NHS Employers’ evidence to the Pay Review Body on Doctors’ and Dentists’ Remuneration 2006/07

September 2005
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1. NHS Employers

Who we are

1.1. We are a new organisation, which started work on 1 November 2004, when we took over responsibility from the Department of Health for much of the NHS human resources agenda. We have four key roles:
   • negotiating on behalf of employers
   • representing employers
   • supporting employers
   • promoting the NHS as a good employer.

1.2. NHS Employers has national responsibility within England for conducting negotiations on behalf of employers on issues such as NHS pay and conditions. We also provide NHS organisations at a local level with advice and support on employment issues by sharing good practice and by promoting strong networking arrangements. Our role in relation to staff in the remit groups is described further in section 3.

1.3. Our aim is to become the national resource on NHS workforce issues. NHS Employers is part of the NHS Confederation but has its own director, policy board and assembly. We set our own strategy and work programme and have our own decision-making powers, but we are ultimately accountable to the Chief Executive and trustees of the NHS Confederation.

1.4. The Department of Health, which remains responsible for developing policy and standards for the health and social care workforce, has set the broad framework within which NHS Employers operates. However, it is the employers themselves who drive the agenda that NHS Employers follows.

1.5. NHS Employers is an England-only initiative. However, a protocol has been developed by NHS Employers and the Health Departments in England, Wales, Scotland and Northern Ireland. The Department of Health in England may provide observers at pay negotiations, while the Devolved Administrations each provide negotiating representatives. However, NHS Employers provides the ‘machinery’ for on-going negotiations on a UK basis by way of a secretariat.
About our evidence

1.6. This evidence is based primarily on information collected from employers by way of the questionnaire designed to collect evidence on issues related to the remit of the Nurses and Other Health Professions Review Body (NOHPRB), the Doctors’ and Dentists’ Review Body (DDRB) and the Pay Negotiating Council. Our objective was to seek a ‘whole workforce view’ from employers. A copy of our letter seeking information and the questionnaire is at Annex A.

1.7. We received responses which represented the views of between one third and one half of employers. Some responses were sent on behalf of the HR community in a strategic health authority (SHA), others represented the views of a single trust or primary care trust (PCT). The most striking result was the degree of commonality in replies. Although, with any set of information returns there is always some diversity of opinion, we are confident that this evidence represents the views of employers covering the majority of the 1.3 million staff employed by the NHS. Where opinion differed significantly we have indicated this.

1.8. This evidence, which represents the views of NHS employers in England only, has been approved by the NHS Employers policy board.

General medical services and general primary dental care services

1.9. Our evidence does not include views on contractors providing general medical services or general dental services. The nGMS contract is currently under review, led by NHS Employers. Negotiators from NHS Employers and the BMA have formally agreed to carry out the review over two stages instead of one. Some changes will be made to the Quality and Outcomes Framework from April 2006. Work will continue on the review of the global sum allocations formula but it will not be implemented until 2007/08 at the earliest.

1.10. Carrying out a two-stage review will give time to further measure the impact of the GMS contract, which has only been in operation for just over a year. It will also allow the review to take into consideration any impact from the forthcoming English white paper on care outside hospitals.

1.11. Negotiations are progressing and the two sides have also been discussing how to include some of the Government priorities, such as patient choice and practice-based commissioning into the GMS contract for England.

1.12. It is hoped that the parties will be able to make a joint statement to the Review Body when negotiations for 2006/07 are complete.
1.13. Reform on dentistry has been confirmed for April 2006 and the Government is moving ahead with new contractual arrangements for general dental practitioners. However, the overall policy towards dentistry is still under consideration in the Department of Health, and NHS Employers has no remit in respect of dentistry. At the current time we do not believe it would be appropriate for NHS Employers to submit evidence on dentistry.

**Foundation trusts**

1.14. NHS foundation trusts (NHS FTs) have implemented the 2003 consultant contract together with the rest of the NHS, offering consultants the opportunity to transfer to new terms and conditions. Once implemented, there are local freedoms which allow NHS FTs the opportunity to innovate in order to develop the workforce for the delivery of high-quality patient care – using their ability to develop new ways of recognising, acknowledging, rewarding and retaining staff. The contractual terms for doctors in training remain the same throughout the NHS.

1.15. We wished to see whether NHS FTs would present a different view to other employers. However, our survey suggests that NHS FTs currently have no specific concerns relating to pay modernisation that differ markedly from other NHS organisations.
2. The economic context

Background

2.1. We recognise that the definitive sources of evidence on the economic context and affordability will be the Treasury and the Health Departments. However, in advance of their allocations for 2006/07, employers will have to take a view on the affordability of their workforce. The following indicators, which are publicly available, together with the current financial positions indicated by the returns to our questionnaire, have helped us form a view on affordability for the sector.

2.2. Recent evidence shows the UK economy is experiencing an economic slowdown. Data from the Office for National Statistics showed that GDP grew just 0.5 per cent between April and June. As a result, year-on-year growth stood at 1.8 per cent, its weakest rate since the first three months of 2002.

2.3. The volume of retail sales in the three months May to July 2005 was 0.7 per cent higher than in the previous three, the highest such growth since November 2004. However, annual growth remained the lowest for more than six years. Compared with the same period a year ago, sales in the three months to July 2005 were up 1.3 per cent, the lowest annual growth since February 1999.

2.4. Labour market statistics published in September 2005 show the trend in both employment and unemployment is broadly flat. The employment rate and the number in employment increased slightly on the previous quarter, and the previous year. The number of unemployed increased slightly over the previous quarter and year, but the unemployment rate remained unchanged at 4.7 per cent. The claimant count increased for the seventh consecutive month. The average number of vacancies was down on the previous quarter and down over the year.

2.5. In addition, UK house prices dipped by 0.2 per cent in August according to the Nationwide Building Society, while annual house price growth fell to 2.3 per cent, the lowest level since May 1996. Other recent house price surveys have also indicated that the property market has slowed sharply in 2005. The Halifax indicated that there had been a significant downward trend with house prices increasing by only 2.1 per cent in the first eight months of this year compared with a 12.5 per cent rise in the same period of 2004.

2.6. Given the evidence on the current state of the economy, pay increases in other sectors are unlikely to rise. This is supported by recent evidence on the level of pay settlements.
Pay settlements

2.7. Evidence from the latest IDS Pay Report (September 2005) shows that the median pay settlement level for the three months to July was 3.1 per cent. The median increase for the three months to June was 3.2 per cent and the level of pay settlements for the past four months has remained steady.

2.8. The range of settlements remained on trend with the lower quartile being 3.0 per cent, slightly ahead of the current RPI inflation rate for the past few months. This means that over three-quarters of pay settlements in the last three months have been above the inflation rate.

2.9. The public sector median for the three months to June was 3.0 per cent. The figures up to July have not been given due to the lack of public sector settlements in July. This compared to a private service sector median in the three months to June of 3.0 per cent.

2.10. In 2004 a large proportion (around two-thirds) of employees in the public sector were covered by long-term pay agreements and this has continued into 2005. Recently, long-term deals have provided for much lower annual increases of 2.5 to 3 per cent per year.1

Average earnings

2.11. Average earnings (seasonally adjusted, excluding bonuses), as measured by the Average Earnings Index three month average, rose by 3.9 per cent in the year to July 2005. This is down from 4.0 per cent in June. Including bonuses, average earnings rose by 4.2 per cent in the year to July, up from 4.1 per cent in June.

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1 Incomes Data Services Ltd, February 2005: Pay in the public services 2005
2.12. Looking at the private and public sectors separately, the annual average earnings growth (excluding bonuses) shows that both public and private sector earnings growth remain above current inflation rates. In the three months to July 2005, pay growth (excluding bonuses) in the private sector remained at 3.8 per cent. Over the same period public sector pay growth increased 0.2 percentage points to 4.6 per cent. In addition, average earnings in the health sector increased by 4.6 per cent, in line with public sector pay growth\(^3\). Including bonus payments, private sector growth stood at 3.9 per cent compared with 5.5 per cent for the public sector.

2.13. The evidence tends to show that public sector earnings growth remains consistently higher than private sector earnings growth despite overall average earnings falling.

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2 Office for National Statistics
3 Office for National Statistics
2.14. The higher rate of growth in the public sector is a consequence of two factors: first, the extra payments and new salary structures to actively solve recruitment and retention problems for key workers; and second, the extra money beyond basic pay increases resulting from pay modernisation. For example, the 2003 consultant contract will continue to increase average earnings as doctors pass through pay thresholds until the contract reaches maturity.

2.15. Given that pay modernisation in the NHS is nearing completion and most staff have witnessed significant increases in their earnings over the period, it seems unrealistic to assume that future pay uplifts would be anywhere near the current level of earnings growth experienced in the public sector. An uplift in line with inflation and current pay settlements would seem more appropriate.

**Inflation**

2.16. In addition to the figures on average earnings growth, it is important to consider the impact of both current and future inflation levels.

2.17. The Consumer Price Index (CPI) annual inflation, the Government’s target measure, rose to 2.4 per cent in August, from 2.3 per cent in July. This was the highest CPI figure since the start of the official series in January 1997 and is mainly a result of a large increase in petrol prices, reflecting movements in crude oil prices.

2.18. As an internationally comparable measure of inflation, the CPI shows that the UK inflation rate is slightly above the average for the European Union as a whole. A provisional figure for the inflation rate for the enlarged EU 25 in July was 2.1 per cent, compared with the UK figure of 2.3 per cent in July.

2.19. The Retail Price Index (RPI) inflation rate fell slightly in August to 2.8 per cent, from 2.9 per cent in July. This was mainly due to a downward influence from housing components excluded from the CPI. RPIX inflation, the all items RPI excluding mortgage interest payments, fell slightly to 2.3 per cent in August, from 2.4 per cent in July.

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4 Incomes Data Services Ltd, August 2005: IDS Pay Report 935
2.20. Evidence from the July IDS pay report shows that RPI inflation is forecast to slow down towards 2 per cent by the end of 2005 and then stabilise at around that rate for much of 2006. The main factors affecting this are stagnant or falling house prices and slower economic growth.

Financial situation in the NHS

2.21. The 2004 Spending Review set spending plans to 2007/08 that protected increased resources delivered in previous Spending Reviews. The expenditure plans as set out in Table 1 represent an annual average increase of 7.1 per cent in real terms between 2005/06 and 2007/08 – a total increase of 23 per cent in real terms over the period.

<table>
<thead>
<tr>
<th>Year</th>
<th>Net NHS spending (£billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>76.4</td>
</tr>
<tr>
<td>2006/07</td>
<td>83.8</td>
</tr>
<tr>
<td>2007/08</td>
<td>92.1</td>
</tr>
</tbody>
</table>

5 Office for National Statistics
6 Department of Health: Departmental Report 2005
2.22. No money within the departmental budgets is specifically allocated to spend on annual pay increases. The pay bills are met at a PCT level from the overall allocation of funding for PCTs. Therefore, any further large increases in pay will have an effect on the amount available for PCTs to spend on additional services.

2.23. Views from NHS employers indicate that there are real concerns over the affordability of the current position. A recent survey by the NHS Confederation revealed that 93 per cent of NHS chief executives do not believe that the current workforce reforms are affordable.

2.24. The NHS star ratings, recently published by the Healthcare Commission, reported that almost a quarter of all trusts did not break even by year end (2004/05). This resulted in a total overspend of almost £500 million. While this is small in the overall budget of the NHS, it is significant for some individual organisations. 24 per cent of PCTs failed to achieve financial balance with one in three acute trusts also failing on this measure. For the first time in four years there was a fall in the number of acute hospital trusts with three stars, partly reflecting difficulties in meeting the indicator relating to financial performance.

2.25. Future policy developments in the NHS may also increase the financial pressure on organisations from 2005/06. Examples of this include the implementation of Payment by Results and the proposed new arrangements for commissioning.

2.26. Given the evidence above, we would ask the Review Body to consider carefully the impact that any pay increase deemed unaffordable by NHS employers would have on an already difficult financial position.

**Proposal for uplift**

2.27. Responses to the questionnaire issued by NHS Employers indicate that the majority view was that a pay award in excess of 2.5 per cent (in line with inflation forecasts) would be deemed unaffordable by the NHS.

2.28. A minority of respondents indicated that no pay award would be affordable and that any pay increase would cause significant problems given the current funding deficits.

2.29. Most respondents indicated that a pay award higher than 2.5 per cent would have detrimental consequences and would lead to a deferment of developments coupled with workforce reductions (through natural wastage or vacancy freezes) and service reconfiguration to reduce costs. Most organisations with deficits are already working towards driving out inefficiencies and have recovery plans and cash releasing efficiency saving (CRES) programmes in place.
2.30. The common view from employers in the NHS is that most resources should be spent on a generic pay award for all NHS staff. Employers are almost unanimous in their agreement that both medical and non-medical staff should receive the same level of generic award. They feel that equity is particularly important in valuing all parts of the workforce and that there should be greater convergence between the two pay systems.

2.31. In addition, a multi-year award would be looked on favourably by employers. Provided it was at an affordable level, they feel it would help create a climate of stability which will assist service and financial planning, and will remove the element of doubt from staff and their representatives about the level of forthcoming pay awards.

Conclusion

2.32. The current evidence shows signs of an economic slowdown in the economy with average earnings falling, pay settlements remaining stable and inflation forecast to fall towards the end of the year.

2.33. Affordable pay settlements are necessary to ensure the current financial position in the NHS does not worsen. A pay uplift of 2.5 per cent in line with inflation targets is the most that could be supported by employers in the NHS.
3. Recruitment and retention

Headline information

3.1. The 2005 vacancy survey figures for consultants from the Health and Social Care Information Centre show an encouraging decrease from 4.4 per cent in March 2004 to 3.3 per cent in March 2005. Furthermore, there were 31,210 consultants, an increase of 1,034 or 3.4 per cent since March 2004. Indeed, the first quarter of 2005 showed continued increases in the numbers of consultants, with an increase of 347 or 1.1 per cent since December 2004.

3.2. At the end of March 2005 there were 32,194 general medical practitioners (excluding retainers and registrars). This represents an increase of 396 or 1.2 per cent since December 2004. This also equates to an increase of 1,067 or 3.4 per cent since March 2004.

3.3. The GP Practice Vacancies Survey was conducted for the first time in 2005. It should be noted that the data collected is not directly comparable with those collected in earlier GP recruitment, retention and vacancies surveys. The 2005 estimated three-month GP vacancy rate is 2.4 per cent for England. Future results from this survey may indicate the attractiveness of employed GP posts.

Views from the NHS

3.4. Employers report that recruitment and retention was generally improving or remaining stable and was helped by a fall in staff turnover in most areas. There are, however, some concerns in particular specialties. These include national shortages of consultants in Accident and Emergency, psychiatry and radiology and of GPs and dentists.

3.5. Overall, it was thought that recruitment and retention premia for consultants are not always appropriate, since the most common cause of inability to recruit is the lack of supply nationally, rather than the inability to attract them to work in a particular area. However, some examples of their use are at paragraph 5.8. It was also felt that recruitment and retention premia generally are only useful where there is widespread competition with non-NHS organisations. This is clearly not the case at present with medical and dental staff.

3.6. International recruitment has been a useful vehicle for maintaining workforce numbers, with 53 per cent of respondents to the NHS Employers recruitment and retention survey indicating that they use international recruitment. Of these, 66 per cent were using international recruitment for consultants and 17 per cent for dentists. An additional 32 per cent indicated using international recruitment for other groups including GPs.
3.7. There has been considerable press coverage of junior doctors being unable to obtain jobs. Some trusts have received hundreds of applications for their junior doctor posts, showing evidence of increased competition. Whilst this does raise a number of issues for the NHS it is clear that there is not a current problem in recruiting junior doctors.

3.8. Employers indicate that in the current climate of challenging recovery plans, a higher than expected and unfunded pay award would lead to extended vacancies and freezing of posts with a subsequent reduction of services and developments. This is against the backdrop of 39 per cent of respondents indicating that they had had recruitment freezes in the last 12 months.

**Improving Working Lives (IWL)**

3.9. Non-pay solutions can be as important as pay in improving recruitment and retention – especially the introduction of flexible working practices. Trusts report that good line management goes a huge way to support retention; sometimes this is irrespective of what someone could earn elsewhere.

3.10. Initiatives under the IWL banner have been well received and many trusts cited positive staff survey reports. Flexible working, education, training and development and childcare provisions are the areas of IWL which appear to have had the most significant positive effects on staff morale, motivation and retention.

3.11. Some employers indicate that service developments have already been curtailed to meet the costs of the consultant contract. Any further unfunded pay award would have a serious impact on further service developments and services would have to be cut.
4. Morale and motivation

**Employer views**

4.1. Many NHS employers report positive signs that the morale of staff working in their organisations is improving. Progress has already been made towards creating a culture of effective communication – NHS employers are listening to staff and responding to their legitimate concerns and aspirations.

4.2. NHS employers recognise that investment in staff is also investment in patient care. Many employers reported that the Improving Working Lives (IWL) standard has had a positive impact on staff morale and motivation, leading the employer to tackle issues at a local level to ensure that staff are supported and developed. Flexible working in particular was cited as a positive benefit for the NHS and the majority of staff. For example, employers have reported some retention gains as a result of this initiative, whilst other employers have said that staff involvement has improved and offered opportunities to influence how money is being spent.

4.3. Within the IWL framework employers are also helping staff to achieve a healthy work–life balance by introducing modern employment practices such as:

- childcare provision and support for carers in the workplace
- flexible careers
- flexible retirement
- improved access to training and development
- healthy workplaces
- staff involvement
- partnership working.

**The NHS Staff Survey**

4.4. The second national survey of NHS staff was conducted by the Healthcare Commission during October and November 2004. The survey results show improvements in terms of staff satisfaction and some elements of IWL such as childcare support. Overall, the results showed:

- 73 per cent were generally satisfied
- 93 per cent had received training and development opportunities in the previous 12 months
- good results in team working (93 per cent) and personal development planning (51 per cent).

4.5. Results from the survey will enable each NHS organisation to inform local improvements in working conditions and practices and can also be used by employers to compare themselves to other similar NHS organisations.
### Some examples of tables from the Healthcare Commission NHS Staff Survey 2004

**Flexible working**
My immediate manager helps me find a good work-life balance

<table>
<thead>
<tr>
<th>Breakdown by group: all trusts</th>
<th>Strongly disagree/disagree %</th>
<th>Neither agree nor agree disagree %</th>
<th>Strongly agree/agree %</th>
<th>Base number of respondents</th>
<th>Yes</th>
<th>No</th>
<th>Base number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/dental staff in all trusts</td>
<td>25</td>
<td>37</td>
<td>39</td>
<td>11,292</td>
<td>76</td>
<td>24</td>
<td>11,331</td>
</tr>
<tr>
<td>Medical/dental (consultants) in all trusts</td>
<td>28</td>
<td>37</td>
<td>35</td>
<td>4,356</td>
<td>83</td>
<td>17</td>
<td>4,374</td>
</tr>
<tr>
<td>Medical/dental (other) in all trusts</td>
<td>23</td>
<td>37</td>
<td>41</td>
<td>6,936</td>
<td>71</td>
<td>29</td>
<td>6,957</td>
</tr>
</tbody>
</table>

**Appraisals**
Have you had an appraisal or individual performance review in the last 12 months?

<table>
<thead>
<tr>
<th>Breakdown by group: all trusts</th>
<th>Yes %</th>
<th>No %</th>
<th>Base number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/dental staff in all trusts</td>
<td>77</td>
<td>23</td>
<td>11,106</td>
</tr>
<tr>
<td>Medical/dental (consultants) in all trusts</td>
<td>78</td>
<td>22</td>
<td>4,280</td>
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<tr>
<td>Medical/dental (other) in all trusts</td>
<td>76</td>
<td>24</td>
<td>6,826</td>
</tr>
</tbody>
</table>

**Training**
In the past 12 months, have you received any training?
Taught courses internal and external.
### Some examples of tables from the Healthcare Commission NHS Staff Survey 2004

#### Job satisfaction
What is the extent to which my employer values my work?

<table>
<thead>
<tr>
<th>Breakdown by group: all trusts</th>
<th>Strongly disagree/disagree %</th>
<th>Neither satisfied nor dissatisfied %</th>
<th>Satisfied/very satisfied %</th>
<th>Base number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/dental staff in all trusts</td>
<td>24</td>
<td>30</td>
<td>46</td>
<td>11,364</td>
</tr>
<tr>
<td>Medical/dental (consultants) in all trusts</td>
<td>25</td>
<td>26</td>
<td>49</td>
<td>4,386</td>
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<tr>
<td>Medical/dental (other) in all trusts</td>
<td>24</td>
<td>32</td>
<td>44</td>
<td>6,978</td>
</tr>
</tbody>
</table>

#### Job satisfaction
I have the freedom to choose my own methods of work.

<table>
<thead>
<tr>
<th>Breakdown by group: all trusts</th>
<th>Strongly disagree/disagree %</th>
<th>Neither satisfied nor dissatisfied %</th>
<th>Satisfied/very satisfied %</th>
<th>Base number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/dental staff in all trusts</td>
<td>12</td>
<td>21</td>
<td>65</td>
<td>11,416</td>
</tr>
<tr>
<td>Medical/dental (consultants) in all trusts</td>
<td>12</td>
<td>16</td>
<td>72</td>
<td>4,408</td>
</tr>
<tr>
<td>Medical/dental (other) in all trusts</td>
<td>14</td>
<td>25</td>
<td>61</td>
<td>7,008</td>
</tr>
</tbody>
</table>

#### Job satisfaction
I get recognition for good work.

<table>
<thead>
<tr>
<th>Breakdown by group: all trusts</th>
<th>Strongly disagree/disagree %</th>
<th>Neither satisfied nor dissatisfied %</th>
<th>Satisfied/very satisfied %</th>
<th>Base number of respondents</th>
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<td>26</td>
<td>51</td>
<td>4,395</td>
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<tr>
<td>Medical/dental (other) in all trusts</td>
<td>24</td>
<td>29</td>
<td>46</td>
<td>7,010</td>
</tr>
</tbody>
</table>
5. Consultant contract

5.1. The available evidence indicates that, at the time of this submission, some nine out of ten consultants will have moved to the 2003 consultant contract. This represents very pleasing progress over the last year and a significant increase on earlier figures. A Department of Health survey, with a 95 per cent response rate and published in February 2005, indicated that as at October 2004, 76.9 per cent of consultants had moved to the contract (up from 68 per cent in August 2004). A more recent BMA survey, conducted in May 2005, found that 86.6 per cent of consultants had transferred by that date. A further Department of Health survey is planned for October 2005.

5.2. Employers report continued activity in preparing and agreeing job plans (an essential precursor to offering the 2003 contract) and there is every reason to believe that the transfer figures will, when combined with first consultant appointments directly onto the 2003 contract and movement between consultant posts, increase by November 2005 to around 90 per cent. The figure is expected to increase further over time, with numbers on the ‘old’ contract continuing to decline as non transferees diminish as a group, through, for example, retirement.

5.3. A common reason given for consultants electing not to transfer is failure to agree upon the number of programmed activities reasonably required to discharge the duties set out in the job plan. Many of these disagreements will have been resolved via the mediation and appeals mechanism set out in the Terms and Conditions, resulting in further transfers during 2005.

5.4. With regard to the DDRB’s recommendations for 2006, NHS employers do not seek to differentiate the percentage increase awarded to those on the ‘old’ contract compared with the award for those consultants on the 2003 contract.

5.5. We recognise that this is a different view from that taken by employers (and presented by the NHS Confederation) last year. 2005/06 was the final phase of a three-year deal for consultants on the 2003 contract which had been declined by the BMA on behalf of those on the ‘old’ contract. That award was linked to the modernisation of the consultant contract and we felt it was not appropriate for that benefit to be applied to those who had not participated. Those circumstances do not apply this year.

5.6. An improving vacancy pattern has been noted at paragraph 3.1 (Chapter 3). A contributory factor, apart from the more favourable terms provided for by the 2003 contract, may be the increased flexibility now applied to working arrangements. As employers and consultants become more skilled at tailoring job plans, the resultant arrangements better accommodate the needs of both the employing trust and the wider NHS, as well as the needs of individual consultants. Employers report that job plans now better reflect local delivery plans and provide opportunities for service
development including new ways of working within teams, clearer agreement upon clinical priorities and revised arrangements for consultant cover and on call.

5.7. Consultants and employers are now expected to work in partnership and expressly agree the number, purpose and allocation of programmed activities. This can provide levels of clarity and a shared understanding of ‘reasonableness’ in the employment relationship that may not have been present previously. This may help explain the general improvement in consultant morale also reported by employers. The fact that so many consultants have elected to transfer to the 2003 contract demonstrates in itself the degree of support that has emerged for the new arrangements.

5.8. Employers report that non-pay solutions to the challenges of recruitment and retention, as illustrated previously, can be as effective as increases in levels of pay. Provision exists within the contract for the payment of recruitment and retention premia but employers report this is not commonly used. Exceptions mostly include specialties where it is acknowledged national shortages exist: psychiatry, radiology and histopathology. In the case of psychiatry, for example, employers report payment of time limited premia of up to 30 per cent of starting salary being granted to consultants in high and medium secure settings and to those working in learning disabilities.

5.9. Overall, it is thought that recruitment and retention premia are not always appropriate, since the most common cause of national shortage is the lack of trained and experienced staff, rather than the ability to attract them to the NHS. There is little competition at present with non-NHS organisations for doctors; rather it is a problem of supply in one or two key specialties.

5.10. Before making such awards employers are expected both to have attempted to deploy non-pay initiatives and to consult other local NHS organisations about their intentions. This appears to be happening, with SHAs frequently playing a co-ordinating role. The current provisions for the local level design and payment of premia are deemed by employers to be satisfactory. No change is sought to these arrangements.

5.11. NHS Employers has published, so far during 2005, five pay circulars related to consultants. A number of issues have been promulgated including amendments to the contract itself (for the purposes of certainty and clarity) and consequential changes made to the Terms and Conditions.

5.12. More favourable arrangements have been introduced for maternity leave and pay; provisions for an employment break scheme have been introduced, as have revised arrangements for public holidays and special leave with and without pay. Other elements of the Terms and Conditions have also been revised to ensure consistency, clarity and ease of use.
6. Doctors in the non-consultant career grades

6.1. As requested by the Secretary of State for Health in May 2004, the NHS Confederation undertook a scoping study to determine the need for a detailed review of terms and conditions of service for doctors and dentists who were on national terms and conditions of service who were neither consultants nor doctors in training. The Confederation reported in November 2004 and acknowledged the need for taking forward nationally negotiated contractual reform for the employed group of doctors who were working to deliver primary or secondary care, but excluding those who were also working as GPs. In April 2005 a final mandate was given to NHS Employers by the Department of Health.

6.2. The mandate agreed to NHS Employers entering into negotiations with the BMA on a new pay structure and associated terms and conditions of service for this group of doctors and dentists in England. Scotland and Wales are also taking part in the negotiations whilst reserving the right to employ some flexibility to accommodate different local circumstances. Northern Ireland elected to attend initially on an observer basis only.

6.3. The mandate stated that the outcomes of the negotiations must:
- support service modernisation
- meet employment law requirements; and
- be compatible with Modernising Medical Careers within a determined funding envelope.

Doctors and dentists who are in the staff grades, associate specialists, clinical medical officers and non-GP clinical assistants and hospital practitioners are included in the review.

6.4. The negotiations are being managed by NHS Employers and are being conducted by NHS managers and representatives of the other UK Health Departments with an objective that the contract should, if possible, be capable of being implemented from 1 April 2006.

6.5. The NHS management’s negotiating team is being led by Heather Lawrence, Chief Executive of Chelsea and Westminster NHS Trust, and the negotiating team includes chief executives, medical directors, and HR managers. Additionally, a reference group of NHS employers has been established to explore views and test modelling via e-mail as proposals develop.

6.6. Negotiators from both sides first met in April 2005 and meetings have been held on a frequent basis since this time and are expected to continue over coming months. It is too early at this stage to give any indication of the overall shape of a final package as
the negotiations are being conducted under a ‘nothing is agreed until it is all agreed’ protocol. It is expected that by the oral evidence stage the process will be more advanced.

6.7. The early stages of the negotiations have been conducted in a very constructive manner with both sides working as a team to identify and share objectives for the negotiations. Work has been on-going to jointly identify current payroll costs and staffing numbers as a solid basis for modelling the payroll costs and implications. A number of sub-groups have also been established to progress work before it is submitted to the joint meetings.

**Objectives of the negotiations**

6.8. Over coming months, the negotiations will focus on developing a new grading structure which will aim to support the objectives laid out in the *Choice and opportunity* document to modernise the non-consultant grades. One consideration will be how movement between this grade and the training grade can best be supported contractually. Movement in and out of training to enhance career development is a key objective in *Choice and opportunity*, but achieving this will require all concerned parties, especially employers, to be willing to support and promote such moves. The negotiations will also need to address the current pay protection arrangements that discourage such moves. Significant work will be required to determine how assimilation into the new grade and then progression in grade can best be achieved.

6.9. The non-consultant career grade has been regarded as a route for those who have not succeeded in the training grades. It has been previously acknowledged that the grade lacks status and recognition within the medical workforce, notwithstanding that these doctors are very productive and make a significant contribution to service delivery in the NHS. An important aspect of the review is, therefore, to improve the recognition given to this group. Two aspects of this are to rename the grade to reflect their knowledge and experience and to integrate the group more fully into the NHS workforce.

6.10. Turning to service delivery and work organisation, a key focus will be on improved annual job planning and ensuring continuing professional development (CPD) is undertaken by this group of staff. This will mean consideration of the structure and make up of the working week. Increased flexibility will be an important consideration and how out of hours working can be encouraged.

6.11. Once key principles have been determined pay modelling will be undertaken with the trusts of the reference group and members of the negotiating team to ensure the funding envelope is adhered to.
6.12. At this stage, much work remains to be done to achieve the target date of 1 April 2006, but both parties have committed to undertaking the work necessary to meet this over the coming months.

6.13. In light of the work being taken forward on contract reform for this group, we are seeking an uplift to their pay range in line with the inflationary uplift sought for all other groups of staff.

**Postgraduate Medical Education and Training Board (PMETB)**

6.14. In parallel to our negotiations, the PMETB is due to commence responding to applications for access to the Specialist Register from 30 September 2005. This will provide a route for doctors in the non-consultant career grades who have the specified skills, experience and training to submit applications for access to the Specialist Register. This will remove the barriers that currently restrict access to the register to doctors completing a defined period and a specified curriculum in training posts. Clearly, our negotiations are mindful of this revised career route and are seeking to ensure that developing proposals support the new structure. Similarly, developments at PMETB are at an early stage and it is not yet clear what the impact on non-consultant career grade doctor numbers will be and what training opportunities there will be to support those for whom PMETB indicates that further assessment or training is required.
7. Doctors in training

The effect of Modernising Medical Careers on pay scales

7.1. The introduction of a foundation programme followed by a single specialist training grade will necessitate the introduction of pay scales which facilitate payment on the new grades.

7.2. Our approach to this is to utilise existing pay points and to formulate scales that enable the new trajectory through training without: changing the rate of pay at any point; adding to employer costs; or creating any disincentive for junior doctors.

7.3. In future, doctors are expected to spend more time training and less on service delivery, but, as now, individuals will spend varying amounts of time at each level due to: ill health; training flexibly; or career opportunity.

7.4. Table 7.1 below shows proposed new scales (at 2005/06 prices) for the foundation programme and a proposal for interim use with pilot schemes in the provisionally titled ‘run through’ grade alongside existing scales. We recognise that the senior scale will need further joint discussion and it is envisaged that senior house officer and specialist registrar scales will be used in parallel for some time until the new pathways are fully embedded. The figures in red in the table indicate an optimum transit through training.

7.5. As well as identifying the progress of this group of doctors for pay purposes it is also important to have recognised pay codes in place so that doctors can be appropriately recorded in the Department of Health’s annual census and on the electronic staff record (ESR).
Table 7.1 Proposed pay scales for new grades for doctors in training

<table>
<thead>
<tr>
<th>Grade</th>
<th>Current</th>
<th>Proposed</th>
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<td>PRHO</td>
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<td>21,601</td>
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<td>SHO</td>
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<td>30,418</td>
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<td>33,813</td>
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<td></td>
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<td>SpR</td>
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<td></td>
<td>31,174</td>
<td>32,607</td>
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<td>42,985</td>
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</table>

Full registration

Figures in red represent the optimum route through training.
Flexible training

7.6. Changes to the pay arrangements for doctors training flexibly have been agreed with the BMA and took effect for new contracts from 1 June 2005. Agreement was reached between the BMA Junior Doctors Committee, NHS Employers, the UK Health Departments and the Conference of Postgraduate Medical Deans on a fresh approach to flexible training. The new arrangements will facilitate:

- access to flexible training
- providing clear guidelines on eligibility
- moving towards integrated rather than supernumerary working
- an equitable pay structure.

7.7. From an employer perspective this should make employing a flexible trainee a more attractive proposition. It is also expected to open up flexible training to doctors who, in the past, may have found difficulty in obtaining it.

7.8. Until recently, doctors in training have worked extremely long hours. This has now reduced and doctors in full-time training may work between 40 and 56 hours a week. But for doctors with domestic or family responsibilities this is still a considerable workload and, increasingly, doctors are hoping to reduce their hours of work still further to enable a balanced lifestyle. Flexible training, where doctors typically work 60 per cent of the hours of a full-time trainee, is very popular, and interest is expected to rise as the proportion of women entering medicine increases.

7.9. The contract needed to be changed because revisions to pay arrangements in 2000 also made them appear more expensive to employ than equivalent full-time trainees and this, together with the fact that many flexible trainees were employed on a supernumerary basis, regardless of service requirements, made increasing the number of flexible trainees an unattractive option to trusts. The result was that some trainees had difficulty finding posts.

7.10. Reform was clearly necessary, and to be effective needed to go hand in hand with a better approach to full-time training that aims to promote work–life balance. But this must be backed up with effective locally tailored strategies on care for junior doctors’ dependants, including childcare, and with efforts to make working patterns more family friendly.

7.11. The revised arrangements cover three themes:

- revised pay arrangements
- better access to training
- better monitoring of the demand for training and the supply of places.
7.12. The latter two aspects are managed by postgraduate deans but the pay arrangements will be of interest to the Review Body and are described in detail at Annex B. These arrangements were supported by an addition to postgraduate deans’ budgets of £7 million recurrently. It is too soon to tell whether this has had an immediate effect on access and we await the first detailed monitoring, due in autumn 2005, with interest.

7.13. Flexible trainees are monitored routinely by the postgraduate medical deaneries through their annual survey, and separately by the trusts themselves during the six-monthly monitoring of all junior doctors’ hours. It is worth noting that these surveys produce significantly different results in respect of the number of flexible trainees in post. The deanery figures show a higher number of doctors training flexibly than the New Deal monitoring figures. This is because the monitoring figures only record doctors working in hospital over a six-month period and do not include, for example, doctors on maternity leave. To illustrate the point, deanery returns for September 2004 showed 2,086 trainees in post, whilst September 2004 trust monitoring showed 1,244. If we are to measure the success or otherwise of the new arrangements properly, it will be important to ensure that monitoring is comprehensive and accurate.

7.14. The chart below shows the UK deanery figures for flexible trainees for the last ten years, with a trend line. The reduction in numbers following the introduction of the arrangements in 2000 demonstrates how the disproportionate cost of flexibles was received by the NHS; only recently has the upward trend returned, and we expect this to further accelerate as a result of the new 2005 provisions.
Pay protection

7.15. Pay protection and its costs has been a constant theme from employing organisations, particularly trusts, since the contract was updated in December 2000. The provisions are, by comparison with those of other NHS staff groups, extremely generous and can affect trust pay bills for several years. The protection arrangements were designed at a time when the service knew that hours must reduce as a result of the European Working Time Directive (EWTD) and were formulated to provide an incentive for junior doctors to work with their employers to bring hours down.
7.16. However, the value of pay protection to the doctor and the extended period over which it can apply have not only provided a perverse incentive for some doctors to perpetuate the long hours culture and maintain their level of income, they have also not provided an incentive for trusts to reduce hours. Although the work available from junior doctors has reduced significantly because of the EWTD, costs have been seen to reduce by little as a result of protection, if at all, in both the short and medium term. The chart shows the reducing weekly hours of doctors in training – in many cases this is not accompanied by a corresponding reduction in cost.

7.17. Some employers feel that doctors should be aware of the reducing working hours and ought not to be protected from pay reductions occurring as a result of these fully anticipated moves. Even without protection doctors are paid at rates agreed with the BMA and supported by DDRB as appropriate for the work undertaken. Nevertheless, if doctors are appointed to specific posts at known pay bands, the service is contractually obliged to maintain pay at the contracted level while the post is occupied. A sense of the scale of change going through pay bands can be drawn from the chart.
7.18. The service has seen an almost complete elimination of Band 3 posts since banding was introduced. This is encouraging, as this band is the most expensive for trusts in pay terms, but the large numbers of posts being made compliant are indicative of the potentially large number of doctors likely to be pay protected at this level.

7.19. The movement of doctors from Band 3 to Band 2A is the probable reason for the significant increase in the numbers in Band 2A in the initial stages to March 2003; the subsequent and continuing reduction in Band 2A numbers, needed to move to 2009 EWTD compliance, suggests this is where the bulk of pay protection issues will remain.

7.20. We anticipate that over time, and certainly after 2009, the majority of doctors will fall into Bands 1A and 1B; movement to these bands from 2A and 2B will be less costly in terms of pay protection and as posts stabilise in Band 1 pay protection will cease to be the major issue it is now. However, the impact of the current and impending EWTD restrictions and of the New Deal are causing significant changes to working practices and these changes will continue beyond 2009, the date for full implementation of the 48-hour week for doctors in training.
7.21. Regardless of the problems it generates, pay protection exists as part of the collective agreement on the contract for doctors in training, and cannot be ignored. The provisions are complex, implementation even more so, and we are aware that some employers may still be applying protection in ways aimed more at expedience than adherence to the letter of the agreement, which can prove rather less than cost effective. NHS Employers is developing guidance on implementation which it intends to publish in the hope of achieving a better common understanding of the issues.

Banding supplements

7.22. The Department of Health (in evidence to DDRB in 2004) argued that the pay supplements currently in place properly reflected the amount of work done and appropriately reflected the unsocial elements of the work; in their report DDRB concurred with this view.
7.23. With the on-going reduction in hours and the definite intention to link hours of work and actual pay, it was expected that average take-home pay would reduce. The expected reduction in overall pay has started following a peak in 2003; nevertheless, after the implementation of the full rates of the new contract and despite pressure to reduce hours, at March 2005 the average hospital training supplement for compliant posts in England was 58 per cent, still 11 per cent higher than the average in the months following the introduction of the contract.

7.24. We expect the average supplement to fall further as we approach 2009, but this inevitable fall in overall salary must, however, be taken in context. Pay is one factor of the overall reward for undertaking work. Just as important is quality of life, and it is entirely right that reduced hours and less onerous working arrangements as demonstrated by reduced bandings should be balanced by a reduction in pay. It would be inappropriate to maintain overall pay at existing levels while reducing hours – this would be to increase effective pay rates without reason.

7.25. An increase in relative pay might be appropriate in circumstances where there was difficulty in recruiting to the profession. However, there is currently no shortage of applications to enter medical school, and considerable competition for posts at all levels of training thereafter, even though the number of occupied training places has expanded significantly, as demonstrated by monitoring.

7.26. Between March 2001 and March 2005 the number of pre-registration house officer and senior house officer posts monitored rose by 14 per cent, whilst the number of specialist registrars rose by 26 per cent over the same period – a most encouraging sign.
7.27. We consider that the banding supplements continue to represent fair reward for work undertaken, seeing no reason to move from the negotiated position and current rates. From a similar perspective, as salaries, particularly salaries on graduation, remain very competitive and there appears to be no shortage of qualified applicants to vacancies at all levels of training we see no reason for any uplift to basic salaries other than to account for inflation. Given that annual increments already add around 4–5 per cent to basic pay, we would suggest that any uplift for 2006 should be limited to 2.5 per cent to give all doctors in training on incremental pay scales a total maximum uplift of around 7.5 per cent.
GP registrars

7.28. When the supplement for GP registrars was raised to 65 per cent, it reflected the average supplement then payable in a hospital training post. The DDRB has recognised that should the hospital average supplement reduce it could be necessary to review the GPR supplement. Given that the average hospital supplement in England is now 58 per cent it might be considered appropriate to suggest the GPR supplement be reduced to 60 per cent. However, the contract is implemented UK-wide, and as average supplements in the other countries range from 58 per cent in England to 68.8 per cent in Scotland we feel that to reduce the supplement now would be to risk adversely influencing recruitment to GPR posts where the hospital supplement is higher than the average. Therefore, we consider that the GPR supplement should remain at 65 per cent in the current pay round but would wish to flag up the trend to DDRB.
8. Salaried general medical practitioners (GMPs)

8.1. The salary range for salaried general medical practitioners (GMPs) employed in primary care organisations is between £49,248 and £74,816, with starting pay, progression and review determined locally. We feel this group of doctors is now becoming established; employers have indicated that demand for the services which this group of doctors can provide is high.

8.2. Employers have reported that the pay range is appropriate. However, we believe we do not yet have sufficient robust information to be able to report on any specific issues with the pay and contractual arrangements for this group of doctors, nor are we able to report at the moment on how the use of local job evaluation is proceeding. To help address this lack of information we are in the process of setting up a NHS Employers salaried GMPs e-mail reference group which will be used to learn more about and evaluate the use of this group of doctors, to seek employers’ views on issues connected with pay and contractual arrangements, and to inform discussions held on behalf of employers with the BMA at a national level.

8.3. We will also be seeking to introduce more favourable arrangements for maternity leave and pay, and provision for an employment breaks scheme to bring arrangements for salaried GMPs into line with other directly employed NHS staff.

8.4. We are seeking an uplift to the salaried GMPs pay range in line with the inflationary uplift sought for all other groups of staff.
9. Salaried primary care dental services

9.1. Salaried dentists have reached the end of a three-year pay agreement for the period 2003/04 to 2005/06. Pending the publication of the outcome of the Creating the Future consultation, we consider that salaried dentists should receive the same inflationary uplift as other staff groups.
10. Pensions

General comparisons

10.1. NHS Employers is reviewing the NHS Pension Scheme with the trade unions. This review is about to go into a new phase with the commencement of scheme-specific negotiations across all public service pension schemes. This may lead to changes in the pensions package available to staff. One of the key issues that will be addressed is the Government’s proposal to increase the normal pension age to 65 (NPA65). Regardless of the outcome of those discussions, the NHS Pension Scheme will remain a defined benefit (DB) arrangement, offering an excellent package of benefits.

10.2. These are considerably better than what is available in the private sector where pension arrangements, where offered to new entrants, are typically on a defined contribution (DC) basis with a lower employer contribution than for the NHS scheme. Most private sector defined benefit arrangements have closed to new entrants.

10.3. The Government Actuary’s Department’s (GAD) Survey of Occupational Pensions 2004 found that the average employer contribution for DC pensions in the private sector was 6 per cent. NHS employers pay 14 per cent. NHS staff pay 6 per cent of salary compared with an average of 3.7 per cent for DC schemes and 4.9 per cent for private sector DB schemes.

10.4. The Pensions Policy Institute study of occupational pension provision in the public sector found that standard public sector benefits such as those received by NHS staff were worth up to 6 per cent of salary more than typical private sector DB schemes. This figure increased significantly when compared with those in DC arrangements or having no pension arrangements (up to 20 per cent). Even if NPA65 is introduced, public sector schemes such as the NHS scheme will still be worth 3–18 per cent of salary more than private sector comparators.

10.5. GAD found that there are now a larger number of public rather than private sector workers in DB schemes (five million active members in the public sector compared to 4.8 million in the private sector) even though public sector workers only make up a quarter of the workforce.

10.6. It has been argued that higher value pension schemes in the public sector compensate for lower pay rises. It is extremely difficult to assess whether public sector workers are being paid more or less than private sector workers because of problems with comparing occupations, hours worked and so on. The Labour Force Survey 2004 found that graduate pay levels are not lower for public than private sector workers in almost all regions of the country with the exception of London, the East and South East.
Pensions as a component of pay

10.7. Arguably, in the past the value of pensions has not been recognised by staff or employers and their value in recruiting and retaining staff has been less than might be expected given the level of investment. Public awareness of the cost of pensions and the need to save more for retirement means that staff now have a better understanding of the value of the NHS pensions package. The considerable benefit that pensions represent, and the guaranteed continuance of DB arrangements in the NHS at a time when the private sector now generally offers only DC arrangements is expected to have an increasingly positive impact on recruitment and retention.

10.8. NHS Employers agrees with the trade unions that pensions are deferred pay. It is important when considering appropriate levels of remuneration to look at both current and deferred pay. The proportion of pay currently deferred to pay for pensions is 20 per cent of pensionable payroll of which staff pay 6 per cent and employers 14 per cent.

10.9. GAD is currently conducting its four-yearly valuation of the NHS Pension Scheme. The Government Actuary will make a recommendation about the level of contribution required for the next four years.

10.10. NHS Employers believes the Review Bodies should take into account pension costs of both employers and employees when considering levels of pay increases. Any increases in employers’ contributions are an increase in deferred pay and should be seen as part of any overall pay award. So if, for instance, the Government Actuary recommended an increase in the employers’ contribution rate, we suggest this should be considered alongside any pay recommendation.
Pay Review Body Questionnaire

To: NHS trust chief executives

CC: Trust HR directors
Strategic health authority chief executives

Evidence to Pay Review Bodies 2006/07
Questionnaire seeking NHS employer views

NHS Employers will be submitting evidence on your behalf to the Doctors and Dentists Review Body (DDRB) and the Review Body for Nursing and Other Health Professions (NOHPRB) and the Pay Negotiating Council in September 2005 for the 2006/07 pay round.

During the period 2003/04 to 2005/06 a three-year pay deal has been in place for the majority of NHS staff. The agreement, which awarded 10 per cent over three years (at 3.225 per cent each year), has provided wage stability and certainty during a period of pay reform for the majority of staff.

The NHS Confederation historically has submitted evidence to the Review Bodies based on advice from its HR committee. This role has been subsumed by NHS Employers which has taken on some responsibilities from the Department of Health for producing evidence.

We envisage that employers’ evidence will be fuller than in the past. In addition to recommendations on rates of pay it will contain: updates on the latest position on Agenda for Change, juniors’ hours and their contracts, progress with contract negotiations on non-consultant career grades and contract issues relating to consultants, GP registrars and salaried GPs. It will also contain employer views on pay and workforce issues such as recruitment, retention and return.

Our evidence may also need to reflect a diversity of views and opinion. However, it must support both with evidence as the Review Bodies have in the past been critical of unsupported assertions and tend to disregard them. The evidence will be submitted on behalf of employers in England only.
This questionnaire gives service managers the opportunity to make their views known and to help us provide sound evidence-based argument. After receiving your evidence we will collate it into a representative report and assess what scope there might be for joint evidence with NHS unions and staff organisations. That process will take place during July and August.

Your views are very important. Please consult with your networks locally to obtain as broad a consensus as possible. Separate attachments may be returned with the questionnaire.

Please return this questionnaire to: payreview06@nhsemployers.org by Wednesday 22 June 2005
Evidence to Pay Review Bodies 2006/07
Questionnaire seeking NHS employer views

Priorities for the 2005/06 pay round

Please enter your responses in the box below the question. Boxes will expand as you type.

1. Affordability/finance

1.1 What level of pay award (excluding incremental steps) could be deemed affordable for 2006/07? Please express this as a percentage increase to your pay bill.

1.2 What would be the impact on services of a higher pay award than expected? Please give examples: e.g. effect on bed capacity, planned recruitment or planned service developments.

2. Distribution of awards

2.1 Would you agree that we should aim to reach joint agreement with staff organisations for a multi-year award?

If so, please state preference for a two-year or a three-year arrangement given that NHS funding has been indicated for 2006/07 and 2007/08 only.

2.2 Should the majority of resources be spent on a generic award (a percentage pay uplift for all staff), or a targeted award (e.g. as regional pay, national recruitment and retention premium, London weighting or high-cost area payment)?

2.3 Do you think that the same generic level of award is desirable for both doctors and AFC staff?
3. **Contract specific issues**

3.1 Consultant contract – are there any structural pay related issues to report (on either the 2003 contract or its predecessor)? Please state which contract you are commenting on.

3.2 Contracts for doctors in training (including GP registrars) – do you have any evidence about the operation of the current banding system as hours of work reduce in the run up to 2009?

3.3 Pay range for employed GPs – is the current range adequate/appropriate? Can you provide evidence to support its use in practice?

4. **Shortage groups – recruitment and retention**

4.1 Is the recruitment situation improving or deteriorating and what is the evidence for this?

4.2 Which staff groups have the worst recruitment and retention problems? (please be as specific as possible, e.g. ‘school nurse’ rather than ‘nurse’).

4.3 Are staffing shortages/recruitment difficulties in the groups named above local, regional or national?
4.4 Would a national recruitment and retention premium help employers to compete in external labour markets for any of these groups?

4.5 Retention problems – what are the reasons for staff leaving the service? What proportions go to: a) other NHS employers b) work outside the NHS c) retire?

4.6 If you have difficulties with recruitment and retention locally, what action are you taking to improve recruitment and retention at local level?

4.7 What are the trends in use of agency staff – higher or lower use – and what are the reasons for this a) for doctors b) for nurses c) for other staff?

5. Evidence of benefits from pay modernisation

5.1 Have you been able to introduce new working practices as a result of pay modernisation? (please provide examples)

6. Morale/motivation issues

6.1 What has been the impact of Agenda for Change implementation on staff?
6.2 What has been the impact of the consultant contract on the consultant body?

6.3 Is there evidence of improvements from the Improving Working Lives initiative? Please describe the initiative and the effect on staff.

6.4 Do you have evidence of other non-pay solutions that are working?

For example: changes to terms and conditions of service such as reduced hours or extended leave.

7. Foundation trusts

7.1 Are there any special issues that are of relevance to foundation trusts, which have not been covered above?

8. Other comments

8.1 Please add below any other comments/evidence you wish to put forward. Evidence may be attached as separate documents.

This evidence is submitted on behalf of: .................................................................
.......................................................................................................NHS trust/SHA or network

Contact name: ........................................ Position: ........................................................
Telephone number: ................................. e-mail: ............................................................
New arrangements for flexible training

This information is only available in PDF format. A link to this is below.

www.nhsemployers.org/docs/doctorstraining_flexible_pay.pdf