NHS Employers’ submission to the pay review body on doctors’ and dentists’ remuneration

2013/14

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Key messages to the Doctor and Dentists Remuneration Body (DDRB)

- The current national pay and conditions arrangements are increasingly not affordable for employers in the NHS, who are faced with the task of meeting growing demand and sustaining the quality of patient care while achieving unprecedented efficiency savings of up to £20bn by March 2015.

- Restraining pay is essential to protect services and minimise job losses.

- There is no evidence from employers that any increase in the national scales is necessary for the recruitment, retention or motivation of staff.

- Recruitment and retention is generally stable or improving across the country. Where there are known recruitment challenges in the medical workforce, these cannot be addressed by adjustments to the national pay scales but need wider solutions.

- The two year pay freeze has not frozen earnings or pay costs in the NHS. Individual employees have continued to enjoy pay progression as they move through training and up incremental steps. On average, these increments result in an individual salary increase for doctors of between 3 and 8 per cent per year.

- The NHS reward package remains highly competitive and is a valuable retention and recruitment tool.

- Staff satisfaction measures, shown by the most recent NHS Staff Survey, remain generally good and, for doctors, better than other NHS staff.

- Employers are increasingly asking for the pay and conditions arrangements to be better aligned to performance and productivity and to be more responsive to local needs.

- There is no compelling evidence for differential awards for different categories of staff either locally or nationally.

- As pensions are deferred pay, planned increases to employee contributions to the NHS Pension Scheme should not be used to justify any additional increase in pay rates. This does not release any money for pay and reward at employer level.

- It is predicted that there will be an over-supply of medical graduates and the accepted need to have more doctors in General Practice and fewer in hospital services over the next 10 to 15 years suggests it is not necessary to raise national scales for hospital doctors.

- The current national pay and conditions are not effective in helping the necessary reform of services and how and where services are delivered.

- There is a compelling case for making changes to the terms and conditions contract for doctors in training and we would welcome a remit to renegotiate.
There is a compelling case for making changes to arrangements for Clinical Excellence Awards, particularly to the local excellence awards.

1. The Employer View on Medical and Dental Pay

Introduction

1.1 The NHS Employers organisation welcomes the opportunity to submit our evidence for 2013/2014. We value the continuing role of independent pay review through the NHS Pay Review Body and the DDRB, in bringing an independent and expert view on remuneration issues in relation to the NHS workforce.

1.2 Following extensive discussions with the Department of Health (DH), the review body secretariats at the Office of Manpower Economics and HM treasury officials, the NHS Employers organisation has accepted responsibility for the submission of detailed evidence on the recruitment, retention and experience / satisfaction of NHS staff. Formerly, this would have been the responsibility of the DH.

1.3 This evidence is not submitted on behalf of Government, but as the voice of healthcare employers in England. The messages contained in this submission have been endorsed by the NHS Employers policy board.

Remit

1.4 2013/2014 will be the first year after the Government’s two year pay freeze for public sector workforces. The Government set out its position in its remit letters to the review bodies. At the 2011 autumn statement, the Government announced that the public sector pay awards should average 1 per cent for two years following the pay freeze. The Government has also asked certain review bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups who will be reporting from July 2012.

1.5 The Government states in the remit its belief that the need for pay restraint across the public sector remains strong, believing that there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year, and that pay restraint remains a crucial part of its plans to put the UK back on the path of fiscal sustainability.
While recognising the review bodies’ role in providing independent advice on pay in 2013/14, the government will limit increases to an average of 1 per cent in each workforce. Government has said that the review body should therefore focus on how the 1 per cent will be apportioned within their remit group, and that consideration may be given to the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff.

This evidence seeks to address the DDRB’s remit and provide an update on relevant wider developments.

**Employer engagement**

The NHS Employers organisation has been continuing a programme of employer engagement with the full range of NHS organisations on their priorities for national pay and conditions of service over the last year. We have held discussions at meetings of regional human resources directors, NHS Confederation and other employer networks throughout the year. There has also been substantive discussion with the NHS Employers policy board, its medical workforce forum and with employer representatives on the NHS Staff Council and the employer representatives on the joint negotiating committees on doctors and dentists terms and conditions.

The NHS Employers policy board considered the submission of review body evidence at its July meeting. In essence the board’s position was:

- there was no money available to lift national pay scales from April 2013
- there were no (national) pay related recruitment and retention difficulties to address
- that sustaining the quality and volume of patient care while delivering the financial challenges facing the service were the priority.

A proposed narrative and key messages was distributed to the policy board during August. Board members’ feedback confirmed the proposed approach. It was noted that the continuing good staff satisfaction measures from the latest available NHS Staff Survey, suggested that morale, although lower than last year, remains acceptable.

We have also shared the approach with our medical workforce forum meeting during August and they endorsed the approach being taken. The approach has

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1. The 1 per cent uplift should be applied to the basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, RRP or other allowances.
also been shared with regional HRD networks where it has broadly been welcomed.

1.12 To complement these broader qualitative employer engagement activities, we have also conducted a short online survey\(^2\) of employers through the NHS Employers website. The responses to this have reinforced the key messages, as have many face to face meetings and telephone calls with CEOs and other trust executive directors.

1.13 The recruitment and retention issues specifically referred to by respondents are either both locality and specialty specific or are part of known labour supply problems. Neither of these types of difficulty can be solved by raising national pay scales. For example, in relation to emergency medicine physicians, where other initiatives are being taken through a national task force to recommend non-pay actions in relation to service demand, service configurations, better training programmes, clearer careers guidance, and a planned growth in the numbers of specialty training opportunities over the next three years.

1.14 Employers responding to the online survey have also told us that they feel that increased pay costs would be unaffordable; that the majority of them do not favour differential increases in pay between staff groups or within medical staff groups. There was little appetite among them for regional variations in pay awards, though one respondent suggested that this may have to be looked at “going forward”.

1.15 Respondents were asked for any overall comments on pay for 2013/14. For example one respondent said:

> “1 per cent is a level of award that if distributed evenly makes little difference in terms of motivation and will simply serve to increase the pressure on NHS organisations in terms of realising savings. Nevertheless, there is also significant unhappiness amongst the workforce about the ‘pay freeze’, especially in areas of high and increasing housing and transport costs like London and the South East (SE). Maintaining the freeze would help NHS finances and is unlikely to lead to an exodus of staff (where would they go?). Paying 1 per cent gives some help to staff but is also unlikely to raise morale, being so low an award. The evidence published about differences between public sector and regional private sector pay rates is also relevant with London and SE staff likely to be more demanding of an increase (whatever that may be) than areas where NHS pay compares more favourably with other sectors.”

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\(^2\) Annex A gives a summary of the responses
This seems to neatly encapsulate the general comments received from employers.

1.16 In summary, our extensive programme of employer engagement tells us that:
   - in order to sustain effective, high quality services any pay increase is not affordable – unless additional funding is provided
   - employer efforts are directed at ensuring sustainable workforce costs – increasing national pay scales in any way would undermine those efforts
   - any pay award should be offset by the level of progression pay
   - if any pay award is made, it should be as low as possible, not necessarily as much as 1 per cent and paid equitably to all staff groups
   - there is no compelling evidence for differential awards to change national pay scales more for some staff groups or geographical areas than for others (given that any possible award is likely to be too little to make a difference).

**Affordability**

1.17 The NHS Employers organisation is being told consistently by employers that any increase in pay costs will be unaffordable unless matched by commensurate increases in the tariff, sufficient to cover the full increase in any employment costs. Cost pressures from increased earnings from whatever source will not be affordable and savings will need to be found elsewhere from efficiencies or reductions in service or both.

1.18 The NHS will need to achieve unprecedented levels of efficiencies to achieve the £20bn savings required before 2014/2015. The King’s Fund surveyed the sixty members of their panel of financial directors. Of these, 23 (38 per cent) “indicated that their organisations had missed their planned savings targets for 2011/12,” although the majority of the panel had achieved a surplus or breakeven position. The average savings represented 4.7 per cent compared to an average planned saving of 5.1 per cent; leaving a shortfall of 10 per cent.3 Acute trusts in particular have struggled to achieve the “challenging savings targets”. With “just a quarter of the first year [to achieve the £20bn of efficiency savings by 2014/15] outstanding, 65 of the 69 [94 per cent] were behind on cost

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improvement programmes.Monitor estimates that NHS foundation trusts are aiming to deliver cost improvement programmes at greater than 4.1 per cent of costs (in 2012/13) to 4.3 per cent (in 2013/14.) Although Monitor had agreed that this level of performance, in delivering Cost Improvement Programmes (CIPs) was “encouraging”, it was still deemed to be “below Monitor’s assessor case efficiency requirements (4.5 per cent in 2012/13 and 5 per cent in 2013/14 and 2014/15).”

1.19 Some NHS foundation trusts have told us that they have to achieve cost improvement plans significantly higher than this of up to 9 per cent over the coming year. The cost of meeting incremental pay progression is a factor which makes it more challenging for NHS trusts to achieve these challenging targets.

1.20 An understanding of the extent of the financial challenge faced by foundation trusts, and how they anticipate dealing with it, can be gained by looking at the three-year plans of foundation trusts which are published by Monitor (2012).

1.21 Monitor observed that whilst “the sector’s [foundation trusts] balance sheet should remain in reasonable shape... at the end of 2011/12,...[but] we expect the sector’s finances to be weaker by the end of 2015”. Monitor commented that "all trusts face the challenge of improving the quality of care they provide and delivering significant savings year-on-year while meeting an increased demand for services and more stretching service targets". Those most at risk will be “small and medium-sized district general hospitals, trusts with significant private finance initiatives and those located in challenged local health economies". There is an expectation that an "an increasing number of individual trusts to be placed in significant breach for financial reasons over the next three years".

1.22 Foundation trusts are facing the combined challenge of managing a reduced income (reducing by 1 per cent per year after 2012/13) and making increases in efficiency which are estimated at 4.5 per cent to 5 per cent per year. The reduction in income is driven by a combination of tariff reductions, falls in operating income, and a reduced growth in activity. Pay costs are putting increased pressure on budgets. These are anticipated to grow from 57 per cent of the total in 2012/13 to 63 per cent by 2014/15. Trust plans include between 3

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per cent and 6 per cent fewer clinical staff, 5 per cent fewer beds, more efficient working, and a reduction in administrative and clerical costs. At the same time organisations must ensure that quality of services is not compromised.

1.23 A recent NHS Confederation members’ survey\(^7\) indicates that financial pressures are already a real and significant challenge for the NHS, and in some cases these are starting to impact on the quality of services. Key messages from the survey were:

- 28 per cent of respondents stated that the financial pressures currently facing their organisation were “the worst they had ever seen”. A further 46 per cent stated the financial pressures were “very serious, but not the worst I have ever experienced”
- 85 per cent of respondents expected that the financial pressure “would increase over the next 12 months”
- 42 per cent of respondents felt that patient experience had been the area of care most affected by the financial pressures on their organisations over the past 12 months, followed by waiting times. 63 per cent of respondents felt that patient experience would be the area most affected in the next 12 months
- When considering the outlook for the quality of care across the NHS over the next 12 months, “47 per cent predicted a decline, 38 per cent felt that it would stay the same and 15 per cent felt that it would improve.”

The need for earnings restraint

1.24 There is cross-Government and employer agreement on the need for pay restraint. However, this will not prevent the pay bill rising for the next two years (2013/14 and 2014/15) as it has over the previous two years.

1.25 The total pay and reward of doctors and dentists in the NHS remains competitive in relation to tangible benefits such as pay and pensions, and non pay benefits. Generally, the NHS reward package remains highly competitive and is a valuable retention and recruitment tool.

1.26 Employers are concerned about containing pay costs within the tariff, particularly in light of the in-built incremental cost of the NHS pay systems, which is

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\(^7\) Picker Institute, June 2012, NHS Confederation Members’ Survey, Final Report, http://www.slideshare.net/secret/LOQHb67Rkxy9ucC/. Last accessed 18 September 2012. The NHS Confederation asked the Picker Institute Europe to survey the chairs and chief executives of all its member organisations. The survey was conducted between 26 April 2012 and 16 May 2012. It was sent to 625 chairs and chief executives in 362 organisations. There were 252 completed surveys - a response rate of 40 per cent - from 200 organisations. Responses came from the heads of acute trusts, primary care trusts, ambulance trusts, mental health trusts and independent sector providers of NHS care.
accentuated by current low turnover. Employers tell us that while they will make every effort to protect front line services, the changes that are required are likely to impact on those services.

1.27 Affordability of any increases in earnings dominates the thinking of employers in the NHS, in England, due to the risk of negative impacts on patient care. This is the clear message that employers in the NHS have given to the NHS Employers organisation in relation to pay costs.

Pay progression

1.28 Incremental progression in the pay structures each year continues to make a noticeable contribution to earnings growth for doctors and dentists employed in the NHS. Basic pay increased by an average of 1.1 per cent\(^6\) between 2010/11 and 2011/12 despite the pay freeze.

1.29 Consultants on the 2003 contract receive basic pay increases of between 3 per cent and 7 per cent as they progress through pay thresholds (excluding any clinical excellence awards). For the first five years, consultants would normally expect to receive basic pay increases each year, after which the pay progression thresholds are spaced five years apart. Specialty doctors and associate specialists on new contracts will have incremental progression every year or once every two or three years, depending on their position along the pay spine averaging between 3 per cent and 10 per cent of basic pay. Doctors in training grades receive annual incremental pay progression increases of between 4 per cent and 8 per cent. Pay progression as they move through their training programmes can add up to 24 per cent in a year.

\(^6\) DH estimate
Figure 1 demonstrates how medical staff have received incremental pay increases over the pay freeze period, expressing the pay increases as a per cent of the previous years’ pay. The line labelled F1 min, also reflects grade progression as usually individuals spend one year in each grade i.e. From foundation year one, to foundation year two on to specialist registrar. Full data tables detailing the value of incremental progression pay increases by pay point can be found in annex B. As an illustrative example, a consultant working 11 programmed activities who started on the minimum point of the 2003 consultant contract in April 2010 would have been earning £81,954. By April 2013, the same consultant will be earning £89,652. An increase of £7,698 or 9 per cent, despite a two year pay freeze. Further information on earnings is given in section three.

1.31 These additional increases in earnings already exceed the Government’s public sector pay policy. Thus we would urge the DDRB to give consideration, as permitted under their remit, to the level of progression pay provided to doctors and dentists in the NHS and to include this earnings growth in the 1 per cent average referred to in Government policy.

The need for service reforms

1.32 This year’s pay review is occurring at a time when the NHS in England is facing significant changes, including:
the organisational structure is changing with the introduction of the NHS Commissioning Board and primary care commissioning groups

the future shape of postgraduate training is being reviewed⁹, following the Foundation for Excellence report of Prof. Collins¹⁰. The Shape of Training Review is looking at potential reforms to the structure of postgraduate medical education and training across the UK under the chairmanship of Professor David Greenaway

the future shape of the medical workforce is under debate and has been subject to Centre For Workforce Intelligence (CFWI) work on Starting the Debate¹¹. An oversupply of UK medical graduates is predicted from August 2013¹².

the preparations for the introduction of medical revalidation from December 2012, subject to the approval of the Secretary of State, are well advanced

new specialty and sub-specialties and changes to curriculum have been introduced or are being proposed

task forces on emergency medicine¹³ and on psychiatry have made recommendations on the training, recruitment, career structure and service delivery in those work areas

a further task force in relation to general practice is being formed

there is a greater emphasis on shifting training number to general practice from hospital

new arrangements have been introduced in relation to the commissioning of training in the NHS with the creation of Health Education England and local education and training boards with a view to better aligning training commissioning with service commissioning and delivery. A description of the new arrangements is given at annex C.

1.33 All of these changes are indicative of significant innovation in the NHS to improve services for patients while meeting the continuing need for cash releasing efficiencies of an unprecedented level. The NHS strives to make efficiency savings of up to £20bn, which includes a 45 per cent reduction in management costs by 2015. NHS organisations are expected to achieve these

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⁹ Shape of Training, http://www.shapeoftraining.co.uk/ Last accessed 19 September 2012
¹³ http://www.careers.bmj.com/careers/advice/view-article.html?id=20008702#
through the Quality, Innovation, Productivity and Prevention (QIPP) programme.\textsuperscript{14}

1.34 Employers tell us that they are interested in changing the way in which services are delivered to better meet the needs and expectations of the public and ensure safe care. They are also interested in reshaping the medical workforce and changing the way in which it works. They are challenged by the advice of CfWI, the national authority on workforce planning and development, in their \textit{Shape of the Medical Workforce} report\textsuperscript{15} which warns that without changes there will be 60 per cent more consultant doctors by 2020. For example, more evening and weekend out-of-hours working; more consultant doctor presence; better handover; training programme changeover and shadowing for foundation year one (F1) doctors. The Chief Medical Officer’s initiative to introduce four additional days before the start of the F1 year itself led to F1 doctors receiving payments equivalent to F1 basic salary for those at least four days from July 2012. This increase represents about 1 per cent more in earnings for F1 doctors compared to F1 basic salary for a typical F1 year prior to 2012/13. We estimate this will cost the service in the order of £1.9 million.\textsuperscript{16}

1.35 Better medical management and leadership will also be needed if the service is to meet the challenges faced. This need has led to the creation of a new Faculty of Medical Management and Leadership\textsuperscript{17} that aims to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefits of patients. Earlier this year, the General Medical Council (GMC) produced guidance on \textit{Leadership and management for all doctors}\textsuperscript{18}, saying that good healthcare is about more than safe and effective medical interventions, and doctors have a crucial leadership role to play, in terms of their own practice and that of their colleagues, and indeed in the teams and organisations in which they work.

1.36 All of this will require terms and conditions to be responsive to local needs, affordable and sustainable. Employers do not believe that higher national pay scales will help deliver the necessary local level changes that are needed.

\textsuperscript{14} http://www.improvement.nhs.uk/Default.aspx?alias=www.improvement.nhs.uk/qipp
\textsuperscript{16} Unpublished NHSE calculation
\textsuperscript{17} http://www.fmlm.ac.uk/
\textsuperscript{18} General Medical Council (2012) \textit{Leadership and management for all doctors} London, GMC http://www.gmc-uk.org/Leadership_and_management_for_all_doctors_FINAL.pdf_47234529.pdf
The need for employment contract reform to meet the needs of service

1.37 The contracts need to change to remove barriers to the innovative development of services, the timing of when service is delivered and where service is delivered.

1.38 National CEAs will be referred to later in this submission, but money for local awards needs to be used locally to incentivise excellence in delivering more local services, better, and quicker for patients.

1.39 Employers in the NHS have welcomed the UK wide review into compensation levels and incentive systems and the various Clinical Excellence and Distinction Award Schemes for NHS consultants at both national and local level in the UK conducted by the DDRB. The Secretary of State’s decisions in relation to any recommendation made by the DDRB are awaited.

1.40 Employers told us that they did not see any justification for any increases to the value of any awards or for any new awards to be made.

1.41 The terms and conditions contract for doctors in training is widely accepted as not fit for purpose and needs reformed to incentivise training and service, remove punitive penalty payments, and remove its unfortunate interactions with the Working Time Regulations.

1.42 Contract reform for consultants and doctors in training needs to be integrated into a single model of what is trying to be achieved by the service – in terms of what we train doctors to do, and how we train them; how many we need and at what skill levels; how we satisfy the public, boards and parliament of the competence of doctors to do the things we employ them to do; as well as how we most effectively distribute available pay money across the staffing structures.

1.43 Career and pay progression, from F1 to consultant excellence, should be linked to performance, competence and progressive continued professional development, the need for the work at a particular level and affordability. The national scales and progression arrangements should embrace management and leadership roles, as well as clinical roles.

1.44 However, the notion of automatic progression has taken hold despite the progression rules in the current contracts and this balance needs to be redressed. Employers find that their efforts to do this can be constrained and threatened by challenges in the employment tribunals.

1.45 All contracts need to be able to achieve appropriate value in return for what is being paid. If additional money is available for pay and reward employers believe
it should be used locally to incentivise: behaviours; attitudes; performance and adaptability.

1.46 Employers believe that any increases in the value of pay should be contingent on greater contract flexibilities being achieved, to allow some more innovative ways of using pay money to deliver reformed contracts that are fit for purpose and assist in delivering services in new ways and in different settings.

1.47 The need for 24/7 services, greater consultant leadership and presence out of hours at evenings and weekends is now widely accepted and the NHS Employers organisation is working with the Academy of Medical Royal Colleges\(^\text{19}\) to develop recommendations on how these needs can best be met. A report of the Seven Day Consultant Present Care Working Party of the Academy is in the process of being finalised.

1.48 The NHS Employers organisation believes the report should robustly set out the right thing to do for patients. There will be a need to negotiate with stakeholders to agree a way to achieve the needs set out.

1.49 Achieving all the standards of service being discussed would represent a shift for NHS (and other public sector) staff and the report may go far wider than the recommendations on consultant delivered care made by Professor Temple\(^\text{20}\) in his report *Time for Training*. The work will need be integrated with the work of the Better Training Better Care Project.\(^\text{21}\)

1.50 It is really important when looking at significant reform that this is not simply seen as an extension of the current pay system. Service reform and reconfiguration on this scale needs to go hand in hand with changes to the pay system to ensure affordability, sustainability, and be responsive to local needs.

\(^{19}\) [http://aomrc.org.uk/item/benefits-of-consultant-delivered-care.html](http://aomrc.org.uk/item/benefits-of-consultant-delivered-care.html)


\(^{21}\) [http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care/pilot_site_projects.aspx](http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care/pilot_site_projects.aspx)
2. The financial challenge in the NHS

2.1 Earnings restraint is essential if the NHS is to meet its financial challenges.

2.2 The NHS aims to meet increasing demands, and continually improve the quality of patient care, within a fixed budget in any given year. Hard decisions about what services and treatments to fund have always been necessary in the NHS.

2.3 In the current economic environment in the UK, the NHS faces these clinically and financially challenging decisions more frequently. The NHS’s budget is under unprecedented pressure. Annual savings of at least 4 per cent per annum are required until March 2015. As referred to in the previous section, the NHS Confederation’s 2012 survey of NHS leaders found 28 per cent of respondents described the current financial position as “the worst they had ever experienced” and a further 46 per cent said the position was “very serious”.

2.4 It is also clear that the financial challenge will continue beyond 2015. David Flory, DH Director General of Finance, Performance and Operations, recently told the Financial Times that, “It isn’t suddenly going to get better by the next spending review. It’s really important that the service gets used to operating in this resource climate... It’s not a question of just doing it for a year or two and then getting out of the woods; this is it as far as I can see ahead.”

2.5 The Audit Commission has reported on the NHS financial year 2011/12 and found that the number of NHS trusts and foundation trusts in deficit increased from 26 in 2010/11 to 31 in 2011/12. Mike Farrar of the NHS Confederation, commenting on the Audit Commission report said the report, “… shows the commissioning side having a good financial position, but an increasing number of providers are being squeezed.” He called for efforts to be made to help providers put their services on a sustainable footing to ensure hospitals can sustain local services in the long run. Commenting on the specific issues raised in the report about providers, Mr Farrar said, "pressures are continuing to grow. It is worrying that the number of trusts in deficit has more than doubled in the past year and a significant number of trusts are receiving financial support.”

2.7 Although the NHS is reducing management costs, this can only deliver a small one-off contribution to the £20bn savings target. Good management is of course vital in improving productivity and delivering efficiency savings.

2.8 The NHS needs to be constantly considering many radical approaches to delivering high quality services efficiently, in the face of financial and

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22 Financial Times, 27 March 2012, [http://www.ft.com/cms/s/0/57a08d8a-7763-11e1-827d-00144feab49a.html#axzz1yVwu9gFy](http://www.ft.com/cms/s/0/57a08d8a-7763-11e1-827d-00144feab49a.html#axzz1yVwu9gFy)
23 [http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/nhsfinancialyear1112.aspx](http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/nhsfinancialyear1112.aspx)
demographic challenges, such as providing more services in the community, genuinely integrating care and doing more to get the best from our talented staff. As David Nicholson, chief executive of the NHS Commissioning Board, told the NHS Confederation annual conference in June: “We need to change the model of care to one which supports patients and focuses more on preventing ill health from happening in the first place... and move away from the default position of getting someone into a hospital bed”.

2.9 The options available to the NHS to save money and improve the way care is provided can be controversial, and some will be very difficult for people who are personally affected. Good quality of engagement with staff is therefore needed to get the best decisions and the best implementation of decisions.

2.10 Monitor regulates the work of NHS Foundation Trusts. Its Review of NHS foundation trusts annual plans for 2012/2013 reports that all NHS foundation trusts are required to make savings as part of the Government’s efficiency challenge, but not at the expense of patient care or service quality. Over the past three years a step change in CIPs has been seen (2.0 per cent in 2009/10 rising to 3.9 per cent in 2011/12). CIPs are forecast to remain at more than 4.1 per cent of operating costs each year from 2012/13 onwards (peaking at 4.3 per cent in 2013/14).

2.11 The 2011/12 consolidated accounts of NHS foundation trusts revealed that over half did not meet their cost improvement targets.

2.12 The forecast CIP delivery of Foundation Trusts is below Monitor’s assumed efficiency requirements (4.5 per cent in 2012/13 and 5 per cent in 2013/14 and 2014/15). Monitor has also indicated that the impact of a reduced tariff income could increase the efficiency challenge by 2 per cent.

2.13 The NHS needs to reduce the costs of care and the CIPs relate predominantly to pay costs (increasing from 57 per cent of the total in 2012/13 to 63 per cent by 2014/15). Sustaining delivery of CIPs at these levels, while maintaining and improving quality, will continue to present a challenge to the sector as a whole. Action will be needed on staff numbers, skill mix, pay and terms and conditions, including those for front-line clinical staff and including doctors.

2.14 Pay accounts for approximately 70 per cent of trusts’ costs – a total of £22.6bn in 2011-12, £576m above plan. Meanwhile, unpublished results of a separate Health Service Journal survey (12th July 2012) revealed that acute foundation trusts aimed to reduce more than £500m off their pay bill in 2012-13.

25 http://www.nhsemployers.org/Aboutus/Publications/Pages/StaffEngagementInTheNHS.aspx
2.15 In last year’s annual plans, trusts planned significant reductions in clinical staff (6-8 per cent in years two and three). Both mental health and acute trusts are forecasting only a small change in frontline staff (acute +1 per cent; mental health -1 per cent). However, acute trusts and mental health trusts are planning a 3 per cent and 6 per cent reduction respectively in clinical staff; both are forecasting a circa 5 per cent reduction in beds over the following years.

2.16 The Institute of Fiscal Studies (IFS) and Nuffield Trust report in July 2012, noted that public spending on the NHS increased faster than economy-wide inflation since the 1950s, with an average growth rate of 4.0 per cent per year between 1949/50 and 2010/11. The percentage of spend on the NHS as a share of national income has grown from 3.5 to 7.9 per cent over this period. The Government has committed to above inflation growth in NHS funding each year. This will be 0.1 per cent above inflation during 2012/2013.

2.17 Their report noted that the four year spending round, starting 2011/12 represents the tightest four year period of funding for the NHS in the last 50 years. Spending increased particularly rapidly under the previous Government, with an average real growth rate of 6.4 per cent a year between 1996/7 and 2009/10.

The general economic context

2.18 The financial and service challenges faced by employers in the NHS are in the context of the UK economy. ONS reported in August 2012 that the public sector current budget deficit was £13.2 billion in August 2012; this is a £0.4 billion higher deficit than in August 2011, when there was a deficit of £12.8 billion.

2.19 The Government’s current fiscal consolidation plan covers the next seven years. Total public sector current expenditure is forecast to increase from £647.3bn in 2011 to £708.6bn in 2016/17 – a reduction of 0.9 per cent on average in real terms. Public sector current expenditure is forecast to reduce as a percentage of GDP from 42.6 per cent in 2010/11 to 36.5 per cent in 2016/17. The Chancellor stated in March 2012 that spending on public services in the UK would still need to be reduced in real terms by an average of 1.7 per cent per year over 2015/16 and 2016/17 to keep to current Government spending plans.
2.20 The trend in pay levels across the UK workforce in recent years may be significant, since 2008, private sector pay levels have fallen behind the public sector – although it appears that this gap is closing as the private sector recovers and public sector pay restraint continues. Comparisons between public sector earnings and private sector earnings may not, however, be very useful in relation to employed doctors and dentists pay. The characteristics of these two workforces can be very different.

2.21 Taken together, the financial challenges to the service and the general financial outlook for the UK suggest to employers that further restraint on pay costs will be needed for some time ahead.
3 Staff numbers and earnings

Doctor numbers

3.1 There are now more than 140,000 hospital and community health services (HCHS) doctors and GPs. Figure 2\(^{32}\) shows the growth in the HCHS medical workforce since 2000. New healthcare methodology for 2010 and 2011 data is not fully comparable with previous years due to improvements that make it a more stringent count of absolute staff numbers. A table of staff numbers, (both headcount and full-time equivalent) can be found in annex D.

![HCHS Medical Workforce by Grade](image)

Figure 2

3.2 The latest annual census figures for England confirm that the NHS medical and dental workforce has increased in 2011 to the highest ever recorded\(^{33}\), and

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\(^{32}\) Source: Information Centre, NHS Staff 2001 - 2011 (Medical and Dental): Bulletin tables


Last referenced 11 July 2012

\(^{33}\) Source: Information Centre, NHS Staff 2001 - 2011 (Medical and Dental): Bulletin tables
figure 2 shows that medical numbers in nearly all of the staff groups continued to grow during the year to 30 September 2011, in particular:

- the numbers of hospital, public health medicine and community health service medical and dental staff increased by 2,510 (headcount) or 1.8 per cent and 1,834 (full time equivalents (FTE)) or 1.4 per cent
- consultant numbers increased by 1,336 (headcount) or 3.5 per cent and 1,184 (FTE) or 3.3 per cent;
- the number of specialty doctors, staff grades and associate specialists increased by 210 (headcount) or 2.1 per cent and increased by 157 (FTE) or 1.8 per cent;
- the numbers of doctors in training and equivalents increased by 725 (headcount) or 1.4 per cent and 597 (FTE) or 1.2 per cent
- GP numbers – excluding GP retainers and GP registrars – increased by 448 (headcount) or 1.3 per cent, and increased by 35 (FTE) or 0.1 per cent
- GP registrars increased by 133(headcount) or 3.4 per cent and 66 (FTE) or 1.8 per cent.

3.3 Figure 3 shows the composition of the medical workforce based on the latest census figures.
Figure 3

Turnover

3.4 Figure 4 shows the Hospital and Community Health Service (HCHS) turnover statistics (both leaving and joining rates) for all HCHS doctors (excluding locums and trainees) in England, dating from the September to December 2009 quarter to the December 2011 to March 2012 quarter. Joining rates have consistently exceeded leaving rates over the period\(^{34}\). This shows that NHS overall recruitment and retention has not only been sufficient to maintain workforce numbers, but also sufficient to expand the medical workforce by 3.4% between September 2009 and March 2012\(^{35}\).

We refer in section 10 to the situation in known areas of recruitment challenges such as psychiatry, emergency medicine and GPs.


Figure 4

NHS Hospital & Community Health Service (HCHS) quarterly workforce statistics turnover
All HCHS doctors (excluding locums & trainees)
Doctors earnings

3.5 The NHS Information Centre produces a quarterly publication of NHS staff earning estimates which show medical workforce earnings by staff group, taken from the Electronic Staff Record (ESR). Access to ESR is now complete and the most recent data covers every NHS organisation, apart from two foundation trusts which have not joined ESR.

3.6 Changes in the average earnings by staff group arise from actual increases in individuals’ pay due to pay awards, back pay and incremental progression or changes in the composition of the workforce due to pay reforms and/or the impact of new organisations joining the sample. A separate analysis of earnings has shown that some of the changes in earnings arise from changes in the sample rather than true changes in average salary.

3.7 Figure 5 indicates annual basic pay and total pay for each staff group from April to June 2012, compared with the same quarter of 2011. The mean enhancement is based on the difference in mean basic pay and mean total earnings, divided by the mean basic pay. As the Information Centre only publishes mean earnings to the nearest £100, these enhancements are approximations only. Where earnings have reduced, one of the contributory factors is likely to the better management of rotas and additional programmed activities.

<table>
<thead>
<tr>
<th>Key staff group</th>
<th>Mean Basic Pay (FTE)</th>
<th>Mean Total Earnings (FTE)</th>
<th>% change from last year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr-Jun 11</td>
<td>Apr-Jun 12</td>
<td>% change from last year</td>
</tr>
<tr>
<td>Foundation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 1</td>
<td>£22,600</td>
<td>£22,600</td>
<td>0.0%</td>
</tr>
<tr>
<td>Year 2</td>
<td>£29,100</td>
<td>£29,100</td>
<td>0.0%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£37,700</td>
<td>£37,800</td>
<td>0.3%</td>
</tr>
<tr>
<td>Consultants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Contract</td>
<td>£85,400</td>
<td>£84,400</td>
<td>-1.2%</td>
</tr>
<tr>
<td>New Contract</td>
<td>£89,500</td>
<td>£89,800</td>
<td>0.3%</td>
</tr>
<tr>
<td>Associate Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Old Contract</td>
<td>£82,600</td>
<td>£83,400</td>
<td>1.0%</td>
</tr>
<tr>
<td>New Contract</td>
<td>£78,300</td>
<td>£79,700</td>
<td>1.8%</td>
</tr>
<tr>
<td>Staff Grade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£62,900</td>
<td>£64,200</td>
<td>2.1%</td>
</tr>
<tr>
<td>Specialty Doctors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£57,300</td>
<td>£58,000</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Figure 5

Consultants

3.8 Consultant numbers increased by 1,336 (headcount) or 3.5 per cent and 1,184 (FTE) or 3.3 per cent during the year to 30 September 2011. The number of consultants (FTE) at 30 September 2011 was 36,965, the highest ever recorded.

3.9 The mean basic salary of consultants is estimated at £89,800, for those on the 2003 contract (the majority of consultants are on this contract.) Additional earnings, including Clinical Excellence Awards, constitute £27,200 (30 per cent) for consultants on the new contract and £17,300 (20 per cent of basic pay) for consultants on the old contract. For those on the new contract, mean total earnings have decreased by 0.8 per cent over the year whilst mean basic pay has increased by 0.3 per cent compared to the same period in 2010.

3.10 The September 2011 workforce census indicated that 38% of the consultant headcount of 39,088 working in the NHS in England were aged 50 or over, and 8% were aged 60 or over. These proportions are around the same as those as in September 2009 and 2010. The latest information on consultant retirements is in annex E.

3.11 The overwhelming majority of consultants (97 per cent) are now on the 2003 consultant contract37, which applies to all new consultants and has eight pay thresholds ranging from £74,504 to £100,446. The remaining 3 per cent of consultants are on the old pre-reform contract (a five point incremental scale rising to £80,186).

3.12 Some consultants also receive recruitment and retention premia which we refer to in the next section and in annex F.

Specialty and associate specialist doctors (SAS)

3.13 The total number of associate specialists, specialty doctors and staff grade doctors increased by 210 (headcount) or 2.1 per cent and 157 (FTE) or 1.8 per cent during the year to 30 September 2011. The number of doctors (FTE) in this group at 30 September 2011 was 8,876, the highest ever recorded.

3.14 In the year to September 2011, the numbers of associate specialists, which is a closed grade, decreased by 69, or 1.8 per cent. The number of specialty doctors

increased by 852 (17 per cent), whilst the number of staff grade doctors decreased by 573 (40 per cent.)

3.15 Associate specialists (new contract) have a mean basic salary\(^{38}\) of £79,700 and a mean total pay of £91,400. This figure shows that additional earnings add £11,700 (15 per cent) to basic pay. The median pay is very much lower than the mean total for total earnings but not basic earnings. Their average basic pay has increased by 1.8 percent since the previous year whilst total earnings have increased by 2.0 per cent.

3.16 Staff grades earn a mean basic salary of £64,200 and earn an additional £6,700 (10 per cent) in additional pay. Their mean total annual earnings are £70,900. Median earnings are lower than the mean earnings, suggesting a possible positive skew in staff grade earnings. Mean basic pay has increased by 2.1 per cent whilst mean total earnings have increased by 2.3 per cent since the previous year.

3.17 Specialty doctors earn a mean basic salary of £58,000 and an additional £10,800 (19 per cent) in additional pay. Therefore, their mean total annual earnings are £68,800. The median total earnings from April to June 2012 is lower than the mean total earnings, suggesting a possible positive skew in specialty doctor earnings. Their mean basic pay has increased by 1.2 per cent since the previous year whilst mean total earnings have increased by 0.4 per cent.

**Doctors in training**

3.18 At the September 2011 census, the number of doctors in training in England was 52,872 - an increase of 725 (1.4 per cent) on the September 2010 census. The FTE figure increased by 1.2 per cent in the year to 2011 (from 51,397 to 51,993) and by 62 percent (19,989) from 2001.

3.19 In the year to September 2011, the numbers of doctors in foundation year one (including house officers) increased by 34, or 0.5 per cent. The number of doctors in foundation year two (including senior house officers) decreased by 23 (0.3 per cent), whilst the number of registrars increased by 733 (1.9 per cent.)

3.20 Doctors in foundation year one (including house officers) received a mean basic salary of £22,600 and their mean total earnings are £32,300. These figures show a mean enhancement equivalent to £9,700 or approximately 43 per cent of basic pay. Both mean basic pay and mean total earnings stayed the same compared to the equivalent quarter in 2011.

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3.21 Doctors in foundation year two (including senior house officers) received a mean basic pay of £29,100 and mean total earnings of £41,100. These figures equate to a mean enhancement of £12,000 or 41 per cent of basic pay. Mean basic pay was unchanged compared to the equivalent quarter in the previous year, whilst total earnings decreased by 0.5 per cent.

3.22 Registrars receive an estimated basic pay of £37,800 and total pay of £55,600. These figures equate to a mean enhancement of £17,800 or 47 per cent of basic pay. This shows a mean increase in basic pay of 0.3 per cent and a mean decrease of 0.4 per cent in total earnings compared with the equivalent quarter in 2011.

Graduate starting salary comparisons with other professions

3.23 The most recent Graduate Recruitment Survey from the Association of Graduate Recruiters (AGR) continues to show that total earnings for medical graduates entering their first post remain very competitive, especially when the number of posts is taken into account\(^{39}\) as illustrated in Figure 6. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in the high proportion of graduates that are immediately able to enter their chosen career.

Figure 6

Median predicted graduate starting salary by sector in 2011-2012 compared to Junior Doctor total median earnings
3.24 The same survey showed that graduate vacancies are predicted to decrease by 0.6 per cent in 2012. This follows an increase of 8.9 per cent in 2010, and an increase of 1.7 per cent in 2011, which signals sustained recovery of the graduate recruitment market. Survey respondents estimated that the average starting salary would increase by 6.0 per cent to £26,500.

3.25 AGR employers stated that at the time of the survey, they had received 73.2 applications per vacancy since the beginning of the recruitment season, an overall drop of 12.0 per cent; although the majority of employers had reported that they had not received any reductions in applications. For those employers who had reported a drop, this was put down to graduates being more selective about which jobs they were applying for.

Fill rates for entry to specialty training 2012

3.26 The medical programme board of Medical Education England has received reports\(^{40}\) updating it on progress of specialty recruitment in 2012. As at July the majority of recruitment across all specialties had been completed, although a few remaining specialties were still offering places through clearing processes. Depending on the specialty, remaining vacancies were either passed to deaneries to fill locally or have been carried over to further rounds of national recruitment later in the year or in early 2013.

3.27 Figure 7 illustrates the fill rates at CT1/ST1 level after the initial round one of recruitment and recruitment to the re-advertised vacancies from round one.

\(^{40}\) Unpublished papers from MEE Medical Programme Board July 2012.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Fill Rate – 2012 (%)</th>
<th>Fill Rate – 2011 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia and ACCS Anaesthesia</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>Clinical Radiology</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>General Practice</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>Core Medical Training and ACCS Acute Medicine</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>Core Surgical Training</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>ACCS – Emergency Medicine</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>Core Psychiatry</td>
<td>86</td>
<td>78</td>
</tr>
<tr>
<td>Histopathology</td>
<td>84</td>
<td>86</td>
</tr>
<tr>
<td>Public Health</td>
<td>83</td>
<td>99</td>
</tr>
</tbody>
</table>

Figure 7

Recruitment has been successful with eight specialties attaining a fill rate of 90 per cent or higher.

3.28 Core psychiatry has been seen as an improvement with an 86 per cent fill rate in 2012 compared to 78 per cent in 2011, perhaps befitting from the recommendations of the psychiatry taskforce referred to in detail later in section 10. For 2012, there have been 380 applicants appointed at CT1 compared to circa 240 ST4 training posts available each year. The psychiatry taskforce is currently reviewing methods to improve attrition rates within core psychiatry.

3.29 A review of public health recruitment is to be undertaken by the lead dean, academic registrar for public health and officials at the DH to assess the recruitment process and suggest changes for 2013 recruitment.

3.30 Recruitment into specialty (ST) 3 specialties is in line with expectations with the majority of specialties receiving good fill rates. An overview of the status for fill rates can be found in annex G.

3.31 Recruitment into ST4 emergency medicine remains poor, with a 44 per cent for 2012. The emergency medicine taskforce, referred to in detail in section 10, have developed an interim report with various recommendations to address the low fill rate. A further round of recruitment is planned later in the year.

3.32 Psychiatry ST4 recruitment is variable with general adult psychiatry achieving 97 per cent fill while old age psychiatry has only achieved a 30 per cent fill. All
remaining vacancies for 2012 have been returned back to Deaneries for local recruitment. As stated earlier in this submission, these difficulties relate to labour market supply issues rather than pay related difficulties, as reflected by the modest number of recruitment and retention payments across England as shown in annex G. For example, based on the NHS Employers organisation’s analysis of the Electronic Staff Records (ESR) data warehouse, it is estimated that just 1 per cent of old age psychiatry consultant workforce receive an Recruitment and Retention Premium payment.

3.33 The psychiatry taskforce has made a number of recommendations to change the recruitment process for 2013 including recruiting twice a year in August and February. This is detailed later in section 10. Surgery continues to attain high fill rates across all specialties. The exception was Oral and maxillofacial surgery which only attracted 19 applicants that met the long listing criteria which led to a fill rate of 56 per cent. Again, this is about supply issues. Recruitment has been successful in the majority of medical specialties.
Potential Oversupply

3.34 In its report, *The state of medical education and practice in the UK*\(^{41}\) 2012, the GMC states that there are concerns about demand for foundation training and consultant posts. As the number of doctors on the register continues to grow, there is an ongoing debate about a potential oversupply of doctors in the future and the career opportunities that will be available to them.

3.35 The GMC believe that it is possible that there will be more medical graduates emerging from UK medical schools than foundation places. This has been caused by a range of factors, including reported unintentional over-recruitment to some medical schools, and the growth of student numbers from the European Economic Area (EEA), and others with a right to work in the UK. The Health Education National Strategic Exchange, a national forum for senior members of the higher education and health sector, has commissioned the Centre for Workforce Intelligence (CfWI) to undertake analysis to inform its review of provision of medical and dental training numbers.

3.36 Debate also continues about the potential size of the future consultant workforce. As referred to earlier, the CfWI in England estimated that, based on current trends, and assuming that all eligible doctors become consultants within the current grade structures and terms and conditions, the number of fully trained hospital doctors will increase by over 60 per cent to 60,000 by 2020.\(^{42}\) This would result in an estimated £6 billion annual spend on consultant salary costs, an increase of £2.2 billion on the 2010 spend. These figures are not projections on the medical workforce that the health service might need, but predictions based on the current shape of the workforce. However these are viewed they raise questions about need and affordability.

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\(^{42}\) Centre for Workforce Intelligence (2012) *Shape of the Medical Workforce: Starting the debate on the future consultant workforce* London, CfWI, p4
4  Staff experience data from the NHS Staff Survey

4.1 The purpose of the reward package in the NHS, as for any employer, is to ensure the recruitment and retention of the appropriate numbers of staff, the appropriate skill and knowledge mix among the staff and the correct quality of application of that skill and knowledge at the correct place and time, to provide the services required. While economic conditions have effects on the labour market and on affordability, earnings need to reflect this purpose.

4.2 Reward is not only about pay rates. It is also about tangible and non-tangible non-pay rewards. It encompasses pensions – deferred wages; conditions of service, such as annual leave, sick pay, enhancements for work out of hours and payments for additional duties; and how staff are managed.

4.3 In comparison to other professional jobs in the economy, doctors and dentists are in an occupation on which prevailing economic circumstances have a more limited effect since the employment and contracting of doctors and dentists is largely within the NHS. Competition with the wider labour market and the wider economic circumstances are not thought by employers in the NHS to be the primary factors in the recruitment and retention of doctors and dentists.

4.4 An element of the effectiveness of the pay rates and pay systems is reflected in the staff satisfaction and attitudes and how that affects staff morale as a key driver of the motivation of staff. The factors that are important to staff are linked, to one degree or another, to better patient and public satisfaction, and enhancement of the reputation of the NHS.

4.5 The 2011 NHS Staff Survey\(^{43}\) was reported during March 2012. It is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution. It continued to reflect the focus on the NHS as an employer arising from the publication of the NHS Next Stage Review in July 2008 and the NHS Constitution for England\(^{44}\) in March 2010. The four pledges in the NHS Constitution include what the NHS expects from its staff and what staff can expect from the NHS as an employer.

4.6 The 2011 Staff Survey indicates that doctors and dentists remain more likely than their colleagues in other NHS occupations in all trusts to report that they are satisfied or very satisfied with their level of pay (57 per cent). When compared to their colleagues, doctors and dentists are more satisfied with their pay, less likely to be planning to leave their trust, more satisfied with their jobs, healthier,

\(^{43}\) [link to website]

\(^{44}\) DH, The NHS Constitution for England [link to website]
get better access to training and learning, and are less stressed. They report experiencing a poorer quality of life than the average for all NHS staff.

4.7 Doctors and dentists generally scored higher than average on individual questions related to job satisfaction. For all NHS staff, the average score for job satisfaction (ranging from one for very dissatisfied to five for very satisfied) was 3.49. Consultant medical/dental staff scored 3.64, doctors in training 3.64 and for all doctors 3.64. The results for motivation show higher motivation among doctors (3.94), particularly consultants (3.97) compared to NHS staff as a whole (3.80).

4.8 A further measure of job satisfaction is provided by the three questions relating to the intention to leave current jobs or search for new positions. The responses for doctors and dentists show a much lower level of intent to leave than the all staff average.

4.9 Overall, the 2011 survey generally shows continuing good levels of job satisfaction, with

- 93 per cent of doctors and dentists agreeing with that their role makes a difference to patients, compared with 90 per cent of all staff
- 77 per cent felt satisfied with the quality of work and patient care given to patients, compared to 74 per cent of all staff
- 87 per cent of doctors and dentists felt valued by their work colleagues (77 per cent for all staff)
- 57 per cent agreed that there were good opportunities to develop their potential at work.

Further selected numbers from the survey are given in Figure 8.
Selected Results from the 2011 NHS Staff Survey

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>All staff</th>
<th>All doctors</th>
<th>Consultant docs</th>
<th>Docs in training</th>
<th>Other docs</th>
<th>Qualified nurses and midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied or very satisfied with your pay</td>
<td>38%</td>
<td>57%</td>
<td>63%</td>
<td>53%</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>Feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>74%</td>
<td>77%</td>
<td>73%</td>
<td>81%</td>
<td>84%</td>
<td>69%</td>
</tr>
<tr>
<td>Agreeing their role makes a difference to patients</td>
<td>90%</td>
<td>93%</td>
<td>95%</td>
<td>91%</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>Feeling there are good opportunities to develop their potential at work</td>
<td>40%</td>
<td>57%</td>
<td>58%</td>
<td>77%</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Overall job satisfaction</td>
<td>3.49</td>
<td>3.64</td>
<td>3.64</td>
<td>3.64</td>
<td>3.58</td>
<td>3.56</td>
</tr>
<tr>
<td>Staff intention to leave jobs</td>
<td>2.59</td>
<td>2.39</td>
<td>2.34</td>
<td>2.48</td>
<td>2.43</td>
<td>2.68</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.80</td>
<td>3.94</td>
<td>3.97</td>
<td>3.95</td>
<td>3.91</td>
<td>3.86</td>
</tr>
</tbody>
</table>

Figure 8

4.10 The continuing attractiveness of medicine as a career in the UK is seen from the number of applications to study medicine at University in 2011 rising, compared with 2010, by 3.9 per cent in the 2010 round of applications to 83,300.\(^47\)

4.11 The Chartered Institute of Personnel and Development (CIPD) Summer 2012 Employee Outlook Survey\(^48\) reported:

- **Redundancies** - The proportion of public sector staff saying that there had been redundancies in their organisation was 56 per cent, compared to 38 per cent overall.
- **Pay freeze** - The majority (69 per cent) of public sector respondents were the most likely to report a pay freeze, compared to 44 per cent overall.
- **Recruitment freeze** - 57 per cent of employees in the public sector stated that their organisation had frozen recruitment, compared to 32 per cent of all employees.

5. Consultants

5.1 Earlier, we described the numbers and earnings of those doctors employed on the national terms and conditions of service for consultants. This section provides some supplementary description of other connected matters.

Consultant job planning

5.2 The NHS Employers organisation and the British Medical Association have agreed and published joint guidance on consultant job planning. The consultant job plan is the principal mechanism through which consultants and managers can meet their shared responsibility to provide the best quality care within the resources available to them. The joint guidance emphasises the importance of a collaborative and constructive approach to job planning based on agreed outcomes, which will help to focus activity on improving patient care in challenging financial circumstances. Work is continuing to develop a joint training package to help employers and doctors incorporate the principles set out in the guidance into their local job planning discussions.

Clinical Excellence Awards

5.3 Employers believe that the current arrangements for consultants' Clinical Excellence Award schemes should end, or be significantly reformed, as outlined in the NHS Employers organisation’s 2010 submission to the DDRB.

5.4 Representing employers’ views in the review of consultants’ clinical excellence and distinction awards, the NHS Employers organisation submission also states that if reformed, the process should include stronger employer control over decisions on pay and reward at a local level.

5.5 In our submission to the DDRB we said that NHS organisations also believe that the awards should not be pensionable, protection should end and any available

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49 http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/ConsultantsAndDentalConsultants/ConsultantJobPlanningToolkit/Pages/ConsultantJobPlanningToolkit.aspx

50 http://www.nhsemployers.org/SiteCollectionDocuments/Evidence_DDRB_Clinical_Excellence_Distinction_Award_Schemes_fb011210.pdf
money - as a result of the reform - should be redistributed directly to employers, to use as part of their pay and reward system.

5.6 Employers believe that any award system should be:

- affordable
- fair
- effective
- strongly linked to local objectives
- free of unlawful discrimination.

5.7 If the current arrangements remain unchanged, employers say it is unlikely that the above principles will be met.

5.8 NHS organisations are divided on whether the schemes should continue. Many believe that Clinical Excellence Award (CEAs) should end whilst others accept there is a benefit in having a system which rewards outstanding contributions by medical colleagues. However employers draw a clear distinction between local and national awards and want the local awards' money to be available for them to help incentivise excellence in delivering more local services, better and quicker for patients.

5.9 There is broad agreement among employers that the current financial and policy framework is not fit for purpose. In particular, employers have expressed concerns about the:

- need to strengthen local employer control over local pay and reward systems
- payments being pensionable
- protection arrangements
- awards not truly awarding excellence
- consolidation into pay, so that additional programmed activities get awards pro rata
- equality proofing of the schemes
- requirement to spend an allocated proportion of the pay bill, regardless of the number and quality of applicants
- dominance of the system by doctors
- value of the awards
• disconnect from the reward and encouragement of excellence elsewhere in the workforce
• disconnect with performance, appraisal and job planning
• lack of transparency
• portability of the awards to subsequent employers.

5.10 The Government response to the recommendations of the DDRB report on the future of Clinical Excellence Awards systems is still awaited. Employers would welcome the opportunity to explore with the British Medical Association (BMA) and others, whether a scheme can be devised that provides organisations with the flexibility to reward consultants in a way that is better integrated into local systems and needs.
6. Specialty and associate specialist doctors

6.1 Earlier, we described the numbers and earnings of those doctors employed on the national terms and conditions of service for specialty and associate specialist (SAS) doctors. This section provides some supplementary description of connected matters.

SAS 2008 contract assimilations

6.2 DDRB asked to be updated on assimilation to the 2008 SAS contract. 12,891 doctors were considered to be eligible to assimilate to the new Specialty Doctor or Associate Specialist contract by the end of March 2008, just before the launch of the contract on 1 April 2008. By the end of July 2012, 6,636 of these doctors were recorded as being as either assimilated or eligible to assimilate to the new contract (the remainder had moved to posts with non-eligible grades, had left the NHS or had not been recorded in the ESR\textsuperscript{51} data warehouse in July 2012.)

6.3 Of the 6,636 doctors remaining, 4,752 (72 per cent) had assimilated to the new contract (see Figure 9).

6.4 Of the 1,884 remaining doctors who had not transferred to the new contract:

- 28 per cent were Associate Specialists on the old contract
- 29 per cent were General Medical Practitioners or General Dental Practitioners in March 2008.
- 26 per cent were Staff Grade Doctors
- 16 per cent were Hospital Practitioners.

\textsuperscript{51} ESR Data Warehouse Staff In Post data, dating between March 2008 and July 2012. NHSE own calculations. It should be noted that staff belonging to each type of post have been identified by recorded ‘grade code’ in ESR. This analysis is dependent on those grade codes being administered correctly. It is also important to note that there are doctors working on multiple assignments, which are recorded over more than one type of post i.e. Associate Specialist and Staff Grade, these doctors have been assigned to the most appropriate type of post in these instances. The methodology used to calculate headcount broken down by old and new grades may vary to some extent from that used by the DH in their 2012-13 submission to the Doctors’ and Dentists’ Review Body.
<table>
<thead>
<tr>
<th>March 2008 Grade Description</th>
<th>Eligible Staff at March 08</th>
<th>Eligible Staff (not assimilated) at July 2012</th>
<th>Assimilations (up to and including July 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Staff</td>
<td>% of total</td>
<td>Number of Staff</td>
<td>% of total</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>3,555</td>
<td>28%</td>
<td>531</td>
</tr>
<tr>
<td>Clinical Assistant GMP/GDP</td>
<td>4</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Practitioner Staff Grade</td>
<td>2,024</td>
<td>16%</td>
<td>550</td>
</tr>
<tr>
<td></td>
<td>1,018</td>
<td>8%</td>
<td>306</td>
</tr>
<tr>
<td>Total</td>
<td>12,891</td>
<td>100%</td>
<td>1,884</td>
</tr>
</tbody>
</table>

Figure 9

6.5 As expected the numbers have flattened off as the pool of eligible staff wishing to transfer is almost exhausted. As the transfer is optional, it is likely that these staff have elected to remain on their old contracts. The window of opportunity to assimilate to the new contract has closed several years ago and we do not believe it should be necessary to continue to monitor the assimilations.

Job planning

6.6 The NHS Employers organisation and the British Medical Association (BMA) are in the process of agreeing joint guidance on specialty and associate specialist (SAS) job planning. The guidance is based on the consultant job planning guidance and shares the same values of providing the framework for a collaborative approach, to enable SAS doctors and clinical managers to meet their shared responsibility for providing the best possible patient care.

6.7 It is important that job planning for SAS doctors is seen as important and the guidance will help establish that – it is important to get equality of access to this important development tool within the contract. Subject to agreement by both parties, we aim to publish the guidance this autumn and will publicise this on our website.

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http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/ConsultantsAndDentalConsultancy/ConsultantJobPlanningToolkit/Pages/ConsultantJobPlanningToolkit.aspx#1
6.8 The recent Organisational Readiness Self Assessment exercise\(^{53}\), conducted as part for the preparations for the introduction of revalidation in the medical profession, shows only 53% of SAS doctors have had an appraisal in the last year. Appraisal is a cornerstone of revalidation and both the BMA and the NHS Employers organisation are keen to work urgently to rectify this. We believe there are two principle issues causing the low rates of appraisal for SAS doctors – first, one of engagement of SAS doctors in appraisal; second, the issue of access to appraisal.

6.9 The NHS Employers organisation is planning some events in partnership with the BMA, Revalidation Support Team (RST), GMC and others in the autumn, specifically around appraisal for SAS doctors.

6.10 They will likely be in two parts - firstly a webinar aimed at employers, to engage with them about their responsibilities to appraise SAS doctors of which access to appraisal will be a key theme.

6.11 The second part will be regional workshops for SAS doctors, aimed at medical directors, responsible officers, SAS reps and BMA reps. These will focus on addressing concerns about revalidation in order to gain better engagement from the SAS community. They also aim to encourage SAS doctors to become appraisers themselves.

On call clarification

6.12 The BMA raised concerns about SAS doctors being required to work a large proportion of their hours in out-of-hours. They were specifically concerned about the developmental impact this may cause and the safety risks associated with persistent disruption during on call shifts. To address this issue, NHSE and the BMA’s SAS Committee agreed a short guidance document\(^{54}\) which we have published on our website. This highlights the European Working Time Directive (EWTD) rules around rest and compensatory rest and sets out that persistent disruption during the out of hours period may indicate a need to review the design of the rota.

Acting down guidance

6.13 The NHS Employers organisation has recently added some examples of ‘Acting Down Guidance’\(^{55}\) to our website. This aims to address concerns raised by the BMA that some specialty doctors had been covering doctors in training rotas on a regular basis for one session a week. This reportedly sometimes resulted in SDs covering the doctors in training night shift and then working their normal shift the next day.

6.14 In addition to the guidance, we have explained on the website that senior doctors can be asked to act down, but that employers should take account of the doctor's other commitments and how these can be covered; and the requirement for, and arrangements for provision of compensatory rest.

GPs joining the specialty doctor grade

6.15 The NHS Employers organisation and BMA have recently agreed to add a frequently asked question (FAQ) to our SAS FAQ document\(^{56}\), which gives employers the flexibility to recognise GP principal (not salaried GP) service for those entering the specialty doctor grade. There was a provision under the old contract for GP principal income to be protected for GPs moving to the old staff

\(^{54}\) [http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/StaffAndAssociateSpecialistDrs/ContractDetails/Pages/JoiningNegotiatingCommitteeSAS.aspx](http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/StaffAndAssociateSpecialistDrs/ContractDetails/Pages/JoiningNegotiatingCommitteeSAS.aspx)

\(^{55}\) [http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/ConsultantsAndDentalConsultants/Guidance/Pages/Consultants-Guidance.aspx#arrangements](http://www.nhsemployers.org/PayAndContracts/MedicalandDentalContracts/ConsultantsAndDentalConsultants/Guidance/Pages/Consultants-Guidance.aspx#arrangements)

grade or old associate specialist contracts, but there is no such provision under the new contracts.
7. **Doctors in training**

7.1 Earlier we described the numbers and earnings of those doctors employed on the national terms and conditions of service for doctors in training. In this section, we provide some supplementary description of the need for contract reform, and matters related to the maintenance of the current contract.

7.2 The four health departments of the UK commissioned the NHS Employers organisation to conduct a scoping study to consider the efficacy of the current terms and conditions for non-consultant doctors in training. This would cover all doctors in the two years of foundation training and the subsequent years of specialty registrar training.

7.3 The commission for the report arose from a suggestion from the DDRB, following evidence from the British Medical Association (BMA) that they believed the current arrangements are not fit for purpose.

7.4 The report of the study was submitted to the four health departments during July 2011. It establishes that there is a case in principle for change. Some further work has also been submitted on the costing of alternative arrangements.

7.5 The NHS Employers organisation would welcome a remit from the four health departments to negotiate more effective arrangements based on the principles set out in our report. Those principles were:

- better patient care and outcomes
- doctors in training feeling valued and engaged
- affordability
- producing the next generation of medical professionals
- improving relationships (particularly between doctors, employers and deaneries).

7.6 The current contract was implemented in 2000 with a specific remit to reduce doctors’ (in training) hours and enforce minimum rest breaks and working conditions. This contract applies to doctors in the training grades below consultant level, including both years of foundation training and all the subsequent years of specialty registrar training.

7.7 The report was an employer side report based on the views of a wide range of the NHS employers organisation across the UK. The views of the BMA and the British Dental Association (BDA) were also obtained and reflected upon when drawing our conclusions.
All parties came to a broad consensus that the existing contract is not suitable and is proving unable to deliver this vision in the current context.

The report set out three broad options for reform:

- no change
- amending the current contract
- full renegotiation of the contract.

A full renegotiation would be the most demanding option, but would allow the contract to be fully redesigned around the current context, the actual needs of the service and the training needs of the doctors, while being affordable, sustainable and responsive to local needs.

The NHS Employers organisation would welcome a remit to negotiate new arrangements with the BMA on a four country basis.

**Engagement with junior doctors committee**

Until such time as a remit is granted, maintenance of the current contract continues and we report below some matters related to that during the past year.

**Induction**

The BMA raised concerns about the increase in the number of online induction programmes that doctors in training were expected to complete before they commenced employment and were not paid to complete. To address this issue, NHSE and the BMA’s Junior Doctor Committee agreed a paragraph which states that where the employer deems that induction activities are mandatory before beginning work then this should be undertaken in working time during the first week of employment. Where this is not possible and the doctor is expected to undertake this activity before they commence employment then the doctor should be reimbursed in some form.
Prospective cover and band 1C

7.14 Following discussion the BMA and NHSE agreed to republish the banding questionnaire which was available to the service in 2000 as part of the contract implementation to remind all parties of the parameters of band 1C and prospective cover.

Banding appeal panels

7.15 The BMA raised the issue of the composition of banding appeal panels once SHAs are abolished. The trainee doctors’ contract refers to the regional improving trainee doctors’ working lives action team (RAT) or equivalent; these RATs were generally based in SHAs. A number of SHAs devolved the RAT function and where this occurred the employer was generally expected to find an independent representative from a nearby trust. NHSE is currently consulting with the service to determine current practices and the preferred way forward.

Maternity provisions

7.16 The NHS Employers organisation generated guidance in late 2011 to improve knowledge in the service, and reduce the number of errors in the application of the complex contractual maternity provisions. The guidance document is currently being further expanded to detail all of the questions the service raises around maternity leave and we are working with the BMA to ensure the new version is a jointly agreed document.

Shadowing

7.17 Following recommendations made in the Prof. Collins’ Foundation for Excellence Report, Medical Education England’s medical programme board agreed that all medical graduates due to start their foundation programme in 2012 should undertake a paid period of four days’ shadowing with their first foundation year one employer immediately prior to the start of their employment. The agreement to introduce shadowing was not negotiated through the Joint

Negotiating Committee (JNC), however it impacted on pay costs as noted earlier in this submission.
8. Salaried general practitioners and dentists

Salaried general practitioners

8.1 The salaried GP pay ranges remain fit for purpose and present no recruitment and retention issues for employers. In as much as any recruitment issues arise they are location specific labour market supply issues.

Salaried dentists

8.2 There are about 1200 salaried dentists working in England in a variety of organisational settings. They do not appear to be a noticeably different situation to the rest of the employed doctors and dentist workforce.

Dental trainees

8.3 The old SHO (MN21) scale is now only applicable to a specific group of dentists in training, and the NHS Employers organisation would like to clarify this point in the short term by renaming the SHO scale. However, there is an anomaly that will need to be addressed in the pay circular.

8.4 Dental trainees achieve full registration on leaving dental school and then enter the vocational dental practitioner (VDP) year (dental foundation year one), which is treated in the foundation training pathway as approximately equivalent to the F2 grade in medicine. Pay for the VDP year is separately recommended by DDRB and is currently £30,132. The dental foundation year two (DF2) grade is considered to be equivalent to the old Senior House Officer (SHO) grade, and trainees entering DF2 are placed on the first point above the minimum of the SHO scale, currently £29,616, as per the DH letter of 17th January 200858.

8.5 This creates a pay discrepancy for some trainees on entry to dental foundation year two - for those who receive banding, the basic salary falls; however, those who do not receive banding have their pay protected at the VDP level of £30,132, a level that is higher not only than the SHO salary but which also exceeds the entry level salary for the parallel specialty registrar grade.

8.6 The interaction between the vocational dental practitioner salary, the SHO scale and the specialty registrar (StR) scale gives rise to discrepancies in pay which need to be addressed. We would recommend that this issue be resolved via discussions between the NHS Employers organisation, the DH and the BDA.
9. **Pensions and total reward in the NHS**

**Introduction**

9.1 The purpose of the reward package in the NHS, as for any employer, is to ensure the recruitment and retention of the appropriate numbers of staff, the appropriate skill and knowledge mix among the staff and the correct quality of application of that skill and knowledge at the correct place and time, to provide the services required. While economic conditions have effects on the labour market and on affordability, earnings need to reflect this purpose.

9.2 Doctors and dentists employed in the NHS enjoy a range of valuable benefits beyond their current earnings. Arrangements in the NHS provide one of the most generous pensions available. For example, an inflation proofed pension of £68,000 per annum requires a pension pot of nearly £2 million in the private sector. Higher paid NHS employees, including doctors and dentists in the current pension scheme defer a reasonable amount of their pay towards their pension, similar in proportion of their pensionable pay as colleagues on lower incomes while typically receiving better benefits. Higher earners contribute typically 6.54 per cent of their pay after tax relief. They also enjoy the 14 per cent of their pay deferred into their pension pot from their employer.

9.3 Doctors and dentists also typically receive other valuable rewards for their work in addition to their pay and their employer’s 14 per cent contribution to their pension, such as:

- flexible early retirement provision from age 55
- life insurance of twice their annual pay and generous death benefits for widows/widowers and dependents/children
- up to 41 days annual leave compared with 28 day statutory requirements
- sick pay of up to six months full pay and six months half pay, compared with statutory sick pay of less than £90 per week for up to 28 weeks
- redundancy arrangements that pay up to two years salary with a maximum of 24 years reckonable service
- maternity pay of eight weeks full pay, 18 weeks half or full pay, 13 weeks statutory maternity pay and an optional 13 weeks unpaid leave.

9.4 Reward is not only about pay rates. It is also about tangible and non-tangible non-pay rewards. It encompasses pensions – deferred wages; conditions of
service, such as annual leave, sick pay, enhancements for work out of hours and payments for additional duties; and how staff are managed.

9.5 When there is limited growth in headline pay rates it is all the more important that the full value of the reward package is transparent and clearly explained to staff. This has led to a renewed interest among employers in the NHS to a total reward approach.

**Total reward**

9.6 Total reward values the entire employment package and experience that an employee receives for undertaking a role. The Hay Group developed a model\(^{59}\) of total reward that was used for the public sector which reflects the diverse components of the reward package as in figure 9:

The Hay Group’s public sector total reward model:

<table>
<thead>
<tr>
<th>Tangible rewards</th>
<th>Quality of work</th>
<th>Work/life balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Competitive pay and progression</td>
<td>• Perceived value of the employee’s work</td>
<td>• Supportive environment</td>
</tr>
<tr>
<td>• Good benefits</td>
<td>• Challenge/interest</td>
<td>• Recognition of life-cycle needs</td>
</tr>
<tr>
<td>• Incentives for higher performance</td>
<td>• Achievement opportunities</td>
<td>• Flexible work and retirement options</td>
</tr>
<tr>
<td>• Recognition awards</td>
<td>• Appropriate freedom and autonomy</td>
<td>• Security of income</td>
</tr>
<tr>
<td>• Fairness of reward</td>
<td>• Fairness of reward</td>
<td>• Social environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future growth opportunity</td>
<td>Enabling environment</td>
<td>Inspiration/values</td>
</tr>
<tr>
<td>• Learning and development beyond current role</td>
<td>• Physical environment</td>
<td>• Quality of leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public service values</td>
</tr>
</tbody>
</table>

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| • Career advancement opportunities | • Tools and equipment | • Promotion of diversity |
|• Regular feedback on performance | • Training for current role | • Organisation’s reputation |
| | • Sound IT/work processes | • Risk sharing |
| | • Safety/personal security | • Recognition of achievements |
| | | • Dialogue, communication, consultation |

This model illustrates that tangible and financial awards are only part of the overall package and only part of the reason why an individual is attracted, motivated and retained by an organisation.

9.7 In a time of pay restraint, pressure to reduce costs and pension reform, employers need to be more strategic when it comes to describing the way they reward their staff. Demonstrating that all the elements in the model are part of the reward package allows for much more flexibility and creativity in how the right staff are attracted, retained and motivated.

**NHS Employers reward survey (August 2012)**

9.8 To understand the current strategic approach to reward at a local trust level, the NHS Employers organisation undertook a short survey asking HR professionals what their local approach to reward is.

9.9 It is clear from that survey and wider engagement with employers that very few employers have clearly defined the whole value of the reward they provide to their employees. However, 39 per cent of employers are developing a strategy for reward which highlights the growing development of strategic reward in the NHS, and the increasing recognition for the requirement to have a localised approach to reward that more effectively explains the whole value of the employment reward package their staff receive.
The NHS reward package

9.10 As explained, in times of pay restraint and reduced budgets, the necessity for NHS employees to understand their reward package is greater than ever (IES 2011). The overall value of the NHS reward package is not understood by, or communicated well to, many who are employed by the NHS. To help remedy this, from 2013 NHS staff will receive a total reward statement that will demonstrate better what the individual gets paid and additional local employer benefits they receive, together with their annual pension benefits statement. This will help staff understand the value of each element of the reward package. Previously they might not have realised or considered the full value of the reward they receive for their work.

Total reward statements

9.11 The total reward statement will provide a tool for employers to use when considering and defining their overall reward strategy. The next 12 months will see the increasing promotion of how employers can develop their local approach to reward and start to think about this in a strategic context that supports their overall organisation objectives and the needs of the workforce. This is important when it is local action rather than changes to national pay scales, that will maximise the attraction, motivation and retention of doctors and dentists.

9.12 This will be delivered through pilot exercises of the statement and through a reward engagement group networking employers to discuss issues about reward and how they can use this creatively to support their organisational objectives.

Non-financial and intangible rewards

9.13 There is much evidence to suggest that individuals are not only driven by the monetary gains they receive, but also the non-financial elements of working for an organisation. It is these non-financial benefits that employers need to develop and promote if they are to improve morale, motivation and retention of talent in the workforce.

9.14 NHS Organisations already provide a wide range of extra benefits locally including childcare facilities, voucher schemes, variety of salary sacrifice schemes.

http://www.employment-studies.co.uk/pdflibrary/mp4.pdf
and staff discounts. In addition to this, health and wellbeing initiatives are commonly utilised in NHS trusts alongside well supported learning and development opportunities which are all part of the total reward package for NHS staff.

The Pension Scheme as part of employee reward

9.15 The NHS Pension Scheme can be seen by employers as a cost ‘done to them’ rather than something they own. As a result employers often do not routinely make clear the value of the pension scheme to their employees.

9.16 The abolition of the default retirement age in October 2011 has placed employers under increasing pressure to develop new ways to support older workers. Different age groups have different needs and perceptions and as a result the workforce motivations and needs, in terms of reward, are becoming broader. For example, simply promoting the pension benefits will not motivate and attract younger workers, whereas focussing solely on career progression opportunities may not suit the needs of an older workforce. Employers are facing the challenge of understanding the impact of working longer and how this will influence their strategic reward decisions.

9.17 The Proposed Final Pension Agreement\(^61\) detailed the required research into the impact of working beyond the age of 65. A joint employer/trade union group is reviewing the implications of the workforce working longer and aims to make recommendations during 2013 on how the NHS employers organisation should support staff and change career pathways to support workers to stay healthy and in work for longer.

9.18 The NHS staff reward package includes an automatic entitlement to membership of the NHS Pension Scheme (NHSPS). The NHSPS is a defined benefit occupational scheme linked to salary. Membership of the NHSPS currently stands at 86% (July 2012) of the total NHS workforce.

9.19 Benefits for most staff in the 1995 section of the NHSPS are based on 1/80th of pay for each year of service, includes a separate lump sum, life assurance, ill health, partner and dependent benefits. Unreduced pensions are payable at the normal pension age of 60, based on the best of the last three years service. Since April 2008, most staff can increase their separate lump sum payment by commuting (or giving up) some of their pension. New entrants join the 2008 section of the NHSPS.

\(^{61}\) DH (2012) Reforming the NHS Pension Scheme for England and Wales: Proposed Final Agreement
Since October 2009 all contributing members of the 1995 section of the scheme could choose to transfer their accrued service to the 2008 section of the scheme. The 2008 section, open to new entrants since April 2008, has a normal pension age of 65, a 1/60th pension, and no automatic lump sum, but members are able to commute part of their pension in order to secure a lump sum payment. Pensions in the 2008 section are based on an average of the best three consecutive years in the last ten years. Around a third of all scheme members are now in the 2008 section.

Non eligible staff

There is a small group of staff who are excluded from membership of the NHSPS, primarily due to the fact that they are already in receipt of a pension or have reached retirement age with preserved benefits. However, workplace pension reforms are due to come into effect on 1 October 2012 as part of the Pensions Act 2008, which introduces measures aimed at encouraging greater personal saving. This means that employers will need to take action to identify those staff who are not eligible to join the NHSPS and automatically enrol them into alternative pension arrangements. Employer compliance duties will be introduced in stages from October 2012, broadly based on the size of the employers pay as you earn (PAYE) scheme, with the first NHS organisations starting in March 2013. Employer contributions will also be staged over time and by 2018 they must be at least 3 per cent of the employee’s earnings. The employee will be responsible for contributing an additional 5 per cent of their earnings.
Public service pensions reform – proposals for NHS

9.22 Following a fundamental structural review of public service pension provision (underpinned by the recommendations made by the Independent Public Service Pensions Commission62, chaired by John Hutton) the Government has confirmed that it intends to move forward to implement a new scheme design for the NHS from 1 April 2015.

9.23 The Government’s intentions are set out in the ‘Reforming the NHS Pension Scheme for England and Wales – proposed final agreement’63, published on 9 March 2012. Its key features include:

- a contribution of 14 per cent of pensionable pay from the employer
- protection of the accrued rights of current scheme members
- additional protection of future benefits for those members within ten years of their current normal pension age. Further limited protections with linear tapering is available to members in the 1995 arrangements who are within a further 3 years and 5 months of their current normal pension age, (i.e. up to 13 years and five months from their normal pension age)
- a pension scheme design based on career average earnings
- an accrual rate of 1/54th of pensionable earnings each year with no limit to pensionable service
- revaluation of active members’ benefits in line with Consumer Price Index (CPI) plus 1.5 per cent per annum
- a normal pension age equal (NPA) to the state pension age (SPA), which applies both to active members and deferred members (new scheme service only). If a member’s SPA rises, then NPA will do so too for all post 2015 service
- pensions in payment to increase in line with inflation (currently CPI)
- benefits to increase in any period of deferment in line with inflation (currently CPI)
- member contributions on a tiered basis to produce a total yield of 9.8 per cent of total pensionable pay in the scheme

62 http://www.hm-treasury.gov.uk/indreview_johnhutton_pensions.htm
63 http://www.dh.gov.uk/health/2012/03/final-agreement/
The early/late retirement factors on an actuarially neutral basis; being able to retire and return to the pension scheme; as in the current 2008 section.

Clearly both the present and proposed pension arrangements in the NHS represent a high value contribution to the whole reward package received by employees.

Wider Pension Reform agenda

The Government has also announced:

- The use of the CPI for the price indexation of public service pensions alongside benefits and tax credits. This does not just impact on members of the NHS Pension Scheme, but on all members of occupational pension schemes and recipients of the state retirement pension.

- Changes to tax relief arrangements, specifically:
  - from April 2011 the annual allowance (AAL) for tax-privileged saving will be reduced from its current level of £255,000 to £50,000. HMRC estimate that 85% of public service pension scheme members will be unaffected by the changes. However, the impact will be greater for NHS Pension Scheme members because of the numbers of higher earners it covers.
  - from April 2012 the lifetime allowance was also reduced, from its current level of £1.8m to £1.5m.

- Increases on employee contributions.

The Government's 2010 Spending Review announced that public sector workers would be asked to contribute an average of 3.2 per cent more for their pensions, phased in over three years from April 2012. 40 per cent of the increases where introduced in April 2012, the details of which are set out in figure 10. Only one year is currently agreed, as the subsequent two years remain under discussion nationally with the pensions governance group.
<table>
<thead>
<tr>
<th>Full-time 2010/11 pay</th>
<th>2010/11 contribution (gross)</th>
<th>2012/13 contribution (gross)</th>
<th>Contribution increase (gross)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £15,000</td>
<td>5.0%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>£15,001 to £21,175</td>
<td>5.0%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>£21,176 to £26,557</td>
<td>6.5%</td>
<td>6.5%</td>
<td>0%</td>
</tr>
<tr>
<td>£26,558 to £48,982</td>
<td>6.5%</td>
<td>8.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>£48,983 to £69,931</td>
<td>6.5%</td>
<td>8.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>£69,932 to £110,273</td>
<td>7.5%</td>
<td>9.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Over £110,273</td>
<td>8.5%</td>
<td>10.9%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

**Figure 10**

9.27 A progressive approach to the application of the increases was adopted which ensured that staff on lower salaries, who provide a significant amount of patient contact, were protected from further costs in the second year of a period of pay restraint.

9.28 Under this new structure of tiered member contributions, the Government Actuary’s Department (GAD) estimates that the number of employees who will pay nothing extra in 2012/13 will be 630,000; this represents approximately 48 per cent of the total NHS Pension Scheme membership.
NHS Injury Benefit Scheme

9.29 The NHS Injury Benefit Scheme provides an annual income to an employee who suffers a temporary loss of NHS earnings through temporary injury allowance (TIA), or a permanent loss of earnings ability through permanent injury benefit (PIB)\(^{64}\), resulting from an injury wholly or mainly attributable to the duties of their NHS employment. The scheme may also pay benefits to the spouse and dependants of a NHS employee whose death has been caused by, or hastened by, their NHS duties.

9.30 Clearly this is very valuable part of the whole reward package received by employees in the NHS.

9.31 The scheme is now subject to reform based on negotiations between employer and employee representatives. The negotiations have led to recommendations to replace the current regulations with a clear and transparent contractual provision of the NHS terms and conditions handbook, which would recompense staff while they are in employment, who have temporarily lost income due to an injury or illness as a result of work, for up to 12 months. The rights of existing beneficiaries would be preserved.

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\(^{64}\) TIA is paid while the individual is off sick and still employed by the NHS. Payment ends when the individual returns to work or retires/resigns from NHS employment. PIB is paid where an individual is forced through injury to retire or to move to another, lower paid employment. PIB provides a guaranteed income for life and where employment ends as a result of injury/ill health, a lump sum payment. Payments vary according to length of NHS service and the permanent reduction in earning ability caused by the injury. Under this scheme, both physical and psychological problems are covered.
10. General workforce matters

Future shape of medical workforce

10.1 The CfWI prepared a report\(^{65}\) for leaders within the healthcare system on the future shape of the consultant medical workforce. CfWI set out the challenges and opportunities that employers, the medical profession and workforce planners face in relation to the future supply and shape of the consultant workforce. Looking ahead to 2020, the CfWI presented possible future scenarios, the associated risks and opportunities and set out the need for urgent debate and action.

10.2 CfWI concluded that:

- the system should reduce labour supply in a range of hospital-based specialties;
- the current growth in general practice is not strong enough to meet the predicted need;
- more evidence from service commissioners and employers on service demand would enable the system to make decisions on further specialty specific changes across the training system.

10.3 The CFWI scenario modelling predicts that unless action is taken to alter the current trajectories, then there could be:

- more fully trained hospital doctors than the current projected demand suggests will be required
- an increase of over 60 per cent in the fully trained hospital doctor headcount by 2020
- an estimated £6 billion spend on total consultant salary costs (based on headcount and the pay bill is based on full time equivalent (FTE)), an increase of about £2.2 billion on the 2010 figure, if all eligible doctors become consultants.

10.4 Current trends in the supply of fully trained doctors have the potential to drive up quality, through increased competition for consultant appointments and the scope for developing new service models, with new roles for doctors in community settings. The modelling also suggests that the numbers completing

training overall would offer the capacity to move to a 'trained doctor' model of service, albeit with the need for significant rebalancing between specialties.

10.5 In addition, this debate needs to take account of the work of Medical Education England (MEE) in relation to:

- the Better Training Better Care programme that aims to improve patient care by improving the quality of training.
- the Shape of Training programme that is reviewing the roles and responsibilities of trainees and the day one consultant or GP, and the responsiveness of training programmes to the needs of patients, employers and trainees.

We refer to these work programmes later in this section of the submission.

10.6 As part of their work CFWI sought the views of employers and found that employing organisations were concerned about sustaining the current shape and cost of the medical workforce into the future. They found that employers recognise the need for change in both the medical and the non-medical workforce and are already adopting a range of different approaches to manage their medical workforce more flexibly. Employers are interested in reshaping the medical workforce; the need for more out-of-hours working; more presence of trained doctors; and better changeover and shadowing at points of transition in doctors’ careers.

10.7 The Foundation Trust Network (FTN) submitted written evidence to the CFWI study. In that evidence, the FTN supported further exploration of the models suggested, in particular consolidated training and graded consultant structures, as part of a holistic look at the deployment of the entire workforce. They noted the “...NHS Employers report from 2008 concerning the employers’ vision of the future medical career, where largely the principles then identified remain true – though of course the framework has changed significantly with the advent of Health Education England (HEE) and local education and training boards (LETB)s.”

68 http://www.nhsemployers.org/Aboutus/Publications/Documents/Medical%20Training%20and%20Careers.pdf
10.8 The NHS Employers organisation's report set out its main findings as:

- Employers favour a modular approach to postgraduate medical training built around care pathways that provide recognised ‘credentialing’ to support doctors’ development over a range of flexible career routes.
- A multidisciplinary approach to workforce planning based on the needs of health service provision, with more refined tools and systematic engagement with employers, is essential.
- A clear balance between service delivery and creating a supportive environment for learning and development is required.
- A small planned oversupply in the medical workforce is desirable to enable a flexible response to changing staff and patient demographics.
- The future NHS will not require all doctors to progress to the current role of consultant. New roles and structures must be developed that will meet the needs of employers and patients with the flexibility to adapt the structure to suit local circumstances.

10.9 Thus, employers believe that contract and service reform are needed if we are to have an affordable, sustainable and locally responsive pay system, helping deliver more 24/7 services.

10.10 Employers seek to answer these key strategic questions in relation to contract and service reform –

- What will patients need from the healthcare system in the future? Do the types of services and location of services need to change?
- What are we trainee doctors to do? Have we the right balance between doctors and other occupations? Are we over or under training? How do we avoid boom and bust in trying to create stability of labour supply, which is affordable and fit for purpose?
- How many of them do we need and in what skill mix (both within medicine in terms of level of job and the balance between generalists and specialists, and with other health professions)? What does this mean for career expectations?
- How do we reassure the public of the continuing competence of those we employ to do what we employ them to do?
• How much money is available for the pay and reward system and how should that be distributed in order to recruit, retain and motivate the correct numbers and skill mix of staff?

• Is the distribution of available money correct among different types of doctors – for example, should the ratio of consultant earnings to the earnings of doctors in training remain much the same as is currently the case?

• And, how do we engage effectively with the medical workforce to deliver more, better and quicker to meet the healthcare needs of people in the UK?

So, pay cannot be seen in a silo; it must be seen as being useful to help achieve what is being done in the other areas.

Medical specialty training planning

10.11 The CfWI 2010 analysis to inform the numbers of doctors going into medical specialty training after completing foundation training, made recommendations on numbers for the 2011 intake, and subsequently for the 2012 intake.

10.12 The report contained:

• an overall analysis of numbers going into medical specialty training
• more detailed analyses for each specialty
• identification of which medical specialties are at risk of over supply as well as identifying the geographical balance.

10.13 The report made reliable recommendations and identified emerging messages when considering the shape and size of the overall workforce needed for the NHS of the future. It informed the latest planning assumptions (provided by Medical Education England to deaneries and employers each year) for recruitment to specialty training. These suggest a further significant move toward more general practitioner specialty training and fewer hospital specialties in 2013. Where deaneries cannot achieve this rebalancing they are required to set out a plan to achieve the changed numbers by 2015.

10.14 The planning assumptions require that Local Education and Training Boards (LETBs) review what can be achieved locally and seek to reinvest resource where

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70 Unpublished material from the Joint Working Group on Specialty numbers
possible to new priorities accepting that some transitional funding will be required where programme numbers are removed. They are encouraged through this process to look for non-medical solutions where training numbers are reduced or removed.

10.15 All planning numbers may not be attainable by LETBs within 2013. Where that is the case action plans will be required from LETBs on how they aim to achieve them by 2015.

10.16 Across England, the number of specialty/core training (ST1/CT1) posts across all specialities should not exceed 6,500 nationally in 2013, a reduction from the circa 6700 in 2012. The supply number for GPST1 is set as 3250 per year by 2015. 2012 recruitment was to be 3000, but actual vacancies advertised in 2012 were 2687 (Source: General Practice National Recruitment Office)\(^7\). The planning assumptions will be revisited by a new national GP workforce currently being established together with input from the CfWI, which is referred to later.

10.17 Therefore, the 2013 planning assumptions represent an expansion of GP training posts to 3,000 with LETBs aiming to achieve their share of 3250 ST1 GP training posts by 2015. ST1/CT1 posts in specialties other than GP should not exceed 3,500. As GP numbers increase, non-GP specialty numbers should reduce to 3,250 by 2015.

10.18 In addition, there should be no CT2/CT3 recruitment in any specialties other than ACCS Emergency Medicine and Core Psychiatry training. The number of core surgical training posts at CT1 should not exceed 550 down from 600 posts in 2012. This will ensure appropriate competition ratios between CT2 and ST3 of circa 2:1

10.19 What these planning assumptions mean is that there should be a noticeable shift of posts from hospital specialties to general practice. This suggests that an increase in pay for hospital doctors is not required.

10.20 We have referred earlier to the work of the Shape of Training Review; Better Training Better Care; the GMC’s review of Medical Practice in the UK; and the taskforces on psychiatry, emergency medicine and general practice and we summarise these below.

\(^7\) [http://www.gprecruitment.org.uk/](http://www.gprecruitment.org.uk/)
10.21 In 2011, MEE identified issues facing the future of postgraduate medical training. A steering group scoped out key themes for a review of the structure or shape of postgraduate medical education and training. The themes that were identified were:

- the tensions between the needs of the service and the demands of training
- the balance between generalist and specialist care
- flexibility and value for money and the need for innovation set against the risks of de-stabilisation.

10.22 In May 2011, the steering group agreed that further work on the shape of training was necessary and should be taken forward, led by an independent chair. Professor David Greenaway, Vice Chancellor of Nottingham University, was appointed as chair of the review in February 2012.

10.23 To help assist the chair in considering written and oral submissions from stakeholder groups and support review activities such as research, seminars and speaking engagements, an expert advisory group was formed. Members of the group were selected for their independent expertise and advice rather than as representatives of their organisation.

10.24 The review will look at potential reforms to the structure of postgraduate medical education and training across the UK. The review’s aim is to make sure that we continue to train effective doctors who are fit to practice in the UK, provide high quality and safe care and meet the needs of patients and the service now and in the future.

10.25 There are five themes which have been identified as focus points for the review:

- workforce needs – specialists or generalists?
- the breadth and scope of training
- the needs of the health service
- the needs of the patient
- flexibility of training.

The review plans to report during the autumn of 2013.

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http://www.shapeoftraining.co.uk/
Better Training Better Care

10.26 The MEE Better Training Better Care programme aims to improve the quality of training and learning for the benefit of patient care.

10.27 The programme aims to enable the delivery of the key recommendations from the Time for Training and Foundation for Excellence reports. DH ministers commissioned both reports and MEE is now taking forward the recommendations from these reports.

10.28 Better Training Better Care seeks to deliver improved patient outcomes, safety and experience through better training and better systems of care. This will be achieved by:

- building on service redesign which will draw upon greater consultant involvement in the delivery of care
- improved and more immediate supervision of trainees
- enhanced multidisciplinary working which supports training
- trainees undertaking training on procedures and skills in simulation environments.

10.29 The programme has involved 16 pilot sites, each one of which is running a project with the aim to improve the quality of learning and training whilst improving patient care. To view the project outline and posters for these pilots, visit the MEE website.

10.30 The consultant led aspect of Better Training Better Care is supported by the Academy of Medical Royal Colleges' January 2012 review into the Benefits of Consultant Delivered Care. The NHS Employers organisation submitted a response to the AoMRC review, broadly supporting the concept of consultant delivered healthcare, with patients able to expect to be treated in hospital by fully qualified practitioners, fit for practise and up to date in their clinical expertise. This is an objective which employers are working to achieve, reducing the traditional reliance on training grades to support service requirements, and developing alternative care models.

10.31 However, this has to be seen in the context of wider improvements to medium to longer term workforce planning as referred to in relation to the advice of CfWI earlier.

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73 [http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care.aspx](http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care.aspx)
10.32 It is for health economies and employers locally to determine the staffing and skill mix needed in their areas, according to their local service delivery plans. This includes whether additional consultants or other doctors or health professionals are required to meet patient demands and the changing healthcare requirements of a 21st century NHS.

10.33 Changes to the NHS structure have given the system an opportunity to re-state the importance of the employer voice being heard at the right levels in informing education and training commissioning decisions so that we can properly balance individual training requirements and service needs longer-term. Annex C provides a description of the new education and training system and the employer's role within it.

10.34 Employers are committed to care and treatment being delivered based on the individual patient needs, by the most appropriate health professional, with the right training and skills. This might mean that some doctors will need post-CCT training or experience before they are equipped for particular roles. It is also a good thing for any employer that they have a ‘pool’ of talent to draw upon with a level of competition for posts. Of course, any job (at whatever level) will always need to be attractive to draw good applicants.

10.35 Rather than simply continuing to expand the number of doctors employed on the consultant contract conditions of service, certainly at the rate seen over the past ten years or so, cost effectiveness and affordability need careful consideration. The National Audit Office and Health Select Committees’ concerns about whether the new consultant contract has actually delivered improved productivity – whether measured by volume, quality or outcomes - is also relevant here. There may be cases where other professions such as allied health professionals and healthcare scientists may offer more effective higher quality care.

10.36 As stated previously, the NHS Employers organisation supports the aim of delivering a modest over-supply of trained doctors against anticipated service needs. Medical career structures will also need to remain attractive to encourage the best students into medicine.

10.37 There is increased need for flexibility across the NHS, both in working patterns and working across and beyond traditional organisational boundaries. The future consultant workforce needs to be adaptable to this, leading and promoting the changes that will benefit patients.

State of medical education and practice in the UK
10.38 The GMC published its second report on the *State of Medical Education and Practice in the UK*\(^78\) on 18 September 2012. They report that the number of doctors on their register continued to grow last year and, for the first time, the number of female doctors passed the 100,000 mark. They also report that changing lifestyles and expectations of doctors mean that the need for flexible working and training is becoming increasingly important. A third of UK doctors qualified outside the UK, although there are changes in the countries from which doctors come to the UK to practise, with the profession shaped by external factors.

10.39 The GMC report the continuing debate about the distribution of doctors across specialties, particularly whether the UK has an appropriate balance between specialists and generalists, and if the UK has enough doctors in the right specialties to care for an ageing population.

10.40 The GMC has worked with the NHS Employers organisation and other stakeholders to prepare for the introduction of revalidation to the UK later in 2012. Medical revalidation is the process by which all doctors with a licence to practise in the UK will need to satisfy the GMC, at regular intervals that they are fit to practise and should retain that licence.

10.41 The regulations that will make revalidation a legal requirement will come into force in late 2012. The NHS Employers organisation is working with the GMC, the NHS Revalidation Support Team (RST) and the DH to help NHS organisations prepare for the introduction of revalidation and ensure that the processes recommended are streamlined and based on existing clinical governance and HR systems.

10.42 The NHS Employers organisation briefing\(^79\) (November 2011), *Medical revalidation: what employers need to know and do* provides a timeline of activity, the key milestones and a useful checklist of actions that organisations need to carry out if they are to be ready for the introduction of revalidation. The briefing provides information on the following key areas:

- the role and training of responsible officers
- appraisal and appraiser capacity
- portfolios of supporting information and information management
- working across organisational boundaries
- changes in NHS organisations and structure
- handling and responding to concerns.

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\(^{79}\) [http://www.nhsemployers.org/Aboutus/Publications/Pagev/Medical-revalidation-employers.aspx](http://www.nhsemployers.org/Aboutus/Publications/Pagev/Medical-revalidation-employers.aspx)
10.43 The NHS Employers organisation have published guidance for the appointment and employment of NHS locum doctors. This includes a section on how locums should be revalidated.

10.44 The GMC report on the State of Medical Training and Practice in the UK 2012, points out that the quality of medical practice is not only determined by the characteristics of individual practitioners, but can be shaped and influenced by the contexts in which they work and train.

10.45 They found workforce issues are continuing to impact on medical training and practice. There is a growing body of evidence that patient outcomes are worse on evenings and weekends, times when there is less senior doctor cover. And, in some specialties in particular, recruitment difficulties are affecting both service provision and training, particularly in ensuring that doctors in training have access to adequate supervision and protected time for education.

10.46 Despite the number of doctors registered and licensed to practise in the UK continuing to grow in recent years, as has the number of doctors working in the NHS, workforce pressures continue to affect certain specialties. The reasons for these pressures are complex and can vary from one organisation to the next, but are likely to include how services and staff are organised.

10.47 It is becoming increasingly clear that there are poorer patient outcomes at weekends and night and that this appears to be linked to fewer senior medical staff being on duty. Studies have demonstrated not only that patient experience can be affected over weekends and holidays, but that these times are associated with higher death rates. The outcomes of care are worse in a number of areas.

10.48 NHS London predicted in the Case for change for emergency services in London that, if the weekend mortality rate was the same as the weekday rate, 500 lives could be saved each year. It concluded that this reduced mortality rate was directly related to reduced service at the weekend.

10.49 The 2011 Dr Foster Hospital Guide took this finding one stage further and reported a link between higher mortality rates at the weekend and reduced

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80 http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Future-of-the-medical-workforce/Pages/Guidanceontheappointmentandemploymentoflocumdoctors.aspx
81 http://www.gmc-uk.org/publications/13887.asp
consultant presence\textsuperscript{84}.

10.50 A large study involving an analysis of more than 14 million NHS admissions in 2009–10, in the \textit{Journal of the Royal Society of Medicine} also showed an increased mortality rate of 11 per cent and 16 per cent for patients admitted on Saturdays and Sundays respectively, compared with patients admitted on a weekday. This was after adjusting for the differences in patient characteristics for patients admitted on different days\textsuperscript{85}.

10.51 The evidence does suggest in particular that the absence of senior doctor support is a critical factor – in too many places hospitals are relying on doctors in training to provide care and treatment without adequate supervision. As the Academy of Medical Royal Colleges has recognised, there is an urgent need to map out the staffing requirements and service implications of implementing a consultant-delivered service throughout the seven-day week, at least in those specialties where evidence shows that outcomes are poorer at weekends and holidays\textsuperscript{86}.

10.52 The NHS relies heavily on postgraduate doctors in training for much service provision\textsuperscript{87}. In some specialties, implementation of the Working Time Regulations has increased pressure on service rotas, meaning that doctors in training are often required to fill gaps in rotas\textsuperscript{88}. This can have a direct impact on the ability of certain specialties and organisations to meet service needs.

10.53 These pressures in psychiatry and in Emergency Medicine have led to taskforces, including representation from the NHS Employers organisation, making recommendations to improve the availability of labour in these areas.

\textsuperscript{84} Dr Foster Intelligence (2011) \textit{Inside your hospital, Dr Foster Hospital Guide 2011} London, Dr. Foster Intelligence
\textsuperscript{87} Imison C (2011) \textit{Reconfiguring hospital services: Briefing} London, The King’s Fund, p5
Psychiatry Taskforce

10.54 Due to concerns about recruitment and progression in psychiatry training, MEE’s medical programme board invited The Royal College of Psychiatrists to establish a taskforce to make recommendations to secure the supply of CCT holders in psychiatric specialties.

10.55 The psychiatry taskforce recommended:

- Increasing opportunities for Foundation doctors to gain experience in psychiatry through taster modules and rotations.
- Piloting a second recruitment round and February 2013 intake.
- That the Royal College of Psychiatrists (RCPsych) implement a recruitment strategy to increase recruitment to the CT1 grade of Core Psychiatry Training, achieving a 50 per cent increase in applications and a 95 per cent fill rate by the end of a five year campaign, including a range of tools:
  - best practice guidance for work experience, tasters and foundation programme rotations
  - regional registers of work experience opportunities, psychiatry summer schools and expand and publish the database of psychiatric electives
  - development and distribution of high quality booklets, articles, videos etc to promote careers in psychiatry
  - courses in each deanery to enhance the teaching skills of psychiatrists
  - improving progress through training to secure the supply of CCT holders in psychiatric specialties who are fit for the purpose of providing safe and effective patient care, including:
    - commissioning of better workforce planning data to ensure supply meets clinical demand and addresses the current mismatch between numbers of ST1 posts and opportunities to progress to ST4
    - a review of the content and structure of the membership of the RCPsych examination.

Emergency medicine taskforce

10.56 The emergency medicine (EM) taskforce was set up to look into staffing challenges in emergency departments amid concerns that patient safety was being put at risk and an increase in overnight closures. Recruitment issues are widespread across the grades, although they are most acute among doctors in
training grades where typically less than half the posts are filled during national recruitment.

10.57 A summary of recommendations from the taskforce’s interim report is:

- Increase emergency medicine consultant numbers to ensure a consultant presence for 16 hours a day, seven days a week in all emergency departments and 24 hours a day in larger departments or major trauma centres.
- Work with CfWI to explore future numbers and workforce modelling in EM.
- Calibrate EM trainee numbers to support continued consultant expansion.
- Adjust the position of EM training within the training programme to improve early experience and better chances to pass the appropriate examinations.
- Develop alternative routes into EM training for trainees currently in other specialty programmes.
- Explore the recognition of transferable competencies of trainees currently in other specialities to increase the pool of trainees eligible to apply for higher specialty training (HST) posts in EM.
- Support specialty doctors in their roles to ensure retention and work satisfaction, including
  - job planning to avoid unsocial predominance and support for continuing professional development
  - the College of Emergency Medicine would explore credentialing, Masters degrees and other opportunities for specialty doctors.
- Better co-ordination with local GPs to manage demand for accident and emergency services and develop better recognition of GP emergency medicine skills and special interests.
- Expand training of clinical nurse specialists and physicians assistant’s, and define their roles underpinned by national curricula, standards and assessment.

General practice taskforce

10.58 A further taskforce is being set up, on similar lines to those for psychiatry and EM, to make recommendations in relation to rebalancing the medical workforce, with more doctors entering general practitioner training and fewer into hospital specialties. Its task is to ensure that we have the right numbers of hospital sector
training posts out of the current system so that we can meet the future demand for GP numbers – in this way we will use the availability of recognised training opportunities to pull trainee doctors into the desired specialties rather than using the pull of financial rewards.

10.59 As mentioned above, the CfWI report “Shape of the Medical Workforce: Informing Medical Training Numbers” (August 2011) has been used as a baseline for better workforce planning numbers and assumptions in relation to the annual recruitment training numbers for each specialty and geography.

In 2009, £100m of capital expenditure was invested to create additional GP training capacity; mainly focussed on enhancing practice facilities in areas where GP numbers was low compared to national norms. It was expected that this would contribute significantly to an increase in training capacity, and we have seen GP recruitment numbers grow. However, there is still a shortfall compared with the target for England of 3250 GP training places.

10.60 The strategy required to increase the GP training number capacity is complex, with a range of issues affecting the system.

10.61 In discussion between the DH director of medical education, with SHA cluster Leads, DH workforce and English deans, it was recommended that a GP taskforce (similar to the other two national priority taskforces in EM and psychiatry) be established to coordinate and manage a programme of initiatives that will improve the current position.

10.62 The taskforce will need to work across the new education and training landscape and ensure local priorities and needs are taken into account while ensuring that changes are made that will provide direction to ensure the 3250 target for GP training places is met by 2015. It will:

- review the current national employment environment including vacancies, retirement trajectory, retention, attrition and participation rates
- review how improvements can be made to GP workforce data collection
- assess the changing options available for the General Practice employment in the light of recent changes to the wider NHS commissioning landscape, including career progression
- review the historical average time of GP training to completion to training
- review the current training capacity by deanery and assess where immediate opportunities are available and undertake a gap analysis of where need is most required
- assess and understand the cost of GP training in its constituent parts and to review alternative options
- assess and cost, by LETB/deanery, a three year plan to reach national GP training levels with mitigation for lost specialty numbers in other specialties
• understand the motivation factors and barriers of trainees to want to work in general practice
• review what factors might boost interest and fill rates into GP training positions
• undertake a stocktake of good practice for using a range of other professionals as part of the primary care team and plan a coordinated plan for spreading good practice
• make recommendations to the medical programme board covering workforce, education and training, cost and timescale for delivering the national training numbers required by 2015
• note any implications of a four year GP training programme to the above (whilst recognising that such a change is not approved).
11. Conclusion

Employers do not believe that increases in national pay rates from April 2013 are either necessary or affordable. This is because earnings have continued to grow for individual members of staff during the freeze of national pay scales, due to the effect of pay progression and incremental step increases as individuals move through their careers. Recruitment and retention in the NHS is generally satisfactory, and wider solutions are being implemented where specific supply issues have been identified.

The annual measures of staff experience in the NHS remain good and the total reward of doctors in the NHS remains competitive in relation to both tangible benefits such as pensions, and non pay benefits.

Our research and engagement with employers throughout the NHS shows that the NHS reward package remains highly competitive and is a valuable retention and recruitment tool.
Annex A
Summary of responses to the NHS Employers organisation DDRB recruitment, retention and morale survey

Respondents who answered ‘Yes’ to the question “Is your trust experiencing any recruitment and retention issues?” and who gave further explanations.

<table>
<thead>
<tr>
<th>SHA (pre-October 2011)</th>
<th>Organisation Type</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>Acute foundation trust</td>
<td>Consultant &amp; middle grade doctors in emergency medicine; SAS doctors in anaesthetics.</td>
</tr>
<tr>
<td>East of England</td>
<td>Acute foundation trust</td>
<td>Some in relation to recruitment of a limited number of consultant posts i.e. urology, trauma &amp; orthopaedics and anaesthetics. This does not seem to be related to pay, but a lack of suitable candidates.</td>
</tr>
<tr>
<td>North West</td>
<td>Mental health foundation trust</td>
<td>As a mental health trust, there is a shortage of applicants and appointments for junior doctor training posts, Trust junior doctor level posts and specialty doctors. I understand this is both a local, regional and national problem.</td>
</tr>
<tr>
<td>North West</td>
<td>Acute trust</td>
<td>A&amp;E and anaesthetics.</td>
</tr>
<tr>
<td>South Central</td>
<td>Acute trust</td>
<td>In certain specialities i.e. geriatric medicine and emergency medicine particularly. This is with senior and junior medical grades. Trust grade junior doctors are being increasingly difficult to recruit.</td>
</tr>
<tr>
<td>South West</td>
<td>Acute foundation trust</td>
<td>The recruitment and retention issues for medical staff mainly relate to national shortages in some specialities in some grades – related to immigration issues and not pay.</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>Acute foundation trust</td>
<td>Doctors at middle grade level are particularly difficult to recruit to and the calibre, being a DGH is not perhaps as high as one might like. Training doctors pull out if they get a better offer or use it as a means to step onto the VTS training schemes leaving positions difficult to fill with anyone other than a locum.</td>
</tr>
<tr>
<td>National Professional Association</td>
<td></td>
<td>I am continually getting reports from trusts of difficulties to recruit emergency medicine ST4 level, and the usual trusts in the North West of England to recruit staff in general!</td>
</tr>
<tr>
<td>Not given</td>
<td></td>
<td>Middle grade paediatrics, middle grade A&amp;E, all dermatologists.</td>
</tr>
</tbody>
</table>
Respondents who gave further explanations to the question “*Does your trust feel that increased pay costs would be affordable?*”

None of the survey’s respondents felt increased pay costs would be affordable.

<table>
<thead>
<tr>
<th>SHA (pre-October 2011)</th>
<th>Organisation Type</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>East of England</td>
<td>Acute foundation trust</td>
<td>Ongoing cost improvement requirements.</td>
</tr>
<tr>
<td>London</td>
<td>Acute trust</td>
<td>The trust has to make savings of 5% per annum. There is also uncertainty about the scale of transfer of resources into community settings (and associated income) so the trust’s income may not be secure. Any increase in pay costs makes it more difficult to achieve savings.</td>
</tr>
<tr>
<td>North West</td>
<td>Acute trust</td>
<td>CCGs are reducing income of the trust. We need to take costs out to cover loss of income.</td>
</tr>
<tr>
<td>South West</td>
<td>Acute foundation trust</td>
<td>With cost pressures, we are needing to reduce pay costs overall in very challenging circumstances. It is unrealistic to give an increase, especially if the national tariff is not increased accordingly.</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>Acute foundation trust</td>
<td>Given the austerity measures the NHS is facing this would give us added financial pressures and cost savings would need to be met elsewhere.</td>
</tr>
<tr>
<td>National Professional Association</td>
<td></td>
<td>No, not in a country-wide recession.</td>
</tr>
<tr>
<td>Not given</td>
<td></td>
<td>The new SAS contract and the 2003 consultant contract are extremely expensive to run, especially with 2.5 SPA for consultants.</td>
</tr>
</tbody>
</table>
Respondents who gave full answers to the question “Would you welcome regional variations to the distribution of the 1 per cent award?”

The majority of respondents did not want regional variations to the distribution of the 1 per cent award.

<table>
<thead>
<tr>
<th>SHA (pre-October 2011)</th>
<th>Organisation Type</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>Mental health foundation trust</td>
<td>No. As well as mental health trusts, colleagues in acute trusts report that any variance in pay offered by trusts, including within region, creates opportunities for doctors to play trusts off against one another for both salaries and locum rates.</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>Acute foundation trust</td>
<td>This would add to the pressures of recruitment and retention as doctors would move to those areas providing better remuneration deals.</td>
</tr>
<tr>
<td>London</td>
<td>Acute trust</td>
<td>There is strong evidence that the cost of living varies regionally (mostly based on housing costs) and that HCAS (or London weighting) does not adequately recognise this. The 1% might be directed at those areas where salaries within the NHS have kept pace least with local increases in the cost of living, particularly the SE and London.</td>
</tr>
<tr>
<td>London</td>
<td>Acute trust</td>
<td>No. I certainly don’t think that there is a case for London paying a higher award.</td>
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<td>South Central</td>
<td>Acute trust</td>
<td>I do not think that a 1% award would significantly affect recruitment for senior medical staff. Recruitment for junior doctors is getting increasingly difficult in certain specialities. Potentially making trusts more competitive with one another with regional pay variations will only make it more challenging for certain areas.</td>
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<td>South West</td>
<td>Acute foundation trust</td>
<td>No, but that may prove necessary.</td>
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<tr>
<td>South West</td>
<td>Acute trust</td>
<td>Yes. This organisation is a very attractive employer for doctors but very expensive for other staff groups. The ability to weight the available funding to groups where the local cost of living is a significant barrier would be helpful (albeit difficult!).</td>
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<td>North West</td>
<td>Acute trust</td>
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<td>South Central</td>
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<td>SHA (pre-October 2011)</td>
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<tr>
<td>National Professional Association</td>
<td>Very difficult... the hospital next to the one increasing wages will always have a drain on staff as they move locally to the higher paying organisation. Local mergers expose where one trust has used a raised banding pay structure to introduce a retention initiative, resulting in one trusts staff being overpaid for the work output they produce. At merger time, they are the ones who are uncompetitive, as far as price and skills are concerned.</td>
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<tr>
<td>Not given</td>
<td>I think this is something which has to be looked at going forward, so potentially yes.</td>
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Respondents who gave full answers to the question *Do you have any overall comments on pay for 2013/14?*

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<tr>
<td>East of England</td>
<td>Acute foundation trust</td>
<td>Whilst the need for ongoing cost improvement and austerity is recognised. It is also recognised that the cost of living continues to increase and staff have faced a pay freeze for yet another year; would make things very difficult for staff. Morale amongst all staff including doctors is low.</td>
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<tr>
<td>London</td>
<td>Acute trust</td>
<td>1% is a level of award that if distributed evenly makes little difference in terms of motivation and will simply serve to increase the pressure on NHS organisations in terms of realising savings. Nevertheless, there is also significant unhappiness amongst the workforce about the 'pay freeze', especially in areas of high and increasing housing and transport costs like London and the SE. Maintaining the freeze would help NHS finances and is unlikely to lead to an exodus of staff (where would they go?). Paying 1% gives some help to staff but is also unlikely to raise morale, being so low an award. The evidence published about differences between public sector and regional private sector pay rates is also relevant with London and SE staff likely to be more demanding of an increase (whatever that may be) than areas where NHS pay compares more favourably with other sectors.</td>
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<tr>
<td>London</td>
<td>Acute trust</td>
<td>Most trusts have a real affordability problem with cost of living increases at present. However, it is also the case that the majority of staff are experiencing real reductions in take home pay because of the pension contribution rises. When there is an upturn in the economy we will need to be mindful that we may lose those staff who are able to get employment outside of the NHS.</td>
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<td>North West</td>
<td>Acute foundation trust</td>
<td>In the salaried dental service we need a national mechanism by which we can pay for out of hours/ weekend services. Something along the line of the AFC provisions would be useful.</td>
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<td>South Central</td>
<td>Acute foundation trust</td>
<td>The pay freeze combined with changes to pension contributions would lend itself toward a pay award next year, although concern over affordability is a real issue if this should fall to trusts as a cost pressure.</td>
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<td>South East Coast</td>
<td>Acute trust</td>
<td>In the current climate it may be necessary to consider a further pay freeze to protect jobs.</td>
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<td>South West</td>
<td>Acute foundation trust</td>
<td>We would like greater flexibilities to reward high performance and not reward poor performance in all staff groups.</td>
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<td>Yorkshire and the Humber</td>
<td>Acute foundation trust</td>
<td>I feel that an overhaul of the pay structures should be considered in light of the financial pressures experienced in the NHS. Additional remuneration should also be re-evaluated, for example payment of CEAs, seniority payments, etc.</td>
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<td>National Professional Association</td>
<td>Keep as is... keep the belt tight.</td>
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<td>I think most trusts are already struggling to meet the cost of their existing paybill, many of us are looking at reducing staff numbers in some areas e.g. admin &amp; clerical. Paying a further 1% to increase salaries of doctors and dentists seems inappropriate given that the existing paybill is unaffordable and that other staff will be losing jobs whilst others get pay rises.</td>
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Annex B
The value of incremental progression pay increases by pay point (excludes any annual headline uplift)

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Increments on the medical payscales range between 2.8% and 10.6% with a mean average increment of 5.5%.
Typical basic pay progression of doctor starting at the minimum point of each grade in 2010/11, through until 2013/14

### F1 -> F2 -> Registrar group

<table>
<thead>
<tr>
<th>Pay point / grade</th>
<th>Year</th>
<th>Salary</th>
<th>£ increase</th>
<th>Annual % pay progression</th>
<th>Cumulative % increase</th>
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### Specialty doctor

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Executive summary

- It has been widely acknowledged that the current model for commissioning education and training is unsustainable in the long term. This is because service development planning is often poorly integrated with financial and workforce planning, and medical workforce planning is largely done in isolation from the planning of education for other healthcare professionals. There are well known examples in the English NHS where historic education and training planning and practices have led to a significant mismatch between what patients need now and what is actually being provided, for example, the over-supply of physiotherapy graduates between 2006 and 2008 and the under-supply of midwives leading to the national initiative to increase numbers by 4,000 during the similar time period.

- We believe that the current problems arise partly because employers – i.e. the people who plan, commission and provide care to meet patients’ needs in their local areas – have not previously been allowed enough of a say in shaping the education and training of their staff. The regular changes to architecture have also made stable, long-term planning harder.

- We need a model that is driven by evidence of what is required to meet patients’ needs. Employers in the NHS strongly believe that all levels of the system, national and local, must be led by employers, in constructive dialogue with the professions. They fully support the plans to place them at the front of decision making in planning and commissioning the education, training and development requirements for the health service workforce. This shift in responsibility and accountability is integral to ensuring employers have the appropriately skilled staff available to meet the changing needs of patients.

- All levels of the education and training system must be joined up and connected to work with the service commissioning system. It is also essential that the new system coordinates education and training for the whole healthcare workforce, not only the traditional professional groups. For example, the work of healthcare assistants and assistant practitioners has a big impact on that of clinical professional colleagues and neither group’s education and training should be considered in isolation.

- The activities of the local education and training boards (LETBs) and Health Education England (HEE) must mirror the strategic workforce intentions of local employers and reflect evidence of the needs of services. In so doing, they must:
  - cover the whole healthcare workforce
  - take decisions as locally as possible – reflecting the increasingly local commissioning of patient services
• decide locally their own models of operation, based on local agreement, to best fit local circumstances.

• Health Education England (HEE) must be employer-led and patient-focused. It must operate at a national level. Its focus should primarily be setting standards and providing assurance.

• Employers across the country have invested significant time in working together locally to form shadow arrangements to enable them to be in a position to apply for authorisation as LETBs and be ready to have the new system in place by April 2013.

• Employers value the critical functions provided in deaneries and recognise the need to retain skilled staff to ensure continuity in some core functions particularly for doctors in training. It is critical to ensure roles that are retained from the deaneries form part of LETBs and are therefore part of the planning for the workforce as a whole.

• The financial and service-delivery implications if staff receive training within different providers in future need to be thought through locally by LETBs. However, these are not insurmountable problems and should not be a reason for stopping moving forwards.

• To ensure decisions about education and training are based on reliable data on future needs, we recommend the Centre for Workforce Intelligence:
  • ensures the data and intelligence is sufficiently ‘local’ to be meaningful to local employers
  • ensures strong partnership working with HEE and LETBs
  • targets information collection where it identifies information gaps.

• We support ring-fencing of the education and training budget at a national level. But budgets for specific services or parts of the workforce must not be ring-fenced as this would stifle change and innovation from the outset.

• The Government’s NHS reforms necessitate some changes to the architecture for commissioning education and training. But, in truth, reform would be needed even without those wider changes. It is therefore essential that we do not merely ‘lift and shift’ the current architecture for commissioning education and training into the reformed NHS structures.

• The reforms to education and training present a unique opportunity to maximise the benefits to patients of the £5 billion annual national investment in education and training, and additional local investment. Everyone involved should focus on making the architecture already set out work as well as possible. The aim must be to change the system from the current focus on creating a supply of professionally trained individuals to one of training to improve the outcomes of patients.
About NHS Employers and our role in the system

1.1 The NHS Employers organisation (NHSE) represents the whole range of views from across employing organisations in the NHS in England on workforce issues, and supports employers to put patients first. The NHS Employers organisation is the accountable and representative voice of employers and is part of the NHS Confederation.

1.2 Our role is to help employers understand and contribute to changes in the system to enable them to improve the quality of patient care. This includes providing general advice and guidance on good practice, as well as representing NHS organisations to policy makers. We work with the HR community and the whole range of board level members to ensure we arrive at a position based on the views of employers. As NHSE we will continue to help shape the design and development of all aspects of the revised system to ensure that we can fully represent the range of employers in this process at national level and support them at local level with good practice, advice, support and information.

1.3 In order for the commissioning of education and training to be a success, we must see its function in the broader context of the workforce. Our work spans the whole remit of workforce issues and has both an overview and responsibility for the delivery of a number of workforce functions including pay, reward, employment practice, regulation, workforce planning and education and we have an integral role in the new architecture, supporting employers at a local level and representing them nationally within Health Education England (HEE).

1.4 Furthermore, because NHSE represents the views of both providers and commissioners and sits within the NHS Confederation, we are well placed to comment on how to support close working relationships between the service and education commissioning functions within the new architecture, so that the workforce is equipped to manage and deliver the services being commissioned for the future.

1.5 Employers have asked, through consultation and influencing the design of the new system, for the new system to be bold in its thinking if they are to make the most of the opportunity this reform presents to deliver better, more sustainable care for patients.

What employers in the NHS want from the education and training system

2.1 Many employers have invested heavily in development programmes for their current staff, from offering apprenticeships, vocational training courses and foundation degrees to staff in support roles and postgraduate training opportunities for staff with previous clinical and non-clinical qualifications. Employers have told us this has helped meet changing age demographics of the local workforce, address local skills gaps and has enabled their staff to be better equipped to meet the needs of patients.
2.2 Back in 2008 NHSE asked employers what they needed from a new modernised medical training and career system. They told us they wanted:

- a modular approach to postgraduate training which allows people to build up credentials for different skillsets which enable them to have flexible career routes
- a multi-disciplinary approach to planning based on the needs of organisations delivering services for patients
- a small over-supply to create competition, flexibility and drive up quality
- a clear balance between the needs of patient services (of which trainees are often an integral part) and the needs of staff for a supportive learning environment
- a managed change in career expectations: in no other profession does each trainee expect to reach the top of the profession and stay there for the remaining duration of their career and in the same professional capacity.

2.3 To date, there has been little progress in meeting the requirements outlined above. However, we are pleased that the current reforms now offer the opportunity for these to be taken forward. If we are to enable employers to make further advances then the outcome must be to create a system where patient need precedes professional development.

The role of local education and training boards (LETB)

3.1 NHSE supports the creation of LETB to bring together employers, professional advice, education providers and patients to consider the whole workforce requirements of the locality and take responsibility for commissioning the appropriate training and development to meet service and patient needs. They will include skills and expertise from some of the current SHA and medical deanery commissioning functions. Key functions of LETBs should include:

- considering the training of the whole healthcare workforce including staff in support roles as well as the traditional professional groups
- commissioning education and development programmes for current staff and the future workforce based on local need and the ability to deliver quality care
- collecting and sharing best practice across the locality and beyond, seeking to ensure that the education and training programmes lead to better patient outcomes
- enabling service commissioners to work with providers to map out longer term commissioning plans that will enable workforce plans to become longer term and reflect these service commissioning intentions.
3.2 Employers across the NHS have told us that the system for commissioning education and training must be led and managed from a local level if it is to be effective in meeting the needs of patients. Top down, initiative led, workforce decisions do not have a good record of success. The creation of the physician assistant role is an example often cited as not being as successful as perhaps other supporting roles. Whereas the more generic and evolving assistant practitioner role, created from a service need and then designed, developed and implemented by many employers across the NHS, with significant input from education providers, has been hugely successful in helping employers to work on transforming the shape of the workforce to better and more flexibly meet the needs of patients.

3.3 To create a joined up system with local ownership, accountability and responsibility, the LETB must be a structure that is designed, developed and run by employers and involves their key partners. We recommend each LETB be allowed to decide locally how it wishes to carry out its functions, in a form which reflects local circumstances and meets with local agreement. HEE should award full delegation of powers to a LETB based on an authorisation process which evidences it has the capacity and capability to deliver, rather than seeking to own and mould them into a particular model.

3.4 In order for employers and their partners to truly own and lead their LETB there is strong support from employers for the structure to sit within the locality. Employers across the country have already invested significant time into developing shadow arrangements that will enable them to be in a position to apply for authorisation to exist, employ staff and enter into contracts with educational establishments. Many different forms have been discussed from social enterprise to hosting in a foundation trust.

3.5 It has been suggested that one model of LETBs is to adopt a structural form within Health Education England (HEE). However, the risk of this approach is that decisions about how to develop the workforce to meet local population need would shift towards the centre, whilst the services that require the staff would be commissioned at a very local level. This would make it harder to align the commissioning of services and education to ensure that local areas have the right workforce for their patient services. If the LETB were to become an ‘outpost’ of HEE, the NHS would miss huge opportunities to change the outcomes of education and training commissioning, and to embed an innovation culture within education and training. If this model does go forward, even as a holding measure, it becomes even more important that HEE is constructed to be employer-led.

The role of Health Education England (HEE)

4.1 HEE must be employer-led and patient-focused. It must start from the premise of focusing on doing what only a national organisation can do if it is to be successful. We
need to avoid scenarios that mean HEE is established as an ‘administrator’ of LETBs. If so, it will not succeed in its strategic objectives.

4.2 Its role should be working with key partners including the NHS Commissioning Board, Public Health England, the NHS Employers organisation, CFWI and its partners in the other UK countries and regulators to focus on:

- setting standards
- quality outcomes
- assuring that the system is delivering for the medium – long term needs of patients
- resolving any conflicts in the system
- providing assurance that LETBs are properly accountable and well governed, and the education and training commissioning plans align with the services being commissioned and will meet the needs of patients.

4.3 Way of working – the Educational Outcomes Framework

HEE was set up in shadow form in June 2012 and will be fully operational from April 2013. It has been confirmed that it is responsible for setting up a new system that can produce the flexible workforce. It recognises it needs to address future challenges, aspires to excellence in training as well as a better educational experience for all staff (including trainees and students), and is supported by a fair and responsive funding system.

It will use the Education Outcomes Framework and an approach to quality which will directly link education and learning to improvements in patients’ outcomes. By providing a clear line of sight and improvement to patient outcomes, it intends to help address variation in standards and ensure excellence in innovation through high quality education and training.

Work is currently underway to develop indicators which will help measure delivery against these outcomes.

The five high level domains of the Education Outcomes Framework are identified in the guidance document From Design to Delivery published in January 2012, and outlined below:

- **Excellent education**: Education and training is commissioned and provided to the highest standards, ensuring learners have an excellent experience and that all
elements of education and training are delivered in a safe environment for patients, staff and learners.

- **Competent and capable staff:** There are sufficient health staff educated and trained, aligned to service and changing care needs, to ensure that people are cared for by staff who are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs the service needs, whilst working effectively in a team.

- **Adaptable and flexible workforce:** The workforce is educated to be responsive to innovation and new technologies with knowledge about best practice, research and innovation that promotes adoption and dissemination of better quality service delivery to reduce variability and poor practice.

- **NHS values and behaviours:** Healthcare staff have the necessary compassion, values and behaviours to provide person-centred care and enhance the quality of the patient experience through education, training and regular continuing personal and professional development (CPPD), that instills respect for patients.

- **Widening participation:** Talent and leadership flourish free from discrimination with fair opportunities to progress and everyone can participate to fulfill their potential, recognising individual as well as group differences, treating people as individuals, and placing positive value on diversity in the workforce, and that there are opportunities to progress across the five leadership framework domains.

**The role of the Secretary of State**

5.1 The role of the Secretary of State, as defined in the Health and Social Care Bill 2011, shows a clear line of accountability for the system to Government.

5.2 However, it is not clear how tensions or disagreements between different parts of the system will be resolved, for example when aspirations from professional groups, politicians or others to increase numbers in a particular profession are not the same as the views of employers. HEE, as an employer-led organisation, has a clear role here to ensure there is a mechanism for resolving disputes.

**Plans for the transition**

6.1 Employers across the country have invested significant time in working together locally to form shadow arrangements within the SHA structure that will enable them to be in a position to apply for authorisation to exist as LETBs, employ staff and enter into contracts with educational establishments.
6.2 There are concerns to ensure that the formation of HEE is not modelled on Medical Education England as this will lead to a missed opportunity to have a truly employer-led innovative system that delivers for patients.

**The future of postgraduate deaneries**

7.1 Employers value the critical functions provided in deaneries and recognise the need to retain skilled staff throughout the transition and beyond to ensure continuity in some core functions particularly for doctors in training.

7.2 If roles such as the postgraduate dean are to remain then it is essential that they form part of the LETB team in which they are located. This is critical to ensure that the planning and training of the medical workforce is properly aligned with that of the rest of the health service workforce.

**The implications of a more diverse provider market within the NHS**

8.1 There are already a diverse range of providers of healthcare receiving NHS monies to deliver commissioned services (GPs, social enterprise, private providers running NHS services, a whole range and size of independent and voluntary sector organisations as well as the traditional NHS provider organisations). As the landscape potentially becomes more diverse there is a need to look at the provision of training opportunities. In this case it may be more helpful to think about the provision of training and education with those receiving public monies to deliver services and care to patients.

8.2 We recognise that the potential challenges for acute sector organisations in maintaining out of hours medical rotas if trainees begin receiving training in other parts of the system as opposed to an acute hospital. We also recognise the potential financial implications for some providers if a model of funding following the student is used and training moves to a different provider. These implications will all need exploring and thinking through locally as part of the LETB arrangement. However, they are not insurmountable problems and should not stop us moving forward with changes that have been developed in order to deliver a workforce that better meets patient needs.

8.3 The NHS Partners Network have highlighted the views of their independent sector members. The independent sector already does a significant amount of training for non-medical professions in relation to softer skills. Many registered clinical staff also move between the independent, private and public sectors sharing knowledge and expertise. Some independent providers will be enthusiastic in the future about taking greater responsibility for training, particularly if they provide a greater range of procedures and care.
The impact on the public health workforce

9. Clarity is needed in defining the public health workforce if we are able to understand any potential impacts. There are nurses and midwives with specific roles in public health but who are currently not classified as public health workers. This example can be replicated across professional groups and support staff. We recommend that HEE needs to have overall oversight of the health workforce, or arrangements in place to ensure alignment. HEE will need to work closely with Public Health England but it will be for LETBs working with local authority partners to determine the public health requirements locally and what this means for the commissioning of education.

The role and content of the proposed National Education Outcomes Framework

10. The National Education Outcomes Framework will provide a helpful framework for the DH and HEE to establish their accountability and relationship. The link between education inputs and health outcomes is to be welcomed. There needs to be some caution in the establishment of indicators for health providers – it should be for LETBs to hold providers to account and not HEE.

The role of the Centre for Workforce Intelligence (CfWI)

11. Having access to credible data to base decisions upon and continually improving demand-led modelling are both essential to enable any system and ensure value for money and return on investment. The CfWI has a potentially pivotal role in working with local employers, the professions and regulators to analyse and share data to allow evidence based decision making to occur. We recommend the CfWI:

- ensures the data and intelligence is sufficiently ‘local’ to be meaningful to local employers
- ensures strong partnership working with HEE and LETBs
- targets information collection where it identifies information gaps.
The role of skills for health and skills for care

12. The sector skills councils have an important role in working on the development of educational frameworks in particular for those roles in levels 1 to 4 on the career framework, which are often essential patient facing support roles. NHSE looks forward to working with them in the new system.

Protecting and distributing funding in the new system

13.1 There is an expectation that the budget allocated to HEE will remain ring-fenced for the purpose of delivering education and training for the current and future healthcare workforce. Employers would support ring-fencing at this level.

13.2 However, it is important this approach does not also become ring-fencing or protection of budgets at the level of specific services or parts of the workforce. The danger of such an approach lies in its inflexibility and inability to allow education and training to adapt to changes in the services and staff skill mix that are needed to enable changes in patient care (such as greater provision of care in community settings). We must not set up a system that stifles innovation from the outset. We would nevertheless expect LETBs to spend money in a transparent way, with appropriate safeguards, and HEE to ensure they meet the appropriate requirements. The allocation of funding must be designed to complement local needs and plans in the short, medium and longer term.

Overseas educated staff within the workforce

14.1 Overseas trained staff have a valuable role in the NHS. Individuals contribute greatly to education, training, research and the delivery of high quality care to patients. The NHS Employers organisation has worked closely with the UK Border Agency to ensure that the changes needed to the immigration system do not inadvertently have a negative impact on employers’ abilities to recruit highly skilled staff when required.

14.2 Even with these necessary changes to the education system, the NHS has a commitment with its global partners to offer training opportunities to individuals from less developed nations and a reputational need to remain competitive in an increasingly global health care labour market. To retain a position of positive international reputation, the UK must be able to attract the most innovative and skilled individuals from across the world who will develop and deliver leading edge healthcare for patients.
Annex D

Hospital and community health services medical and dental staff, England, at 30 September, 2001 – 2012

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<td>3,989</td>
<td>4,003</td>
<td>3,994</td>
<td>4,273</td>
<td>4,259</td>
<td>4,663</td>
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<td>4,890</td>
<td>5,240</td>
<td>5,203</td>
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<td>7,186</td>
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<td>10,450</td>
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<td>7,525</td>
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<td>4,451</td>
<td>1,987</td>
<td>4,236</td>
<td>1,740</td>
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</table>

Sources: England: The Information Centre, Medical and Dental Workforce Census. All rights reserved.
1 England has a new headcount methodology for 2010 data. 2010 data is not fully comparable with previous years data due to improvements that make it a more stringent count of absolute staff numbers. Further information on the headcount methodology is available in the Census publication. Headcount totals are unlikely to equal the sum of components.
2 Consultant also includes Directors of Public Health.
3 From August 2007 there was a new specialty registrar grade introduced which also included staff previously graded as senior house officer. Therefore note that these staff have been included in the registrar group and this is the reason that the 2007 figures have almost doubled from the previous year.
4 Foundation Programme Doctors in their second year (FY2).
5 House Officer includes Foundation Programme Doctors in their first year (FY1) and other doctors in training which refers to those doctors with an unknown grade or payable but with a recognised occupation code indicating they are a doctor in training.
6 Includes Specialty Doctors from 2008. Negotiations between NHS Employers and the BMA’s Staff and Associate Specialist Committee resulted in a new contract for the associate specialist grade and the creation of the new specialty doctor grade from 1 April 2006.
7 Other includes Hospital Practitioner, Clinical Assistant, Senior Dental Officer, Dental Officer, Community Dental Officer, Clinical Medical Officer, Senior Clinical Medical Officer, Dental Clinical Director, Dental Ass Clinical Director, Other (Med Practitioners doing part-time work) and Other (Salaried Dental Practitioners)

Annex E

The table below shows data from the NHS Pensions Division, part of the Business Services Agency that administers the NHS Pension Scheme for members in England and Wale. The table shows the number of consultants who received a pension award, from the NHS pension scheme between 1997 to 2012 by category of retirement. The figures include all retirements on grounds of age, ill health, premature retirements following redundancy or interests of efficiency and voluntary early retirement (introduced from 6 March 1995). Where possible data is shown separately for each category. As with previous years’ evidence, the figures relate to England and Wales as it has not been possible to disaggregate Welsh data for this exercise.

The total number of pension awards has increased over the period as the size of the workforce has increased. The number of age retirements is higher now than it was in the late 1990s, but this reflects the age profile of the current workforce rather than any change in retirement rates.

The NHS Pensions data recording system manages over 1.3 million active records most of which are subject to regular updates year on year. Retirement data will therefore represent a "snapshot" at a given period, which will be subject to change over time.

In addition to the above considerations, NHS Pensions introduced a pension processing system in October 2005. The retirement data provided since September 2006, to assist in supporting evidence/guidance for DDRB, represented an extract from this new pension processing system. This system is designed to assist in the daily processing of pension calculations and will in the future support scheme valuation. However, development to utilise the system for valuation has yet to be fully defined and validated. The latest information has been amended to reflect the latest extract over retrospective years, but comparisons across the yearly reports is not possible.

Work has been undertaken this year to define the extraction routine used for employment groups and whilst NHS Pensions is confident that the current data extract displays a trend of retirement in the table listed below, this should only be used for guidance. It is important to stress that the current extract may not be consistent with previous DDRB extracts due to a number of factors e.g. on-going program to cleanse member records.
## Consultant retirements and reasons for retirement

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<thead>
<tr>
<th>Year end 31 March</th>
<th>Age</th>
<th>Ill-health</th>
<th>Deferred pension benefits</th>
<th>Redundancy</th>
<th>Agreed voluntary early retirement (AVER)</th>
<th>Voluntary early retirement (VER)</th>
<th>Unknown</th>
<th>Total pension Awards</th>
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<tbody>
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<td>43</td>
<td>19</td>
<td>*</td>
<td>*</td>
<td>38</td>
<td>431</td>
</tr>
<tr>
<td>2000</td>
<td>293</td>
<td>54</td>
<td>53</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>29</td>
<td>440</td>
</tr>
<tr>
<td>2001</td>
<td>337</td>
<td>67</td>
<td>54</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>35</td>
<td>504</td>
</tr>
<tr>
<td>2002</td>
<td>354</td>
<td>67</td>
<td>44</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>35</td>
<td>507</td>
</tr>
<tr>
<td>2003</td>
<td>321</td>
<td>60</td>
<td>47</td>
<td>7</td>
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<td>*</td>
<td>39</td>
<td>474</td>
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<tr>
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<td>57</td>
<td>57</td>
<td>16</td>
<td>*</td>
<td>*</td>
<td>49</td>
<td>540</td>
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<td>49</td>
<td>9</td>
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<td>*</td>
<td>51</td>
<td>521</td>
</tr>
<tr>
<td>2006</td>
<td>490</td>
<td>52</td>
<td>60</td>
<td>7</td>
<td>4</td>
<td>44</td>
<td>55</td>
<td>712</td>
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<tr>
<td>2007</td>
<td>603</td>
<td>59</td>
<td>54</td>
<td>6</td>
<td>3</td>
<td>77</td>
<td>49</td>
<td>851</td>
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<tr>
<td>2008</td>
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<td>60</td>
<td>39</td>
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<td>6</td>
<td>90</td>
<td>46</td>
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<td>1038</td>
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<td>9</td>
<td>4</td>
<td>172</td>
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<td>1344</td>
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<td>1007</td>
<td>8</td>
<td>15</td>
<td>7</td>
<td>200</td>
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<td>95</td>
<td>1332</td>
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* AVER and VER Data for 1997 – 2005 is not separately captured in this extract.
### Annex F
RRP payments to consultants by specialty

<table>
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<th>Specialty</th>
<th>Estimated % of specialty in receipt of a RRP payment</th>
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</thead>
<tbody>
<tr>
<td>Forensic psychiatry</td>
<td>8%</td>
</tr>
<tr>
<td>Public health medicine</td>
<td>6%</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>3%</td>
</tr>
<tr>
<td>General medical practitioner</td>
<td>3%</td>
</tr>
<tr>
<td>Psychiatry of learning disability</td>
<td>2%</td>
</tr>
<tr>
<td>Medical microbiology</td>
<td>2%</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>1%</td>
</tr>
<tr>
<td>Old age psychiatry</td>
<td>1%</td>
</tr>
</tbody>
</table>

All other specialties have fewer than 1% of staff in receipt of an RRP.
Annex G
Specialty recruitment fill rates (July 2012)

<table>
<thead>
<tr>
<th>GRADE</th>
<th>POSTS</th>
<th>FILL RATE - 2012</th>
<th>FILL RATE - 2011</th>
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</thead>
<tbody>
<tr>
<td>Emergency Medicine Core and ST4</td>
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<td>94</td>
</tr>
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<td>Emergency Medicine</td>
<td>ST4</td>
<td>198</td>
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</tr>
<tr>
<td>Anaesthesia Core &amp; ST3</td>
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<td></td>
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<td>Anaesthesia and ACCS Anaesthesia</td>
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<td>Core Medical Training and ACCS Acute Medicine</td>
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<tr>
<td>Clinical Genetics</td>
<td>ST3</td>
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<td>ST3</td>
<td>7</td>
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<td>ST3</td>
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<td>Speciality</td>
<td>Grade</td>
<td>Posts</td>
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</tr>
<tr>
<td>------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>------------------</td>
</tr>
<tr>
<td>Clinical Pharmacology &amp; Therapeutics</td>
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<td>ST3</td>
<td>70</td>
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<tr>
<td>Endocrinology &amp; Diabetes</td>
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<td>82</td>
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<tr>
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<td>Haematology</td>
<td>ST3</td>
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### Psychiatry Core & ST4

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<th>Fill Rate - 2011</th>
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</thead>
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<td>88</td>
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<td>End</td>
<td>Pass</td>
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<tr>
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<td>30</td>
<td>68</td>
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<td>Psychiatry of Learning Disability</td>
<td>ST4</td>
<td>23</td>
<td>61</td>
<td>93</td>
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<td>50</td>
<td>57</td>
</tr>
<tr>
<td>Surgery Core &amp; ST3</td>
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**RUN-THROUGH SPECIALTIES**

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Note: Fill rate is for NTN vacancies only and does not take into consideration LAT vacancies.
NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. The NHS workforce is at the heart of quality patient care and we believe that employers must drive the workforce agenda. We work with employers to reflect their views and act on their behalf in four priority areas:

• pay and negotiations
• recruitment and planning the workforce
• healthy and productive workplaces
• employment policy and practice.

NHS Employers is part of the NHS Confederation.

Contact us
For more information on how to become involved in our work, email getinvolved@nhsemployers.org

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enquiries@nhsemployers.org

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