018, the NHS experienced significant delays in doctors being able to start work due to the extreme pressure being placed on the immigration system. This was of huge concern to employers who had worked hard to recruit doctors only for posts to remain unfilled, adding to the pressure on existing staff. We also welcome the recent proposal to expand the number of doctors able to come to the UK through the medical training initiative.

42. The NHS benefits by employing talented international doctors not just in terms of their expertise, but also in places that have not been able to attract suitable

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20 Health Education England (December 2017), Facing the facts, shaping the future p.9
21 Gov.uk (Nov 2018), Shortage occupation list 2018 call for evidence
22 Gov.uk (Nov 2018), Immigration rules appendix K: shortage occupation list
trainees. These posts would either have remained unfilled or would be covered by expensive locums. In the short term at least, we will need to rely on international doctors to help us deliver services as demand rises, to complement our homegrown talent and the expansion of medical schools.

Implications of Brexit

43. Around 9 per cent of doctors and 16 per cent of dentists are from the European Economic Area (EEA). The decision to leave the EU has had a clear effect on the health and social care workforce.

44. Since July 2016, NHS Employers together with NHS Providers and The Shelford Group has carried out a quarterly survey of NHS organisations on the impact that Brexit will have on recruitment and retention of staff from the EU. The full survey results for the first 12 months of data are available on the NHS Employers website.23 The series of surveys provide an indication that two years on from the referendum vote, employers feel that the decision to leave the EU has had a negative impact on their workforce and there are fewer employers with plans to recruit from the EEA due to the continued uncertainty.

45. The number of EEA-registered doctors has fallen. In 2012, there were 22,967 registered EEA doctors. In 2017, this figure stood at 21,609, seeing a 5.9 per cent reduction.

46. Details on the Home Office settlement scheme24, the success of the first pilots and its practicalities for EU citizens, have gone some way to reassuring employers and their EU staff.

47. The system that is in place after the UK leaves the EU will need to ensure that, alongside the strategy to increase domestic workforce supply, it supports the ability of our sector to provide the best care to our communities. It will need to secure clear and reasonable routes to immigration and it must be flexible enough to allow health and social care employers to recruit appropriately from outside of the UK to fill workforce shortages and maintain services.

48. NHS organisations also need to ensure that the UK remains an attractive place to live and work for both EEA nationals and colleagues from across the world.

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23 NHS Employers (February 2018) Brexit one year on
24 Gov.uk (June 2018), Home Office publishes details of settlement scheme for EU citizens
Medical associate professions

49. One response to the workforce challenge has been the emergence of new and extended roles working within multi-disciplinary teams. We have been working with HEE to raise awareness among employers of the medical associate professions as increasing numbers of students are progressing through training. These include physician assistants, physicians’ associates (anaesthesia), surgical care practitioners and advanced critical care practitioners. Each medical associate professional is trained to provide patient care under the supervision of a doctor. With the right training, management and working conditions, their presence in the workforce can release time for doctors to focus on more complex patient issues.

50. For many within the health service, the future of workforce deployment lies in greater use of multi-disciplinary teams to treat increasingly complex, long-term conditions.

51. In a report by the Workforce Development Expert Group, Dr Chris Streather, group chief medical director of the Royal Free Hospital, said: ‘In the long-term we need to look at innovation both in medical careers and creating new roles – having jobs that are traditionally done by doctors, done by other people. If we don’t do that we will get into difficulties. The elective environments are those where it is safer to try new things in terms of organising the workforce. For instance, we can bring in people who are the surgical equivalents of physician associates. A lot of urgent primary care provided in A&E can be delivered by pharmacists.'

52. Although these roles can benefits patients, staff and employers alike, they need to be fully embedded within the existing workforce. A recent BMA survey showed that while 47 per cent of doctors approved of recent trends in expanding the non-medical clinical workforce to ease pressures (27 per cent disapproved), there were some concerns around accountability and that they would be a cheaper alternative to doctors and undermine recruitment.

53. Employers therefore have a vital role to play in ensuring that they have planned and modelled their workforce strategically and that their incentive for introducing new or extended roles into the workforce is to improve service delivery and patient experience.

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25 https://beyondtheroster.co.uk

26 BMJ 2018; 362: K4001
Bullying and harassment

54. In previous reports, the review body has expressed concern about the extent of bullying and harassment experienced and reported by doctors and dentists at all levels. We have also noted the BMA’s survey of doctors in which respondents commented on the extent of bullying and harassment and the underlying causes. We cannot expect any of our staff to want to work and provide excellent care if they feel bullied, disadvantaged or unsupported.

55. As well as the impact of bullying and harassment on individual members of staff, there is also a wider cost to organisations and the NHS more generally. This affects organisational effectiveness because of increased sick leave and the cost of sickness absence, reduced productivity, employee turnover and litigation costs. The combined cost to the NHS of these specific impacts has been estimated at £2.281 billion per year.\(^\text{27}\)

56. It is imperative that the NHS remains an attractive place for our doctors to work. They need the tools to do their job, but they also need support and leadership to flourish.

57. The BMA survey reported a correlation between bullying and people under pressure. The long-term plan for the NHS needs to focus on improving those areas where doctors and other staff report the greatest pressures on their ability to care for patients. A report by the National Guardian’s Office has shown a steady increase in the number of cases referred to local freedom to speak up guardians. In the year 2017/18, around 45 per cent of cases involved bullying and harassment. However, only 6 per cent of all referrals came from doctors. There are other routes for staff to raise concerns, but we would encourage doctors to consider approaching their local guardian where other routes have not been suitable.\(^\text{28}\)

58. The Social Partnership Forum (SPF) has issued a collective call for action which asks employers and trade unions in all NHS organisations to work in partnership to create positive workplace cultures and tackling bullying. To support this work, the SPF is publicising the views of NHS leaders and experts.

\(^{27}\) The price of fear. Estimating the cosy of bullying and harassment in the NHS. Public Money and Management, October 2018.

\(^{28}\) Speaking up in the NHS in England. National Guardian’s Office, September 2018
on this topic and signposting information, tools, resources and case studies that can help partnership initiatives.\textsuperscript{29}

59. Professional bodies have also been active in developing resources and initiatives to address bullying and harassment. The Royal College of Surgeons of Edinburgh launched the #LetsRemoveIt anti-bullying and undermining campaign in June 2017, and over the past 12 months has undertaken and implemented activities to help address and lead cultural change across the healthcare professions.\textsuperscript{30}

60. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives have developed a toolkit to address the challenge of bullying and undermining behaviour in maternity and gynaecology services.\textsuperscript{31}

61. The Royal College of Anaesthetists has joined the National Guardian for the NHS and other healthcare organisations to support forming an alliance to address the unacceptably high levels of undermining and bullying behaviour throughout the NHS. The alliance will coordinate activity, share best practice and develop resources to tackle undermining and bullying, while also scrutinising the complex cultural, behavioural and systematic issues underpinning it.\textsuperscript{32}

62. NHS Employers has an extensive range of resources and support to help employers develop a positive culture to tackle bullying.\textsuperscript{33} Some of the key actions that employers need to take include engaging with staff, ensuring that action is taken, establishing effective local policies and being held to account through monitoring and evaluation.

63. Our organisational development web pages and resources can help employers to create a positive culture within their organisations.\textsuperscript{34}

64. Tackling bullying and harassment is one way of contributing to the overall health and wellbeing of staff. Healthcare leaders need to support staff by


\textsuperscript{30} https://www.rcsed.ac.uk/professional-support-development-resources/anti-bullying-and-undermining-campaign

\textsuperscript{31} https://www.rcog.org.uk/underminingtoolkit

\textsuperscript{32} https://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/collaborative-alliance-tackle-bullying

\textsuperscript{33} https://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/tackling-bullying-in-the-nhs

\textsuperscript{34} https://www.nhsemployers.org/campaigns/organisational-development
providing an environment which positively encourages greater wellbeing. A successful health and wellbeing programme requires engagement, time and commitment as well as sustainable investment.

**Medical staff engagement**

65. The overall level of staff engagement for medical staff registered in the most recent NHS Staff Survey (2017) remains relatively high. The overall staff engagement index for medical staff is 3.88 compared to 3.78 overall. Medical staff have, in particular, a high level of motivation (4.02 compared to 3.90). This reflects the commitment of medical staff and their dedication to the NHS. Medical staff have more positive scores than other occupational groups in almost all areas except for appraisal. We are aware that NHS England has started a conversation about the focus of appraisal, and how to make it more relevant in promoting and supporting professionalism and high-quality patient care.

66. However, the levels of violence, bullying and harassment experienced by medical staff remain unacceptable and work-related stress is a cause for concern. Despite these undoubted challenges, medical staff are positive about their jobs and are willing to recommend the NHS as a place to work.

67. As noted by the review body in its previous report, the 2017 staff survey data showed a worsening in the scores for medical staff in line with the general trend in the survey. The increasing pressures on the service are likely to have intensified the challenges facing medical staff.

68. NHS Employers works to support organisations across the service to sustain staff engagement and improve health and wellbeing.
Contract Reform

69. The combined pressures that arise from the current financial, transformation and workforce challenges are reflected in our approach towards medical and dental contract reform, which is consistent with the aims of the ten-year plan. We believe the approach will help employers meet some of the productivity and efficiency targets that we expect they will be required to meet over the next few years.

70. Our overarching approach to reform is to reach agreement with the medical trade unions on contracts that provide employers with the flexibility to recruit and deploy doctors in a sustainable and affordable way. This will enable them to meet the needs of their patients while providing a fair system of reward, supporting training and development and offering appropriate work/life balance for staff.

Doctors in training

71. The BMA remains formally in dispute with government on the way that the new contract was introduced and so has not collectively agreed the terms under which most doctors in training are now employed. However, NHS Employers and the BMA have held constructive discussions to ensure a smooth implementation of the new arrangements in the interests of both trainees and employers.

72. Good progress has been made in implementing the 2016 contract and we recognise all the hard work that has taken place locally to make this happen. We are now in discussions with stakeholders to review the contract in line with the commitment made in the 2016 Acas agreement.35

73. Under the auspices of Acas, the BMA, the government and NHS Employers have agreed to enter into a formal collaborative bargaining process to jointly review the efficacy of the contract and negotiate any changes necessary to address areas for improvement identified as part of that process.

74. Both parties have agreed priority areas for consideration, including:
   - less-than-full-time training and equalities
   - pay and transitional arrangements
   - workforce
   - safety and wellbeing
   - education and training.

35 Junior doctor contract agreement. ACAS, May 2016
75. Five sub groups have been established to explore and consider each of these themes in depth.

76. NHS Employers has recently surveyed employers on their recommendations for the 2018 review. Feedback received suggests that many of the current challenges could be addressed through successful implementation of the good rostering guidance within employing organisations, and this will form part of the evidence supporting the review.

77. The review sub groups will deliver reports and recommendations to the Joint Negotiating Committee (Juniors) on 11 January 2019, to inform negotiations between January and April 2019 on changes to the contract, with a view to reaching a collective agreement with the BMA after consultation with its members.

78. The review has a strong focus on safety and training, and on ensuring that exception reporting is working as intended. Both parties recognise that work is needed to improve the reporting of missed training opportunities so that they are not lost because of service pressures. Overall, the process seems to be working well but there is a need for more consistency in data collection in respect of both hours, and education and training.

79. Work scheduling processes are also being reviewed. The current arrangements are inconsistent and resource intensive. Employer feedback suggests that the process needs to run much more smoothly than it does now.

80. The 2016 terms and conditions state: ‘From 2 October 2019 onwards, an allowance shall be paid to doctors who are formally designated by their employers to undertake roles as senior decision makers in line with appropriate clinical standards.’ We are currently in discussion with the BMA about how this will be implemented.

81. Work is being undertaken by both parties to explore options to extend the current transitional arrangements beyond 2022. Options will be considered as part of negotiations in 2019.

82. Safe working hours is a priority for the review, and both parties are reviewing the efficacy of the contractual safety limits. Employer feedback suggests that further clarity is required on some of the limits.

83. Other aspects of the contract are also being considered, including the current leave arrangements, the application of the contract in non-hospital settings.
(such as general practice, public health and medical academics) and the effectiveness of the locum clause.

84. As part of the non-contractual discussions, all stakeholders including HEE have been reviewing the work scheduling and exception reporting arrangements for education and training. Employers’ feedback suggests that there is a lack of reporting in this area.

85. Beyond the review, the Secretary of State has allocated a total of £10m to be made available to the guardian of safe working in each trust, to be spent locally and in agreement with doctors in training, on measures to improve working conditions. The distribution of this is being discussed with stakeholders including HEE.

86. The pay premia introduced for GP training and some other hard-to-fill programmes were established so that there were no disadvantages in pay that could deter trainees from entering these programmes. The contract has been in place for two years and an analysis of both fill rates and retention figures will be necessary to assess whether the premia are operating as intended. A new premium for histopathology was introduced from October 2018.

**Targeting pay**

87. The review body has been asked to consider targeting pay either by extending the current flexible pay premia or establishing new premia to address geographical challenges. At this point in time, we do not believe that there is a sufficiently well-developed evidence base to justify targeting pay in this way, particularly within the current pay envelope.

88. We believe that further work is needed to understand the range of factors influencing the career decisions of doctors in training. This would include reviewing the historic position and seeking the views of employers, staff and others to develop sustainable, long-term solutions that might include options other than targeting pay. We will work with other stakeholders including HEE and NHSI to develop options and we will share these with the review body in due course.

**Consultant contract**

89. The initial remit for contract reform was set in 2013 and remains a manifesto commitment. The remit was refreshed following the review body’s report *Contract reform for consultants and doctors and dentists in training* –
supporting healthcare services seven days a week which was published in 2015\textsuperscript{36}.

90. In the latter half of 2017, the negotiation parties reprioritised activity on contract reform to focus on reaching an interim agreement on arrangements covering employer-based clinical excellence awards (as set out below). Negotiations on wider contract reform were deferred until the government’s response to the review body’s 46\textsuperscript{th} report (July 2018) was known.

91. When it came, the government’s response was not well received by the medical trade unions. As a result, they have been considering their approaches to engagement in future pay review rounds. The government’s response indicated commitment to future negotiations on a multi-year pay deal from 2019/20, and we were optimistic this would provide the basis on which to formally re-enter negotiations on wider contract reform.

92. In October 2018, the Department of Health and Social Care (DHSC) confirmed the likely pay settlement envelope for consultants over the next three years. The trade unions again expressed disappointment with the proposals, particularly in the wake of the amount and staging of the 2018/19 pay award and against the backdrop of ongoing staff shortages and rota gaps which place significant pressure on the consultant workforce. There was also a view that consultants felt undervalued given the 3 per cent per annum pay envelope which operated for the recent NHS Terms and Conditions of Service negotiations. Our current understanding of the BMA’s position is that they do not think that it would be in the best interests of members to continue contract negotiations within the expected envelope. The BMA will consult its members to explore other options to attempt to secure an improved offer. This decision has effectively stalled the negotiations on consultant contract reform.

93. We are also aware of the dissatisfaction expressed by the Hospital Consultants and Specialists Association (HCSA) on the outcome of the previous pay round. The HCSA believes that this will have a detrimental impact on recruitment, retention and morale. It is currently considering its position on how to proceed, and we are continuing to engage with the HCSA on developing a future work programme.

94. We are now exploring how to progress residual items falling out of the local clinical excellence awards agreement, and ongoing contract maintenance issues, if wider contract reform is no longer a possibility. The view of employers has been consistent over the period of negotiation that, in return for additional

investment in pay, a reformed contract should aim to align pay incentives more closely to meeting and exceeding organisational objectives.

Local clinical excellence awards

95. An interim agreement was reached in March 2018, covering the three-year period from April 2018 to March 2019. NHS Employers and the BMA agreed joint guidance on the new arrangements in July 2018.37 We have supplemented the guidance with a range of employer FAQs and other materials to support implementation. The guidance reflects the provisions set out in Schedule 30 of the Terms and Conditions – Consultants (England) 2003 and explains how the arrangements work at a local level, who is eligible and how to apply.

96. To date, most of the queries we have received from employers have been on practical matters of implementation, for example, where previous annual rounds were out of alignment or had been delayed. Employers have also been keen to discuss where flexibilities exist within the new arrangements and the scope of their discretion. Early indication suggests that employers are taking the opportunity to agree local arrangements that support the delivery of local priorities.

97. In the case of clinical academic consultants, we are in discussion with the BMA and the Universities and Colleges Employers Association (UCEA) to consider amendments to the current model honorary clinical academic contracts. This is to reflect recent changes in the LCEA scheme where employers have agreed that consultant clinical academics will be eligible in their local awards scheme.

98. The negotiating parties’ expectation is that where such consultants have previously been eligible through local schemes to apply for local awards then they should continue to do so, subject to the agreement of the individual employer, and that employers will adjust the investment ratio proportionately.

99. In line with previous review body evidence, our intention is that future arrangements for performance pay will continue to be non-consolidated and non-pensionable, promote the engagement of consultants in the delivery of agreed objectives and reward those who make an exemplary contribution to the health system. Establishing a much closer link to objectives will present an opportunity for employers to incentivise performance and reward consultants for meeting organisational priorities. A system based on meeting and exceeding objectives, rather than the current application-based scheme, is intended to widen access and participation for those groups of consultants.

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37 Local clinical excellence awards guidance 2018-21. NHS Employer, July 2018
who are currently under-represented, including women and those from black and minority ethnic backgrounds.

100. Following the government’s announcement of the pay award, 0.5 per cent of the pay bill will be targeted on the new system of performance pay to increase the amount available for awards from 2019/20. This will mean that the investment ratio will be increased from 0.3 to 0.5 per eligible consultant and we will continue to discuss this with the BMA.

Targeting pay

101. Following the remit set by the Secretary of State, the review body asked that evidence should address the issue of targeting pay, including to support increased productivity. Since discussions on contract reform and the role of pay in supporting reform have stalled, we do not believe that there is sufficient evidence currently available to justify any specific targeting of pay for consultants.

Specialty and associate specialist (SAS) doctors

102. In 2017, there were approximately 22,500 individuals within a broad definition of the SAS grades within the medical workforce on national SAS grades contracts and local contracts. In 2016, around 10,275 were on national terms and conditions, including 7,337 on the specialty doctor contract, 2,483 on the associate specialist grade and 455 on other staff grade contracts.

103. Exact numbers are difficult to define due to the coding of such doctors on the electronic staff record system. One of the recommendations arising from HEE’s SAS strategy is to develop an improved data set on SAS doctors via the model hospital.

104. The workforce is extremely varied, from doctors in early stages of training to highly experienced associate specialists.

105. Over recent years, both the review body and the annual staff survey have reported a significant level of dissatisfaction within the SAS grade. NHS Employers has worked collaboratively with others on initiatives such as the SAS appraisal guide, the SAS Charter and the SAS development guide.38

106. In August 2017, NHS Employers undertook a survey to identify the issues affecting the SAS workforce from an employer perspective. The BMA also carried out a survey of its members from the SAS workforce. The results of both surveys were consistent with findings from previous review body reports

38 https://www.nhsemployers.org/your-workforce/pay-and-reward medical-staff/sas-doctors
on matters which were of concern to SAS doctors, including:

- bullying and harassment
- career development and progression
- morale and job satisfaction
- job planning and workload
- pay
- recruitment and retention
- recognition and status.

107. Health Education England has been developing a strategic approach to SAS development with national stakeholders including NHS Employers. The strategy, which we expect to be published in January 2019, will include recommendations to raise awareness of SAS doctors and mechanisms to ensure they are effectively developed, supported and deployed to deliver high-quality patient care. The SAS Charter already sets out a range of recommendations around recruitment, contracts, job planning, support, development and involvement in local management and organisational structures.

108. Therefore, one of the key recommendations within the strategy is for HEE and NHS Improvement to work with NHS Employers to help support providers to implement the SAS Charter and gain a greater understanding of the barriers which prevent providers from being able to do so.

109. The strategy also makes recommendations around developing an improved data set for SAS doctors via the model hospital and making improvements to SAS doctor induction, development and e-portfolio access. It recommends that HEE should explore, in partnership with other interested parties, how the SAS role can be supported and utilised as a viable alternative to training and consultant grade roles. It also states that HEE should ensure consistency of funding for SAS doctors.

110. At the same time, NHS Employers has recently used the findings of both surveys to initiate a range of engagement activity with SAS doctors, SAS tutor networks and SAS committees, to discuss these challenges further and seek feedback on potential actions which could be undertaken by employers and system partners in the short, medium and long term. Feedback received suggests that many of these challenges could be addressed through successful implementation of the SAS Charter and SAS development guide within employing organisations. NHS Employers is aware that organisations who have successfully implemented the SAS Charter have benefited from the investment in the time and resources in terms of improved recruitment and
retention, improved morale, the creation of a more positive work environment, and most importantly, ensuring that patients receive the best care possible.

111. NHS Employers and the BMA have developed an online toolkit which will help employers to assess their progress in implementing the SAS Charter within their organisation.\(^{39}\) This covers the principles of the charter such as recruitment processes, appropriate contract, job planning and recognition. As employers work their way through the toolkit they are directed to resources to help them in areas where they may need support in good SAS doctor employment. Throughout the toolkit’s design phases, feedback has been sought from employers, representatives of professional bodies, and others.

112. NHS Employers has also developed a SAS Charter implementation checklist and case studies, which highlight good practice in the development and employment of SAS doctors. The case studies cover topics such as positive management attitudes, induction and a quality improvement fellowship programme.\(^{40}\)

113. We are developing a professionalism and cultural transformation programme in partnership with Hull and East Yorkshire Hospitals NHS Trust. This project will develop an online toolkit to inspire employers and other key stakeholders to transform the culture within their organisation and address unprofessional behaviours exhibited by members of staff across all levels. We are coordinating the release of this toolkit in 2019, to ensure that managers are equipped with the tools needed to manage any increase in concerns raised around bullying and harassment. The toolkit will be piloted with SAS doctors, but the intention is that it could be applied to any group of staff.

114. In June 2018, HEE responded to a freedom of information request about SAS development funding. The response highlighted a variation in the allocation of SAS funding across the HEE regions. We do not know the current method of allocation and the process for gaining access to funds differs. There are also challenges around the coding of SAS doctors, which makes it difficult for regions to determine how many SAS doctors employed on national terms are working within each of the HEE regions. Accurate data on the SAS workforce is therefore vital to the success of the SAS strategy.

115. The SAS development fund is intended for training and continuing professional development (CPD) for SAS doctors working in the NHS. HEE has control over the allocation of funding, which is distributed locally. SAS


development funding benefits the individual, the service and the wider workforce.

116. There have been reports of difficulties in accessing funding and of reductions in local budgets since the SAS development fund came under HEE’s responsibility. The HEE SAS strategy states that: ‘HEE will ensure consistency of funding for SAS doctors in terms of geography and activities funded through SAS tutors, associate deans and/or a nominated individual with responsibility for SAS doctors.’ Throughout the development of the SAS strategy, HEE has taken the view that future SAS funding will also be available to trust grade doctors.

117. Feedback from the Joint Negotiating Committee (JNC) SAS was that funding should be ringfenced for SAS doctors only. Both NHS Employers and the BMA accept that trust doctors require some form of development funding. However, as employers are appointing more and more trust grade doctors, the amount available for SAS development will be diluted.

118. A HEE SAS strategy meeting, held on 7 November 2018, confirmed that development funding would be available for SAS grades and trust grade doctors employed on contracts that reflect national terms.

119. We have heard that nomenclature and contract status were important to SAS doctors in ensuring that they felt valued in the workplace, and that the closure of the associate specialist grade has resulted in some dissatisfaction. Many employers are offering annual leave, pay, and in some cases, additional time for supporting professional activities (SPA) beyond the provisions set out in the 2008 national terms. Although reverting to the use of old terms might solve some issues around recruitment and retention, this alone will not address the other challenges facing the SAS workforce. There is a risk that the national contract is diminished along with some of the contractual guarantees it provides.

**Introducing a new contract**

120. As part of the announcement of the 2018/19 pay award, the government said that it intends to review the salary structure for SAS doctors as part of a wider review of their role, career structure, and the developmental support available to them. The Secretary of State wrote to the BMA in September 2018 and made it clear that he wanted to see the valuable role of SAS doctors recognised in their contract arrangements, and in the development and support they receive. He also made a commitment to look at introducing new contract arrangements for a new ‘associate specialist’ grade soon. This reflects a shared aim across the parties to establish SAS as a positive career
choice and maximise the role of this group within the medical workforce. Our understanding is that this will not simply be a case of re-opening the closed associate specialist grade but will effectively create a new role.

121. We are awaiting a formal negotiating remit from the DHSC. Meanwhile, NHS Employers is undertaking scoping work with employers early in the new year to see how this direction links to the long-term plan, SAS strategy and wider reform agenda for the SAS grade. Any formal negotiation process is likely to commence at the earliest from March 2019.

122. The Secretary of State also set out his expectations that trusts should be implementing the 2014 SAS Charter (England) which sets out minimum conditions and appropriate support and development for SAS doctors, as well as information on accessing the SAS doctor development funding held and allocated by HEE.

123. Feedback from our engagement sessions with SAS doctors, SAS tutor networks and SAS committees suggests that interpretation of the SAS contract is a challenge, particularly around annual leave and job planning.

124. We are running four engagement sessions with employers and stakeholders in early 2019. These sessions will include discussions around areas of the contract that may be impacting on the morale, recruitment and retention of the SAS workforce. The sessions will also assess whether the recommendations within the HEE SAS workforce strategy which seek to make improvements to employment, development and utilisation of the SAS workforce will resolve the challenge, or whether it needs to be discussed as part of wider contract reform. At the same time, we will provide advice, guidance and training around job planning and revalidation for SAS doctors.

125. Of those employers who replied to our survey, 71 per cent thought that the option of a new contract would help with recruitment and retention in the SAS grades, noting the potential for career development. Previous survey data showed that employers were experiencing difficulties in recruiting to SAS posts. The specialties that proved hardest to fill were emergency medicine, psychiatry and paediatrics. The BMA has also reported that less than half of SAS doctors would recommend their career path to other doctors. Our engagement work suggests that career progression is important to SAS doctors and a new contract would provide an opportunity to do so.

126. However, contract reform on its own will not be enough to address concerns about annual leave, job planning and appraisal. Wider action by medical leaders is needed to support and develop this important group of staff and to allow them to reach their full potential.
127. One of the recommendations in the HEE SAS strategy is that: ‘HEE, in partnership with other interested parties, should explore how the SAS role can be supported, developed and utilised as a viable alternative to training and consultant grade roles.’ We will continue to explore this in our employer-based SAS engagement sessions, together with how we can make the role attractive in terms of support and development and how, in turn, this links to contract reform.

Targeting pay

128. In view of the 3 per cent pay award from October 2018, and the proposal to open a new specialty doctor grade, we do not think that any additional targeting of pay within specialty doctor and associate specialist grades is required.

129. We need better understanding of how employers currently use or would want to use SAS doctors in future. Support for employers is now in place through the SAS Charter, the SAS strategy and other jointly agreed resources. There is cross-stakeholder support for SAS doctors so that they remain an essential part of the workforce and service delivery.

Salaried GPs

130. Employers have not raised any significant issues relating to salaried GPs, although trusts do seem to be employing them in increasing numbers as they either take over or provide primary care or GP-led services. We currently have no negotiating forum to discuss the salaried GP contract and terms and conditions, and there are some elements of the contract which need to be updated. Some of the respondents to our survey noted difficulties in recruiting in certain areas, for example in Plymouth and in urgent care, and one noted with some concern the high locum rates offered by private organisations such as Babylon.

Salaried primary care dentists

131. Salaried primary care dentists have now been separately identified as an occupational group within the NHS Staff Survey, although survey data will not be available until the next round.

132. We have re-established the Joint Negotiating Committee (Dental) with the British Dental Association and the survey findings will provide useful information to shape future discussions within the group. The revised JNC(D) has a wider remit than salaried primary care dentists and will cover employed dentists on national terms and conditions.
133. Employers have not raised any particularly widespread issues relating to salaried primary care dentists, although one employer in our survey said that their rural location made it difficult to recruit to community dentistry.
Total reward and pensions

**Total reward**

134. NHS Employers engages with NHS organisations on reward through the Total Reward Engagement Network (TREN), our annual survey of employers, and through members of the pensions and reward team’s continued engagement with employers, ensuring we work closely with them on reward-related resources.

135. The NHS continues to provide a comprehensive and attractive core employment offer, through a well-regarded package of valuable benefits, including an attractive pension scheme.

136. The national pay and conditions of service systems remain at the core of reward in the NHS, yet employers see reward as much more than this. The NHS employer proposition now includes a growing range of benefits, some of which are unique to specific organisations in presentation and approach.

137. The NHS Pension Scheme remains an important component of NHS reward, though employers report that more could be done to help their staff understand the value of the scheme as a way to attract and retain staff.

138. Reward in the NHS continues to evolve as organisations address the current challenges of rising health demand, new models of care, efficiency challenges, workforce shortages and staff morale. The NHS is, but must also be perceived widely in society to be, an honourable, rewarding, and exciting place to work. Employers are keen to ensure their staff are recognised and celebrated for the hard work that they do.

**A strategic approach to reward**

139. In our survey this year of more than 60 employers, over 70 per cent said they were using reward to meet their strategic objectives, including recruitment and retention of staff. This is consistent with the findings in our survey last year. In a highly competitive labour market there is an increased local focus on the diversity of the reward offer to meet organisational need.

140. TREN members report that their organisations are prioritising recruitment and retention and are increasingly looking at how their reward package can support these. Yet recruitment and retention premia and other financial benefits continue to be the exception rather than the rule. Financial premia
and relocation packages tend to be used to attract candidates to hard-to-fill posts. These posts often require specialist skills and employers face stiff competition locally from other employers, often in the private sector, for example for posts requiring computer software and hardware skills.

141. Employers are seeking to better understand the needs and aspirations of their increasingly diverse workforces, which is leading to the evaluation of reward packages. Around 58 per cent of respondents to our survey reported evaluating reward packages using feedback from the workforce. Methods used include surveys of their staff, including leavers and joiners.

**Components of reward in the NHS**

142. Research shows that if staff feel supported at work, and feel well, they are better placed to deliver quality care to their patients. Both the Boorman Review\(^{42}\) and the Five Year Forward View\(^{43}\) highlighted the importance of NHS staff health and wellbeing and the direct impact it has on patient care. Staff retention rates are shown to improve where the employer shows that it cares about their health and wellbeing\(^{44}\) and NHS leaders are supporting this important agenda in working towards the health and wellbeing CQUIN.

143. Feedback through TREN indicates that organisations see their health and wellbeing strategies as long-term projects requiring engagement, time and commitment. The health and wellbeing pages\(^{45}\) on our website are designed to help employers navigate their way through what is required, including the latest research and evidence.

144. The contractual annual leave allowances are attractive to potential recruits and beneficial to existing staff, but some organisations are allowing employees the flexibility to alter their entitlement by buying and selling annual leave. We understand from employers that longer-serving employees are often targeted, as the chance to have more control over work/life balance may be a more enticing part of the reward offer.

145. Flexible working is seen as part of the solution for addressing recruitment and retention issues\(^{46}\) and achieving increased staff engagement. The challenge for organisations is to be as flexible as possible while maintaining high standards of patient care.

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\(^{42}\) NHS health and wellbeing review: Department of Health and Social Care: January 2013

\(^{43}\) NHS Five Year Forward View: NHS England


\(^{45}\) NHS Employers health and wellbeing resources

\(^{46}\) https://www.nhsemployers.org/case-studies-and-resources/2018/12/flexible-working
146. The approach to salary sacrifice schemes continues to be mixed, with some organisations continuing with some or all of their schemes while others have terminated their schemes. There is concern that staff will perceive recent changes\(^{47}\) as a reduction in their benefits, but the full impact of these changes has not yet become apparent.

147. In response to our survey, most employers said they adopted a generic approach to reward and did not distinguish between medical and non-medical staff. In 2017, we also undertook a benchmarking exercise which explored all trust websites and confirmed that organisations prefer to adopt a whole-workforce approach when designing their local reward packages, rather than targeting specific elements at medical and dental staff. Where organisations have reported specific measures for medical staff, other than pay/terms and conditions, these include more favourable relocation and recruitment benefits, staff wellbeing schemes and support with study time for education and research.

**Strategies to engage staff effectively**

148. Our employer survey asked for examples of how employers communicate their reward offer. Electronic communications are regularly used, and organisations with large workforces spread over several sites and in a broad geographical area, are using apps and social media to ensure the same communications reach everyone at the same time. Equality is an important aspect of reward communications.

149. TREN members report their organisations are looking at the age profile of the workforce as well as feedback from staff to explore the possibility of using specific methods of communication for certain staff. For example, there is evidence that 68 per cent of Instagram users are under 35.\(^{48}\)

150. Effectively promoting the reward offer during induction provides an early demonstration of the employer’s investment in staff and the importance of reward as part of organisational values. Some employers report supplying benefits information with offer letters and making reward information sessions an integral part of their induction programmes.

151. Our website reward pages\(^{49}\) assist in the local development of new materials and our resources on communicating reward\(^{50}\) provide further case studies of how some organisations have approached this challenge.


\(^{49}\) NHS Employers reward resources

\(^{50}\) NHS Employers resources on communicating reward
Total reward statements

152. Total reward statements (TRS) are one way in which NHS organisations promote the benefits they offer locally, as well as providing useful information about the value of the pensions scheme through an annual personalised summary of the package.

153. 2017/18 was the fourth year of operation of TRS in the NHS. Information from the NHS Business Services Authority indicates that a total of 2,380,681 statements were available in England and Wales. The number of unique statements that were viewed between 20 August 2017 and 9 June 2018 was 603,010. Compared with the position at the same time last year, this is an increase of over 30 per cent in the number of staff accessing their statements.

The NHS Pension Scheme

154. The 2015 NHS Pension Scheme was launched on 1 April 2015, replacing the 1995 and 2008 sections (except where individual protection applied). The 2015 scheme is a career average revalued earnings (CARE) defined benefits scheme. It pays a pension based on the average of a member’s pensionable earnings throughout their whole career, revalued in line with the Consumer Prices Index (CPI) plus 1.5 per cent per annum.

Employer contributions

155. The employer contribution rate for both the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme is 14.3 per cent of pensionable pay. This rate is determined by the funding methodology applied by the scheme actuaries. Employers pay a scheme administration levy equal to 0.08 per cent of pensionable pay in addition to the standard employer contribution rate.

Member contributions

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

157. As basic pay for doctors, dentists and GPs ranges from £27,146 to £105,042, most medical staff will pay contribution rates at the highest tiers, in the range of 9.3 per cent and 13.5 per cent of pensionable pay.
<table>
<thead>
<tr>
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<th>Pensionable pay (whole-time equivalent)</th>
<th>Contribution rate from 2015/16 to 2018/19</th>
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<td>1</td>
<td>Up to £15,431.99</td>
<td>5.0%</td>
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<td>£15,432.00 to £21,477.99</td>
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<td>3</td>
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<td>12.5%</td>
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<td>13.5%</td>
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<tr>
<td>7</td>
<td>£111,377.00 and over</td>
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</table>

**Review of employee contributions from 1 April 2019**

158. At the request of the Secretary of State, the NHS Pension Scheme Advisory Board (SAB) has reviewed the basis on which member contributions will be assessed from 1 April 2019. A key objective of the review was to ensure the required yield is collected going forward. SAB submitted a recommendation on member contributions in July 2018 and awaits the outcome of this.
**Actuarial valuation 2016**

159. The employer contribution rate is reassessed by the scheme actuary every four years. The results of the 2016 valuation will determine the employer contribution rate from 1 April 2019.

160. The valuation directions published by HM Treasury on 6 September 2018 announced a proposed change to the discount rate assumption, from a rate of CPI plus 3 per cent to CPI plus 2.4 per cent. This will result in an increase to employer contributions.

161. The Prime Minister announced in June 2018 that an extra £1.25bn in funding would be made available for the NHS to cover a specific pension cost pressure, but more details are needed to understand if the funding is sufficient, when and how the funding will be made available to employers, and if all employing organisations participating in the NHS Pension Scheme will be eligible.

162. SAB has received preliminary valuation results and was asked to provide advice to the Department of Health and Social Care. A consultation on proposed scheme changes was launched on 18 December 2018.

**Scheme membership**

163. The overall membership of the NHS Pension Scheme has increased by 4.4 percentage points from October 2011 to June 2018. Shorter-term trends show an overall increase of 0.3 percentage points for the 12-month period ending in June 2018 and a small fall in membership rates by 0.1 percentage points from May - June 2018.

164. In comparison, membership levels for doctors have fallen by 1.4 percentage points from October 2011 to June 2018. In the shorter term, membership rates for doctors have fallen by 0.6 percentage points for the 12-month period ending in June 2018 and by 0.2 percentage points from May to June 2018.

165. Although scheme membership for doctors remains high (90 per cent), the recent fall in membership for doctors may be due to the impact of pension tax allowances.
166. The increase in membership in the lower contribution tiers has served to reduce the contribution yield below the required 9.8 per cent level. As most NHS employers have passed their initial staging date for auto-enrolment it is unlikely that auto-enrolment alone will have a significant further impact on the contribution yield.

### Table: Scheme membership trends (Source: ESR summary data June 2018)

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1,062,116</td>
<td>91%</td>
<td>-0.1%</td>
<td>0.3%</td>
<td>4.0%</td>
<td>89%</td>
<td>-0.1%</td>
<td>0.3%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Staff groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Doctor</td>
<td>105,109</td>
<td>91%</td>
<td>-0.1%</td>
<td>-0.5%</td>
<td>-1.4%</td>
<td>90%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>-1.4%</td>
<td></td>
</tr>
</tbody>
</table>

167. The actual member contribution yield is set out in the scheme’s annual resource accounts and has been 9.5 per cent in each year since the new structure was introduced (2015/16, 2016/17 and 2017/18). It has therefore been consistently under target.

168. The proportion of members accruing benefits on a CARE basis is increasing rapidly, while the number of members in the final salary sections of the scheme continues to fall. This continuing change in membership profile was

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31 [NHS Pension Scheme accounts](#)
considered in the context of the member contributions review, particularly the use of WTE earnings to determine member contribution rates.

<table>
<thead>
<tr>
<th>Date</th>
<th>1995 members</th>
<th>2008 members</th>
<th>2015 members with final salary link</th>
<th>2015 members no final salary link</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/03/2016</td>
<td>237</td>
<td>18</td>
<td>1,063</td>
<td>141</td>
<td>1,460</td>
</tr>
<tr>
<td>31/03/2017</td>
<td>203</td>
<td>16</td>
<td>1,000</td>
<td>269</td>
<td>1,488</td>
</tr>
</tbody>
</table>

Table: Changing membership of the scheme (Source: GAD)

**Pension taxation**

169. We reported in our evidence to the pay review bodies for 2018/19 about the impact of the annual allowance (AA) and lifetime allowance (LTA) pension tax limits. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years, and the introduction of the tapered annual allowance, mean that more staff are likely to be impacted. The pension tax allowances continue to present significant issues for staff and employers.

170. Any NHS employee who has pension benefits above tax thresholds may be liable to a tax charge. This has the potential to damage the perceived value of the NHS Pension Scheme as a benefit, and influence member behaviour.

171. We previously reported that in the 2016/17 scheme year, 35,000 members (approximately 2.3 per cent of the total membership) breached the AA and 2,360 members (approximately 0.16 per cent of the total membership) accrued benefits worth more than 100 per cent of the current LTA.

172. After undertaking some research into how trusts are being affected by the tax allowances, we have found that some trusts are experiencing their consultants and doctors either leaving the pension scheme, cutting down their hours, or leaving the profession. Some trusts are also struggling to recruit for higher earning roles as employees are worried they may exceed the allowance.

173. Employers reported that an increasing number of medical staff who are affected by the pension tax allowances are taking early retirement, and this is adding to existing recruitment and retention challenges particularly in specialist areas.
174. Many doctors are requesting to reduce their working hours to control their pensionable income and employers are finding it difficult to recruit staff to fill the remaining small, part-time medical posts.

175. Employers explained that where practitioners are employed in small, part-time posts, additional responsibilities often further reduce the available treatment time. There are growing concerns about the impact this could have on patient care, including reduced supervision and delays in treatment times.

176. In our survey of over 60 employers in the NHS, employers told us they feel the scheme is becoming less attractive to high earners due to the impact of the tax allowances. The tax allowances are particularly impacting higher earning staff, with some employers seeing a decrease in applications for leadership roles. It was indicated in the survey that staff feel they are being ‘penalised’ for taking a post which attracts a higher salary. Some employers indicated within the survey that recruiting and retaining staff, particularly high paid staff, is becoming an issue.

177. Employees are facing significantly higher marginal tax rates once pension tax charges are factored in and large pay rises can sometimes lead to very little increase in take-home pay. This effect is well illustrated in the 40th annual report by the review body on senior salaries. The review body noted that: ‘for gross salaries between £118,000 and £170,000, take-home pay increases by less than £3,000. Marginal tax rates above 100 per cent are experienced between £118,800 and £122,600, although this calculation does not factor in increases to the value of the pension. Such high marginal tax rates mean it could be rational for an individual to seek to work part time rather than work full time. This may result in a need to recruit more post-holders or to deny requests to work reduced hours, impacting negatively on motivation.’\(^\text{52}\) We endorse that observation.

178. The current contribution design relies on high earners paying higher member contributions to subsidise those paying lower contributions. If the trend of high earners leaving the scheme continues, this may have an impact on the yield and the ongoing sustainability of the scheme. This is a key consideration for the employee contribution review. We would welcome any review by HM Treasury of the impact of current pension tax rules on key public servants.

Pensions flexibility

179. Employers remain keen to ensure the scheme is attractive to all staff across the workforce. The scheme should be appealing to staff of all generations and levels of income. Employers would like to offer more flexible pension options to achieve this.

180. Some employers suggested it would be helpful for members to be able to choose a level of pension contributions or benefits to suit their personal circumstances. This would provide members with alternative options for pension saving in addition to either joining the NHS Pension Scheme or having no workplace pension savings.

181. It was also reported in the survey that due to lack of flexibility in the scheme, some staff were now working via locum agencies, particularly due to the pension tax rules. Employers feel that if the scheme became more flexible in order to retain staff working directly for trusts, they would save money through spending less on locum doctors.

50:50 option

182. From our engagement with NHS organisations, we know employers support the introduction of a 50:50 section that allows members to pay half the standard contribution rate in return for half of the standard benefit accrual. This would allow medical staff to control their pension growth, while at the same time providing a more affordable method of pension saving for lower earners.

183. The 50:50 section is an existing feature of the Local Government Pension Scheme.

184. As the NHS Pension Scheme is unfunded, the introduction of such changes will be subject to extensive and detailed consultation and will require HM Treasury approval. Scheme changes would need to be considered alongside the pension arrangements for other public-sector workforce groups with staff who are experiencing similar pension tax challenges such as the judiciary, senior members of the armed forces, teachers and civil servants.

Life assurance only membership

185. Some employers suggested there could be more choice around opting to only contribute to the death in service element of the scheme, to avoid breaching their lifetime allowance with continued pension contributions.
Pensionable pay

186. A pensionable pay cap or giving staff more choice over which elements of pay are pensionable may help staff control the value of their pension accrual and avoid exceeding the tax allowances.

The NHS Pension Scheme as an attraction and retention tool

187. We asked over 60 employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff. A total of 86.6 per cent of employers rated the scheme as effective or somewhat effective at retaining staff, with only 13.4 per cent rating the scheme as not effective. A total of 76.9 per cent of employers rated the scheme as effective or somewhat effective at attracting staff, with only 23.1 per cent rating the scheme as not effective.

![On a scale of 1-5, how would you rate the effectiveness of the NHS Pension Scheme to retain staff?](chart1)

![On a scale of 1-5, how would you rate the effectiveness of the NHS Pension Scheme to attract staff?](chart2)
Understanding the value of the NHS Pension Scheme

188. Employers feel that more could be done to help their staff understand the scheme. The complexity of the scheme is one reason why employers believe that staff are not understanding its value. They believe there should be clear information available, with increased marketing of the scheme, to help existing and potential staff to understand the long-term benefits provided.

189. Employers have observed that staff perception of the value of the pension scheme has fallen since the introduction of the new 2015 scheme. Some staff seem to view the scheme as being constantly changed and eroded, and some have the view that the terms will become less favourable in the future. The complexity of the scheme makes it difficult to generate staff interest and engagement.

190. Employers feel that promoting the positive benefits of joining the NHS Pension Scheme is key to increasing the level of understanding and appreciation of the value of the scheme.

191. Employers suggested the following ways in which they need help promoting the value of the NHS Pension Scheme:

- better communication
- national advertising of the rewards and benefits of the scheme
- simple sessions for employers to equip them with knowledge to share with their staff
- more promotional resources and marketing materials for the scheme
- enable previous TRS statements to be available to show the growth over time.

192. Many employers are communicating the value of the scheme through their staff intranet. They are encouraging the use of total reward statements for staff to see their own benefits. Some employers also have materials to give to their staff to show them the value of the scheme, such as benefits brochures, handbooks and leaflets.

193. Many employers run pension workshops and pre-retirement courses to help staff understand the value of the benefits provided by the NHS Pension Scheme. The sessions can be an effective way of encouraging staff to engage with their pension savings, and help staff appreciate the value of the scheme as part of their reward offer.
194. NHS Employers continues to produce resources to support employers to promote the value of the NHS Pension Scheme.  