NHS Employers

NHS Employers' submission to the Doctors' and Dentists' Review Body 2023/24

January 2023

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Context setting

Introduction

Employers are currently experiencing exceptional workforce challenges. Despite everything the NHS is doing to recruit and retain its workforce, there is no escaping that the service is facing unprecedented service pressures and a profound workforce shortage. Even though we have record numbers of employees in the NHS, we also have a record number of vacancies as staff growth lags behind access and quality requirements.

The latest NHS Staff Survey (2021) highlights the range of pressures on the NHS. It is clear there is a need for action to address these challenges, requiring continued investment in workforce supply and education to increase staff numbers and reduce pressures on staff.

For the NHS to fully recover from the pandemic, tackle its waiting lists and support its staff, it will need the government to provide investment for an ambitious long-term plan for the workforce. The staff working in the NHS also need to be given hope that help is coming – and will keep coming.

At the same time, employers recognise that all staff groups are concerned that the value shown for their work, and the unprecedented context for that work, via their pay has been falling behind for some time. There are particular challenges for the medical workforce: with lower investment in the medical paybill relative to

other staff over the last 12 years. Long-term contractual agreements have meant lower pay awards in some cases, and there are taxation issues related to pensions that undermine the value of the total package for some senior clinicians.

Notwithstanding the challenges facing the exchequer employers do support investment in all areas of the paybill. However, it is essential to employers, that any pay award is fully funded and affordable. The implications of not providing fully funded pay award uplifts would require the NHS to divert funds from investment plans and/or service improvement. Any unfunded pay award decisions would create significant and unwelcome challenges for national, system and local NHS leadership to manage. Previous experiences strongly suggest that funding pay uplifts through assumed efficiency saving targets is not a viable option.

Employers have most recently been prevented from meeting efficiency targets by the pandemic and by service transformation agendas. In its Autumn Statement 2022 the government confirmed that it is expecting the NHS to make further efficiencies (2.2 per cent), as well as delivering improved performance, so these challenges will remain.

It is also important to bring the timetable of the pay review body round back to normal, enabling a return to prompt implementation and payment of pay awards. The prompt decision about, and payment of pay awards will benefit all staff (particularly in the present environment of high costs of living) as well as avoid the additional administration burden associated with retrospective payments.

The medical and dental workforce

Medical and dental workforce numbers

As reported by NHS Digital, the NHS Hospital and Community Health Service (HCHS) monthly workforce statistics confirm that there were 127,890 full-time equivalent (FTE) doctors and dentists in July 2022. This is 2.8 per cent (3,513) more than in July 2021.

The GMC (General Medical Council) report The State of Medical Education and Practice in the UK: The Workforce Report 2022 confirms that while the number of doctors joining the workforce overall has grown by around 17 per cent, over the last five years, that growth is not consistent. It varies considerably between different groups of doctors, particularly leaving a shortfall in primary care.

The report highlights that the number of SAS and locally employed doctors on the GMC register has increased, largely driven by doctors coming from overseas.

Vacancy rates

NHS Digital data shows that in April 2022, medical vacancy FTE stood at 10,582 (up from 8,075 in April 2021) providing a medical percentage vacancy rate of 7.3 per cent (up from 7 per cent in April 2021).

Leavers

NHS Digital data shows that from April 2021 to April 2022, 20,218 doctors left the NHS, with 4,557 either retired or quit. Of these, 380 doctors wanted a better work-life balance, and nearly 9,000 doctors gave no reason for leaving.

NHS Long Term Plan – workforce implementation plan development

In a hugely important and long overdue step, NHS England has been commissioned by the government to produce a comprehensive workforce plan to support the implementation of the NHS Long Term Plan. The aims are to ensure a sustainable balance between supply and demand across all staff groups, and to identify opportunities for innovation and development. For doctors, the proposed focus will be on improving career development for medical staff and reducing geographical and specialty imbalance. The plan is a vital component is reassuring an over-stretched service, that the government is willing to seriously engage in planning for the workforce required to meet the needs of the population. For the people working in the NHS, it will hopefully provide hope that help is coming.

The government's Autumn Statement 2022 confirmed that an independently verified plan would be published by the government to address the number of doctors, nurses and other professionals needed in the NHS in five, ten and 15 years' time, that takes full account of the need for better retention and productivity improvements. Current expectations are that the plan will be published in spring 2023 and NHS Employers will continue to present the views of employers where opportunities arise to contribute to its development. The challenge will be to clearly agree the priority areas for any initial investment available from the government.

In the shorter term, NHS England recognises that the NHS will need more new staff, alongside creating more opportunities for current staff and those returning to practice to work flexibly and remotely, and to develop new skills to progress in their careers, in order to meet its elective recovery plan targets.

Reward

Satisfaction with pay

The 2021 NHS Staff Survey reported that 32.7 per cent of all occupation groups were satisfied with their level of pay. This has declined by four percentage points since 2020 (36.7 per cent) and is lower than in 2019 (38.0 per cent) and 2018 (36.3 per cent). The satisfaction with pay for medical and dental staff fell from 56.9 per cent to 49.8 per cent.

Flexible working

The 2021 NHS Staff Survey reported that 53.9 per cent of all occupation groups said they are satisfied with the opportunities they have for flexible working patterns. This is down three percentage points from 2020 (56.9 per cent) following four years of improvement where this question reached its highest level across the last five years in 2020. Satisfaction levels for medical and dental staff fell from a below average 49.4 per cent to 45.1 per cent.

Cost-of-living challenges

Increasingly high inflation rates resulting in soaring energy, food, housing, and transport costs is increasing the cost of living for NHS staff. Take-home pay is not going as far as it would have done previously, making working unaffordable for some members of the workforce. All staff are affected by the rising cost of living, the extent of which will differ depending on individual circumstances. The lower paid are likely to be disproportionately impacted, but some staff groups are also more at risk than others, including families without full-time workers, single parent families, families caring for a person (or persons) with disabilities, families with three or more children, those living in rented accommodation, and ethnic minority households.

Increased childcare costs and less relative take-home pay to spend on childcare costs has the potential to cause problems for the medical workforce, but is more obvious and acute for the lower paid in the non-medical workforce. We are aware that some employers are trying to support their staff with childcare responsibilities by offering flexible working practices.

We have heard from employers that they have put in place many short-term solutions to support their staff in financial hardship.

Most tax increases announced by government in its Autumn Statement 2022, are backloaded until after 2025. However, from 6 April 2023 the top 45 per cent rate of tax will start from £125,140 rather than £150,000, potentially affecting some senior medical and dental staff.

In addition, take-home pay for NHS staff will continue to be impacted by the freezing of personal tax thresholds/allowances until 2028. We strongly urge the government to consider reversing the policy decision, which would then enable staff to earn more tax-free pay in line with increases in earnings (if the basic threshold was increased) and reduce the numbers of staff subject to higher rate tax (if the 40 per cent threshold was also uplifted).

Employers have told us that NHS pay needs to be looked at in the context of the total reward package, including base pay, additional payments and other benefits.

Wellbeing and engagement

The 2021 NHS Staff Survey showed a declining position on health and wellbeing measures across all occupation groups. There were increases in stress, staff attending work when unwell, and musculoskeletal injury levels, compared to 2020. In addition, the new burnout question demonstrated high levels of burnout. Ambulance (operational) staff (51 per cent) and registered nurses and midwives

(40.5 per cent) were most likely to describe feeling burnt out. A significant risk of burnout applied to 31.3 per cent of medical and dental staff.

Most staff did report there was positive action on health and wellbeing being taken by their employer and that they received support from their line manager, but this fell from 64.3 per cent to 56.8 per cent for medical and dental staff against an average of 68 per cent across all occupation groups.

The overall staff engagement indicator has declined for the first time in three years. This was driven largely by the reduction in the percentage of staff willing to recommend the NHS as a place to work, and reductions in most indicators of staff motivation and staff involvement, which are the other elements of the staff engagement indicator. In 2021, 52.5 per cent of all staff looked forward to going to work: a decline from 58.8 per cent in 2020 and 59.5 per cent in 2019. Some of the largest declines between 2020 and 2021 were seen among those in frontline roles. Medical and dental staff engagement declined from 65.6 per cent to 58.1 per cent.

All these indicators point to a workforce under increasing pressure.

Staff sickness rates

As reported by NHS Digital, the sickness absence rate of NHS doctors in England stood at 2.6 per cent in January 2022, dropping to 2 per cent in June 2022. This is set against an average across all staff groups of 5.3 per cent in June 2022. Since January 2017, the sickness absence rate of doctors in England has remained lower than those of nurses, midwives and ambulance staff.

National training survey findings

The GMC's annual national training survey 2022 reveals a continuing downward trend regarding workload pressures and risk of burnout.

The GMC is concerned that the pandemic continues to impact doctors' workload and wellbeing and that the risk of burnout has increased for many. The risk of burnout is the highest it has been since tracking began in 2018, with over half of trainers and nearly two-thirds of trainees at moderate or high risk of burnout.

The report also highlighted positive action taken in response to missed training opportunities by gaining skills in other areas of their work but highlighted a large variation across the specialties. It was also revealed that a significant minority have not had an education appraisal in the last 12 months.

International recruitment

International recruitment remains a vital source of workforce supply for the NHS and there is a need to ensure that the UK remains an attractive place to live and work both for European Economic Area (EEA) nationals and colleagues from across the world.

The We Are The NHS: People Plan for 2020/2021 acknowledges the importance of increasing our ethical international recruitment and building partnerships with new countries. Work is also underway to remove barriers to international recruitment and increase capacity for induction and support to overseas recruits.

The NHS Employers international recruitment toolkit helps employers to improve their international recruitment approach, from planning to onboarding and supporting new doctors to settle into their new roles and communities in the UK.

International medical graduates

The State of Medical Education and Practice in the UK: The Workforce Report 2022 published by the GMC highlights that the

number of SAS and locally employed doctors on the GMC register has increased, largely driven by doctors coming from overseas:

- The report recognises that supporting the varied career aspirations of SAS doctors will be crucial to a sustainable medical workforce. Barriers to career development and progression need to be removed and there should be more flexibility in positions available to them.

- The report highlights a dramatic increase in international medical graduates (IMGs) practising in the UK and the need for employers to improve the retention of these staff. Poor working environments have been a key factor in driving doctors away. Other factors for leaving the profession cited repeatedly by doctors across all groups are burnout, stress, lack of flexible working arrangements and poor organisational and team cultures.

- While the report recognises that employers have created more opportunities for SAS and LED recruitment, it advises that employers should provide more structured support for their growing numbers of IMG doctors to ensure integration into the workforce.

- The report signals that the GMC is seeking to introduce more flexibility and autonomy in designing less intensive ways of recognising SAS doctors' skills, enabling them to join the GP or specialist registers.

We note that the source data is not able to determine the split between SAS and LEDs. Further analysis of the workforce data is required to better understand the relative position of each group.

Support for IMGs is one of the five initial priorities identified against the Medical Workforce Race Equality Standard, and a key element of this has been the introduction of national guidance for standardised IMG induction. This was developed by a range of stakeholders and launched in June 2022. We will be working with employers to support the introduction and further development of this process.

The issue of data relating to locally employed doctors is considered in more detail in section 3.

International recruitment challenges

During the course of 2022, issues with the pay criteria used by the Home Office and UK Borders Agency when approving visas have been raised by a number of employers, leading to recruitment and retention issues of qualified overseas doctors within the NHS in England.

The Nuffield Trust has reported that, following exit from the EU, stagnation in the number of EU doctors in a number of specialties has exacerbated existing shortages of qualified staff. Further research will be necessary to better understand the drivers of migration, but the suggestion is that the decision to leave the EU in 2016 is likely to have had some impact.

Section 1 – Key messages

- Investment in pay and reward is one of the ways in which we recognise the valuable contribution of staff and is fully supported by employers.

- Employers want to see a pay award that is fully funded and sustainable, allowing them to continue to prioritise workforce growth in key areas.

- Doctor and dentist workforce numbers have increased in the year to July 2022 by 2.8 per cent, but this growth has not been sufficient to keep pace with rising demand on services.

- Workforce shortages remain a significant concern for employers and supply issues have yet to be fully addressed. Employers are committed to improving retention measures, but the health and wellbeing of staff and the risk of burnout, coupled with gaps in the workforce, continue to make this a greater challenge.

- The pressing need is for continued investment in workforce supply to help increase staff numbers and reduce pressures on staff, especially in the context of addressing the backlog of care.

- The 2021 NHS Staff Survey showed that satisfaction levels have fallen for medical and dental staff, with pay and with the opportunities they have for flexible working patterns.

- There is a worsening position on health and wellbeing measures across all occupation groups. Almost a third of medicine trainees are at a high risk of burnout, with emergency medicine consistently being the specialty with the highest proportion of trainees at high risk of burnout.

- The number of doctors leaving the workforce remains high, with pull factors such as the pursuit of new opportunities and working abroad, alongside push factors including poor working conditions, wellbeing issues and inflexible career paths.

- Over the last five years, the number of doctors joining the workforce has grown by around 17 per cent. There has been an increase in the numbers of specialty and associate specialist doctors, and locally employed doctors joining the General Medical Council's (GMC) register, that has been mostly driven by doctors coming from overseas.

- International recruitment remains a vital source of workforce supply for the NHS, but a range of recruitment and retention issues of qualified overseas doctors persist.

Doctors and dentists in training

- 2022/23 was the final year of the framework agreement for doctors and dentists in training. Our employer engagement activities have revealed that most employers believe that future pay awards for this staff group should be in line with other staff groups. We were disappointed that the government was not able to revisit the value of the award in the final year to bring it in line with other staff groups, given the prevailing and unprecedented cost of living pressures.

- Employers understand the importance of securing an equitable geographical distribution of training places and key specialist training posts, but significant reservations remain as to whether this

can be achieved through the targeting of pay. Further research into how such an approach would make a positive difference would be necessary to make the case for change to employers.

- Employers support a review of flexible pay premia to ensure that it remains fit for purpose, particularly in respect of appropriately incentivising movement of trainees into hard-to-fill specialties.

- There continue to be challenges with exception reporting (ER), including the changes in culture needed to embed ER in certain specialties and the technological solutions to streamline the ER and board reporting processes

- It was agreed with Health Education England (HEE) that nodal point 5 will include specialty training (ST) 4 and ST5 for dental training pathways as equivalent to medical ST6 and ST7. These clinicians are deemed equivalent in the skill and experience they possess regardless of the medical or dental pathway.

Specialty and specialist grade doctors (SAS)

- In January 2021, an agreement was reached which covers a three-year period from 1 April 2021 to 31 March 2024, for a reformed specialty doctor contract and a new specialist contract

- Due to the transitional nature of the supporting three-year pay deal, and the annual changes to the temporary transitional pay points, the new pay progression process which removes automatic progression will come into effect from 1 April 2023, when the pay scale reaches the final position of five pay points.

- There has been less uptake than originally forecasted from doctors wanting to transfer to the 2021 specialty doctor contract. The main contributing factor to this was the application of the higher than

assumed national pay awards to those doctors remaining on the closed 2008 specialty doctor contract.

- Remedial action in future years will be necessary to reset the pay differentials between the open and closed SAS contracts. This should secure the benefits of contract reform and encourage movement on to the new, jointly agreed terms and conditions as an attractive career option.

- The new contract does provide a wider set of benefits to both the doctor and the employer, but in specific pay terms the incentive to transfer is currently diminished. It is important that the expected future benefits associated with the introduction of the new contract arrangements are secured.

Consultants

- An opportunity to modernise the consultant contract and reform the pay structure to secure system-wide benefits would be welcomed by employers.

- The current consultant contract is now nearly 20 years old and would benefit from modernisation and reform to promote greater flexibility around deployment and to address the key recommendations set out in the independent review of gender pay gaps in medicine report (The Dacre Review). However, there are several implementation issues that would require further consideration before any preferred approach to contract reform is selected.

- Following the outcome of the negotiation process on reforming the local clinical excellence awards (LCEA) we have provided employers with information about their contractual responsibilities under the new arrangements.

- For the 2022/23 award year, most employers will be applying an equal distribution approach to spend available funds. Employers plan to return to a full competitive LCEA round and reviews for the 2023/24 award year.

Salaried primary care dentists

- Salaried primary care dentists are a relatively small group of dentists spread across a varied group of providers within different sectors.

- Securing comprehensive employer views for salaried dentists remains challenging but issues with the career structure, pay, and terms and conditions for this group of staff continue to be highlighted as the main employer concerns.

Additional information: locally employed doctors

- There are a range of reasons why employers may use local contracts but there is insufficient information at a national level about the number of locally employed doctors (LEDs) and the employment models in use.

- A high number of international graduates are LEDs, and we believe it is particularly important to gather more information and insight about this group of doctors.

- We recommend that work should be commissioned to construct a more comprehensive data set and evidence base on the employment and pay arrangements for locally employed doctors, to promote equitable employment practices and how they can be supported and developed.

Additional information: border trusts

- Employers have sought information about specific recruitment and retention challenges associated with land borders and contractual differences between different parts of the UK.

- In the last 12 months, there have been no meaningful changes in recruitment levels from other devolved nations reported by employers. The same applies in respect of employing organisations in England losing staff to other devolved nations. Where recruitment from the devolved nations has taken place, the organisations reporting back have confirmed that there were no additional costs as a consequence of doing so.

Additional information: treatment of closed national medical and dental grades

- NHS Employers retains an archive of terms and conditions for all the closed medical and dental grades in the NHS. While those employed under the terms of closed grades can retain them for the duration of their employment, these grades are now closed to new entrants.

- Employer views are predominantly that the pay structures that continue to be used for doctors and dentists remaining employed on closed grades terms, should be no longer uplifted in line with those open to new entrants.

- Limiting the number of contract variations that they need to maintain in perpetuity and to enable the benefits provided by the new contracts to be more widely realised, is attractive to employers.

Additional information: pensions

- The NHS Pension Scheme remains one of the most generous in the UK. It is an important part of the total reward offer for NHS employees and a valuable tool for employers to attract and retain staff.

- Employers contribute 20.68 per cent of pensionable pay into the NHS Pension Scheme (correct until 31 March 2024). In comparison, the average employer contribution in the UK private sector was reported to be less than 6 per cent of pay in 2021.

- In September 2022, the government set out its plan to make pension changes to aid staff retention. Additional pension flexibilities will support both employers and employees aimed at increasing workforce capacity by retaining staff in the service.

- Employers continue to be concerned about the impact of the annual allowance (AA) and lifetime allowance (LTA) on retention, workforce capacity, service delivery and patient care. Employers report staff are taking early retirement, reducing their work commitments, and a reluctance to apply for promotions or take on additional work and responsibilities due to potential pension taxation effects.

  https://www.nhsconfed.org/publications/letter-chancellor-exchequerWe wrote to the Chancellor of the Exchequer to request that urgent action is taken on the NHS Pensions Scheme to help support staff retention initiatives and to tackle waiting lists. The government subsequently launched a formal consultation (closes 30 January 2023) regarding a number of proposed changes, including a change to the basis upon which pension growth is calculated and the rate of Consumer Prices Index (CPI) that is allowed for in AA calculations.

We remain clear in our view that the AA should not be applied to public sector pension schemes, including the NHS Pension Scheme members

- NHS England is developing a national policy on recycling employer contributions to support staff affected by pension taxation.

Additional information: pay award timetable

- We welcome the government's desire to bring the timetable of the pay review body round back to normal, enabling a return to prompt payment of the pay award at the beginning of the financial year. A timelier payment of pay uplifts will benefit staff and avoid the additional administration burden for employers associated with retrospective implementation of all pay award changes. In the present climate it would both be a respectful step and also one which recognises the financial pressures facing many households.

Section 2 – Informing our evidence

We welcome the opportunity to submit our evidence on behalf of healthcare employers in England. We continue to value the role of the Doctors' and Dentists' Pay Review Body (DDRB) in bringing an independent and expert view on remuneration and wider issues in relation to doctors and dentists.

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

- engaged with our regional network meetings of HR directors
- engaged with employers who sit on our joint negotiating committees for consultants, SAS, trainees, and dentists
- engaged with our guardians of safe working hours network
- met with our contracts experts' group (medical staffing leads) and the medical and dental workforce forum, which is a sub-committee of the NHS Employers policy board.

NHS Employers acts as a link between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies. We are part of the NHS Confederation, the membership organisation that brings together, supports and speaks for the whole healthcare system.

Our submission reflects the views of employers on the challenges faced by the NHS in respect of their medical and dental staff.

Section 3 – The remit groups

Doctors and dentists in training

NHS Employers and the British Medical Association (BMA) agreed a work programme to take forward commitments to future work set out in the 2019 framework agreement for doctors and dentists in training. These include rostering best practice for less-than-full-time (LTFT) trainees, safe working hours, and additional guidance for the guardians of safe working hours.

Four thematic joint working groups have been agreed as part of the contract maintenance discussions, under the following topic headings:

- The health and wellbeing of doctors and dentists in training.
- Non-resident on call arrangements.
- Annual leave provisions and the calculation of pay while on leave.
- Recruitment and retention of trainees in general practice and pay parity with hospital medicine.

We have reluctantly agreed to pause progression against these work programmes while attention and resources are focused on potential

industrial action being taken by trainees, with the intention that it will be picked up again once the current dispute is resolved.

We have included relevant information to the doctors and dentists in training remit group, highlighted below. It shows the focus of the work we have been progressing with our national partners and stakeholders since our last submission.

Implementation issues for employers

Following the implementation of the provisions set out in the 2019 framework agreement, we have found an unintended added cost pressure for employing organisations as a result of moving from a maximum of one in two weekends, to a maximum of one in three weekends. The introduction of this provision has resulted in the need to recruit additional staff or cover gaps with locums and has impacted specialties such as emergency medicine and intensive care. In addition, the excess in weekday activity has, in some cases, led to reduced training opportunities.

Impacts of pay progression due to COVID- 19

As a result of the pandemic impacting upon training progression, HEE introduced a number of measures to mitigate the impact, including introducing new ‘no fault’ Covid ARCP outcomes. Outcome 10.2 is used when a trainee is at a critical progression point in their programme and there has been no derogation to normal curriculum progression requirements given by the relevant Medical Royal College or faculty. This means that additional training time is required before the trainee can progress to the next stage in their training, or Certificate of Completion Training (CCT). A guidance document has been developed for trusts when considering pay, to mitigate against the career earnings impact within the Terms and Conditions – Consultants (England) 2003 for those who, when in a training post, had not progressed specifically due to the impact of COVID-19.

Nodal point 5 and dentists

It has been agreed with HEE that nodal point 5 will be accessible to trainee dentists working at the higher specialist training levels ST4 and ST5. While access to nodal point 5 following the introduction of the 2016 contract has been restricted to those at higher specialist training ST6 and ST7, these trainee dentists have similarly weighted job responsibilities requiring similar levels of skill and experience. Both sets of trainees are also the same amount of time away from being eligible for a consultant post, therefore their training trajectory is considered equivalent. At the time of writing, HEE is finalising the implementation arrangements and we expect that this will be implemented during 2022/23.

Pay

2022/23 is the final year of the 2018 framework agreement for doctors and dentists in training. As there has been a divergence in the level of pay uplifts applied to basic salary levels between those covered by multi-year pay award arrangements and all other staff, we sought the views of employers as to whether anything specific should be recommended for this group in the 2023/24 pay round. The majority of employers have indicated that pay awards following the end of multi-year award arrangements should be in line with other staff groups (and we would have supported this step being taken for the final year of the framework agreement).

When considering the relationship between the doctors and dentists in training multi-year award deal and the pay awards applied to all other NHS staff, it is worth highlighting that a simple comparison with the headline pay award is not straightforward.

The investment over the four years (2019-2023) covered by the 2018 framework agreement for doctors and dentists in training consisted of

a total of 2.3 per cent in 2019/20 and 3 per cent in each of the following three years to 2022/23. Of this total investment, doctors and dentists in training received an annual pay uplift of 2 per cent.

In 2016, the changes brought in protected average earning levels and allowed individual pay to be more predictable and less variable between placements. Doctors and dentists in training are now paid more appropriately for actual work done, with an increase in basic pensionable pay; additional pay for additional rostered hours; enhanced rates for unsocial hours; allowances for weekend working; on-call availability supplements; pay for anticipated work done while on call; and flexible pay premia.

A fifth nodal point was also agreed for trainees at ST6 and above to recognise the significant contribution these trainees make. It was introduced through a staggered approach between October 2020 and 1 April 2022 and now stands at a value of £58,398.

Full details of the changes introduced as part of the 2016 and 2018 contract reviews are available from NHS Employers website.

HEE and NHS England are working collaboratively to address health inequalities by reviewing and aligning specialty training placements to the areas of greatest need across England.

The DDRB 2022 report highlighted support for exploring the effectiveness of geographic or specialty targeting of pay in order to address localised recruitment and retention issues.

In response, we have sought the views of employers and a variety of views were provided.

Employers understand the importance of securing an equitable geographical distribution of training places and key specialist training posts, but reservations remain as to whether this can be achieved through the targeting of pay. Employers' reservations stem from potential unintended consequences, such as competition between

organisations if pay varies significantly between regions. If additional pay creates an incentive to move location, this may also create rota gaps elsewhere. There may also be a reluctance for trainees to move to or remain in the more expensive places to live in England as the cost-of-living crisis continues.

If further research clearly demonstrated that the targeting of pay made a positive difference in addressing these issues, we would certainly welcome the opportunity to discuss this evidence further with employers.

The DDRB report also stated that it would welcome information on how well flexible pay premia is delivering against its objectives, and the extent to which it may inform future developments.

Employers have told us that they would support a review into flexible pay premia arrangements that were introduced as part of the 2016 contract arrangements. Flexible pay premia are for those training in GP practice placements and recognised hard-to-fill training programmes where there is the greatest need. Currently these include emergency medicine (ST4+) histopathology, and psychiatry (all grades). Premia will also be payable to doctors who return to clinical training after successfully undertaking a pre-agreed period of approved academic research, and to those who train in oral and maxilla-facial surgery (OMFS).

It is recognised that there is a lack of published evaluations on how cost effective pay supplements have been for recruiting and retaining trainees. A review would also help to provide employers with an updated picture of hard-to-fill specialties and identify if some are no longer appropriate or whether additional categories are needed.

Trainee experience

Employers have provided examples of actions trusts are taking to continue to improve trainee experience. This is against a background

of actions taken to improve the experiences of all staff. Some of the examples that have been shared with us include:

- improvements to the experience of overseas trainees throughout their on-boarding journey and employment, with the introduction of a buddy system, dedicated support and joint sessions with the GMC

- a range of cost-of-living initiatives, which are made available to doctors and dentists in training along with all other staff.

Employers regularly highlight the need to ensure that any improvements to staff experience implemented across an organisation are equally accessible by doctors and dentists on rotation.

Enhancing Juniors Doctors' Working Lives is a cross-system collaborative programme, led by HEE to create meaningful improvements to the quality of life of doctors in training.

The programme has developed some key initiatives this year:

- HEE is focusing on providing flexibility in training and enabling a medical career to be more tailored to the individual. For example, through allowing all doctors and dentists in training to apply to train less than full time (LTFT) for any reason, and the recognition of experience completed outside of training programmes.

- The 'F3 phenomenon,' exploring the reasons why foundation doctors are choosing not to progress directly into specialty training.

- Reviewing medical rotations to consider flexible start dates, staggered changeover dates and the geographical boundaries of rotations.

- How recruitment processes have been adapted following the pandemic.

- Investing £26 million into the COVID-19 training recovery programme.

Many employers agree that the initiatives that the Enhancing Junior Doctors' Working Lives deliver are something that they value and therefore support the drive to continue. However, it was highlighted that better communications of the benefits for employers were needed. It was also noted that some of the changes, such as the expansion of LTFT options for trainees, presented challenges for medical staffing departments to implement.

Fatigue and burnout

As reported by the GMC, the risk of burnout is at the highest it has ever been and has increased since 2021 across all specialties. According to the GMC survey, one in three emergency medicine trainees are at a high risk of burnout, with emergency medicine consistently being the specialty with the highest proportion of trainees at high risk of burnout.

There are a number of safe working limits set out in the 2016 Terms and Conditions of Service for doctors and dentists in training, however employers do not feel that these contractual safeguards by themselves have helped to address fatigue and burnout issues. Doctors experiencing burnout are more likely to consider leaving the profession, reducing their hours or taking early retirement.

The Joint Negotiating Committee (Juniors) has created a health and wellbeing working group to consider a number of these issues, including access to and awareness of health and wellbeing services, working patterns, and the BMA's fatigue and facilities charter. This work has been paused due to reduced capacity to progress it, because of industrial action activities.

Exception reporting and guardians of safe working hours

NHS Employers seeks regular employer input to determine whether or not exception reporting is working as intended. There continues to be challenges with exception reporting, including the changes in culture needed to embed exception reporting in certain specialties and the technological solutions to streamline the exception reporting and board reporting processes. ER is a tool used to protect trainees, patients, and the trust from potential harm resulting from working non-compliantly. Where ER is not embedded, there is a risk that trainees are unable to highlight instances where they have worked additional hours, missed training and education opportunities and identified immediate safety concerns, or concerns over the support available to them during duties.

We continue to support guardians of safe working hours (GoSWH). We hold regular regional GoSWH network meetings with representatives across the regions. This helps to inform us of any significant issues relating to the safe working of doctors and dentists in training and the exception reporting system. Where problems are identified, we collectively explore any potential solutions. We continue to review and update the range of resources and information for guardians and hold an annual GoSWH conference to help promote a broader understanding of the role, share best practice and to discuss how to overcome challenges.

Specialty and specialist doctors

Specialty and specialist (SAS) doctors are a group of experienced doctors, ranging from doctors and dentists with four years' experience to senior doctors and dentists practising independently, who can form a significant proportion of the medical workforce in any organisation. They are one of the most diverse branches of practice in the health service and play a pivotal role in the provision of hospital services. However, many say they lack workplace support,

find it hard to move between specialties, have limited access to training and regularly reported incidences of bullying.

The new specialty doctor and specialist grade contracts were introduced in April 2021. The Joint Negotiating Committee for SAS (JNC (SAS)), continues to monitor the transition of doctors and dentists onto the new contracts.

The aim of the SAS contract reform was to support employers to attract, motivate and retain SAS doctors and dentists. The development of the new contracts seeks to improve their contractual arrangements and support SAS doctors and dentists with a positive, fulfilling career choice and to ensure they are a supported and valued part of the workforce.

The contract reform package includes an investment of an average of 3 per cent of the total SAS paybill per year over three years (2021/2022 - 2023/24) to support the introduction of a new set of pay scales and wider contract reform.

The pay structure of the specialty doctor grade is being reformed over a three-year transition period, which commenced on 1 April 2021. Due to the transitional nature of the three-year deal and the annual changes to the temporary transitional pay points, the new closed gateway pay progression process will come into effect from 1 April 2023. It is at this point that the new pay scales reach the final position of five pay points.

SAS doctors were originally given until the end of September 2021 to express their interest to transfer onto the new specialty doctor contract, or they could choose to stay on their existing contract. However, the impact of the pay awards effective from April 2021 saw interest in the new contracts decline and in response the JNC (SAS) agreed to give doctors on closed grades in England and Northern Ireland the contractual right to transfer to the specialty doctor contract during any time in their employment, with the expectation

that they would seek to transfer at the point it become financially beneficial for them.

Specialty doctors

The new contracts have been in place for over a year, and we have seen employers become more familiar with them and better understand the benefits that they seek to deliver.

However, fewer doctors transferred to the 2021 specialty doctor contract than was originally forecast. The main contributing factor is the pay award of 3 per cent in 2021, which was awarded to SAS doctors on the old contracts. The new contracts were excluded as the multi-year pay arrangements determined the pay uplifts and were based on assumptions that a lower pay award was more likely to be delivered by the government.

Subsequently, the 4.5 per cent uplift awarded in 2022 has compounded this issue further and basic pay for those doctors on the older contracts is now generally higher than those on the new 2021 contract. As a result, we now have examples of doctors who transferred onto the new contract that would have been financially better off to remain on the old contract.

The new contract does provide a wider set of benefits to both the doctor and the employer; notably faster pay progression, additional earnings and annual leave and working pattern safeguards. However, in specific pay terms the incentive to transfer is currently diminished. This raises concerns about potential requests from doctors to seek local remedies to secure the same pay uplifts attached to their old, now closed, contracts.

Remedial action will be necessary to reset the pay differentials between the open and closed SAS contracts to encourage transition onto the new contracts as an attractive career option and to secure the benefits of the new, jointly agreed, contract arrangements.

Employers understand that the options for remedial action are limited to securing additional investment to uplift the new contract pay scales or to target available pay award funds, or a higher proportion of them, onto the new contract pay scales.

Employer expectations on accessing additional funds are understandably low and traditionally don't support the targeting of pay awards for specific purposes, as it introduces some complexity to communicating with staff. However, employers have offered views on how they think closed grades should be treated in general, including the 2008 SAS contracts. This is detailed in the closed contracts section below.

Specialist grade

There continues to be a steady but slow increase in doctors entering the specialist grade as employers and doctors become more acquainted with the new role. We continue to promote the benefits of the new contract to employers and have seen experienced specialty doctors successfully apply for this role as intended.

The creation of specialist grade roles is to be driven by employer needs locally to meet their service delivery requirements. As such, funding for these roles needs to be secured locally and we are aware that employers are experiencing difficulties with this, which has contributed to the slow uptake. We continue to engage with employers on how best to approach this local funding issue and promoting best practice.

We remain confident this issue will diminish over time as understanding of local funding processes improve. The new specialist grade contract provides consistency in employment for SAS doctors and provides career progression, recognition and appropriate remuneration for SAS doctors working at a senior level and will allow employers to better recruit, motivate and retain them.

However, the application of the 2022/23 pay award means that a specialty doctor on the top of the 2008 scale (£82,611) is now earning more than someone at the bottom of the specialist grade pay (£80,963). An overlapping of these pay scales is not something that was intended following the introduction of the new grades but is a consequence of the higher value pay awards being applied to those on the closed 2008 specialty doctor contract. We are currently exploring remedial action to ensure that a transition from the 2008 specialty doctor grade remains an attractive career option.

SAS advocates

During contract negotiations in 2021 there were discussions regarding the health and wellbeing of all SAS doctors and dentists, in particular the experience of SAS doctors with bullying and harassment in the workplace. From these discussions, the SAS advocate role was introduced to help promote and improve support for SAS doctors' and dentists' health and wellbeing. This is an additional role for an existing employee, and it is not intended to replace existing support for SAS doctors and dentists. This role is distinct to that of the SAS tutor, with the expectation that the two will cooperate where appropriate.

The role of a SAS advocate is crucial in maintaining the strong level of engagement and collaboration among SAS doctors and dentists, and provides mutual benefits for doctors, dentists and employers. Providing SAS doctors and dentists with access to an advocate will help demonstrate the employer's commitment to improving their experience and allows the sharing of good practice across the organisation and potentially with other organisations too.

We continue to encourage employers to allocate adequate programmed activities (PAs) to SAS advocates. However, there isn't a contractual requirement for employers to support these posts.

As data on SAS advocate roles is currently limited, we are working with a newly established network in England. The network will focus on promoting the creation of SAS advocates roles, sharing best practice, and promoting the health and wellbeing of SAS doctors and dentists.

Transition to new SAS contracts

Our data shows transition to the new contracts from April 2021 – September 2022 has been less than originally forecast. Overall, there are 522 specialist doctors in England, which represents 22 per cent of the SAS workforce, and 3,462 specialty doctors on the 2021 contract, which represents 37 per cent. Of the specialist doctors appointed, 33 per cent transferred from the 2008 specialty doctor contract, which is promising and highlights the intended career progression of the new contracts.

The treatment of closed grades is explored in further detail below.

SAS Week 2022

NHS Employers, in collaboration with the BMA, held the first SAS Week in October 2022. The aim of SAS Week was to provide a national platform for stakeholders and employing organisations to highlight their work and promote the value of SAS grade doctors.

During the week, we received an overwhelmingly positive response from organisations and individuals who were keen to show their support for SAS doctors. This underlines the importance of SAS doctors and the vital role they play in the medical and dental workforce. NHS Employers and the BMA plan to hold another SAS Week in 2023.

BMA rate card for SAS doctors

The BMA released a consultant rate card mid-2022 to provide a suggested set of pay rates that should be made available to consultants for participating in non-contractual extra work or activity. This was subsequently extended by the BMA to include SAS doctors. Further detail is set out in the section below covering consultants.

Consultants

Consultant contract reform

In 2018, the government offered the medical trade unions a 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 were 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.

There remains no current mandate from the government for any reform of the 2003 consultant contract. However, employers would still welcome an opportunity to modernise the consultant contract and reform the pay structure to secure system-wide benefits. The current consultant contract is now nearly 20 years old and would benefit from updating, including promoting greater flexibility around deployment and addressing the recommendations set out in the independent review of gender pay gaps in medicine report. Previously stated employer priorities for any wider contract reform remain, and include:

- shortening the pay scale to allow consultants to reach the top of the pay scale more quickly and help reduce the gender pay gap

- modernising the terms and conditions to make sure that they are fit for purpose under a changing NHS and provide greater consistency and alignment with other reformed medical contracts and staff groups where appropriate.

The removal of the opt-out clause, which allows consultants the right to refuse non-emergency work after 7pm and before 7am, continues to be supported by employers as it will allow better deployment of the consultant workforce according to service needs.

While employers recognise that there would be benefits to reforming the 2003 contract, there is some caution that doing so could risk potential disengagement of their consultant workforce at a time when the system is under significant strain and requiring their continued support.

There is some support among employers for targeting consultant pay grades with differential pay awards to help address the gender pay gap, but this is not a universally adopted position. There are other concerns about the use of targeting pay awards in general, particularly where there are limited funds to invest, given that there are perceived winners and losers of such an approach.

An alternative to reforming the current contract could be to create a new contract for new starters with an option to transfer for those employed under 2003 terms. While this would delay the take up of new terms for the whole consultant workforce and the benefits that contractual changes would represent, there is some appetite from employers to take this approach.

Maintaining engagement of their current consultant workforce remains the priority for employers and all reform options are being considered from that perspective. Additionally, potential industrial action across the NHS makes providing appropriate resourcing and attention on contract reform challenging.

Local clinical excellence awards (LCEA)

The tripartite negotiating group of NHS Employers, the BMA, and HCSA concluded negotiations on LCEA successor scheme arrangements without agreement.

The proposals reached via negotiations were not agreed by the oversight structures in the BMA and HCSA; the necessary support from their executive committees was not secured due to concerns regarding the level of funds committed nationally, and local variability in available funds across trusts. Some trusts were identified as potentially not having any funds to invest in new awards in the first year due to the scale of the funding commitments required to maintain awards that were granted prior to 2018/19.

Therefore, a reversion to the post-2022 contractual arrangements, set out in Schedule 30 of the 2003 terms and conditions of service for consultants, now applies.

From 1 April 2022, employers are required to continue to run awards rounds every year but with some flexibility about how the scheme is run locally. Awards remain non-pensionable and non-consolidated, and employers will need to put in place processes for handling appeals and reviews of pre-2018 awards.

Variations to previous LCEA arrangements can be implemented in consultation with an employer's joint local negotiating committee. Our expectation is that local arrangements will mature over time through a process of incremental improvement, and we hope that it will offer opportunities for employers to incentivise and reward their consultant workforce in ways that works for their organisation and their doctors and dentists.

Following the outcome of the negotiation process we have provided employers with information about their contractual responsibilities under the new arrangements.

Our subsequent engagement activities with employers have revealed that for the 2022/23 award year the vast majority will be applying an equal distribution approach to spend available funds, as has been the case for the last two award years where normal rounds were suspended due to the ongoing pandemic response.

Employers have also raised concerns about the amount of time and resource it will take to process reviews of awards granted prior to 2018. As all legacy awards are now due for review, this is a considerable undertaking for most employers and as such, they are looking to postpone those arrangements for another year.

Employers have also reported that an absence of appropriate IT solutions to help administer the contractual arrangements is a significant barrier to improving the administration of the arrangements locally.

Employers have informed us that they plan to return to a full competitive award round and reviews for the 2023/24 award year. While we see that there has been limited progress on developing their own local approaches, employers have expressed interest in doing so during 2022/23. The requirement to undertake reviews of legacy awards based on an assessment against the previous domains structure is also a concern to employers, as any deviation in their new award scheme designs will mean that they will need to maintain two separate assessment processes.

We are supporting employers to navigate the 2022/23 award year by developing a suite of implementation support materials to assist with meeting their contractual obligations.

An unintended consequence of not reaching agreement and defaulting to terms contained within Schedule 30, is that there is now a financial disincentive for some consultants who hold a legacy award to apply for a national clinical impact award (NCIA) due to NCIA award values and pensionable aspects. A level 7 and level 8 award are both above the value of an N1 national award of £20,000.

Local awards are pensionable and consolidated and range in value from £3,092 to £36,192. A consultant would need to surrender their local award in the event of being successful for an NCIA, the NCIA is non-consolidated and time-limited to five years.

Views from employers remain that LCEAs should end, and available funds should be used and re-directed to support wider contract and/or pay structure reform. Influencing this view are concerns around the administrative burden of running rounds and as to whether an awards process can be considered truly fair, equitable and help to incentivise the delivery of employer priorities.

BMA consultant rate card

The BMA unilaterally released a consultant rate card in mid-2022, to provide a suggested set of pay rates that should be made available to consultants for participating in non-contractual extra work or activity. Some employers have had the rates presented to them by consultants refusing to do any additional work over and above their contractual requirements until the rates have been met. Employers stated they have discussed the rate card at JLNCs (Joint Local Negotiating Committee) and are continuing to work collaboratively with their neighbouring trusts and across their local integrated care system (ICS) to minimise competition between organisations and to secure additional consultant capacity. Employers are clear that the rates suggested by the BMA are unaffordable and were disappointed with how this was introduced.

We are monitoring developments and impact in discussion with employers and our national stakeholders and continue to register our strong concern.

Salaried primary care dentists

Salaried primary care dentists are a relatively small group of dentists spread across a varied group of providers within different sectors. Community dentistry is generally referred to as the salaried service, which is a managed service in which dentists have a contract of employment to fulfil and service standards to meet.

We have surveyed a small number of employers who each employ salaried dentists. However, the size of the sample and the responses received were limited and can only provide a snapshot of some of the general issues facing some employers of salaried dentists. As securing comprehensive employer views remains challenging, we will consider options to improve our data collection activities for future evidence submissions.

Career structure, pay, terms and conditions

Employers noted continuing issues with the career structure, pay and terms and conditions for salaried dentists, as highlighted in our evidence to the DDRB last year. Pay continues to remain less favourable in comparison to practice posts, with annual leave also being less favourable.

Improving dental services

NHS dental services are provided in primary care and community settings, as well as in hospitals for more specialised care. NHS England is responsible for the commissioning of dental services and its current priorities include:

- to reduce oral health inequalities and improve oral health in children under the age of five

- flexible commissioning

- to oversee national dental access and address area of weakest dental provision

- to ensure a consistent and fair approach to contract performance management is applied nationally to dental contracts

- dental contract reform.

Additional information: locally employed doctors

Locally employed doctor roles are a vital part of the NHS, supporting among other things stability of care for patients, safer working hours for teams, opportunities for postgraduate doctors to take a break from training while remaining in NHS medical practice, and bespoke arrangements for particular employment needs.

The term locally employed doctors covers a wide range of employment arrangements for medical staff. A significant proportion of these doctors are likely to be working on rotas alongside doctors in training and employed on parallel local contracts, but local employment contracts also apply to any doctors across the medical grades who are employed outside the available national contracts.

For instance, some doctors have been appointed on contracts that mirror closed national arrangements, such as associate specialist (closed 2008), or the previous specialty doctor contract (closed 2021). Any doctors appointed to such arrangements after the national grade was closed are by definition LEDs. Other doctors may be employed on bespoke arrangements rather than mirroring national terms and conditions.

There are a range of reasons why employers may use local contracts:

- An LED contract parallel to that of doctors in training on the same rota may be more appropriate than a specialty doctor contract,

particularly if there is access to exception reporting and educational opportunities, which some employers are putting in place. The national 2016 contract only applies to doctors and dentists in recognised training posts.

- For example, some LEDs who are taking a break from training after Foundation Year 2 but wish to remain in employment, may be in the process of deciding on their specialty and will not meet the eligibility criteria for the specialty doctor grade.

- Other LEDs may be on specific bespoke working arrangements, for their own benefit and/or to meet the needs of the service.

- Doctors and dentists in training posts are rotational and therefore employers have little control on vacancies or appointments to established posts. The implementation of LED posts allows employers greater control over their workforce and works to reduce vacancies and the consequential reliance on locums.

- Some trusts have links to medical schools and therefore have a requirement to provide undergraduate medical education. To support this, LED contracts are often used with the appointment of clinical fellows. These doctors may additionally provide rota support alongside their junior doctor colleagues.

The number of LED posts has also increased for several reasons:

- There was a change to curricula and core trainee (CT) doctors were placed in LED posts as there were not enough ST3 posts. Some remain in these posts and are still struggling to get a ST3 post.

- Trainees are sometimes pulled from rotas and the gaps are filled by LEDs.

- Contractual changes impacting rotas, such as self-development time, prospective cover and one-in-three weekends have seen the

need for additional staff. Additional posts for service and rostering needs are generally filled by LEDs as national training numbers are determined by HEE.

However, more information is needed about how these contracts are being designed and utilised and how far these arrangements are equitable. This will help to provide the insight for future local pay and contract flexibilities and any frameworks that should continue to operate for this staff group.

Pay codes

Many locally employed doctors are on the same Electronic Staff Record (ESR) pay codes as doctors on national contracts. Where this is the case, they receive any pay uplift applied to the relevant group.

Where doctors are employed in parallel to doctors in training, the national LED pay codes MT01-05 are available and we strongly recommend their use. These are kept in line with the nodal points for doctors in training to ensure parity. Although we cannot instruct employers how to amend pay for locally employed doctors, MT01-05 points are always increased on ESR in line with any pay award to doctors in training, so that there is no divergence in either direction that would disadvantage either doctors in training or LEDs.

Because some doctors in training on Section 2 pay protection are protected on 2002 pay codes, all the 2002 rates for doctors in training have been uplifted on ESR each year to reflect any pay award to doctors in training. As such, these increases have been applied to all LEDs on these codes.

It is difficult to identify locally employed doctors from national ESR data because of the use of national pay codes. Only a small number of staff are employed on local pay codes. All other LEDs will be on the same pay codes as their nationally contracted equivalents and cannot be distinguished using the national data.

It would be neither possible nor desirable for employers to apply a pay uplift that is specifically for their locally employed doctors, due to the lack of ability to identify LEDs on ESR, the variety of contracts they are on and the need to ensure that parallel arrangements like the MT01-05 nodal points remain consistent with the national contracts.

Equity

Because LEDs are on locally determined contracts, and a high number of IMGs are LEDs, we believe it is particularly important to gather more information about this group in order to promote equitable employment practices and access to support and development. It is difficult to identify issues with sufficient clarity, or to propose significant changes, when the number and distribution of these doctors cannot be determined from the national data.

Further research

There is insufficient information at a national level both about the number of LEDs, the employment models in use and the rationale for using them. Furthermore, there has been a tendency in other UK reports to conflate SAS doctors (who are on national contracts) and LEDs (on local contracts). These are distinctly different groups and, although there may be some commonalities, they will often have different experiences.

Employers support further research into how LEDs are being employed. We strongly recommend that work should be commissioned to construct a more comprehensive data set and evidence base on the employment and pay arrangements for locally employed doctors, to provide better insight into this significant group of doctors and how they can be supported to ensure equitable treatment.

Border trusts

The DDRB in its 2021 report, requested further information about specific recruitment and retention challenges associated with land borders and contractual differences between different parts of the UK, and between Northern Ireland and the Republic of Ireland

Our considerations are restricted to the position in respect of England, Wales, Scotland and Northern Ireland.

As annual pay awards and contract reform programmes have diverged between doctors working in each of the devolved countries, we have sought views from trusts operating around the borders of England to better understand any recruitment and retention challenges that they are experiencing. The employers contacted were at border trusts in the West Midlands, the north west and north east regions.

The organisations that respond reported there has been no meaningful change in recruitment levels from other devolved nations in the last 12 months. The same applies in respect of English trusts losing staff to other devolved nations. Where recruitment from the devolved nations has taken place, organisations have confirmed that there were no additional costs as a consequence of doing so.

An analysis of the latest pay scale values (annex A) across the medical contracts highlights that regardless of the different value of annual pay awards being applied across the devolved administrations, the pay scales remain relatively aligned. Some divergence is clear to varying degrees across each of the contracts, but as there are a range of additional benefits associated with their respective reward packages, a simple comparison of pay scales does not reveal significant financial push and pull factors affecting employers in England. For example, in Scotland, they have retained the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 for doctors and dentists in training that includes

banding supplements for non-compliant rotas and provides up to an additional maximum of 1.8 x basic hourly rate.

The financial incentives to move are therefore not currently evident and would support the position being reported by employers.

A comparison of the contractual differences that exist between the grades across each of the devolved nations (annex B) also reveals that the range and scale of variations are limited in scope. As with the difference in pay scales values, these variations do not reveal significant push and pull factors affecting employers in England.

Closed national contracts

NHS Employers retains an archive of terms and conditions for all the closed medical and dental grades in the NHS. While those employed under the terms of closed grades can retain them for the duration of their employment, these grades are now closed to new entrants.

Following any successful negotiation and implementation of new national contracts for the medical and dental workforce, the contract that has been replaced is formally closed to new entrants and is no longer maintained by the collective bargaining partners.

Where individuals choose to remain on a closed contract it is the responsibility of the employer locally to ensure that these contracts are maintained in accordance with employment law. NHS Employers provides support and advice to employers on the application of closed contract terms.

Closed contracts	Open contracts
Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 Applicable to: Staff grades, senior clinical medical officers, clinical medical officers, hospital practitioners, clinical assistants (part-time medical/dental officers), consultants (appointed pre-2003) and doctors and dentists in training (appointed pre-2016)	• Terms and Conditions – Consultants (England) 2003 • Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016
2008 specialty doctor contract	2021 specialty doctor
2008 associate specialist contract	2021 specialist grade

Historically, all pay awards are applied universally to all staff/medical pay codes, with the exception of those staff covered by muti-year pay award arrangements, regardless of whether they are employed under closed or open national contracts.

While the numbers of doctors employed on closed national grades are diminishing it remains a significant group, representing around 20,000 doctors, which is equivalent to 13 per cent of the medical and dental workforce.

The ongoing maintenance of closed contracts has several implications for employers:

- Providing annual pay awards to those on closed contracts ties up funds that could be better deployed to incentivise movement on new contract terms, which are jointly agreed in partnership with the trade unions.

- Employers will often use closed grade pay codes to set pay for doctors not employed on national terms and conditions, that is, locally employed doctors.

- Employers retain responsibility for the management of multiple contracts with differing provisions. This builds additional complexity into management and HR/pay roll processes, requiring additional employer resources that are locally determined and can vary widely. Reducing the number of contract variations that employers need to understand, deploy, and provide support and advice on, would be welcomed. Where doctors have comparable responsibilities and working patterns but are treated differently contractually also potentially introduces a degree of risk in terms of equitable treatment over the longer term.

While recognising that there are difficulties in implementing such an approach (as noted previously in respect of the remedial action required to resolve the issues associated with the SAS contracts), employer views are predominantly that closed contracts should in principle no longer be uplifted in line with those open to new starters. Limiting the number of contract variations that they need to maintain, and to enable the benefits provided by the new contracts to be realised sooner, is attractive to employers.

Providing the same level of uplift to both contracts simply means that the take-up of the new contracts is very slow, delaying benefit realisation of new contract provisions for both doctors and employers.

Employers believe an approach that is simple to communicate and administer is preferable rather than a more targeted approach, which would provide higher awards for staff on new contracts over time to make the new contracts progressively more attractive.

Section 4 – Pensions

Pensions

The NHS Pension Scheme continues to be one of the most comprehensive and generous schemes within the UK. The scheme benefits are secure and guaranteed by government, pensions are increased each year to help keep up with the rising cost of living. It also provides options to increase benefits and retire flexibly, valuable life assurance and ill health benefits, employers make a significant financial contribution and contributions are tax free, bringing down the cost of membership. It is an important part of the total reward offer for NHS employees and a valuable tool for employers to attract and retain staff. Our poster supports employers to promote the key benefits of scheme membership.

Employers currently contribute a 20.68 per cent of pensionable pay into the NHS Pension Scheme (correct until 31 March 2024). In comparison, the average employer contribution in the UK private sector was reported to be less than 6 per cent of pay in 2021.

Benefits are protected from financial uncertainty and members are guaranteed a secure pension payable for the rest of their lives. Pension income increases annually with inflation to keep up with the rising cost of living, making it future-proof for members. As well as providing financial security, the NHS Pension Scheme provides family protection via ill-health retirement and life assurance (death in service), offering members valuable peace of mind.

The pressures facing the scheme now relate to how greater flexibility can be given to NHS staff to make reduced contributions into the scheme, and the application of a taxation regime that is not fit for purpose and incentivises higher earners to leave the scheme or is some cases employment.

Flexible retirement

Many employees are considering how they can gradually adjust their working patterns to achieve a healthy work-life balance and a smoother transition from their working life into retirement. The shift towards retiring flexibly leaves behind the expectation that retirement means permanently leaving the workplace and employment, or that full-time work should immediately be replaced with full-time retirement.

Flexible retirement allows staff and employers to be flexible about the age at which staff retire, the length of time staff take to retire, and the nature and pattern of work in the lead up to final retirement. Our retirement flexibilities poster shows which options are available to members in different parts of the scheme. Our flexible retirement web page explains the options in more detail and provides examples to show how flexible retirement can be used to support staff to retire in a way that suits their individual circumstances.

Retirement flexibilities are mutually beneficial to both staff and employers. Retire and return enables employers to welcome back retired staff to the workplace to fill gaps in capacity and help deliver high-quality patient care. Organisations can use flexible retirement options to retain experienced and knowledgeable staff with highly valuable skills, which can also be passed on to other staff to aid succession planning. Employers may also gain financial savings through reduced recruitment and training costs, agency spend and employer pension contributions. McCloud

The McCloud remedy is the process of removing age discrimination from public service pension schemes, including the NHS Pension Scheme. The discrimination resulted from allowing older members to remain in their legacy (1995 or 2008) scheme rather than being moved to the 2015 scheme when it was introduced. The different treatment of members, depending on their age, was found to be unlawful discrimination.

From October 2023, staff nearing retirement will be given the option to choose to take their benefits for the remedy period from the legacy scheme or the new scheme. For some members, this may mean they can take a higher pension from an earlier age. This change could mean that NHS staff are able to retire earlier than expected, without the need to return to work to supplement their pension income. Although employers can promote the various flexible retirement options already available, the McCloud remedy could remove the incentive to continue working. A wider range of new retirement flexibilities would further support employers to retain this important part of the NHS workforce.

Pension measures announced in Our Plan for Patients

In September 2022, the government set out its NHS plan for winter and beyond: Our Plan for Patients. The announcement included some pension changes to aid staff retention:

- Introducing new retirement flexibilities for members of the 1995 section of the scheme to support members to access their pension while continuing to work in the NHS.

- Extending the temporary suspension of abatement and the 16-hour rule to help maximise workforce capacity.

- Correcting the CPI disconnect in pension tax calculations to ensure rapidly rising inflation does not impact on AA calculations.

- Strongly encouraging employers to consider local options to retain senior staff who are affected by pension tax, such as recycling employer contributions.

Proposed new 1995 section flexibilities

The proposed flexibilities will support both employers and employees. The changes aim to increase workforce capacity by retaining staff in the service through partial retirement; make it easier for retired staff to return to work and continue to build up pension; and help to bridge the financial gap for staff between claiming their NHS pension and receiving the state pension.

The current flexible retirement options available to 1995 section members are step down, wind down or retire and return. Compared to other members in the 2008/2015 parts of the scheme, 1995 section members have the least flexibility and are not able to take their benefits without leaving employment; they are not able to ‘draw down’ part of their pension and continue working in the NHS; and they are unable to re-join the NHS Pension Scheme once they have claimed their 1995 section pension benefits.

The new proposed flexibilities may allow staff with benefits in the 1995 section to:

- drawdown some or all of their 1995 section pension while still working

- re-join the 2015 scheme, after claiming their benefits, to build up more pension upon their return to work

- remove the need for a break in employment when retiring and returning

- manage pension growth within AA limits.

Any agreed changes are expected to be implemented from 1 April 2023, following a public consultation in winter. We welcome the proposals and will support their introduction in our consultation response. NHS Employers plans to promote and raise awareness of all retirement flexibilities to help educate and prepare employers in advance of changes being introduced in 2023.

Abatement suspension

From March 2020, the government temporarily suspended certain rules in the NHS Pension Scheme to support retired staff to return to the NHS during the pandemic without their pension being affected. The suspension provided valuable additional capacity from retired staff, during increased sickness absence and demand on NHS services.

The temporary suspension of these rules has supported employers to retain the skills and experience of these individuals, as well as their ability to encourage, support, mentor and train younger colleagues. The easements have helped NHS organisations to safely staff patient services and to support staff in terms of health and wellbeing and flexible working opportunities. They have also allowed experienced staff to undertake additional work that is desperately needed to tackle the elective backlog caused by the pandemic.

Pension taxation

Employers continue to be very concerned about the impact of the AA and LTA on workforce capacity, service delivery and patient care. Employers report staff taking early retirement, reducing their work commitments, and a reluctance to apply for promotions or take on additional work and responsibilities due to the impact of pension taxation.

There is an increased risk that more members of the NHS Pension Scheme will breach the AA and incur tax charges in the 2022/23 tax

year due to the rapidly rising inflation, and employers are concerned about the impact this will have on care and the ability to tackle treatment backlogs.

We raised employer concerns about the impact of rapidly rising inflation on AA issues in a letter to the Chancellor and asked HM Treasury to take two urgent actions:

- Amend the calculations so that pension growth, which is solely caused by rapidly increasing inflation, is excluded from the test for AA.

- Allow pension growth across the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme to be aggregated before it is tested against the AA. This would allow any negative growth in the 1995/2008 NHS Pension Scheme to be offset against positive growth in the 2015 NHS Pension Scheme.

We welcome government plans to amend the revaluation date that is used in AA calculations in the NHS Pension Scheme to correct the inflation position for tax year 22/23 and future tax years. However, we believe the measures announced should have also included proposals for pension growth in both schemes to be aggregated. We will continue to represent employers' views on this issue in our response to the upcoming consultation on these proposals expected before the end of the year.

We will also continue to make clear that we do not believe that the AA should be applied to defined benefit schemes such as the NHS Pension Scheme(s). Reform of the tax system in relation to pensions is long overdue and would greatly alleviate the concerns of many senior clinical staff in the NHS.

Local options to support staff affected by pension taxation

The former Secretary of State announced she will strongly encourage employers to explore local solutions to support staff affected by pension taxation, including recycling employer contributions. We published pension tax guidance for employers on the local options employers can put in place.

Many employers have implemented local policies on recycling employer contributions and others are considering and exploring other options, such as using multiple contracts of employment to manage pension growth.

A national policy on recycling employer contributions

NHS England is leading the development of a national policy on the recycling of employer contributions in response to the announcement from the Secretary of State. While it is not intended to be mandatory for employers to use this policy, the y will be strongly encouraged to do so.

While some employers have operated recycling schemes for some time, others have decided against introducing recycling policies due to concerns about equality risks. Many employers have told us they feel uncomfortable offering additional pay to those opting out of the scheme for tax reasons, where no similar flexibility is offered to staff opting out of the scheme due to affordability or other reasons.

Employers operating recycling policies have told us that the number of staff taking up the offer is low, as many have been advised that staying in the scheme is still valuable, despite having to pay AA charges.

We are working with NHS England as part of a task and finish group to develop the national policy on recycling employer contributions. During the discussions to date, we have stressed the need for

employers to have assurance in relation to potential equality risks. We will be updating our guidance for employers once the position around the national policy is confirmed.

Scheme flexibilities

We remain of the view that introducing greater flexibility over the level of contributions members pay into the scheme and the value of benefits they receive in return is key to ensuring the NHS Pension Scheme remains attractive and valuable to all NHS staff.

Allowing members to pay a lower level of contribution to the scheme for a proportionately lower pension in return, could help to encourage more members to join the scheme and access a broader reward package from their employer. Increasing membership levels across the whole workforce makes the scheme a stronger tool for reward, recognition and retention.

We would welcome the opportunity to explore ways of combining flexible pension accrual with recycling unused employer contributions for all staff. We believe that a more flexible and modernised reward offer, one that enables staff to save towards their retirement while receiving support from their employer towards other more immediate financial priorities, would be attractive to both staff and employers.

Understanding the value of the NHS Pension Scheme

We continue to support employers to understand the value of the NHS Pension Scheme so they can explain and promote the key benefits of scheme membership to staff. We have launched an online learning course designed for HR and reward professionals who wish to improve their knowledge and understanding of the value of the NHS Pension Scheme. The course aims to equip employers to have confident conversations about the NHS Pension Scheme to support retention.

Annex A

Comparison of medical and dental pay scales across the devolved nations

Consultants

	England	Wales	Scotland	Northern Ireland
Years' experience				
0	£88,364	£86,063	£91,474	£84,975
1	£91,131	£88,804	£93,406	£86,303
2	£93,898	£93,388	£96,185	£90,299
3	£96,665	£98,710	£98,967	£92,958
4	£99,425	£104,791	£101,741	£95,611
5	£99,425	£104,791	£101,741	£95,611
6	£99,425	£104,791	£101,741	£95,611
7	£99,425	£104,791	£101,741	£95,611
8	£99,425	£104,791	£101,741	£95,611
9	£105,996	£108,258	£108,345	£101,933
10	£105,996	£108,258	£108,345	£101,933

11	£105,996	£108,258	£108,345	£101,933
12	£105,996	£108,258	£108,345	£101,933
13	£105,996	£108,258	£108,345	£101,933
14	£112,569	£111,732	£114,949	£108,253
15	£112,569	£111,732	£114,949	£108,253
16	£112,569	£111,732	£114,949	£108,253
17	£112,569	£111,732	£114,949	£108,253
18	£112,569	£111,732	£114,949	£108,253
19	£119,133	£111,732	£121,548	£114,567

Specialty doctor 2021

	England	Wales	Scotland	Northern Ireland
			(Rates TBC)	
Years' experience				
0	£50,373	£50,620	£54,903	£50,485
1	£50,373	£50,620	£54,903	£50,485
2	£50,373	£50,620	£54,903	£50,485
3	£56,906	£57,182	£65,497	£56,850
4	£56,906	£57,182	£65,497	£56,850
5	£58,756	£58,756	£65,497	£58,756
6	£64,237	£64,550	£69,507	£64,150

7	£64,237	£64,550	£69,507	£64,150
8	£64,237	£64,550	£69,507	£64,150
9	£71,654	£72,003	£77,532	£71,550
10	£71,654	£72,003	£77,532	£71,550
11	£71,654	£72,003	£77,532	£71,550
12	£75,361	£75,730	£85,554	£75,430
13	£75,361	£75,730	£85,554	£75,430
14	£75,361	£75,730	£85,554	£75,430
15	£75,361	£75,730	£85,554	£75,430
16	£75,361	£75,730	£85,554	£75,430
17	£78,759	£79,144	£85,554	£79,000

Specialist doctor 2021

	England	Wales	Scotland	Northern Ireland
Years' experience				
0	£80,693	£80,693	£83,130	£80,693
1	£80,693	£80,693	£83,130	£80,693
2	£80,693	£80,693	£83,130	£80,693
3	£86,139	£86,139	£88,740	£86,139
4	£86,139	£86,139	£88,740	£86,139
5	£86,139	£86,139	£88,740	£86,139
6	£91,584	£91,584	£94,250	£91,584

Doctors and dentists in training

	England	Wales	Scotland	Northern Ireland
FY1	£29,384	£26,714	£27,653	£25,563
		£28,382	£29,380	£27,159
		£30,051	£31,106	£28,752
FY2	£34,012	£33,135	£34,299	£31,706
		£35,303	£36,543	£33,778
		£37,468	£38,787	£35,853
CT1/CT2	£40,257	£35,408	£36,472	£33,880
		£37,537	£38,704	£35,955
		£40,600	£41,821	£38,849
CT3	£51,017	£42,431	£43,706	£40,601
		£44,635	£45,978	£42,712
		£46,844	£48,251	£44,825
ST1/ST2	£40,257	£35,408	£36,472	£33,880
		£37,537	£38,704	£35,955
		£40,600	£41,821	£38,849
ST3/ST4/ST5	£51,017	£42,431	£43,706	£40,601
		£44,635	£45,978	£42,712
		£46,844	£48,251	£44,825
		£49,051	£50,257	£46,938
ST6/ST7/ST8	£58,398	£51,259	£52,800	£49,049
		£53,465	£55,073	£51,161

£55,674	£57,349	£53,273	

SAS 2008 specialty doctor

	England	Wales	Scotland	Northern Ireland
Scale value				
0	£44,300	£44,519	£45,193	£42,598
1	£48,088	£48,324	£49,057	£46,242
2	£53,012	£53,274	£54,080	£50,976
3	£55,652	£55,925	£56,772	£53,514
4	£59,454	£59,744	£60,651	£57,171
5	£63,242	£63,552	£64,516	£60,814
	£63,242	£63,552	£64,516	£60,814
6	£67,115	£67,443	£68,466	£64,538
	£67,115	£67,443	£68,466	£64,538
7	£70,990	£71,336	£72,418	£68,263
	£70,990	£71,336	£72,418	£68,263
8	£74,864	£75,231	£76,370	£71,988
	£74,864	£75,231	£76,370	£71,988
	£74,864	£75,231	£76,370	£71,988
9	£78,737	£79,123	£80,321	£75,713
	£78,737	£79,123	£80,321	£75,713
	£78,737	£79,123	£80,321	£75,713
10	£82,611	£79,440	£84,272	£79,438

SAS 2008 associate specialist

	England	Wales	Scotland	Northern Ireland
Scale value				
0	£62,111	£62,415	£63,361	£59,725
1	£67,104	£67,432	£68,454	£64,527
2	£72,095	£72,448	£73,546	£69,326
3	£78,687	£79,071	£80,271	£75,665
4	£84,401	£84,814	£86,099	£81,158
5	£86,772	£87,194	£88,517	£83,438
	£86,772	£87,194	£88,517	£83,438
6	£89,865	£90,304	£91,673	£86,413
	£89,865	£90,304	£91,673	£86,413
7	£92,958	£93,413	£93,880	£89,388
	£92,958	£93,413	£93,880	£89,388
8	£96,051	£96,520	£96,945	£92,362
	£96,051	£96,520	£96,945	£92,362
	£96,051	£96,520	£96,945	£92,362
9	£99,145	£99,630	£100,008	£95,335
	£99,145	£99,630	£100,008	£95,335
	£99,145	£99,630	£100,008	£95,335
10	£102,240	£102,740	£103,074	£98,314

Annex B

Comparison of key contractual provisions across the devolved nations

Consultants

	England (2003)	Wales	Scotland	Northern Ireland
Working hours	40 hours excl. meal breaks	10 sessions averaging 37.5 hours a week	40 hours excl. meal breaks	40 hours
Premium time hours	Premium Time: any time outside 7am - 7pm Monday to Friday, and any time on a Saturday or Sunday, or public holiday	7pm-7am, weekends and Bank Holidays	8pm-8am Mon-Fri, Sat & Sun & Bank Holidays	7pm-7am, weekends & Bank Holidays
Additional earnings e.g., on-call, flexible pay	Cat A - 3%, 5% or 8% Cat B 1%, 2%, 3% Overtime - Additional	on-call & additional sessions	Extra programmed activity PA depending	Additional sessions

premiums (FPP) etc	programmed activity		on frequency of OOH	
Leave allowances	6 weeks + 2 days, depending on service	6 weeks + 3 days	6 weeks	6 weeks
Maternity leave provisions	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA

SAS grades

	England (2021)	Wales	Scotland 2021	Northern Ireland
Working hours	40 hours excl. breaks	Same as England	40 hours	40 hours
Premium time hours	9pm-7am and weekends/BH	Same as England	7pm-7am, weekends & BH	7pm-7am, weekends & BH
Additional earnings e.g., on-call, FPPs etc	Cat A - 3%, 5% or 8% Cat B 1%, 2%, 3% Overtime - Additional programmed activity	Same as England	Extra programmed activity & Level 1 or 2 availability supplement for on-call (same as England %)	Additional sessions
Safety limits	60% IH/40% OOH Max 4 nights Max 4 LD	Same as England	no more than 40% OOH	Same as England

Leave allowances	5 weeks + 2 days, then 6 weeks & 3 days after 2 years	Same as England	5.6 weeks, increasing to 6.6 after 2 years	6 weeks
Maternity leave provisions	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	Same as England	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA

Doctors and dentists in training

	England (2016)	Wales	Scotland	Northern Ireland
Working hours	40 hours including meal breaks	40 hours	40 hours	40 hours
Premium time hours	10pm-7am time and a half Sat 7pm-10pm time and a third Sun 7am-10pm time and a third	7pm-7am, weekends & BH	7pm-7am, weekends & BH	7pm-7am, weekends & BH
Additional earnings e.g., on-call, FPPs etc	On-call between 2-6% depending on frequency	Banding	Banding	Banding
Leave allowances	On first appt to NHS 25 days, after 5 years' service 30 days	5 weeks	5 weeks	5 weeks

Maternity leave provisions	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA	8 weeks full pay, 18 weeks half pay, 13 weeks SMP/SMA

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