

**NHS EMPLOYERS'
SUBMISSION TO THE
DOCTORS' AND
DENTISTS' REVIEW
BODY 2020/21**

DECEMBER 2019

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KEY POINTS

Strategic context

- The NHS Long Term Plan has set out the future strategic direction and ambitions for the NHS in England and provides the basis for a five-year funding settlement up to 2024/25. While this provides some stability for longer-term planning, the overall level of investment is still lower than in previous years. The Interim NHS People Plan sets out how the workforce will be supported and transformed in order to deliver the aims of the NHS Long Term Plan.
- Political instability and uncertainty around the impact of Brexit remains. Health leaders are concerned about the extra demands on existing staff in making EU exit preparations and the effects of ending freedom of movement. They are also concerned about the personal impact of Brexit on their EU staff.
- The NHS continues to feel the combined effects of financial pressure, workforce shortages and rising demand. The impact can be seen in current budget deficits and through a decline in key performance standards. This affects the quality of care and patient experience and has a detrimental effect on the health, wellbeing and morale of staff.
- Despite these pressures, the Care Quality Commission's (CQC) recent annual report on the state of health and social care in England found that most of the care provided by the NHS is good quality and, overall, the quality of care is improving. This is a tribute to the commitment and hard work of all NHS staff.
- The pensions tax issue is having a major impact on senior staff across the NHS. In a growing number of cases, consultants have reduced their hours, stopped waiting list work, given up additional roles and duties and many are considering their long-term future. This has had a significant impact on service delivery, most immediately on some elective care waiting lists.
- We believe that a combination of scheme flexibilities, removal of the taper and better information for scheme members is likely to provide the best solution overall. We take the view that if scheme flexibilities are introduced then they should apply to all staff in time for the 2020/21 financial year. However, even if a solution is found fairly soon, there is a risk that some consultants will decide not to return to their previous level of activity.

Financial challenge

- The Chancellor has described the 2019 autumn spending review as 'turning the page on austerity and the beginning of a decade of renewal'. Some might see increased spending on the NHS as an opportunity to invest more in pay, despite the political uncertainty which

currently exists and whether there will be a comprehensive spending review or a series of in-year settlements. However, there will be difficult choices ahead about where funds should be directed.

- Managing expectations on pay will be important as we begin to think about planning beyond the end of the current multi-year pay deal for doctors in training and any possible deal for specialty and associate specialist (SAS) doctors. Our priorities will include delivering the NHS People Plan and continuing to support recruitment and retention initiatives to address the 10,000 vacant medical posts which currently exist.
- Revenue funding is fixed to 2024/25. Employers will also face pressure on capital budgets, the challenge of balancing rising demand and the efficiency savings required in the NHS Long Term Plan, and the possibility of having to fund increases in pay. Any pay award uplifts for staff higher than that based on existing funding assumptions would be unaffordable, leaving employers with difficult choices on service delivery and patient needs and pressing workforce needs.

Workforce challenge

- The Interim NHS People Plan sets out a plan of action to enable all those who work in the NHS to deliver the aims and objectives of the NHS Long Term Plan. However, 65 per cent of respondents to an NHS Confederation survey said that they were either not very or not at all confident that their local health system would be able to meet their staffing needs. There is a real risk that without the right workforce the aims of the NHS Long Term Plan will not be met.
- The Interim NHS People Plan is clear about the need to increase the number of doctors by improving international and domestic supply, and by focusing on recruitment and retention. One of the themes of the plan is to make the NHS the best place to work. It recognises the compelling evidence that the more engaged our people are, the more effective and productive they are, and most importantly, the higher the quality of care they deliver to patients.
- We also recognise that doctors and dentists work as part of a team and rely on the contribution and support of others. If conditions are poor for some then this affects the whole team. Analysis of the data from the 2018 NHS Staff Survey in England revealed that doctors who worked in real teams had higher levels of work engagement, and more satisfaction with their organisation and work environment. They also had far lower intentions to quit and were less likely to be unwell from stress.¹ We are building on the extensive work that we have already undertaken to support employers in their efforts to value and engage their staff, to promote their health and wellbeing, to improve the leadership culture and to safeguard their staff from bullying and harassment at work.

¹ [Caring for Doctors, Caring for Patients. General Medical Council. November 2019](#)

Interim NHS People Plan priorities

The following themes are outlined in the Interim NHS People Plan:

- Making the NHS a great place to work - supporting and retaining our current NHS staff.
- Improving our leadership culture - managing talent and succession.
- Taking immediate action to tackle the nursing challenge - growing workforce supply to meet demand, supporting the third sector, other volunteers and carers, optimising new workforce roles.
- Delivering 21st century care - preparing for technology shift, preparing for the implications of new models of care, enabling workforce productivity.
- A new operating model for workforce - capacity and capability to deliver.

Targeting pay

- We have considered the potential for targeting pay as requested in the Department of Health and Social Care's (DHSC) remit letter ² to the review body. In doing so we have sought the views of employers and looked at the range of factors that might influence career choices either by location or specialty.
- We carried out a short survey of employers to help inform our evidence for this submission, which asked for views on the issue of targeting pay. We also included questions about targeted pay in a separate survey regarding SAS doctors. There was some consistency across the two surveys with around 40 per cent of employers agreeing that targeting pay had or would help with recruitment and retention. There was a general view that if targeting was to happen then it should be aimed at remote, rural or isolated locations. Those who didn't support targeting pointed out the impact on other staff and other factors that affect recruitment and retention.
- Financial considerations are not the only factors that influence career choice, whether this is the specialty in which doctors choose to practise or the location, and this was reflected in our survey responses. There are often complex socio-demographic factors involved as well as other reasons that motivate career decisions, such as a supportive culture and a positive working environment.
- A national programme board established as part of the Interim NHS People Plan is looking at the distribution of specialty training and geographical distribution and will be informed by an option appraisal working group. This group, which will include employer representatives, will examine a range of measures to address identified inequalities in distribution and will consider a range of mitigating factors such as use of the wider workforce skill mix,

² [Department of Health and Social Care. Remit letter on the 2020-21 pay round](#)

incentivisation, cultural, peer, and other educational factors. The work will cover both trainee and trained doctors.

- There is no evidence to demonstrate that the flexible pay premia (FPP) introduced as part of the 2016 junior doctor contract has had a significant impact on recruitment to those specialties covered, or if any recruitment can be wholly attributed to the FPP and not the efforts of Royal Colleges and others over several years to make those specialties more attractive. This would require a formal evaluation of all those factors which might influence career choice.
- Our view is that we should await the outcome of the programme board's work to see how pay and reward features in their recommendations before considering any further targeting of pay by specialty or location.

Doctors in training

- In June 2019, the British Medical Association (BMA), NHS Employers and the DHSC agreed a framework which sets out both the pay investment that will be made and the amendments to the 2016 junior doctors' contract that the parties are planning to implement.³
- The agreement covers the period from 1 April 2019 to 31 March 2023. In 2019/20, this resulted in a total investment of 2.3 per cent in the contract. In each of the three subsequent years (from 2020/21 to 2022/23) this will mean annual pay uplifts of 2 per cent and a further 1 per cent of additional investment in other terms within the contract.
- The collective agreement sees additional investment, alongside amendments to the contract for doctors in training that aim to improve the working lives of junior doctors, making the contract safer and more effective. This agreement was a hugely important step and brought an end to the BMA Junior Doctors' Committee's long-running dispute with the government and has allowed for normalised partnership working to be re-established. Collaborative working has begun with the development of joint guidance, which aims to support employers and doctors in training with implementation of the jointly agreed contract.

Specialty and associate specialist doctors

- The government's response to the review body's recommendations in July 2019 committed to negotiations on a multi-year agreement, incorporating contract reform for the SAS grade to be introduced from 2020/21. An additional 1 per cent, on top of the 2.5 per cent already paid, to be added to pay in 2020/21 will be made available, conditional on contract reform.
- The programme to reform the SAS grades is running concurrently with ongoing work to implement and embed the SAS charter, develop SAS guidance and improve working lives and

³ [NHS Employers. Framework agreement - junior doctor contract](#)

career opportunities for the whole SAS group.⁴ Our survey of employers shows that although there have been improvements in awareness and implementation of the SAS charter, there is still more work to do.

- We expect that the formal negotiation process will start early in 2020 and continue through the 2020/21 financial year. This is a significant opportunity to re-establish the SAS doctor role as a positive and valued career choice which can meet both personal work-life balance requirements and those associated with professional development and progression.

Consultants

- In 2018, the government offered the medical trade unions a 2 per cent multi-year pay deal based on the funding envelope available at that time. The BMA and Hospital Consultants and Specialists Association (HCSA) did not believe that this on its own was enough to incentivise them to enter into meaningful negotiations including contract reform, unless it was combined with pension tax flexibilities. Discussions on contract reform have therefore paused, pending any announcement that further funding might become available.
- The pensions tax issue is the most pressing current issue for consultants. We have discussed the impact of this with the Office of Manpower Economics and worked with other public sector organisations to raise concerns with government ministers.
- We have noted above, in the section on the strategic context, the impact on patients and colleagues of consultants reducing their hours and ceasing extra responsibilities and duties. However, we also recognise the considerable personal impact that this has had on many individual consultants. The consultant workforce will provide the leadership necessary to transform and deliver services in the way anticipated in the NHS People Plan and will train the doctors that we will need in the future. We should therefore be looking to retain and not disengage the consultant workforce.
- The pensions tax issue has had an impact on Local Clinical Excellence Awards (LCEAs). There is some evidence from our survey of employers on LCEAs that consultants are not applying for awards at the same rate. Employers have reported some concerns about having to spend the whole investment pot, or carry any underspend forward, where there are fewer applications and how this might affect the integrity and intention of the scheme.
- We also need to ensure that any changes to the LCEA scheme, and any other initiatives on pay, address the gender pay gap in medical and dental pay. Employers responding to our LCEA survey did not believe that consultants should receive any award beyond a cost of living increase.

⁴ [NHS Employers, SAS development resources.](#)

Salaried primary care dentists

- The salaried primary dental care workforce has been affected by changes to the commissioning and design of services over recent years. As we reported last year, our stakeholders have cited low morale amongst community dentists, with many practitioners not being paid for the specialist work that they have been trained to do. Lack of career progression is also an issue.
- We have been working to ensure that the NHS Staff Survey allows for identification of different dental groups to enable better identification of the state of satisfaction, morale and other issues relevant to salaried primary care dentists.

INFORMING OUR EVIDENCE

Introduction and context

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England for the 2020/21 pay review. We continue to value the role of the Doctors' and Dentists' Pay Review Body in bringing an independent and expert view on remuneration issues in relation to the medical and dental workforce.
2. Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations about their priorities. We have:
 - had direct discussions at one-to-one meetings with NHS chief executives
 - had discussion at the NHS Policy Board about priorities for pay and reward and links to the People Plan
 - maintained regular contact with HR directors
 - attended regional network meetings of human resources directors, the NHS Confederation and other employer networks
 - engaged the NHS Employers' medical workforce forum
 - carried out a brief survey of employers
 - undertaken detailed engagement work with employers on matters including SAS development, the role of the medical associate professions, the 2018 junior doctor contract review, and the consultant contract.
3. In his letter of 16 October 2019, the Secretary of State for Health and Social Care asked the review body to consider targeting awards to support recruitment and retention and to support productivity. We have addressed those issues in this submission.
4. The NHS Long Term Plan published in January 2019 sets the future strategic direction for the NHS in England. Together with the 2019 spending review this provides the basis for a five-year funding programme up to 2024/25. This will be based on a new service model which places more emphasis on prevention and health inequalities, improving the quality of care and health outcomes across all major health conditions and harnessing technology to transform services.
5. The NHS workforce will be instrumental in delivering the ambitious programme of work set out in the NHS Long Term Plan, and the Interim NHS People Plan describes some of the significant workforce challenges currently faced by the NHS. However, for the quarter ending in June 2019, there were 11,304 advertised vacant whole-time equivalent medical posts, a vacancy rate of 8.8 per cent with considerable variation according to region and sector.

6. Despite the acute workforce challenge and in the face of rising demand, the Care Quality Commission's (CQC) report on the state of health and social care in England 2018/19 found that most of the care that we see across England is good quality and, overall, the quality is improving.⁵ Once people gain access to services, ratings suggest that they are caring, with 87 per cent of NHS acute care services rated as good and 11 per cent as outstanding for the key question 'are services caring?'. That trusts have been able to improve in spite of this pressured environment is a huge credit to the hard work, commitment and professionalism of everyone in the NHS.
7. However, the report presents a less encouraging view on access to services, with urgent and emergency services feeling the most immediate effect of the rise in demand. Latest figures on performance show committed teams struggling to deliver what they know their patients need. Demand for A&E is at a record high, with an increase in A&E attendances of more than 20 per cent in 2019 compared to when records began and 7 per cent more than this time last year. And waiting times are lengthening, with 76,000 fewer patients being seen within four hours in September 2019 than shown in figures from the first records in September 2011.
8. This is not just an NHS problem. As the CQC's State of Care report acknowledges: 'A lack of treatment options outside of acute settings can have an impact on the availability of hospital beds. For example, we have seen that when people cannot be kept well in their communities, their conditions can deteriorate, which leads them to need urgent treatment through an emergency department or as an inpatient, therefore putting further pressure on beds in acute settings.'⁶
9. While the five-year funding deal provides some stability for longer-term planning, the level of funding is still lower than in previous years. The announcement of an increase in capital spending was also welcome but it is substantially short of the £6 billion maintenance backlog that has built up in recent years. We would like to see a long-term funding agreement to support capital projects in line with funding arrangements set out elsewhere in the NHS Long Term Plan.
10. The Interim NHS People Plan also proposes that future workforce policy will be devolved to regional integrated care systems. While some issues such as professional regulation, credentialing and prescribing rights will remain nationally controlled, along with pay policy and the pension scheme, the plan states that accountability arrangements will be developed 'to enable integrated care systems (ICSs) to take on greater responsibilities for these activities, while ensuring we do not push ICSs to take on greater responsibility than they are ready to do.' We should recognise that workforce planning, including pay and the terms on which doctors and dentists will be employed, will increasingly be informed by system-level thinking and that as new models of employment evolve, the most appropriate level of responsibility for workforce planning at national, system and local level will begin to become more clearly defined.

⁵ [Care Quality Commission, The state of health care and adult social care in England 2018/2019, November 2019.](#)

⁶ [CQC ibid](#)

11. Our submission therefore reflects the combined effect of the financial, workforce and transformation challenges faced by the NHS. It considers the impact and emerging priorities of the NHS People Plan and the wider direction of travel set out in the NHS Long Term Plan, and how these factors might come together to influence decisions on pay and reward.

FINANCIAL CHALLENGE

12. The NHS continues to feel the combined effects of rising demand, workforce shortages and financial pressure. The impact of this is seen through budget deficits, a worsening of key performance standards and the implications for quality of care and the health, wellbeing and morale of staff.
13. The NHS in England received a five-year funding settlement worth £20.5 billion in April 2019. This followed ten years of the lowest funding increases in the history of the NHS, with an average of 1.1 per cent real-terms growth from 2009/10 to 2014/15. While this new funding has provided a much-needed boost to an overstretched system, some doubt continues to remain on whether the amount will be enough to modernise and transform services in order to meet the triple challenge and fully deliver the ambitions of the NHS Long Term Plan.
14. The announcement on NHS capital investment was also welcomed but, overall, was not believed to be enough to modernise services and working environments to improve the quality and efficiency of patient care. In an NHS Confederation survey, eight out of ten frontline health leaders said that a lack of NHS capital investment has inhibited the ability of local health systems to deliver the goals of the NHS Long Term Plan.⁷
15. The Healthcare Finance Managers Association has estimated the cost of eradicating backlog maintenance at £6 billion in 2017/18, up from £4 billion in 2011/12. According to the Health Foundation's analysis, just bringing the UK up to the OECD average number of MRI and CT scanners would require more than £1.5bn in extra capital spending.
16. The physical environment matters to staff and patients. The report *Quality buildings, quality care* found that services provided from new healthcare premises have been three to four times more likely to be rated outstanding by the CQC than services provided from older premises. There is lower turnover of staff in newly built hospitals, and staff take fewer sick days. The difference in staff sickness absence is equivalent to 900,000 working days per year if the median sickness absence rate in newer buildings were replicated across all NHS acute trusts. Modern facilities are also safer for patients, with 30 per cent lower fall rates and 10 per cent lower overall patient harm in new hospitals, and similar reductions in new care homes.⁸ At the moment, the backlog of maintenance and lack of investment in infrastructure, IT and technology more generally in hospitals and beyond, represent a source of frustration for staff as well as putting a brake on what is possible if we are to transform care and ensure the safety of patients.

⁷ [NHS Confederation. Unfinished business: the need to invest in the whole health and care system. June 2019.](#)

⁸ [British Property Foundation, Quality buildings quality care. How buildings contribute to patient care and staff wellbeing, November 2015.](#)

17. A further area of challenge and ongoing uncertainty is future funding for social care and the impact this has on NHS services. As the National Audit Office noted in its report on the health and social care interface, the financial pressures faced by both the NHS and social care are a barrier to joint working:
- ‘Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnerships from seeking system-wide benefits that may be detrimental to them as individual organisations. Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.’⁹
18. The Chancellor announced at the Conservative Party Conference in September that the government would seek to increase the national living wage to £10.50 an hour over the next five years. This would make a difference to many low-paid health and care staff, particularly in social care where the difficulties in recruitment are more acute. However, responding to a question from the Health Service Journal about whether the budget would be adjusted to fund this, the Treasury said that: ‘the historic settlement we’re giving the NHS...include the provision for future pay rises for NHS staff.” Our view is that without the similar level of investment which accompanied the three-year pay deal for Agenda for Change money intended for the NHS Long Term Plan will be reduced and pressure on fragile local finances increased.’¹⁰
19. The NHS Long Term Plan is clear that: ‘the extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.’ Putting the NHS back on to a sustainable financial path is a key priority in the plan and is essential to allowing the NHS to deliver the service improvements set out within it. The plan will depend on:
- the NHS (including providers) returning to financial balance
 - cash-releasing productivity growth of at least 1.1 per cent per year, with all savings reinvested in frontline care
 - reducing the growth in demand for care through better integration and prevention
 - reducing variation across the health system
 - improving providers’ financial and operational performance
 - making better use of capital investment and existing assets to drive transformation.
20. Productivity savings at this level is a separate challenge given that acute hospitals have seen the amount of care they provide increase by 3 per cent a year on average during the period 2010/11 and 2016/17, with growth of 3.6 per cent in 2016/17. The Health Foundation has projected that over the next five years, without any improvement in the quality and range of services, acute and specialist hospital activity will need to increase by 2.7 per cent a year just to keep pace with demand. The additional funding announced as part of the ten-year plan would allow for activity growth of up to 2.3 per cent a year. The Health Foundation notes that

⁹ [The National Audit Office, The Health and Social Care Interface, July 2018.](#)

¹⁰ [Health Service Journal. 1 October 2019.](#)

level of activity that can be delivered can depend on pay. If demand cannot be moderated, then lower pay growth would allow for higher activity growth, but they argue that given the recent history of prolonged pay restraint and recruitment challenges it would be difficult for the NHS to once again restrain pay and support recruitment and retention.

21. The NHS Long Term Plan also commits to reforming the payments system and moving away from activity-based payments towards funding that is more population based. The aim is to allow local areas to develop new models of care around the needs of patients and to support the pledge within the plan 'to redesign services so that over the next five years patients will be able to avoid up to a third of face-to-face visits, removing the need to up to 30 million outpatient appointments a year'. There are similar proposals to develop the payment system to support objectives for the delivery of maternity and adult critical care services.¹¹
22. The Chancellor also described the 2019 autumn spending review as 'turning the page on austerity and the beginning of a decade of renewal'. However, for most NHS staff, the previous decade has been one of experiencing pay restraint and real-terms pay cuts.
23. Some might see increased spending on the NHS as an opportunity to restore wages to previous levels through above inflation pay rises. However, policy makers will be faced with difficult choices about where funds should be directed. For example, Chair of NHS Improvement Dido Harding, said recently that if she had an extra £1 billion to spend, she would put it into social care, where healthcare assistants in social care are the most underpaid and the most difficult to recruit and retain.
24. The Review Body's recommendation in the 47th report that SAS doctors should receive a higher pay uplift than other medical staff, without mention of any additional funding, resulted in a significant amount of unplanned future expenditure. Budgets have been set until 2024/25. The pressures of meeting increasing demand and at the same time delivering efficiency savings means that any similar unfunded commitments will result in additional financial pressure for employers.

¹¹ [NHS Improvement, Key areas of work for the 2020 tariff, November 2019.](#)

WORKFORCE CHALLENGES

25. In July 2019, the NHS Confederation surveyed NHS leaders to assess their views on the barriers and enablers on the journey towards delivering the NHS Long Term Plan. Workforce continues to be the most serious challenge facing the NHS, with 65 per cent of respondents saying they were either not very or not at all confident that their local health systems would be able to meet their staffing needs.
26. When asked to identify roles or sectors where their local health system was experiencing particularly severe workforce shortages, mental health staff (nursing, psychiatrists and psychologists) were frequently highlighted, as were GPs, community and primary care nurses and general nursing roles.
27. Workforce and activity growth pressures remain enduring challenges for health systems and respondents to the Confederation's survey are uncertain that the plan's proposals are enough to resolve some of these deep-seated issues.¹²
28. More recently, the NHS Confederation asked members to rank their critical priorities for the incoming government in order of urgency. Most of those health leaders surveyed identified workforce as a key priority, with 54 per cent ranking it as the top priority. More than 90 per cent either agreed or agreed strongly with the statement that 'understaffing across the NHS is putting patient safety and care at risk'. Over 83 per cent agreed that the NHS Pension Scheme is having a detrimental impact on workforce pressures and 70 per cent said the same about patient care.¹³
29. Census data from the Medical Royal Colleges is also useful in helping to assess the impact of workforce shortages. A survey of more than 8,600 consultants and higher specialty trainees by the Royal Colleges of Physicians found that close to half (43 per cent) of advertised consultant posts with an advisory appointment committee (AAC) went unfilled due to a lack of suitable applicants. This year the number of consultant posts advertised with an AAC also fell by 33 per cent.
30. The ratio of consultant physicians to population served varied widely across the UK, and regions with fewer consultants also have the highest rates of unfilled advertised posts.
31. The census gives some insight into the factors which affect career choice. As in previous years, trainees clearly regarded geographical location as the most important factor when applying for a consultant post, with 55 per cent of women and 51 per cent of men rating this

¹² [NHS Confederation, June 2019 *ibid.*](#)

¹³ [NHS Confederation, *Fit for the future. How should the incoming government help the NHS in England, November 2019.*](#)

highest. The second most important factor was the proportion of specialty time in their job plan, with 22 per cent of women and 31 per cent of men rating this highest. Less than full time (LTFT) working or the ability to work flexibly was the third most important factor for women, although 29 per cent of LTFT women trainees rated this highest. For men it was academic opportunities and links.

32. The census notes that given trainees' prioritisation of geographical location, illustrated by the fact that only 23 per cent of medical CCT (Certificate of Completion of Training) holders reported applying for a consultant post outside their deanery, it is crucial that in future the geographical distribution of trainees in the UK better matches the geographical and population demand for consultant physicians.¹⁴
33. The Colleges have called for a significant increase in the number of medical school places across the UK with the aim of a small surplus of supply. They will estimate the costs of such an expansion and explore how it could help regions with lower numbers of doctors. The Interim NHS People Plan also committed Health Education England to work with key stakeholders and partners on a national consultation to establish 'what the NHS, patients and the public require from 21st-century medical graduates.' This work will look at the role of the doctor within the context of the future multidisciplinary team and consider how they interact with the evolving roles of other healthcare professionals.
34. The importance of the workforce in delivering the plan is also highlighted in a report by the Royal College of Psychiatrists, which stated that the rate of unfilled NHS consultant psychiatrist posts had doubled in the past six years. This comes at a time where demand for mental health care is increasing and the view of the College is that, unless this shortage is addressed, the government's long-term ambition to transform mental health care will fail.¹⁵ The Royal College of Radiologists' Clinical Oncology UK Workforce Census Report 2018 sets out the current staffing crisis among clinical oncologists. Based on data from every UK cancer hospital, the report shows that:
 - vacancies for clinical oncology posts are double what they were in 2013, with more than half of vacant posts empty for a year or more
 - the UK's clinical oncology workforce is currently 18 per cent understaffed and without investment the shortfall is predicted to grow to at least 22 per cent by 2023
 - to close the gap between supply and demand for cancer doctors, oncology trainee numbers need to at least double, and even with that investment the gap would not be closed until 2029.
35. The survey also found that attempts to recruit staff from abroad have been varied, with only five centres successfully hiring overseas doctors last year. Some of the factors affecting recruitment included not having the resources to support consultants trained overseas, as

¹⁴ [Royal College of Physicians, Focus on Physicians 2018/19 census, October 2019.](#)

¹⁵ [Royal College of Psychiatrists, Plans to transform mental health services set to fail, October 2019](#)

well practical problems with remote job interviews and the need for more hospital HR expertise to deal with complex overseas recruitment issues.¹⁶

WORKFORCE SUPPLY

36. The Interim NHS People Plan recognises doctors amongst staff group shortages and commits to address these, in addition to the focus on nursing shortages.¹⁷
37. The NHS Long Term Plan describes how the NHS will transform models of care over the next five years to provide more co-ordinated, proactive and personalised care and better health outcomes. The Interim NHS People Plan states these changes will require workforce growth across the overall workforce including the medical workforce to address gaps in specialties and regions, addressing training and flexible working approaches. These themes will be developed further in the full NHS People Plan, which we expect will be published early in 2020.
38. The Interim NHS People Plan commits to recruiting more doctors from overseas in the short to medium term. A best practice toolkit from NHS Employers supports this by helping employers to effectively recruit from overseas and effectively retain these staff. Restrictive immigration policy and the uncertainty around Brexit currently constrains this.

Immigration and Brexit

39. Since the June 2016 referendum, NHS Employers together with NHS Providers and The Shelford Group have carried out a quarterly survey of NHS organisations on the impact Brexit is having on the workforce. The results of over two years' worth of data is available on the NHS Employers website¹⁸. The results identify that over half of employers are unsure of the impact of Brexit on their workforce, with most recent 2019 data showing 27 per cent feel it will have a negative impact.
40. Statistics from the survey show that 9.5 per cent of hospital doctors are from EU countries outside of the UK. The number of hospital doctors in post since the referendum has increased from 110,084 to 119,597 (March 2019 figures). The number of hospital doctors with known EU nationality has also slightly increased from 10,106 in June 2016 to 10,873 as of March 2019.¹⁹
41. General Medical Council (GMC) data²⁰ on registrants from EEA countries shows a steady inflow of doctors since the referendum: 2,048 in 2016 and 2,057 in 2017 with a marginal drop to 2,021 in 2018.

¹⁶ [Royal College of Radiologists, Clinical Oncology. UK workforce census 2018, March 2019.](#)

¹⁷ [Interim NHS People Plan](#)

¹⁸ [NHS Employers. The impact of Brexit on the NHS workforce. September 2019.](#)

¹⁹ [House of Commons Library, Briefing Paper](#)

²⁰ [GMC, Our data about doctors with a European primary medical qualification in 2018, October 2018.](#)

42. The introduction of the Home Office EU settlement scheme, now having received over two million applications, has gone some way to reassuring EU staff of their rights to remain and work in the UK. NHS Employers continues to highlight the scheme to employers, so they can support and encourage their EU staff to apply.
43. The Migration Advisory Committee's (MAC) shortage occupation list (SOL), published by UK Visas and Immigration, has acknowledged workforce shortages for some time and the list now includes all medical practitioners (effective from October 2019). This addition, which removes the Resident Labour Market Test requirement, could see an increase of overseas applicants to the Foundation Programme.
44. The current Tier 2 points-based route and sponsorship system remains unattractive for smaller providers such as GP practices, as the recruitment costs are disproportionate. It is also restrictive for several professions who do not meet the current salary thresholds. We are keen to understand the detail for the future immigration system as soon as possible, including a new points-based system which we hope will facilitate the movement of overseas staff into both health and social care roles across required skill levels.
45. It will be important for the government to progress quickly with new immigration policy, to ensure employers have time to prepare for new arrangements and be clear on how they can recruit to roles across health and social care in future.
46. In May 2019, MAC²¹ alluded to a disparity between the pay of migrant workers and their domestic counterparts, depending on occupation. NHS Employers has engaged with employers to try and determine any differences in pay and the reasoning for this. Recruitment practice does differ, with some organisations recognising experience in host countries. NHS Employers continues to look at any disparity and communicate with employers to help ensure consistency in practice across the country.
47. The GMC's 2019 workforce report confirms that the medical workforce is increasingly international and diverse. For the first time, more non-UK medical graduates took up a licence to practise than UK medical graduates. The number of international medical graduates (IMG) has doubled each year between 2017 and 2019. IMG doctors make up a larger proportion of SAS and locally employed doctors than other register groups. Most IMG joiners come from South Asia but increasing numbers are coming from Africa and the Middle East.²²
48. However, there is some concern about whether the future supply of overseas doctors can be guaranteed. In October 2019 The Chief Medical Officer gave evidence to the Lords Science and Technology Committee inquiry on ageing, science, technology and healthy living. He touched on our reliance on overseas healthcare professionals and whether this model was sustainable in the face of demographic change across Europe and the rest of the world. He said that:

²¹ [The Migration Advisory Committee, Full review of the shortage occupation list. May 2019](#)

²² [General Medical Council. The state of medical education and training in the UK. Workforce report 2019.](#)

“... it is very important that we look seriously at our neighbours in Europe and the wider world and what is happening to them, because in reality our current model is based on the ability to hire in medical nursing and care workers from around the system.

If you look at the demographic pyramids in Europe, we will have a relatively gentle path down to that change in age group. It will still be relatively steep, but it will be steady. That is not true for most of our European neighbours - Germany, Spain, and most of the southern European ones - which moved from a population pyramid that bulges right out to a very narrow population pyramid over a period of about a decade. Which decade it was varied slightly. Therefore, they will go through the demographic bump that will occur extremely hard and will move from having a large supply of people and a relatively low demand to a very large demand and a much smaller supply of people over a very short period of time.

If you look more widely globally, the same process is happening in east Asia, China, Japan, South Korea and various other places that are demographically slightly ahead of us, and it is increasingly happening in south Asia and in Latin America. So we will be in a global competition - I do not mean that in a negative sense but in a purely economic sense - for each of these classes of workers.

Therefore, our model will have to take account of the fact that simply expecting that we can buy-in help when we need it will be very difficult to sustain, and certainly economically difficult to sustain”.²³

49. This view is shared by Mark Britnell in his book *Human - solving the global workforce crisis in healthcare*. He suggests that staff shortages will be experienced globally but that they will be spread unevenly. He predicts that the growth in demand for healthcare workers will be highest in upper-middle-income countries, driven by growing economies, populations and ageing. This will fuel global competition for skilled health workers. He describes China's shortage of 200,000 paediatricians, 160,000 general practitioners and 40,000 psychiatrists and how the relaxation of the one-child policy would require an extra 160,000 obstetricians.²⁴
50. The GMC workforce report indicates that, for the moment at least, the UK remains an attractive destination for international medical graduates. But the report also contains a warning. We have already noted that according to GMC data, SAS and locally employed doctors currently represent the highest proportion of overseas joiners. However, the GMC also expressed concern about the number of doctors leaving, including large numbers of IMGs under 55. Between 2012 and 2014, SAS and locally employed doctors were twice as likely to have relinquished their licence and not returned by 2019. Improving the experience of SAS doctors generally is key to improving retention.

²³ [House of Lords, Science and Technology Select Committee, 15 October 2019.](#)

²⁴ Britnell, M. *Human- Solving the Global Workforce Crisis in Healthcare*. Oxford University Press 2019.

Improving domestic supply and supporting retention

51. In its recent State of Care report, the CQC observed that the reputation of hospitals, their CQC rating, and the culture and work environment can affect recruitment. They said that they had noticed an emphasis on retaining staff in the services that they inspect, through a greater focus on staff wellbeing, training and career development. They also found that investing in staff and empowering them to do their jobs can support staff morale and retention. These themes are consistent with the aims of the NHS People Plan and initiatives to grow the workforce through improving staff retention and making the NHS the best place to work.
52. The need to increase the numbers of doctors through improving domestic supply and retention is a key component of the Interim NHS People Plan. The plan lays the foundations for the workforce transformation needed to deliver the new service models and ways of working set out in the NHS Long Term Plan. It is structured around five main themes:
 - making the NHS the best place to work
 - improving the leadership culture
 - taking immediate action to address the nursing challenge
 - delivering 21st century care
 - developing a new operating model for workforce.
53. Medical workforce priorities include growing the overall workforce by around 2 per cent a year and increasing substantive staffing by improving staff retention and securing future supply. At the same time, the NHS will also be required to improve efficiency through a combination of workforce productivity and workforce redesign. There are a range of workstreams within the Interim NHS People Plan aimed at the medical and dental workforce.
54. At undergraduate level, the Interim NHS People Plan is seeking an expansion in undergraduate medical schools, a review of medical education to develop the doctor of the future and establishing wider access to medical training programmes. Data from the Universities and Colleges Admissions Service (UCAS) shows that there are increases in medicine applicants from all four countries of the UK (collectively up 5 per cent to 18,500), and from international students, with EU applicants up 1 per cent to 1,680, and non-EU applicants increasing by 10 per cent to 3,530.²⁵ There will also be a review of postgraduate medical training; the development of doctors with more generalist medical skills; a return to training programme; a programme to improve junior doctors' working lives; rebalancing the geographical distribution in specialty training; more flexible training and working arrangements.
55. Undergraduate medical school places have increased by 1,500 supported by the opening of five new medical schools in England. Expansion is under review by NHS England and NHS Improvement.
56. Priorities regarding SAS doctors include reforming the SAS grades and establishing the role of the SAS doctor as a positive and rewarding career choice, as described in the *Maximising*

²⁵ [UCAS, More people than ever want to be a doctor, November 2019](#)

the potential guidance document²⁶. Other work includes developing medical credentials, models of multidisciplinary team working and clinical leadership. The vision of the Interim NHS People Plan is that: 'there will be a sustainable supply of doctors as a result of a sufficient flow of additional medical trainees and improved retention of doctors at all stages of their medical training and career, through improved working lives, flexible training options and rewarding careers and conditions.'²⁷ We discuss some of these programmes of work in greater depth in the sections below, which cover the individual remit groups.

TARGETING PAY

57. In setting the Review Body's remit for the 2020/21 pay round, the Secretary of State for Health and Social Care asked for its views on targeting of available funds in 2020-21 to ensure that recruitment and retention pressures are properly addressed.
58. The Interim NHS People Plan states that: 'in implementing the recommendations of Health Education England's review of the foundation programme, over the next five years we will preferentially distribute training places in the geographies and specialties where the NHS most needs them and in alignment with the specialty priorities of the NHS Long Term Plan'.
59. Foundation priority programmes will better attract and retain trainees in remote and rural and under-doctored areas; provide enhanced exposure to shortage specialties, including general practice and psychiatry; and support widening participation programmes and the development of a future academic workforce. Collectively, these initiatives will start to address historic distribution imbalances and reflect future patient and service needs set out in the NHS Long Term Plan.
60. A cross-system National Programme Board has been established to consider the redistribution of existing postgraduate training posts in England, while at the same time exploring incentives to address distribution issues in the trained and training medical workforce. It is generally accepted that up to now the distribution of postgraduate medical training posts across England has been based on historical arrangements.
61. The board's work will take account of the evidence that postgraduate medical trainees tend to remain in the geographical area where they complete specialist training. This means that the consultant workforce also tends to be recruited from those who trained locally. This is consistent with the findings of the Royal College of Physicians (RCP) survey mentioned above, which states that only 23 per cent of medical CCT holders reported applying for a consultant post outside their deanery.
62. There is also an emerging body of research using the UK Medical Education Database (UKMED), which explores the socio-demographic and educational factors that can influence the choice and location of specialty training. This includes experience at medical school, age and gender.²⁸ Some of the work on the gender pay gap has explored why women are less

²⁶ [Health Education England and NHS Improvement, Maximising the potential - essential reasons to support SAS doctors, February 2019.](#)

²⁷ [Interim People Plan, The future medical workforce.](#)

²⁸ [UKMED, Accepted applications.](#)

represented in some of those specialties where there are a greater proportion of more highly paid doctors.

63. A study of doctors in training in Scotland looked at the many personal and work-related factors which influence their career decision making. 84 per cent of 798 eligible Foundation 2 (F2) doctors responded. Choice can be influenced by gender, the importance of financial incentives, professional development, location, work-life balance, working conditions and education. The survey found that location was the most important consideration, followed closely by the presence of a supportive culture and working conditions. It also found that F2 doctors would need to be compensated by an additional 45.75 per cent above potential earnings to move from a post in a desirable location to one in a less desirable location.²⁹
64. What makes one location more desirable than another may vary. In this study, amenities and proximity of family and friends were defining features of a desirable location. However, there are other factors including the status of the employing organisation, job and career opportunities for partners, and availability of schools and childcare. Some of these factors may be beyond the control of organisations, but they are able to support the development of supportive cultures and good working conditions, which are also cited as important factors influencing choice.
65. The GMC's 2019 workforce survey found that while the number of doctors on the specialist register had grown by 14 per cent in the period from 2012 to 2019, there were different patterns among specialties. They observed a strong growth in the number of emergency medicine doctors with a 5 per cent increase in the last year and 20 per cent over the past five years. Their view is that this is most likely the result of curriculum changes over the last five years, where training opportunities, and the number of doctors attracted to them, have both increased.
66. The GMC also noted that the number of psychiatrists was beginning to increase, reversing a period of decline.³⁰ In general practice, the number of GP trainee places that have been accepted has beaten the annual target for a second consecutive year. Health Education England has reported that 3,538 GP trainees have been accepted in the past year, beating the annual target of 3,250.
67. These specialties were among those selected for the award of a Flexible Pay Premium (FPP) as part of the 2016 junior doctor contract negotiations. The reasons for establishing the FPP were largely driven by the need to avoid disincentives that could apply as the result of changes to the junior doctor contract, particularly around the reduced potential for earnings based on out of hours and on-call work.
68. There has been no research so far on whether the FPP has had an impact on the recruitment and retention of doctors to these specialties. Any research would also have to take account of other factors that may have led to increased recruitment. For example, the Royal College of Psychiatrists launched its 'Choose Psychiatry' campaign in 2017. Since then, the number of

²⁹ [BMJ Open, What factors are critical to attracting NHS Foundation doctors into speciality or core training?](#)

³⁰ [General Medical Council, The state of medical education and practice in the UK. The workforce report, November 2019.](#)

doctors choosing to train in psychiatry has risen by a third across Great Britain. The College has also introduced other initiatives such as a child and adolescent mental health run-through programme, which allows junior doctors to specialise in child psychiatry at the beginning of their training. According to the College this allows them to do this closer to home than was previously possible. The College found that high quality exposure to psychiatry during medical school made a difference to the likelihood that students would choose psychiatry as a specialty.

69. Similar efforts have also been made in making general practice a more attractive option for trainees, through the work of the General Practice National Recruitment Office, the 'One Career, Endless Opportunities' campaign and other initiatives led by national stakeholders.
70. Before extending FPP to other shortage specialties, it would be helpful if we were able to assess whether they have had any impact separate to those specialty based recruitment initiatives described above.
71. We recently asked employers for their views on targeting pay through a short survey. We asked if the FPP introduced as part of the 2016 contract for doctors in training had helped recruitment and retention within those specialties. 41 per cent said yes and 59 per cent said no. Two employers said that it had helped in general practice. Several trusts replied that HEE was responsible for recruitment. One respondent said that the FPP had helped in circumstances where, due to the demands of the rota, junior doctors had reduced their time to 80 per cent, which had lessened the impact of the reduction in pay. Several respondents said that factors other than pay were important, with the ability to offer less-than-full-time training to help with recruitment. One trust had arranged a 'golden hello' within the terms and conditions to attract hard-to-fill specialties.
72. Views were gathered on whether targeting pay by location would help with recruitment and retention. 65 per cent said that it would help, 35 per cent said that it would not. Of those in favour, the most common view was that remote and rural locations would benefit most to compensate for additional travel and other costs and that this might also encourage them to remain in the area.
73. Other respondents pointed out other factors, such as the relative desirability of organisations within the same geographical location and that district general hospitals often struggled to compete with neighbouring teaching hospitals. One respondent said that some locations might have difficulties in recruitment and retention due to issues around working conditions rather than geography.
74. Those who did not support targeting pay were concerned that without additional supply, premia would simply encourage 'churn' and that there needed to be clear and objective criteria for targeting pay.
75. We asked whether targeting pay in certain specialties would help. Replies were varied and reflected local recruitment pressures. The most common specialties mentioned were psychiatry, particularly in rural locations, and emergency medicine.
76. Other issues affecting recruitment and retention include national shortages; work permit and visa issues; pay disparity and local competition; workload and intensity of the rota; the increasing impact of the pensions tax issue; and a greater demand for flexibility, work-life

balance and less-than-full-time working. One respondent said that the number of vacancies within an organisation could itself discourage recruitment and retention:

‘The key issues which make somewhere a great place to work are four fold: having a good work environment; work flexibility with good rotas and the option to work less than full time; having avenues for professional development with access to professional forums where they can develop excellence in their field; and a supportive management culture which supports all the above for its employees.’

77. Employers were asked whether consultants should receive anything other than a cost of living award. 74 per cent of those who responded said that they should not. While some respondents noted the impact of the pensions tax position, the general view was that consultants should not be treated any differently to other staff and that they had opportunities for additional remuneration through the clinical excellence awards scheme. As senior members of staff, any additional pay should be based on performance.
78. One respondent commented that unless significant additional money was made available to support targeting pay then it was likely to be counterproductive. Other employers said that if targeting were to happen then it should be focused on location rather than speciality.
79. Our survey of employers on SAS doctors also included questions around targeting pay. Although the questions were asked specifically about SAS doctors, we believe that there is some relevance to other staff groups.
80. Of those employers that responded to our survey, 80 per cent reported difficulties in recruiting to SAS posts, compared to 77 per cent in 2017. Employers reported the area with most difficulty in recruiting was emergency medicine (52 per cent) followed by general medicine (32 per cent) anaesthetics (31 per cent). 37 per cent of employers reported recruitment problems that related to location.
81. 41 per cent of employers thought that targeting pay towards certain specialties or locations would help with recruitment and retention. The most common reason for this answer was because of the hard-to-recruit areas such as emergency medicine, psychiatry and anaesthetics. Only two comments were made regarding location and this was due to high cost areas being outside of London weighting and for areas that are less popular with greater health and social deprivation.
82. Of the 38 per cent of employers who didn't think targeting pay would help with recruitment and retention, one fifth were director or deputy director level. The two most common reasons cited were that this would create unwanted variation and difference of treatment of staff between specialities. Employers commented that pay is not necessarily the answer for SAS doctors. For this group of staff, career progression and development is a bigger motivator and will have a bigger impact.
83. Just under half of the respondents to NHS Employer's Total Reward Network survey launched in September 2019 said that they are currently using recruitment and retention premia to support recruitment into hard-to-fill posts. Of those who said they did, it was common that these applied to specialist clinical roles. Employers have used these for pathology, forensic, SAS level and mental health specialist roles.

84. There are existing provisions in the current consultant terms and conditions for employers to pay recruitment and retention premia. Some employers also offer additional programmed activities beyond the standard ten per week. Schedule 16 paragraph 16 of the terms and conditions also provides employers with wide discretion to pay consultants, such other payments and allowances, as they decide. There are no similar provisions in the specialty doctor terms and conditions although we have seen employers offering local contracts that mirror the now closed, but more favourable, associate specialist contract.
85. For doctors in training, flexible pay premia exist for a small number of specialties. We are aware that some employers are offering locally determined reward packages to meet specific local challenges. Trainees have been offered £7,000 to undertake foundation or specialty training in north Cumbria as part of a targeted recruitment scheme. This has been accompanied by measures to improve the training experience, including protected time for developmental supervision, skills development and opportunities for educational research.
86. Employers also make use of social media including Facebook and Twitter to engage and promote their reward offer. Many include the reward offer in specific recruitment microsites. These strategies are effective in demonstrating the reward packages of individual organisations, especially where the objective is to promote location. This is regularly seen for areas near to London, such as Oxfordshire, and those in very rural locations, such as Cumbria and the South West coast.
87. The reasons why doctors make the career choices that they do, in terms of specialty and location, are complex and depend on many factors that may vary at each stage of their career. What might be important in the early stages of a career might be different to the priorities at a later stage, where perhaps the requirements of partners are more influential.
88. The national programme board looking at the distribution of specialty training will be informed by an option appraisal working group. This group, which will include employer representatives, will examine a range of measures to address identified inequalities in distribution and consider a range of mitigating factors such as use of the wider workforce skill mix, incentivisation, cultural, peer, and other educational factors. The range of options produced may vary by specialty, geography and location, but their overarching aim is to reduce inequalities whilst mitigating risks to maintain standards of healthcare quality.
89. Pay is not the only factor that influences career choice, whether this is the specialty in which doctors choose to practise or the location. There are often complex socio-demographic factors involved, as well as other reasons, which motivate career decisions, including a supportive culture and a positive working environment. These are more within the control of organisations than location. There has been some improvement in the number of doctors attracted to specialties that have attracted FPP, but there have also been considerable efforts by different organisations over a significant period to make these specialties more attractive choices.
90. We believe that the work of the National Programme Board will provide a methodologically sound evidence base to inform the extent to which financial incentives could help recruitment in certain specialties and locations, and the relative importance of these in relation to other non-financially based initiatives and incentives. Over time this might be combined with a large scale, formal survey of trainee and trained doctors to advance the research evidence on

those factors that influence career choice, which can in turn help inform local, regional and national workforce planning.

TRANSFORMATION CHALLENGES

91. The NHS Long Term Plan maintains the direction of travel towards more integrated and joined-up services established previously in the five-year plan. The aim is to deliver integrated health and care focused on population health, with greater investment and focus on community, primary care and mental health services, as well as an emphasis on prevention and health inequalities. These measures are essential if we are to improve care for patients, reduce pressure on hospitals and other services, and put the NHS on a sustainable path in the face of rapidly rising demand.
92. The plan anticipates that the NHS will reduce demand for acute care through better integration and prevention. However, only one in four respondents in an NHS Confederation survey believed their local health systems would reduce significantly the rate of growth in acute activity as a result of the reforms in the plan. Many areas of the country have already been pioneering service changes designed to keep people well and living independently in the community, but funding cuts to social care and public health are undermining this work.
93. Four out of five survey respondents said reductions in public health funding have already restricted the ability of their local health system to deliver NHS services either somewhat or to a great extent. The cuts to public health services such as smoking cessation, sexual health and drug and alcohol services have created health problems that could have been avoided.³¹
94. The Interim NHS People Plan accepts that the workforce planning model in the NHS needs to change. It argues that functions should be undertaken at the best level to meet the needs of the services. It commits to devolution of responsibility to the integrated care systems (ICSs); over time, and as they develop, they will take on greater responsibility for people planning and transformation activities.
95. The Interim NHS People Plan states that sustainability and transformation partnerships (STPs) and ICSs will have a core role in testing and refining emerging proposals aimed at delivering those key actions linked to the development of the new workforce structure. One of the strands of the plan concerned with securing current and future workforce supply is around matching workforce supply to the needs of geographies, and there is a recognition within the plan that local health systems will have workforce needs to be managed collaboratively within local labour markets.
96. This shift from competition to collaboration, will provide opportunities for employers to work dynamically across organisations. Employers are beginning to actively explore ways they can embrace collaboration whilst retaining focus on the needs of their own staff. For example, 25 per cent of respondents to our Total Reward Network survey told us that they are currently collaborating with others on their reward offering. We do know that collaboration does work in individual health geographies. For example, one region is beginning work collaboratively across equality, diversity and inclusion, flexible working and health and wellbeing strands. This has largely stemmed from working collaboratively on NHS passporting.

³¹ [NHS Confederation, Unfinished business, The need to invest in the whole health and care system, June 2019.](#)

97. We also know that individual employers are specifically looking at and beginning to collaborate on specific areas such as health and wellbeing initiatives and on place-wide frameworks for areas such as organisational development and talent management.
98. Collaboration also offers employers opportunities to provide new opportunities in training and development for their staff. More varied and complex placements could be offered across health systems, aiding staff to gain new skills, experiences and develop careers in dynamic ways. Continuing to seek ways to collaborate whilst ensuring individual employers remain focused on the specific needs of their own staff in relevant and motivating ways is key.
99. While some issues such as professional regulation, credentialing and prescribing rights will remain nationally controlled along with pay policy and the pension scheme, the plan expects that accountability arrangements will be developed 'to enable ICSs to take on greater responsibilities for these activities, while ensuring we do not push ICSs to take on greater responsibility than they are ready to do'.
100. There is a possibility that, in future, decisions on pay and workforce policy might be more influenced at ICS level in collaboration with local employing organisations. This could result in different models of employment across ICS organisations, which will require a similar devolution of decisions where decisions on pay and reward might be similarly influenced by local priorities and circumstances. Over time, devolved responsibility for workforce planning will increasingly lead to locally based solutions to specific recruitment and retention issues.

DOCTORS IN TRAINING

101. Following the junior doctor contract review, which began in August 2018, NHS Employers and the BMA entered negotiations in early 2019 to agree the outcomes of the review and any necessary changes. The review had a strong focus on further embedding the safety and training changes set out in the new contract.
102. At the conclusion of negotiations with the BMA in July 2019, 82 per cent of BMA members who responded to the referendum voted in favour of the amended junior doctor contract. This collective agreement has marked the end of the 2018 review process and brought the BMA's dispute with government concerning the introduction of the 2016 contract to a close.
103. The Joint Negotiating Committee for Juniors (JNCJ) will now resume routine meetings to collectively maintain this contract, focusing in the coming year on delivering the various guidance projects and working groups agreed as part of the negotiated deal.
104. The parties have agreed that pay protection for trainees who currently remain on the 2002 contract will be based on an updated 2016 transitional schedule to ensure that these trainees can move to the 2016 terms in a fair and equitable manner, ensuring they will not earn less than they did prior to transition.
105. NHS Employers and the BMA have agreed an implementation timeline with a staggered introduction of the agreed provisions.³² NHS Employers has continued to support the implementation of the recently agreed contract through developing resources for employers.³³
106. NHS Employers and the BMA remain committed to commission further working groups and continue to review the outstanding issues resulting from the 2018 review.

Junior doctors pay deal

107. As part of the recently agreed deal, the government and NHS England have agreed to make available a pay envelope which supports further investment into the contract.
108. The investment is over four years and consists of a total of 2.3 per cent in 2019/20 and two per cent in subsequent years, with a further 1 per cent in additional investment. This additional investment has enabled the introduction of:
 - a weekend allowance uplift to ensure those working the most frequent weekends are remunerated more fairly
 - an enhanced rate of pay for shifts that finish after midnight and by 4am
 - a new nodal pay point 5.
 - £1000 LTFT allowance

³² [NHS Employers. Implementation timeline - junior doctor contract](#)

³³ [NHS Employers. Junior doctor contract. Implementation resources.](#)

109. Some trainees will be affected as a result of the 2019/20 pay uplift. Their increase in pay, either as a result of receiving an uplift as part of the 2016 contract deal or the DDRB recommended uplift, will result in a move from tier 4 to tier 5 pension contributions which will reduce the overall take-home pay.
110. During negotiations, NHS Employers was presented with evidence from the BMA on the serious implications of the risk of fatigue. This is recognised as a contributory factor in the feeling of burnout among doctors in training and featured significantly in the GMC's National Training Survey. The GMC survey highlights that since 2016, the proportion of trainees who say they worked beyond their rostered hours daily has halved (from 18.3 per cent to 9.1 per cent). However, 45.3 per cent of doctors in training worked beyond their rostered/contracted hours on at least a weekly basis, as did a considerably larger proportion (72.4 per cent) of trainers.³⁴
111. The parties have committed to address fatigue and burnout issues by reviewing the contract to include:
- a third 30-minute paid break for doctors who work a night shift
 - rest after night shifts, with a 46-hour rest period applied to any number of rostered shifts
 - efforts by employers to avoid rostering at a frequency of greater than 1 in 3 weekends.
 - reduction in the maximum number of consecutive shifts rostered or worked from eight to seven, and the maximum number of consecutive long day shifts reduced from five to four.
112. Employers have highlighted several challenges as a result of the newly agreed deal, particularly around the safety limits:
- Challenging timeframes for the implementation of the provisions mean additional administrative burden for employers.
 - The added cost pressure for employing organisations as a result of the 1:2 weekend frequency provision. Some specialties, particularly emergency care, are likely to face service implications unless additional doctors are recruited to cover gaps on rotas. Some of the provisions in the agreement have resulted in a lack of flexibility to agree local arrangements.
 - Difficulties in filling rota gaps where employers feel that further restrictions to the safety limits has potentially added to this problem.
 - Unintended consequences of the agreed deal remain a concern for employing organisations.

Exception reporting

113. The mechanism of exception reporting was a new process introduced as part of the 2016 terms and conditions. As might be expected with a new system being implemented at pace, some implementation issues and teething problems have emerged. However, even taking these into account, it has become apparent that there are systemic issues with how the process was designed from the outset, along with endemic cultural problems around the practice of exception reporting.

³⁴ [General Medical Council. National Training Survey 2018](#)

114. The intention behind exception reporting was to create an efficient and streamlined system through which trainees could indicate when they had worked additional hours; missed training or education opportunities; experienced immediate safety concerns, or else had concerns about the level of support available to them during their duties.
115. There are several cultural barriers for trainees to overcome when submitting exception reports. These include a fear that reporting will damage working relationships and that reports would be used against them at ARCP (annual review of competence progression) meetings or development meetings.
116. Much work is still required to improve the culture around exception reporting, despite reporting being endorsed and encouraged by most national stakeholders. This collective endorsement of exception reporting is apparent from the many supportive statements that have been issued. The exception reporting working group led by NHS Improvement issued a joint statement in June 2018 last year setting out a shared understanding of the purpose and potential of exception reporting.³⁵
117. There are also numerous issues relating to the current process and operation of exception reporting. These are inhibiting the effectiveness of exception reporting for both trainees and employers, and are likely to contribute to some of the negative cultural attitudes surrounding exception reporting that dissuade trainees from submitting reports. The GMC national training survey also highlighted that systemic pressures continue to impact training and around 30 per cent of trainers weren't always able to use their allocated time for that purpose. And over a quarter of trainees and trainers said that it wasn't unusual to miss training opportunities due to rota gaps.
118. The recent deal has taken these concerns into consideration and there has been agreement to amend the contractual provisions relating to exception reporting. This includes:
- what can be reported
 - what the exception reporting reviewal process should include
 - a review of the response time for educational supervisors for exception reports linked to missed educational opportunities.

³⁵ [NHS England, Exception reporting for junior doctors, June 2018](#)

SPECIALTY AND ASSOCIATE SPECIALIST (SAS) DOCTORS

119. As of June 2019, according to NHS Digital there were around 10,784 doctors on national SAS terms and conditions in England, including 2,129 associate specialists, 8,309 speciality doctors and 346 on staff grade contracts.
120. It continues to be a challenge to define the exact numbers of SAS doctors on national terms and conditions due to the coding of such doctors on the electronic staff record system. Health Education England's (HEE) SAS working group has been trying to determine which roles fall within the scope of SAS doctors to establish the size of the SAS population. An improved data set is now also available via the model hospital.
121. There has been a growing emphasis nationally on supporting and developing the SAS workforce with publication of the joint HEE and NHS Improvement report in March 2019 ,which sets out 11 shared commitments made by national stakeholders to give SAS doctors access to improved support and better development opportunities.³⁶
122. This was followed by commitments in the Interim NHS People Plan to recognise expertise gained while not in a formal training role, introduce a reformed associate specialist grade, provide opportunities for progression and to provide better support for SAS doctors. The overall aim is to make these roles a more attractive and positive career choice.
123. National stakeholders have made good progress on the 11 commitments since March 2019 to support, develop and promote the SAS role. This includes providing more support to implement the SAS charter; increasing e-portfolio access for SAS doctors; applying consistency of funding for SAS doctors and recognition of SAS doctors as supervisors in the Gold Guide and HEE guidance on excellent supervision.
124. In the recent GMC survey of SAS and locally employed doctors, only 6 per cent of SAS doctors reported not having access to an e-portfolio after having asked for it.
125. Across all specialties, HEE has committed to providing funding to support the development of SAS doctors. This funding has been distributed to HEE local offices for 2019/20 along with guidance on recommended activities for these monies to be spent on. The funding has been distributed equitably based upon whole-time equivalent SAS doctors within each HEE local team and the use of this fund is being monitored nationally.
126. NHS Employers has continued to support the implementation of the SAS charter through developing new guidance and resources for employers. A range of tools has been developed in collaboration with the BMA to support the implementation of the SAS charter at a local

³⁶ [Health Education England and NHS Improvement. Maximising the potential. Essential measures to support SAS doctors.](#)

level, to help track progress and measure performance at department and organisational level. This was followed by a joint webinar in September 2019 with the BMA to raise awareness of the charter and showcase two best practice examples of collaborative approaches to implement the charter's recommendations.

127. NHS Employers has recently published new guidance to support the induction of SAS doctors³⁷. The recent GMC survey showed that 77.5 per cent of SAS doctors felt they had their role and responsibilities clearly set out, but only 58 per cent said their induction was good or very good. The SAS induction checklist aims to support what trusts already have in place locally to ensure that SAS doctors are best supported in their transition into a new role. We know that many SAS doctors come from overseas and therefore have also included information on inducting doctors from overseas, signposting to helpful and relevant information.
128. In August 2019, NHS Employers published the *Professionalism and cultural transformation (PACT) toolkit*, which aims to educate and empower staff to improve professionalism within their workplace. The toolkit is based on the principles of work undertaken by Hull University Teaching Hospitals NHS Trust and can be used for any member of staff. However, we have, with the help of the BMA SAS committee, targeted communications for the SAS workforce due to the continued challenges they face with bullying and harassment.
129. NHS Employers undertook four engagement sessions in early 2019, focusing on better understanding and discussing the key challenges facing SAS doctors. They were attended by 97 employer representatives and 27 SAS leads/tutors/doctors. Each session was oversubscribed, demonstrating the commitment from employers to begin a conversation about making positive changes for this group.
130. Career development, pay and recognition continued to be highlighted as the biggest challenges facing the SAS workforce. However, this engagement showed that there was a lack of awareness of the SAS guidance and resources available to employers. There has therefore been an increased emphasis on promoting and sharing information through our medical workforce networks and wider HR audience.
131. In October 2019, NHS Employers undertook a survey with employers to identify the issues affecting the SAS workforce and to evaluate any changes since the last survey in August 2017. 93 per cent of employers were aware of joint NHS Employers and BMA resources to support implementation of the SAS charter, showing an awareness of the support available.
132. 85 per cent of employers reported taking steps to implement the charter, with over 40 per cent saying they had implemented most of the recommendations.
133. The recent GMC survey showed that in England, 27 per cent of SAS doctors said they were not aware of the charter and 33 per cent of SAS doctors agreed that their employer had taken steps to implement the SAS charter. Comparing this to the BMA survey back in 2017, only 22 per cent of doctors reported their employer had implemented the charter in part or full, and 53 per cent had not heard of the charter. This shows signs that awareness and

³⁷ [NHS Employers. SAS induction checklist](#)

implementation of the SAS charter by employers has increased but that there is more potential for employers and SAS doctors to work together to improve implementation.

134. 58 per cent of employers that we surveyed have taken steps to implement the SAS appraisal guidance and 52 per cent of employers have taken steps to implement the SAS doctor development guide. NHS Employers will continue to support employers in the application of the guidance. We will be leading on the update of the SAS development guide, which will be a collaborative piece of work with NHS England and NHS Improvement HEE, BMA and The Academy of Medical Royal Colleges. It will include good practice examples of development for SAS doctors, their uptake in management roles, supervision and other leadership activity.
135. Employers continue to report difficulties in recruiting and retaining SAS doctors. 80 per cent of employers we surveyed reported difficulties in recruiting compared to 77 per cent in 2017. As in 2017, career progression was the most common reason for SAS doctors leaving. Employers continue to offer their support to SAS doctors with 62 per cent offering dedicated support for gaining the Certificate of Eligibility for Specialist Registration; offering access to development programmes and encouragement to apply for management roles.

SAS contract reform

136. In September 2018, the Secretary of State made a commitment to look at introducing new contract arrangements for a new associate specialist grade. The preparatory work with stakeholders to re-open a reformed senior SAS grade identified a strong feeling that the newly reformed grade must be aligned with a strategy for reform to the whole SAS grade.
137. The government's response to the DDRB recommendations in July 2019 committed to negotiations on a multi-year agreement, incorporating contract reform for the SAS grade to be introduced from 2020/21. An additional 1 per cent, on top of the 2.5 per cent already paid, to be added to pay in 2020/21 will be made available, conditional on contract reform.
138. NHS Employers and the BMA received a letter from the DHSC in July 2019 inviting both parties to consider how reform of the SAS contract would meet the objectives outlined in both the 46th and 47th DDRB annual report, as well as the commitments set out in the Interim NHS People Plan. Parties jointly responded to this letter confirming their participation in this process in September 2019.
139. The overarching aim of reform is to ensure that the contract provides a framework that gets the best out of SAS doctors and ensures they are recognised and rewarded appropriately. The reform will be aimed at raising the profile, attractiveness and status of SAS roles to support a positive, engaged workforce that delivers the maximum benefit to the service.
140. Employers from our SAS engagement events in early 2019 recognised the positive opportunity that a new senior SAS grade brings in driving new roles based on service need, and continue to support the introduction of a senior grade to support career progression for this group.
141. The creation of a senior SAS grade will provide senior and experienced doctors with opportunities for career progression and will help make the SAS grade a positive career choice.

142. Through SAS contract reform we also aim to support flexible career development, including different routes to joining the specialist register, by recognising expertise and experience gained outside of the formal training pathway and by allowing doctors to step in and out of training.

CONSULTANTS

143. In 2018, the government offered the medical trade unions a 2 per cent multi-year pay deal based on the funding envelope available at that time. The BMA and Hospital Consultants and Specialists Association (HCSA) did not believe that this on its own was enough to incentivise them to enter into meaningful negotiations including contract reform, unless it was combined with pension tax flexibilities. Discussions on contract reform have therefore paused, pending any announcement that further funding might become available. Consultant contract reform is not one of the immediate priorities set out in the NHS Long Term Plan and the Interim NHS People Plan is not focused on consultant contract reform.
144. We have continued to keep an open dialogue with staff side on the residual consultants' work programme, and we have supported employers on issues affecting their senior doctor workforce. Discussion with each of these stakeholder groups has been dominated recently by the pension tax issue, which continues to have a huge impact on the workforce. Employers from our strategic medical and dental workforce forum and the NHS Employers Policy Board are concerned that, as well as the significant impact on patient care of reducing clinical time, there will also be implications if consultants reduce the amount of time that they spend on work such as management and research duties, education and supervision. The workforce is already poorly engaged, and even if the situation were to be resolved, employers think that it is a possibility that those consultants who have dropped to the baseline eight programmed activities (PAs) will be reluctant to take on additional work again.
145. Employers have noted several challenges associated with the consultant workforce. Some consultants have assessed that it is effectively costing them money to go to work and they fear receiving significant tax bills, which often arrive unexpectedly. In some extreme circumstances this has had an adverse effect on individuals and families, driving many consultants to reduce their commitment in terms of time either by dropping any additional PAs or reducing their base contract.
146. These issues, combined with low morale and workplace pressures, have seen more consultants planning to leave their posts and retire earlier than previously expected. The results of a survey by the Royal College of Surgeons on the NHS Pension Scheme shows how the current pension taxation issues have had an impact on retention, waiting list initiatives and training. The survey revealed that 69 per cent of consultant surgeons had reduced the amount of time they spent working in the NHS as a direct result of changes to the NHS pension taxation rules. 61 per cent of those who had taken financial advice had been specifically advised to refrain from taking part in waiting list reduction initiatives. 68 per cent of consultants were considering taking early retirement and 71 per cent were considering reducing non-clinical commitments such as education and managerial roles.³⁸
147. We are increasingly getting requests for advice from medical staffing teams who are having to respond to senior doctors who wish to refuse the financial element of pay progression

³⁸ [Royal College of Surgeons, Pensions survey, 9 November 2019](#)

points and clinical excellence awards. We have discussed this with the BMA, who have been receiving similar requests for advice, and our response is that the doctor should seek appropriate independent financial advice, given the very individual nature and circumstances that link to this position. The DHSC proposal to phase increases in pensionable pay was developed in response to feedback by staff.

148. The BMA doubts that deferring increments would be a cost-effective way for doctors to avoid the pension tax issue, and that it may be preferable for individuals to propose some form of 'pay smoothing' to their employer, i.e. where the value of the larger increments were spread over several years, or for them to seek to reduce their PAs or additional PAs, rather than deferring or refusing a pay increment. Ultimately, we understand that it is the individual's money to defer or refuse, so they are free to decide their own course of action. However, from an employer's perspective, we would strongly advise that they agree clear arrangements that cover situations where circumstances change and the consultant reconsiders, and any possible impact on future pay progression.
149. Employers support the need for pension reform for the wider workforce, not only for consultants, but also for those on the lower bands on Agenda for Change who often cannot afford to be part of the NHS Pension Scheme. We discuss the wider implications of the pension tax issue in more detail below.

Local clinical excellence awards

150. Following agreement between NHS Employers and the BMA, new contractual provisions were introduced for local clinical excellence awards (LCEAs) with interim arrangements for the period 1 April 2018 to 31 March 2021 now in place. Further arrangements will apply from 1 April 2021 if a new performance-related pay scheme is not agreed and implemented prior to that date. All employers are required to run an annual local CEA round. New awards are time limited and non-pensionable.
151. The Treasury's commitment of 0.5 per cent of the total consultants' pay bill to increase the pot available for local awards has been translated into an investment ratio for employers to use, which has been set in the terms and conditions at a minimum of 0.3 CEA points per eligible consultant annually until March 2021. There has been much discussion about how this should be apportioned, which has created uncertainty and frustration for employers.
152. In our 2018 evidence to the review body, we expressed our intention that future arrangements for performance pay should continue to be non-consolidated and non-pensionable, promote the engagement of consultants in the delivery of agreed objectives, and reward those who make an exemplary contribution to the health system. By establishing a closer link to objectives, employers hope to be able to incentivise performance and reward consultants for meeting their organisational priorities. We also maintain that a system based on meeting objectives, rather than on applications, would widen access and participation for under-represented groups of consultants, including women and those from black and minority ethnic backgrounds.
153. We have continued to consult the BMA and the Universities and Colleges Employers Association (UCEA) about the position of consultant clinical academics within the revised local CEA scheme. We continue to be challenged by the Clinical Academic Staff Advisory

Group (CASAG) and UCEA about clinical academic access to local CEAs. There is no contractual entitlement for clinical academics, but we encourage employers to continue to offer access to the scheme where they have done so in the past.

154. NHS Employers continues to promote the Follett principles, which encourage employers to work with their higher education institutions to support clinical academics. We have said that employers and universities should be jointly involved in awarding CEA points, which also offer an opportunity to improve communications and relations between the joint employers. We anticipate further BMA legal challenges about clinical academic eligibility and whether collective agreements could apply to honorary contracts.
155. Employers have said that CEAs are presenting several challenges. The need to spend a growing pot of money combined with a drop in the number of applications (in large part due to the pension tax threshold) is causing employers to rollover funds from year to year. Despite a strong desire to stick to the intentions and the principles behind the revised scheme, some employers are feeling compelled to allocate all the money to almost all who apply, which means the awards no longer truly reward 'excellence'. One of the employers who replied to our recent survey on local CEAs, said:

'This remains a competitive process designed to reward excellence and the local committee are keen to ensure a minimum standard, rather than to simply hand out awards to anyone who applies. The increase this year to 0.5 minimum investment may make this challenging.'
156. Employers have been working to support increased and improved applications from minority groups, through initiatives such as the analysis and reporting of data, by sending communications directly to all consultants from senior managers encouraging applications, and the provision of information and workshops for these groups.
157. Our CEA survey of employers suggests that some are seeing a rise in female applicants, and in those who identify as BAME, but most have seen no change despite efforts. This, employers suggest, is largely down to the nature of the awards being given by application rather than being performance related. Some subgroups, including those who work less than full time, are less inclined to put themselves forward.
158. In addition to the threat of an unaffordable tax bill, some consultants feel that there is too little money in terms of the net benefit, which discourages some senior doctors from applying for local awards. Others maintain that awarding individuals feels antiquated, as does simply offering financial awards. There is also a perception that those who come to work every day and simply work very hard are not appropriately recognised / rewarded by the current system.
159. These issues will influence our work with partners and stakeholders to develop a successor scheme from 2021.

SALARIED PRIMARY CARE DENTISTS

160. The salaried primary dental care (SPDC) workforce has been affected by changes to the commissioning and design of services over recent years. As we reported last year, our stakeholders are citing low morale among community dentists. The role has changed and is often intense, with dentists often working with child and adult patients with very complex and specific needs. Many practitioners are not being employed or paid for the specialist work they have been trained to do.
161. As with the wider dental workforce, lack of career progression is an issue for SPCDs, and there are few opportunities for in-house training and development. Following the publication of the report on advancing dental care by Health Education England, there is some national work taking place to consider how to improve the current dental team education pathways as well as other strategic moves to help to address some of the issues faced by this workforce.³⁹
162. As the review body noted in its previous report, there is a lack of service and workforce data for the dental workforce in general. We have been working to ensure that the NHS Staff Survey allows for identification of different dental groups to enable better identification of the state of satisfaction, morale and other issues relevant to salaried primary care dentists.
163. The Joint Negotiating Committee (Dental) JNC(D) is currently concerned about instructions from NHS England for commissioners of services to call for accreditation of Tier 2 dental practitioners. This has raised some unresolved employment-related issues. JNC (D) has invited NHS England and NHS Improvement to attend their meeting in December to discuss these in more detail.
164. Specialty and associate specialist (SAS) dentists make up a large proportion of the dental workforce and they are keen to be engaged in the SAS contract reform work.
165. There is an issue with dental core trainee (DCT3) posts, which has come about as a result of the 2016 contract for doctors and dentists in training. The number of posts available to dentists who wish to undertake a DCT3 year prior to taking up specialty training has continued to significantly reduce in England, compared to the number before the new contract was introduced in 2016. This is a problem as the third year of training attracts more pay without an equivalent increase in responsibility and some employers are reluctant to offer such posts. In order to try and address this, some run-through posts are being piloted in the Yorkshire and Humber region. Run-through posts are based on a single competitive selection process and depending on progress cover the entire specialty curriculum. These are different to uncoupled posts which require a second stage of competitive recruitment.

³⁹ [Health Education England. Advancing dental care. Education and training review. April 2018.](#)

STAFF ENGAGEMENT

166. The NHS Staff Survey 2018 showed a service under continuing pressure, with impact on staff including doctors. There was progress on some aspects of people management including appraisal, but scores in areas such as health and wellbeing worsened. There was a shift to analysing data by key theme rather than key finding and the majority of these remained the same as between 2017 and 2018. Staff engagement held stable overall, with a minority of organisations managing to improve. There was also a small improvement in the willingness of staff to recommend the NHS as a place to work. However, levels of stress have increased, and levels of bullying, harassment and violence remain unacceptably high. Medical staff remain hugely positive about their jobs but are concerned at staffing levels and the quality of care that is provided in some organisations.
167. The picture for medical staff remained broadly similar to previous years on most key indicators. Medical staff overall continued to have the highest levels of willingness to recommend the NHS as a place to work (68 per cent of consultants and 71 per cent of doctors in training). There was a small improvement in staff feeling valued, with 55 per cent of consultants reporting feeling valued by their organisation in 2018 compared with 51 per cent in 2017. This may reflect the increased focus on local approaches to recognition and initiatives on staff engagement in organisations. The score also increased from 49 per cent to 56 per cent for doctors in training, which may reflect the impact of the range of actions being taken to address the experience of doctors in training.
168. On pay, the picture is mixed. Overall satisfaction with pay for all medical staff remained stable and higher than average for NHS staff. For consultants, satisfaction with pay fell from 63 per cent to 62 per cent, whereas for doctors in training it rose from 41 per cent to 46 per cent. This may reflect the differing pay awards of the two groups during the period. A new question was introduced into the staff survey asking staff if they intended to leave for another job in the next year. Eight per cent of doctors said they intended to do so, which is one of the lowest figures for any occupational group. However, this question is not considered to be a good predictor of leaving decisions. More conclusions may be possibly be drawn once there is two or more years of data.
169. Following the release of the Interim NHS People Plan in July 2019, work has continued to develop the final plan, which we expect will be published early in 2020. This will include a national framework designed to promote improved staff experience in the NHS, known as 'Best Place to Work'. This aims to support better staff experience through the concept of a core offer, which would set out expectations for staff in areas ranging from health and wellbeing to flexible working. It is also intended to address and reduce the variation between approaches in different organisations. As an initial step to support a greater focus on staff experience, new metrics have been included in the updated Outcomes Framework for the NHS, which will support work to address bullying and harassment, promote teamworking and enhance equality, diversity and inclusion.

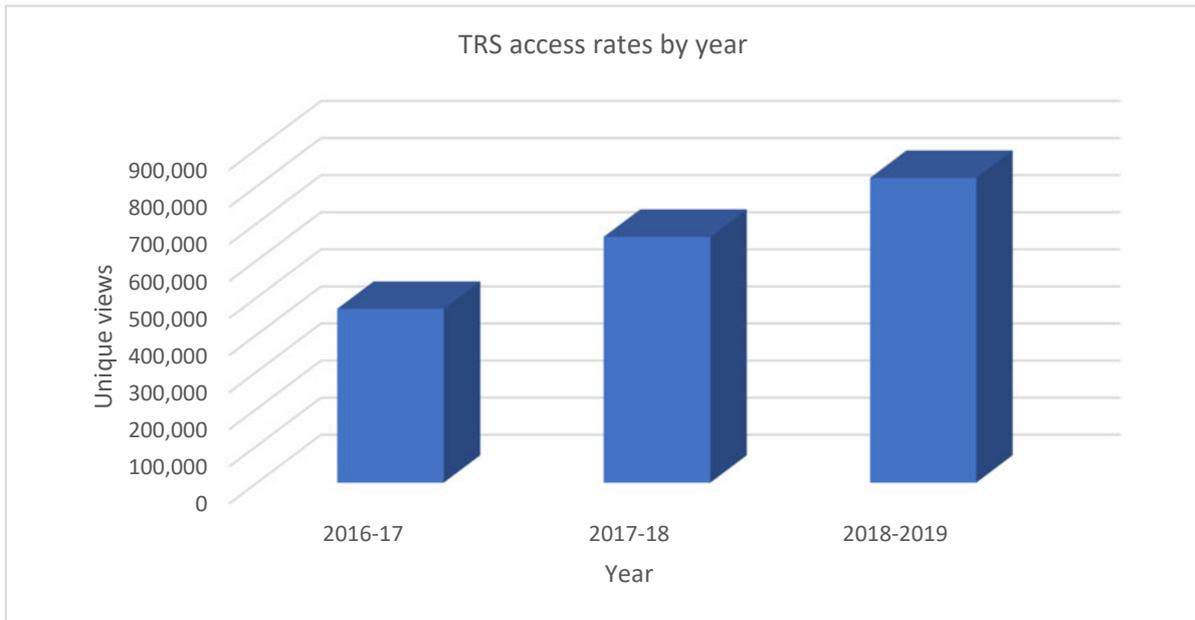
PENSIONS AND TOTAL REWARD

170. NHS Employers engages with NHS organisations on reward via various channels. We run a national Total Reward Engagement Network (TREN), undertake an annual survey of workforce professionals and work closely with employers nationally to understand their challenges and successes and tailor our work programme to meet their needs.
171. We support NHS organisations in making staff aware of the value of the NHS Pension Scheme as a component of the reward offer. The NHS continues to provide a comprehensive and attractive core employment offer, through a package of valuable benefits including the highly regarded pension scheme.
172. The national collective bargaining on pay and terms of conditions of service remains the core of reward in the NHS. Yet employers see reward as much more than this. The employer proposition to employees now includes a growing range of benefits some of which, in presentation and approach, are unique to specific organisations. In a highly competitive labour market, many organisations are designing total reward packages of pay and benefits with the purpose of attracting staff to their organisations and improving retention.
173. Reward in the NHS continues to evolve as organisations address the current challenges of rising health demand, new models of care, efficiency challenges, workforce shortages and staff morale. Raising the profile and recognising the contribution of the staff we already have is an important part of the workforce agenda both nationally and locally. Employers are emphasising the psychological contract between employer and employee. The NHS is, but must also be perceived widely in society to be, an honourable, rewarding, and exciting place to work. If staff excel, they will be recognised and celebrated as much as they would be in any other working environment.
174. Employers are working collaboratively on some aspects of this work as health geographies evolve and integrated care systems become more established. However, there is recognition that there can be much more development in this area in conjunction with ensuring individual trusts engage with staff to understand their needs. It remains important to employers to ensure they attract, recruit and retain a diverse workforce, including a multi-generational workforce, which is representative of the communities served.
175. As highlighted in the Interim NHS People Plan and the NHS Long Term Plan, there is a major challenge for employers in ensuring their staff feel motivated to work in rewarding roles, establishing the NHS as the best place to work.

Total Reward Statements

176. Total Reward Statements (TRS) are a key way for employers to demonstrate the local benefits of the holistic reward packages they offer to staff. They also demonstrate valuable information on the value of the NHS Pension Scheme.

177. 2019/20 was the fifth year of operation of TRS in the NHS. Information from the NHS Business Services Authority indicates that a total of 2,453,240 statements were available to staff in England and Wales, including those working in primary care. The number of unique views between 19 August 2018 and 3 August 2019 was 821,917. Since 2016, there has been a steady increase in unique views of around 353,140 to date.
178. Compared with the position at the same time last year, this is an increase of just over 30 per cent in the number of staff accessing their statements. Employers are committed to making use of and promoting their local reward offer by utilising their Total Reward Statements (TRS). The below table shows TRS access rates by year.



Reward offer for medical staff

179. Employers understand the importance of ensuring all staff feel rewarded, valued, motivated and recognised for the important part they play in the delivery of high-quality patient care.
180. Employers who responded to our survey on reward carried out in autumn 2019 told us they use reward to support workforce objectives with regards to their medical workforce. For example, just over 20 per cent of employers offer specific reward for medical staff. Specific reward focuses on financial support to aid recruitment and retention through offering relocation packages and fees, especially when relevant to shortage specialties. Some employers offer study days to support retention of those clinical staff undertaking continuing education and training.
181. Employers will be able to support the health and wellbeing of their junior doctor workforce through the £10 million worth of funding announced by the Secretary of State in September 2018. This funding is intended to be used by NHS organisations to support junior doctors, aligning their work with the Fatigue and Facilities Charter.⁴⁰

⁴⁰ [NHS Employers. Funding to improve working environments for junior doctors.](#)

182. 65 per cent of employers who responded to our reward survey told us that they were currently using reward to meet long-term workforce objectives including recruitment, retention, and wellbeing. Employers are also using reward to attract a diverse and futureproof talent pipeline, to ensure they can meet patient service needs of the future.

The NHS Pension Scheme

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

Member contributions

184. 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.

| Tier | Pensionable pay (whole-time equivalent) | Contribution rate from 2015/16 to 2021/22 |
|------|--|--|
| 1 | Up to £15,431.99 | 5.0 per cent |
| 2 | £15,432.00 to £21,477.99 | 5.6 per cent |
| 3 | £21,478.00 to £26,823.99 | 7.1 per cent |
| 4 | £26,824.00 to £47,845.99 | 9.3 per cent |
| 5 | £47,846.00 to £70,630.99 | 12.5 per cent |
| 6 | £70,631.00 to £111,376.99 | 13.5 per cent |
| 7 | £111,377.00 and over | 14.5 per cent |

185. As basic pay for doctors, dentists and GPs ranges from £27,146 to £105,042, most medical staff will pay contribution rates at the highest tiers, in the range of 9.3 per cent to 14.5 per cent of pensionable pay.

186. Employee contributions are currently under review by the NHS Pension Scheme's Scheme Advisory Board (SAB), with any changes to be implemented with effect from 1 April 2021. SAB's recommendations to date include:
- determining employee contributions based on actual pay, to better reflect CARE accrual
 - avoiding 'cliff edges' where a pay increase forces an individual into the next contribution tier, sometimes leading to a reduction in take-home pay
 - exploring ways to minimise opt outs.

Employer contributions

187. The employer contribution rate for both the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme increased to 20.6 per cent of pensionable pay from 1 April 2019. This rate was determined by the funding methodology applied by the scheme actuaries during the 2016 scheme valuation.⁴¹
188. Employers pay a scheme administration levy equal to 0.08 per cent of pensionable pay in addition to the standard employer contribution rate.

Age discrimination ruling in public service pension schemes

189. In December 2018, the Court of Appeal ruled that the transitional protection given to older members of the judges' and firefighters' pension schemes during the 2015 scheme reforms gave rise to unlawful discrimination on the grounds of age. The transitional protections allowed members who were close to retirement age at the time of the 2015 scheme reforms to stay in the final salary schemes until retirement, or to delay moving to the new career average schemes. The Government sought permission from the Supreme Court to appeal the ruling, but this was denied.
190. It has since been confirmed that the ruling will apply to all public service pension schemes, including the NHS Pension Scheme. The government is now required to introduce a remedy to compensate affected members for any loss. Implementing an appropriate remedy will be a complex exercise and is likely to involve significant scheme changes, which will need to be carefully considered and communicated to staff and employers.
191. We expect a similar remedy will be applied across all public service pension schemes. Until the remedy is known, there remains some uncertainty about scheme costs from 1 April 2015. This uncertainty will impact the ongoing review of employee contributions and the 2016 actuarial valuation process.

⁴¹ [Government Actuary's Department, NHS pension scheme actuarial valuation at 31 March 2016., February 2019.](#)

Actuarial valuation 2016

192. The results of the 2016 actuarial valuation were published in February 2019. The valuation has two key objectives:
- to assess the cost of benefits against the cost cap mechanism.
 - to set the required employer contribution rate from 1 April 2019 to 31 March 2023.
193. The valuation results showed that the cost of the benefits provided by the scheme has fallen to a point where scheme changes are required to bring scheme costs back in line with the cost cap. The fall in costs is predominantly due to pay increases and life expectancy improvements being lower than expected. Scheme changes are required to either improve member benefits or reduce member contributions. The Scheme Advisory Board (SAB) developed a recommendation for DHSC on how the cost cap breach should be rectified. However, due to the current level of uncertainty around scheme costs due to the age discrimination ruling, the cost cap process has been paused. This will have an impact on SAB's ongoing review of employee contributions from 1 April 2021.
194. The required employer contribution rate has increased from 14.3 per cent to 20.6 per cent, mainly due to a reduction in the SCAPE (superannuation contributions adjusted for past experience) or discount rate assumption, which is set by HM Treasury. The increase to employer contributions was implemented from 1 April 2019, with most employers receiving full funding for the increase in costs.

Scheme membership

195. ESR summary data on scheme membership trends from July 2019 shows that the overall membership of the NHS Pension Scheme continues to rise, with membership levels increasing by 5.5 percentage points from October 2011 to July 2019. Shorter-term trends show an overall increase of 0.7 percentage points for the 12-month period ending in July 2019 and an increase of 0.6 percentage points from April 2019 to July 2019.
196. In contrast, membership levels for doctors have declined over the long and short term. Membership levels for doctors have fallen by 2.2 percentage points over the period October 2011 to July 2019. Shorter-term trends show a decrease of 1.5 percentage points for the 12-month period ending in July 2019 and a fall of 0.4 percentage points from April 2019 to July 2019.
197. Although scheme membership for doctors remains high (90 per cent), the continued fall in membership for doctors is likely to be due to the impact of pension tax allowances.

Opting out of the NHS Pension Scheme

198. The data below summarises the number of staff who chose to opt out of the NHS Pension Scheme from April 2018 to March 2019 and the reasons for opting out.

| Reason for opting out | Number of opt outs | Percentage of total opt outs |
|---|--------------------|------------------------------|
| Affordability | 22,288 | 28.61 |
| Annual or lifetime allowance | 3,359 | 4.31 |
| Contributing to another pension scheme | 21,785 | 27.96 |
| Fixed or enhanced protection | 478 | 0.61 |
| Other | 432 | 0.55 |
| Secured retirement income via other means | 3,798 | 4.87 |
| Temporary opt out due to other financial priorities | 24,844 | 31.89 |
| Would prefer not to say | 93 | 0.12 |
| No reason given | 835 | 1.07 |

Table: Summary of opt out data and the reasons for opting out for 2018/19. (Source: NHSBSA)

Pension taxation

199. We reported in our evidence to the pay review bodies for 2018/19 and 2019/20 about the impact of the annual allowance (AA) and lifetime allowance (LTA) pension tax limits. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years, and the introduction of the tapered annual allowance, mean that more staff are likely to be impacted. The pension tax allowances continue to present significant issues for staff and employers, the details of which have been well publicised in the press and social media.
200. Any NHS employee who has pension benefits above the 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.
201. During the 2018/19 scheme year, 16,793 members (approximately 1 per cent of the total membership) breached the AA and 1,500 members (approximately 0.1 per cent of the total membership) accrued benefits worth more than 100 per cent of the current LTA.
202. Members can carry forward unused annual allowance from the three previous tax years to offset or eliminate a tax charge. However, many individuals have now exhausted their unused allowances in previous years, which means the chances of incurring a tax charge are increasing.

203. NHS Employers commissioned First Actuarial to carry out independent research to gain a detailed understanding of the impact of the annual and lifetime allowances in the NHS on employing organisations, NHS staff and the risks to service delivery and patient care.
204. The report includes the analysis of the results of an online survey which gathered the opinions and experiences of over 2,500 NHS employees and their employers. The report of the research findings⁴² and a two-page summary are available on the NHS Employers website.⁴³
205. Around 70 per cent of employees who completed the online survey had not yet breached their annual allowance limit. However, 45 per cent of staff who have not yet breached their annual allowance and 84 per cent of staff who have already breached the annual allowance believe they will be affected again in future. This is shown in the chart below.

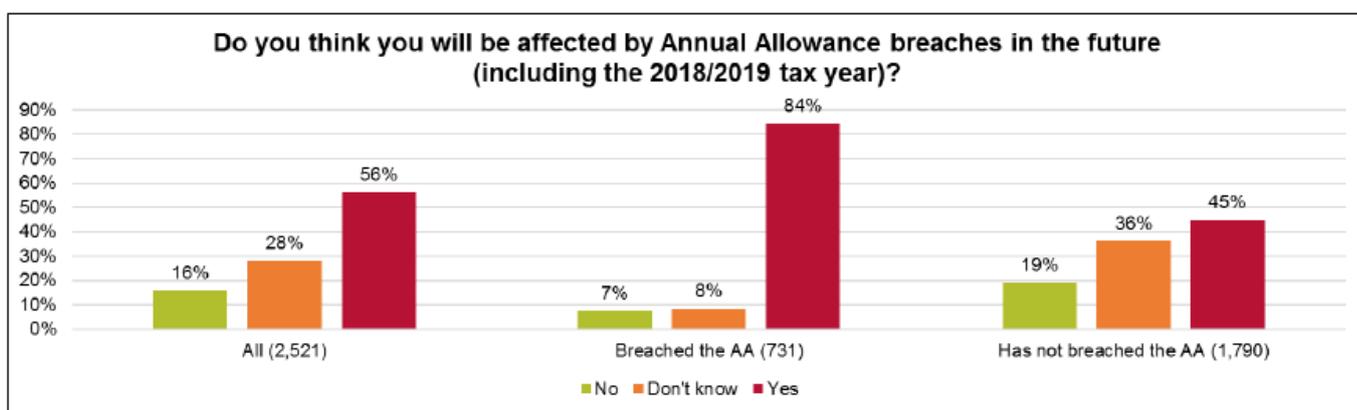


Chart: Possible annual allowance breaches [Source: Employee survey, First Actuarial research]

206. Staff may believe they will be affected due to exhaustion of carry forward, the introduction of the tapered annual allowance, or an element of misunderstanding. Information can often be distorted or misunderstood through word of mouth, potentially leading some staff to take unnecessary action. However, as such a high proportion of staff believe they will be affected in future, this increases the likelihood of more staff acting to avoid these issues.
207. Many of those staff who have been affected or expect to be affected by pensions tax issues in the future have taken or are considering taking action to try and avoid these issues. The chart below shows the actions employees are considering as a result of pensions tax issues.

⁴² [NHS Employers, Research into the impact of pensions tax in the NHS. June 2019](#)

⁴³ [NHS Employers. Summary document of research into pensions tax in the NHS. June 2019.](#)

| Actions employees are considering as a result of pensions tax issues | Action taken (%) | Action considered (%) |
|--|------------------|-----------------------|
| Early retirement | 3 | 33 |
| Retire and return to work | 3 | 21 |
| Reducing hours | 18 | 44 |
| Reducing additional work | 42 | 40 |
| Avoiding promotions | 20 | 27 |
| Opting out of the NHS Pension Service | 9 | 35 |
| Leaving the NHS | N/A | 26 |
| Other | 10 | 5 |
| No action | 39 | 21 |

Table: Action taken and considered by staff in relation to pension tax issues (Source: Employee survey, First Actuarial research)

208. Employers are particularly concerned about the impact on staff retention. Employees requesting to reduce their hours, refusing additional work, taking early retirement, and avoiding promotions have been identified as key concerns for NHS employers, due to the impact on workforce capacity, service delivery and patient care.
209. The chart below shows the key concerns highlighted by employers and the estimated scale of impact seen to date. The highest impact seen so far has been in connection to staff turning down additional work, requesting to reduce their hours, and agency costs. The amount of HR time and resources has also been raised as a growing concern, with significant time being spent by HR teams dealing with queries and engaging with staff to implement local measures and solutions.

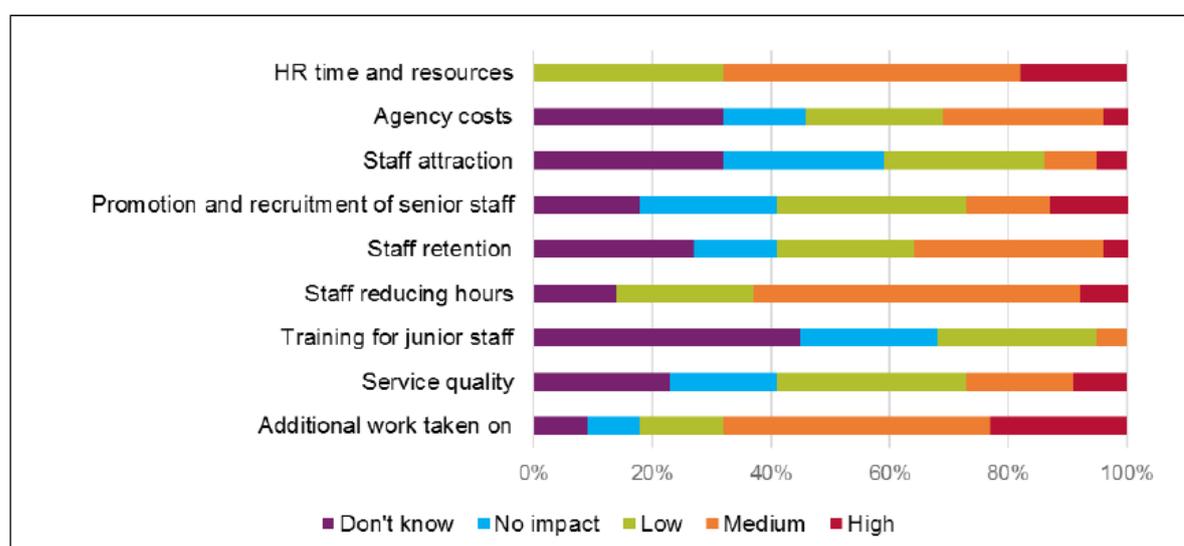


Chart: Impact of pension tax on workforce. Source: Employers Survey, First Actuarial research

210. Although the impact is not high in all areas shown, more staff believe they will breach the allowances in future years, which means more staff will act to avoid pension tax issues, meaning the impact on employers is likely to be a growing issue.

DHSC consultation on introducing scheme flexibilities

211. The Department of Health and Social Care (DHSC) has consulted on new proposals to change the NHS Pension Scheme to address the impact of pension taxation on NHS staff, organisations and service delivery.
212. The new proposals are designed to make the scheme more flexible, to enable members of the scheme to control the value of their pension growth. DHSC sought views on proposals to:
- introduce a new flexible accrual option, which would allow senior clinicians to choose to build up a lower level of pension benefits and pay correspondingly lower employee contributions (the options available would range from almost zero to 100 per cent, in 10 per cent increments)
 - allow scheme members to phase their pensionable pay increases over a set period to avoid spikes in pensionable pay that can create annual allowance issues
 - target pension flexibilities at senior clinicians only improve scheme pays
 - provide support and guidance for individuals.
213. In our response to the DHSC consultation we said that while we broadly support the introduction of flexibilities, we believe that they should apply to all staff. Limiting access to senior clinicians could risk limiting their overall effectiveness and raises issues around equality. In our response we included research from First Actuarial showing the relationship between extending flexibilities to all staff, and higher participation rates in the NHS Pension Scheme as well as higher levels of staff retention and better patient care and service delivery. We also agreed strongly that individual staff should be supported to understand their own tax liabilities and use the new flexibilities where appropriate.⁴⁴

HM Treasury review of the annual allowance taper

214. HM Treasury announced it will set up a working group to review the operation of the tapered annual allowance to support the delivery of public services.
215. The tapered annual allowance was introduced in April 2016 with the intention of reducing pension tax relief for the highest earners. Employees may have a lower, tapered annual allowance limit if their adjusted income (taxable income and pension savings) is over £150,000 and their threshold income (taxable income excluding the value of pension savings) is over £110,000. The rate of reduction in the annual allowance from the current maximum of £40,000 is by £1 for every £2 that the adjusted income exceeds £150,000, up to a maximum

⁴⁴ [NHS Employers. Response to the NHS pension scheme consultation on increasing flexibility. November 2019](#)

reduction of £30,000 at £210,000. This means an individual's tapered annual allowance will be between £40,000 and £10,000.

216. NHS Employers welcomes this review and is pleased to be involved in the review to represent the views of employers. The taper is particularly problematic as all taxable earnings are included in the calculation, meaning non-pensionable earnings and earnings from outside NHS employment, such as from rental properties and investments, could cause an individual to breach their annual allowance. Employers and NHS Pensions are not aware of earnings from outside the NHS and are therefore unable to accurately target communications at those who may be affected.
217. The tapered annual allowance applies to all UK workers and therefore the removal of or changes to the taper will require extensive consultation and consideration with stakeholders across all sectors and industries. The fiscal impact of changes to the annual allowance taper will be significant for HM Treasury and will be closely monitored and evaluated during the review.

NHS Employers guidance

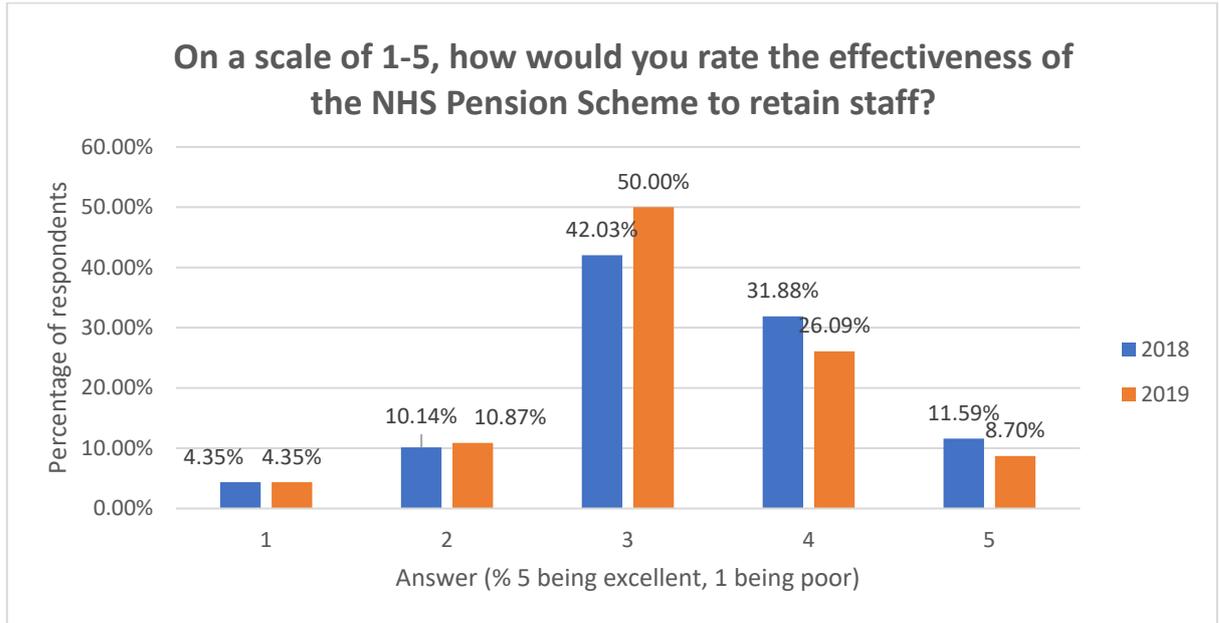
218. NHS Employers has published guidance on the temporary, optional measures employers may implement to support staff and service delivery during this financial year, in advance of a national solution being implemented from April 2020.⁴⁵ These optional measures include:
- facilitating access to independent financial advice and guidance
 - using existing flexibilities to enable employees to remain in the NHS Pension Scheme
 - possible arrangements for employees who decide to opt out of the NHS Pension Scheme.
219. We continue to produce resources to raise awareness and improve understanding of the annual and lifetime allowance.⁴⁶
220. We believe a combination of improvements to the annual allowance taper, the introduction of greater scheme flexibilities and measures taken by employers at a local level will support staff and employers to improve service delivery and patient care.

The NHS Pension Scheme as an attraction and retention tool

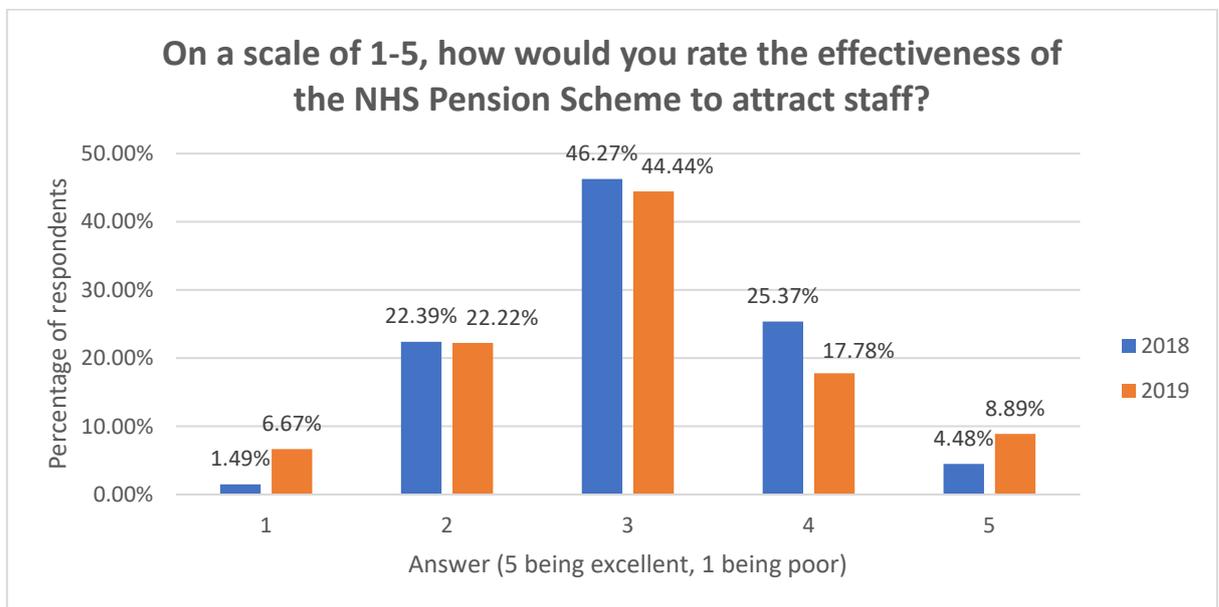
221. In September 2019, as part of our annual reward in the NHS survey, we asked employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff.
222. 84.8 per cent of respondents rated the scheme as being somewhat effective, effective, or excellent in retaining staff, with only 15.2 per cent rating the scheme as not effective. The proportion of employers rating the scheme as effective or excellent in retaining staff has fallen since our 2018 survey, which could indicate the impact of pension taxation issues on retention.

⁴⁵ [NHS Employers. Pensions tax guidance. September 2019.](#)

⁴⁶ [NHS Employers. Annual and lifetime allowance. September 2019.](#)

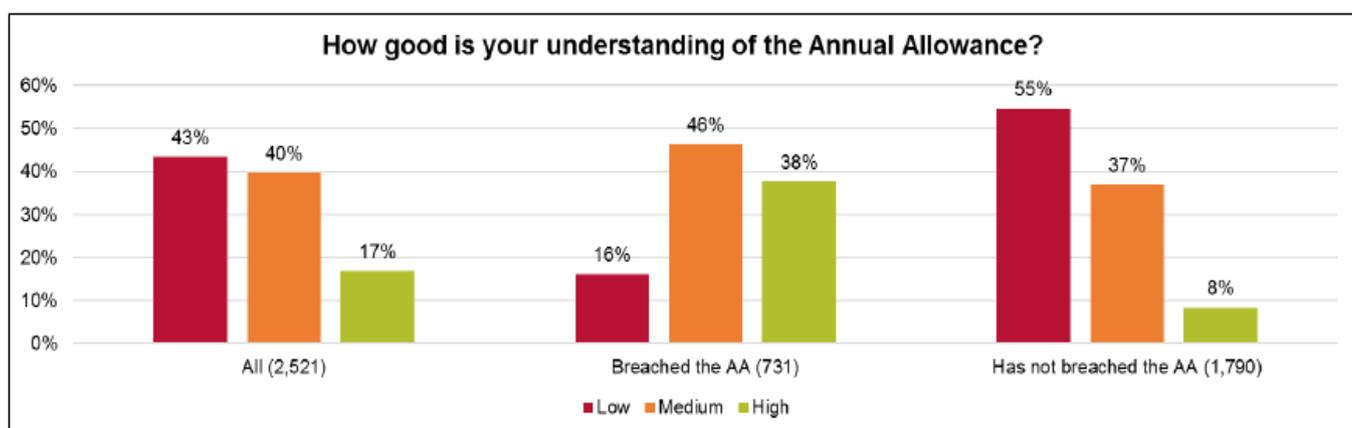
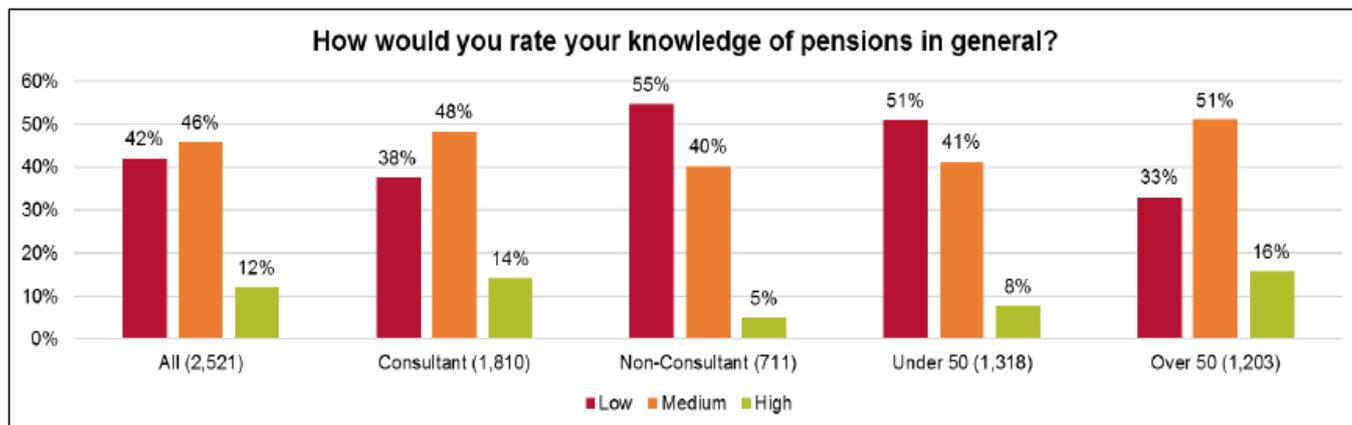


223. A total of 71.11 per cent of respondents rated the scheme as being somewhat effective, effective, or excellent in attracting staff, with only 28.89 per cent rating the scheme as not effective or poor. The proportion of employers rating the scheme as somewhat effective, effective, or excellent in attracting staff has again fallen since our 2018 survey, which could again be in part due to the impact of pension taxation issues, particularly the negative coverage and potential impact on perceptions of the scheme's value.



Providing financial education, guidance and advice

224. Our research with First Actuarial revealed a lack of understanding of the NHS Pension Scheme, pension taxation issues and pensions in general. This is evidenced in the data from the employee survey shown in the following two charts.



225. The introduction of scheme flexibilities from April 2020, combined with any scheme changes introduced to compensate those affected by the recent age discrimination case, will introduce more complexity and choice for scheme members. This strengthens the need for education, guidance and advice to ensure staff understand the value of the NHS Pension Scheme and can make well-informed decisions about their pension benefits.
226. 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.
227. Employers are communicating the value of the NHS Pension Scheme using their staff intranet sites and Total Reward Statements, as well as increasingly using social media and electronic communications to reach staff who are not based in a single location. Employers are developing communication materials and using resources produced by NHS Employers to promote the value of the scheme during recruitment, such as posters and benefits brochures.

228. Employers told us they would like more online support for scheme members, such as projection tools to allow staff to model their retirement options and estimate their income, as well as education materials such as webinars and training courses. Employers also suggested communication materials should be targeted at younger staff and new joiners to improve engagement with this area of the workforce.
229. NHS Employers continues to produce resources to promote the Total Reward offer⁴⁷ including resources to support employers to promote the value of the NHS Pension Scheme.

⁴⁷ [NHS Employers. Case studies on reward](#)