NHS Employers
Part of the NHS Confederation

NHS EMPLOYERS' SUBMISSION TO THE DOCTORS' AND DENTISTS' REVIEW BODY 2021/22

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CONTENTS

CONTEXT

The outbreak of the COVID-19 pandemic has presented one of the biggest challenges that the NHS has ever faced. Across the NHS demand for services is up, available capacity is down, and waiting lists for non-COVID-19 services are continuing to rise.

NHS workers have made huge sacrifices during the pandemic and sadly many have lost their lives. There is evidence from the first wave of disproportionate mortality amongst black and minority ethnic (BME) people, including our NHS staff, who have contracted COVID-19[1] and many of our staff are suffering from mental health problems which may prove to be long term[2].

The pandemic has highlighted long-standing strategic challenges facing employers across the NHS and social care. These include:

- how services are being used now
- what changes will be needed to these in the future
- how to address rising levels of demand
- the workforce numbers needed to meet rising demand for existing and new services
- the need for a sustainable long-term funding model to support service provision across both health and social care.

In responding to the pandemic employers have faced significant increases in demand on workforce, services, and equipment.

Increases in capacity were created at speed to successfully manage and respond to the immediate COVID-19 challenge. Greater use of cross-organisation and system collaboration and workforce innovation has been central to the employer response, including the adoption of new and more flexible approaches to staff deployment.

This has been supported by attracting people back into the profession and fast-tracking students into employment, thereby avoiding some of the problems seen in other countries.

The incredible response and effort shown by the workforce in rising to meet the challenges presented by the pandemic, whilst also keeping other essential services running wherever possible, has been truly outstanding.

Not only have staff been flexible they have also been innovative. In the face of adversity, employers and staff have united in forging new and stronger partnerships that have delivered

[1] NHS England and NHS Improvement, Addressing the Impact of Covid-19 on BAME staff in the NHS.
[2] NHS England and NHS Improvement (2020), NHS Strengthens Mental Health Support for NHS Staff.

care in extreme circumstances with continued high levels of professionalism, whilst working under extreme operational pressures and personal sacrifices.

In conversations with employers about NHS Reset[3], the NHS Confederation found that around three-quarters of NHS leaders were not confident of meeting targets to restore routine operations to last year's levels by the end of October 2020. Nine in ten employers said that lack of funding was a significant barrier to this. Resuming normal services can only be achieved with the proper investment in personal protective equipment (PPE), mental health services, social care, and the NHS workforce. The additional funding announced in the 2020 Comprehensive Spending Review for PPE and test and trace is welcome. However, NHS leaders will expect the government to continue to find the money needed to enable staff to respond to the pandemic. The £3 billion of additional funding to tackle the care backlog, the increased demand for mental health services and wider pressures is also welcome, but it falls short of the £10 billion the Health Foundation says is needed[4].

At the time of compiling our written evidence submission, employers are dealing with the impact of the second wave of the virus and managing this alongside trying to maintain services and grapple with the familiar autumn and winter pressures. The NHS is also leading on the largest vaccination programme in NHS history.

Whilst the response to this set of challenging operational pressures will be an essential consideration for employers over the coming months, they still need national policy makers to address the wider strategic challenges that we have highlighted in this and previous submissions.

Our evidence on behalf of employers will return to these in this year's submission.

[3] NHS Confederation (2020), NHS Reset.
[4] Health Foundation (2020), Spending Review 2020. Priorities for the NHS, Social Care and the Nation's Health.

KEY MESSAGES

- The NHS Long Term Plan continues to set the future direction for the NHS in England and is the basis for a five-year funding programme up to 2023/24. While this provides some stability for longer-term planning, the overall level of investment is still lower than in previous years.

- The We are the NHS People Plan 2020/21 – Action For Us All[5], along with Our People Promise, sets out what our staff can expect from their leaders and from each other. It builds on the creativity and drive shown by our staff in their response, to date, to the COVID-19 pandemic and the Interim NHS People Plan[6]. It focuses on how everyone in the NHS must continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow the workforce, train staff, and work differently to deliver patient care.

- The NHS faces the multiple challenges of rising demand for services, insufficient capital investment, tackling the causes of trust financial deficits and growing workforce shortages. While the NHS must focus on the immediate demands of the pandemic, it must not become a reason for avoiding policy decisions on these critical longer-term issues.

- Workforce shortages remain the highest concern for employers and the supply issues need to be addressed. Employers remain committed to retaining staff but the health and wellbeing of staff and the risks of staff burnout, especially considering the pandemic, coupled with gaps in the workforce make this a greater challenge.

Financial challenges

- Employers have welcomed the additional funding provided to the NHS to help it cope with the pandemic, including £13.4 billion to write off previous loans. However, whilst this is welcome action, such targeted injections of resources do not address the underlying structural issue of financial sustainability being required in the short, medium, and longer term. The Health Foundation has identified a potential funding gap in 2021/22 of around £10 billion[7].

- We need a strategy for exiting from the pandemic. This must be sustainable and affordable and retain innovation and the transformation of services as central elements.

[5] NHS England and NHS Improvement (2020), We are the NHS People Plan 2020/21 – Action for Us All
[6] NHS Improvement (2019), Interim NHS People Plan.
[7] Ibid

- Further investment is needed. This must include a new capital settlement, sustainable long-term investment in workforce education and training and agreed new priorities for the delivery of public health and social care services.

- In relying on the workforce to deliver the ambitions set out in the NHS Long Term Plan, working in new ways and in new teams in evolving healthcare systems imply we will need a significant and sustained programme, properly supported with sustainable funding, around workforce training and development for the foreseeable future.

- Employers share the desire to recognise and reward the contribution of all NHS employees during the pandemic and across their careers. Any uplifts to pay must remain fully funded, including by association, appropriate funding provisions being made to NHS England and NHS Improvement and to public health budgets. Without additional funding support, plans for workforce growth in key areas will be jeopardised.

- The government must urgently follow through on its commitment to social care reform; a modern social care system supported by a new sustainable funding model remains a priority.

- We welcome the confirmation in the 2020 Spending Review that staff in the NHS will receive a pay award. Fair investment in pay and reward is one of the ways in which we can recognise the valuable contribution of our staff, but this should not be at the expense of other priorities, including improving workforce supply. Employers want to see a pay and reward offer that is fully funded and sustainable and which is fair to all staff.

Workforce challenges

- The dedication and professionalism of staff has been evident throughout the pandemic. However, the NHS entered the first phase of the crisis with more than 8,300 medical vacancies. There are variances in the geographical spread of vacancies and in some locations this has led to the temporary closure of services. Leaders agree that we must speed up our efforts to fill these workforce gaps. They are also raising concerns with us about staff health and wellbeing and burnout, which is expected to increase.

- Medical and dental careers remain popular choices for UK graduates and we welcome continued efforts to increase domestic supply. However, we must do more both locally and nationally to retain doctors, particularly those who are increasingly taking early retirement, to ensure that the work that goes into improving supply will result in real and sustained increases in overall numbers.

- Employers are continuing to manage the NHS response to the pandemic while bringing other services back, alongside preparing to respond to expected winter pressures. It is essential that employers continue to receive appropriate levels of financial support to help them address the full range of these complex pressures.

- Modern, fit-for-purpose accommodation is a vital requirement if the NHS is to deal with the backlogs of treatment it now faces, along with investment in technology. This must be delivered, supported, and maintained with proper sustainable capital funding.

- The focus on staff health and wellbeing has been central to the pandemic and is now rightly seen as part of good employment practice. Maintaining this focus will be essential in terms of retention. The key to this will be making sure staff are given the time to look after their wellbeing, which will need to be considered in terms of delivery expectations.

- We must continue to reinforce our support for staff while also promoting realistic expectations of what can be included in 2021-22 delivery plans and political leaders need to manage public expectation.

Doctors in training

- A multi-year pay agreement covers the period from 1 April 2019 to 31 March 2023.

- In addition, a total of £90 million will be used to fund changes over and above the pay uplifts over the four-year period, which include:
    - weekend allowance uplift to ensure those working the most frequent weekends are remunerated more fairly
    - an enhanced rate of pay for shifts that finish after midnight and by 4am
    - a new nodal pay point 5 in place of a senior decision-maker allowance.

- COVID-19 has impacted on trainees and those who train them. Learning opportunities were disrupted and many trainees were redeployed into unfamiliar areas.

- We have maintained dialogue with the trade unions over the course of the pandemic to address issues relating to terms and conditions of service.

  In the early stages of the pandemic parties agreed that, when it was not possible to implement the relevant working hours restrictions and rest requirements in the terms and conditions of service (TCS), they would be suspended, and the Working Time Regulations 1998 (WTR) would be the fallback position for the duration of the pandemic. The British Medical Association (BMA) withdrew from that agreement in August as conditions, at that time, began to ease. There is no further agreement in place.

Specialty and associate specialist (SAS) doctors

- The review body said in its previous report that it expects a new contract to be in place by April 2021 and that the extra 1 per cent awarded to SAS doctors in 2019, which the government decided would be contingent on contract reform, is included in the funding envelope. Through reform we aim to attract and retain SAS doctors, create contracts that are attractive for employers to adopt and offer doctors fulfilling careers with opportunity for progression.

- In December 2020, the parties concluded negotiations on two contracts: a new specialty doctor and specialist grade contract. The framework agreement is going through usual procedures for sign off and if approved will be put to a referendum of BMA members in the SAS grades. It is the shared intention of the parties to write to the DDRB to set out the contract offer in further detail.

- Our work programme this year has focused primarily on SAS contract reform, but we have continued to promote our existing SAS charter resources through our usual communications channels.

- NHS Employers has led on the review of the SAS development guide, originally published in 2017. The updated guide was published in September 2020 and included more information on continuing professional development, autonomous working and extended roles for the SAS workforce.

Consultants

- There is no remit from government to explore consultant contract reform beyond the work that is currently underway on reform of Local Clinical Excellence Awards (LCEAs). However, employers still believe that contract reform is important. This has been highlighted further by the independent report into the gender pay gaps in medicine, which recommends reducing the current emphasis on years of service as a driver in medical pay and addressing the very long pay scales which exist in the consultant and some other grades[8]. We would support more investment to enable consultant contract reform in favour of further investment in junior doctor and SAS contracts, which have seen recent investment. This is important if we are to be able to make progress in addressing the gender pay gaps in medicine.

- The impact of COVID-19 meant that an LCEA round was not run for the current year 2020/21. Instead, money allocated to LCEAs is set to be distributed equally among eligible consultants. Employers are also concerned at the prospect of running a round in 2021, due to the redeployment of staff during the pandemic and the numbers of those who have had to shield, which is likely to impact a greater proportion of BME staff deemed to be at higher risk.

- The Department of Health and Social Care has asked NHS Employers to develop, through negotiation with key stakeholders, a new consultant reward scheme to succeed the transitional arrangements from April 2021.

- Negotiations were due to start in the spring of 2020 but were paused due to the pandemic. Discussions have now recommenced, and the intention is to work through the various phases of negotiation covering the development of underlying principles, scheme details, engagement and consultation. The aim is to agree a new scheme, which will be announced in

[8] Department of Health and Social Care (2020), Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England.

2021 and in place on 1 April 2022, so that employers can begin their own process for issuing awards in the autumn of 2022.

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.

- Feedback from employers suggests that in some areas there are recruitment difficulties. A range of reasons were given, including location, lower remuneration than high street practices, a lack of vacancies at higher bands that impacts both salary and career progression, and a lack of understanding of the role, particularly at undergraduate level, which might influence career choice.

- The terms and conditions have largely been unchanged since they were first introduced in 2008. Employers have suggested that there should be a way of recognising additional qualifications or skills within the pay structure, but one that does not require a move to a higher banded post, which in many areas do not exist. Although some employers pay an enhanced rate for work done out of hours, there is no provision for this within the terms and conditions.

- Overall, across the medical and dental workforce, employers are keen to see a long-term financial settlement to deliver a modern reward package that supports recruitment and retention and which, through investment in contract reform, can address the gender pay gap in medicine. Such a settlement must also provide for a fully funded pay award.

INFORMING OUR EVIDENCE

Introduction

1. 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 in bringing an independent and expert view on remuneration and wider issues in relation to doctors and dentists.

2. Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations, about their priorities. The healthcare response to the pandemic was the focus of much of our discussions and it has restricted our face-to-face contact with employees. However, we have made extensive use of communication technologies available to us and NHS colleagues and when possible, we have:

    - attended regional network meetings of human resources directors, the NHS Confederation and other employer networks
    - carried out a survey on reward
    - engaged with the NHS Employers Policy Board and the medical and dental workforce forum sub-committee, our medical contract experts' group and other networks

3. 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.

4. Our submission reflects the views of employers on the combined effect of the financial, workforce and transformation challenges faced by the NHS and the impact of the pandemic. It considers the impact of the NHS People Plan and the strategic direction set out in the NHS Long Term Plan, and how these factors might come together to influence decisions for employers on pay and reward in 2021/22 and the years ahead.

2. THE IMPACT OF COVID-19

5. This submission is an opportunity for us to say thank you once again for all that staff across the NHS have done and continue to do to support the NHS during these difficult and unprecedented times. The resilience of NHS and social care staff has been tested to extraordinary limits.

6. We also recognise those health and social care staff who have died from COVID-19 and the many others who have suffered and are still suffering from the long-term effects of the virus.

7. Supporting the health and wellbeing of our staff is vital if the NHS is to be able to withstand the combined pressure of dealing with urgent COVID-19-related work, restoring services and dealing with the backlog of work. At the time of writing, the number of COVID-19 cases and hospital admissions are rising rapidly. We must recognise that staff have been under considerable stress, with little time to rest and recover and that there will be little respite over the coming winter.

8. In September this year, the NHS Confederation published, NHS Reset: A New Direction for Health and Social Care[9]. This was the culmination of the NHS Reset campaign, which involved extensive engagement with members and a survey of over 250 leaders. The report identifies factors which are fundamental to achieving a first-rate health and care system for the future.

9. In doing so, the report recognises that COVID-19 is the greatest challenge we have faced for more than a generation. To meet that challenge there are several ways in which the NHS needs to be supported by government and its arm's-length bodies.

10. Firstly, the service needs to be able to operate in an environment of honesty and realism. The service needs government investment to support new ways of working that will be needed to restore services safely. It will also require a degree of understanding by the public while it deals with the backlog, which also involves political leaders being able to manage expectations.

11. Secondly, we have stressed that funding needs to be reassessed as part of the Comprehensive Spending Review, with additional revenue and capital funds needed to cope with rising demand and the backlog of work. In the NHS Confederation's survey, fewer than one in 10 members were confident that they would achieve the goals of the NHS Long Term Plan within their existing funding settlements. Any additional unfunded pay award would make this situation worse.

[9] NHS Confederation (2020), Reset: A New Direction for Health and Care.

12. Finally, the NHS should work within a lighter and leaner culture free from unnecessary burdens. We must ensure that we hold on to different ways of doing things and embrace a culture which allows clinicians to lead and innovate.

13. During the pandemic we saw how staff mobilised into different health and care roles. The speed and flexibility with which staff and services adapted to rapidly changing circumstances allowed the NHS to respond in the way that it did.

14. Clinicians, managers and teams united around a clear and pressing shared purpose. This led to more agile and innovative working and more rapid decision-making, with clinicians and teams empowered to do things differently across teams and across settings. Through our conversations with employers, we have heard a clear message to use the learning from recent months to make decisions about the future that will have a positive impact on all our staff, and there is no desire to roll back on the progress that has been made so far.

15. The impact of the pandemic is continuing to affect the delivery of hospital services in many ways. Assessments of the risks faced by staff in high-risk categories continue to be carried out, and some staff may need to be removed from the care of COVID-19 patients, often exacerbating the staffing shortages that existed before the pandemic. There is also some anxiety amongst staff who believe that their training or career development is being adversely affected. We must act to ensure this does not result in a disproportionate longer-term impact on staff, particularly those BME staff who are at higher risk.

16. Remaining staff are having to make many changes to their daily work routines. These include changing in and out of personal protective equipment (PPE), administering tests and reorganising multiple site visits or ward rounds. This reduces the amount of work they can do in a day. There are also many other ways in which the impact of COVID-19 continues to be felt:

    - The need to test patients and ensure increased infection prevention mean that treatment times are increased.
    - The restarting of planned care, which requires a reliable and adequate supply of PPE.
    - Patients who are still nervous about infection and who may not turn up for appointments.
    - The need to assume patients who are admitted in emergencies are COVID-19 positive, requiring enhanced PPE and extra time for cleaning beds, imaging equipment and operating theatres between patients.
    - The impact on the NHS estate, where there is shared accommodation and narrow corridors makes segregating patients with and without the virus difficult. Finding adequate waiting areas where social distancing with be possible will be another challenge in some buildings.
    - The NHS needs to manage capacity for the second and third waves. Although the arrival of the vaccine has provided some hope for the future, there has been a

short-term increase in demand. There is a long way to go towards recovery and dealing with long waiting lists with a tired and exhausted workforce[10].

17. In response to the pandemic, NHS England and NHS Improvement (NHSEI) suspended the implementation of the NHS Long Term Plan and made temporary changes to trust payment mechanisms. Commissioners were asked to report on the variations to standard procedures and the response to the pandemic delayed the publication of the 2020/21 tariff. Financial control was taken away from trusts when they were responding to the urgent needs of very ill patients, by implementing locally designed changes to procedures.

18. Elective activity in the NHS was suspended to free up capacity[11] and this has put more pressure on waiting lists. Despite encouragement to use A&E services, many patients have stayed away. This means that patients in need of urgent care may not be accessing it.

19. NHSEI asked local health systems to step up services not related to the pandemic and consider options to resume non-urgent care. However, it remains difficult for local health systems to determine what demand there will be for services after the pandemic and therefore, what resources need to be allocated where.

20. The initial financial arrangements for trusts during the pandemic were for the period April to July 2020. Trusts are having to plan for services beyond summer 2021, as well as winter pressures, while having to retain spare capacity to deal with future surges in the pandemic.

21. On 30 January 2020, as the pandemic emerged, a level 4 national incident was declared. The Department of Health and Social Care (DHSC), NHSEI, Public Health England (PHE), Health Education England (HEE) and NHS Employers, collated the latest workforce advice into a resource for workforce leaders in the NHS[12] on the NHS Employers website.

22. The guidance covered workforce issues that were thought likely to emerge during the pandemic. It was regularly updated and supplemented as the crisis developed, so that employers could protect and support their workforce, use their workforce in the most effective way, and recruit as quickly as possible from returning staff, volunteers, and students in training.

23. The special COVID-19 arrangements were a temporary departure from existing national and local contractual terms and conditions and other agreements, which are being restored in line with local operational circumstances.

24. Employers are continuing to manage the NHS response to the pandemic while bringing other services back, as well as managing the testing of staff and preparing for the work on the vaccination programme. There are also the usual winter pressures which in any normal year would add to the difficulty in maintaining day-to-day services. We would like to see additional support given to employers to help them cope with these demands.

25. There is a danger that lingering worries over contracting the virus may deter potential job applicants. The disproportionate impact the virus has had on ethnic minorities is well known

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[10] Nuffield Trust (2020), Covid-19: The NHS Not Returning to Normal Any Time Soon.
[11] BMJ (2020) News: 368:m1106
[12] NHS Employers (2020) COVID-19 Guidance for NHS Workforce Leaders.

and may discourage potential recruits from these communities. Urgent research into this challenge is needed so that we can develop effective ways to mitigate risks. The need to redeploy some BME staff will create issues within organisations.

26. It will take time for the NHS to recover from the pandemic, and we need realistic expectations on what the NHS can deliver. Understanding the strain of the pandemic on health and care staff and the cumulative effects of restoring services, dealing with significant vacancy rates and further waves of the virus will be critical. Employers are providing higher levels of support to staff to strengthen their nursing and wider workforce.

NHS Reset

27. NHS Reset is an NHS Confederation campaign, involving its members and wider partners in health and social care, to shape what the health and care system should look like in the aftermath of the COVID-19 pandemic. The aim of the campaign is to:

- recognise both the sacrifice and achievements of the health and care sector's response to COVID-19, including the major innovations that have been delivered at pace
- rebuild local service provision to meet the physical, mental and social needs of communities affected by severe economic and social disruption
- reset our ambitions for what the health and care system of the future should look like, including its relationship with the public and public services.

28. Based around 10 key themes, ranging from workforce to health inequalities and from mental health to economic and social recovery, the purpose of the campaign is to influence national strategies, including from NHSEI, and its priorities for a reset.

29. The health and care workforce strand of the campaign reflects employer feedback on a selection of national policy and funding decisions to support employers with workforce priorities. Through our conversations with employers, they have given a clear message of the opportunity we have to use the learning from recent months to make decisions about the future that will have a positive impact on all our staff.

30. There have been significant changes in how many of our services are delivered. We have seen people working together differently within and across, teams, primary care, community and secondary care settings, to provide the best care possible.

31. There is no desire from anyone to roll back on the progress made, especially where there have been improvements in the offer or experience for our staff, as well as the population being served. However, we have seen deep-rooted problems with workforce discrimination and inequality come to the fore, which must be addressed. There are also long-standing workforce supply issues in need of urgent action. Themes emerging from the workforce strand include:

Local focus

The experience an individual has at work is created in the place where they work. Any actions need to empower local leaders to work with local partners, to make decisions about how best to support their workforce.

Blocking discrimination

The pandemic has shown the inequality experienced by BME and other colleagues, which employers want to address through approaches to recruitment, people management and the design of ongoing talent management or development plans. All of which is underpinned by listening to the voices of our people through local and national networks.

Addressing long-standing workforce issues through national policy and funding decisions

Many of the workforce issues facing employers, especially around skills gaps and supply, predate the pandemic. Making changes to the way in which the apprenticeship levy can be used, funding additional placement capacity, enhancing the mental health and wellbeing offer for staff and running a national campaign to attract into training and employment across health and social care, will help. Alongside these, long-term investment funding to deliver a modern total reward package is essential as a core component of any attraction and retention offer for staff.

Partnership working between employers and staff organisations

Through the height of the pandemic several temporary workforce and employment-related changes were agreed between national staff organisations, employers and the DHSC. As we move into the next phases of managing services with COVID-19, these must be revisited and not assumed as long-term changes.

3. FINANCIAL CHALLENGES

32. Although funding for the DHSC continues to grow, the rate of growth slowed during the period of austerity that followed the 2008 economic crash. Budgets rose by 1.4 per cent each year on average (adjusting for inflation) in the 10 years between 2009/10 to 2018/19. Compared to the 3.7 per cent average rises since the NHS was established[13].

33. As a sector, NHS trusts have not been in financial balance since 2012/13[14]. Trusts in financial difficulty have been dependent on short-term measures to meet their financial targets, including loans issued by DHSC to pay for their day-to-day services.

34. In June 2018, the government announced a long-term funding settlement for the NHS which will increase the NHS budget in England by £33.9 billion in cash terms by 2023/24[15]. This is an average annual, real terms increase of 3.4 per cent. In January 2019 NHSEI published the NHS Long Term Plan[16]. The plan sets out how the NHS will achieve the range of priorities set by government in return for the additional investment provided by the long-term funding settlement.

35. This year's pay round is set against both the health and economic impact of the pandemic. The final cost of COVID-19 to the NHS and to the wider economy will not be known for some time, but it will be significant. Public sector net debt, excluding public sector banks, (PSND ex) rose by £276.3 billion in the first seven months of the financial year to reach £2,076.8 billion at the end of October 2020. Public sector net borrowing (PSNB ex) in the first seven months of this financial year, (April to October 2020) is estimated to have been £214.9 billion, which is £169.1 billion more than in the same period last year[17] and the highest public sector borrowing in any April to October period since records began in 1993.

36. The Institute for Fiscal Studies (IFS) has forecast that the deficit will reach in the region of £350 billion – six times the level forecast at the Spring Budget – suggesting that once the economy has been restored a period of fiscal tightening could follow[18].

37. The IFS also noted that health spending has been maintained over the decade to 2019/20, whereas real-terms public service spending elsewhere has been cut by 20 per cent.

38. HM Treasury (HMT) announced on 21 October 2020 that the Chancellor of the Exchequer would conduct a one-year spending review to conclude in late November. The statement confirmed that the multi-year NHS resource settlement would be fully funded. The statement also said that: 'as outlined in July, in the interests of fairness the government must exercise

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[13] The King's Fund (2020), The NHS Budget and How It Has Changed.
[14] The Committee of Public Accounts (2020), NHS Capital Expenditure and Financial Management. Eighth Report of Session 2019-21.
[15] Ibid
[16] NHS England and NHS Improvement (2019), The NHS Long Term Plan.
[17] Office for National Statistics (2020), Public Sector Finances, UK: October 2020.
[18] Institute for Fiscal Studies (2020), The IFS Green Budget.

restraint in future public sector pay awards, ensuring that across the year and the spending review period, public sector pay retains parity with the private sector.'[19]
On 25 November 2020, the Chancellor set out the government's one-year spending plans and announced an extra £3 billion for the NHS in England for 2021/22 to help tackle backlogs in the health service. He also said that a pay uplift for NHS staff in 2021/22 would be based on advice from the national pay review bodies:

- Pay for the rest of the public sector will be paused for a year.
- Public sector workers earning less than £24,000 will receive a pay increase of at least £250.
- Local authorities' core spending power on social care will increase by 4.5 per cent, giving access to £1 billion more to fund social care on top of the extra £1 billion social care grant announced earlier this year.

39. Employers welcome the extra resources, which are much needed to help clear the backlog of elective procedures, respond to rising demand for mental health services and help ease other pressures resulting from COVID-19. The announcement of more funding for PPE and test and trace is also welcome. Yet the Health Foundation has suggested that this level of resource does not plug a £10 billion funding gap the Foundation[20] has calculated will be in place in 2021/22.

40. While the NHS long-term funding settlement of 2018 will continue to be funded up to 2022/23, significant extra funding will continue to be needed to ensure there is sufficient NHS capacity alongside the extra demands caused by treating COVID-19 patients and implementing infection control measures. The NHS Confederation's submission to the Comprehensive Spending Review (CSR)[21] noted that the cost of managing the pandemic has required an additional £31 billion of support for health and social care above that already planned in the current settlement. This is as the result of increased operational costs, including additional staff; restraints on capacity, including the need to manage infection control; and a significant backlog of clinical demand.

41. The additional £500 million for mental health services announced in the Spending Review will go some way to helping providers meet the additional mental health demand. Yet it is less than the £1 to £1.4 billion the Health Foundation[22] estimates is needed to fully meet the extra demand in these areas of care.

42. Capital funding is set to increase to £9.4 billion next year and this will enable the NHS to make progress on building 40 new hospitals by 2030, as well as delivering around 70 other upgrades in health infrastructure. However, this is lower than the £10.5 billion the Health Foundation[23] estimates is needed, There remains sub-standard equipment in estates in primary care and mental health.

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[19] GOV.UK (2020), News Story: Spending Review to Conclude Late November.
[20] Ibid.
[21] NHS Confederation (2020), Comprehensive Spending Review Submission.
[22] Ibid.
[23] Ibid.

43. The NHS was struggling to keep pace with demand prior to the pandemic. The additional funding announced in the Review is unlikely to cover the funding gap that has been exacerbated by COVID-19. Social care and public health also require greater investment over the long term.

44. In a survey of 250 NHS leaders carried out by the NHS Confederation, 9 out of 10 respondents were not confident that they could achieve the goals of the NHS Long Term Plan within their existing revenue settlement, with workforce cited as the most common pressure[24].

45. The condition of the NHS estate is also a factor. Making better use of capital investments and existing assets to drive transformation is one of the financial commitments in the NHS Long Term Plan. In the last few years, trusts have had to use some of their capital budgets to sustain day-to-day services. This amounted to £470 million in 2019/20[25].

46. In the NHS Confederation's submission to the CSR[26] it noted that some of the long-standing workforce supply and vacancy challenges were mitigated during the pandemic by a reduction in the amount of non-COVID work carried out. It also noted that NHS leaders continue to be concerned about the impact of Brexit and the need to remedy long-standing inequalities that have been highlighted during the crisis.

47. Additional funding must continue if the service is to be able to meet expectations in the future. We would welcome a multi-year settlement that recognises these pressures, and which will allow the NHS to stabilise and get back on track in delivering the ambitions set out in the NHS Long Term Plan. The transformation already underway needs to be supported by adequate investment in capital expenditure, education and training, public health, and social care.

48. Investment is needed to grow the clinical workforce and to address long-standing workforce challenges through a national attraction and recruitment campaign. The NHS Confederation's submission argued that such national investment in workforce will offer some hope to those currently working in highly pressurised workplaces, that their working conditions will improve.

49. Fair investment in pay and reward is one of the ways in which we can recognise the valuable contribution of our staff, but this should not be at the expense of other priorities, including improving workforce supply. Employers want to see a pay and reward offer that is fully funded and sustainable and which recognises the skills and talents of staff.

50. The NHS's offer to potential new recruits is supported on foundations of secure long-term employment and valuable and rewarding career development. Retention relies on our delivering these elements of the offer.

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[24] Ibid.
[25] National Audit Office (2020), Review of Capital Expenditure in the NHS.
[26] Ibid.

4. WORKFORCE CHALLENGES

51. The NHS Long Term Plan[27], published in January 2019, sets the future direction for the NHS in England. Together with the 2019 Spending Review, this provides the basis for a five-year funding programme up to 2024/25. This is based on a new service model that places more emphasis on prevention and health inequalities; improving the quality of care and health outcomes across all major health conditions; and harnessing technology to transform services.

52. It is the NHS workforce which will deliver the programme of work set out in the NHS Long Term Plan, and the NHS People Plan for 2020/21 identifies some of the significant workforce challenges currently faced by the NHS. The workforce currently in post is our means of delivering safe, effective, and timely care. Yet the growth of that workforce has lagged well behind growth in activity.

53. The COVID-19 pandemic is the biggest challenge the NHS has faced, yet due to the professionalism and dedication of its staff, every COVID-19 patient needing hospital care, including ventilation, was able to receive it. The rapid changes delivered by staff to increase intensive care beds and capacity avoided problems seen in other countries. They were supported by health professionals who returned to work, student nurses, doctors and other health professionals who committed to early placements in hospitals, NHS volunteers, and partners in local government, social care, the Armed Forces, the voluntary sector, hospices and the private sector.

54. The co-ordination and rapid deployment of this diverse additional workforce has been a testament to the skill and commitment of all who have been involved. NHS leaders have demonstrated flexibility and agility under extreme operational pressure.

Retention

55. In 2017/18, one in nine staff (135,000) left the NHS[28]. There is now a large body of authoritative research confirming that happy, motivated staff who enjoy their jobs are less likely to leave their employment.

56. Retention relies on staff experience in work and employers tell us that the leadership culture is the most important influence on staff motivation and their desire to stay in the NHS. In their joint report Closing the Gap[29], the King's Fund, Nuffield Trust and the Health Foundation suggest that retention is directly related to the leadership and culture of the organisation. The report states that people leave because they feel overworked, underpaid, poorly treated, unable to deliver good care, unable to progress, or a combination of these things.

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[27] Ibid.
[28] Public Accounts Committee (2020), NHS Capital Expenditure and Financial Management.
[29] Kings Fund, Nuffield Trust, Health Foundation (2019), Closing the Gap.

57. Line managers execute the leadership vision of the organisation and have an important role to play in the design and development of the total reward package and communicating all aspects of this reward offer to employees.

58. Feedback from our Total Reward Engagement Network indicates that the needs of staff vary, influenced by factors such as age, personal circumstances and career aspirations. Within NHS organisations, there are different groups of employees who are motivated in different ways and the needs of each group will have different implications for reward design.

59. These considerations are driving the development of local total reward package offers that are shaped by regular feedback from employees through line managers and a variety of other channels, including focus groups and apps.

60. NHS colleagues tell us that staff at the beginning of their careers need higher levels of management support as they make the transition to roles with increased levels of responsibility. If this support is not available, their level of engagement will drop and their mental wellbeing may suffer. Such situations contribute to rates of attrition.

61. Employers tell us that many staff in the later stages of their careers who want to continue to work are put off by long shifts and undesirable work-life balance. Employers recognise that by providing more flexible working patterns and managed reductions in participation, these experienced and talented people can continue to make an important contribution, including in the support of new recruits.

62. In last year's report, the review body expressed some concerns around the rate of retirement of consultants and the impact that this had on vacancy rates. We will discuss this further in the workforce supply and pensions sections below.

NHS People Plan

63. Employers repeatedly tell us that staffing shortages are one of the biggest risks to delivering the NHS Long Term Plan. Workforce planning is the responsibility of DHSC, NHSEI, HEE and the universities. NHS leaders tell us that these bodies must work together urgently, to produce an evidence-based plan which supports the NHS Long Term Plan. Local leaders in new health and care systems, in trusts and other provider organisations must have more say earlier on in the workforce planning process.

64. The NHS People Plan[30] is designed to address the challenges of the pandemic and improve physical and mental health support for staff. The plan builds on innovations driven by staff during the pandemic and sets out how the NHS can embed them.

65. It focuses on how we must look after each other and foster a culture of inclusion and belonging, as well as action to grow and train our workforce, and work together differently to deliver patient care.

66. The plan is focused primarily on the immediate term (2020-21) with an intention for the principles to create longer lasting change. Whilst there are some funding commitments made within the plan, there is additional investment that will need to be secured as part of

[30] Ibid.

any Spending Review process. Some of the workforce growth aspirations outlined in the interim plan and the government's manifesto, require further discussion and are therefore outside of the scope of this plan.

67. Central to the plan is Our People Promise, which outlines behaviours and actions staff can expect from NHS leaders and colleagues to improve the experience of working in the NHS for everyone. The following are some of the measures that are most relevant to the medical and dental workforce:

- Employers should be open to all clinical and non-clinical permanent roles being flexible, and should cover flexible working in standard induction conversations for new starters and in annual appraisals. Flexible working should not require justification and as far as possible should be offered regardless of role, team, organisation and grade.
- Investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit.
- Investing in an extra 250 foundation year two posts, to enable the doctors filling them to grow the pipeline into psychiatry, HEE 2020/21 general practice and other priority areas, notably cancer, clinical radiology, oncology and histopathology.
- Exploring the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration.
- Working with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training.
- Developing the educational offer for generalist training and working with local systems to develop the leadership and infrastructure required to deliver it.

68. Every NHS trust, foundation trust and clinical commissioning group must publish progress to ensure that at every level the workforce is representative of the BME workforce. There should also be a new quarterly staff survey to better track staff morale.

Workforce supply

69. It is disappointing to report once again that the NHS does not have a published workforce plan.

70. The NHS People Plan is supported by NHS HR, yet directors of HR have commented to us that it does not say fully how our workforce shortage, of around 100,000 staff vacancies, will be addressed. Perhaps this is not surprising as the plan does not come with new resources. Recruitment of staff from abroad is becoming more difficult due to the global effects of the pandemic, and filling vacancies with home-grown talent is at best a medium-term fix because of the time taken to train a new starter.

71. We believe that workforce planning in the NHS must be a continual process to align the needs and priorities of the system with those of the workforce. This needs to be supported

through long-term investment in training and development given the length of time it takes to train staff, particularly doctors. Evidence-based workforce development strategies will enable us to factor in the long-term impacts of the pandemic on the existing workforce.

72. The features employers want to see in our workforce planning at both local and national level are:

- based on health and social care strategy and business plan
- focused on future need
- flexible enough to deal with constant change
- subject to constant feedback and review
- planning for staff numbers and skills, staff potential and how staff will be deployed and organised.

73. NHS leaders advise us that we will need to plan to recruit staff with new and different skills sets to match the requirements of new care settings, technological developments and new integrated models of service delivery. Multidisciplinary team working will be more important, as will the need for staff to use a broader range of skills in a wider range of settings.

74. It is also disappointing that we do not have a workforce plan for social care, where the impacts of the pandemic have been so severe on both care users and staff. Now, more than ever, we need a comprehensive workforce plan for health and social care.

75. It is important to recognise that the NHS has experienced workforce supply issues for several years and that this has been exacerbated by the COVID-19 pandemic. Although steps have been taken to increase medical school places by 1,500, it will take some time to translate these into trained clinical staff.

76. Although the medical workforce has grown, so has demand and the difficulty has been to ensure that there are the right numbers of staff in the right places to meet patient need. We therefore need to continue to recruit doctors through domestic and overseas supply and to retain doctors at all stages of their careers.

NHS People Plan and the role of employers

77. The NHS People Plan[31] now gives employers a clear set of actions and workforce supply priorities for the coming months. However, it does not provide an immediate solution to years of disinvestment and clinical staff cannot be domestically grown overnight.

78. The NHS People Plan calls for employers to overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community, and regional and national labour markets. NHS Employers will continue to help guide employers through the various recruitment strategies, tools and resources available to them to achieve this. In line with the Interim People Plan, the NHS People Plan recognises that doctors, along with other

[31] Ibid.

groups, are in shortage and commits to address this through return to practice initiatives, flexibility for junior doctors and a focus on expanding shortage specialties.

79. The Interim NHS People Plan committed to recruiting more doctors from overseas in the short-to-medium term, which is supported by NHS Employers through a best practice toolkit to support employers to effectively recruit from overseas and retain these staff. The NHS People Plan does not specifically mention overseas doctor recruitment, however the UK will still need to attract and recruit to the medical workforce from overseas to support domestic recruitment efforts. It will of course be important to bear in mind the impact of the second and potential future waves of the current pandemic and further potential immigration restraints.

Immigration, COVID-19 and Brexit

80. The COVID-19 pandemic has had a significant impact on the numbers of overseas recruits able to travel to the UK. Border closures and worldwide lockdown made it impossible for candidates to travel. In addition, some countries enforced deployment bans, preventing individuals from leaving countries when borders reopened, to support the crisis in their country of origin.

81. Overseas recruitment and travel have picked up recently, however the growing pandemic could further prevent inflow into the UK. Of course, COVID-19 did not just have an impact on overseas supply. HEE undertook extensive work to ensure the maintenance of trainees' recruitment in August, and NHSEI's bringing staff back campaign and the fast-tracked introduction of medical students, provided additional capacity.

82. The Home Office and regulators put in place a series of measures to enable overseas candidates already here in the UK, to extend their visas and join temporary registers, to enable them to help support the pandemic. Work continues to support the ability to move from temporary to permanent registration.

83. Of the current medical workforce, 71 per cent of hospital and community doctors are British[32], which is a lower figure than other NHS staff categories. 13.5 per cent (16,523) of doctors report an Asian nationality and two thirds of these are from India or Pakistan.

84. Since the June 2016 referendum, NHS Employers, together with NHS Providers and The Shelford Group, have carried out a quarterly survey of NHS organisations on the impact Brexit is having on the workforce. The results of over two years' worth of data are available on the NHS Employers website[33]. The pandemic has prevented issuing a more recent survey to employers.

85. The numbers of hospital doctors with known EU nationality has slightly increased from 10,686 in June 2018 to 11,155 as of January 2020[34].

86. The introduction of the Home Office EU settlement scheme, now having received over four million applications, reassures EU staff of their rights to remain and work in the UK. NHS

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[32] House of Commons Library (2020), Briefing Paper, Number 7783 4 June 2020
[33] NHS Employers (2019), The Impact of Brexit on the NHS Workforce
[34] Ibid.

Employers continues to support the Home Office to highlight the scheme to employers so they can support and encourage their EU staff to apply ahead of the June 2021 deadline.

87. The Migration Advisory Committee's (MAC) shortage occupation list (SOL), published by UK Visas and Immigration, has acknowledged workforce shortages for some time and the list continues to include all medical practitioners.

88. The current Tier 2 points-based route and sponsorship system (due to change in January 2021 to the skilled worker route) remains unattractive for smaller providers such as GP practices, as the recruitment costs are disproportionate.

89. The new points-based immigration system incorporates a new health and care visa, which benefits from quicker three-week processing times, lower fees and exemption from the immigration health surcharge. Individuals here in the UK, who paid the surcharge after 31 March 2020, are eligible for a reimbursement.

90. The new immigration system no longer requires employers to demonstrate the resident labour market test and the cap on the numbers of certificates of sponsorship issued each year is currently suspended.

91. NHS organisations 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 NHS Employers international recruitment toolkit demonstrates the importance of pastoral support to help overseas recruits settle into their new roles and communities in the UK.

92. Ethical overseas recruitment is a key government priority across England and the devolved administrations, and work is underway to update the Code of Practice for International Recruitment and the list of countries that should not be targeted for overseas recruitment.

93. In May 2019, MAC[35] alluded to a disparity between the pay of migrant workers and their domestic counterparts. NHS Employers has engaged with employers to try and determine any differences in pay and reasoning for this. Recruitment practice does differ, with some organisations recognising experience in host countries. NHS Employers continues to look at any disparity and communicate with employers to help ensure consistency in practice across the country.

The Workforce Race Equality Standard and the medical workforce

94. The Workforce Race Equality Standard (WRES) was introduced in 2015 to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In September this year, a bespoke set of WRES indicators was developed for the NHS medical workforce.

95. Four of these indicators reflect pay and six represent the perception of medical staff about how they feel treated by colleagues, their employers and patients. Indicators include:

- the percentages of staff by ethnicity in those pay bands covering non-medical staff and very senior managers

[35] The Migration Advisory Committee (2019), Full Review of the Shortage Occupation List.

- the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants
- the relative likelihood of BME staff entering formal disciplinary process compared to white staff
- the percentage of deferred decisions of revalidation
- the percentage of staff experiencing bullying and harassment from patients and the public over the previous twelve months
- the percentage of staff experience bullying and harassment from other staff
- the percentage of staff who have personally experienced discrimination at work.

96. The development of these indicators was influenced by a 2018 report by the Royal College of Physicians, which found evidence that trainees from BME backgrounds, were less successful at consultant interviews. This report was part of an annual survey of medical certificate of completion of training (CCT) holders, monitoring career progression.

97. Surveys from previous years showed that candidates from white ethnic backgrounds applied for fewer posts but were more likely to be shortlisted and to be offered a post. This year's survey results show that this is still the case.

98. White respondents had a 98 per cent chance of being shortlisted after their first application, compared with 91 per cent of BME respondents. This gap widened even further when it came to the likelihood of being offered a post the first-time round. Twenty-nine per cent of white respondents were offered a post after being shortlisted for the first time, compared with just 12 per cent of BME respondents[36].

99. There is still much to be done to deliver true equality of opportunity. Managers, doctors and the wider clinical team need to confront and eliminate the discrimination faced by BME colleagues in their workplaces and careers.

Wellbeing and engagement

Wellbeing in the NHS pre-COVID-19

100. Despite efforts from employers and national organisations, the wellbeing of the NHS workforce was already under significant pressure pre-COVID-19 and has been for some time.

101. The 2019 NHS Staff Survey found that 40.3 per cent of respondents reported feeling unwell due to work-related stress in the previous 12 months (this score has been steadily increasing since 2016)[37]. The survey also found that 56.6 per cent of respondents said that in the last three months they had gone to work despite not feeling well enough to perform their duties (there has been little change in this figure over the last three years). The national sickness absence rates rose from 3.8 per cent in April 2018 to 4.1 per cent in April 2019, which is the

[36] Royal College of Physicians (2019), 2019 Survey of Medical Certificate of Completion of Training (CCT) Holders' Career Progression
[37] NHS England and NHS Improvement (2019), NHS Staff Survey Results.

highest level reported at that time of the year in a decade[38]. The most common cause of sickness absence was anxiety, stress, depression and other psychiatric illnesses, which accounted for nearly a quarter of staff absences.

Impact of COVID-19 on staff wellbeing

102. NHS employers have told us that in the first wave of the pandemic, much of the workforce coped well but they are seeing the impact on individuals' mental health. They anticipate mental health issues will continue to develop in the coming months and years. This is consistent with the evidence base, which suggests that burnout and post-traumatic stress disorder may only start to emerge in the period following a crisis[39] [40]. Employers report to us anecdotally that the second wave has been much tougher than the first. Their staff are beginning to show signs of fatigue, exhaustion and emotional distress.

103. There are many ongoing studies exploring the impact of the COVID-19 pandemic on the wellbeing of the NHS workforce, several of which will explore the impact on different staff groups, such as those with a disability or from BME backgrounds[41] [42]. At the time of writing, the only published studies are relatively small-scale, however, they do provide indicative findings that the pandemic has had a negative impact on the mental wellbeing of a significant proportion of the NHS workforce.

104. Feedback from employers describes a breadth of issues arising from COVID-19 which have had, and may continue to have, a negative impact on the mental wellbeing of the NHS workforce. Specific issues include increased workloads and working hours; greater pressure and the impact of the hero narrative; emotional strain from seeing large numbers of patients dying; anxiety about their own and loved ones' health and infection risk; guilt experienced by those shielding or working from home; and worries about being able to provide high-quality care.

What employers have already achieved

105. There has been a significant amount of support for staff wellbeing put in place through the COVID-19 pandemic. This includes national support through wellbeing apps, a helpline, peer support and training for line managers[43]. Locally, employers have rapidly implemented comprehensive support packages for staff, building on existing wellbeing support.

106. Employers are committed to making continuous improvements for their workforce. Mersey Care NHS Foundation Trust is a pioneer of the just and learning culture approach in the NHS, building trust and empowering staff, whilst reducing bullying and blame[44]. Many NHS organisations are focusing on building staff engagement[45], encouraging freedom to speak

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[38] King's Fund (2019), NHS Sickness Absence: Let's Talk About Mental Health.
[39] Royal College of Psychiatrists (2020), Going for Growth.
[40] British Psychological Society (2020), The Psychological Needs of Healthcare Staff as a Result of the Coronavirus Outbreak.
[41] NHS Employers (2020), Disabled Staff Experience During COVID-19 Survey.
[42] NHS Confederation (2020), The Impact of COVID-19 on BME Communities and Health and Care Staff.
[43] NHS England and NHS Improvement (2020), Our NHS People Support Now.
[44] Mersey Care NHS Foundation Trust (2020), Just and Learning Culture.
[45] NHS Employers (2019), The Dudley Group NHS Foundation Trust Case Study.

up[46] and tackling stigma around mental health[47]. NHS Employers has been working with trusts for several years to support their approaches to retention, focusing on supporting new starters, career development, flexible working and flexible retirement[48]. We are continuing this work in partnership with NHSEI, to complement its direct support programme and the delivery of the NHS People Plan. NHSEI's direct support programme has reduced turnover in participating organisations by an average 1.6 per cent[49].

107. Employers have adapted their support to staff because of COVID-19. This has ranged from improved access to food and drink, and to mental health counselling. There was particular emphasis on setting up safe spaces (which have been referred to by different names in different organisations) where staff could take a break, talk with colleagues or just have time to reflect. However, trusts have seen a reduction in these safe spaces in the second wave of the pandemic due to services being reopened and space within the estate being extremely limited. On site and telephone support services were also extended.

108. Organisations also offered digital tools to assist with issues such as sleep, stress and resilience. Absence levels did rise substantially during the surge and it is anticipated that there will be an ongoing impact on staff health and wellbeing. The national support package is being sustained to the end of the year and employers are reviewing local provision to support this in the future. More specialist support is being developed with mental health trusts for those at higher risk.

109. Organisations have also adapted their approach to staff engagement during the pandemic. Initially organisations suspended usual staff engagement activity and focused on improved communication. After the initial phase, organisations developed a range of innovative methods to secure staff feedback. These included greater use of face-to-face team meetings/huddles, as well as a widespread shift to virtual meetings with senior leaders. Many organisations developed local staff surveys focused on COVID-19 issues to respond to staff concern. Real-time feedback tools were also successfully used in a range of trusts, as well as crowdsourcing for ideas to change services.

110. Despite these positive examples, the impact of this work is limited by continued workforce shortages. These shortages must be addressed if significant improvements to the wellbeing of the health and social care workforce are to be made.

111. Employers struggle to make the changes needed to prevent ill health and improve staff wellbeing without sufficiently staffed services. We know that organisations want to improve their approaches to flexible working, reduce the pressure and stress of high workloads on staff, and give managers and staff time to invest in their teams, their own development, and building positive and inclusive cultures.

112. It will take time to recover from the pandemic there needs to be a realistic expectation of what the NHS and our staff can deliver. The strain of working with COVID-19, together with the cumulative impact effects of restoring services, significant vacancy rates and a possible

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[46] NHS Employers (2019), Developing a Patient Safety Culture Through Freedom to Speak Up Case Study.
[47] NHS Employers (2019), Deborah Lee on Mental Health - Leading the Way and Tackling Stigma.
[48] NHS Employers (2019). Improving Staff Retention: A Guide for Employers.
[49] The Health Foundation (2019), A Critical Moment: NHS Staffing Trends, Recruitment and Attrition.

second peak will have a major impact on staff, and we must do all that we can to support them.

113. The wellbeing and sustainability of the NHS workforce should also continue to be supported nationally by:

- investing in educational training places to improve workforce supply into the NHS in the long term
- providing funding to enable employers make the changes outlined in the NHS People Plan to their working environments and people practices, reducing attrition and improving staff experience
- investing in accessible local wellbeing support packages for the health and care workforce, and supplement this where it makes sense to commission national services
- funding the training and deployment of additional mental health trained professionals to be available locally to support staff wellbeing
- continuing to provide a national attraction and recruitment campaign for health and social care to encourage applications from all parts of our communities to join the team.

5. TRANSFORMATION CHALLENGES

114. Staff should be at the heart of transforming services in the NHS and successful engagement, locally and nationally, will be essential if changes are to be sustainable in the long term.

115. The NHS Long Term Plan[50] set out a vision of integrated working across the health system and between health and social care. The aim is to integrate primary and social care, physical and mental health services, and health and social care. This is to be achieved by integrating teams of GPs and community health and social care staff. Teams in neighbouring GP practices will work together with local NHS, social care, and voluntary services. Flexible teams will work across primary care and local hospitals, meeting the health and care needs of the local community with inputs from GPs, allied health professionals, district nurses, mental health nurses, therapists and a range of professionals in reablement teams. Workforce shortages in social care have been made more difficult by an immigration system that does not permit recruitment of care workers, and this will have an impact on the NHS. The two systems are interdependent and integration will be difficult to achieve without sufficient staff with the right skills.

116. The NHS Confederation's NHS Reset[51] initiative reflects the widely held view, including among NHS leaders, that restoring the NHS to a pre-pandemic status quo would be to waste the huge amount of energy, ingenuity and creativity generated by clinicians and managers in response to the pandemic. The pandemic and the NHS's response to it should inspire new and innovative ways of working to secure lasting and sustainable changes to the planning and delivery of care.

117. The challenge is to do this while routine work is stepped up, at the same time as the NHS manages ongoing COVID-19 cases and develops contingency plans in case of a further wave of infections in the future. There is also likely to be a delayed surge in demand as the result of patients not presenting at GPs or A&E and as screening programmes are stepped up.

118. The NHS Reset report said that any reset must create a model for the NHS that supports integration, partnership working and cooperation between health and care services. However, there is still some uncertainty about how systems should operate and how they should be underpinned by legislation. To date, the role of systems has been limited by uncertainty about their form and function and they have developed within a policy framework that focused on competition rather than collaboration.

119. However, financial allocations for the second half of 2020/21 were made to local systems, adjusted through incentives and penalties to system-level performance in restoring elective capability. In making this change NHSEI said its expectation was that all organisations should

[50] Ibid.
[51] Ibid.

work together to ensure that resources are used to deliver maximum benefit for patients across the whole system.

120. The NHS Reset report argues that a future model of system working must be underpinned by the right financial framework. This must recognise that, in order to foster collaboration within systems, commissioning needs to move away from transactional relationships (such as those created through payment by results) towards an approach based on shared incentives, risk-sharing, and evaluation based on outcomes rather than activity.

Transformation and the workforce

121. New joint working will allow teams of health and care professionals to focus on supporting people with complex health and care needs to manage their chronic conditions. We hope this will result in more opportunities for staff to move between acute, primary, and social care. This flexibility to work with and between different health and care sectors needs to be reflected in the way the NHS employs its staff and in new approaches to career planning.

122. Requiring staff to repeat basic training when moving between care sectors is inefficient compared with having accredited training schemes. We will also need to consider what the publicly funded health and social care system's offer is to staff, and whether this involves guaranteed and consistent levels of pay, training, and easy transfer of training between roles, jobs, and locations.

123. Staff have shown great flexibility by adapting their working hours and practices, taking on different roles in different locations, changing job plans and pausing academic and continuing professional development (CPD) activity. It has also been a very stressful time for many staff and the full impact on health and wellbeing may not become apparent until the worst of the crisis is over. Staff may wish to go back to their normal roles, or they may wish to change their normal working patterns, roles, and responsibilities.

124. On the other hand, organisations might want to make permanent changes to jobs and rotas, such as more work scheduled at evenings and weekends or revised on-call arrangements, and other employment terms.

125. We will therefore need to work closely with national and local staff-side representatives to balance the wish to reset the planning and delivery of services, with the wish of staff to reset their working and professional lives and how they are supported, developed, recognised and rewarded.

126. Points noted so far in the NHS Confederation's conversations with the NHS:

- The need for terms and conditions of service that provide flexibility for employers to plan and deliver services effectively, enabling them to deploy and reward staff appropriately.
- A set of contingency arrangements within terms and conditions which can be easily adapted/introduced if there is a repeat of the pandemic.
- Renewed focus on the total reward offer, which demonstrates the value and importance of staff and which supports recruitment and retention. For example, we saw the positive impact of the suspension of car parking charges for staff.

- Engagement with employers on long-term pay and reward strategies to underpin a programme of recovery, restoration and reform.
- Commitment to empowering staff and giving them a voice, by learning from the public health/occupational health lessons related to the deployment of potentially vulnerable staff, (particularly BME staff) in certain roles and situations where they might be at risk.

127. The national workforce implementation plan places a stronger emphasis on the role of integrated care systems (ICSs) in workforce planning locally. It is likely that future systems will look to resolve workforce challenges collaboratively with partners within their system and across other systems. Our discussions to date have largely been centred around the needs and capacity of individual employers. In future, we will have to consider the role of systems in ensuring that the right staff, with the right skills, are in the right place to meet the evolving needs of their patients.

6. THE REMIT GROUPS

Doctors in training

128. The General Medical Council's (GMC) national training survey, published in October 2020, acknowledges the profound impact that COVID-19 has had on trainees and those who train them. Many trainees reported that the disruption had reduced their access to learning. Many had been redeployed, often working in unfamiliar settings.

129. However, the same willingness to change at pace seen across the NHS was also present within the training environment. Most trainees said that they felt supported despite the pressure. Around 80 per cent felt that their workplace encouraged a culture of teamwork between healthcare professionals and the same proportion said that they felt a valued member of their team[52].

130. In contractual matters, priorities for the negotiation partners currently include implementation of the outstanding contract amendments, agreed as part of the 2018 review of the 2016 terms and conditions of service (TCS) for doctors and dentists in training. Full details of the agreed improvements to the contract for doctors in training are set out in a framework agreement following negotiations between NHS Employers, the BMA and the DHSC[53].

131. There has been some delay in completing full implementation of the framework agreement as the result of the redirection of resources to support the COVID-19 response. This included a delay to the joint production of new or updated guidance on matters such as the Good Rostering Guidance and guidance on exception reporting.

132. To support the COVID-19 response, NHS Employers and the BMA agreed a joint statement that recognised it may not be realistic to maintain all the contractual limits, during the pandemic, and that a more pragmatic approach would be necessary. The parties agreed that when it was not possible to implement the relevant working hours restrictions and rest requirements in the TCS, they would be suspended and that the Working Time Regulations 1998 (WTR) would be the fallback position for the duration of the pandemic[54].

133. The BMA withdrew its support for the statement at the start of August as the NHS was de-escalating its COVID-19 response and reintroducing normal service activities. It has not been possible to secure a second joint statement on the same terms in support of the second COVID-19 surge. The BMA released a statement separately in October that promotes the need for strict adherence to the contractual terms and conditions of service.

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[52] General Medical Council (2020), National Training Survey 2020: Summary of Results.
[53] NHS Employers, British Medical Association (2019), Framework Agreement.
[54] NHS Employers, British Medical Association (2020). Joint Statement on the Application of Contractual Provisions during the Pandemic.

134. While the default position of adherence to the TCS is strongly supported by employers, the junior doctors' contract is viewed as rigid and inflexible and not entirely able to cope with the unprecedented pressures created by COVID-19 surges. Flexibilities do exist within the contract, but these are limited in scope so we believe that consideration of temporary adaptation of contractual terms may be necessary according to clinical/patient need. As there is no prospect of reaching a national agreement on the suspension of contractual terms, any divergence from the national TCS will need to be taken forward locally in line with the organisation's relevant policies and procedures.

Exception reporting

135. In the previous report, the review body noted that some concerns had been expressed during site visits about the effectiveness of the exception reporting system.

136. The guardian of safe working hours (GoSWH) role began with the introduction of the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The role is designed to reassure junior doctors and employers that rotas and working conditions are safe for doctors and patients, and helps to ensure that there are stronger protections on working hours and patterns. Guardians support safe care for patients through protection and prevention measures to stop doctors working excessive hours.

137. NHS Employers supports the GoSWH role in several ways. There is an extensive range of resources and information on our website and we hold an annual national conference for GoSWH. We also organise regular meetings of regional GoSWHs.

138. Over the last two years, significant issues relating to the 2016 TCS have been raised and addressed through the GoSWH meetings. Since the introduction of the junior doctor contract, the meetings have occurred twice a year and have provided an opportunity for GoSWHs to network with colleagues from other regions. They can share best practice, discuss current issues in each of their respective regions and resolve any ongoing issues with the experts. The regional GoSWH representatives are key to ensuring that safe working principles are adhered to and that concerns relating to hours are being shared and addressed nationally.

139. We spoke to several regional GoSWHs about how they thought the system had evolved and what changes could be made.

140. They each agreed that the process adds value. Trainees are given a voice, a mechanism through which to raise safety issues, and they can initiate positive change. Educational supervisors can be alerted to problems before trainees leave the organisation, and departments have been encouraged to use the outcomes of exception reports to help establish business cases for tackling staffing issues. The information also can be used to triangulate data generated by the national training survey. Medical staffing colleagues also fed back that exception reporting had increased as trainees become more familiar with the process, which has allowed them to make minor adjustments to rotas rather undertake wholesale change.

141. The GoSWHs pointed out that, unlike exception reports, the national training survey was anonymous. It was possible that some trainees thought that raising an exception report might be received negatively and that this might be reflected in future references.

142. The role of the education supervisor is important in ensuring that the system works well, and GoSWHs noted that there was variability in the time that some supervisors were able to assign to it and the administrative effort that could be required. However, overall, the regional guardians thought that exception reporting was working well and that it had brought tangible benefits.

Safety limits

143. Greater level of prescription in the new contract has led to less flexibility overall. Concerns regarding the new contractual limits both post- and pre-COVID-19, particularly with the weekend working provision, has led to filling rota gaps and increased cost in areas like emergency medicine, neonatal care and intensive care units. This is an additional cost to employers and was not costed as part of the £90 million investment to fund improvements in the contract in 2019. This change was due to be implemented across all trusts by August 2020, however due to COVID-19, many organisations paused the introduction so the full financial impact may take some time to emerge.

Trainees taking time out of training

144. The review body also commented on the increasing numbers of trainees who take time out of training at certain points during their career, usually at natural breaks within the training programme, and if this was now an established pattern that needs to be considered in workforce planning.

145. Employers tell us that this has indeed become increasingly common and can, at times, leads to difficulties in recruitment even though they also recognise that many continue to provide NHS services albeit in a different role.

146. Working outside a traditional training programme for a short while can help prevent burnout. Doctors can work more flexibility and enjoy a broader range of experience, which can include:

- opportunities to build CVs through projects and portfolio work without the demands of an on-call rota
- research
- locum work
- further education
- experiencing different specialties or exploring a specialty in more depth
- more experience in their chosen specialty
- travel
- a complete break to ensure that they are ready to move onto the next stage of training.

147. NHS organisations can often offer a range of incentives including additional training, research opportunities and study leave, so that doctors choosing to join them fulfil their wishes to work more flexibly and do something different and provide vital service activity as well.

148. This is often offered as an FY3 role, although jobs have a range of titles including clinical education fellow, clinical specialty fellow, locally employed doctor, junior specialty doctor or trust doctor.

149. We asked the medical staffing contract experts' group whether they had noticed if trainees were more likely to take a break in training. Just over half said that they had and there were mixed views on the impact. Some said that it had led to a reduction in junior doctor cover and an increase in bank staff use; others said that they had been able to recruit FY3 and established non-training grade rotas.

150. There does appear to be a well-established trend for an increasing number of doctors to take a break during training. The idea of a temporary break from the education and exam treadmill has even begun to take hold at medical school[55]. While this can have an impact on local workforce planning, employers are finding that offering non-training posts, such as FY3, can retain capacity within the NHS at the same time as meeting the evolving needs of doctors in training. HEE's work on the Out of Programme Pause initiative will provide further support for trainees choosing to step away from training for a short period.

Nodal point 5 (ND5)

151. The 2016 contract provided for a senior decision-makers' allowance to be introduced. However, during the 2018 review and contract negotiations, DHSC, NHS Employers and the BMA agreed that instead of an allowance, a fifth nodal point will be introduced for specialty trainees (ST) in years 6 to 8. This was to recognise the significant high-service contribution these trainees make.

152. There have been some conversations about how the new nodal point affects dentists in training, and whether it should be applied from ST4 for these trainees. Dentists at ST4 may gain the equivalent competencies to be eligible for ND5 however, as they do not progress to the ST6 grade (due to the training pathway) they do not qualify. ST6 was used as proxy for the eligibility of ND5 but does not take the progression route for dentists into account.

153. The DHSC maintains that ND5 should be applied to ST6s as per the agreement with the BMA. There are inconsistencies with the structure of the dental training pathway that will need to be clarified between HEE, dental deans and the British Dental Association (BDA) before any agreement is reached. It is not within the parties' remit to change the pay structure or alter the principles to accommodate any inconsistencies, but we are keen to explore this further at future meetings of the respective joint negotiating committees for junior doctors and employed dentists.

154. The BDA is preparing a formal case for dental trainees to be included within ND5, but this would present some cost implications as these trainees were not taken into consideration by the BMA during the negotiating stages. There is no new funding available, so if dental ST4 trainees were to be included then this would come from within the existing funding envelope.

[55] BMJ (2020), Harriet Kinahan, Stepping Off the Treadmill - the Reality of Taking a Year Out of Medical School.

Specialty and associate specialist (SAS) doctors

155. As of March 2020, according to NHS Digital, there were around 10,717 doctors on SAS terms and conditions in England, including 2,149 associate specialists, 8,193 speciality doctors and 375 on staff grade or other closed contracts.

156. Work has been undertaken to better understand the number of SAS doctors, with improved datasets being developed for contract negotiations. However, difficulty remains in identifying those employed on national terms and conditions compared to those employed on local terms and conditions, particularly for the associate specialist grade, as there is no way of separating the two on the Electronic Staff Record (ESR).

157. The review body has previously noted the significant proportions of female and BME SAS doctors within the workforce, and the numbers of SAS doctors reporting bullying and harassment. Bullying and harassment and the day-to-day working life experience has been raised and discussed in contract negotiations many times. However, conversations have been driven by issues across the grade rather than those which apply specifically to certain groups. For example, pressure to work at certain times or on unfavourable shifts, or having work taken away and given to other members of staff, are common experiences across all SAS doctors. The negotiating parties are looking at ways to improve the experience of SAS doctors both in the current round of discussions on contract reform and through guidance and other support.

158. The review body said in its previous report that it expects a new contract to be in place by April 2021 and that the extra one per cent awarded to SAS doctors last year, which the government decided would be contingent on contract reform, will be included in the funding envelope. We describe the progress on contract reform further below.

159. In its previous report the review body expressed concern about slow progress in promoting and embedding the SAS charter. Our work programme this year has focused primarily on SAS contract reform, but we have continued to promote our existing SAS charter resources through our usual communications channels. We have also started using Twitter, using the hashtag #SASdoctors to promote the SAS charter and other resources to support SAS doctors.

160. The impact of COVID-19 has meant that many programmes of work have had to be paused whilst organisations focused their efforts into supporting the COVID-19 response. This has included the delay in publishing the HEE and NHS Improvement one year on report, Maximising Potential; Essential Measures to Support SAS Doctors. The report will highlight the ongoing of work of stakeholders to progress each of the 11 commitments set out in March 2019. This includes NHS Employers' work to support the implementation of the SAS charter, raise awareness of guidance and ensure that the SAS role is supported, developed and promoted as a career.

161. NHS Employers has led on the review of the SAS development guide, originally published in 2017. The updated guide was published in September 2020 and included more information on CPD, autonomous working and extended roles for the SAS workforce. Eight new case studies have been included to promote examples of SAS development programmes, certificate of

eligibility for specialist registration (CESR) support, and the inclusion of SAS doctors in different leadership roles across the NHS[56].

162. The GMC surveyed SAS doctors in 2019, offering further insight into the challenges faced by SAS doctors. The GMC brought together stakeholders from across the four home nations to discuss the findings and explore opportunities to work together. This group has sought to collate all the work already ongoing across the four nations and to highlight the gaps and priority areas such as implementing the SAS charter. The group was due to meet later in 2020 to bring together a four-country action plan to support SAS doctors, but this was postponed due to priority work on COVID-19.

SAS contract reform

163. On 24 February 2020, NHS Employers and the BMA received a mandate from government to start negotiations for SAS contract reform in England and Wales. Northern Ireland officially joined the negotiations on 7 July. Heads of terms were published in July 2020, which set out the key areas for discussion[57].

164. The negotiating teams have continued to work towards the original timescale for implementation of revised terms and conditions from April 2021. After only two face-to-face negotiating meetings, the negotiating parties were forced to continue virtually due to the COVID-19 pandemic. Two meetings were lost due to both the clinical and non-clinical pressures on both sides of the negotiating teams as the result of the COVID-19 response.

165. In December 2020, parties concluded negotiations on two contracts, a new specialty doctor and a specialist grade contract that will replace the closed associate specialist grade. The framework agreement is going through usual procedures for sign off and if approved will be put to a referendum of BMA members in the SAS grades for implementation from April 2021. Further detail of the contract package will be made available once the framework agreement has been approved.

166. To support negotiations, a separate working group was established, bringing together expertise from stakeholders across the system, to define the new specialist grade including the broad roles and responsibilities a doctor in this grade will undertake.

167. We have continued to see an increase in the number of trust associate specialist posts being advertised and appointed to. In September 2020, NHS Employers ran a brief survey to which 47 employers responded. Just under half of trusts responding to the survey had appointed doctors into trust associate specialist posts on local terms and conditions. Approximately 167 posts in total were identified.

168. The survey also highlighted that 46 out of 47 trusts were expecting to use the new grade once it became available, citing a variety of reasons including but not limited to: providing career progression for specialty doctors, helping meet service need and helping with recruitment and retention.

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[56] NHS Employers (2020), SAS Doctor Development: Summary of Resources and Further Work.
[57] NHS Employers (2020), Heads of Terms for SAS Contract Reform

Consultants

169. There is no remit from government to explore consultant contract reform beyond the work that is currently underway on the reform of the Local Clinical Excellence Awards (LCEAs).

170. The impact of COVID-19 meant that an LCEA round was not run for the current year 2020/21. Instead, money allocated to LCEAs is to be distributed equally among eligible consultants.

171. Following representations by NHS Employers, the BMA and HCSA, the government acknowledged the exceptional circumstances caused by the pandemic and the resulting significant operational pressures. An agreement was reached to halt the LCEA round and related work to allow clinicians and managers to focus on immediate priorities. As a result, the current interim arrangements have been extended for a further year.

172. It was also agreed to redistribute funding equally among all eligible consultants as a one-off, non-consolidated payment, in place of the normal LCEA round. The existing funding includes any money rolled over from the last two years, including money from previous award rounds that may not have been run or completed so far. The investment ratio for this current year has been agreed and discussions to agree the ratio for year four (2021/22) are continuing.

A new reward system for NHS consultants

173. The DHSC has asked NHS Employers to develop, through negotiation with key stakeholders, a new LCEA scheme to succeed the transitional arrangements from April 2021. In contrast to other medical and dental contracts, the consultant contract has seen very little change since it was implemented in 2003. Employers and consultants now have a real opportunity to design a new reward system for around 50,000 doctors in England that is fair and open to all and rewards excellence across the full range of consultant activity. However, we would have preferred to have done this as part of a wider programme of consultant contract reform and modernisation. The findings in the gender pay gap review have shone a light on equality issues associated with the current contract. We appreciate that this would require investment at a time where the country faces financial and economic challenges, but we still believe reform to be important.

174. A collective agreement between NHS Employers and its trade union partners will therefore be required to establish and implement a successor scheme arrangement through amendments to Schedule 30 of the terms and conditions of service for consultants - England (2003). If this is not possible then the default arrangements currently set out in Schedule 30 will apply. This allows employers to introduce changes to the structure of the LCEA scheme following engagement with local negotiating committees (LNC). There will be several protections in place for consultants that have been agreed as part of the settlement. The protections stipulate that:

- existing awards granted before 2018 will continue to be protected but they will be subject to a review process
- the overall value of the scheme will be maintained (at least £7,739 per eligible consultant)
- awards rounds will continue to be run

- the national award reversion mechanism will remain
- there will continue to be an appeals process.

175. There is a consensus that the LCEA scheme, which has existed in one form or other since the inception of the NHS, is flawed. Employers and doctors report that it is administratively burdensome and that it exacerbates inequities for doctors in certain groups, such as women, those from the BME community, those who work part time, and those in specialties where excellence is not straightforward to demonstrate.

Employer survey

176. NHS Employers recently surveyed employers to inform negotiations that we are undertaking on their behalf. In doing so we encouraged employers to think creatively about how a new system could be built, rather than making further adjustments to a scheme which the parties acknowledge does not work well for all.

177. We received 104 responses from employers on questions relating to:

- the principles on which the new reward system should be established
- the areas in which quality and excellence should be recognised
- the design and delivery features that any new system should incorporate
- how to ensure fairness and equity in scheme design
- whether employers would prefer a national framework with some local flexibility, a more prescriptive framework, or to be able to design and agree their own schemes.

178. The data is currently being analysed so that we can reflect employer priorities during negotiating meetings. However, some headline findings have emerged:

- There is a clear desire for change and for a system that is simpler, fairer and more inclusive. The preference seems to be for national guidance, with flexibility to allow employers to implement systems according to their local priorities and workforce.
- Excellence should continue to be demonstrated through clinical skills but also through contributions to patient safety, quality improvement, leadership, team working, and the delivery of organisation and system objectives.
- The LCEA system disadvantages groups of consultants because of gender, ethnicity, disability, or because of where they work or their patterns of work.
- Removing the requirement to apply for an award would help to resolve many of the issues of inequity and unfairness.
- There should be links to existing systems and processes, such as job planning and the appraisal system, with greater clarity of what would be necessary to secure an award.

- There should be more support for underrepresented groups with a focus on making the scheme more attractive and accessible.
- Equal recognition for less-than-full-time consultants.
- Assessors should be better supported and reflect the diversity of the workforce.

179. A very small minority of respondents said that there should not be an awards system at all, suggesting instead that the available funds should either be added to the base pay of all consultants, or invested in development and wellbeing programmes.

Plans and timeline for negotiations

180. Negotiations were due to start in the spring of 2020 but were postponed due to the pandemic. Discussions have now recommenced, and the intention is to work through the various phases of negotiation, covering the development of underlying principles, scheme details, engagement and consultation. The aim is to agree a new scheme which will be in place on 1 April 2022 so that employers can begin their own process for issuing awards in the autumn of 2022.

181. In addition to our survey of employers we have begun to engage with other stakeholders, including those representing minority groups, clinical academics and other interested parties such as the gender pay gap in medicine team.

Retaining consultants

182. The review body has commented on the number of consultants taking earlier retirement and importance of retaining such skilled and experience doctors. The pensions and tax issues have undoubtedly influenced the decisions of some doctors, but there are other factors that affect the choices of those later in their careers. We discussed some of these retention issues with members of our NHS management team leading the current negotiations on LCEAs.

183. One organisation surveyed consultants over the age of 50. They found that reducing or stopping unpredictable on-call work and working fewer hours more flexibly, were the main factors that would influence their decisions to continue working. Some consultants within the organisation would be content to swap unpredictable on-call work for more predictable weekend daytime work, thereby still contributing to cover for unsocial hours. Pensions are clearly an issue, but workload intensity seems to be an increasingly cited reason for leaving. Others want to face new or different challenges.

184. One of our employer representatives pointed out that the pensions issue is particularly relevant for those consultants who are still in the 1995 scheme, which matures at age 60. The advice is generally to retire and return if they want to continue working. However, they were less sure what would happen with those in the 2015 scheme who reach their mid-to-late 50s with a significant pension pot.

185. Another said that workload and intensity had increased generally, and many specialities find it difficult to accommodate older consultants due to rota requirements. There also needs to be more thought given to job development away from frontline services.

186. These themes are consistent with the findings of surveys carried out by some of the Colleges. The Royal College of Obstetricians and Gynaecologists published its Late Career and Retirement Report in March this year[58]. Its recommendations include:

- improving flexibility of job plans during later careers
- reducing or stopping on-calls at 55-60 where desired
- recognising and celebrating the skills of senior colleagues through teaching and mentorship of newer colleagues
- ensuring that the pension taxation system does not prevent those who want to provide extra sessions from doing so
- improving workplace culture and addressing burnout
- reducing the administrative burden of revalidation.

187. Some of these recommendations are more challenging for employers to implement than others, particularly while they are trying to accommodate the flexible working requirements of other doctors and health professionals. However, this also presents an opportunity for more involvement of SAS doctors in areas where they have the skills and experience to contribute, as well as the deployment of medical associate professions and others within the multi-professional team.

Salaried primary care dentists

188. Salaried primary care dentists are a relatively small group of dentists spread across a varied group of providers within different sectors. In the past this has meant it has been difficult to obtain a range of employer views on issues concerning the recruitment, retention and morale of salaried dentists.

189. Earlier this year a small group of employers responded to a short survey and provided us with their views. The size of the sample limits the extent to which any broad conclusions may be drawn across the whole workforce, but it does at least provide a snapshot of some of the issues facing some employers of salaried dentists.

190. We first asked about difficulties in recruiting and all said that this was the case. One employer said that recruitment had traditionally been difficult due to their rural location. Remuneration was lower than in high-street dentistry and that there was a lack of career progression within the salaried service. They thought that undergraduates were seldom exposed to special care patients and that salaried careers were not fully understood or valued. There are few vacancies at higher bands, so pay can seem artificially low when dentists are undertaking higher-grade work or have the competence to do so.

[58] Royal College of Obstetricians and Gynaecologists (2020), Later Career and Retirement Report.

191. Another employer commented that budgets and commissioning arrangements had not changed over the years, so there were few posts at consultant or specialist band C level that might attract new and ambitious dentists.

192. Other reasons given for recruitment difficulties were a general workforce shortage and less attractive locations away from larger teaching hospitals and professional networks. There was some agreement that the salary was not as attractive as that available in high-street dentistry and that they had not kept pace with remuneration in the private sector. There is no allowance within the contract for working extended or unsocial hours.

193. There was some agreement across our employers that retention was less of a problem. Where dentists had been lost, this was due to either work-related stress linked to lengthy waiting lists, no opportunity to progress, or no access to flexible working. Workload has increased in volume and intensity, but the workforce has not increased in proportion. One employer described wider system access as an issue, with a lack of capacity on the high street adding to their client base of those for whom registration is a problem. Another said that while retention was good at bands A and B, some band C dentists had left either to progress their careers or to reduce travelling time.

194. There were mixed views on morale. One employer said that while many dentists valued the interaction they have with patients and the results they were able to achieve, they were weary of organisational change, and changes to commissioning arrangements that predated the impact of the pandemic. Another employer described the positive response to the challenges of COVID-19 and the pride that dentists had taken in their role, but also said that they were feeling the pressure of very high demand for both urgent and routine care. Morale had been good where dentists had been able to build networks across merged services; community-based roles can sometimes feel a little isolated from the organisation.

195. We asked what support and development was offered to salaried dentists. This included in-house training for certain procedures, opportunity to study for postgraduate qualifications, leadership training, joint training with specialists and consultants, and funded study leave. One employer said that they had found hosting dental trainees had generated some enthusiasm.

196. However, one employer said that in their view, salaried dentistry was something of a 'Cinderella service,' falling in between the structures to support medical education and the allied health professions' framework. More support should be given to help trust HR teams to better understand dental contracts.

197. We asked how conditions for salaried dentists could be improved. Suggestions included some way of recognising additional qualifications within the pay structure rather than relying on a vacancy at a higher banded post. For example, the current extended competency points could be extended to form an intermediary band to recognise additional responsibilities. At the moment, service budgets do not allow for this. Although one employer paid a local out-of-hours allowance, another said that there should be agreed enhanced rates for out-of-hours work. Finally, one employer noted that the pay structure itself had not changed since 2008.

7. PENSIONS AND REWARD

The NHS Pension Scheme

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

Member contributions

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

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

200. Employee contributions are currently under review by the NHS Pension Scheme Advisory Board (SAB), with any changes likely to be implemented with effect from 1 April 2022 to coincide with the end of the remedy period for the age discrimination ruling in public sector pension schemes). The board's considerations to date include:

- determining employee contributions based on actual pay, to better reflect career average revalued earnings accrual
- avoiding 'cliff edges' where a pay increase forces an individual into the next contribution tier, sometimes leading to a reduction in take-home pay
- exploring ways to minimise opt-outs.

Employer contributions

201. The employer contribution rate for both the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme increased to 20.6 per cent of pensionable pay from 1 April 2019. This rate was determined by the funding methodology applied by the scheme actuaries during the 2016 scheme valuation[59].

202. Employers pay a scheme administration levy equal to 0.08 per cent of pensionable pay, in addition to the standard employer contribution rate. In 2019/20 and 2020/21, NHSEI centrally covered the additional employer's pension contribution of 6.3 per cent for employers receiving funding from NHS England budgets or from the NHS, to deliver NHS services.

Age discrimination ruling in public sector pension schemes

203. In December 2018, the Court of Appeal ruled that the transitional protection given to older members of the judges' and firefighters' pension schemes during the 2015 scheme reforms gave rise to unlawful discrimination on the grounds of age. The transitional protections allowed members who were close to retirement age at the time of the 2015 scheme reforms to stay in the final salary schemes until retirement, or to delay moving to the new career average schemes. The government sought permission from the Supreme Court to appeal the ruling, but this was denied.

204. It was confirmed that the ruling applies to all public service pension schemes, including the NHS Pension Scheme. The government is required to introduce a remedy to compensate affected members for any loss. HMT published its consultation to gather views on proposed remedy options on 16 July 2020.

205. The consultation outlined that affected members will be given a choice of whether they receive benefits from their legacy scheme (1995/2008) or from the reformed (2015) scheme for the remedy period. The remedy period will be between 1 April 2015 and 31 March 2022. The consultation outlined two options for when this decision is made: immediate choice or deferred choice. It is proposed that all members would move to the 2015 scheme on 1 April 2022. We responded to the consultation on behalf of employers[60].

[59] Government Actuaries Department (2016), NHS Pension Scheme: Actuarial Valuation 31 March 2016.
[60] NHS Employers (2020), NHS Pension Scheme Consultations.

Pension taxation

206. We reported in our evidence to the pay review bodies over the last few years about the impact of the annual allowance and lifetime allowance pension tax limits. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years, and the introduction of the tapered annual allowance, meant that more staff were likely to be affected.

207. In our evidence last year, we reported that employers were particularly concerned about the impact on staff retention, with employees requesting to reduce their hours, refusing additional work, taking early retirement, and avoiding promotions due to pension taxation. This was having an impact on workforce capacity, service delivery and patient care.

208. During the 2019/20 scheme year, 16,405 members (approximately 0.95 per cent of the total membership) breached the annual allowance and 1,841 members (approximately 0.11 per cent of the total membership) accrued benefits worth more than 100 per cent of the current lifetime allowance.

209. In 2019/20, HMT undertook a review of the annual allowance taper and in the Budget on 11 March 2020 it was announced that the income thresholds associated with the taper would each be increased by £90,000.

210. From 6 April 2020, these now apply to those whose threshold income is greater than £200,000 and whose adjusted income is greater than £240,000. Those with a total income of less than £200,000 will now not be impacted by the taper, with modelling suggesting that 98 per cent of consultants and 96 per cent of GPs will now not be affected based on their NHS earnings. These changes apply to all parts of the economy and therefore to staff groups across the NHS workforce, including those in clinical and non-clinical roles.

211. As we reported last year, employers were taking a range of mitigating actions to support those staff affected by pension tax. However, since the changes to the taper, some of these initiatives have now been withdrawn or reviewed.

212. Employers tell us that some staff who had opted out for these reasons have now opted back into the scheme, although some said that it was difficult to tell the full extent as COVID-19 struck at the same time as the Budget changes were introduced.

213. One employer said that they expected waiting list initiative (WLI) work to pick up, particularly in specialties in which activity had been curtailed due to the pandemic. On the other hand, another employer said the arrival of annual pension statements might lead to some consultants deciding not to undertake WLI work. In some cases, consultants who had reduced sessions had stuck to their new work patterns. We believe that, given the impact of COVID-19 it will take a while for the impact of the changes to become fully apparent.

NHS Employers' guidance

214. NHS Employers has published updated guidance[61] on the optional measures employers may implement to support staff and service delivery for those still impacted by pension tax.

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[61] NHS Employers (2020), Local Options for Affected Staff.

215. We have also produced an NHS Pension Scheme Annual Allowance and Tax Ready Reckoner, which is designed to help staff understand the benefits they are building up in the scheme and the annual allowance (AA). The ready reckoner provides members of the NHS Pension Scheme with a broad insight into their AA position, including whether the tapered AA may apply to their circumstances. It also provides an estimated breakdown of the total annual cost of scheme membership and estimates by how much their NHS pension is projected to increase. The ready reckoner presents staff with a traffic light system to assess the potential risk of breaching their annual allowance. The purpose of the traffic light system is to highlight when an employee can have relative comfort in their position, or when they ought to be seeking independent financial advice. The tool looks at the 2020/21 tax year only.

216. We continue to produce resources to raise awareness and improve understanding of the annual and lifetime allowance, including the changes that were announced in the March 2020 Budget. We published a refreshed pension tax web section in October 2020 to support employers and their staff.

Scheme flexibilities

217. The DHSC consulted on proposals to change the NHS Pension Scheme, to address the impact of pension taxation on NHS staff, organisations, and service delivery.

218. The proposals were designed to make the scheme more flexible, enabling members of the scheme to control the value of their pension growth. The DHSC sought views on the following proposals:

- Introduce a new flexible accrual option that would allow senior clinicians to choose to build up a lower level of pension benefits and pay correspondingly lower employee contributions. The options available would range from almost zero to 100 per cent, in 10 per cent increments.
- Allow scheme members to phase their pensionable pay increases over a set period to avoid spikes in pensionable pay that can create annual allowance issues.
- Assess who pension scheme flexibilities should be available to.
- Improve scheme pays.
- Provide support and guidance for individuals.

219. In our response we said that while we broadly supported the introduction of flexibilities, we strongly believed that they should apply to all staff. We also included research from First Actuarial showing the relationship between extending flexibilities to all staff: higher participation rates in the NHS Pension Scheme, higher levels of staff retention and better patient care and service delivery.

220. In the Budget on 11 March 2020, it was confirmed that the government will no longer be pursuing pension flexibilities options for clinical staff following the consultation.

221. Our research suggests that lower earners may be caught between choosing to either be full members of the scheme, or not at all. Introducing a more flexible reward offer could help lower earners participate in the Scheme and find the right balance between in-work affordability and in-retirement adequacy.

222. As set out in the NHS People Plan 2020/21: 'if we do not take radical action to become a flexible and modern employer in line with other sectors, we will continue to lose people entirely or see participation rates decline.' We believe that greater flexibility for all staff will go some way to providing a modern reward offer. The introduction of greater scheme flexibilities will ensure that membership of the NHS Pension Scheme is attractive, affordable and accessible for all staff with competing financial priorities. This will ensure the scheme remains a valued part of the reward offer, to support recruitment and retention across the NHS.

Compensation scheme

223. NHSEI wrote[62] to local health leaders regarding pension tax arrangements in 2019/20 for all members of the NHS Pension Scheme who are in active clinical roles. NHS England confirmed the use of the existing scheme pays option for annual allowance charges arising in 2019/20, which allows members to ask the NHS Pension Scheme to pay their annual allowance tax charge to HMRC on their behalf.

224. Normally, in return, the member's benefits in retirement would be reduced by a corresponding amount. However, where a clinician incurs this reduction because of using scheme pays, the employer will make an additional payment, equivalent to the reduced pension benefits, to the member on retirement.

225. NHSEI has confirmed this will be funded nationally and it will provide employers with financial support to ensure employers do not face additional costs because of this arrangement. NHS Employers has communicated the arrangements to employers so that they can make staff aware.

Actuarial valuation 2016

226. The results of the 2016 actuarial valuation were published in February 2019. The valuation has two key objectives:

- To assess the cost of benefits against the cost cap mechanism.
- To set the required employer contribution rate from 1 April 2019 to 31 March 2023.

227. The valuation results showed that the cost of the benefits provided by the scheme has fallen to a point where scheme changes are required to bring scheme costs back in line with the cost cap. The fall in costs is predominantly due to pay increases and life expectancy improvements being lower than expected. Scheme changes are required to either improve member benefits or reduce member contributions.

228. The SAB has developed a recommendation for the DHSC on how the cost cap breach should be rectified. However, the current level of uncertainty around scheme costs due to the age discrimination ruling meant the cost cap process was paused. The government has announced that the pause of the cost control mechanism will be lifted, and the cost control element of the 2016 valuations process will now be completed. The costs of addressing the discrimination identified in the McCloud judgment will be included in this process, and HMT

[62] NHS England and NHS Improvement, 2019/20 Pensions Tax Annual Allowance Charge Compensation Policy.

will set out in the directions the technical detail of how these costs should be considered in the cost control element of the valuations process.

Actuarial valuation 2020

229. The 2020 actuarial valuation will go ahead as expected with any changes due to be implemented in 2023. As a result of the cost cap breach, the government has asked the Government Actuary's Department to conduct a review of the cost control mechanism. It is expected the review will conclude in time for the 2020 valuation.

COVID-19 response

230. The emergency legislation in response to COVID-19 enabled recently retired professional staff to re-join the workforce, through nationally and locally co-ordinated processes. The COVID-19 bill suspended several rules that may have prevented staff from returning to the pension scheme. These included:

- suspension of the 16-hour rule, which currently prevents staff who return to work after retirement from the 1995 NHS Pension Scheme from working more than 16 hours per week in the first four weeks after retirement
- suspension of abatement for special class status holders in the 1995 scheme
- suspension of the requirement for staff in the 2008 Section and 2015 NHS Pension Scheme, to reduce their pensionable pay by 10 per cent if they elect to draw down a portion of their benefits and continue working.

Scheme membership

Opting out of the NHS Pension Scheme

231. Total membership of the NHS Pension Scheme is around 1.6 million. The data below summarises the number of staff who chose to opt out of the NHS Pension Scheme from April 2019 to March 2020 and the reasons for opting out.

Month	Total	Affordability	Annual allowance/LTA	Contributing to another pension scheme	In receipt of a fixed or enhanced protection certificate	Other	Secured retirement income via other means	Temporary opt out due to other financial priorities	Would prefer not to say	No reason given	Number of joiners
Apr-19	8,076	2,789	354	1,541	69	90	423	2,544	51	215	33,264
May-19	12,741	4,620	405	2,027	48	202	808	4,226	98	307	47,673
Jun-19	11,972	4,259	488	1,834	51	197	756	4,166	82	139	33,905
Jul-19	14,262	5,311	539	2,119	54	145	957	4,907	82	148	34,404
Aug-19	12,416	4,368	461	1,966	39	136	777	4,481	66	122	38,621
Sep-19	11,521	3,953	490	2,020	41	135	688	4,056	47	91	57,431
Oct-19	12,000	3,780	564	1,994	29	87	768	4,616	28	134	45,518
Nov-19	9,932	3,324	494	1,690	20	50	551	3,712	17	74	49,863
Dec-19	6,950	2,216	304	1,222	13	34	414	2,689	11	47	31,522
Jan-20	7,849	2,232	323	1,700	38	29	485	2,985	6	51	32,675
Feb-20	6,819	1,919	233	1,555	18	21	384	2,641	6	42	33,185
Mar-20	8,051	2,675	251	1,801	16	23	453	2,761	12	59	38,773

Table: Monthly opt-out data and the reasons for opting out from April 2019 to March 2020. (Source: NHS Business Services Authority (NHSBSA))

Providing financial education, guidance, and advice

232. As our evidence stated last year, our research with First Actuarial revealed a lack of understanding of the NHS Pension Scheme, pension taxation issues and pensions in general.

233. The changes to the annual allowance taper, combined with any scheme changes introduced to compensate those affected by the recent age discrimination case, will introduce more complexity and choice for scheme members. This strengthens the need for education, guidance and advice to ensure staff understand the value of the NHS Pension Scheme and can make well-informed decisions about their pension benefits.

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

235. Employers are communicating the value of the NHS Pension Scheme using their staff intranet sites and Total Reward Statements, as well as using social media and electronic communications to reach staff who are not based in a single location. Employers are developing communication materials and using resources produced by NHS Employers, to promote the value of the scheme during recruitment, such as posters and benefits brochures[63].

236. Employers told us they would like more online support for scheme members, such as projection tools to allow staff to model their retirement options and estimate their income, as well as education materials such as online webinars and training courses. Employers also suggested communication materials should be targeted at younger staff and new joiners to improve engagement with this area of the workforce.

237. Offering flexible retirement is one of the ways employers can attract and retain a diverse workforce across a range of settings. Throughout the response to COVID-19, NHS organisations have demonstrated enormous capacity to adapt and work in innovative ways to deliver high-quality patient care during the most challenging of circumstances.

238. Much of the NHS workforce will have been placed under immense pressure in managing the response to COVID-19. The potential exists that this could signal an increase in the desire of those nearing the end of their careers to bring forward their retirement plans and it is important to consider how increased access to flexible retirement could be used to mitigate this risk.

239. Equally, there are many clinicians who had previously retired from NHS service that registered an interest in returning to work to support the response to the pandemic. It is helpful to assess how continued access to more flexible forms of employment could help retain some of these individuals.

240. Similarly, it is important to acknowledge any feelings of burnout that may be reported among older workers and consider whether these could be addressed through transfers to different

[63] NHS Employers, Promoting the Value of the NHS Pension Scheme Resources.

wards or departments, or by stepping back from clinical duties and into more administrative-focused roles.

Total reward

241. In this section we report on the action employers are taking, in line with the NHS People Plan, to ensure a positive and rewarding employment experience for all staff.

242. NHS leaders say that making the NHS an attractive employer, as part of efforts to tackle workforce shortages (which, without intervention it is suggested, might rise to 250,000 by 2030[64]) is the biggest challenge the NHS faces.

243. The NHS continues to provide a comprehensive and attractive core employment offer through a well-regarded package of valuable benefits, including financial and non-financial rewards, and a highly regarded pension scheme. In our 2020 survey of employers, around two thirds of respondents said they were using the reward package to meet their long-term workforce objectives of attraction, recruitment and retention of staff.

244. Given the number and diversity of NHS organisations it is not surprising that a strategic approach to reward is manifested differently in each organisation. Yet increasing demand for services is pressing all employers to use reward to ensure a stable, competent, and engaged workforce that can be deployed flexibly. This means that total reward in the NHS has many elements, which are evidenced in organisations according to their workforce needs.

245. The NHS Pension Scheme continues to be one of the most comprehensive and generous schemes in the UK. There is more work for all stakeholders to do to improve understanding of the NHS Pension Scheme among both employers and staff. NHS Employers is stressing the importance of engaging staff with the scheme throughout their careers, to help them make financial plans[65].

246. As employee priorities change during the span of their careers it is important that they can make use of flexibilities in their reward package. In our survey we asked employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff. Employers confirmed that the Scheme was an important benefit of working in the NHS. Yet employers also said more was being done to raise awareness of the scheme to all existing employees and potential new staff as part of retention and attraction strategies. Employers welcomed our support to develop concise communications that clearly present the benefits of the NHS Pension Scheme.

247. In response to our reward survey conducted this summer, just under half of the respondents said they were working collaboratively on reward with other employers in their area. NHS Employers believes that cooperation on reward between employers in local health communities is an essential part of tackling recruitment and retention challenges.

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[64] NHS Digital (2020), NHS Sickness Absence Rates: January to March 2020.
[65] Ibid.

248. Employers in local communities understand the demographics of their communities and are best placed to plan their workforce needs in both long and short terms. The HR community has always advised us that competition among provider organisations using pay and reward as levers is not a sensible approach, as it only leads to unaffordable pay spirals. Pay is one part of a bigger reward package and the other important elements need to be designed around the needs of staff in organisations and systems and aligned with service and workforce objectives.

249. Career development for staff must be about identifying talent, including leadership talent, but it must also be about designing progression around the needs of individuals as these needs change during a lifetime.

250. In previous submissions we have drawn the review body's attention to the elements of the national terms and conditions that give employers the means to support staff to achieve a successful balance between work, and their lives and commitments outside of work. These include contractual allowances that compare favourably with those provided elsewhere in the public and private sectors, including annual leave, sickness pay and leave, and pay for new parents.

251. Working with nationally agreed guidelines, employers also provide leave and pay when parents experience the death of a child, employment break schemes, and flexible working arrangements such as school term working. These arrangements give employers and staff opportunities to make temporary changes to employment arrangements where there are ongoing or new caring responsibilities outside of work. Employers also provide parental leave and shared parental leave. During the pandemic, many staff have been working from home and employers are offering job shares where two or more individuals can collaborate to design working patterns around their needs.

252. There are also additional components of employers' reward packages:

- Policies to ensure a healthy, motivated, and engaged workforce. Employers we have spoken to are working with third parties to offer access to apps such as Headspace to promote mental wellbeing. Many organisations run national campaigns such as Time to Talk, to promote a culture of being open and supportive about mental health at work.

- The public and businesses have recognised the need to protect the mental wellbeing of NHS staff and have been donating food products to support relaxation and managing stress, counselling, discounts, and priority access to supermarkets at specific times.

- Employers are providing access to providers of financial services to support staff in establishing financial wellbeing. Some organisations are working with high street banks and credit unions. Employers are providing financial education for different life stages, such as new entry staff, mid-life saving (for example, for first homes or weddings) and preparing to retire. The NHS Pension Scheme features in these discussions, including involving younger staff to ensure they can plan responsibly for their future.

- The buying and selling of annual leave remains a popular element of the reward package. More organisations offer buying annual leave than selling. Those offering both recognise the significant impact this can have on work-life balance and financial wellbeing.

253. The 2016 Autumn Statement introduced tax-free childcare from 28 April 2017, but also confirmed that existing employer-supported childcare schemes were able to accept new entrants until October 2018. Some organisations are continuing with their schemes while others have terminated schemes. Some organisations offer salary sacrifice options for the provision of on-site nursery care.

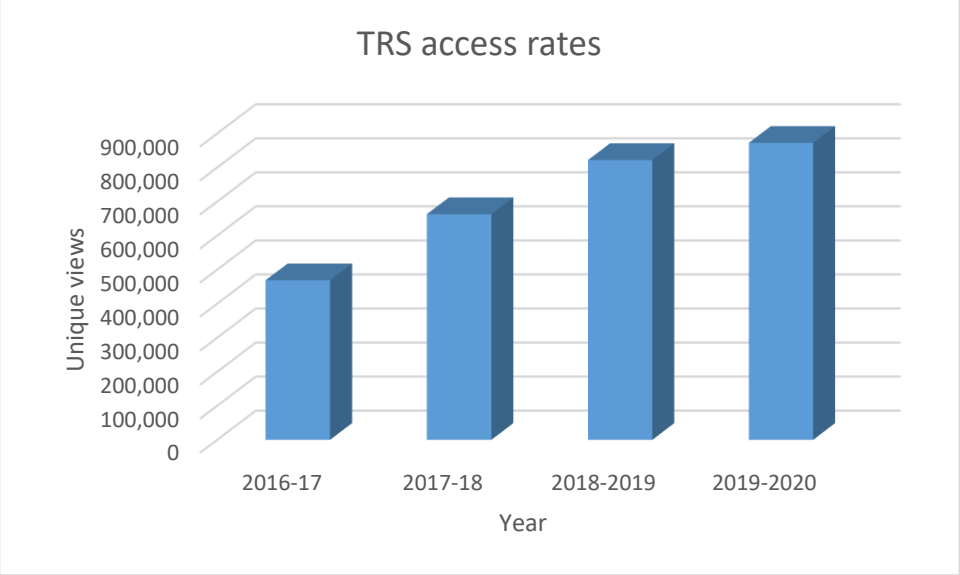
254. Organisations continue to offer salary sacrifice options for their staff. These schemes are also becoming more aligned to green and sustainability strategies with removal of the cap on bicycle costs, and the addition of electric.

Total Reward Statements

255. Total Reward Statements (TRS) enable employers to demonstrate the value of the total reward package, including the NHS Pension Scheme.

256. 2019/20 was the sixth year of operation of TRS in the NHS. Communications by employers, NHS Employers, the NHS Business Services Authority, and other national stakeholders have helped to increase take up.

257. At the end of August 2019, around 821,917 members had viewed their statements, whereas at the August 2020 refresh, around 872,401 members had viewed their statement, an increase of about five per cent.



258. Although the TRS access rate may be considered low across the service, we know that employers regularly engage with and use local benefits templates to communicate their local reward offer to their staff, but more needs to be done. Research by the Institute for

Employment Studies (IES)[66] has indicated that staff who fully understand the content and value of their total reward package also develop a greater appreciation of it.

[66] IES, NHS Employers (2016), The Relationship Between Total Reward and Engagement.