NHS EMPLOYERS' SUBMISSION TO THE DOCTORS' AND DENTISTS' PAY REVIEW BODY 2018/19

December 2017

Contents

Key messages

The financial challenge

- Last year, our evidence set out the unprecedented financial and service challenges faced by employers. This position has not substantially changed. The financial outlook remains extremely challenging and restricts the NHS' ability to invest in pay without additional funds.

- Although the NHS has been protected from the full impact of austerity since 2010 with funding for the NHS increasing by more than inflation, the increase is substantially less than the increase in demand for services and other cost pressures. This is compounded by the relative disinvestment in other public services, especially social care.

- NHS organisations are having to manage growing disparities between rising demand for services - and the staff needed to provide them - and the amount of funding available, while continuing to meet public and patient expectations.

- Although the overall financial deficit in trusts fell from £2.5 billion in 2015/16 to £791 million in 2016/17[1], the persistent level of structural debt has limited the financial resources available to local leaders for delivering current services and transforming how these services will be delivered in future.

- The increasing demand for services is from a growing population comprising older people, a greater prevalence of long-term and often complex patient conditions, all of which is keeping sustained pressure on available resources at a time of rising costs.

- Employers are engaged on programmes to improve quality and drive up efficiency, yet these require additional resource and will take time to deliver results. Resources in the current climate are focused on meeting urgent need.

- Employers have already met, and are continuing to deliver, productivity above the national average. It would therefore be extremely difficult for employers to fund any additional investment into pay without having to make difficult choices about the number of staff that they employ and the services that they provide.

[1] The Kings Fund (July 2017) Nine things we learnt about provider finances in 2016/17

- As the King's Fund, the Health Foundation, and the Nuffield Trust said in their pre-budget analysis: 'Productivity in the NHS is improving by 1.7 per cent a year and is outperforming the wider economy. The NHS must continue to focus on improving productivity by tackling variations in care, improving clinical practice, and making better decisions about how money is spent. Even so, this will not be enough to bridge the gap between rising pressures and planned funding.'

The workforce challenge

- NHS employers spend approximately two-thirds of their budgets on staff. Sustainable workforce costs are essential to helping the NHS meet the quality and efficiency challenges that employers face. The cost of staff will remain central to efforts to manage budgets, improve efficiency, and transform services.

- In a highly pressured financial environment in which there is no ability to fund additional pay within the existing resources, the importance of valuing, supporting and developing staff to have rewarding careers within a positive working environment becomes even more important.

- In this difficult climate, employers repeatedly tell us that their workforce is their greatest priority. There is widespread recognition of the need to support the recruitment and retention of staff and there are many national and local initiatives in place.[2] However, we recognise that much more needs to be done, both nationally and locally, if we are to attract, recruit and retain the workforce that we need both now and in the future.

- We welcome the Secretary of State's recent announcement of a robust, coordinated approach to workforce strategy. The recently published *Health and care workforce strategy for England to 2027*[3] sets out the vision for this transformation. Getting workforce policy right in the future will be central to delivering sustainable and affordable high-quality health and care services.

- The workforce strategy makes clear how the NHS will collectively address the future supply, retention, and development of its workforce. This is an opportunity to set out how actions to date will help employers in the short, medium and longer term, as well as being clear on what further actions will need to be taken at every level of the NHS, and across government.

- Embedding and realising the benefits of a strategic workforce plan will require leadership and a commitment by organisations to ensure that all staff feel valued, supported, and developed throughout their careers. The

[2] NHS Employers (Sept 2016) Improving Staff Retention - a Guide for Employers

[3] Health Education England (December 2017) Facing the facts, Shaping the Future

link between effective staff engagement and outcomes is well known. The more that NHS organisations value their staff and make their working lives a positive experience, the better placed they will be to meet difficult recruitment and retention challenges and, above all, to be able to provide consistently safe, compassionate and high-quality care to their patients.

The transformation challenge

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

- In the face of continuing financial and demographic challenges, the NHS regularly considers new and innovative approaches to delivering high-quality services efficiently. These include focusing on providing more services in the community, genuinely integrating health and social care, preventing illness, promoting health and wellbeing and doing more to get the best from talented staff.

- The development of sustainability and transformation partnerships (STPs), accountable care systems (ACSs) and devolution, all provide the NHS with opportunities to provide joined-up, better coordinated care, with change led at system level.

- It is recognised that if transformation plans are to improve outcomes for patients, there must be new workforce plans that reflect more collaborative working across established organisational boundaries.

- These necessary developments will require new contracting, funding, workforce and information governance models.

Contract reform

- We believe that there are opportunities to link contract reform to the improvement and efficiency agenda and to align aspects of reward more closely to individual contribution and performance. This is dependent on additional national investment into pay following the period of pay restraint. To be clear, employers cannot realise greater efficiency to fund any increase in pay for medical staff.

<u>Consultants</u>

- A compelling case for change remains to ensure that the consultant contract supports the NHS in the delivery of the priorities set out in NHS England's Five Year Forward View. Through such reform, the contract will

address quality and efficiency/productivity challenges, the changing needs of patients and new models of care.

- National negotiations between NHS Employers and the British Medical Association (BMA) over an amended contract for consultants have been ongoing in some form since 2013.These talks have been constructive, but progress has been slower than anticipated.

- Considering the review of the government's public sector pay policy and the delayed DDRB process for 2018/19, it is no longer considered feasible (or viable) that an agreement on a full package of contract reform will be reached in time for implementation with effect from April 2018. The negotiation parties will consider a revised implementation timetable following the outcome of the DDRB process and the subsequent response from government to any recommendations.

Junior doctors

Good progress has been made in implementing the 2016 junior doctors' contract and we are very grateful for the hard work which has taken place locally to make this happen. We are also supporting work to improve the overall training experience for doctors and we are in discussions with stakeholders on a review of the contract in line with the ACAS agreement.[4]

SAS doctors

- There is currently no work underway on SAS doctors' contract reform. In its previous report, the review body asked parties for more detailed evidence on SAS doctors, particularly around issues of morale, recruitment, retention, and development. We carried out a short, informal survey of employers which revealed that employers were undertaking a wide range of initiatives locally to address problems identified around these issues.

- As a means of being able to offer higher pay and status than that provided by the existing national staff grade contract, some employers seem to be increasingly offering local terms which mirror the old, and now closed, associate specialist contract. Although reverting to the use of these old terms might solve some local recruitment and retention problems, there is a risk that the national contract is diminished along with some of the contractual guarantees which it provides. NHS Employers would welcome a steer from the DDRB on this point and the wider contractual issues linked to SAS doctors.

[4] BMA, NHS Employers, Department of Health (May 2016) Junior Doctors' Contract Agreement

The pay award

- We welcome the government's announcement in September 2017[5], confirming the relaxation of pay restraint. This decision could help support existing employer initiatives to address recruitment and retention and continued improvements in workforce productivity.

- Employers understand that we need to move out of the period of prolonged pay restraint in a sensible, but managed, way.

- The chancellor's Autumn Statement did not contain any specific provision for additional investment in pay for the medical and dental workforce.

- Employers have emphasised to us very strongly that any additional investment in pay must be fully funded through additional funds from the Treasury.

- Investment in pay that is not fully funded in this way will create significant additional financial pressures and adversely impact on the delivery of quality care and patient services.

- Although pay in isolation does not seem to be the key influence or determining factor in career choice decisions for doctors and dentists, we nevertheless recognise the impact on this workforce group that further continuation of pay restraint will have.

- When asked previously about targeting decisions on pay, employers have said that the amounts available for investment have not really been enough to make, or have, a significant effect.

- Employers have suggested that this year, the DDRB might wish to consider some specific points in formulating its recommendations. We would therefore welcome a strategic and evidence-based discussion on further consideration of areas for targeted pay investment.

- Some employers have said that the current national locum rate for doctors in training is difficult to work within. They have also asked whether, in some cases, geographical pay premia, in addition to the current specialty based premia, might help with recruitment and retention. Employers have also suggested that reintroducing nodal point 5 could help improve recruitment and retention.

- If an increase in pay is recommended above the current 1 per cent cap and is funded by the Treasury, we would seek the DDRB's endorsement to target investment in pay which supports employers' pay reform priorities and the longer-term ambitions for reform of the consultant contract.

[5] Chief Secretary to the Treasury letter to the NHSPRB chair: September 2017

- Consolidated pay awards at the top of the consultant pay structure should be maintained at 1 per cent.

- Any consideration for recommendations above 1 per cent should, subject to funding, be targeted on mid-range consultant career pay points (at years 5 and 8). This will help to reduce future costs and the time taken for a transition to a reformed new two-point pay structure.

- Entry level and years 1-4 should also be held at 1 per cent as this group of staff continue to receive the value of annual pay increments at around 3 per cent.

- Any additional funded investment above the 1 per cent should also be targeted at enhancing local clinical excellence award funds to reward performance, productivity efficiency, and the delivery of excellent care to patients. This would support organisational objectives aligned with wider initiatives such as Getting it Right First Time (GIRFT), the Model Hospital and the patient safety agenda, the national service strategies, and the delivery of the accountable care system programme.

1. Informing our evidence

Introduction

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England for the 2018/19 pay review. We continue to value the role of the DDRB in bringing an independent and expert view on remuneration issues in relation to the NHS 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 for pay and for terms and conditions reform. We have:

- had direct discussions at one-to-one meetings with NHS chief executives
- attended regional network meetings of human resources directors, the NHS Confederation and other employer networks
- carried out a survey on issues facing SAS doctors
- carried out a survey on reward
- maintained regular contact with medical staffing colleagues in the NHS.

3. As in previous years, our evidence is framed within the challenges faced by the NHS around finance and workforce. These have become even more acute during 2017 and will continue to develop in complexity and intensity as the pressures on demand continue to increase. For most NHS leaders, the most pressing of these issues is workforce.

The financial and workforce challenges

4. As the NHS approaches its 70th anniversary, employers are facing unprecedented financial and service challenges. Demand for health care has been rising rapidly due to a combination of an increasing population, longer life expectancy, changing patterns of disease and ill health, and the development of new treatments and technologies. Additionally, there have been significant increases in the numbers of attendances at accident and emergency (A&E) departments, the numbers of emergency admissions to hospital, and in elective admissions.

5. At the same time, the NHS has been operating within a highly constrained financial environment in which it has been expected to respond to increasing demand at the same time as meeting exacting efficiency savings. This mismatch between demand for services and

funding is unlikely to be resolved soon. According to analysis by the Nuffield Trust, 'projections for future years suggest that even under optimistic assumption for inflation and continued high level of savings, NHS providers will continue to run a large collective underlying deficit until at least 2020/21'.[6]

6. However, despite these dual pressures it is the challenge of having enough staff, with the right skills and in the right places, which employers currently consider to be the most pressing. Increasing demand for safe and high-quality services has led to demand for more staff to deliver them. Where the demand for staff cannot be met, either because of a shortfall in supply or insufficient resources, the result is an increasingly pressurised workplace which impacts adversely on morale, wellbeing, motivation and retention. This, in turn, has the potential to jeopardise quality of care and patient safety.

7. In its report on the state of healthcare and adult social care, the Care Quality Commission (CQC) said that, despite very real challenges, the quality of health and social care has been maintained and that most patients are getting good, safe care. They added that the fact that quality has been maintained in the toughest climate most people can remember is testament to the hard work and dedication of staff and leaders.

8. We agree, and we have seen countless examples of NHS staff at all levels, in all professions, and in all disciplines, working tirelessly for the benefit of patients. Whether that has been in the background designing and managing the delivery of services, or on the frontline, responding with bravery and professionalism to major incidents such as those which took place in Manchester and London.

9. However, the CQC also warned that: 'the combination of greater demand and unfilled vacancies means that staff are working harder than ever to deliver the quality of care that people have a right to expect. However, there is a limit to their resilience'.[7]

10. The fragility of the current position was also highlighted by the King's Fund in its quarterly monitoring report. The document cited projections that the NHS is to miss targets for improving A&E performance, reducing delayed transfers of care and financial targets for reducing deficits in the provider sector. However, the report acknowledges that this is not due to lack of effort by staff or poor management within individual NHS organisations, but that *'the health care system is now so overstretched that even when effort and resources are focused on a smaller set of priorities, the required performance levels remain elusive'.*[8]

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[6] The Nuffield Trust (2017) The Bottom Line - understanding the deficit and why it won't go away

[7] Care Quality Commission (October 2017) The state of health and social care in England 2016/17

[8] The King's Fund (November 2017) Quarterly Monitoring Report no 24

11. The report also describes the impact on the workforce. In their survey of trust finance directors, the issues which most concerned them, even more than performance, was the morale of staff. The report concludes that ‘as frontline staff try their best to improve quality of care and access for patients, it is increasingly apparent that we are setting them an impossible task’[9].

12. One of the factors that has tested the resilience of staff has been the imposition of a prolonged period of restraint during which time earnings have diminished in value. The Secretary of State for Health’s announcement in October this year that the cap on NHS pay will come to an end will have been met with mixed reactions among employers in the NHS. On one hand, relief at the relaxation of extended pay restraint, which has been a major factor affecting their ability to recruit and retain staff. On the other, concern about their ability to meet the extra costs from within existing budgets without the guarantee of additional funding.

13. These views are widely shared among NHS providers, commissioners and professional bodies and were expressed in a joint letter to the chancellor from the NHS Confederation and other signatories which said that:

    ‘The current pressures on recruitment and retention are already affecting the care and treatment that is being delivered with staff shortages across all parts of the country. Pay restraint is a major factor affecting staff working in health, social care and the wider public sector. Vacancy rates, particularly in clinical grades in both hospital and community alternatives, are now affecting the quality of care that people experience. We therefore support a relaxation of pay restraint, but additional costs which result must be funded in full by the government.’[10]

14. This is also the view of national NHS leaders. Giving evidence to the Health Select Committee, the chief executive of NHS England Simon Stevens said ‘… we said from the get-go that over time it will be necessary for NHS staff to get rates of pay that are consistent with … the rest of the economy. It is not reasonable indefinitely to expect people to take the kind of net pay cuts that they have seen, but that does need to be funded.’[11]

15. At the same committee session, the chief executive of NHS Improvement, Jim Mackey, said of a pay rise beyond the planned 1 per cent that ‘it is my view… that needs to be funded. The NHS is

[9] The King’s Fund ibid
[10] NHS Confederation (October 2017) open letter to the Chancellor of the Exchequer
[11] Health Committee. Oral Evidence: The work of NHS England and NHS Improvement HC430 Q28

generating serious levels of efficiency. It is very hard to imagine how that sort of pay award could be internally financed'.

16. Pay restraint has been the single biggest contributor to the delivery of the efficiency savings challenges set out in the Five Year Forward View, but there seems to be consensus on all sides that continued restraint no longer remains a viable option. There also seems to be agreement that, having delivered considerable efficiency savings so far, the NHS is not placed to find even more efficiencies to fund higher increases in pay than those already planned. Without additional funding the choice for NHS organisations is stark – reduce staff or reduce services.

17. While pay restraint and NHS pay more generally have understandably featured prominently in much of the debate around the financial and workforce difficulties facing the NHS, it's clear that just concentrating on pay alone will not resolve the multiple challenges that NHS organisations currently face in meeting the demand for high-quality care. The prospect of a higher, but still relatively modest, pay increase will not be a cure for all problems.

The recruitment and retention challenge

18. We welcome the range of initiatives that have been introduced recently to increase the supply of healthcare professionals, although we acknowledge that in many cases it will take some time for this increased supply to take effect. It is important that we complement important national initiatives on supply, and support innovative local work on recruitment, by continuing to focus on retaining, supporting and developing the highly trained, talented and committed staff that we already have.

19. This is even more important given the current uncertainties arising from Brexit which, in future, could reduce access to EU healthcare professionals on which the NHS has increasingly relied.

20. There is no single action which will resolve staff retention issues. We recognise that some turnover of staff is healthy and is to be expected as they move on to new opportunities. However, high volume turnover combined with difficulties in recruitment leads to rota gaps, which in turn adds to pressure on the remaining staff and can lead to an over-reliance on expensive agency and locum staff. We have set out a range of actions which employers can take to help retain and develop existing staff. The guidance draws on the learning and experience of organisations we have worked with over the course of 2016 and 2017.[12]

[12] NHS Employers (September 2017) Improving staff retention: a guide for employers

These actions advise:

- improve staff engagement to increase retention, staff morale and productivity
- support and promote health and wellbeing
- provide a safe and open environment in which concerns can be raised and acted upon
- offer flexible working and e-rostering to help staff balance their personal and professional lives
- develop a culture which recognises and values difference and delivers a positive workplace experience
- tackle bullying and harassment
- provide educational and training activities to support professional and personal development and career planning
- offer flexible retirement options.

21. Pay and reward is an equally influential factor in staff retention. During the time in which pay restraint has had an impact on salaries, employers have continued to promote the full range of reward and benefits that the NHS and their organisations offer. Such non-pay related benefits include access to the NHS Pension Scheme, annual leave and other contractual benefits, flexible working and family-friendly working arrangements.

22. While the measures we have described above will provide a firm foundation on which to improve the retention of staff, they are also significant factors in making a career in the NHS more attractive, so that staff with the right values, skills and knowledge are recruited into the organisation and that they are supported and developed as they progress within it.

The productivity challenge

23. A motivated and engaged workforce is important if the NHS is to work in new and innovative ways to meet the challenges ahead. Any extra funding for the NHS will result in little benefit if there are not enough staff. Neither will there be any benefit in recruiting extra staff without thinking critically about how they are deployed and organised. This is reflected in statements from the Secretary of State that any increase in pay will need to be accompanied by improvements in productivity. A joint statement from the King's Fund, the Health Foundation, and the Nuffield Trust said recently that, despite the considerable efforts that the NHS had made to meet the efficiency challenges required by the Five Year Forward View 'there is still scope for more fundamental improvements in productivity by tackling variations in how care is

delivered, improving clinical practice and making better decisions about how funding is spent'.[13]

24. However, as a recent King's Fund report on embedding a culture of quality improvement pointed out, this kind of work takes time and in a period of sustained pressure it can be difficult to find the space in which to do so. The report concludes that NHS leaders play a key role in creating the right conditions for quality improvement by engaging with staff, empowering frontline teams, and ensuring that there is an appropriate infrastructure in place to support staff and spread learning.[14]

Pay and contract reform

25. A common thread linking the recruitment, retention, workforce and productivity challenges, is the national pay and contract framework and the related work around contract reform. These contractual arrangements are fundamental in helping to ensure that employers can recruit, retain and motivate staff and that they are able to deploy them flexibly in an affordable and sustainable way. In return, staff can expect to be appropriately recognised and rewarded for the contribution that they make. As we continue with our programme of contract reform, there will be opportunities to link this work to some of the national quality and efficiency programmes, including Lord Carter's review of operational productivity and the Getting it Right First Time (GiRFT) project. There will also be opportunities in future to use the information and data emanating from these programmes to help improve the alignment of pay and individual contribution and performance.

A coordinated approach

26. There are many programmes of work currently underway within many different organisations aimed at tackling the various financial and workforce challenges the NHS faces. These include boosting training numbers, tackling retention, improving the workplace experience and reforming pay and contracts. Although in most cases these will be undertaken separately, there is a considerable amount of interdependency between them, where failure to resolve issues in one area can potentially undermine work in another.

27. In its report on workforce profile and trends in the NHS, the Health Foundation concluded that 'proper workforce planning is required that looks across different staff groups to evaluate impact – not focusing purely on the numbers of consultants or nurses separately'.[15] This point was also made in an earlier Health Foundation report on consultant productivity which found that hospitals with a higher proportion of nurses and support staff within their total workforce, had higher consultant

[13] Nuffield Trust, King's Fund and Health Foundation. The Autumn Budget 2017 joint statement

[14] The King's Fund (November 2017) Embedding a culture of quality improvement

[15] The Health Foundation (April 2017) In short supply: pay policy and workforce numbers

productivity and that increasing the share of nurses by 4 per cent increased consultant productivity by 1 per cent.[16]

28. We therefore welcome the Secretary of State for Health's recent announcement of a robust, coordinated approach to workforce strategy to make clear how the NHS will collectively address the future supply, retention and development of its workforce. This is an opportunity to set out how actions to date will help employers in the short, medium and longer term, as well as be clear on what further actions will need to be taken at every level of the NHS and across government.

29. Embedding and realising the benefits of any strategic workforce plan will require leadership and a commitment by organisations to ensure that all staff are valued, supported and developed throughout their careers. The link between effective staff engagement and outcomes is well known. The more that NHS organisations value their staff and make their working lives a positive experience, the better placed they will be to meet difficult recruitment and retention challenges and, most importantly, be able to provide consistently safe, high-quality care to their patients.

[16] Health Foundation (March 2017) A year of plenty? An analysis of NHS finances and consultant productivity

The workforce challenge

Pay and contract reform

30. A key priority for NHS Employers is to maintain and reform national pay and conditions so that they are fit for purpose. The case for medical and dental contract reform has been set out in previous evidence, taking into account recommendations from the DDRB.

Consultant contract

31. A compelling case for change remains to ensure that the consultant contract supports the NHS in the delivery of the priorities set out in NHS England's Five Year Forward View and addresses quality and efficiency/productivity challenges, the changing needs of patients and new models of care.

32. Employers are seeking a balanced package of reforms that supports the recruitment, retention and motivation of consultants as well as enabling organisational objectives without creating new additional cost pressures. For employers, reform of the consultant contract is not about cutting the pay bill, it is about getting the very best value for the money spent annually on consultants' pay for leading and delivering care to patients.

Reform priorities

33. Employer priorities which continue to inform the negotiations process for reform of the consultant contract are focused on:

- affordability
- workforce engagement
- increasing flexible and affordable capacity across the working week
- improving retention by targeting the pay bill more efficiently - contract reform must support attraction to harder to recruit specialties which require substantial out-of-hours working
- introducing stronger links between pay progression and performance
- improving links between reward, effort and current performance through reform of the current local clinical excellence award (CEA) scheme as previously recommended by DDRB.

Progress to date

34. National negotiations between NHS Employers and the British Medical Association (BMA) over an amended contract for consultants have been ongoing in some form since 2013.

35. These talks have been constructive, but progress has been slower than anticipated. The Hospital Consultants and Specialists Association (HCSA) has been involved in the process since the beginning of 2017 following their recognition for the purposes of national collective bargaining for medical contracts (December 2016). Reaching an agreement has proved difficult within the constraints of the government's public sector pay policy and the wider financial and service delivery challenges facing the NHS.

36. In light of the review of the government's public sector pay policy and the delayed DDRB process for 2018/19, it is no longer considered feasible for an agreement on a significant package of contract reform to be implemented from April 2018. The negotiation parties will consider a revised implementation timetable following the outcome of the DDRB process and the subsequent response from government.

37. Creating a stronger link between performance and pay will assist in this ambition, with progression through the pay scale being contingent on performance, and by offering access to performance payments linked to the delivery of objectives above and beyond the standard job role.

38. Employers are seeking to avoid having to apply and maintain a variety of contractual terms and remain focused on reaching a collective agreement that will result in the vast majority of consultants being employed under the same contractual terms.

Scope of contract amendments under discussion

39. The parties have continued focused discussions on amendments to the 2003 contract using the principles listed below.

Base pay

40. Replacing the current eight-point pay scale with a new scale using two fixed payment points equating to two stages of a consultant's career - newly appointed and established - bringing an end to the current incremental pay progression system.

Affordable available capacity

41. Employers are seeking to remove the contractual provision to opt out of non-emergency work out of hours with the replacement of several contractual safeguards.

42. Such safeguards aim to promote and protect the health and wellbeing of consultants and safe practice for patients where changes are made to the delivery of services.

43. Any agreed safeguards will need to ensure that employers are able to maintain flexibility around service provision, staff deployment and management of the consultant workforce pay bill.

Out-of-hours working

44. No immediate changes are being proposed or discussed in respect of the current contractual allowances that reward work undertaken out of hours. Reform remains an employer priority over the medium to long-term, but as the data and evidence base around current working practices is currently not clear, further data collection and analysis will need to be undertaken to inform more detailed discussions.

45. Understanding the implications of organisational re-configurations, and the re-definition of local service provision and local operating models, adds a further degree of complexity and provides additional justification to pursue a longer implementation timetable to deliver reforms.

Local clinical excellence awards (CEAs) / Local performance pay

46. The review body's report *Contract reform for consultants and doctors & dentists in training – supporting healthcare services seven days a week* (July 2015) endorsed NHS Employers' proposed approach to performance pay as it broadly mirrored the recommendations in its report published in December 2012 on reforming local CEAs. This endorsement was supported by the Department of Health following publication.

47. Employers' preference remains for the development and introduction of a new performance management scheme for all eligible consultants. It is accepted that consideration for such new awards should be made with:

    - agreed and ring-fenced funding
    - protection for existing awards already in payment - these will be subject to review under new renewal and review criteria, with scope for a partial reduction of awards in payment where levels of performance no longer meet criteria.

48. An overview of the proposed basic structure of a new exemplary performance scheme is set out below.

Aims

- To introduce a new performance-related pay scheme to replace the current local CEA scheme, which is linked to the delivery of objectives above and beyond the standard job role.
- To remove the existing by-application process and competitive-based quota requirements, with payments being made to all those who meet the agreed standard (after in-year moderation and governance processes are completed).

Proposal

- Awards would be non-consolidated, non-pensionable and time-limited for up to three years (with one year the expected norm).
- All consultants who meet a required standard receive a share of the in-year performance reward sum based on the performance rating they receive through a moderated self-assessment process.
- National guidance would set out expected reward values anticipated distributions and all the in-year funding should be spent. The aim would be to allow consultants access to similar earnings potential as now, with the total in-year payment capped to the value of the agreed in-year-performance pay cap.
- The actual value of local awards would necessarily be influenced by factors such as local protection requirements, the numbers who reached the standard, and any ongoing time limited awards.
- Organisational and team payments would be introduced where appropriate for the trust (for example when sufficient funding is available). Trusts would have the flexibility to decide how these would operate.

DDRB considerations

Consultants' headline pay award uplifts

- Should pay recommendations in 2018 on headline awards be considered above the current 1 per cent cap, we are seeking DDRB endorsement for the targeting of awards that support employers' structural pay reform priorities.

Consolidated pay awards

- Consolidated pay awards at the top of the pay structure should be maintained at 1 per cent.
- Any such awards above 1 per cent should be targeted on mid-range consultant career pay points (at years five and eight). This will help to reduce future costs and the time taken for a transition to a reformed two point pay structure.
- Entry level and years one to four should also be held at 1 per cent (as this group of staff receive annual pay increments).

Local clinical excellence awards

49. Any additional investment above the 1 per cent should also be used to enhance local excellence award funds to reward performance, productivity and efficiency in support of organisational objectives. For example, sustainability and transformational partnerships/ accountable care systems (STP/ACS) delivery, as well as those aligned with wider

system initiatives such as Getting it Right First Time (GIRFT) and The Model Hospital.

Consultant workforce

50. The number of whole-time equivalent consultants rose by over 20 per cent in the period March 2010-2016, which suggests that a career in medicine remains attractive. However, this growth in numbers masks considerable variations. Over the same period the number of psychiatrists fell by 0.4 per cent and there are vacancies in other specialties and locations which have been traditionally hard to fill.

51. Employers continue to make use of the flexibilities in the current contract, such as recruitment and retention premia, payments for additional responsibilities, and additional programmed activities to attract staff. However, as we refer to in Section 4, pay is only one aspect of reward and employers must continue to value, support and engage their consultant workforce within a positive working environment.

52. In a rapidly changing world, greater flexibility and new ways of working will be needed if we are to continue to meet the evolving needs of patients. Employers are seeking a balanced package of reform which supports the recruitment, retention and engagement of the consultants we need to lead and deliver change.

The national contract for doctors in approved postgraduate training programmes in England

53. October 2017 marked a year since the beginning of a phased implementation of the 2016 contract. All eligible trainees are now working on this contract. This has been the result of a great amount of work by trusts, their medical staffing teams and trainees. NHS Employers acknowledges and thanks them for this.

54. The BMA remains formally opposed to the contract and the way it was implemented. Despite this position, we have been working with the BMA to produce guidance and responses to frequently asked questions in the interests of patients, trainees and employers. Further, we remain committed to reinstating national collective mechanisms with the BMA's junior doctors' committee (JDC) during 2018.

Highlights

55. Some of the key features of the new contract include work schedules, guardians of safe working and exception reporting. There has been some variation in how they have been taken up in different areas but, in general, we have seen real and significant changes happening in many

places. Boards are talking about training more than ever before. Junior doctors are working with their guardians and educational supervisors to identify and make changes to poor working practices. Over 6,000 rotas have been redesigned to make them compliant and safe.

Challenges

56. There are still challenges to overcome, and culture change takes time. Although exception reporting is working well, there is still much more of a focus on reporting practice which has an impact on hours, rather than missed or poor-quality educational experiences.

57. Work scheduling, although an integral process, has turned out to be resource intensive for medical staffing teams – both in terms of personnel and financially. Designing rotas in the mixed economy of doctors on old and new terms is also very onerous. However, employers generally feel that the underlying principle of the new contract - that doctors should be paid for the work they do - is the right one and, in the long run once all junior doctors are on the 2016 contract, the long-term benefits will be worthwhile.

Morale and staff experience

58. We have received mixed reports about the experience of junior doctors. Many employers say that as the contract has been implemented, they are receiving far fewer complaints about it. For most doctors (F2s excluded), their basic pay is higher than it would have been on the 2002 contract. Guardians of safe working and medical staffing colleagues report that where the guardian role and the junior doctor forum (now enshrined in the new contract) have been well embedded, this has had a positive impact on morale – junior doctors feel that they have a forum to air their concerns, and that these are being heard. The guardians' impartiality and direct access to the board have been influential factors in this.

59. However, there have been issues which have affected morale in some locations, including:

- difficulties in accessing flexible working and training patterns
- rota gaps (because of supply issues discussed below)
- rota uncertainty when trainees join a new employer
- the administrative burden when rotating to new training placements
- cultures that do not encourage exception reporting.

60. The various agreements reached with the BMA's JDC are being honoured by the NHS. A large number of actions were identified, the progress of which is currently being reviewed.

61. We are working to address these issues. NHS Employers is closely involved in the enhancing working lives of junior doctors group. This group is working towards several (non-contractual) outcomes which aim to make improvements to trainees' experiences. These include opportunities to streamline processes, such as the recruitment, induction and rotation procedures that many trainees currently find burdensome and repetitive.

Workforce supply issues

62. We know that recruitment and retention issues equally affect doctors in training. This has an impact on the wider workforce which then must cover the gaps.

63. There is some emerging, anecdotal evidence to suggest that the flexible pay premia introduced to address hard-to-fill specialties (emergency medicine, general practice and psychiatry) have had an impact, but it will take time to be able to fully evaluate their overall effectiveness in both attracting and retaining trainees throughout the duration of the programmes. However, some regional variations persist. The South East now has an oversubscription to GP training programmes whereas rural and coastal areas generally continue to struggle to recruit.

64. Some employers have suggested that it might be worth considering how flexible pay premia could be targeted in a strategic way to address those challenges determined by location and geography as well as by specialty.

Pay issues

65. Employers have identified some other issues related to pay.

- In the transition to the 2016 contract, there is a view from some employers that F2s might benefit from a slightly higher uplift to their pay than others who benefited from the transition financially. This would improve engagement and aid retention among this group of staff.

- The clause in the 2016 contract, which requires trainee doctors to offer their additional time to the NHS bank before others, was intended to contribute towards a reduction in the cost of agency spend. However, employers report that the national locum rates set by NHS Improvement are not always workable. They are not competitive with local labour market rates and trainees will not work for them. Employers are therefore agreeing higher rates locally to secure cover, and being penalised for doing so. They have suggested that the rates be reassessed.

- Some employers have expressed concern about the withdrawal of nodal point 5 and the potential impact upon doctors with longer term

career pathways. Trainees moving from ST/SpR2 – ST/SpR3 (nodal point 3-4) receive a large pay rise of just under £10,000, which is then followed by an extended period where their training and competencies progress but which is not reflected in their pay. ST6 work, for example, differs greatly from the expectations on an ST3-level trainee. Some employers feel that, in the interests of retention, morale and equity, that this could be addressed by freezing nodal point 4, and reintroducing nodal point 5 at an appropriate junction in the training pathway.

Devolved nations pay protection

66. An amendment to the contract is underway following instructions from the Department for Health. The new contract allowed a period of pay protection for trainees moving from the 2002 contract in England, to the 2016 contract. The amendment, expected to be finalised at the end of 2017, will also make eligible for pay protection all trainees transferring from relevant training contracts in Scotland, Wales, Northern Ireland, the Channel Isles, and the Isle of Man – as well as those on other relevant contracts, such as clinical academics, lead employer and defence deanery trainees. The intention is that these payments are backdated for eligible trainees. In order to provide equity for trainees within a cohort, the pay protection clock is to start from the relevant point in the 2016/17 implementation schedule (except for trainees who are out of programme and who are provided for under other terms in the contract)

67. This is expected to have several implications for trainees and employers, not least a potentially significant resource impact for employers, but it might help to attract trainees to England, and perhaps address some of the workforce shortfall, although of course there may be an effect on the devolved nations.

Acute common care stem (ACCS) (anaesthetics) - change to curriculum

68. The Royal College of Anaesthetists, with the support of Health Education England (HEE), is currently progressing a change to the ACCS (anaesthetics) curriculum to reflect enhanced educational progression, which will mean that third year (formerly CT2(b)) trainees should now be classified as CT3 for payment purposes. This could have a potentially significant cost implication for employers, which will need to be reflected in HEE's funding provision for this group of trainees.

Dental trainees – nomenclature related to pay

69. NHS Employers is currently working with employers of dental trainees, and their union, to address some issues in terms of inconsistent application of the pay protection provisions in the contract. This is the result of the nomenclature relating to dental trainee pathways. By way of example, dental specialty trainees (DST) at level 2 are at a level of training considered equivalent to medical trainees at ST5 level.

2018 review of the contract

70. The ACAS agreement included the following commitment to review the 2016 contract:

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

71. This will be commissioned from August 2018. We have begun high-level engagement and planning which has resulted in the development of some overarching principles:

- The scope of the review must stay firmly within the boundaries of contractual issues. Non-contractual issues are within the remit of other organisations, such as Health Education England.

- In line with the public sector equality commitment, the review must include an equality impact assessment (to consider groups such as less-than-full-time trainees).

- There will be some priority areas for consideration which have been raised by both parties throughout implementation of the contract. A fair process for agreeing priority areas will be determined in planning phases.

72. We are currently in discussions with stakeholders (including the BMA and the HCSA) about the 2018 review of the contract, in terms of process and potential aspects of the contract to be included in the review.

Staff grade, associate specialist and specialty (SAS) doctors

73. Staff grade, associate specialist and specialty (SAS) doctors and dentists are a diverse group with a wide range of backgrounds, skills and experience. They work as staff grade doctors, associate specialists, specialty doctors, hospital practitioners, clinical assistants, senior clinical medical officers and clinical medical officers. Within these roles they tend to work within nationally agreed terms and conditions.

74. There is also another group, which the National Association of Clinical Tutors describes as locally employed doctors, who also fall within the wider group of doctors who are neither consultants nor in training posts. These can include trust-grade doctors and doctors in fellow posts who will be employed on local terms and conditions. In its report last year, the review body noted that trusts had been increasingly advertising roles as associate specialist posts. Although the grade is now formally closed, some elements of the old terms and conditions seem to have been incorporated into locally agreed contracts.

75. The review body also highlighted a number of issues concerning the recruitment and retention, morale, career development and pay of SAS doctors. Evidence from the NHS Staff Survey also indicated areas of dissatisfaction and we have agreed with the BMA's SAS committee to work together to address these concerns. We will also engage with the HCSA following their recognition for the purposes of national negotiations.To help NHS Employers gain a better understanding of some of these issues from an employer's perspective, we undertook a brief survey of employers in August this year.

Recruitment and retention

76. Analysis of the survey showed that 77 per cent of respondents had experienced some difficulty in recruiting to SAS posts. The specialties which proved hardest to fill were emergency medicine, psychiatry and paediatrics. A small number of trusts reported that they had difficulties recruiting to all specialties. The most common reason given to explain recruitment difficulties was the general supply position and national shortages (82 per cent) followed by pay and conditions (57 per cent), location (39 per cent) and job design (18 per cent).

77. When asked about retention, 31 per cent of respondents said that they had experienced problems, which means 69 per cent had not. The most common reasons for leaving were career progression (78 per cent), which could be due to SAS doctors moving on either by re-entering training or following the certificate of entry specialist route (CESR). Other reasons given for leaving included pay (57 per cent), morale (48 per cent), career development (43 per cent) and workload (26 per cent).

78. Respondents described a variety of local initiatives they had put in place to support recruitment and retention. Those adopted by more than one trust included:

- the introduction of programmes to aid progress towards CESR where support, development and rotation to other specialties for CESR were offered
- developing recruitment and retention initiatives, including a recruitment campaign and job descriptions which reflect the SAS charter and promoting development

- granting additional annual leave beyond the contractual amount
- focusing on continued professional development (CPD) in the form of SAS development, leadership and teaching programmes
- implementing the SAS charter
- providing time for supporting professional activities (SPA)
- improving job planning
- supporting overseas doctors.

79. Other examples included offering acting-up opportunities, increasing autonomy, providing mentoring and support, full integration of the SAS doctor group, and encouraging appointments to key management committees. The SAS development fund remains a valuable resource to support the development of SAS grade doctors working in England although there does appear to be some variation in the use of these funds across regions.

Motivation and morale

80. We asked employers about some of the specific issues they have identified which affected the morale and motivation of SAS doctors. The most common issue cited was lack of professional development. This was also linked to career progression and access to study leave where it was felt that SAS doctors were not offered equal access to opportunities. Lack of funding for development was also a factor, as was the availability of time for supporting professional activities.

81. Pay was the next common issue with the long incremental pay scale and slow progression as a source of dissatisfaction adding to the effect of a sustained period of pay restraint. Some employers noted that the disparity between contract and agency locum pay rates had been a cause of concern.

82. Equally prevalent was the perception among SAS doctors that they were not sufficiently valued or recognised for their skills, experience, or contribution. They also felt unjustifiably neglected in comparison to doctors in training and their consultant colleagues. This has led to some SAS doctors feeling less respected by their peers and less valued by the organisation. For example, by being excluded from involvement in management and decision-making. There was a view that much of this was perpetuated by the use of the term ‘middle-grade doctor’. We have previously advised employers to avoid using the term middle grade to refer to SAS doctors as there is no such grade. Specialty and associate specialist doctors should be referred to by the contract they are on, for example, specialty doctors, associate specialist doctors, staff grades, or in short, SAS doctors. One of the issues which linked both pay and recognition was the closure of the old associate specialist grade and the loss of a recognisable job role, higher pay and eligibility for discretionary points.

83. We also heard that there was a perception that those SAS doctors on local trust contracts, which were often fixed term rather than nationally agreed terms and conditions, were not offered the same opportunities for participation and development (for example access to study leave). SAS doctors often applied for the role for its flexibility in terms of career choices. However, they are often covering rotas and on call to provide cover for annual leave, study leave and vacancies and do not always have the same access to training and development opportunities as doctors in training or consultants.

84. Several respondents raised ineffective job planning as an issue within their organisation, highlighting that supporting professional activities (SPA) time within the job plan for SAS doctors varied from very good to less supportive and that often this was pushed back to accommodate service requirements. A few trusts mentioned the laborious nature of the CESR application process and the lack of support available for candidates.

85. Other factors which had an impact on morale and motivation included lack of parity on annual leave with consultants, lack of access of an equivalent to the clinical awards scheme to reward excellence and innovation, a requirement to concentrate on routine work and lack of engagement in service change which led to uncertainty.

86. The NHS Staff Survey highlighted that 24 per cent of SAS doctors had experienced bullying, harassment or abuse during the previous 12 months and that only a proportion of those who had experienced such behaviour had reported it. The NHS Social Partnership Forum has issued a collective call for action to tackle bullying in the NHS. It encourages NHS organisations to tackle bullying, support staff to respectfully challenge problem behaviours, and publish their plans and progress so that staff, patients and the public can hold them to account.[17]

87. We asked about some of the work that employers had undertaken to improve the morale of SAS doctors. This resulted in a varied list of initiatives often aimed at addressing the problems with morale which had been identified elsewhere in the survey. Several respondents cited work around the general heading of improving engagement with SAS doctors, for example, through establishing SAS forums and other engagement sessions where doctors could discuss and resolve concerns. In some cases, this was supported by additional local surveys to help assess SAS doctors' needs and inform further action. A total of 82 per cent of respondents said that they had appointed a SAS tutor. This is an influential role which provides support and guidance to SAS

[17] Social Partnership Forum. Tackling Bullying in the NHS - A Collective Call for Action

doctors and leadership in both the professional development of SAS doctors and the contribution of SAS doctors to education and training of trainees in relevant specialties.

88. Within the area of professional development, employers have undertaken a range of activity including support and development for CESR, support for CPD, improved job planning, ensuring that clinical activity was correctly coded to the doctor, and reviewing local implementation of the SAS charter. The importance of health and wellbeing was also recognised, with one trust running a psychological wellbeing course, and others offering doctors greater control over their working lives and rotas.

Pay and recognition

89. Just over half of respondents said that pay had been a factor in whether SAS doctors had decided to undertake additional duties. Not all employers had agreed local arrangements for rewarding additional work undertaken by SAS doctors. The current staff grade contract does not provide employers with much discretion. However, locally agreed arrangements included acting up payments, payments for additional programmed activities, clinical lead payments, financial support for further educational qualifications, responsibility allowances for tutor roles, and increased rates for some sessions.

90. Employers had mixed views on previously expressed concerns by SAS doctors about equal pay. Employers noted that for some trainees entering the grade, the salary on commencement was lower than that which they would have received under the 2016 contract. There were some issues with overseas doctors and their expectations of starting salary. The relatively low starting salary and long incremental scale made it difficult to recruit in some hard-to-fill specialties.

91. In considering SAS pay compared to their consultant colleagues, some employers said that pay parity could be an issue for experienced SAS doctors when compared to new consultants. There is a disparity between pay for consultants and SAS doctors where the current staff-grade contract does not reward additional responsibilities or clinical excellence. For some, this lack of parity in pay contributed to the feeling by some SAS doctors of a lack of parity of esteem and the value in which they were held.

92. In some cases, the establishment of a trust associate specialist post has been suggested as a solution to recruitment and retention difficulties, as well as a way of addressing some of the issues around pay, recognition and morale. Several employers commented that a return to the old associate specialist grade would help with career development and progression and provide a way of recognising skills and expertise. Otherwise, employers suggested payments for additional

responsibilities, a form of clinical excellence awards or discretionary pay points.

National initiatives

93. It is clear from the survey data that many employers are working hard to improve the recruitment, retention, morale and development of their SAS doctors. The range of work carried out reflects the diversity of the settings and the numbers in which SAS doctors are employed. Equally important is the work currently being undertaken in organisations such as Health Education England and the Medical Royal Colleges to support and develop SAS doctors. We look forward to working with the BMA's SAS committee to help spread and embed good practice whether this is generated locally or nationally.

94. HEE Yorkshire and Humber has several projects currently underway including SAS clinical leadership fellowship schemes, promotion of the SAS charter and development guide, education events and an annual conference. The aim is to provide SAS doctors with equal opportunities to fulfil their career aspirations, to enable mechanisms for SAS doctors to be appropriately rewarded and recognised for the work they do, and to increase parity between SAS doctors and the rest of the workforce.

95. The recent report *Securing the future emergency workforce in emergency departments in England* recognises the contribution that SAS doctors make and describes a shop-floor skills training programme developed for SAS doctors in the West Midlands. The programme aims to support the development of more versatile and autonomous clinicians who are better able to manage the increasingly diverse range of conditions presenting in emergency departments, improve patient care and support a key proportion of the clinical workforce.

96. In preparing this submission we also spoke to an associate postgraduate dean about proposals he had developed for a structured career pathway with progression based on assessment which, over time, could be linked to pay. We discussed this with members of our medical workforce forum who supported the notion of a structured assessment process to underpin career and pay progression, with some renaming of posts to reflect seniority and experience – for example, senior specialty doctor. A process such as this could potentially address concerns about career progression, recognition and status, and aid recruitment and retention.

97. This seems to echo the views of SAS doctors in a recent survey carried out by the Royal College of Anaesthetists. A consistent theme was a desire for recognition of their skills and clinical competence as well as clear career progression pathways. Re-opening of the associate specialist grade was a recurring priority. Many felt that the new specialty doctor contract did not allow sufficient distinction between those early in their career and those effectively working at consultant level in the

clinical setting. It is also preventing current associate specialists from moving posts because any new appointment would be on the specialty doctor contract.[18]

Maximising potential

98. SAS doctors play a vital role in delivering and leading on high-quality services and it is important they are recognised for the contribution that they make. We know from the staff survey and other sources that SAS doctors have felt undervalued and underappreciated for some time. Evidence from employers that we surveyed, backed up by a range of national initiatives, suggests a willingness and determination to address this through better engagement, support and career development. Even so, more needs to be done.

99. The SAS charter and SAS development guide provide a framework for improving the recruitment, retention and development of SAS doctors. Employers, national bodies and others need to work together to maximise the potential of this important group of doctors. Some solutions might require changes to national terms and it is likely that we will wish to revisit the current contracts considering the outcome of the work on the consultant contract. Meanwhile, we will continue to work in partnership with the medical trade unions and others, to take forward work to ensure that SAS doctors are valued, supported and developed to provide high-quality care and outcomes for patients.

Salaried primary dental care services dentists

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

101. The contract mirrors those for consultants or specialty doctors. However, one significant area of difference is the competency framework for Band A dentists, Band B senior dentists and Band C managerial or specialist dentists. This hasn't changed since 2008, despite the changes in the NHS since then. It may need to be revisited to take into account that the majority of SPDC dentists are no longer employed in primary care organisations and that the criteria for

[18] Royal College of Anaesthetists (June 2017) SAS Anaesthetists - Securing Our Workforce

progression through the bands does not reflect current structures. We are aware that dentists are concerned about the lack of opportunity for movement through the bands.

102. Employers have not raised any particular difficulties around the recruitment, retention and morale of SPDC dentists, other than to raise some isolated, local issues largely to do with geography in relation to recruitment.

103. Earlier in 2017, NHS Employers and the British Dental Association wrote jointly to NHS England about the possibility of including SPDC dentists as a discrete group within the annual NHS Staff Survey to provide for a better understanding of some of the issues facing this occupational group. At the time of writing we have yet to have a formal response from NHS England.

Salaried general practitioners

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

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

106. While the salaried GP contract within GP practices has always been an option, there have been some examples recently where contractor or partner GPs have opted for employed status. There has also been an increasing number of cases where NHS trusts have taken on the provision of GP services. Additionally, working arrangements developed under new models of care and new collaborative structures are testing the current salaried GP contract. However, as mentioned above, there is no formal mechanism where the current model salaried GP contract and associated terms and conditions is discussed.

2. Staff engagement and the NHS Staff Survey

Policy context

107. The overall policy context for staff engagement in the NHS has national and local elements. The NHS staff pledges underpin action by local employers and commit the NHS to providing opportunities for individual and collective involvement. The national framework for development published in 2016, *Developing people - Improving care*, also includes a requirement for organisations to develop staff engagement. An assessment of staff engagement practice is included within the overall assessment by the Care Quality Commission of whether an organisation is well led. The Department of Health commissions NHS Employers to provide support to local employers on staff engagement issues.

Metrics

108. The review body remit refers to looking at the 'morale and motivation' of NHS staff. The review body expressed concern in its report as to whether the current metrics within the NHS Staff Survey provide it with data that can assess NHS staff morale and motivation.

109. There have been discussions within the NHS Staff Survey advisory group on the current range of measures. The measures were not changed for the 2017 staff survey. NHS England has, though, agreed to review whether a measure of morale could be developed based on new or amended questions. NHS Employers believes the existing measures within the NHS Staff Survey are valid and reliable measures of staff experience and an acceptable proxy for consideration of morale.

110. It is, though, important to make clear that the key findings need to be looked at as an overall set of indicators. No one indicator can act as a single overall barometer of staff experience.

111. The indicators which are likely to be most relevant to the review body are the findings for staff recommendation, staff motivation and staff involvement (together these comprise the staff engagement index score). Other relevant metrics are the staff satisfaction with support indicator, the health and wellbeing indicator, and the workload indicator.

112. The trends in these are examined below. Overall, the 2016 staff survey showed improvement in the majority of key findings. The degree of improvement was variable and there continued to be a range of performance between NHS organisations.

Trends

113. In the case of staff engagement, the improvement in 2016 was small but built on notable progress in 2015. The staff engagement index rose from 3.78 to 3.79 (on a five-point scale) in 2016. To sustain engagement at this level, given the pressures on the service, is a considerable achievement. Within the overall score, the motivation element remained stable at 3.92 (following significant increase in 2015). Levels of involvement improved slightly (from 69 to 70 per cent), and the measure of willingness to recommend the NHS also improved from 3.72 to 3.75.

114. Other relevant indicators are less positive. The level of staff satisfaction with resourcing and support, which includes issues such as staffing levels, remained lower than for staff engagement. The measure of staff satisfaction with recognition and being valued, although improving, also remained low. The variation between organisations was considerable.

115. Staff engagement trends are also shaped by overall staff experience where the 2016 data indicated a mixed picture. There are improvements in some measures of people management practices but, on health and wellbeing, the picture is mixed. There is an improvement in the staff view of health and wellbeing interventions but stress remained at an unacceptable level and most staff continued to report working additional hours to provide services.

Employer action

116. Employers in the NHS understand the importance of staff engagement and developing approaches to foster and sustain engagement. In 2016, NHS Employers identified 28 organisations which had made significant progress in this area from the staff survey data. These included organisations which have participated in successful programmes such as Listening into Action, the Virginia Mason Partnership and Go Engage, as well as those that have developed their own bespoke approaches.

117. NHS Employers has highlighted some lessons from those organisations that made the most significant improvements and shared these with other organisations via our website and networks. During 2017, NHS Employers also supported networking within ambulance trusts.

118. A particular theme of employer activity in 2017, has been to improve approaches to staff involvement. Several trusts have developed tools that allow for real-time staff feedback using digital technology, while others have developed their own local staff surveys to complement the national staff survey. For example, the Go Engage survey tool is now used by a growing number of organisations. Other innovations have included crowdsourcing staff ideas, greater staff involvement in quality improvement, new approaches to

recognition, training support for line managers, and changes to appraisal.

119. There are some positive indications from the Care Quality Commission inspections which indicate progress in a number of NHS trusts that have historically had lower staff engagement levels. The overall ratings of organisations improved a little in 2017, with more organisations rated as outstanding than inadequate - although the majority continued to be rated as requiring improvement. The CQC now has a focus on engagement in its assessments.

Under pressure

120. Employers appreciate that there are challenges in the current context, and are acting to sustain engagement in the face of these pressures.

121. The 2017 staff survey data is not available at the time of writing. There are, however, widespread reports that staff are under unprecedented pressure and that services are being maintained through their extraordinary efforts. There are risks of a downward spiral of worsening staff experience leading to a decline in staff engagement. NHS Employers will seek to support employers to address this challenge at local level, and national action will also be required.

Medical engagement

122. The 2016 staff survey data indicates that medical staff engagement remained broadly stable compared with 2015 (at 3.90/5). This is in line with the overall trend in staff engagement levels in the survey. The medical staff engagement score also continued to be one of the highest for any occupational group. The source of this level of engagement is the vocational commitment of doctors reflected in the high job motivation score 4.04/5. This has held up even though staff have been placed under ever increasing pressure. Overall, doctors remain willing to recommend the NHS as a place to work and be treated (3.84/5). The staff survey has recorded lower engagement levels and overall satisfaction for doctors in training but they too are positive about the NHS as a place to work (3.78/5).

123. It is in the dimension of feeling involved in decision making where the average score for medical staff (at 75 per cent) is lower than for other dimensions, and not as high as might be expected. The score for feeling valued by managers is also lower than for other dimensions at 3.56, though considerably higher than the overall score for the NHS (3.46). Doctors are generally satisfied with individual level of responsibility but not as satisfied with organisational-level involvement.

124. There is a widely researched issue in healthcare services of the disparity between the high level of involvement doctors have with their job and profession, and the correspondingly lower level of involvement they have with their employing organisation. In the USA, there have

been attempts to address this through structural changes such as devolved medically-led business units, as well as initiatives such as physician compacts. These have had some success, and lessons from them have been disseminated by the King's Fund, NHS Employers and NHS Improvement. The Department of Health has funded a learning partnership between NHS sites and the Virginia Mason Hospital in Seattle.

125. The Faculty of Medical Leadership and Management has developed a tool which analyses medical engagement in more depth than the NHS Staff Survey. NHS Employers has promoted the tool and produced a briefing around the issues of medical engagement. NHS Improvement has assisted organisations in special measures to use it as part of overall engagement efforts with significant success. For example, University Hospitals of Morecambe Bay NHS Foundation Trust, and Barking, Havering and Redbridge University Hospitals NHS trust, have focused on issues including medical engagement and made sufficient progress to be able to come out of special measures.

126. Several high performing organisations have also sought to strengthen medical engagement with greater involvement of medical staff at board level, devolution of decision-making to medical budget holders via service-level management, and quality improvement programmes led by frontline medical staff. NHS Employers has recently highlighted some case studies of medical staff involvement in quality improvement initiatives.[19]

127. The GMC has recently published its report on key findings from the national training survey 2017, which is a valuable source of information on how doctors in training view their training experience.[20]

128. More than 53,000 doctors and 24,000 trainers took part in the survey which is used to measure the quality of postgraduate medical education and training. The survey covered matters such as the frequency that trainees work beyond their rostered hours, whether their working pattern leaves them feeling short of sleep when at work, and the impact of rota design and gaps on training opportunities. Employers can download detailed reports for their trusts. The results will be key to discussions with trainees, trainers and their guardians of safe working hours on improving the overall experience of doctors in training within their organisations.

129. Doctors in training continue to rate the quality of their education highly - 81 per cent of trainees would rate the quality of their experience as

[19] NHS Employers (July 2017) Staff involvement, quality improvement and staff engagement-the missing links?

[20] General Medical Council (Nov 2017) Training Environment 2017

either excellent or good, and 93 per cent of trainees would rate the quality of their local/departmental teaching as either excellent or good. However, we know that there are concerns around areas such as the impact of rota gaps, workload intensity and bullying and harassment. We will continue to work with our partners to resolve these.

3. Workforce supply

Changing landscape

130. The shift towards the establishment of more integrated services is now underway with the development of accountable care organisations (ACOs) which have grown from the sustainability and transformation plans/partnerships established in 2015.

131. This move towards a more integrated, place-based approach to the delivery of care requires a change in the skills and mix of the workforce required to support an ageing population with increasingly complex care needs.

132. Organisations across the country, including those not part of an ACO, are looking for ways to deliver more joined-up service for patients through the development of integrated health and social care roles, such as integrated health and social care apprenticeships and the emergence of the nursing associate role. Despite this gradual shift in care delivery approaches, the health sector continues to face skills and staffing shortages in key areas.

133. Employers across the NHS are looking for, and implementing, new ways to support the delivery of their services to patients through recruiting from overseas, developing new training models for specific professions, and exploring ways in which they can better retain and develop their existing workforce.

134. Policy changes made in the last year have also had an impact on employer activity in securing workforce supply. These changes include the implementation of the apprenticeship levy, the introduction of the immigration skills charge, and the removal of bursary payments.

Specific profession shortages

135. Across the NHS, all providers of care and services are experiencing increased demand – this can be seen in hospitals, emergency services, community settings, and mental health provision[21].

136. Changes to population demand, or policy direction, can significantly impact on an organisation's ability to source the staff they need,

[21] NHS England (March 2017) Next Steps on the NHS Five Year Forward View

impacting on their ability to meet demand and provide high-quality patient care.

137. Employers are looking at ways in which to make best use of all available staff and are reconsidering the way in which services are provided. The sustainability and transformation partnerships in England are looking at the health and social care needs of local populations and at how integrated care can best be designed to meet future needs in a realistic and sustainable manner.

138. However, we know demand can often alter more quickly than we are able to make changes to workforce supply. The distinctive way in which the NHS operates means that it is not possible to respond to workforce gaps quickly through training more people.

139. The Migration Advisory Committee's (MAC) shortage occupation list, published by UK Visas and Immigration (UKVI)[22], reflects some of the supply shortages in the NHS, and currently includes medical practitioners in consultant radiology, emergency medicine and old-age psychiatry (see full list from UKVI).

140. The expansion of training places and exploring other development opportunities are central to a sustainable workforce strategy. Additional domestic efforts that employers undertake should focus on engaging local communities to encourage and attract individuals into employment; improving retention of current staff, and ensuring that their employment practices support their efforts to be an employer of choice.

141. While there are clear opportunities to increasing domestic supply, in the short to medium term, it will be challenging for employers to meet their workforce supply requirements without continuing to access labour and skills from outside the UK. According to the GMC in the year to 30 June 2017, 2,057 graduates from the European Economic Area (EEA) joined the UK medical register (compared to 2,048 at June 2016). The total number of EEA graduates practising in the UK was 21,609 (compared to 21,539 at June 2016).

Medical workforce issues

Career choices

142. The number of people applying for courses in medicine has risen significantly by 8 per cent to 20,730 (an increase of 1,520). This has ended a three-year period of decline, which followed the 2014 peak of 22,740 applicants[23]. It also includes an increase of eight per cent in the number of EU-domiciled applicants.

[22] UK Visas and Immigration. Shortage Occupation List
[23] UCAS Deadline Applicant Statistics October 2017

143. Providing a higher number of NHS work experience placements for school pupils may help increase this figure further. However, it is important that these students are provided with advice and information on the full picture of practising a career in medicine on entry to the courses. This will ensure that they are aware that future career choices are often dependent upon the needs of services and changing patient demographics.

144. Foundation Year 1 (F1) doctors are provided with opportunities to experience different specialties before they need to consider their specialty training application. The most common options in F1 were reported as general surgery and general internal medicine, and for Foundation Year 2 (F2) doctors, the options were general practice and emergency medicine[24].

145. The work undertaken on the broadening the foundation programme [25] showed that the top three specialties experienced by F1 doctors were reported as being general surgery (70.7 per cent), general (internal) medicine (51.3 per cent), and geriatric medicine (27.2 per cent). The top three certificate of completion of training (CCT) specialties experienced by F2 doctors were general practice (47.7 per cent), emergency medicine (44.6 per cent), and general (internal) medicine (20.3 per cent).

Entry to the foundation programme

146. A total of 7,889 applicants were nominated to apply for the 2017 UK foundation programme. This number comprised 7,405 nominations by UK medical schools.

147. Across the UK, 96.08 per cent of F1 posts were filled for an August 2017 start. This is a 2 per cent decrease compared to 2016. The actual fill rate for England was 96.29 per cent. However, the fill rate for entry on to an academic foundation programme increased to 99.13 per cent for England. This may be because those successful will have a post confirmed prior to recruitment to the standard foundation programme, which has previously operated on a reserve list due to an oversupply of medical students and an under subscription of foundation school places.

148. However, the reserve list for the 2017 foundation programme was much smaller than in previous years with only 25 applicants, as the number of vacant F1 places exceeded the number of applicants on the reserve list at the time the programme results were released for primary list applicants.

[24] The Foundation Programme. Annual Report 2016
[25] Health Education England. Broadening the Foundation Programme

149. The number of applicants withdrawing from the foundation programme was 6.68 per cent resulting in 542 vacancies. This is a small decrease compared to the 2016 figure of 6.91 per cent[26]. Reasons for the withdrawal of applications included failing final exams, personal reasons, or not meeting the criteria of local pre-employment checks.

150. Most of the withdrawals occurred in or after June 2017 (220), following the release of medical school failed finals. Local employing organisations aim to fill these places with locum doctors prior to the start of August 2017, but this is not always possible.

151. Considering the undersubscription in 2016, and the anticipated number of vacancies based on application numbers in 2016, a total of 63 foundation programme places across England were removed from the 2017 foundation programme. The posts were funded until April 2018. For the 2018 foundation programme, the 63 posts and associated funding will continue to be withdrawn.

152. The expansion of medical school places (500) are expected to slot into the recurrent vacancies arising from withdrawals, upon graduation as a newly qualified doctor. However, the additional 1,000 places will become problematic to accommodate due to the aforementioned undersubscription to medical school places in 2016.

153. Employers would welcome a gradual oversupply of funded foundation doctors to create the capacity required for these additional students. An oversupply would increase the quality of doctors to enable patient safety, and safeguarding of work and rotas, as EEA and non-EEA doctors would be in direct competition for places on the foundation programme.

Entry into higher training

154. Out of the 7,065 doctors that satisfactorily completed the programme in August 2016, only 50.4 per cent entered specialty training within the UK. 13.1 per cent took a career break from medicine, 8.3 per cent had undertaken service posts within the UK, and 5.9 per cent were still seeking employment within the UK.

155. As such, only 87.87 per cent of training posts at core and specialty year 1 level were filled across the UK, following round one recruitment for entry in August 2017. This is 6.33 per cent less than in 2016, amounting to 485 unfilled posts across the UK.

156. It has become increasingly common for doctors to take a break from training at this stage of their career. Doctors can explore more flexible career options to accommodate family or caring responsibilities,

[26] The Foundation Programme. Annual Report 2016

undertake further study, travel and work abroad, or carry out locum or trust grade work before starting specialty training. Ultimately there will be an impact on training programmes, workforce planning and service delivery, and employers may need to consider how far they can accommodate some of these aspirations while at the same time encouraging retention.

Emergency medicine

157. Recruitment to emergency medicine programmes continues to be stronger in London than in other regions of England. This may reflect the reconfiguration of services providing emergency departments with better rota sizes, enabling the provision of effective training while allowing for an acceptable work-life balance.

158. In 2017, the overall fill rates for acute care common stem (ACCS) emergency medicine was 92 per cent, which is a 4 per cent decrease from 2016. ST3 emergency medicine programmes achieved a fill rate of 13 per cent, with only two of its 16 posts filled. However, 276 trainees progressed from year 2 to year 3 (the figure was 197 in 2015).

159. Fill rate to ST4 emergency medicine programmes achieved 67 per cent, however 181 trainees progressed from year 3 to ST4 (the figure was 145 in 2015). Furthermore, the defined route of entry into emergency medicine (DRE-EM) programme achieved a fill rate of 100 per cent. A further expansion of this programme will ensure that more vacancies are covered by doctors progressing through the training programme without the need for employers to compete with one another through local recruitment processes.

General practice

160. Across England, 3019 doctors were recruited to occupy GP ST1 vacancies. Hard-to-fill areas such as the East Midlands achieved a 95 per cent fill rate, and Yorkshire and the Humber, a 78 per cent fill rate.

161. In 2016, it was proposed to extend deferment for GP applications to allow prospective applicants to hold their GP placement for one or two years. It was envisaged that this would keep potential applicants within the system if they chose to work abroad for a year or undertake other training or education. Applicants wishing to defer were advised that they could return from deferment in August or February to ensure that programme management was maintained. Unfortunately, the number of doctors entering the programme did not increase as a result and employers were left with many vacancies to fill with locums at short notice. Further work needs to be undertaken to use this as a mechanism to attract more doctors to this specialty.

162. The targeted enhanced recruitment scheme for doctors entering GP training in August 2018, may attract more doctors to take up posts in hard-to-fill areas which has had consistently low fill rates over the last

three years[27]. General practice is not listed on the shortage occupation list, therefore migrant doctors must receive the minimum number of points available to apply for a Tier 2 visa.

Psychiatry

163. There are 11,400 medical posts within the UK to care for people who require mental health services. Of these, 1,400 are currently vacant[28], with only 83 per cent of core psychiatry training places filled in 2016. The percentage of unfilled training posts in psychiatry is consistently higher than any other specialty. This is despite core psychiatry being listed on the shortage occupation list to attract overseas doctors.

164. London was the least affected by the shortage of doctors, which suggests that location continues to be a key driver in career choices. Other regions were affected, resulting in implications for existing trainees in terms of workload intensity, quality of training, and rotas.

165. It is recognised that further work needs to be undertaken to improve the morale of trainees to overcome the feeling of isolation sometimes experienced within psychiatry[29]. It is important that it is attractive to those doctors who are experiencing this specialty either as part of a taster, or a clinical placement as part of the foundation programme.

166. Special interest sessions and protected supervision in psychiatric training programmes are unique selling points for this specialty. However, as regional differences exist in terms of their implementation, this may impact on the retention of trainees through to specialty training if core trainees are not aware of its existence. The Royal College of Psychiatrists' 'supported and valued' report sets out core recommendations to ensure that these sessions are protected and available to all trainees.

167. Other changes that could improve work-life balance and training include annual review of competence progression (ARCP) standardisation across the UK, greater access to flexibility in training, and more widespread implementation of enhanced junior doctors' forums. Creation of a workforce development budget may help employers retain and develop their existing mental health workforce[30].

The chief registrar scheme

168. The Royal College of Physicians' future hospital commission programme recommended that a chief registrar be appointed in every

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[27] Health Education England. GP National Recruitment Office

[28] Health Education England (July 2017) Stepping Forward to 2020/21. The Mental Health Workforce Plan for England

[29] Royal College of Physicians (2017) Supported and Valued.

[30] Health Education England (July 2017) ibid

acute hospital. The chief registrar role provides a link between doctors in training and senior clinical leaders and managers.

169. The pilot of the new chief registrar post has been a notable success and an independent evaluation provides important insights into its implementation. Junior doctors have been consistently undervalued and their potential to lead change has been overlooked. The pilot started when junior doctor morale was at its lowest ebb and the achievements of the first chief registrars have been impressive, leading to wide support and doubling of recruitment.

170. Their role gives them close involvement in junior doctor deployment leading to a detailed understanding of patterns of out-of-hours working, shift working, and safe cover. They are also able to ensure that trainees' voices are heard at the highest level within the organisation and they have a forum to raise concerns, share ideas and feel engaged and motivated to deliver change.[31]

Medical associate professionals (MAPS)

171. Although they are employed under Agenda for Change terms, and not within the remit of this review body, this is an umbrella term for four relatively new clinical roles trained to the medical model that work under the direction of qualified doctors:

- Physician associate (PA).
- Physicians' assistant (anaesthesia) (PA(A)).
- Surgical care practitioner (SCP).
- Advanced critical care practitioner (ACCP).

172. There is an increasing interest in these roles and employers are keen to explore MAPs as part of the solution to their workforce supply issues. They could, if successfully introduced, trained, and developed, play a key part in the multidisciplinary approach which providers are taking in the design of their workforce.

173. Currently, employers have not seen sufficient evidence of strategic workforce planning for these roles and would welcome a plan which sets out anticipated numbers of posts and plans for achieving them.

174. Employers also feel strongly that there are insufficient development opportunities for these professionals. There is some evidence of promising talent taking up and succeeding in these roles, but then leaving the workforce altogether, as there is nowhere to progress.

[31] Royal College of Physicians (Nov 2017) The Future Hospital Programme. Delivering the Future Hospital

175. There is some way to go to raise the profile of MAPs and resistance to overcome in some quarters, but employers and doctors who have worked with them are generally positive about their contribution to service delivery.

International recruitment

176. Alongside the need to increase the skills base within the UK, the political narrative around managing and reducing migration has also intensified in the last 12 months.

177. The immigration skills charge introduced in April 2017, paid by employers who recruit skilled workers from outside of the European Economic Area (EEA), is just one policy decision aimed at encouraging employers to invest in the skills and training of the local population.

178. This charge means an additional upfront cost to employers of £5,000 for a migrant entering the UK on a five-year visa. Home Office published data[32] showing the number of certificates of sponsorship granted monthly to employers across all sectors, provides no evidence of a decrease in demand following the introduction of the immigration skills charge.

179. While there are clear opportunities to increase our domestic workforce supply in the short to medium term, it will be challenging for employers to meet their workforce supply requirements without continuing to access labour and skills from outside of the UK. This levy is placing an additional financial pressure on the many NHS organisations that recruit from overseas to be able to meet the demand and deliver high-quality patient care.

Implications of Brexit

180. The decision to leave the EU has the potential to impact on the workforce of many different industries, and the health and social care sector is no different. We have a valued and talented workforce made up of colleagues from the UK, the European Economic Area (EEA) and around the world.

181. In July 2016, NHS Employers in collaboration with NHS Providers and The Shelford Group, commenced a quarterly survey of NHS organisations, looking at the implications of the UK's decision to leave the EU on the recruitment and retention of staff from the EU.

[32] UK Visas and Immigration. Allocation of Restricted Certificates of Sponsorship

182. The series of surveys provide an indication that 12 months on from the referendum vote, a greater number of employers now feel that the decision to leave the EU will have a negative impact on their workforce and there are fewer employers with plans to recruit from the EEA due to the continued uncertainty.

183. The immigration 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. To achieve, this EU nationals currently working in the sector will require the right to remain in the UK. Whatever immigration model is adopted and agreed as part of the negotiation process, 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.

Improving staff experience and retaining the NHS workforce

184. While improving staff experience and retaining a talented workforce have always been important to the NHS to deliver consistent, high-quality care, in recent months there has been a greater focus on improving staff wellbeing and the retention of staff. As referenced in other sections of this report, significant skills gaps exist across the NHS workforce, and trusts across England are struggling to recruit to several key vacancies. Given that recruitment is both a time-consuming and costly activity, and that stability of the workforce is associated with better patient outcomes, there is an immediate need for trusts to look to prioritise the experience and wellbeing of staff, and to improve retention.

185. In headline terms, NHS leaver rates and staff turnover have been deteriorating over the past four years. Particular concern exists with rising turnover rates in nursing and in mental health trusts, issues which are compounded by supply risks in these parts of the workforce.

186. NHS sickness absence rates vary significantly between organisations and staff groups. Estimates from Public Health England put the costs of NHS staff absence due to poor health at £2.4 billion per year - and this is before the added costs of providing agency cover. Deloitte's recent analysis detailed in *Thriving at work* estimates that the cost to the healthcare sector per employee due to mental health is £2,029-£2,174 per year. Mental health and musculoskeletal conditions are the highest reasons for sickness absence for staff in the NHS and are a concern.

187. While there is an urgent need for the NHS to address the issues of staff experience and retention, it is important to note that some turnover is indeed beneficial, making organisations dynamic and supporting career progression for individuals. Furthermore, there needs to be acceptance that while the NHS is doing some excellent work in

addressing the reasons why staff leave, there are numerous factors impacting on staff experience and retention which remain largely outside the control of individual employers. These include:

- sustained pay restraint
- an ageing workforce
- increasing demands of the job due to greater patient numbers and funding shortfalls in social care and public health.

188. It is important to recognise that there's no silver bullet when it comes to tackling retention. The latest report[33] from the Health Foundation looks at some of the factors effecting supply, turnover, and retention. It suggests there needs to be collective action, supported by government, to develop a sustainable strategic approach that can adapt to external factors, such as Brexit, and shape and drive internal policy change.

189. Similarly, there is no single answer when it comes to improving staff experience. NHS England is currently working with six NHS organisations to develop a core wellbeing offer detailing a number of key enablers which have the biggest impact on improving the wellbeing of the workforce. These will be closely aligned to NHS Employers' eight elements of workplace wellbeing, which include leadership, shared strategic vision, engagement, communication, knowing your data, prevention, intervention and evaluation, and taking action.

190. The approaches currently being taken by the NHS to improve wellbeing and the retention of the existing workforce are multi-dimensional. To help design suitable interventions for tackling high leaver, turnover rates, and sickness absence rates, individual trusts are taking an in-depth look at their workforce data and analysing trends. This is helping to identify organisational-wide issues or hot spots.

191. Maintaining an open dialogue with the workforce and regularly engaging with staff has also been critical to employers. This has aided their understanding of what enables staff to have a positive experience at work, how keeping them well encourages people to remain with an organisation, and what else they can do to become an employer of choice.

192. In terms of the actions taken by organisations that have had a positive impact on staff turnover, it is difficult to pinpoint any single activity. Improvements in retention and staff experience, however, are being seen where positive workplace cultures have been created, where staff report how they feel valued and supported, have access to opportunities to work flexibly, and the chance to develop within their careers. Workforce data also indicates that there is a need to support staff at both ends of their employment journey, providing good workplace inductions and preceptorship programmes to support individuals in their

[33] The Health Foundation (Oct 2017) Rising Pressure: The NHS Workforce Challenge

first few months/years of employment, and looking at flexible retirement options to retain staff in the final years of their working lives.

193. During 2016-17, NHS Employers worked closely with over 90 NHS trusts to help equip them with tools and resources to support the development of plans tailored to address workforce retention. Emerging from this work were several themes which impact on the ability to retain staff and best practice was shared throughout the course of the programme. To share this learning, NHS Employers has produced a new resource, *Improving staff retention: a guide for employers*[34], which examines some of the key parameters affecting the retention of staff and highlights examples of where trusts from across England have taken action that has had a positive impact on their ability to retain staff.

194. NHS Employers also continues to work closely with key partners to aid efforts to support trusts with improving retention. As part of this work, NHS Employers currently co-chairs a task and finish group with NHS Improvement, looking at how we can best support the sector with addressing the challenge of retaining the workforce. NHS Employers also continues to work closely with key experts and partners to support trusts to continue to focus on reducing sickness absence, undertaking specific work on mental health and musculoskeletal disorders, as well as broader wellbeing approaches. NHS Employers produced *Creating healthy NHS workplaces*[35], which supports organisations to implement the NICE workplace guidance. This is also endorsed by NICE.

NHS England healthy workforce programme

195. The Five Year Forward View made a commitment to ensure the NHS sets a national example in the support it offers to its own staff to stay healthy. In September 2015, Simon Stevens announced further plans to support this commitment, which included a major drive to improve the health and wellbeing of NHS staff through the introduction of a healthy workforce programme.

196. NHS Employers continues to work closely with NHS England on this programme of work, along with PHE and 11 demonstrator sites in year one, and six demonstrator sites in the current year, to test and develop a core wellbeing offer for the NHS. This will identify key enablers that improve the health of the workforce and will be rolled out across the NHS.

197. In 2017, NHS Employers rolled out a line manager training programme, and developed board and senior leader level role descriptors to support this programme of work.

34 NHS Employers (September 2017) Improving staff retention: a guide for employers

35 NHS Employers (Sept 2015) Creating Healthy NHS Workplaces

198. NHS Employers will continue to work closely with NHS England on this work and support employers to implement any key recommendations.

Quality and innovation

199. In March 2016, NHS England announced a health and wellbeing commissioning for quality and innovation (CQUIN) payment framework. CQUIN enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

200. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider, with active clinical engagement.

201. To achieve the CQUIN, trusts are encouraged to introduce and demonstrate a sustained improvement in the wellbeing of the workforce by way of improved scores in key questions in the staff survey.

202. The CQUIN encourages greater focus on introducing health and wellbeing initiatives, increasing healthy food choices, and encouraging the uptake of frontline staff receiving the flu vaccination.

203. NHS Employers has an active flu programme that continues to provide support, guidance and resources to organisations including presentations and webinars.

4. Total reward and pensions

Total reward

204. This section looks at the approaches taken by NHS organisations on reward, particularly the different components of rewards offered to employees and how reward is being used to meet strategic organisational objectives.

205. In addition to pay and benefits, employers in the NHS are continuing to broaden their definition of reward. There has been an increase in communication of the many benefits available, with a focus on benefits provided locally. With national terms and conditions in place, local benefits are a way of differentiating from other NHS organisations.

206. In times of austerity, and with the perceived degradation of benefits such as the NHS Pension Scheme, organisations are increasingly looking at more creative ways of attracting and retaining staff.

Components of reward in the NHS

207. The NHS provides a comprehensive and attractive employment offer. It has a well-regarded package of valuable benefits, including a generous pension scheme.

208. Through the NHS Employers Total Reward Engagement Network (TREN), organisations have demonstrated that they are adopting a broader definition of reward. TREN is a network facilitated by NHS Employers, open to NHS organisations engaged in total reward work. It provides members of the network with the opportunity to discuss reward-related issues, and share knowledge and experience with colleagues. The network has engaged with over 80 NHS organisations since it was established in February 2016. Via the network, NHS Employers encourages engagement with the total reward agenda on a broader scale, and provides a route to understanding strategic reward in the NHS with relevant products and tools to support reward initiatives.

209. Interactions through TREN show that health and wellbeing, including financial wellbeing, has emerged as a focus for many organisations. Health and wellbeing is an important part of the reward offer, however, it is not always communicated as being part of the employment package so can be viewed by staff as being separate. Having an overall reward brand which includes health and wellbeing has helped some organisations[36] overcome this. Organisations are also working towards the health and wellbeing commissioning for quality and innovation

[36] NHS Employers (Nov 2017) Health and wellbeing as part of the reward offer- a case study

framework. This has supported putting health and wellbeing on employers' agendas.

210. Less traditionally perceived benefits, such as training and development programmes, recognition schemes, the local surroundings, and organisational values, are increasingly being included as part of the offer. This is consistent with the model of strategic reward, such as the Hay Group's public sector total reward model[37].

211. In 2017, NHS Employers undertook a benchmarking exercise which explored all NHS trusts' websites to look at the recruitment information and ascertain the level of reward information provided. The exercise looked at the six key areas within the Hay Group's public sector total reward model. Although this demonstrated how some organisations have expanded their definition of reward, there is more that could be included as part of the external-facing benefit information used to attract candidates.

A strategic approach to reward

212. In 2017, NHS Employers surveyed 76 employers on elements of their approach to reward. They were asked if they are actively using reward to meet their organisation's strategic objectives or goals. 80 per cent responded that they are, particularly to support attraction and retention.

213. In response to requests for examples of the approaches used, in relation to recruitment, these include recruitment and retention premia (RRP) for specialist or hard-to-fill posts, relocation payments, and new clinical excellence award schemes for consultants.

214. These approaches are reflected by members attending TREN. Where RRP and relocation packages are sometimes used to attract staff, this tends to be limited to difficult-to-recruit posts. They are also used where location of services makes recruitment and retention more challenging, such as rural or isolated areas.

215. Recommend a friend schemes are used by some organisations in addition to other recruitment initiatives, often to overcome difficulties recruiting to specific occupations[38]. Incentives range from monetary reward to additional annual leave. The schemes are growing in use as a cost-effective way to respond to recruitment challenges.

216. During the benchmarking exercise, it was found that some organisations have developed web sections with information on reward and recruitment, specifically for certain occupations such as doctors.

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[37] Hay Group's public sector total reward model

[38] NHS Employers (Sept 2017) Using reward as part of an effective recruitment strategy- a case study

These sections include detailed reward and recruitment information used to attract candidates to these occupations, such as details of childcare, flexible working, site rotations, training and development, and relocation packages.

217. In response to requests for examples of the approaches used, in relation to retention these include an increased focus on health and wellbeing initiatives and the introduction of benefit platforms which bring together reward information to make it more easily accessible. Smartphone apps have been introduced in some organisations to increase engagement with staff. This is particularly for those who do not easily have access to a computer[39]. Innovative approaches include the use of appraisals whereby staff can be rewarded with bonus payments for excellent performance and the use of an additional responsibilities allowance to recognise staff contributions.

218. Interactions through TREN reflect these approaches and demonstrate that organisations are increasingly looking at more creative ways of retaining staff, with a focus on non-monetary reward initiatives. One approach includes a holiday of a lifetime scheme where staff can accrue up to five days' annual leave each year, for up to five years, and take all the leave at once. This allows staff to have an extended holiday and return to their role. Retention bonuses have been used to incentivise staff to remain in post. Although these have been successful in some circumstances, they are not commonly used.

219. The use of reward to help reduce agency spend often occurs in the service. Members attending the TREN have used weekly, rather than monthly, payments for substantive post holders who take on additional hours through their trust bank and paid substantive post holders for a fifth bank shift on completion of their fourth shift. A pilot of selling annual leave at one organisation led to 4,000 hours sold back, reducing the requirement for agency staff.

220. In 2016, NHS Employers undertook a survey which asked 100 NHS organisations whether they have a reward strategy. 51 per cent stated that they did not, with 34 per cent stating this was in development and the remaining 15 per cent stating that they do. This picture appears to be the same currently with organisations at TREN being clear that although some may have a strategy in place, or reward included as part of another strategy, they do not see this as a priority to take forward their reward agenda. They are however increasingly looking at how reward can support their organisational priorities. It is clear therefore that having a reward strategy is not a must, but it's important to be clear about how reward can support strategic objectives.

[39] NHS Employers (Sept 2017) Using mobile technology for reward communications - a case study

Local approaches to reward

221. There are a range of local approaches to reward used by organisations which have been discussed at TREN in addition to those referred to above. Organisations are keen to introduce benefits that reduce travel costs for staff, particularly in London. Recognition schemes and long-service awards are also offered throughout organisations, though the approach varies. Buying and selling annual leave has been implemented by some and is often linked to health and wellbeing initiatives as a way of increasing employee control over their work-life balance.

222. Promoting the learning and development opportunities available is a vital part of ensuring staff are aware and understand how they can access them. Highlighting this effectively from recruitment, through the new employee process, and to the existing workforce, is an important part of communicating the overall reward offer. This has also become a focus for organisations.

223. In the 2017 NHS Employers' survey, when asked, other than pay/terms and conditions do organisations provide a different reward offer to their medical workforce, 63 per cent said no and 27 per cent said yes. The different benefits described included local clinical excellence awards, recruitment and retention premia, retention bonuses, spot rates, training funding, and relocation packages.

224. In April 2017, changes to salary sacrifice schemes were introduced which meant that tax and employer National Insurance advantages were removed. There were some exceptions to this, and rules put in place for those already in contracts. Although the changes do not prevent employers from providing benefits by salary sacrifice, they will no longer see any tax and National Insurance advantages to some of the schemes.

225. NHS Employers sought views on the government's consultation on the future of salary sacrifice arrangements in 2016. Employers generally felt that the proposals may exacerbate existing staff shortages in the NHS, however this would be difficult to measure.

226. The changes have seen a mixed approach from employers, with some organisations continuing with some or all of their schemes. For those continuing with their schemes, there was a concern about the impact on staff and the perception that there has been a removal of benefits. Some organisations see salary sacrifice arrangements as a retention tool, for example by offering a three-year salary sacrifice car lease scheme. It is thought this will encourage employees to remain within the organisation for at least the term of the agreement.

227. The 2016 Autumn Statement outlined that existing arrangements have a period of protection. This has allowed organisations to communicate with their employees about the changes.

228. In addition, the government introduced tax-free childcare from 28 April 2017. Existing employer-supported childcare schemes can continue to accept new entrants until April 2018. Most organisations offer some form of salary sacrifice scheme, the most popular being childcare vouchers and cycle to work schemes. Employers will therefore see a financial impact from the changes, as well as a reward impact.

Attractiveness of the reward offer

229. The 2017 NHS Employers' survey of 77 employers explored whether elements of the organisation's reward offer is informed by employee needs. 80 per cent said that they are, mainly through surveys and focus groups. Other examples include feedback through benefit champions, staff benefits committee, events, looking at what staff are accessing, and obtaining feedback from new recruits.

230. When asked whether they evaluate or seek feedback from staff on their reward offer, 62 per cent said yes, again mainly through surveys. Other examples include listening into action events, exit interviews, staff side and benefit champions. There is little evidence of evaluation of initiatives to determine the impact on strategic objectives and therefore further work needs to be done to encourage employers to do so.

231. When asked which aspects of their reward offer they are most proud of, health and wellbeing initiatives and recognition schemes were the most common responses. Other responses include salary sacrifice schemes, branding to bring all the benefits together, events, and recruitment incentives.

Strategies to engage staff effectively

232. The NHS Employers survey asked for examples of how organisations currently communicate their reward offer. The responses echoed the information obtained through TREN and demonstrate how employers are increasing their communication of reward and benefits to engage staff. The main communication routes for reward include roadshows[40], newsletters, events, leaflets, and the intranet. They are also using broader communication channels, such as benefit champions[41], social media, total reward statements, and benefit platforms. Organisations are increasingly embedding their reward information in to their recruitment and induction processes. This broad approach to

[40] NHS Employers (Aug 2016) Promoting staff benefits through rewards - a case study

[41] NHS Employers (Oct 2016) Using benefit champions to promote staff rewards- a case study

communication is important to ensure the breadth of benefits are recognised and valued by employees.

Total reward statements

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

234. The third year of TRS rollout in the NHS was 2016/17. Information from the NHS Business Services Authority (BSA) indicates that a total of 468,777 statements in England and Wales were accessed during the year (August 2016-August 2017). This was an increase of 22.06 per cent compared to the previous year. Approximately half of these statements were viewed when the statements were refreshed mid-way through the year (between December 2016-August 2017).

The NHS Pension Scheme

235. 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 plus 1.5 per cent per annum.

Contribution rates

Employer contributions

236. 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.

237. The employer contribution rate is reassessed by the scheme actuary every four years and the results of the 2016 valuation are expected in April 2018. The Treasury is finalising the directed financial assumptions for the valuation and has announced that the discount rate assumption will reduce by 0.2 per cent. The impact of this change in isolation would lead to an increase in the employer contribution rate from 1 April 2019.

Member contributions

238. 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.

Tiered contribution rates 2015/16 through to 2018/19 for scheme members		
Tier	**Pensionable pay (whole-time equivalent) earnings used to assess contribution rate)**	**Contribution rate**
1	Up to £15,431.99	5.0 %
2	£15,432.00 to £21,477.99	5.6 %
3	£21,478.00 to £26,832.99	7.1 %
4	£26,824.00 to £47,845.99	9.3 %
5	£47,846.00 to £70,630.99	12.5 %
6	70,631.00 to £111,376.99	13.5 %
7	Over £111,377.00	14.5 %

239. At the request of the Secretary of State, the NHS Pension Scheme Advisory Board (SAB) is reviewing the basis on which member contributions will be assessed from 1 April 2019. The key objective of the review is to ensure the required yield is collected going forward. It is likely that contribution rates will increase for some or all members.

The review will focus on:

- the range and number of contribution tiers
- freezing tier boundaries for periods longer than a year
- using whole-time equivalent (WTE) rather than actual earnings to determine the contribution rate payable.

240. We reported in our evidence to the pay review bodies in 2017/18 that the tiered nature of member contribution rates, combined with low pay rises, means that increases to pensionable pay could lead to a reduction in take-home pay. This aspect of the contribution design is still an ongoing issue for staff and employers. Potential solutions are being considered as part of the member contributions review and, if implemented, will not take effect until April 2019.

241. With the introduction of the 2015 pension scheme, it is expected there will be fewer contribution tiers in future. This is to reflect that, in future, all benefits will be accrued based on actual pay, rather than final pay at retirement.

242. The increasing cost of both member and employer contributions was cited by employers in response to our survey as a key challenge presented by the pension scheme. Many employers feel the member contributions are too high and see this as a barrier to staff joining the scheme. This is particularly difficult for lower earners and younger members with competing financial priorities, such as paying off student debt, paying for childcare, and saving for a first home. However, the

data in the next section does not necessarily support this observation as membership levels remain high.

Scheme membership

243. The total membership of the NHS Pension Scheme has increased steadily from 2007–2017. 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 will need to be considered in the context of the member contributions review, particularly the use of WTE earnings to determine member contribution rates.

Scheme Year	1995 only members	2008 only members	1995 + 2008 members	2015 members with FSL	2015 members no FSL	Total members
2007-08	1,210,735	-	-	-	-	1,210,735
2008-09	1,113,695	136,043	2,097	-	-	1,251,835
2010-11	1,007,019	271,743	7,171	-	-	1,285,933
2012-13	898,690	372,258	11,761	-	-	1,282,709
2014-15	801,921	552,822	19,894	-	-	1,374,637
2015-16	330,908	29,585	1,488	949,047	127,830	1,438,858
2016-17	291,871	25,898	1,294	944,936	211,736	1,475,735

Source: NHS Business Services Authority (BSA)

Scheme membership rates are generally high, with an average of 89 per cent of the workforce actively contributing to the scheme.

244. The level of pension scheme membership for doctors is high, with 91 per cent of doctors contributing to the scheme as at June 2017. Membership has fallen by 0.8 percentage points over the period from October 2011 to June 2017. In the shorter term, membership has fallen by 1 percentage point between June 2016 to June 2017. There is no robust data to show the reasons why membership has fallen. There is anecdotal evidence from employers to suggest doctors are opting out of the scheme after exceeding the annual allowance (AA) and lifetime allowance (LTA).

245. This data is taken from the Electronic Staff Record (ESR) Data Warehouse. This is the HR and payroll system that covers all NHS employees with the exception of those working in general practice, two NHS foundation trusts that have chosen not to use the system, and organisations to which functions have been transferred, such as local authorities. ESR data is not centrally validated and its reliability is subject to local coding practice.

Pension taxation

246. 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.

247. The two tax thresholds are the annual allowance (AA) and lifetime allowance (LTA). Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years mean that more staff are likely to be impacted.

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

249. Data provided by BSA shows 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.

250. While it is not entirely clear how the tax allowances are driving member behaviours, we strongly believe that reaching the LTA will have greater influence on driving members to opt out of the scheme or take early retirement than the AA.

251. In our survey of 77 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 impact of the tax allowances is concentrated in certain workforce areas such as consultant doctors. Many employers are looking for alternative ways to reward staff affected by the tax allowances to retain highly skilled and experienced staff.

252. 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 the Treasury of the impact of current pension tax rules on key public servants.

Pensions flexibility

253. Employers want to ensure the scheme remains attractive to all staff across the workforce. There is a need to ensure the scheme is appealing to staff of all generations and levels of income. Employers would like to offer more flexible pension options to achieve this.

254. 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

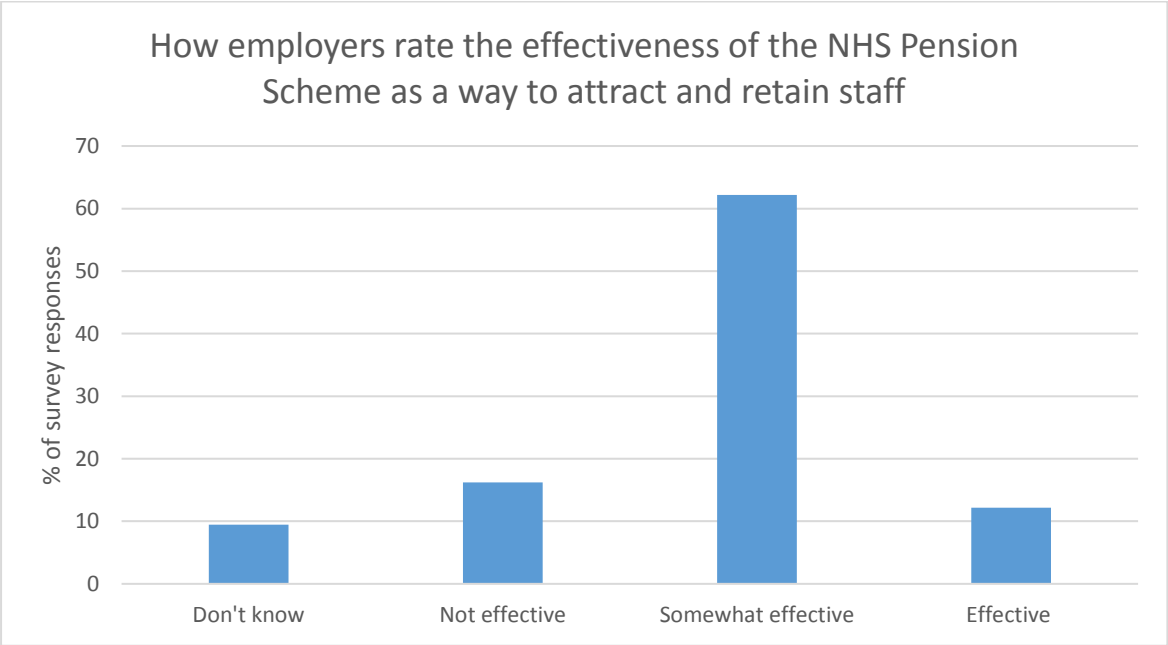
options for pension saving in addition to either joining the NHS Pension Scheme, or having no workplace pension savings. This suggested approach seems similar to the introduction of the 50:50 section in the Local Government Pension Scheme, which allows members to pay half the standard contribution rate in return for half of the standard benefit accrual.

255. A pensionable pay cap may also provide more flexibility for high earners to control the value of their pension accrual and avoid exceeding the tax allowances.

The NHS Pension Scheme as an attraction and retention tool

256. We asked 77 employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff. A total of 75 per cent of employers rated the scheme as effective or somewhat effective, with only 16 per cent rating the scheme as not effective.

257. Employers were not asked to provide any data to support their opinions on the effectiveness of the scheme as an attraction and retention tool.



Abatement

Understanding the value of the NHS Pension Scheme

258. There are certain circumstances where a member's pension benefits may be reduced if they return to work for the NHS after retirement. The

detailed abatement rules[42] vary depending on which section of the NHS Pension Scheme a member belongs to. In general terms, the rules on abatement apply where a member's unearned pension benefits, plus their earnings in their new role, exceed their earnings prior to retirement. It applies to a relatively small group of members. Employers have told us this often encourages staff to return to work for agencies after their retirement, to avoid any reduction to their pension. The abatement regulations seem to be working against the government's policy of reducing agency spend.

259. 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.

260. Employers feel 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.

261. Employers suggested the following ways of improving member pension scheme communications:

- A national promotional campaign.
- More face-to-face conversations about pensions.
- Pension workshops, pre-retirement courses and webinars.
- Simple and clear information that is easily accessible and easy to understand.
- More promotion of total reward statements.
- Using targeted approaches for different age groups.

262. 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.

263. NHS Employers continues to produce resources to support employers to promote the value of the NHS Pension Scheme. A new product is being developed to help employers deliver pension workshops and pre-retirement courses.

[42] NHS Business Services Authority: NHS pension scheme, abatement, basic overview for employers