Department of Health & Social Care

The Review Body on Doctors' and Dentists' Remuneration (DDRB) Review for 2018

Written Evidence from the Department of Health and Social Care for England

January 2018

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Executive Summary

The context for this evidence is the continued focus on discipline in public spending to achieve the Government's fiscal targets and the more flexible approach to public sector pay policy to better meet strategic objectives and improve the productivity of public services.

In the spending review of 2015 the Government committed to backing the NHS with an additional £8 billion in real terms by 2020/21. At Budget 2017 the Government committed a further £2.8 billion of revenue funding by 2019/20, and an additional £3.5 billion of new capital investment by 2022/23 to transform the NHS estate and drive further efficiency savings.

Whilst this is a generous settlement, demands on the health and social care system continue to increase and meeting this demand whilst simultaneously improving quality of service in an affordable way is increasingly challenging. Meeting that challenge requires a focus on efficiency and transformational change.

NHS Workforce Policy

Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the right people with the right skills, values, experience and expertise is central to the future of the Health and Care system and is a fundamental aspect of the Department of Health and Social Care's overarching strategic programme.

The Department continues to take action to increase the supply of trained staff available to work in the NHS and wider health and care system. In conjunction with Health Education England (HEE) and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff. Health Education England has published a consultation document on a draft health and care workforce strategy to 2027.

There has been an increase of 8,113 more doctors since March 2012 and it is estimated there will be an additional 11,420 consultants and doctors in general practice by 2020. The Government has also announced plans to expand undergraduate medical education by funding an additional 1,500 medical school places in England, ensuring the NHS is fit to continue providing high quality, safe and sustainable care.

At present the collection and production of statistics related to vacancies across the NHS is still limited. NHS Digital has established a working group with DH, HEE, NHSI and NHSE aimed at developing a consistent and robust time series that can capture the changes over time.

As a result of NHSI agency controls, expenditure on agency reduced by 22% in 2016/17 and this reduction in agency spend has continued in the first quarter 2017/18

To supplement the evidence on staff numbers, changes and pay, the annual staff survey provides an insight into staff's views and experiences. In general, the scores for DDRB remit groups are quite positive. Since 2012 all three medical/dental groups are feeling more motivated about their work and the number of extra hours worked by consultants and junior doctors has been decreasing.

Pay Policy

As set out in the letter from the Chief Secretary to the Treasury on 21 September, the last Spending Review budgeted for a 1% average increase in basic pay and progression pay awards and there will still be a need for pay discipline over the coming years; however, there is recognition that in some parts of the public sector, particularly in areas of skills shortage, greater flexibility may be required to deliver world class public services, including in return for improvements to public sector productivity.

The Secretary of State's remit letter of 7 December 2017 reiterated the need to continue to consider affordability and invited the Review Body to make recommendations, in relation to the employed medical workforce, about targeting funding to support productivity and recruitment and retention. As we set out last year, targeting is an integral consideration as contracts are being reformed. Chapter 6 sets out the flexible pay premia for doctors and dentists in training and the process whereby these are to be reviewed, and the Review Body is asked to consider detailed evidence from Health Education England both on the flexible pay premia for hard-to-fill-training programmes and on geographical issues and incentives. As set out in chapter 7, as part of negotiations on reform of the consultant contract the parties are exploring the implementation of new performance pay arrangements, something that the Review Body has commented on, on more than one occasion, and recognising the importance of consultants to the overall productivity of the NHS.

Earnings for HCHS doctors have grown in the last five years, although at a lower rate than the private sector, with the exception of 2016/17. Consultants' pay, the most numerous M&D staff group, has grown at a rate significantly lower than the average. Nonetheless, medical practitioners remain amongst the highest (top 6) earning professions. Total average pay for HCHS doctors has increased by 5% between 2012/13 and 2016/17.

The NHS Pension Scheme remains a valuable part of the total reward package for doctors and dentists. NHS members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed. Increases to member contributions in recent years, and the increase to employee National Insurance contributions do not appear to have led to significant numbers leaving the scheme in net terms. However, there is evidence of high earning individuals opting out of the scheme or leaving NHS employment through early retirement.

As in recent years - and reflecting the roles of the Department, its Arms-Length Bodies and other organisations - the Review Body will be invited to consider, alongside evidence from the trades unions, professional bodies and other stakeholders:

- high-level evidence from the Department, including the strategic policy objectives and the economic and financial (NHS funding) context;
- evidence from NHS England on affordability and funding and the Five Year Forward View;
- evidence from NHS Employers and NHS Providers on reformed contracts, total reward, recruitment, retention and motivation;
- evidence from HEE on education, training and workforce capacity supply; and
- evidence from NHS Improvement on how they support the Department and NHS organisations on a range of issues, for example to restore and maintain financial balance, delivering on the clinical standards, workforce planning and bearing down on Agency spend.

1. NHS Strategy and Introduction

1.1. The Government committed to backing the NHS with an additional £8 billion in real terms, by 2020/21 in spending review 2015. At Budget 2017 we have now committed to backing the NHS in England further so that by 2019/20 it will have received an additional £2.8 billion of revenue funding for frontline services than previously planned over the period. This includes £335 million this winter to help trusts to increase capacity. We have also committed £3.5 billion of new capital investment by 2022/23 to transform its estate and drive further efficiency savings.

1.2. Whilst this is a generous settlement compared to other Government Departments, the health and social care system faces increasing demand for its services, driven by an increasingly aged and frail population, and meeting this demand and driving up quality in an affordable way is incredibly challenging.

1.3. The Department's Shared Delivery Plan 2015-2021 is informed by the NHS's own improvement plan - the Five Year Forward View. NHS England's report Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 makes clear that providers cannot choose to either improve care for patients or balance their books - they must do both:

"The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients".

1.4. Transformational change is needed to reduce the long-term costs pressures on the NHS. Chapter 3 sets out the work that is being undertaken by the Department with the health service, partners and patients to deliver key elements of the programme required to achieve the efficiency savings recently reinforced in Next Steps on the Five Year Forward View[i].

1.5. In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. As part of this, local health and care systems in England came together in January 2016 to form 44 Sustainability and Transformation Partnerships (STP) and developed local proposals to help meet the 'triple challenge' set out in the Five Year Forward View, of better health, transformed quality of care delivery, and sustainable finances. A number of the partnerships have now evolved into integrated or 'accountable' care systems (ACSs). In July 2017, NHS England published a dashboard of STP progress which tracks the combined achievements of local services through 17 performance indicators across nine priority areas, each falling into three core themes of hospital performance, patient-focused change and transformation[ii].

Workforce

1.6. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department of Health and Social Care's overarching strategic programme for the health and care system. A new group has been set up to steer the strategic programme for workforce, chaired by the Minister of State for Health and involving all the organisations involved in delivering the programme, and a draft workforce strategy was published, for consultation, by Health Education England on 13 December 2017[iii].

Staff engagement

1.7. Staff engagement is crucial to securing and retaining the workforce that the NHS needs, as is making the most effective use of the entire NHS employment offer - pay and non-pay benefits. We strongly believe that recruitment and retention is not just about pay, it is about creating a culture and environment in the NHS where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, and work hard to keep them safe and ensure bullying and harassment is not tolerated.

1.8. The Developing People, Improving Care framework published in December 2016, set out - for the first time – a jointly agreed aspiration to support leaders so that they can implement cultures of continuous improvement and ensure they create a positive working environment for their staff. Under the aegis of this programme and, separately, through the Social Partnership Forum, we have led work to improve organisational cultures and reduce the rate of bullying and harassment. These programmes, which address entrenched cultural issues, take time to come to fruition but the Department is committed to supporting them over the long term, so that they make a long lasting, noticeable difference.

Government Pay Policy and our Approach to Pay and Contract Reform

1.9. The Government's public sector pay policy aims to ensure that the overall package for public sector workers is fair to them and that we can deliver world class public services which are affordable within the public finances and fair to taxpayers as a whole.

1.10. We know that pay restraint has been challenging for staff and we have been listening to the concerns of NHS staff and their representatives. We have also listened to staff who tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community. The public sector pay cap has been essential to ensuring continued levels of recruitment and retention in support of that: pay

restraint has helped the NHS to recruit over 14,900 (15.8%) more doctors since May 2010.

1.11. We want to help ensure that the NHS can continue to deliver world-class patient care, putting patients first and keeping them safe whilst providing the high quality care we all expect. Patients, and their experience of care, must be at the heart of everything that the system does and the pay review bodies for the NHS are asked, as part of their standing remits, to give regard to that. Putting patients at the heart includes ensuring the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. We continue to focus on public sector pay reform to ensure that terms and conditions are fit for purpose, affordable and sustainable.

1.12. As set out in the Chief Secretary's letter of 21 September 2017[iv] the last Spending Review budgeted for a 1% average increase in basic pay and progression pay awards for specific workforces, and there will still be a need for pay discipline over the coming years. Within the context of a continued need for pay discipline to ensure the affordability of public services and the sustainability of public sector employment, the Government has recognised that more flexibility may be required in some parts of the public sector, particularly in areas of skills shortage, to deliver world class public services, including in return for improvements to public sector productivity. Chapter 2 sets out that, with the exception of Agenda for Change - where additional funding is available on the condition that the pay award supports the drive for improved productivity and efficiency in the NHS - existing spending plans set through the Spending Review 2015 remain in place and recommendations for public sector pay increases above the 1% set out at the Spending Review will need to be considered in this context.

1.13. In its 2017 report, the Review Body recommended that better use be made of existing pay flexibilities, including to address persistent, above average geographic and specialty shortages. As set out in the Department's evidence last year, targeting is an integral consideration as contracts are being reformed. Chapter 6 sets out the flexible pay premia for doctors and dentists in training and the process whereby these are to be reviewed. Chapter 7 covers negotiations on reform of the consultant contract, within which the parties are exploring the implementation of new performance pay arrangements. Chapter 9 describes the targeted investment in recruitment and retention schemes in general practice.

1.14. In his remit letter of 7 December 2017 the Secretary of State reiterated the need to continue to consider affordability and invited the Review Body to make recommendations, in relation to the employed medical workforce, about how resources might be targeted, including:

- through the existing mechanisms of the flexible pay premia in the contract for doctors and dentists in training, taking account of evidence and proposals from Health Education England on hard-to-fill training programmes and regional variations; and
- as a response to discussions between NHS Employers and the medical trades unions on reform of the consultant contract, on which the parties will provide an update in supplementary evidence.

2. Evidence on the General Economic Outlook

Introduction

2.1. The economic and fiscal context in which the Pay Review Bodies (PRBs) will make their recommendations was set out in detail in the November 2017 Budget. However, as in previous years, this chapter summarises points that may be of particular relevance to the pay review process, notably the latest Office for Budget Responsibility (OBR) projections for the economy, and recent trends in the labour market, both in the public and the private sector. This should be considered alongside the rest of the Department of Health and Social Care's evidence when making recommendations.

2.2. In 2017 the Government adopted a more flexible approach to public sector pay, to address areas of skills shortages and in return for improvements to public sector productivity. The Government will continue to ensure that the overall package for public sector workers is fair to them and ensures that we can deliver world class public services, while also being affordable within the public finances and fair to taxpayers as a whole. This makes it all the more important that Pay Review Bodies continue to consider affordability, alongside wider economic circumstances, when making their recommendations.

Public Finances

2.3. As usual, it is important that the PRBs take into account the wider fiscal context when making their recommendations. As set out in the November Budget, the UK economy has demonstrated its resilience. Gross Domestic Product (GDP) has grown continuously for 19 quarters and employment has risen by 3 million since 2010 to a near record high. However, over the last year business investment has been affected by uncertainty, and productivity - the ultimate driver of wage growth - has been subdued. Productivity growth has slowed across all advanced economies since the financial crisis, but it has slowed more in the UK than elsewhere. The OBR has revised down expectations for productivity growth over the forecast period compared to Spring Budget 2017.

2.4. The government has made significant progress since 2010 in restoring the public finances to health. The deficit has been reduced by three quarters from a post war high of 9.9% of GDP in 2009/10 to 2.3% in 2016/17, its lowest level since before the financial crisis. Despite these improvements, borrowing and debt remain too high. The OBR forecast debt will peak at 86.5 % of GDP in 2017/18, the highest it has been in 50 years. In order to ensure the UK's economic resilience, improve fiscal sustainability, and lessen the burden on future generations, borrowing needs to be reduced further.

2.5. The fiscal rules approved by Parliament in January 2017 commit the government to reducing the cyclically adjusted deficit to below 2% of GDP by 2020/21 and having debt as a share of GDP falling in 2020/21. These rules will guide the UK towards a balanced budget by the middle of the next decade. The OBR forecasts that the government will meet both its fiscal targets, and that borrowing will reach its lowest level since 2001/02 by the end of the forecast period. Debt as a share of GDP is forecast to fall next year and in every year of the forecast. These targets will require ongoing discipline in public spending.

2.6. Public Sector pay currently accounts for around £1 in every £4 spent by the government and the public sector pay bill figure for 2016/17 is £179.41bn, up from £173.19bn in 2015/16. Public sector pay policy necessarily plays an important role in controlling public spending.

2.7. Departments are also facing longer-term pressures. The OBR's Fiscal Sustainability report highlighted the significant impact that demographic changes are likely to have on the public finances. Discipline in public spending remains central to achieving the government's fiscal targets. The last Spending Review budgeted for one per cent average basic pay awards, in addition to progression pay for specific workforces, and there will still be a need for pay discipline over the coming years to ensure the affordability of the public service and the sustainability of public sector employment.

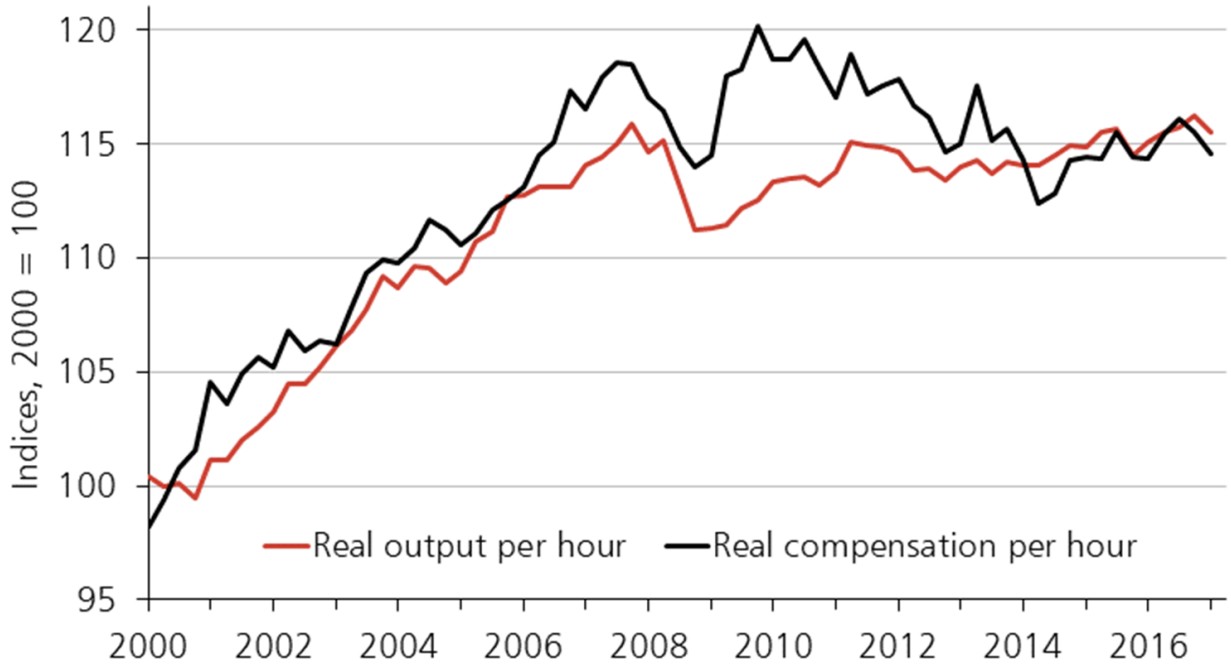
2.8. This makes it ever more important to ensure that our pay bill spending delivers maximum value for money. Between 2010 and 2016, public service productivity increased by 3%, an average of 0.5% per year. But although public service productivity has improved, further improvements are vital in order to deliver government objectives and meet rising demand. In its response to the PRBs Government will consider where pay awards can be agreed in return for improvements to public sector productivity, which also plays an important role in the UK's productivity growth overall.

Labour market

2.9. The UK labour market necessarily forms an important backdrop to the PRB process. The OBR forecast that the number of people in employment will continue to increase to 32.7 million in 2022. The unemployment rate is forecast to increase slightly over the forecast horizon as it returns to the OBR's new estimate of its equilibrium rate, remaining at 4.6% from 2020 onwards.

2.10. Despite the continued strength of the labour market, weak growth in labour productivity has been weighing down on wages and, ultimately, the public finances. As set out in the November 2017 Economic and Fiscal Outlook, the OBR expects productivity to remain flat in 2017, before increasing 0.9% in 2018 and 1.0% in 2019. Productivity growth is then forecast to increase to 1.3% in later years. This compares to the Spring Budget 2017 forecast of 1.7% on average over the forecast period.

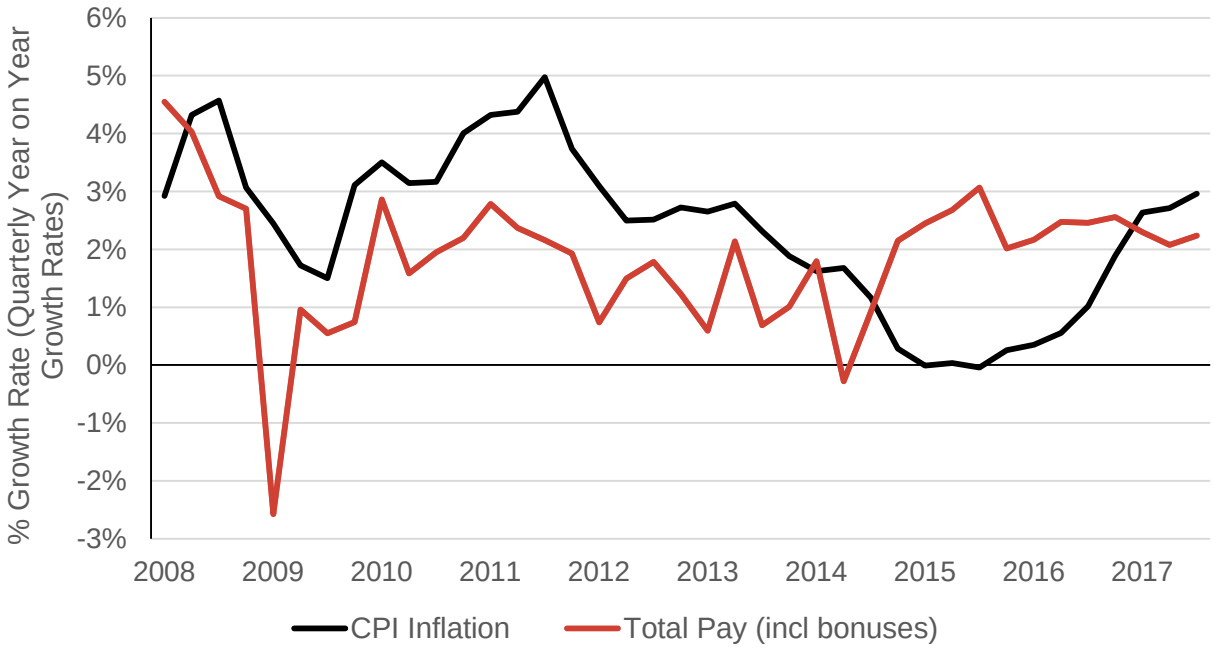
Fig 2.1: Real output per hour and real compensation per hour, year on year growth (ONS November 2017)



2.11. With a lower forecast for productivity growth the OBR expects average earnings growth of 2.3% in 2017, 2018 and 2019. It then increases to 2.6% in 2020, 3.0% in 2021 and 3.1% in 2022. A pickup in productivity is vital for the recovery of cross-economy wage growth rates to pre-recession levels. Public and private sector wages tend to move in similar directions, both because of pay expectations and the implications of tax receipts on public sector budgets. The £31 billion National Productivity Investment Fund and our Industrial Strategy will help to boost productivity and earning power throughout the UK.

2.12. We recognise that higher inflation is putting pressure on all households as well as our hardworking public servants. But historically the relationship between pay and inflation has been a weak one, in part due to the temporary nature of many inflation fluctuations. Most forecasters expect this period of above target inflation to be temporary, as inflation has been pushed above the target by the boost to import prices that had resulted from the past depreciation of sterling . The OBR and the Bank of England both expect inflation to peak at the end of this year and then fall again over 2018 and 2019. The appropriate level of public sector pay award is complex and determined by a variety of factors, notably retention and recruitment. Rates of price inflation are important, but not the only consideration.

Fig 2.2: Whole economy average earnings growth and inflation (ONS November 2017)



Public sector pay and pensions

2.13. Specific evidence on the pay of the NHS workforce is presented elsewhere in this document. However, wider trends in pay and remuneration are also relevant. Following the last recession, public sector wages did not undergo the sharp fall seen in the private sector, and have since grown at a slower pace than private sector wages: for the three months to October 2017 private sector total pay grew by 2.7% on the same period the previous year, compared to 1.8% in the public sector (excluding financial services). However, the overall remuneration of public sector employees when taking employer pension contributions into account remains at a significant premium, as seen in Figure 2.3 below.

Fig 2.3: Percentage public sector pay premium, hourly pay for all employees, controlling for personal characteristics (ONS ASHE)

2.14. When considering changes to remuneration, PRBs should take account of the total reward package. Public service pension schemes continue to be amongst the best available and significantly above the average value of pension provision in the private sector. Around 17% of active occupational pensions scheme membership in the private sector is in defined benefit (DB) schemes, with the vast majority in defined contribution (DC) schemes. In contrast, over 95% of active members in the public sector are in DB arrangements.

2.15. In April 2016, the National Living Wage was introduced at £7.20 for workers aged 25 and over (increased to £7.50 an hour in April 2017, and will increase to £7.83 in April 2018). The introduction of the NLW marked an increase in pay for over a million workers across the UK labour market, including in the public sector. Estimates indicate that approximately 53,000 public sector workers were paid the NLW in 2017. In 2018-19, 1.2 million people on low incomes across the economy will have been taken out of income tax altogether (compared to 2015-16), and a typical taxpayer will pay £1,075 less income tax, compared to 2010-11. Overall, since 2015, we have cut income tax for 31 million people, while freezing fuel and alcohol duty.

Conclusion

2.16. This chapter summarises the economic and fiscal evidence which is likely to be relevant to the recommendations of the PRBs. This is intended to inform their usual consideration of the affordability of specific pay awards, on top of the workforce specific evidence presented elsewhere in this document.

2.17. Much of the evidence presented here will feed into retention and recruitment across public sector workforces. Retention and recruitment will vary considerably across geographies, specialisms and grades, where public sector workers face different labour market structures. We would welcome specific comment and analysis from the PRBs on any trends and how pay systems could help address these issues.

3. NHS Finances

Funding Growth

3.1. This chapter sets out the financial context for the NHS.

3.2. Table 3.1 below gives the NHS England Mandate from 2013/14 to 2018/19

3.3. TDEL is the total departmental expenditure limit which covers both capital and revenue spend.

Fig 3.1 NHS England TDEL (£bn)

	NHS England TDEL (£bn)	Cash growth	Real Terms Growth
2013-14	94.7		
2014-15	97.3	2.8%	1.3%
2015-16	100.5	3.2%	2.6%
2016-17	106.0	5.4%	3.1%
2017-18	109.7	3.6%	2.0%
2018-19	113.5	3.4%	1.9%

- These figures take into account the £800m transferred to DfE for 0-5 year olds, out of the NHSE budget, in 2014-15.
- This assumes NHS England receive the entire £337m (2017-18) and £1.6bn (2018-19) revenue funding added to DH's DEL in the 2017 Autumn Budget.

Share of Resource Going to Pay

3.4. Figure 3.2 shows the proportion of funding consumed by NHS provider permanent staff spend over the last four years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

Fig 3.2 Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

	NHS England TDEL (£bn)	NHS Provider Permanent Staff Expenditure (£bn)	% of spend on staff	Increase in revenue expenditure	Increase in permanent staff spend
2013/14	94.7	43.0	45.3%		
2014/15	97.3	43.9	45.1%	2.8%	2.3%
2015/16	100.5	45.2	44.9%	3.2%	2.8%
2016/17	106.0	47.6	44.9%	5.4%	5.4%

- Excludes ALB and DH core staff expenditure.
- Excludes GPs.
- The 16/17 increase in permanent staff spend growth includes 1.75% for the change in employer national insurance contributions.
- Figures may not sum due to rounding.

3.5. On average, between 2011/12 and 2016/17, increases to the HCHS pay bill accounted for 30% (£6.0bn out of £20.1bn) of the increases in revenue expenditure.

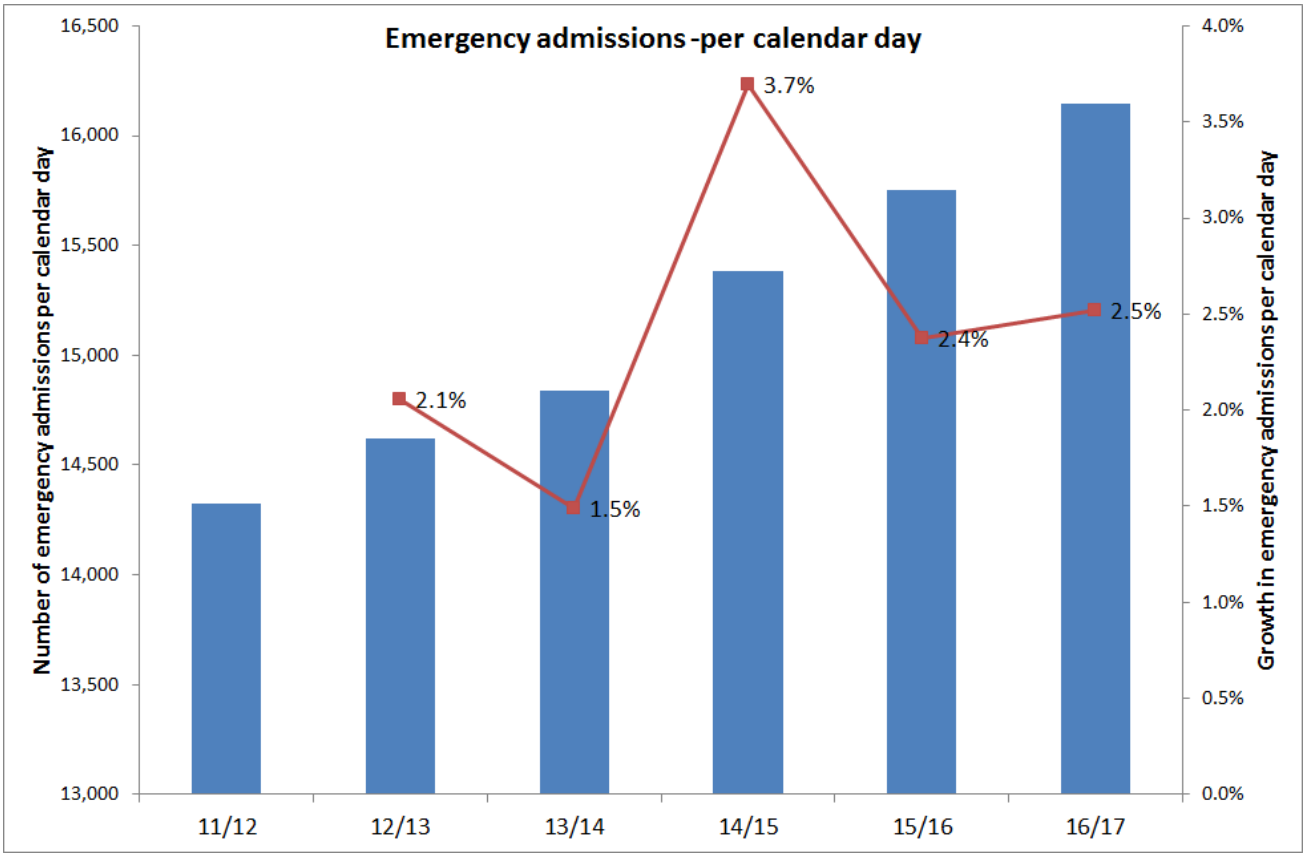
3.6. This shows that despite many competing pressures (e.g. drugs bill growth and service developments), the NHS has managed to increase its permanent staff spend and largely maintain the proportion of expenditure spent on permanent staff.

Demand Pressures

3.7. In recent years the NHS has continued to manage rising demands on its services.

3.8. The number of emergency admissions (an indicator of emergency demand) has grown continuously over the last 5 years.

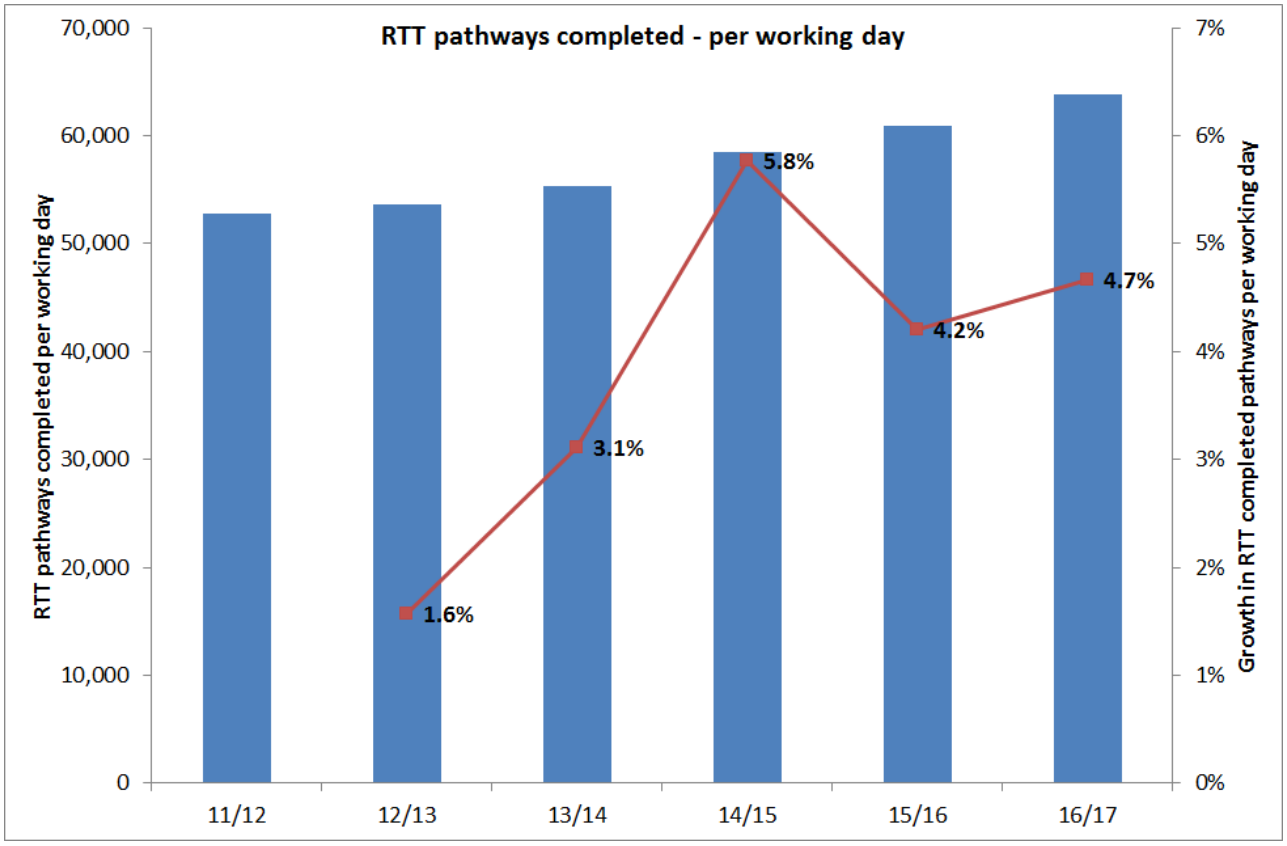
Fig 3.3 Emergency Admissions per day 11/12 - 16/17



Source: Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data

3.9. The number of elective (i.e. non-emergency) patients treated has increased over the last five years.

Fig 3.4 RTT Pathways completed per working day 11/12 - 16/17



Source: NHS England Consultant Led Referral to Treatment Statistics

Productivity in the NHS

3.10. Labour productivity is calculated by dividing total NHS output by an appropriate measure of labour input (usually some form of weighted sum of staff numbers and hours worked). It measures the amount of output generated per 'unit' of labour, and as such is an important component of efficiency.

3.11. The measure of labour productivity we use for the NHS in England is the one developed by the University of York (Centre for Health Economics, CHE). The York measure uses a range of NHS data sources to assess outputs and inputs and also adjusts the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show that in 2014/15 NHS outputs were 93% higher than in their base year of 1998/99, while volume of labour input was 45% higher. This suggests an average growth in labour productivity of ~2% per annum.

Fig 3.5 Labour Productivity Data from York University (CHE)

	Total Output Growth	Labour Input Growth	Labour Productivity Growth	Output Index	Labour Index	Productivity Index
				100.0	100.0	100.0
1999/00	2.2%	1.6%	0.6%	102.2	101.6	100.6
2000/01	2.3%	1.1%	1.2%	104.5	102.7	101.8
2001/02	3.7%	5.4%	-1.6%	108.4	108.3	100.2
2002/03	5.8%	4.7%	1.0%	114.7	113.4	101.3
2003/04	4.9%	4.5%	0.4%	120.4	118.5	101.7
2004/05	6.4%	4.8%	1.6%	128.1	124.1	103.3
2005/06	7.1%	3.4%	3.6%	137.2	128.4	107.0
2006/07	6.5%	0.6%	5.8%	146.1	129.2	113.2
2007/08	3.7%	0.6%	3.0%	151.5	130.1	116.6
2008/09	5.7%	4.2%	1.5%	160.2	135.5	118.3
2009/10	4.1%	4.6%	-0.4%	166.8	141.7	117.8
2010/11	4.6%	1.3%	3.2%	174.4	143.5	121.6
2011/12	3.2%	-0.2%	3.4%	179.9	143.2	125.8
2012/13	2.3%	-2.0%	4.4%	184.1	140.4	131.3
2013/14	2.6%	0.4%	2.1%	188.9	140.9	134.1
2014/15	2.5%	2.8%	-0.3%	193.6	144.8	133.7
Average Annual Growth	4.2%	2.3%	1.8%			

3.12. Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example including drugs. This is called total factor productivity and York University also produce figures on this basis. Their figures show, as before, that in 2014/15 NHS output was 94% higher than in the base year of 1998/99. However, the total volume of factor inputs increased by

85% over the same period, resulting in a moderate growth of 0.2% per annum in total factor productivity.

3.13. More generally productivity, as formally defined here, does not take into account the costs of inputs, including changes in staff pay. A full measure of technical efficiency would, in addition, factor in changes in pay and the cost of inputs relative to a suitable deflator. If pay increases more quickly than GDP deflator, this would have a negative effect on technical efficiency.

Fig 3.6 Total Factor Productivity Data from York University (CHE)

	Total Output Growth	Total Factor Input Growth	Total Factor Productivity Growth	Output Index	Total Input Index	TFP Productivity Index
				100.0	100.0	100.0
1999/00	2.2%	5.1%	-2.7%	102.2	105.1	97.3
2000/01	2.3%	1.6%	0.7%	104.5	106.7	98.0
2001/02	3.7%	6.1%	-2.2%	108.4	113.2	95.8
2002/03	5.8%	7.1%	-1.2%	114.7	121.2	94.6
2003/04	4.9%	7.6%	-2.5%	120.4	130.4	92.3
2004/05	6.4%	6.5%	-0.4%	128.1	138.9	91.9
2005/06	7.1%	7.2%	-0.1%	137.2	148.9	91.8
2006/07	6.5%	1.9%	4.5%	146.1	151.8	96.0
2007/08	3.7%	3.9%	-0.2%	151.5	157.6	95.7
2008/09	5.7%	4.2%	1.4%	160.2	164.3	97.1
2009/10	4.1%	5.4%	-1.3%	166.8	173.2	95.9
2010/11	4.6%	1.3%	3.2%	174.4	175.5	99.0
2011/12	3.2%	1.0%	2.1%	179.9	177.3	101.1
2012/13	2.3%	2.0%	0.4%	184.1	180.8	101.5
2013/14	2.6%	0.4%	2.2%	188.9	181.6	103.7
2014/15	2.5%	1.9%	0.6%	193.6	184.9	103.8
Average Annual Growth	4.3%	3.9%	0.3%			

Efficiency Savings

3.14. The NHS Five Year Forward View plan, anticipated in 2014 a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if the NHS received flat real terms funding increases and no further efficiencies are delivered. To fill this gap, the

NHS will deliver £22 billion of efficiency savings (equivalent to 2%-3% per year). The majority of these are not cost reductions per se, but actions to moderate the rate of spending growth. Alongside this, the Government is providing the £10 billion of additional funding a year that the NHS said it needed to deliver its Five Year Forward View plan.

3.15. The Department of Health and Social Care is working with the health service, partners and patients to deliver key elements of the programme required to achieve the efficiency savings recently reinforced in the Next Steps on the Five Year Forward View, by:

- reducing demand for NHS care by improving the public's overall health, introducing new models and places to care for patients that mean they don't always need to go to hospital and reducing unwarranted variation in care;
- making better use of NHS providers' resources – money, technology, estates and people;
- reducing NHS costs by improving purchasing;
- increasing income to the NHS through charges and commercial opportunities; and
- reducing system overheads by reducing NHS management costs.

3.16. NHS Improvement has also made substantial progress in delivering efficiencies in NHS providers identified in Lord Carter's 2016 independent report Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations through their Operational Productivity programme. This programme is supporting providers to deliver at least £5bn efficiency savings to 2020/21. Some examples where the NHS is implementing the recommendations and delivered savings in 2016-17 include:

- Promoting uptake of better value generic medicines in hospital pharmacies;
- Reducing the number of days that medicines supplies are held in stock by non-specialist acute hospitals across England;
- Development of the NHS procurement price comparison tool to help providers to secure better prices for the equipment and tools that they purchase;
- Increasing provider buying power of everyday hospital consumables through the Nationally Contracted Products programme;
- Improving efficiencies and patient outcomes in trauma and orthopaedics through the Getting it right first time (GIRFT) programme;

3.17. Going forward, increasing focus will be on moderating activity growth through programmes such as the new care models and right care, and delivering improved workforce productivity by continuing work for non-specialist acute trusts to implement the 15 recommendations to optimise clinical and non-clinical resources as part of their business as usual.

Conclusion

3.18. The NHS Five Year Forward View plan anticipated in 2014 a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if the NHS received flat real terms funding increases and no further efficiencies were delivered. To fill this gap we are investing the additional £10 billion that the NHS has said it needs to implement its plan,

alongside the NHS delivering the £22 billion of efficiency savings that it has committed to.

3.19. Meeting this efficiency challenge is likely to require shifting the focus from centrally driven savings to transformational changes, which will reduce the long-term cost pressures on NHS services.

4. Hospital and Community Health Services (HCHS) Medical and Dental Staff Earnings

Chapter Summary

4.1. Chapter 4 analyses how medical and dental (M&D) staff earnings are distributed across the different types of doctors, how they have evolved since 2012/13, and the drivers behind this change. The second half of the chapter discusses how M&D pay compares to that earned in the private sector, in order to identify potential recruitment and retention risks of medical and dental staff.

4.2. Average Earnings for HCHS doctors have grown in the last five years, although at a lower rate than the private sector, with the exception of 2016/17. Consultants' pay, the most numerous M&D staff group, has grown at a rate significantly lower than the average. Nonetheless, medical practitioners remain amongst the highest (top 6) earning professions. Changes in composition by staff group have also contributed to changes in earnings.

4.3. The cost of pay bill per FTE has grown in the last year. Headline pay award and pay reform have contributed to a certain extent to the increase of the pay bill per FTE. There is also an increase in on-costs related to the rise in national insurance contributions from opting out of the state second pensions.

HCHS Earnings & Earning Growth Analysis

4.4. Medical and dental staff working in Hospital and Community Health Services (HCHS) are organised by the different types of doctors according to their level of training. Doctors' earnings in each of the medical career grades presented below vary depending on training, experience and length of service; the estimates reported represent average total earnings per FTE. Consequently, these figures do not represent the earnings growth experienced by staff employed within one group throughout the five-year period. They also include people who joined or left as well as those promoted from one group to another. Most people will have received pay progression increments and some will have had a pay rise on promotion.

4.5. The table below shows how average pay per FTE and corresponding distribution by the medical career grade has evolved over the last five years. In 2017, total earnings per FTE ranged between an average of £33,181 for a Foundation Doctor Year 1 and £118,153 for consultants, the largest medical staff group. Average earnings have also increased in the last five years, although trends also reflect changes in seniority composition within the group. These changes include an increase in the share of consultants (from 39% to 42%) over HCHS Doctors and the changes linked to the

introduction of Specialty Doctors and phasing out of Associate Specialists and Staff Grades.

Fig 4.1: HCHS Medical & Dental Staff Average Cost of Total Earnings per FTE and FTEs by Medical *Career Grade*

Medical Career Grade	Cost of earnings per FTE 2012-13	Cost of earnings per FTE 2016-17	% growth in cost of earnings 2012-13/2016-17	FTEs by grade group in 2012-13	FTEs by grade group 2016-17	% of M&D staff in grade group 2012-13	% of M&D staff in grade group 2016-17
HCHS doctors	**£78,118**	**£82,046**	**5.0%**	**100,123**	**106,282**		
Consultant (including Directors of Public Health)	£115,055	£118,153	2.7%	39,020	44,650	39.0%	42.0%
Associate Specialist	£91,455	£99,397	8.7%	3,109	2,241	3.1%	2.1%
Specialty Doctor	£68,041	£73,816	8.5%	5,328	6,284	5.3%	5.9%
Staff Grade	£71,708	£72,213	0.7%	491	384	0.5%	0.4%
Specialty Registrar	£56,614	£57,898	2.3%	28,840	29,421	28.8%	27.7%
Core Training	£47,533	£48,274	1.6%	8,656	8,770	8.6%	8.3%
Foundation Doctor Year 2	£39,579	£39,534	-0.1%	6,474	6,592	6.5%	6.2%
Foundation Doctor Year 1	£33,033	£33,181	0.4%	6,546	6,426	6.5%	6.0%
Hospital Practitioner / Clinical Assistant	£94,483	£108,095	14.4%	650	551	0.6%	0.5%
Other and Local HCHS Doctor Grades	£71,116	£72,644	2.1%	1,011	962	1.0%	0.9%

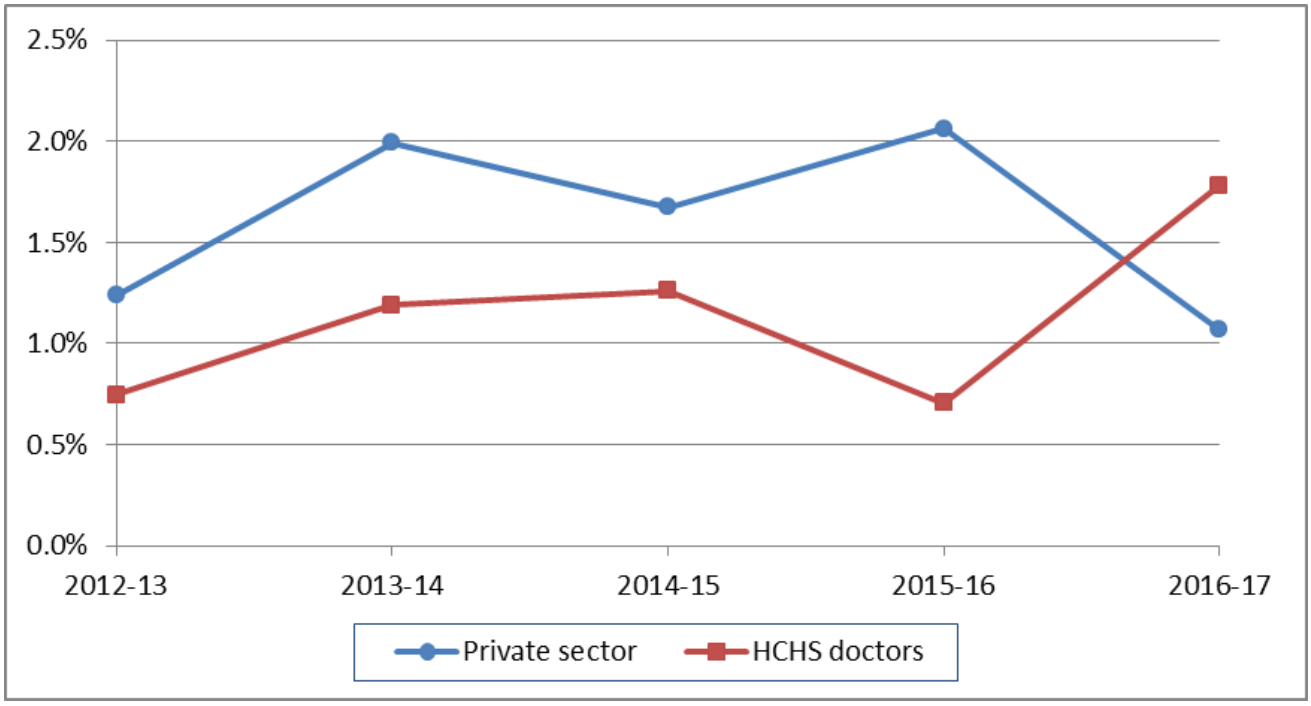
Source: Headline HCHS Pay bill Metric Estimates, NHS Digital Monthly Workforce Statistics

Changes in Earnings

4.6. Comparing year on year growth in earnings between the private sector and the Hospital and Community Health Services is an essential step in assessing medical staff's financial incentives to work in the NHS. The ONS Annual Survey of Hours and Earnings (ASHE) includes comparable data for the private sector. The total earnings for HCHS doctors, as estimated in the pay bill metrics by DH, include basic pay, other additional earnings (mostly for staff working in certain periods) and other payments such as geographical allowances and on-call payments. The total earnings for HCHS doctors as a whole group are presented in the following figures. These include a wide range of pay, as reported in the previous section.

4.7. Year on year growth in private sector pay has been consistently higher than that of HCHS doctors, with the exception of a significant growth (1.8%) in the HCHS doctors' pay in the period 2016-2017. Medical staff pay has increased by a yearly average of 1.1%, while private sector pay increased by a yearly average of 1.6%. Nonetheless, comparisons of total earnings between different sectors should be drawn with caution, as they could hide differences in working and pay arrangements (e.g. geographic and retention allowances, etc.) that could potentially affect recruitment and retention of medical staff.

Fig 4.2: Yearly Percentage Total Earnings Growth for the Private Sector and HCHS Doctors



Source: ONS Annual Survey of Hours and Earnings, Department of Health and Social Care Headline HCHS Pay bill Metric Estimates

4.8. Table 4.3 shows the distribution of earnings for separate medical staff groups and the distribution point for 2012/2013 at the 25th percentile, the median, the 75th percentile and the mean. The table also shows earnings growth at these distribution points between 2012/13 and 2016/17 and a comparison with overall economy earnings (measured as gross earnings for all employees from the Annual Survey of Hours and Earnings).

4.9. The average earnings across the economy have grown by 6% over the past 5 years. This has been higher than the mean growth over the period for the whole HCHS Doctors, in particular for consultants. Some of the higher growth rates for mean earnings are mostly associated with the introduction of Specialty Doctors and the subsequent phasing out of Associate Specialist and Staff Grade Doctors.

4.10. Earnings growth across the overall earnings distribution has been higher for those with earnings in the low and middle part of the distribution. A similar growth pattern can be found consistently across HCHS doctors but not across all grades. On average, earnings comparable to the 25th percentile (quartile 1, Q1) and to the median have increased at a similar rate (6%). Earnings comparable to the 75th percentile (Quartile 2, Q2) have increased at a much lower rate (3%). Data for certain staff groups (such as Associate Specialists) shows similar patterns, although no common trend can be identified.

Fig 4.3: Earnings for medical and dental by grade, and distribution in 2012 and growth to 2017, comparison of medical HCHS staff and all employees from Annual Survey of Hours and Earnings

	Q1 (2012/13)	Q1 (2016/17)	Q1 Growth	Median (2012/13)	Median (2016/17)	Median Growth	Q3 (2012/13)	Q3 (2016/17)	Q3 Growth	Mean (2012/13)	Mean (2016/17)	Mean Growth
All ASHE	*£12,974*	*£14,111*	*9%*	*£21,500*	*£23,099*	*7%*	*£33,076*	*£35,218*	*6.5%*	*£26,756*	*£28,296*	*6%*
HCHS doctors	**£55,750**	£59,250	**6%**	**£84,250**	£89,250	**6%**	**£113,750**	**£117,250**	**3%**	**£73,367**	**£76,827**	**5%**
Consultant (including Directors of Public Health)	£91,250	£92,750	2%	£109,250	£110,750	1%	£130,750	£132,750	2%	£108,686	£111,563	3%
Associate Specialist	£67,250	£75,250	12%	£81,750	£88,750	9%	£96,750	£105,750	9%	£80,710	£88,664	10%
Specialty Doctor	£44,750	£47,250	6%	£62,250	£66,750	7%	£75,750	£82,250	9%	£57,218	£62,852	10%
Staff Grade	£39,250	£40,750	4%	£62,750	£65,750	5%	£77,250	£84,250	9%	£56,463	£60,939	8%
Specialty Registrar & Core Training*	£47,250	£48,250	2%	£54,250	£56,250	4%	£62,750	£64,750	3%	£54,830	£53,778	-2%
Foundation Doctor Year 2	£33,750	£35,000	4%	£39,500	£42,750	8%	£43,000	£46,750	9%	£39,325	£39,191	0%
Foundation Doctor Year 1*	£25,250	£25,000	-1%	£28,750	£29,250	2%	£31,500	£33,750	7%	£32,073	£32,830	2%

Source: ONS Annual Survey of Hours and Earnings and NHS Digital Quarterly Publication on Earnings

*Note: Data for the ONS Annual Survey of Hours and Earnings for 2016/17 correspond to 2016 only due to data availability Categorisation of staff groups changed between 2012/13 and 2016/17. The groups denoted by an asterisk refer to medical career groups with different names. Specialty Registrar & Core Training correspond to Registrar Group in 2012/13 and to average values for Specialty Registrar and Core Training in 2016/17. Foundation Doctor Year 1 corresponds to House Officer and Foundation Year 1 for 2012/13 and Foundation Doctor Year 1 for 2016/17. Mean earnings per person for the combined categories are estimated as weighted averages.

High Earners Comparison Analysis

4.11. Statistics from the Office for National Statistics (ONS) Annual Survey of Hours and Earnings (ASHE) have been analysed to assess movements in medical earnings compared with other high-earning professions. The approach taken has been to identify the highest-earning professions in 2011, using the median and 70th percentile gross annual pay figures, and to assess how these figures have changed by 2016. We report on the ASHE statistics for consistency with comparator groups, but note that these do not tally exactly with the collated metrics in our evidence pack, which show rising 70th percentile earnings over this period. The ASHE figures may therefore over-state any erosion of pay differentials as a result of, for example, sample effects.

4.12. Comparison of the two years' statistics indicates that doctors have broadly maintained their rank position amongst the very highest earners, although relative gaps have been modestly affected by pay restraint. Some shift in NHS versus private sector pay differentials is expected in a period of austerity and restraint, but the statistics do not suggest this has fundamentally altered the attractiveness of medical careers, in terms of earnings compared with other high-earning professions. Doctors are still amongst the very highest earners.

4.13. The tables below show that the annual pay of Medical Practitioners maintained its rank position relative to the other high-earning occupations between 2012 and 2016. Table 4.3 includes each 4-digit occupation code group with a median annual gross pay figure higher than £55,000 in 2012 and a published median figure for 2012, 2016, and the average for all employees. This Table shows that in 2012 and 2016 the median for Medical practitioners was 5th highest amongst the top six, after Chief executives & senior officials, Aircraft pilots & engineers, and Marketing & sales directors, Information technology and telecommunications directors. Medical practitioners gross pay is 2.7 times more than the average for all employees in the UK, despite the fact that Medical practitioners is the only group in the Table that includes junior trainees.

Fig 4.4: Median Annual Gross Pay for High-Earning Occupations in 2011, 2012 and 2016

Occupation	Median Annual Gross Pay		Number of jobs (thousand)
	2012	2016	
Chief executives and senior officials	£80,000	£84,275	64
Aircraft pilots and flight engineers	£78,681	£89,317	7
Marketing and sales directors	£65,696	£69,732	154
Information technology and	£62,628	£69,026	31
Medical practitioners	£61,007	£63,493	182
Senior police officers	£58,955	£62,497	9
All employees	£21,500	£23,099	21,876

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2012 and 2016 – Gross Annual Pay by Occupation (4-digit SOC 2010) http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashetable14

Fig 4.5: 70th Percentile Annual Gross Pay for High-Earning Occupations in 2011, 2012 and 2016

Occupation	70th Percentile Gross Annual Pay		Number of jobs (thousand)
	2012	2016	
Chief executives and senior officials	£116,049	£119,172	64
Aircraft pilots and flight engineers	£94,706	x	7
Medical practitioners	£90,887	£93,217	182
Marketing and sales directors	£89,947	£93,643	154
Information technology and telecommunications directors	£81,729	£79,413	31
Financial managers and directors	£74,211	£81,029	261
All employees	£30,200	£32,244	21,876

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2012 and 2016 – Gross Annual Pay by Occupation (4-digit SOC 2010) http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashetable14

4.14. Table 4.4 includes each 4-digit occupation code group with 70th percentile annual gross pay figure higher than £70,000 in 2012 with published figures for 2012 and 2016. Also shown is the average for all UK employees. The data shows that in both years the 70th percentile pay figure for Medical practitioners was third highest (figure not available for aircraft pilots and flight engineers in 2016) and around three times the figure for all UK employees.

Why has the NHS pay bill per FTE grown?

4.15. There are multiple factors which influence a change in pay bill per FTE from year to year. It can be broken down into to the below drivers:

- Headline pay awards & Pay Reform - this is the in-year pay settlement applied to basic pay value and any known impacts from pay reform that has been implemented.
- Changes in band mix - This is caused by a change in the distribution of staff across the different pay bands, and impacts the basic pay per FTE.
- Changes in point mix - This is caused by changes in the distribution of staff across pay points within bands, and impacts the basic pay per FTE (e.g. high recruitment may weight the distribution the distribution towards lower points in the band).
- Changes in staff group mix - This is caused by changes in the proportion of staff in specific professions which may be down to high recruitment of a specific staff group e.g. consultants.
- Additional earnings effects - can be caused by changes in other earnings at a different rate to basic pay (this may include the use of bonuses, geographical allowances, medical awards, recruitment and retention premiums etc.)

- On-costs effects - these can be caused by changes in the rules that govern employer pension contribution, or employer national insurance contribution requirements (recent effects here have been caused by introduction of the Single Tier State Pension and Apprenticeship Levy.

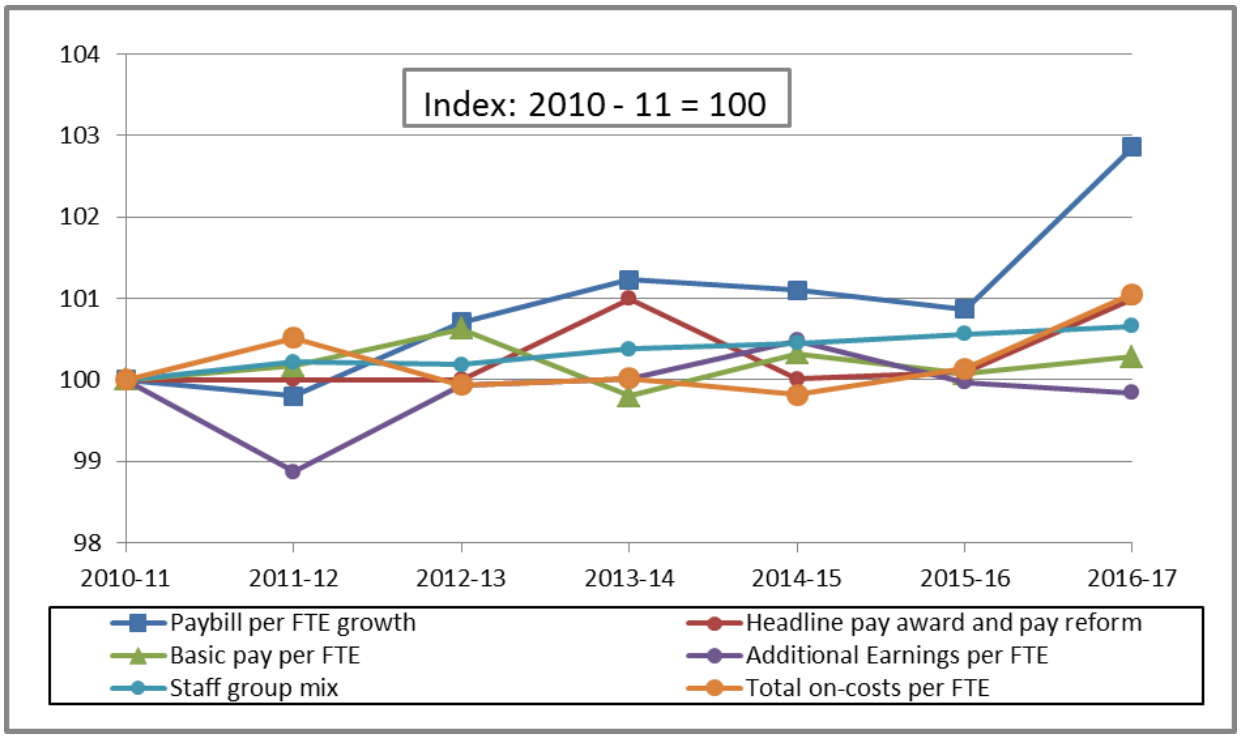
Fig 4.6: HCHS Medical staff pay bill per FTE year on year changes

Medical and Dental	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Paybill per FTE growth	-0.2%	0.7%	1.2%	1.1%	0.9%	2.9%
Headline pay award and pay reform	0.0%	0.0%	1.0%	0.0%	0.1%	1.0%
Basic pay per FTE	0.2%	0.6%	-0.2%	0.3%	0.1%	0.3%
Additional Earnings per FTE	-1.1%	-0.1%	0.0%	0.5%	0.0%	-0.2%
Staff group mix	0.2%	0.2%	0.4%	0.5%	0.6%	0.7%
Total on-costs per FTE	0.5%	-0.1%	0.0%	-0.2%	0.1%	1.1%

Source: Department of Health and Social Care Headline HCHS Pay bill Metric Estimates

4.16. With the exception of 2011/12, the cost of pay bill per FTE for HCHS doctors has increased in the last six years, from £94,441 in 2010/11 to £100,788 in 2016/17. This corresponds to an average increase of 1.1% per year, with particularly strong increases in 2013/14 and 2016/17. While the headline pay award and pay reform has contributed to drive the growth in these two years, it had an almost negligible impact in the other periods. Changes in basic pay (generally due to changes in total FTE employed or to staff moving up spine points) had a sizeable impact on growth in 2012/13 while a decrease in the cost of additional earnings per FTE has offset growth in other components in 2011/12. Shifts in the staff group mix are also responsible for significant increases in pay bill per FTE in all years considered. The highest increase in the pay bill per FTE has been witnessed in 2016/17 (2.9%), with total on-costs per FTE related to an increase in National Insurance due to the impact of the introduction of the Single Tier Pension and Apprenticeship Levy accounting for 1.1% of the growth.

Fig 4.7: Movements in HCHS doctors pay bill components



Source: Department of Health and Social Care Headline HCHS Pay bill Metric Estimates

4.17. The figure above illustrates the changes in each component of the cost of pay bill per FTE as an index of the value in 2010/11. The figure shows how the large increase in 2016/17 is mostly attributable to changes in total on-costs per FTE and in headline pay award and pay reform.

Recruitment & Retention Premia

4.18. Undoubtedly the NHS position is bolstered by the value of the NHS pension scheme, but the question of how staff will react to a relative deterioration in pay must be considered. It is therefore prudent to look at recruitment and retention indicators to ensure an appropriate pay strategy, and to look below the high-level aggregate picture to consider the need for targeting.

4.19. In 2012/13, 128 (HC) HCHS doctors (including locum) received an average Recruitment and Retention Premia (RPP) payment of £16,744. In 2016/17, 225 (HC) HCHS doctors received an average RRP payment of £15,687.

4.20. The number of doctors receiving a retention allowance (recruitment and retention premium) has increased in the last five years, although it remains still limited. The average value has decreased by around £1,057 (6.3%). There is little evidence of an increase in the use of RRPs to address recruitment and retention issues.

5. Recruitment, Retention, Motivation and Medical Workforce Planning

Background

5.1. Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the people with the values, skills, experience and expertise which the NHS needs is central to the future of England's health and care system. Health Education England's draft workforce strategy, out for consultation, describes an approach to shaping the face of the NHS and social care workforce for the next two decades.

5.2. The Department continues to take action to increase the supply of trained medical and dental staff available to work in the NHS and wider health and care system; supporting a world class health education and training system. In conjunction with HEE and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff.

5.3. The supply of new consultants and the growth in the consultant workforce this generates continues to be consistently high and the Government's commitment to expanding undergraduate medical training places will not only increase our supply of doctors but will also provide more opportunities for students with the talent, drive and ambition to train as a doctor.

5.4. HEE has a clear remit to lead workforce planning across the health system to secure the future supply of the workforce, based on local plans which are affordable and take full account of national policy requirements and will assess the extent to which further new posts might be created.

5.5. Effective workforce planning requires reliable and accurate workforce information at both national and local level. HEE's national workforce planning is underpinned by national data collected by NHS Digital and a comprehensive local workforce planning process. This process includes working with Sustainable Transformation Plans and Local Workforce Advisory Boards, to ensure delivery plans for the future reflect the needs of local service users.

5.6. HEE is best placed to address any questions that the review body may have about the quality of workforce planning or the evidence base that underpins its decisions on future workforce investment.

Workforce Information

5.7. Reliable and accurate information is required to support national policy making and public and parliamentary accountability, as well as to underpin workforce planning. The Department works closely with NHS Digital to support the improvement of quality and coverage of published workforce information. Last year the DDRB asked for more detailed evidence and data regarding fill rates, vacancies and attrition rates by staff group and geographical areas, as well as more detailed data on agency spend and how Generation Y behaviours are analysed and factored into future workforce planning. The Department's analytical team is working to bring together data and information from a range of sources to provide a single source for all parties to address some of these issues.

5.8. This chapter includes analysis and data on other factors and conditions in the NHS labour market which may impact on the recruitment and retention of HCHS medical staff gleaned from Hospital and Community Health Services (HCHS) workforce statistics. It starts by classifying medical career groups and how their composition changed in terms of FTEs in the period 2012-2017, and it continues by studying the dynamics of retention in the M&D group and by considering potential reasons for leaving. Analyses of EU M&D staff, agency staff and staff morale will also be presented.

Numbers in work

5.9. NHS Hospital and Community Health Service doctors have increased by 8,113 FTEs (8.3%) in the period between March 2012 and March 2017. Their composition by grade groups has witnessed sizeable changes, which mostly reflect the reforms linked to the introduction of the Specialty Doctor contract in 2008. This group has seen the largest increase (26%) and the two categories who have been phased out by the introduction (Associate Specialist and Staff Grade[v]) have experienced the greatest negative change (-32.6% and -30.3% respectively). Consultants, who represent the most numerous group in the HCHS doctors' workforce, also increased in numbers from 38,159 to 45,096 by 18.2%.

Fig 5.1: HCHS doctors FTEs March 2012 to March 2017

Staff Groups	Mar-12	Mar-17	% change
Consultant (including Directors of Public Health)	38,159	45,096	18.2%
Associate Specialist	3,202	2,157	-32.6%
Specialty Doctor	5,107	6,435	26.0%
Staff Grade	557	388	-30.3%
Specialty Registrar	28,559	29,745	4.2%
Core Training	8,335	8,489	1.8%
Foundation Doctor Year 2	6,449	6,542	1.4%
Foundation Doctor Year 1	6,183	6,194	0.2%
Hospital Practitioner / Clinical Assistant	691	486	-29.7%
Other and Local HCHS Doctor Grades	1,075	899	-16.4%
HCHS doctors	**98,317**	**106,430**	**8.3%**

Source: NHS Digital HCHS monthly workforce statistics

Skill Mix

5.10. The Department continues to work with NHS England and HEE to consider how skill mix changes can help address workforce shortages.

5.11. As well as skill mix changes within the nursing workforce, the NHS Five-Year Forward View , highlighted the increasing need for medical treatment, and advances in clinical care requires a coordinated approach and a greater skill mix within healthcare teams, including the enhancement of existing roles and the introduction of new roles.

5.12. The NHS has seen the emergence and increased use of new professional roles within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high quality care for patients. Four of these professional roles can be grouped under the Medical Associate Professionals (MAPs) heading as they share some similarities in their career framework and education and training. The four roles are:

- Physician associates (PAs)
- Physicians' assistants (anaesthesia) (PA(A))
- Surgical care practitioner (SCP)
- Advanced critical care practitioner (ACCP)

5.13. The use of MAP roles appears to be an acceptable model that could reduce the current skills shortage and provide high quality patient care in both primary and secondary care settings.

5.14. The further growth of this profession is a key part of the Government's policy to develop a more effective, strong and expanding general practice to meet future need. Secretary of State announced in June 2015 that there will be 1,000 more PA available in primary

care by 2020 as part of the wider commitment to make available 10,000 health care professionals in primary care within this timeframe. HEE has committed to recruit 205 PAs into training during the academic year 2015-16. Their current projections forecast an over recruitment into training of 75% (358). HEE's current national workforce plan for England sets out the proposal to commission 657 training places during 2016-17 in support of the 1,000 target.

Expansion of Undergraduate Medical Training Places

5.15. In October 2016 the Secretary of State announced plans for an expansion to undergraduate medical education, by funding an additional 1,500 medical school places in England. At the time, the Government set out its intention to consult on these proposals.

5.16. The Government set out its clear intention that widening participation and incentivising social mobility are central to this expansion. The increase will provide more opportunities for people from all backgrounds to study medicine. By widening participation and ensuring fair selection decisions, access to education and employment regardless of age, race, disability and social status will be allowed.

5.17. Over time, it will mean that we are taking fewer doctors from countries overseas where the domestic need is arguably greater than ours, and it will also help reduce reliance on expensive medical agency staff, and ensure the money is better spent on treating more patients.

5.18. The consultation confirmed that 500 medical school places (to be available to students in September 2018) will be allocated to established medical schools, and sought views on the criteria for a competitive bidding process for the allocation of the remaining 1,000 places. Alongside this the Government announced plans for changes to the arrangements for international students and sought views on maximising taxpayer investment in medical education and the point of registration.

5.19. The Government response[vi] published on 09 August confirmed that the Higher Education Council for England (HEFCE) and Health Education England (HEE) would manage the competitive process for established and new medical schools to bid for the remaining 1,000 places (to be available from 2019). The process focuses on priority specialties (such as GP and psychiatry) and priority geographies (such as rural and coastal).Invitation to place bids closed on 23 November 2017; HEFCE and HEE are expected to announce final allocations in March 2018.

5.20. A review of postgraduate medical education and training was undertaken under the chairmanship of Professor Sir David Greenaway to ensure that doctors now and in the future are able to meet the changing needs of patients, society and health services. The final report, The Shape of Training: Securing the future of excellent patient care[vii] was published in October 2013.

5.21. The UK Shape of Training Steering Group was convened by the 4 UK health departments to provide policy advice and structure to guide implementation of the recommendations from Professor David Greenaway's review.

5.22. The Report from the UK Shape of Training Steering Group[viii] was published on 11th August 2017. The UK health ministers accepted its recommendations and officials from the 4 health departments are working with the GMC and the medical royal colleges on proceeding with implementation.

Analysis of Joiners and Leavers

5.23. The total increase in HCHS doctors is due to more doctors joining rather than leaving the NHS workforce. Analysing changes in the number of joiners and leavers across different staff groups, and the reasons behind them, is an important step in identifying potential risks in recruitment and retention of M&D staff. While education and training provide around a third of joiners to the NHS from external sources, new entrants from non-EU countries have also grown to represent a sizeable component of the joining workforce (13%). The leaver rate for HCHS medical & dental staff was between 14% and 16% per year in the period between 2012/13 to 2016/17.
This analysis is included in Annex 1 and 2.

Retention

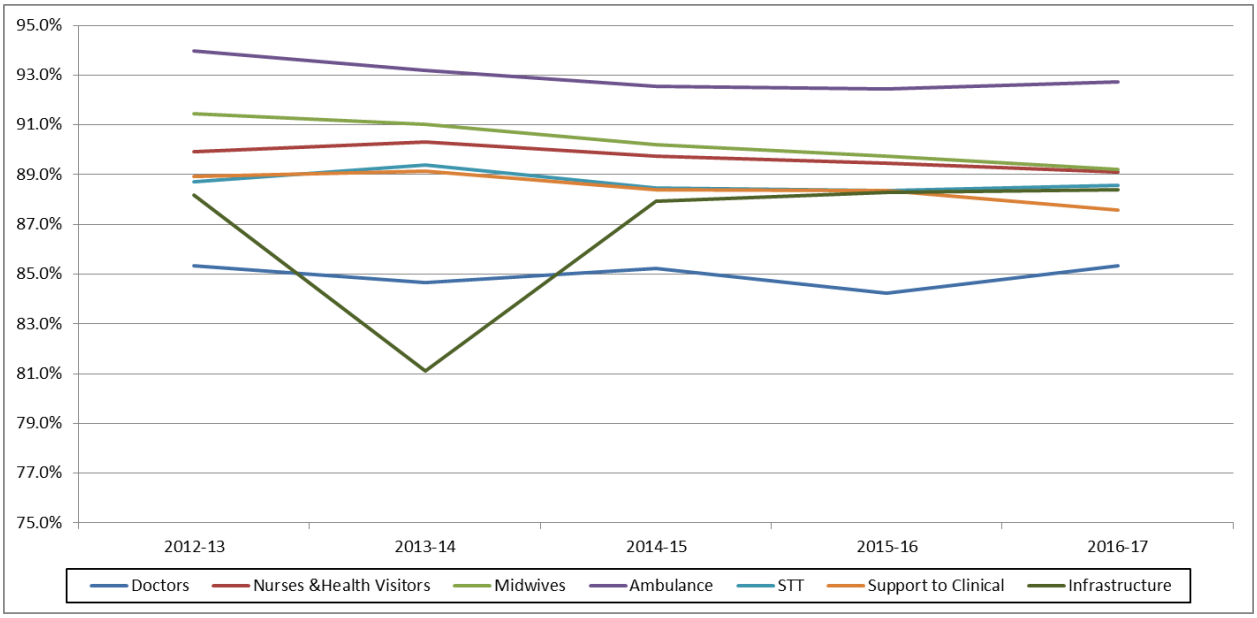
5.24. The stability index captures how successful the NHS is in retaining its staff. The index is computed by NHS Digital on data for England. A comparison between medical and dental staff, nurses and other non-medical staff is presented. On average the NHS has more difficulties in retaining doctors compared to the nursing workforce and other non-medical staff. Higher turnover in medical staff might be attributed[ix] to a higher proportion in this staff group deciding to retire early or to practice abroad. A larger share of doctors taking career breaks could also represent a driving factor. In the last five years no progress has been made in retention of the M&D staff, with the stability index first decreasing to 84.2% and then returning in 2016-17 at the 2012-13 level of 85.4%.

Fig 5.2: Stability index for M&D staff and for non-medical staff in the last five years

Staff group	2012-13	2013-14	2014-15	2015-16	2016-17
Doctors	85.4%	84.6%	85.2%	84.2%	85.4%
Nurses & Health Visitors	89.9%	90.3%	89.7%	89.5%	89.1%
Midwives	91.5%	91.0%	90.2%	89.7%	89.2%
Ambulance	94.0%	93.2%	92.6%	92.4%	92.7%
STT	88.7%	89.4%	88.5%	88.3%	88.6%
Support to Clinical	88.9%	89.1%	88.4%	88.4%	87.6%
Infrastructure	88.2%	81.1%	87.9%	88.3%	88.4%

Source: NHS Digital

Fig 5.3: Stability index for M&D staff and for non-medical staff in the last five years



Source: NHS Digital

Medical staff reasons for leaving

5.25. The Electronic Staff Records (ESR) provides a reliable source to analyse the reasons provided by staff who decides to leave the NHS. Nonetheless, conclusions should be drawn with caution as this section of the ESR is clerically completed by administrative staff in the place of doctors and for a large number of cases no reasons are provided.

5.26. Unlike non-medical staff, for which over half of leavers voluntarily resign, a large proportion of HCHS doctors leave because of the end of fixed term contracts (38.9% in 2016/17). The share of doctors who resigned voluntarily increased in the last five years from 14.8% to 18.8%, although the trend seems to have partially reversed in the last year (a decrease of 0.8%).

Fig 5.4: Reasons for leaving among HCHS doctors

Reason For Leaving	2012/13	2013/14	2014/15	2015/16	2016/17	2012/13	2013/14	2014/15	2015/16	2016/17
Dismissal	111	121	146	138	130	0.2%	0.3%	0.3%	0.3%	0.3%
Employee Transfer	4996	1657	1350	601	1518	9.8%	3.5%	2.8%	1.4%	3.5%
End of Fixed Term Contract	20488	19396	20150	17138	17098	40.2%	41.2%	42.4%	39.7%	38.9%
End of Fixed Term Contract - Completion of Training Scheme	3579	4333	4053	4057	4251	7.0%	9.2%	8.5%	9.4%	9.7%
End of Fixed Term Contract - End of Work Requirement	734	682	820	655	714	1.4%	1.4%	1.7%	1.5%	1.6%
End of Fixed Term Contract - External Rotation	9984	9461	9254	8523	8677	19.6%	20.1%	19.5%	19.8%	19.8%
End of Fixed Term Contract - Other	1667	1637	1371	1542	1478	3.3%	3.5%	2.9%	3.6%	3.4%
Retirement	1347	1666	1554	1704	1508	2.6%	3.5%	3.3%	4.0%	3.4%
Redundancy	208	110	85	75	66	0.4%	0.2%	0.2%	0.2%	0.2%
Voluntary Resignation	7539	7775	8523	8448	8254	14.8%	16.5%	17.9%	19.6%	18.8%
Mutually Agreed Resignation	49	33	28	22	8	0.1%	0.1%	0.1%	0.1%	0.0%
Others	258	213	177	222	220	0.5%	0.5%	0.4%	0.5%	0.5%
Grand Total	**50960**	**47084**	**47511**	**43125**	**43922**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: NHS Electronic Staff Records

5.27. Among those leaving voluntarily, the three most cited causes were relocation, work life balance and undertaking further education and training. Work life balance in particular has increased over the last five years, from 3.8% to 6.3%.

Fig 5.5: Top 3 reasons for voluntary resignation among HCHS doctors

Reason For Leaving	2012/13	2013/14	2014/15	2015/16	2016/17	2012/13	2013/14	2014/15	2015/16	2016/17
Voluntary Resignation - Relocation	1293	1398	1558	1538	1654	17.2%	18.0%	18.3%	18.2%	20.0%
Voluntary Resignation - Work Life Balance	288	339	421	508	523	3.8%	4.4%	4.9%	6.0%	6.3%
Voluntary Resignation - To undertake further education or training	248	251	357	310	348	3.3%	3.2%	4.2%	3.7%	4.2%

Source: NHS Electronic Staff Records

Note: top 3 reasons excluding “Voluntary resignations – other/not known”

Advertised vacancies (FTE) data

5.28. At present the collection and production of statistics related to vacancies across the NHS is still limited. NHS Digital has established a working group with DH, HEE, NHSI and NHSE aimed at developing a consistent and robust time series that can capture the changes over time. Individual organisations have issues FOIs to employers seeking to calculate overall vacancy numbers, however these will be limited as not all employers respond and there is little quality assurance of responses.

5.29. A relatively short time series for advertised vacancy full-time equivalents is currently produced by NHS Digital, drawing on data from the NHS Jobs website. This allows us to obtain some insight on the NHS labour market demand and supply pressures and how these have changed in the two years for which information is available.

5.30. The tables below report how many job adverts were issued each quarter for medical and dental staff, as well as for all of the Staff Groups in the NHS National Workforce Data Set. In the fourth quarter of 2016/17 vacancies among M&D staff accounted for almost 13% off all advertised posts in the NWD.

Fig 5.6: HCHS Medical staff and total staff vacancies (Q1 2015/16 to Q4 2016/17)

Staff Group	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Medical and Dental	8,687	8,877	8,735	9,369	10,210	10,105	10,124	11,155
All National Workforce Data Set	78,051	81,516	77,047	78,112	84,384	87,666	81,674	86,035

Source: NHS Digital Vacancies Publication

5.31. Table 5.7 reports information on the geographical distribution of staff vacancies by region for medical and dental staff, as well as for all staff. Geographical variation in M&D vacancies behind the aggregate position remains quite sizeable in the fourth quarter of

2016/17. The analysis of vacancies by region and by specialty, in conjunction with the main conclusions from previous sections (particularly on the reasons for leaving), can provide an insight into how to address recruitment and retention issues of medical and dental staff.

Fig 5.7: HCHS Medical staff and total staff vacancies by region (Q4 2016/17)

	Medical and Dental	All National Workforce
England	**11,155**	**86,035**
Health Education East Midlands	741	5,784
Health Education East of England	1,170	8,612
Health Education Yorkshire and the Humber	762	6,084
Health Education Wessex	438	4,723
Health Education Thames Valley	299	4,148
Health Education North West London	614	5,496
Health Education South London	850	5,147
Health Education North Central and East London	1,072	6,664
Health Education Kent, Surrey and Sussex	1,073	8,784
Health Education North East	410	3,275
Health Education North West	1,579	10,786
Health Education West Midlands	1,010	7,790
Health Education South West	943	5,943
Special Health Authorities and other statutory bodies	193	2,798

Source: NHS Digital Vacancy Statistics

5.32. Trends and dynamics in vacancies data should be established with caution as the time series is still limited. M&D vacancies systematically increased (from 8,687 to 11,155) between April 2015 and March 2017. The yearly increase varies depending to some extent on the observed quarter, ranging from 13.8% in Q2 to 19.1% in Q4. M&D vacancies have systematically grown at a higher rate than those for all NWD staff groups.

Agency (All HCHS staff)

5.33. The use of Agency and Bank staffing may also provide some indication of the NHS labour market. The available national expenditure figures do not separate NHSPRB Remit from medical and dental staff. They include all expenditure on off-payroll staffing, including agency, self-employed contractors and externally-managed banks.

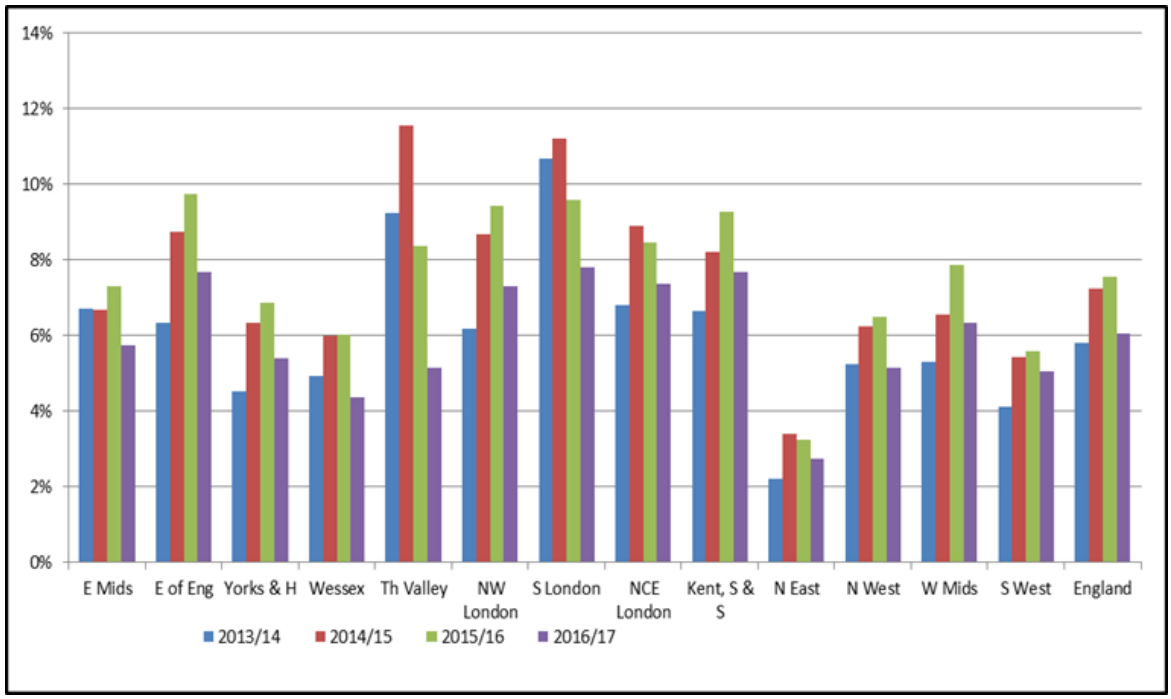
5.34. Spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.7bn), but due to NHSI introduced agency controls, expenditure on Agency reduced to £2.9bn in 2016/17 (a fall of 22% or £800 million across the total workforce in 2016/17).

5.35. We have continued to see a significant reduction in agency expenditure in the first quarter of 2017/18. Overall agency spend was £169 million lower (22%) than Q1 last year and £282 million (32%) than Q1 2015/16. A national ‘bank’ strategy is being developed, to increase bank staff utilisation across trusts and decrease spending even further.

5.36. At a regional level, the expenditure rate (agency as a percentage of total staff costs) is generally higher than average in the East of England, London and Kent. The level of change in the last three years has not followed a clear geographical pattern. During last year there have been decreases in all regions; the largest decreases were in East of England, Thames Valley and NW London.

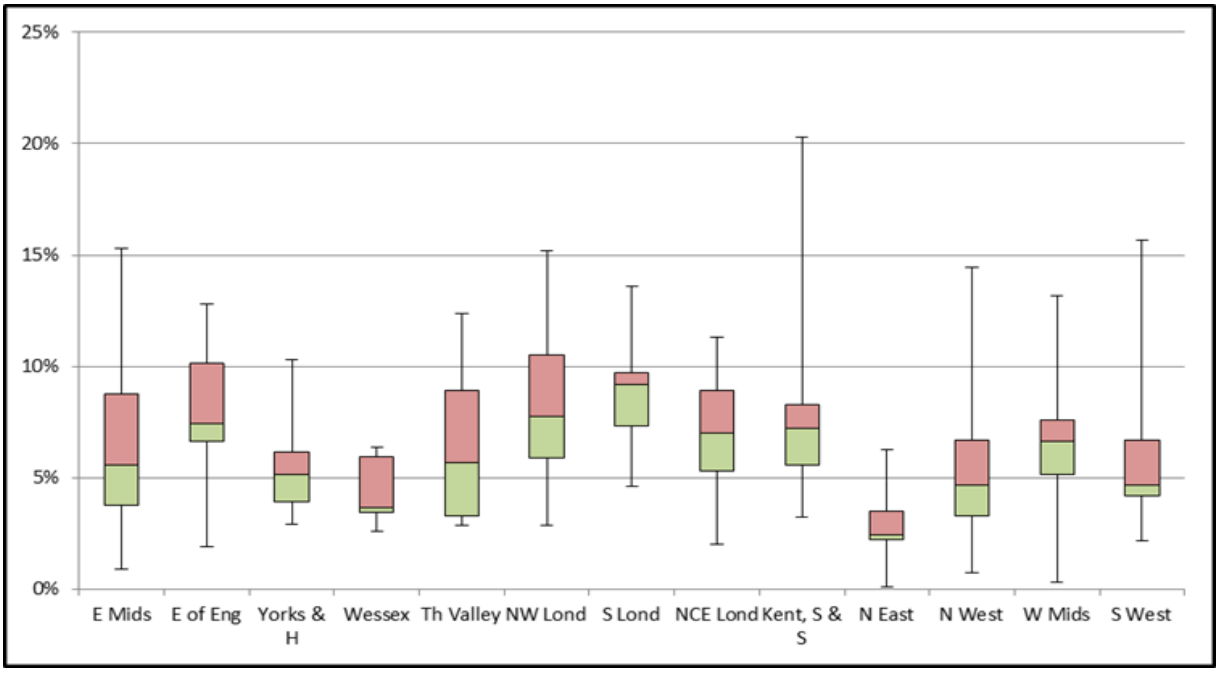
5.37. Agency expenditure is highly variable between Trusts. Variation between Trusts within regions is far greater than variation in the average between regions. In 2016-17 the regional median average varied between 2.4% and 9.2%, and the Trust rate ranged from 0.1% to 20% of staff costs. This might suggests that agency expenditure is driven principally by individual Trust-specific factors.

Fig 5.8: Agency Expenditure Rate by Region, 2013/14 to 2016/17



Source: NHS Improvement

Fig 5.9: Variation in Agency Expenditure Rate, by Region 2016/17



Source: NHS Improvement – Trust Financial Accounts

Note: The chart shows the 4 quartile Trust agency values for each region For example, in East Midlands, the lowest agency expenditure by a Trust was 0.9% of staff costs, the highest was 15.3%, and the median average was 5.6%. The upper and lower limits of the box are the 25% and 75% points: 25% of Trusts had agency expenditure more than 8.7% and 75% spent more than 3.8% of staffing expenditure on agency.

Staff Views and Experience

5.38. To supplement the evidence on numbers of staff, vacancies and changes, the annual staff survey can give useful insight into staff's views and experiences around working in the NHS. This section reports on:

- Staff motivation;
- Staff engagement; and
- Sickness absence

5.39. Employers across the NHS are responsible for improving their staff experience. The Department is working in partnership with Arms Length Bodies, the NHS and unions to develop an Employer of Excellence Standard (EES), the objective being that all trusts should aspire to meet the EES to improve staff morale, motivation, engagement and, therefore, retention. While no final decisions have been made yet, it is anticipated that the Standard is likely to require trusts to achieve an "outstanding" rating in the Care Quality Commission's (CQC) Well Led Domain which has recently been refreshed and relaunched by CQC and NHS Improvement (NHSI), be included in NHS Improvement's list of Segment 1 trusts and/or achieve top quartile scores in the NHS staff survey which may include some new or revised questions to help reflect the EES.

5.40. Components of the EES are likely to include: improvements in leadership and culture, NHS staff health and wellbeing; flexible working; tackling bullying; dealing with violence against and abuse of NHS staff; meeting expectations set out in the Workforce Race Equality Standard; offering reward packages (pay and non-pay) that meet staff needs. Assuming the EES is launched, it is expected to be implemented from April 2018.

5.41. Evidence available to the Department to inform policy development on staff experience continues to evolve as the data from the NHS Staff Survey and the Staff Friends and Family test (staff FFT) improves over time and trends in respect of how staff feel about working in the NHS become clearer.

5.42. NHS Digital is working with a range of stakeholders to improve its sickness absence data which may, for example, include information on length of sickness absence and number of episodes but this work has not concluded yet and no decisions have been taken at this stage about any changes to the publication. However, NHS organisations continue to have access to high quality data sources to help them benchmark against their peers the progress they are making in improving their staff experience. They can use the evidence from the Staff Survey, Staff Friends and Family test, sickness absence data and CQC inspection reports to complement local intelligence to help their plans. The NHS Constitution also continues to provide the framework in respect of what employers should expect of their staff and vice versa.

5.43. An additional opportunity for trusts to assess progress has been developed by NHS Improvement with their "Staff Experience and Outcomes Explorer" which aims to bridge the gap between the online tool available via the NHS Staff Survey website[x] and the research evidence on the impact of staff experience and outcomes for patients. This can be found at NHS Improvement's Hub[xi] and includes a national summary to help trusts answer how they are doing compared to peers or their region. They can filter to create bespoke selections e.g. groups of trusts, all trusts in a region, all similar trusts or in local patches. Summary data shows a high level view of the key findings in terms of which trusts have more or fewer in the top or bottom quintile, or where there has been the most significant changes from the previous survey whether that be positive or negative.

5.44. It has been shown by the CQC that there is a strong relationship between outcomes of their inspections and the staffs' experience, and for that reason the "Explorer" can be used to highlight the relationship across the key factors. It has CQC ratings based on inspection reports for all trust types published up to 6 March 2017 and for each domain, data plots show the range from lowest to highest with interquartile ranges and medians. The "Explorer" covers seven aspects of staff experience: Appraisals; Discrimination; Team working; Engagement; Health Wellbeing; Safety; Freedom To Speak which were selected as key areas from evidence or stakeholders. The "Explorer" has just been introduced.

5.45. The Department has also changed its commission of NHS Employers, bringing together staff engagement; health and well-being; organisational development and tackling bullying into one programme for the provision of advice, guidance and good practice to help NHS organisations improve NHS staff experience. NHS Employers will provide detailed evidence on progress but this change has enabled better use of resources by eliminating overlaps in objectives and outcomes.

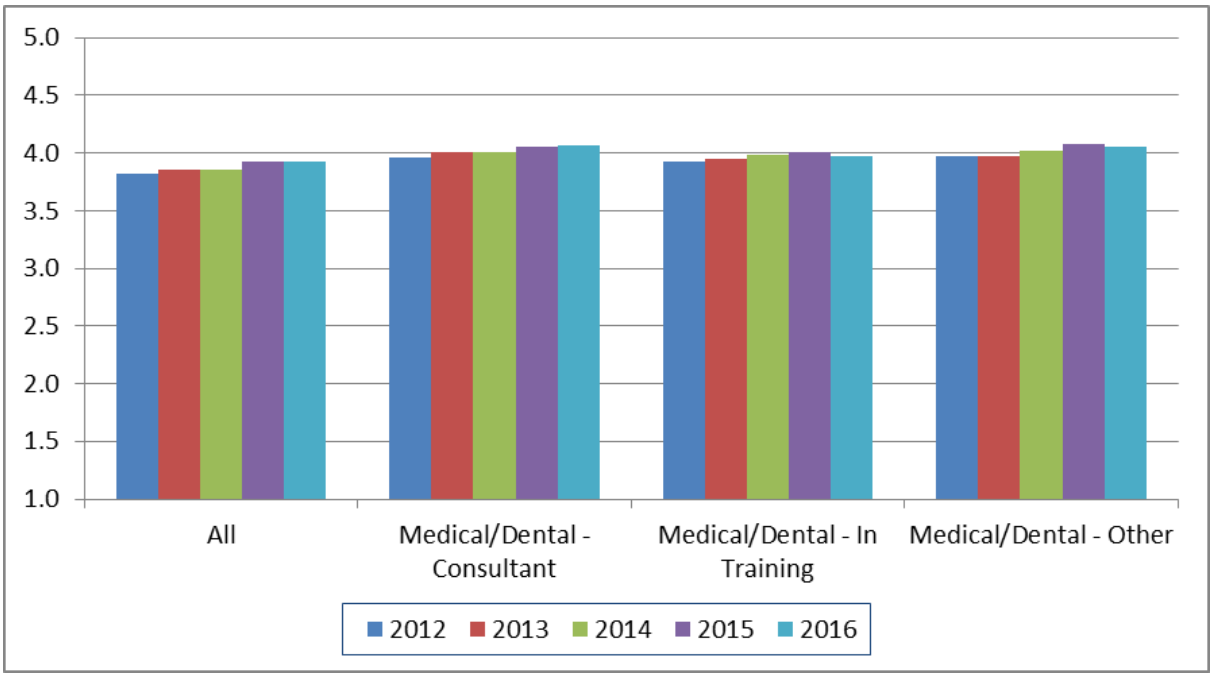
Staff motivation

5.46. Definition: "the intrinsic motivation of NHS staff and the underlying reasons why people do the job that they do and want to put effort into their work such as the desire to provide care, to earn money or to achieve promotion. Measures of this might include whether staff look forward to going to work and if they are enthusiastic about their job".

5.47. The staff survey is administered to eligible staff every year, and asks users to rate their agreement with the statement included in the question on a scale from one to five (the higher the score, the more they agree with the statement). Thanks to the design of this survey we were able to attribute properties of the respondents into groups, allowing a more in-depth analysis of key staff groups. Among other topics, the staff survey aimed at assessing staff motivation on the workplace. Below is a chart showing the average score for three staff groups across five years in response to "Key Finding 4", which includes three statements[xii]. In general, the scores for DDRB remit groups can be perceived as quite positive. Starting from 2012, there has been a marginal increase for all three medical/dental groups, although both doctors in training and the "other" category (including mostly Associate Specialists, Staff Grade Doctors and Specialty Doctors)

have experienced a small dip in the last year. Compared to the average of all staff groups, medical and dental staff were systematically more motivated at work. The need for regularly refreshed support for the NHS in improving motivation is demonstrated by variation in question 2a "I look forward to going to work" from 50% for "other" doctors working in community trusts to 88% for consultants working in ambulance trusts. Part of our work in developing the EES is considering issues facing specific staff groups and potential solutions for those which should complement the EES.

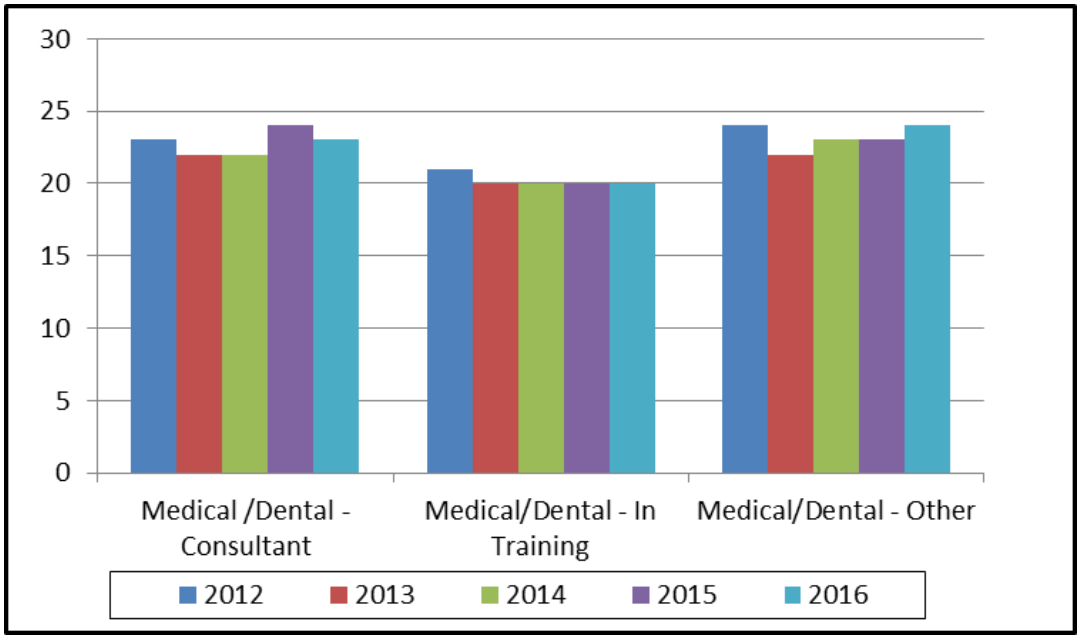
Fig 5.10: Motivation Score for HCHS Medical & Dental Staff, 2012 to 2016



Source: NHS Staff Survey

5.48. Concerns about bullying of SAS doctors raised in last year's DDRB report may be reflected in responses to questions like "I look forward to going to work" and, as can be seen from Figure 5.5, the trend for "other" doctors shows an increase in the last year whereas it is stable for doctors in training and down for consultants. Any level of bullying is too high and detracts from good patient care so this re-emphasises the need for trusts to respond to the national Social Partnership Forum's "Collective Call to Action" on this issue which will help deliver the Government's manifesto commitment to "… act to reduce bullying rates in the NHS, which are far too high". Further details on the collective call to action can be found at https://www.socialpartnershipforum.org/. This should be part of the EES.

Fig 5.11: Percentage of staff experiencing, bullying or abuse from staff in the last 12 months (%)



Source: NHS Staff Survey

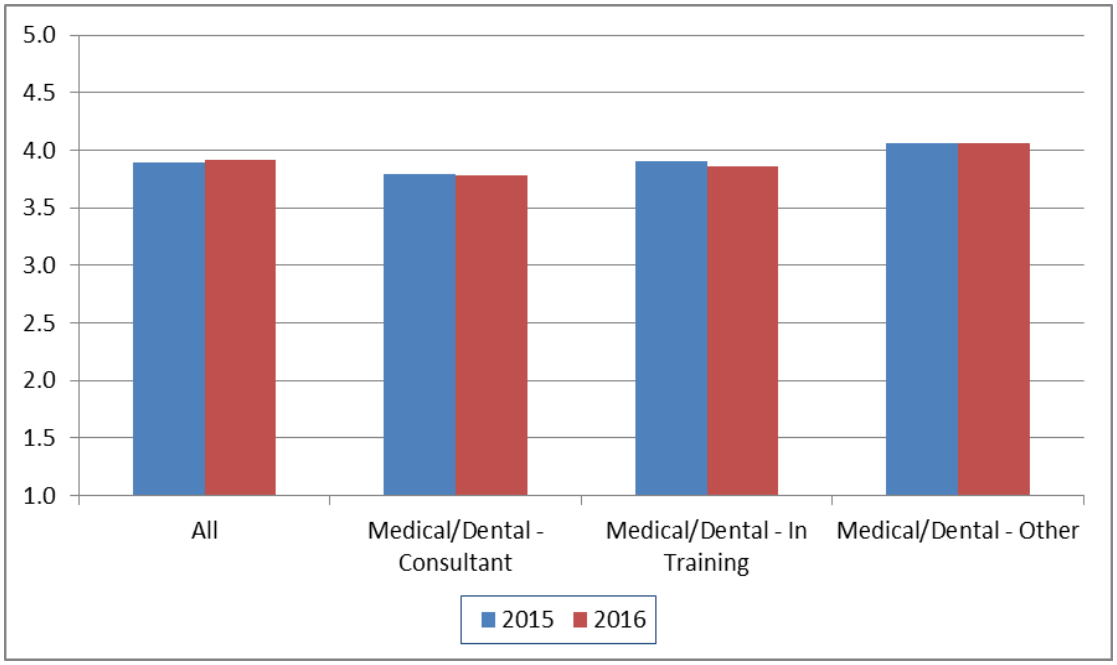
Staff Satisfaction

5.49. Definition: "whether NHS staff are happy with their experience of work and achieve what they set out to. Measures of this might include whether staff feel their work is valued, their satisfaction with the work environment and issues such as workload, and whether they feel able to give the care they aspire to".

5.50. From 2012 to 2014, there was one general question included in the survey relating to staff satisfaction simply titled ‘Staff job satisfaction’. In following waves of the survey additional questions were asked, on topics including ‘Staff satisfaction with the quality of work and care they are able to deliver’, ‘Staff satisfaction with level of responsibility and involvement’ and ‘Staff satisfaction with resourcing and support’. As a result, the two periods are not strictly comparable and the analysis of staff satisfaction is restricted to 2015 and 2016, making it difficult to perform any kind of trend analysis.

5.51. The figure below shows the scores from the two years where the question was included in the survey. Consultants achieved a relatively lower satisfaction with work in both years. Doctors in training have experienced a small drop in satisfaction between 2015 and 2016, while a small improvement in the average score for all staff can be observed between 2015 and 2016.

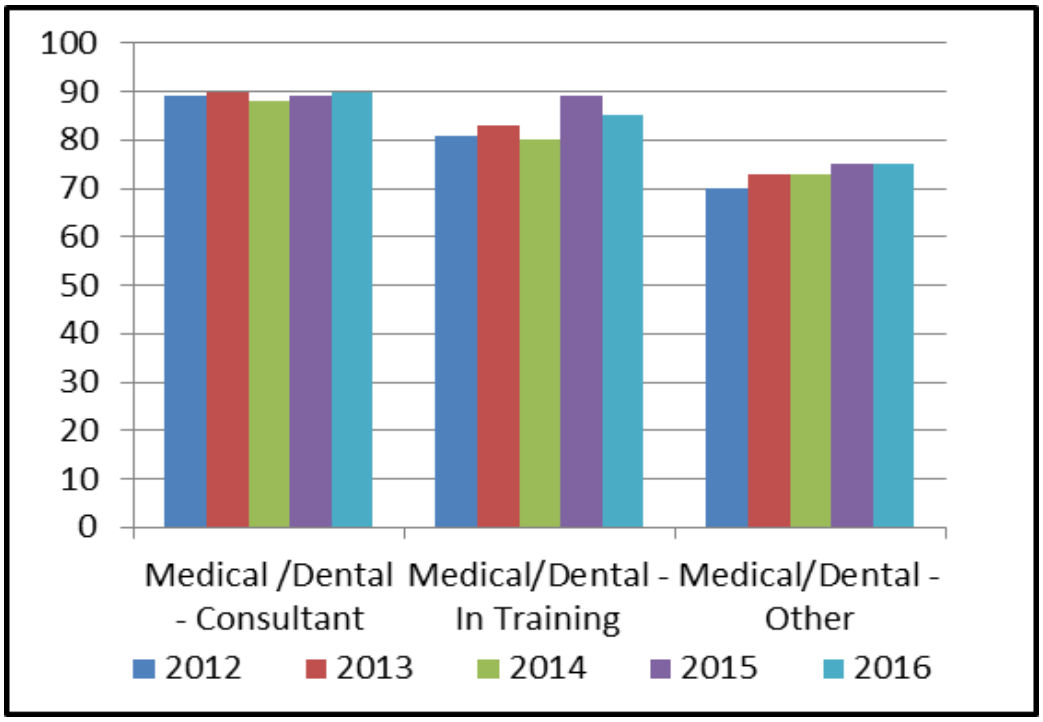
Fig 5.12: Staff satisfaction with the quality of work and care they are able to deliver, 2015 to 2016



Source: NHS Staff Survey

5.52. In terms of workload, almost 90% of consultants and a slightly lower proportion of doctors in training work extra hours.

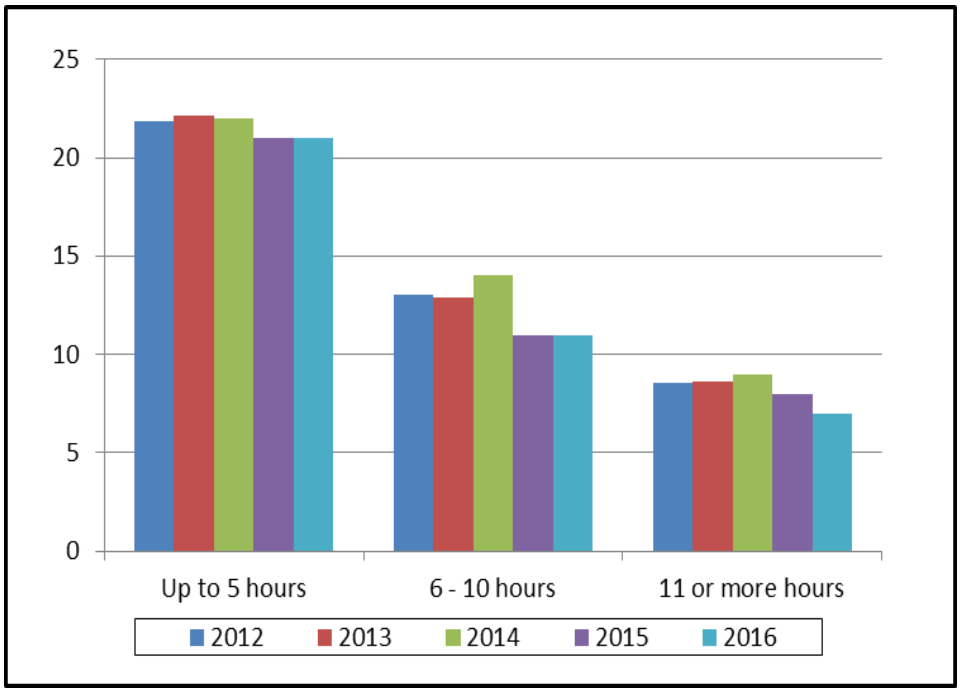
Fig 5.13: Percentage of staff working extra hours (%): 2012 to 2016



Source: NHS Staff Survey

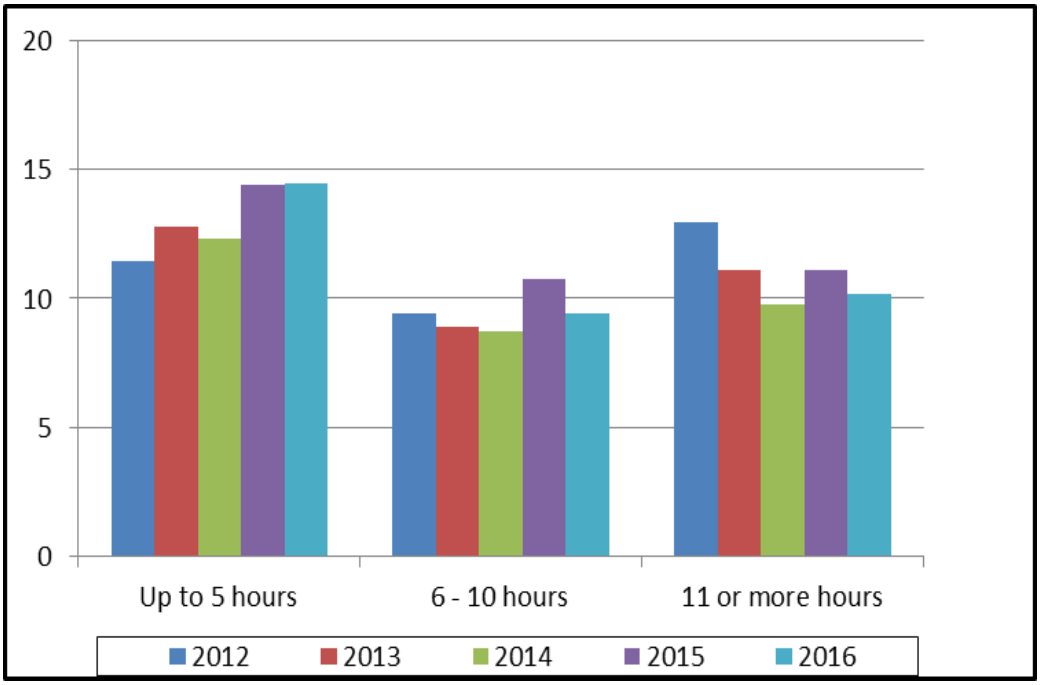
5.53. The trend for consultants over the last 5 years, and doctors in training over the last 2, is that their number if paid extra hours seems to be reducing slightly.

Fig 5.14: Consultants – (extra hours worked per week – paid)



Source: NHS Staff Survey

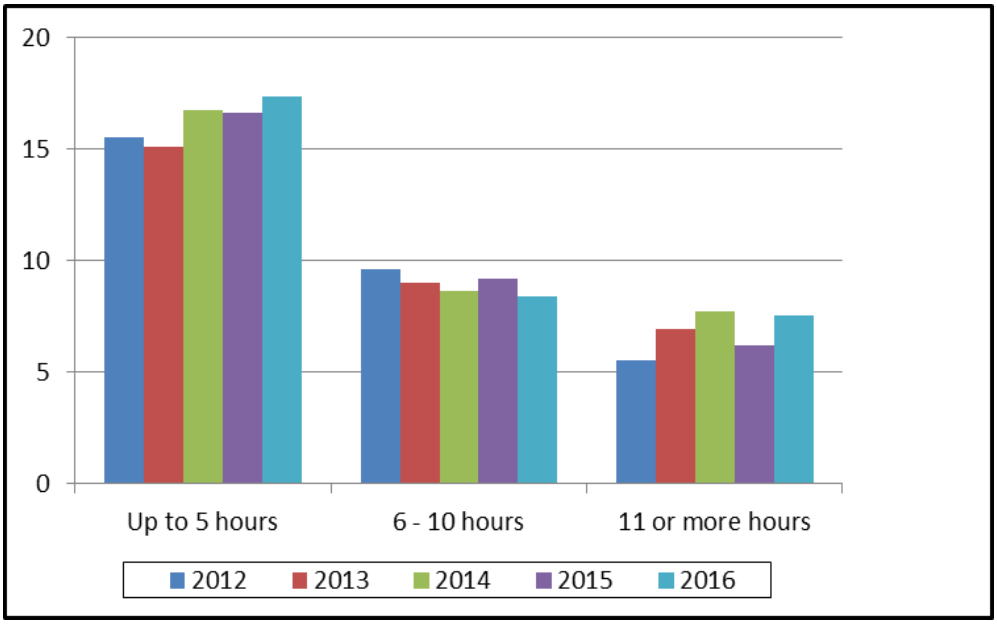
Fig 5.15: Medical/Dental - In Training (Extra hours worked per week - paid)



Source: NHS Staff Survey

5.54. The trend for "other" doctors tends to be for slightly more paid extra hours. This may represent trusts making greater use of lower remunerated doctors although the amount of unpaid work reported by all 3 groups remains high particularly in the working an extra 0-5 hour category. This emphasises the need for excellent staff rostering as part of local workforce planning. Good use of an accredited e-rostering system is likely to be included in the EES.

Fig 5.16: Medical/Dental - Other (extra hours worked per week - paid)



Source: NHS Staff Survey

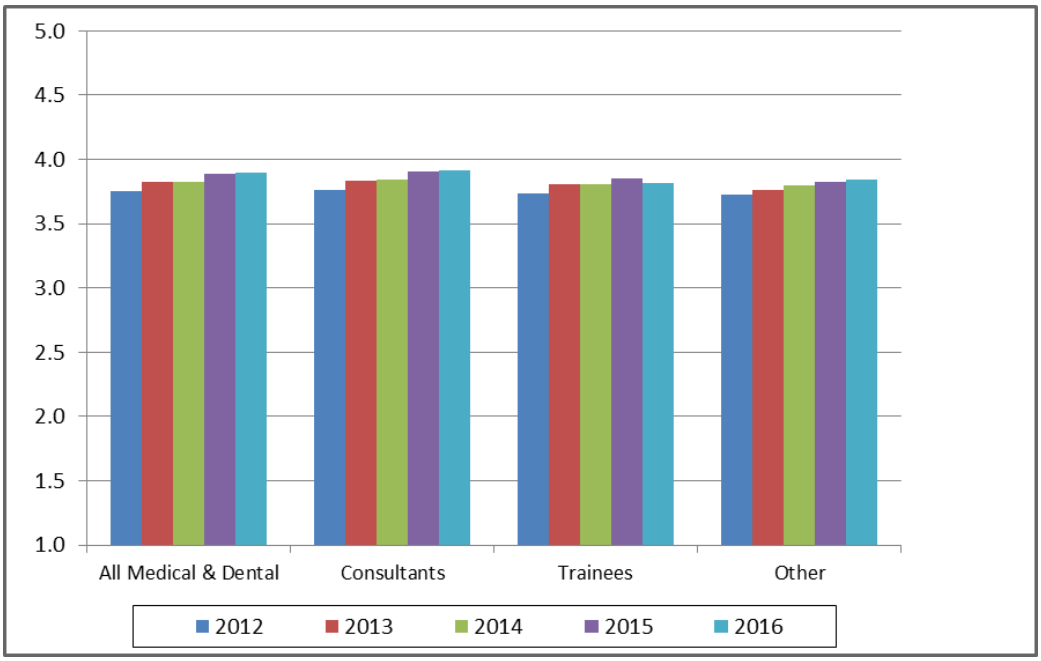
Staff Engagement

5.55. Definition: "how committed staff are to their organisation (affiliation) and whether they will put extra work in to e.g. engage with initiatives aimed at reforming healthcare delivery to improve efficiency (effort)".

5.56. The results published from the NHS Staff Survey include an overall Engagement Index. The Index results from the last five surveys show that for HCHS Medical & Dental Staff overall, as well as for consultants and other Medical & Dental staff excluding doctors in training, the Engagement summary scale score improved marginally year on year. This suggests the need for trusts to ensure their staff engagement plans remain high on their agenda and that they are using the available advice, guidance and good practice from NHS Employers and other sources to support local engagement activity. We continue to use staff engagement scores as a proxy for NHS staff morale but NHS England, which is responsible for the NHS Staff Survey, are working with Professor Michael West - Professor of Work and Organisational Psychology at Lancaster University and Head of Thought Leadership at the King's Fund - to assess whether there might be a better way

to measure staff morale through the NHS Staff Survey given the indications that it may be deteriorating as suggested by some media coverage, union surveys and the PRBs.

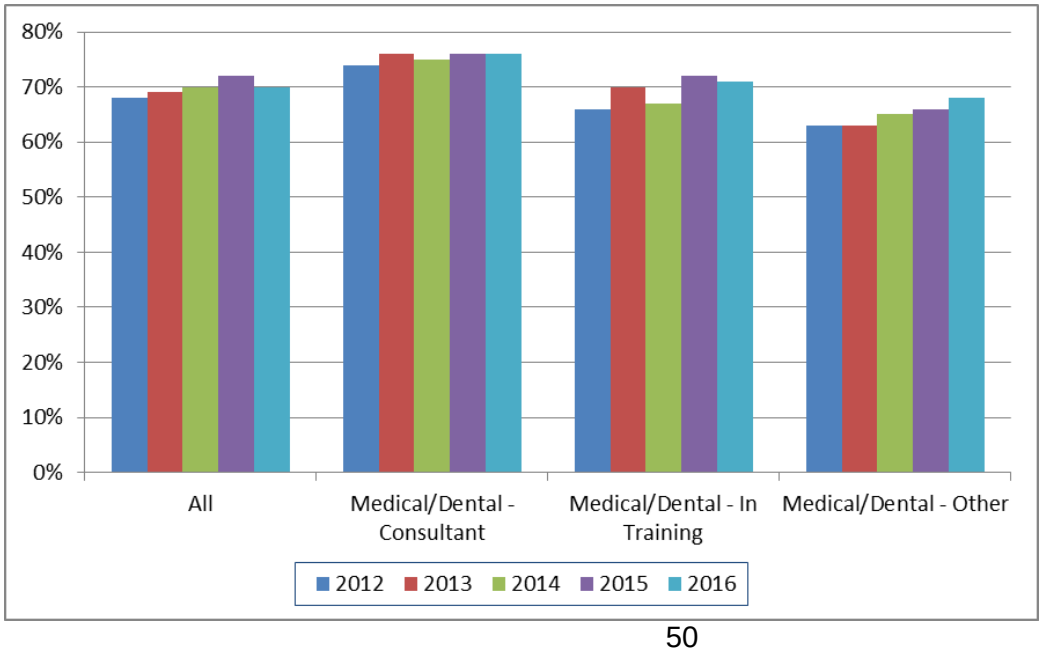
Fig 5.17: Engagement Score for HCHS Medical & Dental Staff, 2012 to 2016



Source: NHS Staff Survey

5.57. The staff survey also included a statement about "Staff able to contribute towards improvement at work", which measures agreement through a binary "Yes/No" response. Thanks to the consistency in the formulation of the question, results from the last five years can be compared. For all staff groups a larger proportion in 2016 compared to 2012 agrees that they are able to contribute towards improvement at work. All in all, consultants represent the group with the largest share of engaged staff.

Fig 5.18: Percentage of staff able to contribute towards improvement at work, 2012 to 2016



Source: NHS Staff Survey

5.58. The Staff Friends and Family Test (FFT), a useful assessment of the extent to which an employee would advocate their trust as a place to work or receive treatment, is undertaken in 3 quarters out of 4 each year by NHS England (it is not published during the same period as the NHS Staff Survey). The latest data available, which is for Q4 2016/17 shows that 64% of staff say they would recommend their organisation as a place to work (up 2% from last year) and 79% would recommend their trust as a place to receive treatment (the same as last year). Its limitation is that it does not separate out staff groups. While direct comparisons between the Staff FFT and the NHS staff survey should be resisted, in response to Q21c, "I would recommend my organisation as a place to work", medical and dental staff overall were at 68% with consultants 68%, doctors in training 70% and "other" 64%.

5.59. While, according to the NHS Staff Survey, staff engagement scores have shown some improvement since 2012, the Care Quality Commission highlights that "Engaging and empowering staff is key to driving improvement in hospital care" and their recently published report "Driving Improvement: Case Studies from eight NHS trusts" demonstrates this. (http://www.cqc.org.uk/news/releases/engaging-empowering-staff-key-driving-improvement-hospital-care).

5.60. Sustainability and Transformation Partnerships continue to put significant emphasis on staff engagement as the basis for refreshing local services for patients. Last year, NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association published a guide to the work vanguards are doing to engage their staff in the design and delivery of new care models. The report – New Care Models and Staff Engagement: All Aboard (https://www.england.nhs.uk/2016/06/all-aboard) aimed to help spread the learning from the vanguard programme across the health and care sector including:

- Enabling different groups of staff across organisations to 'break down the barriers' so people can break out of old working patterns and think differently;
- Recognising that those on the front line of care have the best ideas about how to improve it – but need to feel empowered to do so;
- Recognising that if staff feel that their contribution is valued, they will want to do all they can to make new care models a success.

5.61. Also supporting improved staff engagement, NHS Improvement's Culture and Leadership Programme continues to evolve. Phase 1 (of 3) is complete including a revised toolkit https://improvement.nhs.uk/resources/culture-and-leadership/ along with two short guides. NHSI continue to share learning at events and networks, gather learning from trusts working on culture and they are exploring use of the toolkit with trusts in special measures. Two trusts have used the tools to support a merger. Phase 2, completed in September 2017 includes an evidence base prepared by Professor Michael West and reviewed by participating trusts with seven case studies prepared for phase 2 tools.

5.62. In addition, NHSI working with the CQC has revised the Well Led Framework and NHSI has issued new guidance https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf on developmental reviews of leadership and governance which should identify areas of organisational leadership and governance that would benefit from further targeted development work to secure and sustain future performance. NHSI is encouraging organisations to carry out, every three to five years, externally facilitated, developmental reviews of their leadership and governance using the well led framework.

Staff Health and Wellbeing

5.63. There is an increased emphasis on improving NHS staff health and wellbeing led by NHS England's campaign launched in 2015. https://www.england.nhs.uk/2015/09/improving-staff-health. The Department commissions NHS Employers to provide advice, guidance and good practice to the Service and they are working with NHS England and Public Health England to embed NHS England's programme across the NHS. NHS England's "Commissioning for Quality and Innovation" (CQUIN) £150m incentive scheme is encouraging NHS organisations to invest in services to support staff health and wellbeing with their aim that CQUIN payments will be triggered in 2018/19 for trusts improving NHS staff survey scores for health and wellbeing by 5% from a 2015/16 baseline. This scheme is likely to be included in the EES through which there will be encouragement of fast access for staff to musculoskeletal, mental health and weight management services to support delivery of the Government's manifesto commitment.

5.64. The NHS Staff Survey 2016 shows improvement for DDRB remit groups over the previous year which may indicate to an extent the impact of NHS England's programme and the CQUIN incentive payments. In respect of the percentage of staff feeling unwell due to work related stress over the previous 12 months, they are 31% for consultants (down 2% from 2015), 32% for doctors in training (down 2%) and "other" 32% (the same as 2015).

5.65. The percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves also dropped for consultants to 40% from 46% in 2015, 42% down from 44% for doctors in training and 46% for "other" doctors down from 47% in 2015.

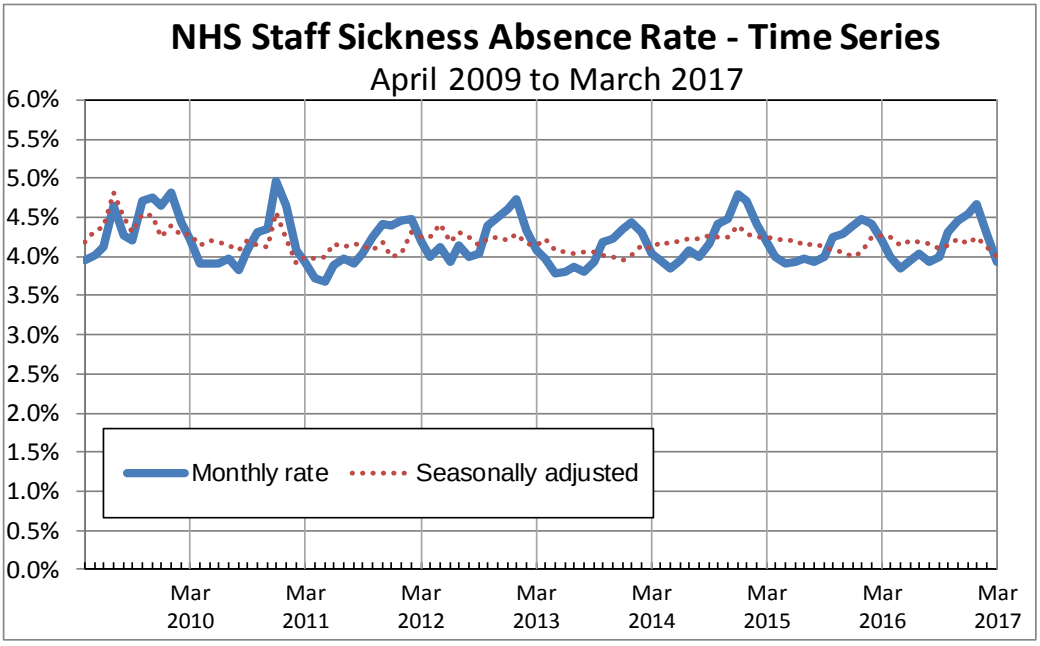
5.66. Organisational and management interest in, and action on health and wellbeing also improved since 2015 for consultants up to 3.52/5 from 3.46 and "other" doctors to 3.62 from 3.56 and stayed the same for doctors in training at 3.56.

Sickness Absence

5.67. Ongoing initiatives to improve NHS staff health and wellbeing and tackle sickness absence have been described previously.

5.68. NHS Digital publishes sickness absence statistics based on information recorded locally in the NHS Electronic Staff Record. The absence rate is calculated as the number of recorded days of absence as a proportion of the total number of calendar days. Sickness absence is subject to month-to-month variation, and some of this is seasonal. The chart shows the 12-month average, which removes seasonal variation. There has been little overall change in recent years. The overall trend remains fairly stable and lower than the 2009 estimate of 4.48% when work began on addressing sickness absence in the NHS following the Boorman Report[xiii]

Fig 5.19: NHS Sickness Absence Rates - April 2009 - March 2017



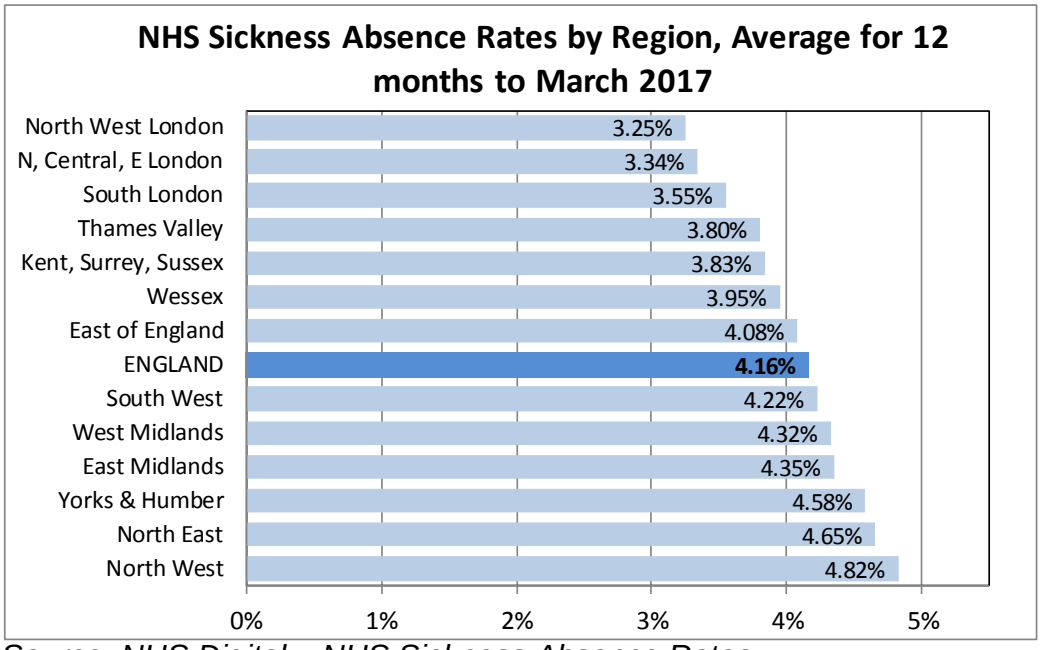
Source: NHS Digital – NHS Sickness Absence Rates

5.69. The 12-month average is an alternative mechanism to smooth the effects of seasonal and also other variation. The latest 12 months' average is 4.16% for the year ending 31 March 2017. This compares to 4.15% for the 12 months' average a year ago, to 31 March 2016. This is a small increase of 0.01 percentage points. At regional level, NHS sickness absence rates are generally higher in the north than in the south.

5.70. For 5 of the 13 Health Education England regions, the most recent 12 month average rate has decreased compared to that over the preceding 12 months. The greatest

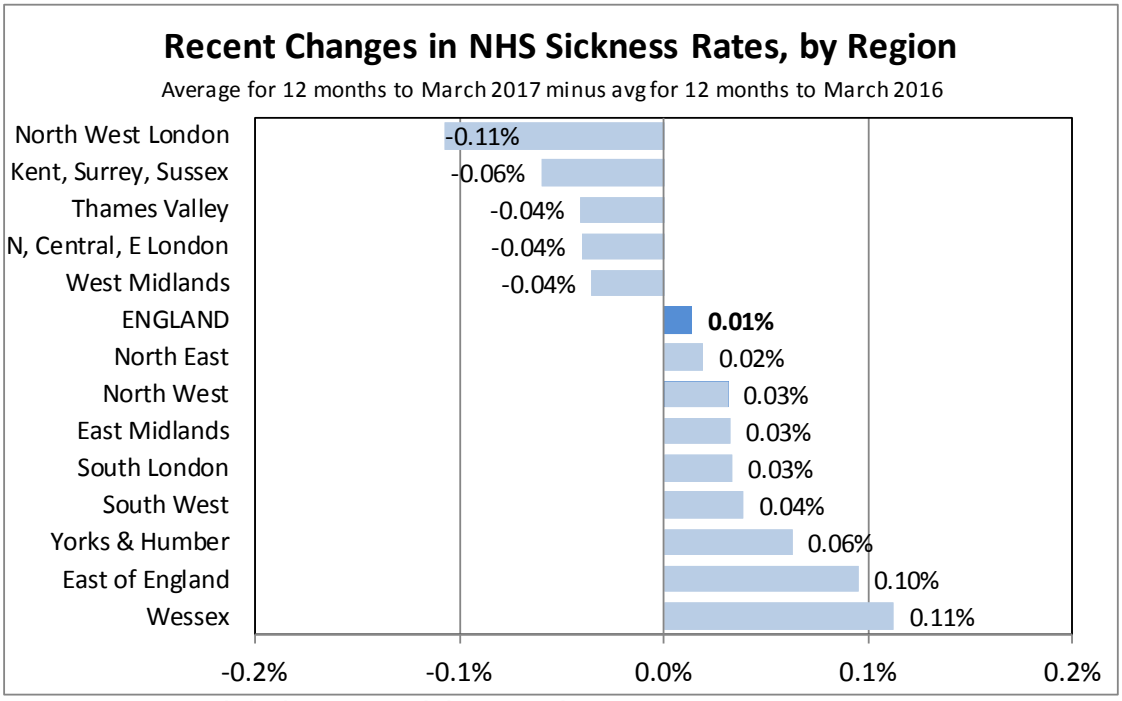
decrease was in North West London at 0.11 percentage points. The largest increases in the other 8 regions were in East of England, at 0.10 percentage points, and Wessex, at 0.11 percentage points.

Fig 5.20: NHS Sickness Absence Rates by Region - 12 months to March 2017



Source: NHS Digital – NHS Sickness Absence Rates

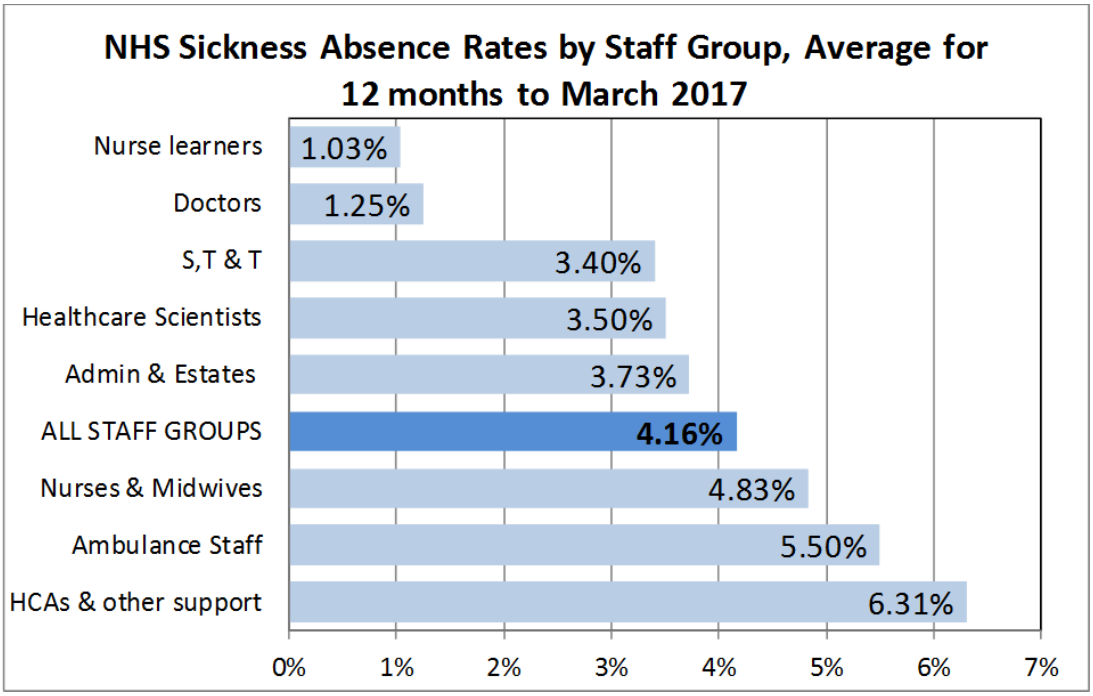
Fig 5.21: Recent changes in Sickness Rates, by Region



Source: NHS Digital – NHS Sickness Absence Rates

5.71. By staff group, doctors' sickness rates are among the lowest (1.25%), together with the nurse learners' category. This is substantially lower than the rate for all staff, which reached an average of 4.16% in the 12 months leading up to March 2017.

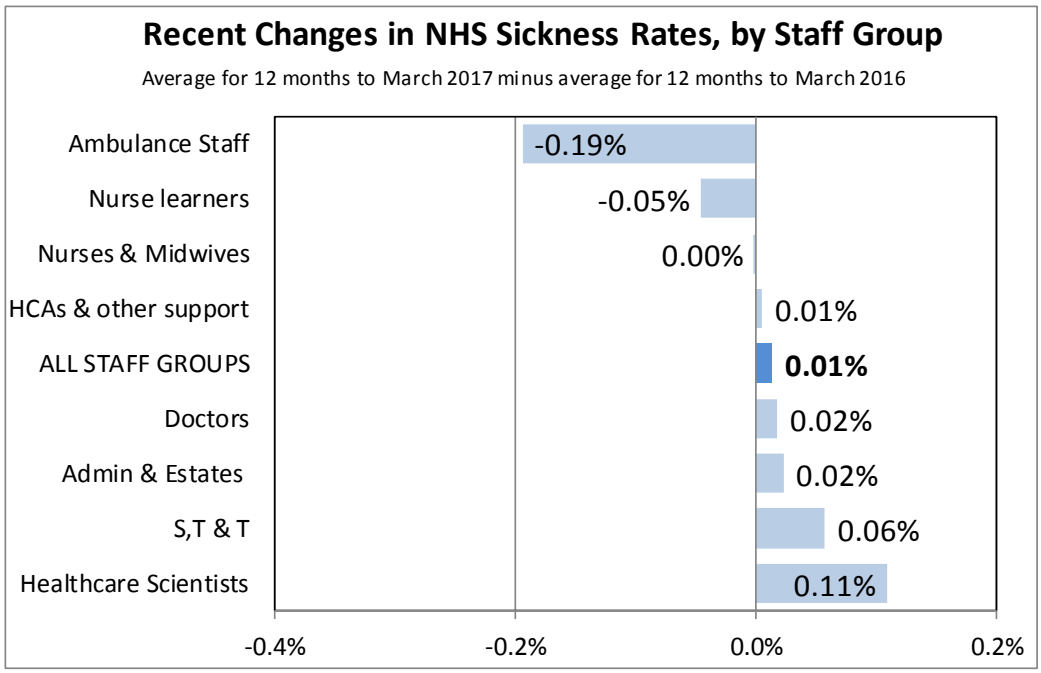
Fig 5.22: NHS Sickness Absence Rates by Staff Group - 12 months to March 2017



Source: NHS Digital – NHS Sickness Absence Rates

5.72. Doctors' sickness absence rates have remained almost unchanged in the 12 months to March 2017, growing by about 0.02 percentage points. This increase is similar to the average for all staff groups, whose 12 months' average rates increased by 0.01% in the period under analysis.

Fig 5.23: Recent changes in NHS Sickness Rates, by Staff Group



Source: NHS Digital – NHS Sickness Absence Rates

5.73. NHS Digital publishes NHS sickness absence statistics monthly, at the following link: http://content.digital.nhs.uk/searchcatalogue?topics=2%2fWorkforce%2fStaff+management%2fSickness+absence&sort=Relevance&size=10&page=1. The national and regional times series analyses, above, are produced by the Workforce Analysis team in DH and feed into the monthly IPS report to the Departmental Board and HMT. Coverage is restricted to those organisations that use the Electronic Staff Record (ESR).

6. Doctors and Dentists in Training

The new contractual arrangements from 2016

6.1. In written evidence for 2017 the Department of Health and Social Care set out the details of the new contractual arrangements for doctors and dentists in training (juniors). The 2016 contract is not a collective agreement with the British Medical Association (BMA); it does, however, include all the provisions negotiated with BMA leaders and set out in the ACAS agreement of May 2016. Whilst BMA members voted not to accept that agreement, it was approved by Government with trusts free to introduce the new terms for new starters or as juniors take up new contracts of employment when moving between posts. In line with the ACAS agreement, a review of the contract will be commissioned in late 2018. (The ACAS agreement had envisaged this review being jointly commissioned by NHS Employers and the BMA).

6.2. In line with the ACAS agreement, a one-year phased introduction of the contract began in October 2016 with different groups of trainees moving onto the new arrangements at different times. This phased approach was to enable trusts to review all rotas and to redesign rotas where needed to ensure that working patterns are compliant with the limits in the new contract. This work has, as expected, shed light on areas where rota gaps exist and has provided an added imperative for trusts to look at service and working pattern redesign to address those. The ACAS agreement of May 2016 had envisaged that the BMA and NHS Employers would jointly review approaches to good rostering practice by January 2017; in the absence of that collective work, the Secretary of State set out, in mid-2016, his expectation that all hospitals should invest in modern e-rostering systems by the end of 2017 as part of their efforts improve the way they deploy staff[xiv].

6.3. The BMA remains in dispute with government and NHS employers, which means there has been a suspension of the normal mechanism for negotiating contractual issues, i.e. the Joint Negotiating Committee (Juniors). However, it is in the interests of all parties that the contract is implemented well and that any implementation issues are identified and addressed. The Department and NHS Employers have therefore continued to have constructive dialogue with the leadership of the Junior Doctors' Committee (JDC) as well as employers who are introducing the contract and to take action where appropriate.

- This led to a change in the pay protection arrangements for Foundation 2 trainees who transitioned in December 2016 and April 2017 who, under the distribution of nodal points agreed with the BMA negotiators in May 2016, were more likely than other grades to see an impact on their pay compared to what they might otherwise have expected.

- A support service was set up for GP practices in the three Health Education England areas where there is no arrangement in place for a lead employer to hold the contract of employment for GP trainees: Thames Valley, Wessex and

Yorkshire & Humber. This has provided GP practices and their payroll providers with advice and support on: calculating pay (and pay protection); determining working hours compliant with the new contract; designing work schedules and responding to exception reports; and ensuring that a Guardian of Safe Working Hours is in place.

6.4. We understand that some employers and juniors think that the limits in the contract – on hours and working patterns – are too restrictive and act as a barrier to flexibility, particularly in general practice. The limits reflect what the BMA negotiators sought in negotiations that led to the ACAS agreement, but this is an area that the review of the contract could consider in 2018.

6.5. The BMA has sought changes to address that fact that the weekend working allowances set out in the ACAS agreement result in a lower effective pay rate for doctors working the most onerous pattern of one weekend in two, compared to those working one in four or one in five weekends. NHS Employers and the Department would be content to discuss this, and to have wider negotiations, in the context of the contract being collectively agreed. For now, the constructive dialogue between the parties continues to be focused on ensuring a smooth implementation of the contract and addressing any implementation issues that arise.

Non-contractual issues

6.6. A number of non-contractual issues were identified by juniors during negotiations and subsequently, relating to juniors' working lives and their experience of training. Some of these had been addressed in the ACAS agreement of May 2016.

6.7. Health Education England (HEE) has undertaken a wide range of work in consultation with the BMA and other organisations to address non-contractual issues, issuing two progress reports in 2017. Many changes have already been made and work includes a pilot of less-than-full-time training in emergency medicine, support for doctors returning to training and a review of the appraisal process to make it simpler and less stressful for juniors. HEE is also working with the Royal College of Surgeons, the BMA and leading teaching hospitals and education providers to pilot a new approach to explore whether a modern 'Firm' structure[xv] could enhance the effectiveness of medical teams, give better support to its members, make juniors feel more properly valued and get better outcomes for patients. (See HEE's evidence for detail).

Gender pay gap review

6.8. The Equality and Human Rights Commission makes a clear distinction between the issues of equal pay (for work of equal value) and the gender pay gap; it notes that the

gender pay gap has complex and overlapping causes including working part-time and taking time out[xvi].

6.9. The system of incremental progression under the old contract meant that those taking longer to progress were paid more than those with the same or greater levels of responsibility. Ending time-based incremental progression aimed to address this unfairness.

6.10. To minimise the potential impact (of ending incremental progression), on those who take time out or train part-time, the new contract includes:

- the nodal pay structure proposed by the BMA negotiators to deliver higher basic pay at the earlier stages of training; and
- specific provisions (flexible pay premia) to ensure that those following a clinical academic pathway, those taking time out for research and those returning/switching to hard-to fill training programmes do not lose out financially.

6.11. The ACAS agreement detailed other areas where the parties would work to improve equality of opportunity, and much of this work is being taken forward by HEE, for example support for those returning to training. When the ACAS agreement was reached in May 2016, Dr Ellen McCourt, one of the BMA negotiators at that time, said that it "emphasises that all doctors are equal, and has put together a really good package of things for equalities"[xvii].

6.12. The period spent in training for a future career cannot be viewed as an isolated period when considering reasons for the gender pay gap. The Secretary of State announced, in 2016, his intention to commission an independent report on how to reduce and eliminate the gender pay gap in the medical profession. The Department of Health and Social Care, working with the BMA and other key organisations have established the review objectives which will help identify the causes of gender pay gap and go on to enable the development and delivery of recommendations. The next stage of the process will commence shortly with potential reviewers being invited to tender to take this review forward.

Flexible pay premia

6.13. The 2016 contract includes flexible pay premia for:

- general practice training: this is payable during the practice-based period of GP specialty training, and replaced the GP training supplement which applied under the old contract to maintain broad parity with average earnings in hospital training placements;
- hard-to-fill training programmes – initially emergency medicine and psychiatry;
- oral-maxillofacial surgery – recognising the need for an undergraduate degree in both medicine and dentistry;
- clinical academic trainees to ensure no loss in pay as a doctor in training (with the premium payable on successful completion of a higher degree); and

- those taking time out of training for recognised activities that are deemed to be of benefit to the wider NHS.

6.14. The terms and conditions, provide that each flexible pay premium will be fixed at the rate applicable at the point in time at which the doctor becomes eligible and shall continue to be paid at that same rate for the remaining period in which the doctor is working in a post as part of the training programme that attracts the premium. (For 2017/18, the review body recommended and Government accepted an increase of 1% to the rate of all flexible pay premia).

6.15. For hard-to-fill training programmes, the intention is that the use of flexible pay premia be reviewed (for future intakes) in line with HEE advice on which programmes are proving hard-to-fill. Applying premia at this point in the career pathway is intended to support recruitment into specialists at consultant level - by ensuring that supply is maintained / increased. (As previously stated, the use of recruitment and retention premia for consultants' remains low, reflecting that the issues are often supply driven and that, in such circumstances, premia for consultants would simply drive up the cost of labour, not increase supply.)

6.16. In its 2017 report the Review Body asked for clarity on its role in relation to assessing these pay premia in the future. The Department remains in agreement with the recommendation made by the Review Body in 2015 that “For future rounds, the parties should submit evidence setting out what advice they have put forward to the relevant bodies on shortage specialties and RRPs (or flexible pay premia) so that we are able to review the effective use of RRPs and make recommendations as appropriate”. Our expectation is that effective workforce planning would identify both the effectiveness of the premia where they have been applied and the case for changes to their future application; and that such evidence would come from HEE and NHS Employers.

Transition

6.17. As set out in evidence for 2017/18 and in the terms and conditions of service, transitional arrangements with two types of pay protection apply to August 2022. As funding is released over time (as those with pay protection complete training) it will be invested in the contract. This is in line with the commitment that reform of the contract should be cost-neutral, other than the costs of additional employer pension contributions arising from increased basic pay which sit outside the envelope.

6.18. The review body will be asked to consider, in future rounds as the contract is implemented, how funding freed up during transition will be re-invested within the pay structure. The terms and conditions of service already provide, in line with the ACAS agreement, that “From 2 October 2019 onwards an allowance shall be paid to doctors who are formally designated by their employer to undertake roles as senior decision makers in line with appropriate clinical standards.”

7. Consultants

7.1. As senior leaders of multi-disciplinary teams consultants take forward many of the changes required to support NHS productivity growth and other system priorities. This includes making sure that urgent and emergency care is of a consistently high standard across the week.

7.2. The case for making changes to the 2003 national consultant contract is well documented and has been set out in recommendations from the National Audit Office and Public Accounts Committee and in recommendations and observations by the DDRB - most recently in the 2015 report Contract reform for doctors & dentists in training – supporting healthcare services seven days a week. These reports have taken into account evidence from a number of organisations including the Royal Colleges and the BMA.

7.3. Our ambition is to ensure that as the consultant workforce continues to grow employers are supported to offer consultants fair and modern terms that facilitates improvements in productivity and quality. This includes making changes that will help to:

- Facilitate and help to improve the engagement of consultants by introducing a fairer and more credible base and performance pay structure.
- Support new ways of working in ways that emphases patient and consultant safety; and
- Support recruitment and retention, including introducing measures that will support consultants' work-life balance.

7.4. National negotiations between NHS Employers and the medical trades unions have been ongoing in some form since 2013. Talks stalled for almost a year in October 2014 when the BMA withdrew from negotiations, and moved at a slower pace at the height of the junior doctors' dispute.

7.5. More recently, talks have been complicated by a legal claim submitted by the BMA suggesting that provisions relating to consultant clinical excellence awards are contractual. The Department denies this and has been defending the claim; and the BMA and the Department have recently applied jointly to the court for the claim to be stayed pending the outcome of further discussions associated with the contract negotiations.

7.6. Overall, discussions have remained positive and constructive, and the parties are focused on developing a cost neutral offer that can be jointly endorsed and collectively agreed. Key features of the emerging offer are outlined below. The parties also expect to provide an update as part of the supplementary evidence process.

- Replacement of the current 19 year and 'all but' automatic incremental pay progression structure with a clearly defined gateway process. This would be linked to newly qualified consultants' performance and development into the role. A new

two point structure would significantly reduce the time it takes for consultants to reach the top of the pay scale, facilitating fairer and more attractive base pay terms. No current consultants' base pay would be reduced under the current proposals.

- Replacement of the contractual clause that allows consultants to decline non-emergency (and in some cases emergency) weekend and evening work with safeguards that prioritise patient and consultant safety and support consultants' work life balance. This will help to facilitate the provision of consistent and affordable weekend and evening care across the week, and help to improve out of hours support for doctors in training.
- Reform the existing non-contractual employer based Clinical Excellence Awards with a new locally driven performance pay system in line of principles of previous observations by the DDRB. This includes making new payments time-limited and non-pensionable, so that resource can be focused on the excellent performers of today. Payments would also have a stronger link to the objectives of trusts and include protection for existing award holders.

7.7. A national agreement on consultant contract reform has the potential to support system wide improvements to patient care, and this remains our favoured outcome. However, we understand that some employers have worked with staff to make changes to the national terms - for example to remove the 'opt out' clause referred to above for new starters. In the absence of national agreement this trend is likely to accelerate as more employers reasonably decide to work with staff locally to change what is an increasingly outdated reward structure.

7.8. This underlines the importance of reaching a timely agreement on terms that are flexible enough to allow employers and consultants to adapt to evolving service priorities going forward.

7.9. In the continued absence of national agreement, it is likely that employers will continue to use available flexibilities to manage the consultant reward package. This includes ensuring they are well placed to support and engage the workforce and to improve patient care.

8. Career grade doctors (“SAS grades”)

8.1. The term “SAS doctors/grades” is widely used as shorthand to cover a number of career roles (other than consultant). It includes, but its use is not limited to, the main career grade of specialty doctor and the closed grades of staff grade and associate specialist (hence SAS) – there are national contracts for each of those three grades.

8.2. In its 2017 report the review body noted the BMA’s view that there is a complex and heterogeneous group of doctors, with a mixture of national contracts and non-standard contracts and a wide range of seniority; and that there are particular issues of concern for ‘trust grade’ doctors (i.e., those employed on local contracts rather than any of the national contracts).

8.3. It is likely that issues of concern will vary between different types of career doctors. The BMA’s evidence to the review body last year gave some headlines from its survey of SAS grades, noting that the survey was still under analysis. Detail of the issues broken down by the different roles/grades would shed greater light on the issues of concern to different staff groups and how these might be addressed.

The specialty doctor contract

8.4. In response to issues raised in the past, regarding career grade doctors who are not consultants, a number of recommendations were made, and consulted on, in the DH publication “Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors”, July 2003. These included:

- “The existing NCCG grades should be integrated into a single, simplified structure with no more than two recognised levels of practice.”
- “A new career structure for NCCGs should be seen as an integrated part of a new, modernised structure for medical careers.”
- “A new career structure and competencies will need new pay and terms and conditions of service which are appropriate for it.”
- Other recommendations related to training opportunities, educational standards, appraisal and continuing professional development.

8.5. A new specialty doctor grade was introduced in 2008, essentially replacing the staff grade. The grades of staff grade, associate specialist, clinical medical officer, hospital practitioner and clinical assistant were all closed in 2008, although there was a window of opportunity for staff grade doctors to apply for associate specialist roles up to 2009.

8.6. The specialty doctor grade was intended to provide an opportunity for doctors to have a rewarding career with progression to the top of the grade over a number of years whilst gaining experience and extending and developing their skills base. Entry to the grade requires full GMC registration and that doctors either:

- have completed at least four years' full-time postgraduate training (or its equivalent gained on a part-time or flexible basis) at least two of which will be in a specialty training programme in a relevant specialty or as a fixed term specialty trainee in a relevant specialty;
- or have equivalent experience and competencies.

8.7. Fundamental to the specialty doctor contract is that doctors will be required to undertake job planning (agreeing with the employer the duties, responsibilities and objectives for the coming year) and appraisal while developing a portfolio to record their progress in the job.

8.8. The specialty doctor pay scale is currently £37,923 to £ 70,718. There are five annual increments after the start of the pay scale, after which doctors progress through two thresholds by evidencing that they have participated in job planning and appraisal and have developed whilst in the role. Incremental progression between threshold one and threshold two is at two-yearly intervals and then at three-yearly intervals post threshold two.

Fig 8.1 Specialty doctor basic pay scale 2017/18

£	Incremental progression %	Notes
37,923		Eligibility for progression is annual
41,165	8.5	
45,381	10.2	
47,640	5.0	
50,895	6.8	
54,138	6.4	Threshold One: Eligibility for subsequent pay points is every two years
57,453	6.1	
60,770	5.8	
64,086	5.5	Threshold Two: Eligibility for remaining pay points is every three years
67,402	5.2	8.9
70,718	4.9	8.10

'Trust doctors'

8.9. In introducing the specialty doctor national contract NHS Employers included a frequently asked question on whether the contract applied to 'trust doctors'. This stated that NHS Employers hoped that the package would prove sufficiently attractive for employers to offer to those on local contracts but that there was no obligation for them to do so. It remains that trusts are free to choose what terms to offer employees, including to continue to employ doctors in 'trust grade posts' on local contracts.

8.10. Some such posts may have been created to meet specific service requirements or tailored to the circumstances of individual doctors; and there is a range of reasons (often positive) for doctors choosing to take up such posts – for example family reasons (such as the flexibility to look after children or other relatives), or wanting a career role without consultant responsibilities such as teaching and management. Whilst the roles (and terms) may suit post holders, there are issues of status and perception, for example the

view that the only ‘proper’ career pathway is one that leads to consultant. The introduction of the specialty doctor grade may have gone only some way to address this.

8.11. There is no definition of a trust grade doctor – the scope of roles is locally determined and varies widely - and no nationally agreed entry criteria/gateway. It is for employers to determine the requirements for a service job, be satisfied that these are met and determine appropriate remuneration. Trust grade doctors might be working at a level broadly comparable to specialty doctors or associate specialists; or they could be working at a level akin to specialty trainees, including those wanting to remain in work while waiting to secure a place on a specialty training programme. Their locally determined pay arrangements (and other terms and conditions) might mirror those for doctors working at a similar level; but note that the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) state that they are “not intended to apply to any doctor or dentist not in training on a General Medical Council (GMC)/HEE approved training programme, or to a dentist training on a dental foundation training programme.”

Numbers, and movement between the grades

8.12. Last year the review body reported that: the BMA told it that trusts in England have increasingly been advertising roles as associate specialist posts; and NHS Providers suggested that re-opening the associate specialist grade would be one way of making career grade roles more attractive. The pay scale for this closed grade is £53,169 to £87,521 (overlapping the bottom of the consultant scale which is currently £76,761 to £103,490).

8.13. Associate specialist numbers have been falling. More detailed analysis would be needed to understand whether numbers are joining the grade as well as leaving it as anticipated, though table 9.5 below suggests that there have been some new entrants to the closed grade since 2010.

8.14. Tables 8.2 and 8.3 below show the number of doctors in the grades of associate specialist, staff grade and specialty doctor over the period 2002 to 2016. (The notes after table 9.3 explain why this is presented in two overlapping time series.)

Career grade doctors (“SAS grades”)

Fig 8.2

Hospital and Community Health Service (HCHS) medical and dental staff by grade, 2002 to 2009

England at 30 September - headcount

	2002	2003	2004	2005	2006	2007	2008	2009
Associate Specialist	1,780	2,001	2,294	2,554	2,830	3,048	3,212	3,536
Specialty Doctor	.	.	.	.	.	.	445	3,213
Staff grade	5,255	5,255	5,467	5,527	5,937	6,055	5,929	3,309

Fig 8.3

Hospital and Community Health Service (HCHS) medical and dental staff by grade, 2009 to 2016

England at 30 September - headcount

	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15	Sep-16
Associate Specialist	3,770	3,758	3,730	3,479	3,218	2,967	2,727	2,483
Specialty Doctor	3,974	5,053	5,866	6,301	6,578	6,985	7,156	7,337
Staff Grade	2,440	1,421	854	616	502	449	478	455

Notes: In table 8.2, the changes between 2009 and 2010 may be partly due to an updated methodology implemented in 2010 by NHS Digital. A further revised methodology was implemented in 2016, but figures using these methods are not available prior to September 2009. Therefore, the 2007-09 headcounts in table 8.2 are not precisely comparable with the 2009-16 headcounts in table 8.3.

8.15. The tables below show the status in 2016 of those who were in the associate specialist grade in 2010 (table 8.4) and those who were in the staff grade in 2010 (table 8.5).

Fig 8.4 Doctors with only associate specialist posts in Jan 2010, followed up in Jan 2016

Grade in 2016	Headcount	Percentage
Associate Specialists	2,111	56.9%
Consultants	330	8.9%
Doctors in training	19	0.5%
Specialty Doctors	75	2.0%
Other	22	0.6%
No longer an NHS employee	1,154	31.1%
Total	3,711	100.0%

Note: Former associate specialists with multiple grades in 2016 were classified as consultants provided at least one of their posts was graded as consultant (consultant is the main grade of interest for associate specialists). Those without a consultant post were classified according to whichever of their posts had the greatest FTE in 2016.

Fig 8.5 Doctors with only staff grade posts in Jan 2010, followed up in Jan 2016

Grade in 2016	Headcount	Percentage
Staff Grades	203	18.2%
Specialty Doctors	247	22.2%
Associate Specialists	72	6.5%
Consultants	107	9.6%
Doctors in training	49	4.4%
Other	12	1.1%
No longer an NHS employee	423	38.0%
Total	1,113	100.0%

Note: Staff grade doctors in 2010 with at least one specialty doctor post in 2016 were classified as such (specialty doctor is the main grade of interest for staff grades). Those without a specialty doctor post were classified according to whichever of their posts had the greatest FTE in 2016

Issues and work being undertaken

8.16. Maintenance of the specialty doctor contract is through the Joint Negotiating Committee (SAS) which is the forum for the BMA to raise with NHS Employers any issues about the contract and other contractual issues of concern to its membership. Neither party has raised any concerns or proposals for changing this contract. As stated in evidence last year, however, it is likely that we would wish to review the contract in the wake of the new contract for doctors and dentists in training and once reforms have been made to the contracts for consultants – for example to look: at the links between pay and job weight/performance; and alignment of the unsocial hours periods and payment structure for work at those times.

8.17. As above, understanding more about the specific concerns of the different groups of career grade doctors would allow the parties to consider appropriate solutions. There may well be a tension between the freedom of trusts to determine local arrangements to meet service needs and the career expectations of the doctors taking up those posts – relating to recruitment, retention and motivation at a local level and the ways in which individual employers deploy and motivate their workforce. Equally, if there is continued use of the closed associate specialist grade, this might indicate an appetite, on the part of employers and doctors, to discuss further changes to the national contractual arrangements for career grade doctors. We would be interested to hear the other parties’ views on these issues.

8.18. HEE's draft workforce strategy (referenced in chapter 4) notes that more discussion and ideas are needed to identify what can be done to support and value this part of the medical workforce.

9. General Medical Practitioners

9.1. The material in this chapter is intended to provide a background to ongoing developments in general practice. Detailed evidence on general practitioners and general dental practitioners will be provided separately by NHS England.

GP Workforce numbers

9.2. Data on the whole general practice workforce are now published biannually, complemented by quarterly publications containing provisional data on the number of doctors in general practice. The latest confirmed figures, for June 2017, showed a total of 41,564 GPs working in England. See table 1 below for a summary of Workforce Minimum Dataset (wMDS) data on doctors working in general practice by headcount and full-time equivalent.

Fig 9.1 – Doctors in general practice by headcount and FTE

	September 2015	March 2016	September 2016	December 2016	March 2017	June 2017	September 2017 - provisional
Headcount							
All Practitioners	41,877	41,985	41,865	41,589	41,891	41,564	41,324
GP Providers	24,826	24,156	23,937	23,598	23,401	23,192	22,919
Salaried/Other GPs	10,775	11,066	10,988	11,045	11,130	11,129	11,497
GP Registrars	4,996	5,299	5,503	5,505	5,068	4,907	4,592
GP Retainers	155	180	171	162	189	201	218
GP Locums	1,370	1,463	1,561	1,591	2,535	2,630	2,631
Full-time equivalents							
All Practitioners	34,592	34,914	34,495	34,126	33,921	33,560	33,302
GP Providers	21,937	21,597	21,163	20,835	20,702	20,499	20,234
Salaried/Other GPs	7,292	7,436	7,295	7,300	7,390	7,359	7,603
GP Registrars	4,729	5,114	5,273	5,259	4,799	4,647	4,346
GP Retainers	67	78	72	69	81	84	90
GP Locums	567	690	692	663	949	970	1,029
Note that data on job role are not complete and hence do not add up to the total for 'all practitioners'							

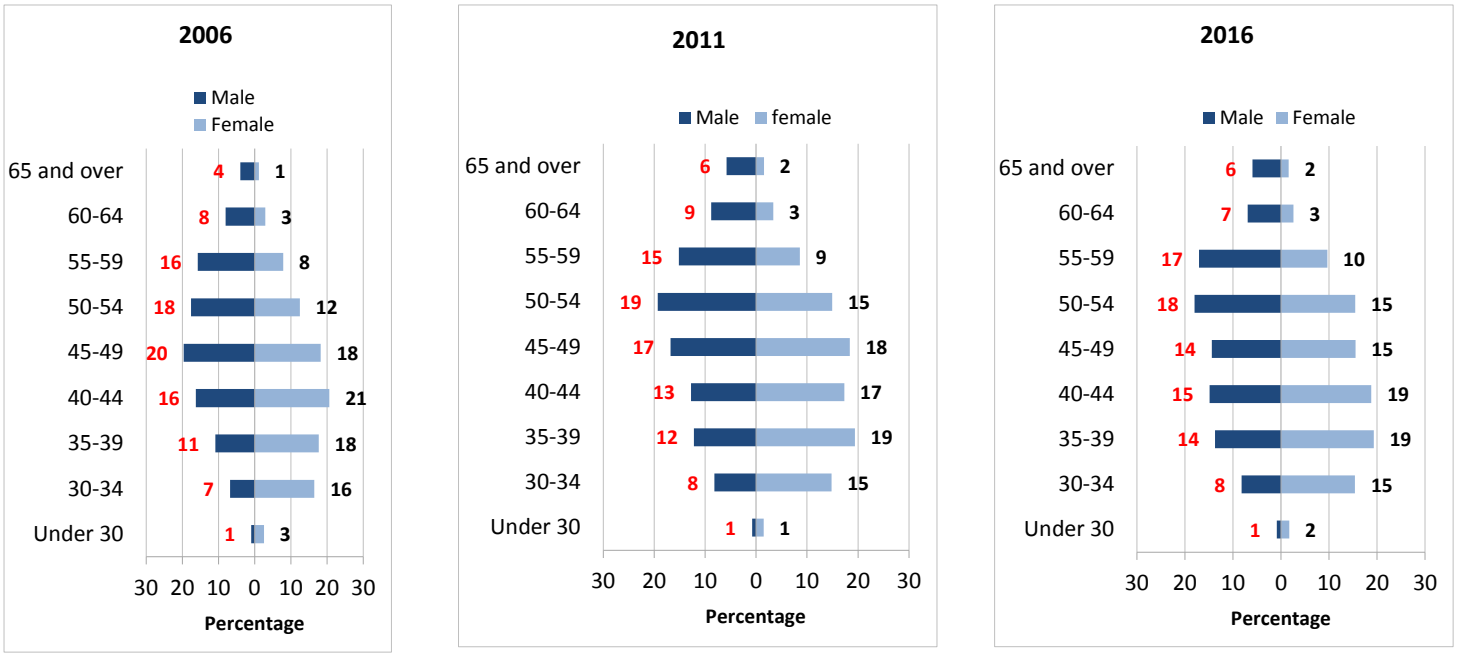
9.3. Overall, wMDS data show that the number of GP contractors in England has been on a decreasing trend. For example, between March 2016 and March 2017, the GP contractor headcount decreased by 3.1% from 24,156 to 23,401, corresponding to a 4.1% decrease in FTEs, from 21,597 to 20,702. Conversely, the salaried GP headcount increased over the same period by 0.6%, from 11,066 to 11,130; in FTE terms, the decrease in salaried GPs was 0.6%, from 7,436 to 7,390 FTEs. Note that comparisons with workforce numbers prior to September 2015 are not possible and that the data for September 2017 are still provisional.

9.4. As the most recent figures demonstrate, there continues to be issues around retention of GPs. A number of policy programmes are being undertaken to both boost retention, and increase the FTE GP number to 39,500 by September 2020. These include:

- an international recruitment programme to recruit 2,000 additional GPs;
- an increase in specialty GP training places, rising to 3,250 per year from 2018/19
- the GP Retention Scheme, which was launched on 1 April 2017, and replaced the Retained Doctors Scheme 2016. The scheme is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or requiring greater flexibility.

9.5. Changes in the shape of the workforce overtime are shown by age, gender and staff type below.

Fig 9.2 - GP Workforce trends by age and gender



Source: General and Personal Medical Services, England, March 2017, Provisional Experimental statistics, (published May 2017) http://www.content.digital.nhs.uk/catalogue/PUB24053 and related publications

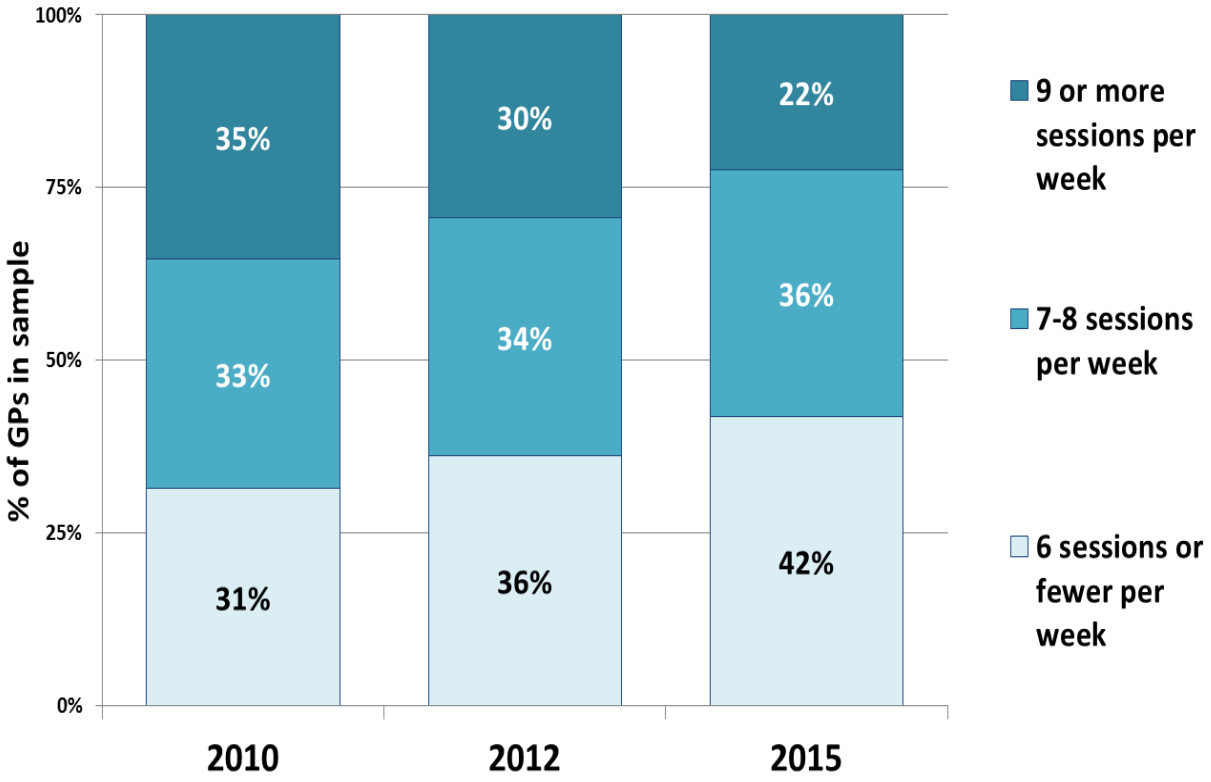
Part-time working and participation rates

9.6. Participation rates are used to measure the extent of part-time working in the GP workforce. They are defined as the ratio of full-time equivalents to headcount, and vary by job type, by age and by gender. Participation rates by age and by job role for the whole GP workforce are shown in table 9.2.

Fig 9.3 - All GPs (excluding locums, registrars and retainers), England, June 2017 , Final

Participation rate = ratio of FTEs to headcount	
By Age band	
Under 30	85%
30-39	77%
40-49	82%
50-59	82%
60+	76%
ALL	81%
By job role	
GP providers (contractor)	88%
Salaried GPs/Other GPs	66%
GP Registrars	95%
GP Retainers	42%
GP Locums	37%

Fig 9.4 - The average number of sessions worked by a GP has fallen steadily over time



GP Locums, vacancies and movement in the workforce

9.7. GP locum data needs improvement.

9.8. Following new guidance issued by NHS Digital to practices about the recording of all staff, including GP Locums, the number of GP locums reported in March 2017 was significantly higher than the number reported previously.

9.9. The reporting of GP vacancies remains poor. Between October 2016 and March 2017, 277 FTE vacancies were reported by only 1,218 GP practices, (representing only around 12% of all practices). Hence the reported vacancy data should be treated with caution. Note also that the vacancy data includes staff moving between practices.

9.10. The data on movements between practices requires improvement. The published data on staff movement include staff who are moving between practices, so that it is not possible to get a clear picture of net leavers and net joiners. For example, for the period 1st July - 30th September, the headcounts for joiners and leavers were 1,897 and 1,512 respectively, implying a net increase of 385. However, the actual change in the workforce was a decrease of 240 in headcount between those two dates. How this data can be improved is currently under consideration.

Current GP pay

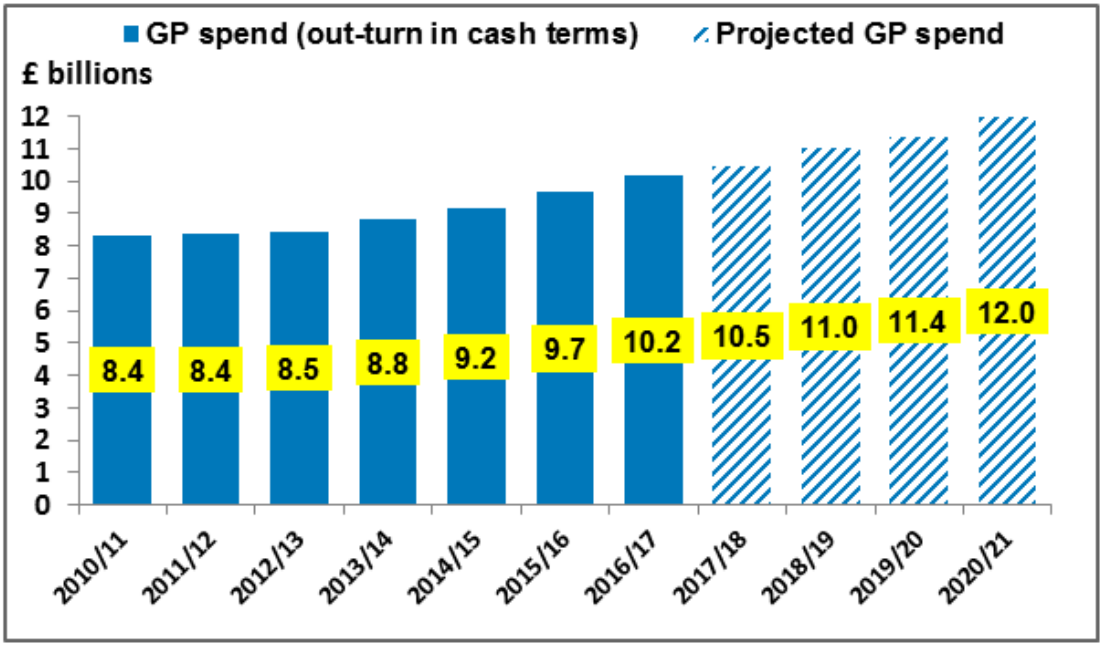
9.11. NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the BMA negotiated an agreement on the GP contract for 2017/18 outside of the DDRB process. This agreement was for investment of £238.76 million[xviii], to deliver a pay uplift of one percent and an expenses uplift of 1.4 percent. The agreement also included changes to the GP retention scheme with an additional £1 million investment, funding to cover expenses for the submission of data for the NHS Digital Workforce Census, and funding for Care Quality Commission fees.

9.12. The General Practice Forward View set a commitment to address rising indemnity costs. These are considered to be an expense for GPs, and £30million funding was included in the contract agreement for 2017-18 to cover indemnity inflation rises[xix].

9.13. Negotiations on changes to the GP contract for 2018/19 are on-going.

Spend on General practice

9.14. Total spend in general practice in England, was £10.2 billion[xx] in 2016/17. This was an increase of 5.2% relative to the £9.7 billion spent on general practice in 2015/16. Total spend on general practice has increased in nominal terms every year since 2003/04 (the first year that data was available). The biggest year-on-year increases were in 2004/05 (19%).



Investment in general practice is increasing in line with commitments in the GP Forward View.

9.15. Taking into account inflation[xxi], total investment in general practice in England was on a declining trend from 2005/06 to 2012/13. However, the last four years of data both show a real increase in expenditure. Total real expenditure in 2016/17 (again using 2016/7 prices) was 35% higher than 2003/04 levels.

GP earnings

9.16. The latest data from NHS Digital[xxii] show that the average income before tax in 2015/16 for a contractor GP was £104,900 in England, compared to £103,800 in 2014/15.

9.17. Figure 9.5 shows the change in contractor GP income in England since 2003/4 in both nominal and real terms (2014/15 prices). The data in this table represent average earnings for GP contractors in both GMS and PMS practices and are based on a survey of GPs' actual earnings by headcount and not by FTE

Fig 9.5 - GMS and PMS contractors in England, Earnings and Expenses - all practice types

	Estimated earnings and expenses			Estimated earnings and expenses in real terms (2014/15 prices)		
Year	Gross Earnings	Total Expenses	Income Before Tax	Gross Earnings	Total Expenses	Income Before Tax
2002/03	£191,777	£116,671	£75,106	£248,588	£151,233	£97,355
2003/04	£212,467	£127,672	£84,795	£269,360	£161,860	£107,500
2004/05	£241,795	£138,231	£103,564	£298,618	£170,716	£127,902
2005/06	£257,563	£143,950	£113,614	£309,822	£173,157	£136,665
2006/07	£260,764	£149,198	£111,566	£304,442	£174,188	£130,254
2007/08	£266,110	£155,971	£110,139	£303,340	£177,792	£125,548
2008/09	£274,100	£164,500	£109,600	£304,200	£182,600	£121,600
2009/10	£278,100	£168,700	£109,400	£304,400	£184,600	£119,800
2010/11	£283,000	£175,300	£107,700	£304,200	£188,400	£115,800
2011/12	£284,300	£178,200	£106,100	£301,400	£189,000	£112,500

2012/13	£289,300	£184,200	£105,100	£300,400	£191,300	£109,100
2013/14	£290,900	£189,000	£101,900	£297,200	£193,100	£104,100
2014/15	£302,600	£198,800	£103,800	£304,600	£200,200	£104,500
2015/16	£315,600	£210,800	£104,900	£315,600	£210,800	£104,900

9.18. The corresponding data for salaried GPs in England are shown below. The real average pre-tax income of salaried GPs in 2015/16 was £55,900, compared to £53,700 in 2014/15. Again, these figures are based on headcount data so will not take account of part time working. Note that in March 2017, the participation rate for salaried GPs in England was 67%.

Fig 9.6 - Salaried GPs England –Earnings and Expenses

Year	Report Population	Gross Employment Earnings	Gross Self Employment Earnings	Total Gross Earnings	Total Expenses	Total Income Before Tax
2006/07	4,704	£47,354	£12,891	£60,245	£6,139	£54,106
2007/08	4,665	£49,854	£12,337	£62,191	£6,260	£55,931
2008/09	5,991	£50,300	£13,800	£64,200	£6,800	£57,400
2009/10	6,650	£50,800	£14,700	£65,500	£7,100	£58,300
2010/11	7,000	£50,000	£15,100	£65,100	£7,300	£57,900
2011/12	7,050	£49,600	£14,800	£64,400	£7,300	£57,000
2012/13	7,550	£49,200	£15,500	£64,700	£8,100	£56,600
2013/14	8,000	£48,200	£15,800	£64,100	£9,200	£54,900
2014/15	8,750	£47,800	£14,700	£62,500	£8,700	£53,700
2014/151	8,750	£50,800 r	£14,700	£65,500 r	£8,700	£56,700 r
2015/16	7,250	£51,500	£12,300	£63,900	£7,900	£55,900

9.19. The data for 2015/16 for contractor and salaried GPs by contract type are shown in the table below.

Fig 9.7 - GP Contractors' earnings and expenses by Contract Type , England, 2015/16

	Gross Earnings	Total Expenses	Income Before Tax
GMS	£304,900	£201,000	£103,800
PMS	£336,000	£229,200	£106,800

Fig 9.8 - Salaried GPs earnings and expenses by Contract Type, England, 2015/16

	Gross Earnings	Total Expenses	Income Before Tax
GMS	£63,700	£9,000	£54,700
PMS	£64,000	£6,800	£57,200

9.20. Mean earnings, expenses and income by age group for GPMS contractors in the UK are set out in the table below

Fig 9.9 – Mean earnings and income by age for all GPMS contractors, UK				
All GPMS contractors, UK	Age band	Average Total Gross Earnings	Average Total Expenses	Average Total Income Before Tax
2015/16	under 40	£255,000	£163,200	£91,800
	40-49	£291,400	£190,500	£100,900
	50-59	£306,400	£199,200	£107,200
	60+	£287,900	£184,900	£103,000

Fig 9.10 - Mean earnings and income for salaried GPs, UK				
All salaried GPs, UK	Age band	Average Total Gross Earnings	Average Total Expenses	Average Total Income Before Tax
2015/16	under 40	£61,700	£7,300	£54,400
	40-49	£64,000	£8,100	£55,900
	50-59	£72,000	£9,300	£62,700
	60+	£60,300	£9,100	£51,100

GP Trainers' grants

9.21. The GP trainer grant which, was previously published in an annex of the Directions to Health Education England[xxiii], is now published as part of the document containing GP Educator pay scales[xxiv] and is currently £7,908.

9.22. In line with the Heads of Terms for negotiations and the ACAS agreement of May 2016, the new contract for doctors and dentists in training extends to GP specialty trainees (GPSTs) in the general practice setting as well as in hospital posts, replacing the terms and conditions previously contained in Directions to Health Education England (regarding payments to GP practices in respect of GP trainees). See chapter 7 of the 45th DDRB report regarding the GP trainee supplement and the support service for GP practices employing GP trainees from August 2017.

9.23. The Department continues to work with stakeholders to develop a tariff based approach for funding clinical placements in GP practices for medical students and trainees. During 2017, the Department has collected information from GP practices to better understand the costs incurred from having medical students and trainees on placement. The outcomes of this exercise are being used to determine the timescales and funding to support the introduction of a tariff payment mechanism.

General Medical Practitioner (GMP) Appraisers' rates

9.24. Since 2002, medical appraisal has been a requirement for general practitioners, as part of the revalidation process. In the forty-fifth report, DDRB said that the GMP Appraisers' rate will be kept under review and that DDRB would welcome evidence on the situation in future rounds.

The Department does not have any further evidence on the rate or on recruitment of GMP appraisers.

GP recruitment and retention

9.25. NHS England and Health Education England (HEE) are working together with the profession to increase the GP workforce. This includes measures to boost recruitment into general practice, encourage GPs to return to practice, and address the reasons why experienced GPs are considering leaving the profession.

Recruitment

9.26. The first round of recruitment to specialty GP training for 2017 saw an increase in total accepted filled posts of 1.26% compared with 2016. In 2016, there were 3,019 new starters recruited to specialty GP training posts. This is the highest number of GP trainees ever.

9.27. While GP training places are increasing year-on-year and many GPs are returning to practice, many practices continue to face recruitment issues, and newly qualified GPs are often working as locums rather than joining a practice as a permanent GP. Some older GPs are also leaving the profession early. This is leaving a gap between the number of doctors practices want, and the numbers they are successfully recruiting and retaining. That is why NHSE are working with partners to partly bridge that gap through scaling up targeted international recruitment, alongside a number of other initiatives.

- In August 2017, NHS England announced plans to accelerate its international recruitment to 2,000 GPs in the next three years. This is an increase from the 500 international GPs which was the original target in the GP Forward View. Further recruitment initiatives include:
- The Targeted Investment in Recruiting Returning Doctors Scheme was a pilot that invested resources in GP practices which could evidence that they have historically encountered difficulty in recruiting GPs. The pilot scheme offered support to practices to promote and advertise their posts. 50 practices took part in the scheme. NHSE are currently in the process of evaluating the scheme.
- The Targeted Enhanced Recruitment Scheme funds a £20,000[xxv] salary supplement to attract GP trainees to work in areas of the country where GP training places have been unfilled for a number of years. The scheme was launched as a one-year pilot in 2016 and was extended for a further year in 2017 and again in 2018.The scheme is open to GP trainees committed to working for three years in areas identified by the GP National Recruitment Office (GPNRO) as having the hardest to recruit to training places in England. The scheme was initially for 122 places of which 109 were filled in 2016 and has been extended to cover 144 training places in 2017 and up to 200 places will be available in 2018.

Retention and Return to practice

9.28. To improve retention, NHS England has launched:

- GP Career Plus which is testing a range of ways to offer greater flexibility and support in order to keep hold of the vital skills and experience of GPs on the verge of leaving general practice. 10[xxvi] pilot schemes are now running with publicity campaigns underway. NHS England will use this learning to develop a sustainable model for ongoing local use.
- The GP Retention Scheme is a package of financial and educational support to help doctors, who might otherwise leave the profession, remain in clinical general practice. The scheme supports both the retained GP (RGP) and the practice, employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support. RGPs may be on the scheme for a maximum of five years with an annual review each year to ensure that the RGP remains in need of the scheme and that the practice is meeting its obligations.
- The National GP Induction and Refresher Scheme provides a safe, supported and direct route for qualified GPs to join or return to NHS general practice in England. To date, a total of 529 GPs had applied to join the scheme. Of these 133 GPs have completed the scheme and are now able to work in practice without conditions. A further 190 are currently on the scheme either undertaking assessments or placements.

Workload

9.29. Manchester University published the Eighth National GP Worklife Survey on Wednesday 23rd September 2015. Findings included:

- GPs reported most stress with: increasing workloads; imposed job changes; having insufficient time to do the job justice; paperwork and increasing demand from patients.
- Workload was the top stressor, as in each of the previous surveys.
- In addition, the following all saw increased reporting amongst GPs: being required to do unimportant tasks, preventing completion of more important ones; not having sufficient time to carry out all work; having to work fast; and working very intensively.
- The largest fall in satisfaction rating is for hours worked, which has fallen by 13% from 4.09 in 2012 to 3.56 in 2015. Satisfaction is measured on a 7-point scale where 1 represents the lowest satisfaction rating, and 7 is the top rating. Average satisfaction for working hours has now fallen below neutral into the 'dissatisfied' portion of the scale, for the first time since 2004. The change in the average satisfaction that GPs report for their working hours has occurred even though the reported hours worked and the reported content of those hours has changed little since the previous survey.
- Workload is the key factor in GP recruitment and retention problems, and addressing workload includes increasing GP workforce supply through the range of actions described above, as well as financial incentives

9.30. NHS England is working to address GP workload issues through new initiatives such as:

- The Releasing Time for Care Programme[xxvii], designed to help practices implement change to release time more quickly and sustainably, has formed 93 cohorts, covering 125 CCGs and reaching 4,103 practices. A series of workshops have reached around 4,800 participants [at October 2017], and survey responses suggest that attending the workshop has had an immediate and substantial effect on practice's optimism.
- As of October 2017, the General Practice Resilience Programme, which supports at risk practices, had selected 2,054 GP practices to be part of the scheme.192 hubs (groups of practices receiving the same support) have been created.
- A new GP Health Service, supporting GPs suffering from burnout and stress, was launched in January 2017. It has been well-received by the sector, and at the end of October 2017, 913 GPs have accessed the service (654 new patients since January and 259 existing patients transferred from other services).

Older GPs leaving the profession

9.31. The issues relating to older GPs leaving the profession have been outlined in Chapter 12 on Pensions and Total Reward, including data on GP voluntary early retirements, numbers of opt-outs and those leaving the service.

Further Developments in General Practice

9.32. In April 2016, NHS England published the General Practice (GP) Forward View[xxviii], a package of support for general practice. The GP Forward View set out:

- an investment of an extra £2.4 billion a year for general practice services by 2020/21 (a 14% increase in real terms);
- a range of measures to increase the workforce, tackle high GP workloads, help improve patient access to general practice, and invest in new ways of providing primary medical care.

9.33. See paragraphs 9.25 to 9.28 for progress made on recruitment and retention measures. Further progress on other initiatives is set out below.

GP Indemnity

9.34. Following the 2016 GP Indemnity Review, DH and NHS England have recognised that the cost increases have reached the point where they are now unsustainable for GPs, and constraining operational priorities in primary care. NHS England have committed to providing additional funds to GPs in 2017 and 2018 to reflect the inflation in indemnity prices. NHS England has also announced additional money for indemnity cover over the

coming winter. The cost inflation has been of concern for the Medical Defence Organisations (MDOs) for some years, and the model of MDO cover has also been undermined by other changes under way which naturally shrink the pool of MDO members, such as GPs retiring, more GPs working for Trusts and GPs moving to new models of care.

9.35. The Secretary of State for Health announced on 12 October 2017 that the Department of Health and Social Care is evaluating the possibility of developing a state-backed indemnity scheme for general practice in England. The ambition is to deliver a more stable and more affordable system for GPs and their patients. The scheme could provide financially sustainable cover for future, and potentially historic, claims arising from the delivery of NHS services. This commitment by the Government will also ensure that general practice is an attractive long-term career option that gives stimulus and stability to medical graduates.

Access to General Practice

9.36. In October 2013, the former Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. That funding was invested in 2014/15.[xxix] Further funding of £100 million for 2015/16 was announced on 30 September 2014 for a second wave which was invested in 2015/16. Bringing both waves together, the GP Access Fund covered more than 2,500 practices and a population of over 18 million people. NHS England from April 2017 is rolling out improved access to GP services nationally in keeping with the NHS Operational Planning and Contract Guidance 2016. CCGs have put in place plans to ensure full national coverage by March 2019, so that by that date the whole population will have access to routine weekend or evening appointments.

9.37. The GP Forward View committed £500 million by 2020/21 to enable clinical commissioning groups (CCGs) to commission and fund additional capacity across England to ensure that, by 2020 everyone has access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services. The Conservative Party Manifesto 2017 sets out the ambition that by 2018 the whole population will be able to get routine weekend or evening appointments at either their own GP surgery or one nearby. The Government's Mandate to NHS England sets delivery for 2017-18 at a total of 40% of the population having access to enhanced GP services, including evening and weekend access.

New Care Models

9.38. The New Care Model (NCM) Programme has been introduced to trial approaches to[xxx]:

- breaking down organisational barriers in order to deliver the personalised and coordinated health services patients need;
- partnerships with patients over the long term rather than providing single, unconnected ‘episodes’ of care; and
- ensure out-of-hospital care becomes a much larger part of what the NHS does with services integrated around the patient.

9.39. A number of these models are developing a ‘whole population’ approach to delivering services:

- Multi-speciality Community Provider: An MCP is a new type of integrated provider bringing together the delivery of primary, community, and mental health services, along with, in some places, adult social care and some services currently delivered in hospitals.
- Primary and Acute Care Systems: A PACS is a new type of integrated provider bringing together acute hospital services, the delivery of primary, community, and mental health services, along with, in some places, adult social care
- Primary Care Hub (also known as a Primary Care Home): The PCH model provides care for a registered population of between 30,000 and 50,000 people. Coming together in hubs of this size facilitates an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care. It aims to align clinical and financial drivers with appropriate shared risks and rewards to deliver a combined focus on the personalisation of care with improvements in population health outcomes. PCHs may be standalone entities or sub-contractors of a MCP/PACS.

9.40. Compared to their 2014/15 baseline both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England. Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.

9.41. GP practices will have the option to either surrender their existing contracts and join an MCP/PACS to deliver primary medical services; suspend their existing contract and provide primary medical services through arrangements with an MCP/PACS; or retain their existing contract and work with the MCP/PACS to deliver primary medical services.

10. General Dental Practitioners

10.1. This chapter provides an update on general dental practitioners (GDPs) providing NHS primary care services.

Workforce Numbers and Recruitment and Retention

10.2. In England, NHS England commissions NHS primary care dentistry from providers who can be individuals or corporate bodies. NHS dentists can be either provider-performers (holding a contract with the NHS) or performers only (working for practice owners or corporate bodies). NHS dentists can also offer private care alongside NHS services.

10.3. NHS Digital publishes data on the number of dentists who have delivered NHS dentistry in any given financial year. This is based on data from NHS Business Service Authority who process dental payments and forms. Figures are shown in Figure 10.1.

Fig 10.1: Number and percentage of dentists with NHS activity by dentist type, 2006/07 to 2015/16

	2006/07	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total	20,160	22,799	22,920	23,201	23,723	23,947	24,089
Providing-Performer	7,585	5,858	5,099	4,649	4,413	4,038	3,449
Performer only	12,575	16,941	17,821	18,552	19,310	19,909	20,640

Source: http://digital.nhs.uk/catalogue/PUB21315IntialAnalysispage16Table1.4

10.4. From 2006/07 to 2015/16 the total number of dentists actively delivering NHS services increased from 23,947 to 24,089. During this period, the number of Provider-Performers fell and they now make up only 14.3% of the workforce. The number of performer only dentists rose from 19,909 to 20,640.

10.5. The percentage of dentists (those undertaking NHS activity submitted by FP17) who are female has increased from 38.8% in 2006/7 to 48.0% in 2015/16). This change is continuing as the proportion of dentists leaving the NHS who are female was 45.4% in 15/16, while the proportion of females joining the NHS in 15/16 was 58.7%

10.6. In terms of age groups, the age band that has shown the greatest decline – in proportion – from 2006/7 to 2015/16 is 45-54 (24.0% to 21.3%), while the age group that has increased most is 55 and over (12.6% to 14.4% over the same period)

10.7. This does not indicate a substantial shift in the workforce to those born in the 1980s and 1990s. The relationship between age group and motivation/morale is confounded by the correlation between age of performers and other factors such as weekly hours, amount of annual leave and proportion of NHS work. It is difficult to determine any conclusive Generation Y impact from these demographics.

Earnings and Expenses

10.8. The average taxable income for all dentists in 2015/16 was £69,200, down from £70,500 in 2014/15. This reflects a fall in the average gross income to £148,000 in 2015/16 from £152,500. The level of expenses to gross income ("the expenses ratio") has dropped to 53.3%. The expenses ratio remains towards the lower end of the range seen during the last ten years. Figure 10.2 has details for the last twelve years.

Fig 10.2: Gross income, expenses and taxable income for all dentists from 2004/05 to 2015/16

	Average Gross Earnings	Average Expenses	Average Taxable Income	Expenses ratio
2004/05	£193,215	£113,187	£80,032	58.6%
2005/06	£205,368	£115,450	£89,919	56.2%
2006/07	£206,255	£110,120	£96,135	53.4%
2007/08	£193,436	£104,373	£89,062	54.0%
2008/09	£194,700	£105,100	£89,600	54.0%
2009/10	£184,900	£100,000	£84,900	54.1%
2010/11	£172,000	£94,100	£77,900	54.7%
2011/12	£161,000	£86,600	£74,400	53.8%
2012/13	£156,100	£83,500	£72,600	53.5%
2013/14	£155,100	£83,400	£71,700	53.8%
2014/15	£152,500	£82,000	£70,500	53.8%
2015/16	£148,000	£78,900	£69,200	53.3%

Source: https://digital.nhs.uk/catalogue/PUB30077AdditonalAnalysispage18table17.1

10.9. In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist or a Performer only dentist. Generally, Provider-Performers tend to

earn more, however, the changing ratio of Providing-Performers to Performer only dentists (as seen in Table 11.2) has moved the average figure closer to the – lower-earning – Performer only dentists. In 2015/16 Providing-Performer dentists had an average taxable income £115,700 a fall from £117,400 in 2014/15. In contrast, a Performer only dentist saw their average taxable income increase to £60,200 in 2015/16 compared to 2014/15 when it was £59,900

10.10. A number of factors make it difficult to compare the level of earnings and gross income from one year to another. These factors include variations in hours worked, in the balance between NHS and private sector activity, the evolving nature of practice business models and the rise of incorporation.

Motivation and Morale

10.11. The Dental Working Hours: Motivation and Morale 2014/15 & 2015/16 report was last published by NHS Digital in December 2016. Motivation is regarded as the internal drive of an individual, e.g. inspiration or enthusiasm. The difference in average motivation between 2013/14 and 2015/16 for Provider-Performers is -0.6%, for Performers the difference is -3.5%. This is shown in the table below:

Fig 10.3: Average motivation results; Average morale results 2012/13-2015/16

	Average motivation (%)		Average Morale (%)	
	Provider-Performer	Performer only	Provider-Performer	Performer only
2012/13	48.3	48.2	27.3	42.1
2013/14	45.7	48.8	27.2	42.7
2014/15	47.5	44.3	22.8	32.9
2015/16	45.1	45.3	22.2	33.4

- Average of ‘strongly agree’ or ‘agree’ responses to the motivation questions
- Percentage of dentists who recorded their morale as ‘very high’ or ‘high’

10.12. In 2015/16, Performer only dentists responded more positively than Provider-Performer dentists with a 45.3% ‘strongly agree’ or ‘agree’ response compared to 45.1%.

10.13. Morale generally relates to comfort and satisfaction. Performer only dentists appear to have higher morale than Provider-Performers. In 2015/16, 33.4% of Performer only dentists answered ‘very high’ or ‘high’ to the question ‘How would you relate your morale as a dentist?’ This contrasts to only 22.2% of Provider-Performer dentists. The

difference in average morale between 2013/14 and 2015/16 for Provider-Performers is -4.9%, for Performers the difference is -9.3%.

10.14. Comparing the data published by NHS Digital for 2012/13 and the BDA Business Trends Survey for 2012, the BDA data reports a higher motivation score for Provider–Performer dentists (58%) than the NHS Digital published survey (48.3%). However, it is difficult to draw too many conclusions from the differences, as the population groups covered by the survey differ. For example, the BDA only canvassed their members, many of them undertaking private only work.

10.15. The Dental Working Group (DWG) is a technical group with a UK wide remit and membership. Its primary role is to carry out agreed programmes of work to meet the requirements of dentists' remuneration (including the associated Review Body on Doctors' and Dentists' Remuneration (DDRB)). The DWG survey covered individuals undertaking more NHS work and working longer hours.

Early Retirements

10.16. The NHS Business Services Authority (NHSBSA) administers the NHS Pension Scheme (NHSPS) for England & Wales.

10.17. Figure 10.4 provides information over a five year period for NHS hospital and community dentists in England and Wales who elected to take their (1995) NHS pension and is broken down into specific age groups. The numbers appear to be low because the data provided by the NHSBSA only relates to hospital/community dentists who are recorded as 'specialists'. This will include maxillofacial surgeons but is not exclusive to that group.

10.18. Figure 10.5 provides the same information in respect of all GDS/PDS General Dental Practitioners.

10.19. The data provided in tables 10.4 and 10.5 only relates to NHS dentists (dentists undertaking some NHS activity) with fully protected 1995 Section membership of the NHS Pension Scheme and those who were (1995/2015) transition members. This will, however, cover the vast majority of NHS dentists and gives a clearer picture of those who potentially left the NHS before age 60.

10.20. The tables do not provide details of NHS dentists who were fully protected 2008 Section members or 2008/2015 transition members. Their normal pension age is 65+ and their minimum pension age is 55.

FIG 10.4: 1995 & 1995/2015 NHSPS - NHS HOSPITAL/COMMUNITY DENTISTS

PENSION YEAR (1 April to 31 March)	TOTAL NUMBER OF HOSPITAL/COMMUNITY DENTISTS CLAIMING THEIR NHS PENSION	THOSE UNDER AGE 40	THOSE AGED 40+ & UNDER AGE 50	THOSE AGED 50+ & UNDER AGE 60	THOSE AGED 60+ & UNDER AGE 70	THOSE AGED 70+
2012/13	11	nil	nil	4	7	nil
2013/14	14	nil	nil	3	10	1
2014/15	14	1	1	2	10	nil
2015/16	12	nil	nil	9	3	nil
2016/17	7	nil	nil	2	5	nil

FIG 10.5: 1995 & 1995/2015 NHSPS – GDS/PDS DENTISTS

PENSION YEAR (1 April to 31 March)	TOTAL NUMBER OF GDS/PDS DENTISTS CLAIMING THEIR NHS PENSION	THOSE UNDER AGE 40	THOSE AGED 40+ & UNDER AGE 50	THOSE AGED 50+ & UNDER AGE 60	THOSE AGED 60+ & UNDER AGE 70	THOSE AGED 70+
2012/13	533	nil	13	186	325	9
2013/14	453	2	7	175	266	3
2014/15	484	1	6	190	286	1
2015/16	464	nil	2	175	284	3
2016/17	452	1	nil	158	291	2

10.21. Whilst the figures indicate the number of NHS dentists who claimed their (1995 Section) NHS pension in a specific pension year (broken down into age groups) they do not indicate the number who actually left the NHS. This is because some dentists return to the NHS after claiming their NHS pension, albeit in a reduced capacity. There will also be some who returned to dentistry but only in a private capacity and those that gave up dentistry completely.

10.22. The NHSBSA does not hold data in respect of the number of dentists who retire ‘per se’ by virtue that some retire in a non-pensionable capacity. Those dentists who took their

NHS pension under the age of 50 will have all retired on ill-health grounds. Where an NHS dentist was both a hospital/community dentist and a GDS/PDS dentist at the point of retiring they have not been counted twice; they have only been included in table B.

Brexit

10.23. There is a lack of good quality data on the nationality of dentists currently practising in England, however previous estimates have been 16-18% are those that are EEA-trained. Further analysis will be undertaken as data becomes available.

Supply of Dentists and status of NHS Contracts

10.24. We are not aware of any robust evidence to suggest there are significant national recruitment and retention issues. DH does not hold information on vacancies, supply of dentists or status of contracts. NHS England, as commissioners of dental services are better placed to respond to this.

Targeting

10.25. Targeting is unlikely to be effective because for General Dental Practitioners (GDS contracts and PDS agreements) commissioners already have the ability to target and commission new services where there is need. They have the flexibility to commission services at an appropriate contract value to reflect local circumstances including the cost of service provision, potential service availability and the level of need.

Dental contract reform

10.26. The Government is committed to reforming the current dental contractual framework including a period of prototyping for a potential new contract (see below). This longstanding commitment, reaffirmed by the current Government, is intended to increase access and improve oral health. The reformed approach will move away from the current all activity remuneration system to a part capitation, part activity model. Capitation will provide financial drivers that align with the new clinical approach, focussed on prevention as well as treatment.

10.27. The clinical approach has been tested for a number of years and since April 2016 selected practices have been testing this with the proposed new remuneration system. Two variations of the combined capitation and activity approach are being tested.

10.28. A full evaluation led by a senior clinician and a reference group with external membership is now close to completion. It covers the first full year of prototyping. A

number of engagement events with stakeholders were held in September and October 2017, the outputs from which will inform the evaluation. The report is expected to be completed this autumn and decisions will then be made on next steps for the approach in 2018/19. Key stakeholders such as the BDA, NHS England and representatives from the profession continue to be engaged in the programme and are members of the Contract Reform National Steering Group.

Community Dental Services

10.29. Salaried dentists working in Community Dental Services (CDS), which are local services commissioned by NHS England; provide an important service to patients with particular dental needs, especially vulnerable groups.

10.30. NHS England commissions dental services, including community dental services, in line with local oral health needs assessments undertaken in partnership with local authorities and other partner organisations. These assessments identify the level of dental need for a particular community and pay particular attention to both access to local dental services and the dental health of the local population.

10.31. The Department of Health and Social Care believes that CDS fill an important role in dental health service provision and are not aware of any specific difficulties in filling vacancies faced by Providers.

10.32. Three CDS practices are prototypes participating in the national contract reform programme. They will continue to test the new clinical approach with their specific, and usually vulnerable, patient groups.

10.33. The terms and conditions for salaried dentists directly employed by the NHS are negotiated by NHS employers on behalf of the NHS.

11. Ophthalmic Practitioners

11.1. The Department of Health and Social Care remains firmly of the view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out nearly 99.9 per cent of NHS sight tests. Commissioning of the NHS sight testing service in England is the responsibility of NHS England. Discussions are to take place with representatives of the professions on fees for 2017/18.

Background

11.2. Between 31 December 2014 and 31 December 2015, the number of OMPs who were authorised by the NHS England in England and the number in Local Health Boards in Wales to carry out NHS sight tests decreased from 274 to 252, and the number of optometrists increased from 12,329 to 12,702 an increase of 3.0 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

11.3. In 2015/16, 13.75 million sight tests were paid for by NHS England and LHBs in Wales. This was 1.7 per cent less than in 2014/15. There were no sight tests carried out by OMPs in Wales in 2014/15.

Sources

General Ophthalmic Services, Workforce Statistics, England and Wales - 31 December 2015.
http://digital.nhs.uk/searchcatalogue?productid=20262&topics=1%2fPrimary+care+services%2fEye+care+services&sort=Relevance&size=10&page=1#top

General Ophthalmic Services activity statistics - England, year ending 31 March 2016.
http://digital.nhs.uk/searchcatalogue?productid=21325&topics=1%2fPrimary+care+services%2fEye+care+services&sort=Relevance&size=10&page=1#top

Eye care statistics for Wales, 2015-16. *http://gov.wales/statistics-and-research/eye-care/?lang=en*

http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/business-trends.aspx

12. Pensions and Total Reward

Introduction

12.1. The NHS Pension Scheme remains a valuable part of the total reward package available to NHS doctors and dentists.

12.2. Eligible members of the NHS workforce will now belong to one of the two existing schemes. The final salary defined benefit scheme consisting of the 1995 and 2008 sections is now closed, other than for a limited group who are eligible for age-related protection. The new NHS Pension Scheme 2015 is a career average revalued earnings (CARE) scheme. Self-employed doctors and dentists (practitioner members) also had their benefits in the 1995/2008 sections calculated on a CARE equivalent basis. The key differences between the two schemes, other than the way benefits are calculated, are different normal pension ages (1995 section – 60, 2008 section – 65, 2015 Scheme – state pension age) and accrual rates (1995 section – 1/80th, 2008 section – 1/60th, 2015 Scheme – 1/54th).

12.3. The new NHS Pension Scheme 2015 continues to provide a generous pension for NHS staff and remains one of the best schemes available. The Government Actuary's Department calculates that NHS members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed. The NHS Pension Scheme is backed by the Exchequer and is revalued in line with price inflation; providing a guaranteed retirement income.

12.4. A junior doctor commencing employment and membership of the 2015 scheme from August 2016 (retiring at 68) can expect a pension of around £61,600 p/a if s/he progresses to be a full-time consultant1.. A similar junior doctor progressing to be a part-time consultant can expect a pension of around £52,600 p/a. Junior doctors progressing to be GPs can expect a pension of around £63,000 p/a1.

Pension Scheme Contributions

12.5. The employer continues to pay more towards the cost of the scheme than the majority of the workforce, currently contributing 14.3% of pensionable pay. Employee contributions are tiered according to whole-time equivalent earnings, with the rate paid by the lowest earners being 5% and the highest is 14.5% for those earning £111,377 or above.

12.6. Member contribution rates and earnings tiers have been frozen since 1 April 2015, and will remain set until 31 March 2019. It is expected that around 10% of members will see their contribution rate increase (by between 0.6% and 3.2% of pensionable pay, depending where they are in the pay range) at some point during the four years 2015-

2019. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

Fig 12.1: Employee contribution rates

WTE Pensionable Earnings/Pay	Contribution Rate
≤ £15,431	5.0%
£15,432 - £21,477	5.6%
£21,478 - £26,823	7.1%
£26,824 - £47,845	9.3%
£47,846 - £70,630	12.5%
£70,631 - £111,376	13.5%
≥ £111,377	14.5%

12.7. In their 2017 report, the NHS Pay Review Body noted that this approach had in some cases led to significant reductions in take home pay for individuals whose pay award meant that a higher contribution tier applied. This also has relevance to doctors. A recommendation was made for the Department to ensure annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds.

12.8. In a Written Ministerial Statement1 to the House of Commons on 28 March 2017, the Secretary of State for Health confirmed that this recommendation will be considered as part of the four yearly valuation of the NHS Pension Scheme. This is a process that determines the appropriate level of employer and employee pension contributions from 1 April 2019.

12.9. The Department has asked the NHS Pension Scheme's Scheme Advisory Board[xxxi] to review the approach to member contributions with a view to reaching agreement on new rates for implementation from 1 April 2019. A number of design aspects will be explored, including the range and number of tiers, whether the rate payable should be determined using whole-time equivalent or actual earnings, and providing for tier boundaries to increase in-line with general pay uplifts.

Pension scheme membership

12.10. The Department continues to monitor changes in scheme membership using data from ESR. Annex A presents the position as of May 2017, and shows the percentage point change over the previous month, the last 12 months and from October 2011

12.11. Membership amongst employed doctors remains high. 92% of employed doctors are members of the pension scheme. The rate decreased by 0.8 percentage points compared to May 2016, and 0.3 percentage points less than the Oct 2011 position. However on a one-month view, the rate increased by 0.3 percentage points for the period April to May 2017.

12.12. The Doctors and Dentists Review Body recommended in their forty-fifth report that evidence be provided on how many doctors and dentists are taking early retirement and the reasons1. The following table shows the number of employed doctors, GPs and dental practitioners claiming their NHS pension earlier than their normal pension age. The figures are based on membership data from the NHS Pension Scheme.

Fig 12.2: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis

	Medical Doctors		General Practitioners		Dental Practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2011/12	-	-	513	33	-	-
2012/13	201	17	591	42	186	35
2013/14	187	14	746	50	175	39
2014/15	222	17	738	51	190	39
2015/16	226	18	677	54	175	38
2016/17	241	19	721	62	158	35

12.13. The decision to claim payment of pension is an individual one. The NHS Pension Scheme does not require members at the point of claim to give a reason. It is therefore difficult to assign and give relative weight to specific factors that contribute to early retirements.

12.14. However claiming an NHS pension does not necessarily mean that individuals have left NHS service permanently. The 'retire and return' employment flexibility enables NHS employers to support skilled and experienced staff who are approaching retirement and may otherwise retire and leave service, to continue working longer with less onerous commitments or fewer hours typically. It is a flexibility well known and used by GPs. There is no cost to the taxpayer or employers as the pension has been fully paid for, with any early payment cost recouped by reducing the pension. However returning to work is not a right: the employer has to agree to re-employ the individual, who must

resign in order to draw their pension. The Department has published guidance to NHS employers on the appropriate use of retire and return[xxxii].

12.15. In addition to early retirements, the following table presents data on the number of GPs, employed doctors and other high earners who opt-out or leave service. This is based on scheme valuation data as of 31 March 2016. The numbers leaving service are gross, and do not account for the fact that some will re-join active service.

Fig 12.3: Number of GPs, consultants and other high earners who opt-out or leave service

	All members with final WTE pay over £110k		GPs only	
	Opted out	Left service	Opted out	Left service
2012-13	715	1,098	397	3,472
2013-14	801	1,285	459	3,306
2014-15	1,177	1,211	867	2,820
2015-16	801	1,082	518	1,558

12.16. Increases to member contributions in recent years, and the increase to employee National Insurance contributions resulting from the abolition of contracting out, do not appear to have led to significant numbers leaving the scheme in net terms.

12.17. However there is evidence of high earning individuals opting-out of the scheme or leaving NHS employment through early retirement. This may be due to the effect of the new lower lifetime and annual allowances tax limits which potentially affect some high earners. From 6 April 2016 these allowances reduced:

- The lifetime allowance is £1m, and will increase annually by CPI.
- The annual allowance now tapers from the standard £40,000 down to £10,000 at a rate of £1 less allowance per £2 of relevant earnings above £150,000. HMRC calculates relevant earnings to include the value of pension growth over the year.

12.18. Placing these tax measures in context of the 1995 final salary section of the NHS Pension Scheme, individuals who use up the full £40,000 annual allowance would see their annual pension increase by around £2,500. Those who reach the £1m lifetime allowance limit will have built up a pension of around £44,000 a year plus a tax free lump sum of £132,000.

12.19. Where individuals have breached either the annual or lifetime allowance, but not both, it is likely to still be a sound financial decision to continue building up pension, but address

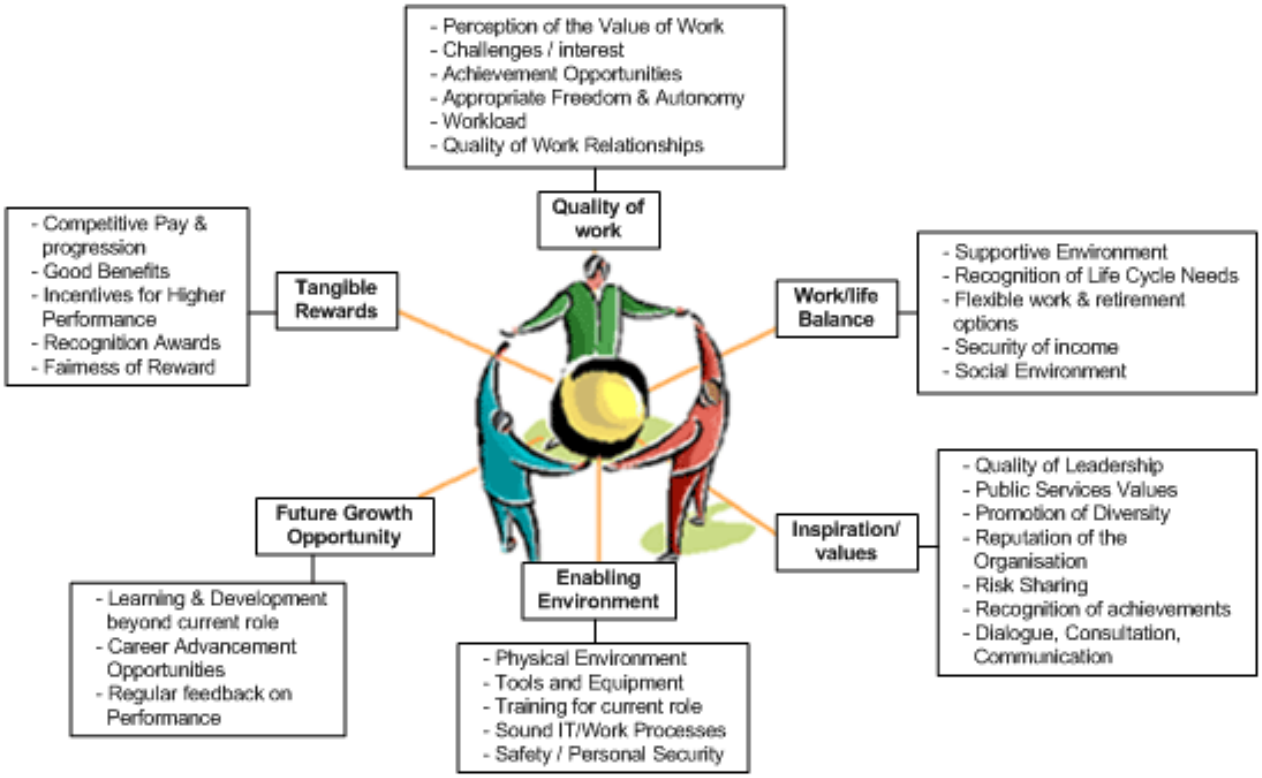
the tax liability by using HMRC's 'scheme pays' facility. Over the course of an average 25 year retirement, an individual can expect the benefit from receiving more pension to outstrip the tax cost of that extra pension.

12.20. The Department notes that greater flexibility within the NHS Pension Scheme may help individuals manage the rate at which their pension benefits build up and create a more dynamic total reward package. The Department is reviewing with HM Treasury the recruitment and retention trends for GPs and consultants, and will explore what if any pension flexibility might be appropriate in the context of total reward and taking account of fiscal considerations.

Total Reward

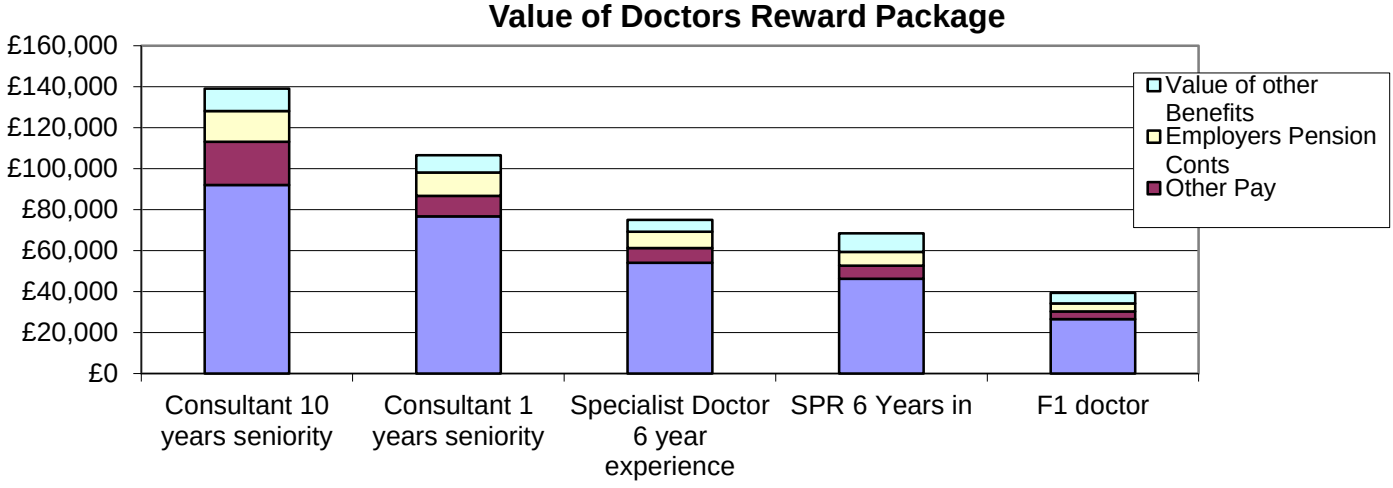
12.21. The Department continues to consider total reward, the tangible and intangible benefits that an employer offers an employee, as central to the ability of NHS employers to recruit and retain staff. There is some evidence that more employers across the NHS are developing a strategic approach to reward which may be a response to: staff demand as access to and use of total reward statements continues to evolve; trusts recognising they may need to do more to recruit and retain staff in an increasingly competitive employment market; employers working to reduce staff sickness and other staff absences by ensuring they are offering the support staff need e.g. for physical and mental health and wellbeing; financial health and wellbeing; trusts recognising the need to promote their overall reward offer in an environment of continued pay restraint.

12.22. The Department's ambitions for the NHS Reward strategy remains that employers should develop their capacity and capability to: utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients, develop and implement local reward strategies that meet organisational objectives and workforce needs; improve staff understanding of their reward package and what options they may have to change aspects of it; strengthen staff experience of working for the NHS; contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill; continue to be at the leading edge of innovation in public sector reward; improve NHS staff satisfaction with pay. For doctors and dentists, satisfaction with their level of pay has increased since 2015 being 58% (satisfied/very satisfied) up from 55%; consultants: 63% up from 62%; doctors in training: 45% up from 44% and "other" doctors 47% up from 43%. The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (below).



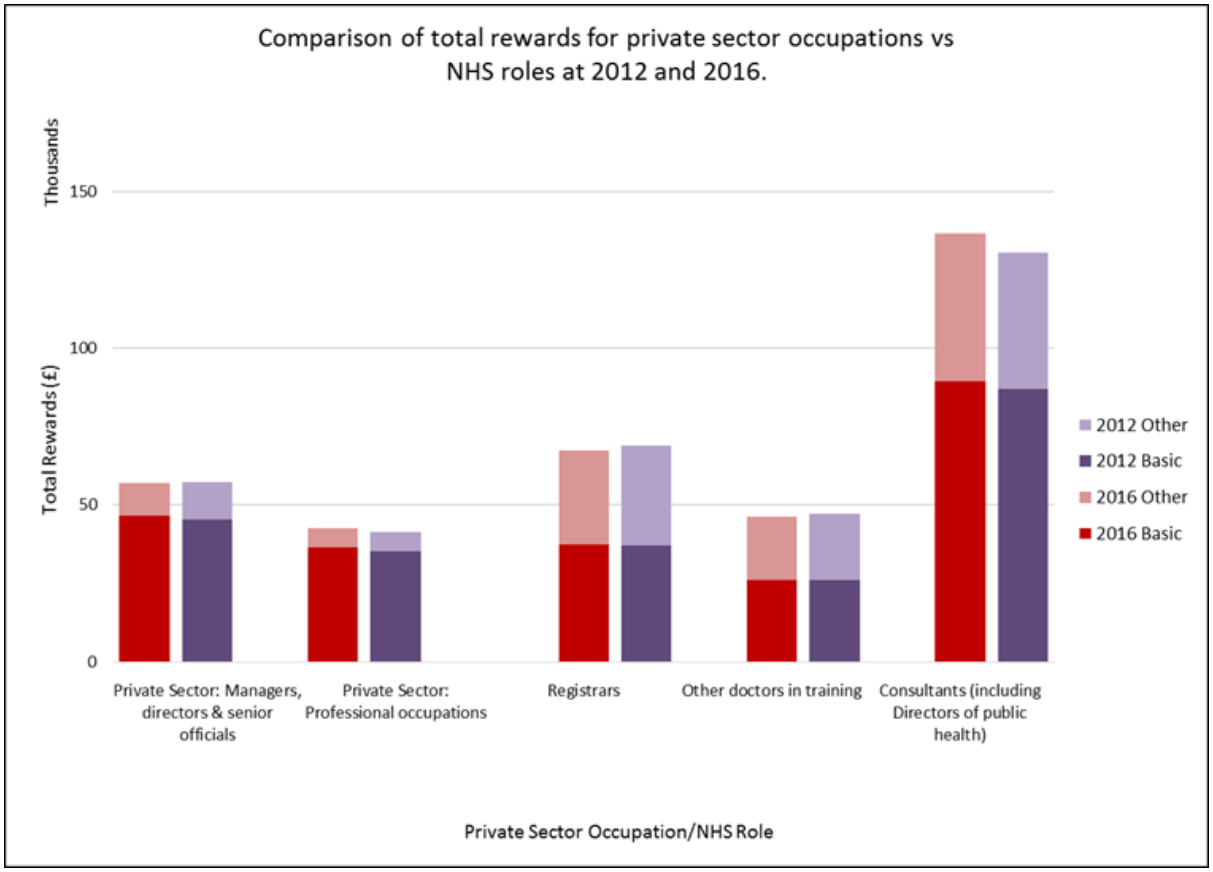
12.23. NHS Employers will, therefore, provide updates on: their work to ensure the strategic context for total reward in the NHS remains "fit for purpose", and aligned with their other work programmes; how their engagement with employers is improving NHS understanding of total reward and why they should be developing their own local reward strategies; their promotion of existing and new tools to support trusts in using strategic reward to deliver local workforce priorities; the continuing development of their total reward engagement network to gain and share intelligence about total reward in the NHS; their promotion of better uptake and understanding of Total Reward Statements.

12.24. The value of reward packages for this remit group is shown in the graph below and includes: basic pay, employers pension contributions, other pay e.g. clinical excellence awards for consultants, out of hours/on call payments, weekend allowances (for Specialist Registrars), extra sessions worked. It also includes: additional leave (over statutory minimum), additional sick leave (over statutory sick pay), and study leave (for doctors in training).



12.25. The Department commissioned the Government Actuary's Department (GAD) to analyse total rewards across various private sector occupations, based on Office for National Statistics (ONS)1 data for salary and pension benefits and compared them against pay rewards for various NHS staff (based on previous GAD analysis) for 2012 and 2016.

12.26. Total Rewards is Basic Salary plus Non Basic Pay, the latter including all other pay elements such as Overtime, Incentives/Other elements of pay, Employer Pension Contributions. The graph below shows the relative change in total rewards over 2012 and 2016 for each of the identified roles, rather than a direct 'like for like' comparison between any one private sector role and NHS role. This is mainly due to the availability of data and difficulty between drawing appropriate comparisons with any one NHS role and other roles. The graph splits basic and non-basic pay for each of the occupations, at 2012 and 2016, and is based on: 2012 Basic / 2012 non-basic = 2012 pension/salary data (private sector occupations), 2011/12 Pay Bands (NHS); 2016 Basic / 2016 non-basic= 2016 pension/salary data (private sector occupations), 2015/16 Pay Bands (NHS).



12.27. Out of the above roles, the only ones to experience an increase in overall total rewards between 2012 and 2016 were private sector professional occupations (about 4%) and consultants (about 5%) between 2012 and 2016.

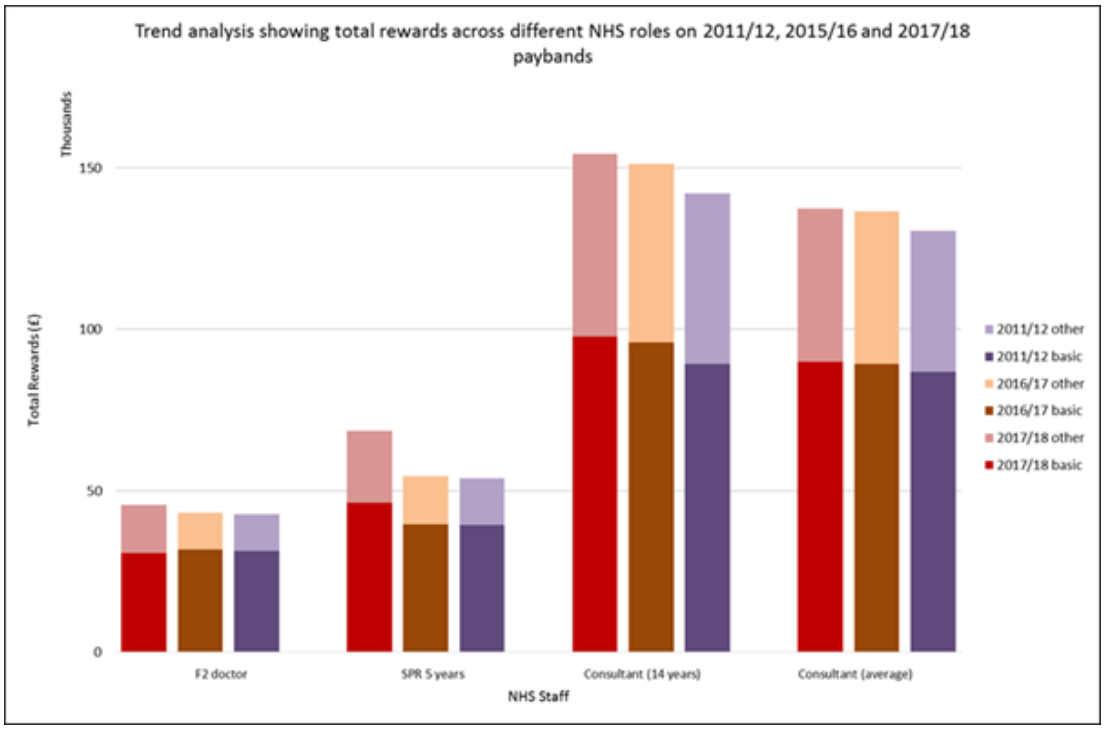
12.28. All other roles analysed saw a reduction in overall total rewards; given that basic pay for all roles in this analysis increased between 2012 and 2016 (or remained the same, as

for doctors in training), the main factor behind the fall in total rewards is the decrease in non-basic pay experienced by Professional Occupations, Registrars and Other doctors in training.

12.29. Non-basic pay makes up a much larger proportion of NHS total rewards across all doctors analysed relative to private sector occupations (about 44% of doctor in training rewards). One driver of this may be higher employer pension contributions available to NHS staff and additional pay elements and awards available, relative to those in the private sector.

NHS Trend analysis:

12.30. GAD also carried out a trend analysis for different NHS staff, based on the previous total rewards analysis that have been carried out at 2011/12 by DH, 2015/16 and 2017/18 carried out by GAD.



12.31. All doctor roles analysed have experienced an increase in total rewards over the period between 2011/12 and 2017/18. All of the roles have more than 30% of their total rewards made up of non-basic pay.

12.32. Consultants with 14 years' experience have had a larger increase in total rewards (9%), than the average consultant total rewards (5%). The reason for this difference is that figures for consultants with 14 years' service are based on the relevant pay band at 11/12 and 15/16 and assumptions made for pay awards (Clinical Excellent Awards, Level 5), out of Hours /on call (3% of basic pay) and overtime (1 additional session assumed at 10% of basic pay). Therefore increases in overall total rewards will be driven by increases in these components. In contrast, for average consultants, figures for these

components are based on average data from NHS Digital. This covers all levels of seniority for consultants which will mean a different mix at 2012 and 2016, causing fluctuations in the overall total pay rewards. This is likely to be the biggest factor driving the difference in increase in total overall rewards, indicating less senior consultants/more junior consultants at 2016, relative to those included in the average at 2012.

12.33. The new 2016 Doctors in Training contract was in place for the 2017/18 analysis. F2 doctors had a relatively small increase of 6% in their total rewards over 2016/17 and 2017/18, but SPRs (5 years' experience) gained a much larger increase of 26% over this same period. This may indicate the relative impact of the change of contract on each of the roles.

Total Reward Statements

12.34. Total Reward Statements (TRS) provide NHS staff with a better understanding of the benefits they have or may have access to as an employee of the NHS. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by your employer. For example, local reward offers by NHS organisations might include: recommend a friend scheme, affordable accommodation, childcare and carer support, counselling and support, various salary sacrifice schemes, discounts, education and learning support, financial wellbeing, physical and mental health and wellbeing etc. For members of the NHS Pension Scheme, TRS may also include an annual pension benefit statement (ABS).

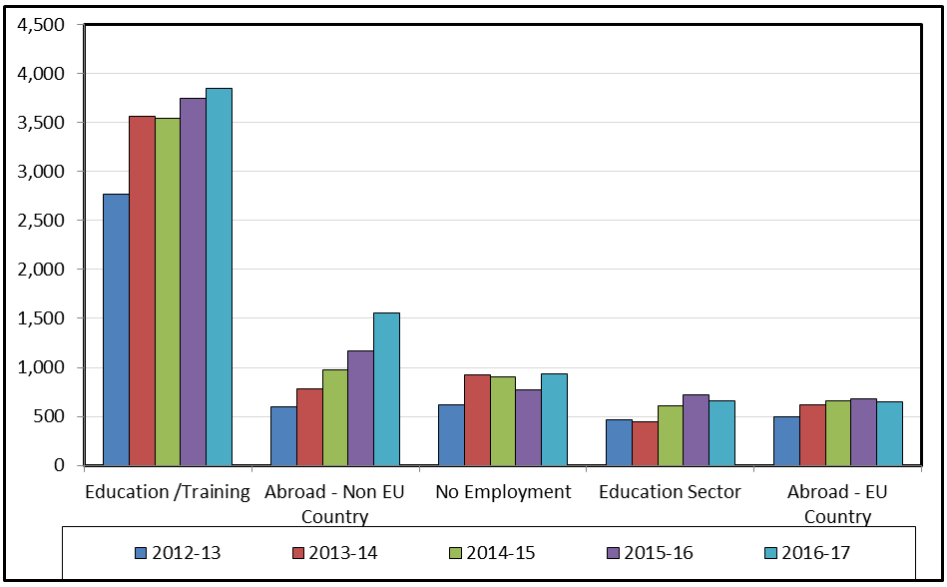
12.35. Since last year, the NHS Business Services Authority (BSA) which is responsible for TRS, have held Stakeholder Engagement Events across the country, tailored to cater for different types of employers with a workshop on TRS so employers understand the role they play in promoting TRS in their organisations and how they can access BSA promotional materials. The workshop also explains the difference between a TRS and an ABS and how BSA creates the TRS. These events continue. BSA has prepared supporting posters sharing with employers the number of TRS accessed nationally and by region and shared these at regional pension groups to promote uptake. BSA has completed introduction emails to over 1 million staff on the Electronic Staff Record aimed at promoting access to TRS in the run up to the TRS refresh.

12.36. The latest access total for this year's TRS is 448,741 compared to 353,220 at the same time last year. Currently there are 2,307,974 TRS available. Refreshed ones were published in August.

12.37. TRS improvements continue including changes to the embedded links following the introduction of BSA's new look website and an update to branding in line with the rest of the NHS. Work continues to put in place alternative arrangements for those who access their TRS via the Government Gateway which ends in 2018 and BSA is also planning to increase the number of TRS available.

13. Annex 1 – Analysis of Joiners (Chapter 5)

Fig 13.1: Number of NHS Joiners from the Five Largest Sources: Time Series

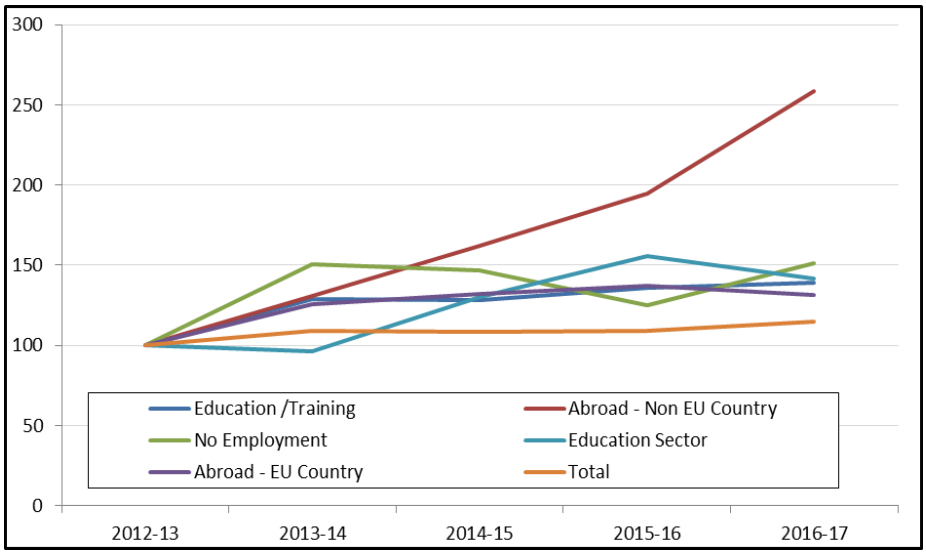


Source: NHS Digital HCHS workforce statistics

13.1. Around a third of joiners from external sourcesxxxiii to the NHS medical workforce come from education and training. The number of new entrants from this source has increased in terms of absolute numbers in the period between 2012/13 and 2016/17. New entrants from non-EU countries have also become a relatively larger component of the new workforce, accounting for around 13% of joiners in 2016/17.

13.2. The number of joiners in the HCHS doctors' workforce has grown by 15% in the last 5 years. The number of new entrants has grown at higher rates particularly in terms of new doctors coming from non-EU countries, as well as of previously not employed staff.

Fig 13.2: Number of Joiners from the Five Largest Sources: Time Series Indices (5 top external sources)

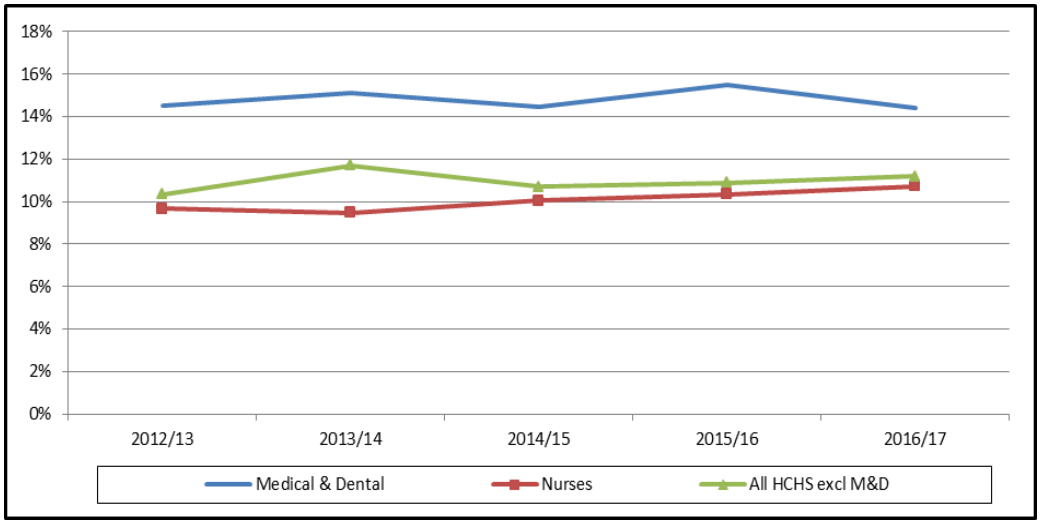


Source: NHS Digital HCHS workforce statistics

14. Annex 2 – Analysis of Leavers (Chapter 5)

14.1. NHS Digital (formerly HSCIC) produces turnover statistics based on information in the NHS Electronic Staff Record. The leaver rate is the percentage of the workforce in the HCHS leaving their staff group in a year. It excludes staff moving between Trusts, but includes people moving from the HCHS to e.g. a GP Practice. The leaver rate for HCHS medical & dental staff was between 14% and 16% per year in the period between 2012/13 to 2016/17. There was a one-off temporary increase in 2013/14 during transformation of the health system, including the transfer of some jobs out of the HCHS into Public Health England. The rate increased between 2014/15 and 2015/16, however decreased in 2016/17 to a rate similar to 2014/15. Across the period, a higher proportion of M&D staff left the NHS per year compared to nurses and the non-medical section of HCHS staff.

Fig 14.1: HCHS Staff Leaver Rates: Time Series



Source: NHS Digital HCHS workforce statistics

Note: the figures include junior doctors, some of whom leave the HCHS as part of their training, e.g. in primary care.

Leavers by region

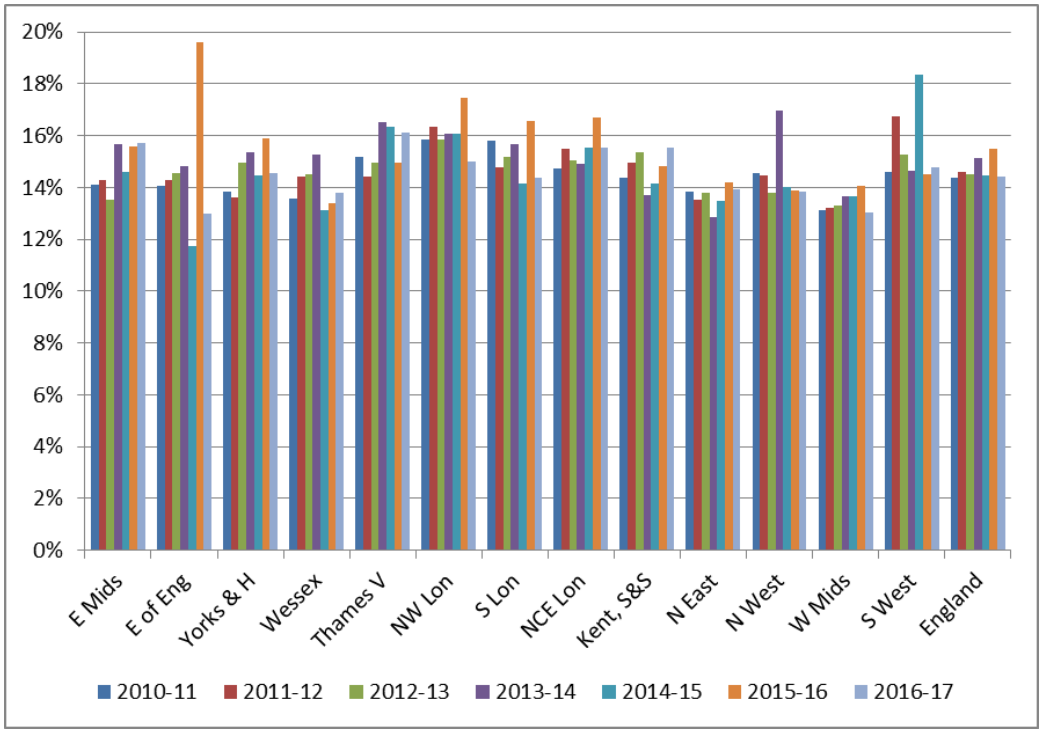
14.2. The data collected by NHS Digital provide a general picture of leaver rates in regions across England. For HCHS doctors, leaver rates vary little between regions, and there are no clear trends. There are signs of possible increase in East Midlands, Yorkshire & the Humber, and some areas of London, but this could be the result of a higher number of moves into Primary Care and/ or Public Health England.

Fig 14.1: 12-months leaver rates by region, HCHS Doctors

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
E Mids	14.1%	14.3%	13.5%	15.7%	14.6%	15.6%	15.7%
E of Eng	14.1%	14.3%	14.6%	14.8%	11.7%	19.6%	13.0%
Yorks & H	13.9%	13.6%	15.0%	15.3%	14.5%	15.9%	14.5%
Wessex	13.6%	14.4%	14.5%	15.3%	13.1%	13.4%	13.8%
Thames V	15.2%	14.4%	14.9%	16.5%	16.3%	14.9%	16.1%
NW Lon	15.9%	16.4%	15.8%	16.1%	16.1%	17.5%	15.0%
S Lon	15.8%	14.8%	15.2%	15.7%	14.1%	16.5%	14.4%
NCE Lon	14.7%	15.5%	15.0%	14.9%	15.6%	16.7%	15.6%
Kent, S&S	14.4%	15.0%	15.3%	13.7%	14.2%	14.8%	15.5%
N East	13.8%	13.5%	13.8%	12.8%	13.5%	14.2%	13.9%
N West	14.6%	14.5%	13.8%	17.0%	14.0%	13.9%	13.9%
W Mids	13.1%	13.2%	13.3%	13.7%	13.6%	14.1%	13.0%
S West	14.6%	16.7%	15.2%	14.6%	18.4%	14.5%	14.8%
England	**14.4%**	**14.6%**	**14.5%**	**15.1%**	**14.5%**	**15.5%**	**14.4%**

Source: NHS Digital

Fig 14.2: 12-months leaver rates by region, HCHS Doctors



Source: NHS Digital

15. Annex 3 (Chapter 12)

Fig 15.1: NHS Pension Scheme membership rate and trends

	FTE (Dec 2016)	% with pension contributions	% point change		
		May 2017	Apr 2017 and May 2017	May 2016 and May 2017	Oct 2011 and May 2017
All	1,187,125	90%	0.2%	-0.3%	4.1%
Staff Groups					
Doctor	113,508	92%	0.3%	-0.8%	-0.3%
Qualified nursing, midwifery & health visiting staff	345,926	91%	0.2%	-0.7%	2.6%
Qualified Scientific, therapeutic and technical staff	152,169	93%	0.1%	-0.3%	2.2%
Qualified Ambulance Staff	20,897	95%	0.1%	-0.9%	-1.5%
Support to Clinical Staff	364,560	88%	0.3%	0.3%	7.9%
Central Functions & Hotel, Property & Estates	155,161	86%	0.2%	0.0%	6.4%
Managers	32,588	91%	0.1%	-0.8%	-2.5%
All Non-Medical	1,073,617	90%	0.2%	-0.2%	4.5%

Notes

Please be aware that these figures are based on data from the Electronic Staff Record (ESR) Data Warehouse. This is the HR and payroll system that covers all NHS employees other than those working in General Practice, two NHS Foundation Trusts that have chosen not to use the system, and organisations to which functions have been transferred, such as local authorities. ESR data is not centrally validated and its reliability is subject to local coding practice.

The measure of pension membership rates is based on the proportion of records where the employer made a pension contribution.

The percentage rates are based on headcount data.

[i] https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
[ii] https://www.england.nhs.uk/stps/sustainability-and-transformation-partnerships-progress-dashboard-baseline-view/
[iii] Facing the facts: shaping the future. https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-strategy
[iv] https://www.gov.uk/government/publications/chief-secretary-to-the-treasury-letter-to-the-ddrb-chair--2
[v] The Associate Specialist grade and the Staff Grade have not been open to new entrants since 2008.
[vi] https://www.gov.uk/government/consultations/expanding-undergraduate-medical-education
[vii] http://www.shapeoftraining.co.uk/reviewsofar/1788.asp
[viii] http://www.shapeoftraining.co.uk/1739.asp
[ix] British Medical Association (2016), "Workload, Recruitment, Retention and Morale", London: BMA.
[x] http://www.nhsstaffsurveyresults.com/
[xi] https://improvement.nhs.uk/improvement-hub/
[xii] Key Finding 4 asked respondents to measure agreement on three statements: 1) I look forward to going to work; 2) I am enthusiastic about my job; 3) Time passes quickly when I'm working.
[xiii] http://www.nhshealthatwork.co.uk/health-work-wellbeing.asp
[xiv] https://www.gov.uk/government/speeches/jeremy-hunt-updates-parliament-on-junior-doctors-contract
[xv] An alternative workforce model, maximising productive training time and making use of the focused specialisms of members of the extended surgical team; involving the multi-disciplinary team within which junior doctors work, who are best placed to provide the support they require in a positive and collaborative environment.
[xvi] https://www.equalityhumanrights.com/en/advice-and-guidance/what-difference-between-gender-pay-gap-and-equal-pay
[xvii] See https://www.gov.uk/government/publications/junior-doctors-contract-equality-analysis-and-family-test
[xviii] https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/
[xix] https://www.england.nhs.uk/gp/gpfv/investment/indemnity/
[xx] https://digital.nhs.uk/catalogue/PUB30090
[xxi] https://www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp
[xxii] https://digital.nhs.uk/catalogue/PUB30072
[xxiii] https://www.gov.uk/government/publications/evidence-for-pay-review-bodies-of-healthcare-professionals, paragraphs 3.58-3.59
[xxiv] https://www.gov.uk/government/publications/gp-and-dental-clinical-educator-pay-scales
[xxv] https://www.england.nhs.uk/gp/gpfv/workforce/building-the-general-practice-workforce/recruitment/
[xxvi] https://www.england.nhs.uk/gp/gpfv/workforce/retaining-the-current-medical-workforce/gp-career-plus/
[xxvii] https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/releasing-time/
[xxviii] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[xxix] Annex A2 of the Investment in General Practice Report (Investment in General Practice Report for 16/17 at Annex A2
[xxx] https://www.england.nhs.uk/ourwork/new-care-models/
[xxxi] The Scheme Advisory Board is a statutory board that advises the Secretary of State on the merits of making changes to the scheme. It comprises representatives from NHS trade unions and employers.
[xxxii] https://www.gov.uk/government/publications/re-employing-staff-who-receive-an-nhs-pension
[xxxiii] All sources with the exception of joiners from NHS Organisations.