



Department
of Health

The Review Body on Doctors' and Dentists' Remuneration (DDRB) Review for 2017

Written Evidence from the Health Department for
England

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The Review Body on Doctors' and Dentists' Remuneration (DDRB) Review for 2017

Written Evidence from the Health Department for England

Prepared by NHS Pay, Pensions & Employment Services Team

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Executive summary

On the back of a strong economy, we are investing the £10bn (with £6bn frontloaded in 2016/17) that the NHS said it needs, along with £22bn of efficiency savings, to implement its plans. Demands on the health and social care system continue to increase, and the NHS must both improve care for patients and balance the books. To find the efficiency savings it needs to make, the NHS is shifting the focus from centrally driven savings to transformational changes, which will reduce the long-term cost pressures on NHS services. We expect trusts to balance their books in 2017/2018. Pay restraint will help trusts by ensuring the workforce is affordable.

The Government's four year public sector pay policy from 2016/17 is designed to ensure that the public sector workforce is affordable and also allows organisations to plan ahead. The remit letter from the Chief Secretary to the Treasury makes clear the expectation that pay awards - annual average increases of 1% - will be targeted to support the continued delivery of public services and to address recruitment and retention pressures, noting the requirement for the review body to consider good, evidence-based propositions. Chapter 1 sets out our approach to targeting, including as an integral part of contract reform. As we explain at Chapter 5, we are making good progress to secure the evidence base the Review Body needs, vacancy data in particular.

Equally important is the intention to reform and modernise terms and conditions, developing more affordable, sustainable pay systems. For the NHS, the aim is also to ensure that contracts support the delivery of quality services across the seven day week, ensuring appropriate reward for those who work most intensively and at the most unsocial times. Chapter 6 describes the aims of contract reform, and subsequent chapters provide an update on progress. These reforms include fundamental redesign of the structure of pay. Under the new contractual arrangements pay will be targeted (as a permanent feature, including performance pay provisions, or through the use of flexible provisions that might change over time) to ensure that reward is fair, relates most closely to work done and is best geared to achieve recruitment and retention.

NHS Workforce Policy

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.

The Department is taking 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 and to increase the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.

There has been an increase of over 25,000 more professionally qualified staff working in the NHS since May 2010 and with over 50,000 nurses and over 50,000 doctors currently in training,¹ the government will continue to make sure there are sufficient staff available to give patients high quality, safe and sustainable care 24 hours a day, seven days a week.

¹ These figures are not directly comparable because the nurses are nursing students on university courses, whereas the doctors figure is the number of "Doctors and Dentists Training in the NHS" (historically referred to as junior doctors), not the number of medical students on university courses.

Economy-wide, medical practitioners' earnings have grown less than other high-earning occupations, but they remain one of the very highest-earning groups, despite being the only such group to include junior trainees.

Overall earnings per person have increased slightly year-on-year since 2011/12. Part of this increase reflects change in grade group mix: the number of consultants has grown faster than other groups, and because consultants earn more on average than other groups, this has increased the average.

A longitudinal study shows that the total earnings of HCHS doctors increased by an average of 3.3% per year between 2010 and 2015.

Pay Targeting

The Department strongly supports the principle of targeting which is integral to how contracts are reformed as evidenced in the new contract for doctors and dentists in training. In 2014/2015, the pay settlement was over two years (2014-5 and 2015-16) and was targeted so that only those medical and non-medical employed staff no longer eligible to receive progression pay received a payment

Case for targeting

We recognise that pay restraint is challenging for staff but ensuring the NHS workforce is affordable will help protect jobs and services and ensure staff can be deployed most effectively.

The leaver rate increased slightly in 2015/16, but medical and dental capacity continued to increase, and there are robust workforce planning arrangements in place. Agency costs have continued to increase, particularly in the south-east, but the figures include all staff groups, not just medical and dental. We expect costs to fall over time as supply increases. Notwithstanding the contractual dispute with junior doctors, morale, as indicated by the Engagement Index and sickness absence, appears not to have changed significantly in recent years.

The NHS needs the right numbers of staff, with the right skills, in the right places at the right times - recruitment, retention and motivation are key to this. It is open to employers to use local payments where recruitment and retention is a concern and to ensure they have the right people strategies in place to help improve staff engagement. At a national level, robust workforce planning, including for education and training will together help secure the supply the NHS needs.

There are some risks to the NHS of continued pay restraint in relation to better earnings growth and improved employment in the wider economy, including recruitment and retention, agency costs and staff morale. However, pay is not the only motivator. It is important that trust boards explore how the entire NHS employment offer, a "Total Reward" approach to pay and non-pay benefits, as described in Chapter 13, can help employers to use the increasing NHS pay bill in the best way to secure, retain and motivate the skilled workforce they need.

For the 2017/2018 pay round, there is insufficient robust evidence on which to make recommendations that would lead to differential pay awards for doctors and dentists. We are making good progress to secure the evidence base that will better inform assessments on vacancy data and regional recruitment and retention challenges to inform the 2018/2019 pay round.

Our proposal for 2017/18 is made in light of:

- ongoing pay system reform with integral targeting to address specialty-specific shortages;
- the fact that the progression pay systems for trained doctors mean that the majority will receive an annual increase of between 3-10%;
- differential targeting can be helpful but we do not have sufficient evidence to support it in this pay round. We are working towards providing the evidence to support targeted pay awards for 2018-19; and
- that the rate of inflation remains very low.

In the absence of strong evidence to the contrary, the proposal is that a 1% increase should apply to both employed doctors and independent contractors.

In Chapter 10 we provide an update on how contractor expenses will inform 2017/18 contract negotiations.

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

The following chapters in the Department's evidence cover:

Chapter 1: NHS Strategy and Introduction

Chapter 2: The General Economic Outlook for the UK Economy - which underlines the need for continued public sector pay restraint

Chapter 3: NHS Finance

Chapter 4: HCHS Medical and Dental Staff Earnings

Chapter 5: Recruitment, Retention, Motivation and Medical Workforce Planning

Chapter 6: The Aims of Contract Reform - with progress and comparisons across the remit groups

Chapter 7: The New Contract for Doctors and Dentists in Training

Chapter 8: Contract Reform for Consultants

Chapter 9: Specialty Doctors and Associate Specialists

Chapter 10: Contract Reform – General Medical Practitioners

Chapter 11: General Dental Services Contractors

Chapter 12: Ophthalmic Practitioners

Chapter 13: Pensions and Total Reward

1. NHS Strategy and Introduction

- 1.1. On the back of a strong economy, the government is investing £10bn more in the NHS by 2020, with £6bn frontloaded in 2016/17. 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. Meeting this demand and driving up quality in an affordable way is incredibly challenging. The NHS is well aware that it must do things differently, harnessing innovation and the creativity of its workforce to deliver the consistent high quality care patients and their families expect.
- 1.2. The Department's Shared Delivery Plan 2015-2021² is informed by the NHS's own improvement plan - the Five Year Forward View³ - improving access to a free and high quality health service. NHS England's report Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21⁴ 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”.

Government Pay Policy

- 1.3. At Summer 2015 budget the government set a four year pay policy from 2016/17 onwards to allow workforces to plan ahead – an average annual pay increase of 1%, to be targeted in a way that best supports recruitment and retention.
- 1.4. Prolonged pay restraint is challenging and needs to be accompanied by a continued focus on public sector pay reform - in the NHS around half of the workforce receive incremental pay of around 3.4% on average, in addition to any annual pay award. We continue to pursue reform of pay systems, to ensure that terms and conditions are fit for purpose, affordable and sustainable.
- 1.5. Those who are leading NHS organisations have a key role in setting an example to other staff of the pay restraint that is an essential part of meeting the challenges that the NHS faces. The Secretary of State for Health set this out clearly in his letter of 2 June 2015 to Chairs of all NHS organisations and his letter now provides the context for decisions on executive pay (see Annex A).

² <https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020/shared-delivery-plan-2015-to-2020>

³ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁴ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

Workforce

- 1.6. The overarching aim of healthcare workforce policy is to ensure the right workforce with the right skills is available and affordable in the right place at the right time to provide the services patients need. To achieve this, the NHS needs to be able to recruit and retain high quality, highly motivated staff in sufficient numbers and enable their training and development throughout their career to reflect the way services and technology will change.
- 1.7. Affordability of the workforce requires a balance of pay and reward which is sufficiently attractive to enable the recruitment and retention of a high quality workforce and maintain good industrial relations. The NHS must improve quality and minimise costs whilst ensuring that:
- it has the engaged workforce it needs;
 - it has a workforce that feels confident to challenge the care it delivers for the benefit of patients; and
 - it is delivering transformational change for the benefit of patients.
- 1.8. Investment in the workforce has delivered an increase of over 25,000 professionally qualified staff since May 2010; investment in educating, training and recruiting doctors has delivered a 10% increase in the medical workforce over that period. Chapter 5 sets out the numbers currently in training, so that we can continue to ensure that the NHS has sufficient staff to deliver safe and sustainable, high quality patient services seven days a week. HEE's annual workforce plan for 2016/17 sets out how current workforce challenges are being met⁵.
- 1.9. HEE's plan for 2015/16 acknowledged the staffing pressures in the NHS and highlighted the difficulties caused as a result of demand outstripping supply in four key professional groups: nursing, paramedics, general practice, and emergency medicine. To ease these immediate pressures we have:
- introduced a cap on the rates of agency pay, making agency working a less attractive alternative and increasing the overall productivity of the workforce;
 - in the new junior doctors' contract included flexible pay premia for general practice and emergency medicine; and
 - begun to implement productivity gains – as evidenced in Lord Carter's review – through more effective rostering of nurses, better work planning for consultants, and more efficient deployment of allied health professionals. The workforce component is expected to contribute £2 billion.
- 1.10. The NHS at a local level is assessing what workforce demands it will have until the end of the Spending Review period and is planning accordingly to ensure it has the right

⁵ <https://hee.nhs.uk/>

numbers of appropriately skilled staff in place. NHS employers, and staff and their representatives, need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high. We are working with our partner organisations to ensure that the future workforce is flexible enough to respond to the changing demands that the NHS will experience.

- 1.11. In December 2015, the NHS shared planning guidance 16/17 – 20/21⁶ outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England is producing a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View⁷ vision of better health, better patient care and improved NHS efficiency. As part of this, local health and care systems came together in January 2016 to form 44 STP ‘footprints’⁸. The health and care organisations within these geographic footprints are working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term. STPs are a key element on the NHS Shared Planning Guidance and the local implementation of the Five Year Forward View. They are supported by six of the national health and care bodies: NHS England, NHS Improvement, the Care Quality Commission (CQC), Health Education England (HEE), Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE).

Contract Reform

- 1.12. Contract reform is part of our strategy for helping the NHS to balance its books whilst continuing to recruit and retain the staff it needs. Contract reform is not about reducing the medical pay bill, but about ensuring it can be used more effectively to support patient care. This includes making changes that support the recruitment and retention of the skilled, dedicated and compassionate staff the NHS needs, and ensuring that terms and conditions help rather than hinder productivity improvements and other measures to support patient care. For junior doctors, the key principles are fair pay and safe hours. For consultants, they are about a fairer approach that supports the training of junior doctors, productivity and patient safety; including by better engaging as senior clinical leaders, and better supporting a seven day service.

Staff engagement

- 1.13. 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

⁶ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>

⁷ <https://www.england.nhs.uk/ourwork/futurenhs/>

⁸ <https://www.england.nhs.uk/2016/03/footprint-areas/>

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.

- 1.14. The overall employment offer should help to incentivise and reward those staff who do the most for patients whenever patients need them. This includes ensuring the value of the NHS reward package in comparison to other employers is communicated effectively, as discussed in chapter 13. We continue to commission NHS Employers to support local employers in developing their employment offer and local staff engagement strategies.⁹
- 1.15. These principles, pay and non-pay, are those we believe employers and trade unions support.

Pay restraint in the NHS

- 1.16. We know that pay restraint is challenging for staff but ensuring the NHS workforce is affordable will help protect jobs and services and ensure staff can be deployed most effectively. Paying more to the detriment of affordable staffing levels would over-stretch the workforce and also risk retention problems. It is essential that the NHS is able to attract, retain, motivate and afford the workforce required to meet patient needs.
- 1.17. Our analysis in Annex B covers earnings growth, recruitment and retention, agency costs and staff morale.
- 1.18. This analysis shows that the leaver rate increased in 2015/16 and that agency costs have grown, though not necessarily for medical and dental staffing. However medical and dental capacity has continued to grow and morale appears to have been maintained. Robust arrangements are in place to ensure supply of the right number of staff with the right skills.
- 1.19. The government is mindful of monitoring the impact of pay restraint. Given affordability constraints and the absence of sustained recruitment and retention difficulties, and after reviewing the available evidence, a uniform 1% pay award for 2017/2018 is considered appropriate in these difficult circumstances.
- 1.20. The government will continue to: monitor the recruitment and retention situation; develop its intelligence base; and to review the application of targeting, beyond that being introduced as part of contract reform, to make best use of available pay resources in the future.

⁹ <http://www.nhsemployers.org/your-workforce/pay-and-reward/reward/total-reward-in-the-nhs> and <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement>

- 1.21. The Department strongly supports the principle of targeting which is integral to, for example, the new contract for doctors and dentists in training (juniors). The Review Body noted last year that funding for the 1% pay uplift could be used differently. It also recognised, however, that its recommendations relate to pay scales that apply to all doctors and dentists in a grade and do not differentiate by specialty or geography, which are the areas that might require targeting. The structure of the new junior doctors' contract reflects this, with flexible pay premia for hard to fill training programmes, and it remains open to employers to use recruitment and retention premia in the consultant contract. As the Review Body has noted, whilst it is not the answer where there are overall shortages, nothing precludes employers from also using local recruitment and retention premia to address location-specific issues.

- 1.22. For this pay round there is insufficient robust evidence on which to make recommendations that would lead to differential pay awards for doctors and dentists. As we explain at Chapter 5 we are making good progress to secure the evidence base that will better inform assessments on vacancy data and regional recruitment and retention challenges to inform the 2018/2019 pay round.

2. Evidence on the General Economic Outlook

Introduction

- 2.1. Following the outcome of the EU referendum, the UK economy is entering a new phase which will pose new challenges to the public finances. Public debt stands at its highest share of GDP since the late 1960s, and the deficit remains among the highest in advanced economies. It is vital that the Government continues with its intention to reduce the budget deficit over an appropriate timeframe.
- 2.2. Public sector pay restraint continues to play a key role in fiscal consolidation. It helped save approximately £8bn in the last Parliament and is expected to save another £5bn in this Parliament.
- 2.3. At Summer Budget 2015 the Government announced that it would fund public sector workforces for pay awards of 1 per cent for four years from 2016-17 to 2019-20. The OBR forecast estimated that this policy will protect 200,000 jobs by 2019-20. The Government made clear that it expects pay awards to be targeted to support the delivery of public services.
- 2.4. At a time when the UK faces a period of uncertainty following the vote to leave the EU, the 1 per cent public sector pay policy will continue to play an important role in delivering the Government's objective of reducing the budget deficit over an appropriate timeframe, protecting jobs and maintaining public services.
- 2.5. The vote to leave the EU has created a period of uncertainty, which will be followed by an adjustment as the shape of the UK's new relationship with the EU becomes clear and the economy responds. The strength of the economy means the UK is well-placed to deal with any short-term volatility and the longer-term adjustment.
- 2.6. The economy is in a far stronger position than in 2010, with the budget deficit cut by almost two thirds from its 2009-10 post-war peak, employment at a record high of 31.7 million, unemployment at 4.9 per cent, the lowest level since 2005, and the highest number of businesses on record, almost 1 million more than in 2010. The World Bank has ranked the UK the sixth best place for doing business, and the World Economic Forum placed it as the tenth most competitive country in the world in their latest survey.
- 2.7. The UK's economic performance has been strong in recent years. The UK economy has grown by 13.8 per cent since Q1 2010, and is 7.7 per cent bigger than at its pre-crisis peak. It was the fastest growing major advanced economy in 2014, at 3.1 per cent, and the second fastest in 2015, at 2.2 per cent, behind only the US. The UK economy grew 0.6 per cent in Q2 2016, following 0.4 per cent growth in Q1 2016.

Evidence on the General Economic Outlook

- 2.8. Inflation was close to zero throughout 2015, predominantly as a result of falling fuel and food prices, and in recent months has begun to edge higher as past falls in fuel prices drop out of the annual comparison.
- 2.9. The Government, the Bank of England and the Financial Conduct Authority have worked together to maintain financial stability following the referendum result. The independent Monetary Policy Committee (MPC) and Financial Policy Committee (FPC) have taken steps to support the economy through this period of adjustment, with the MPC announcing a package of measures designed to provide additional support to growth and to achieve a sustainable return of inflation to the 2 per cent target. Along with the actions the Bank of England has taken, the Government is prepared to take any necessary steps to support the UK economy and promote confidence.

Affordability and Fiscal Strategy

- 2.10. Since 2010 the Government has taken action to cut the deficit which has reduced from its 2009-10 post-war peak of 10.1 per cent of GDP to 4 per cent of GDP in 2015-16. The deficit remains high compared to advanced economies and public sector net debt as a share of GDP has more than doubled since the pre-recession period. The 2015 Charter for Budget Responsibility set out the then Chancellor's fiscal targets, including the fiscal mandate to achieve a headline surplus in 2019-20 and each subsequent year.
- 2.11. The Charter for Budget Responsibility was explicit that the surplus rule will be suspended if the economy is hit by a significant negative shock (defined as 4 quarter-on-4 quarter GDP growth below 1 per cent). This provides flexibility to allow the automatic stabilisers to operate freely when needed. Following a shock, the Government of the day will be required to review what are the appropriate fiscal targets as the public finances return to surplus. The framework does not prescribe what the targets should be, allowing the Government of the day to respond to the circumstances. However, the targets will be voted on by the House of Commons and assessed by the Office for Budget Responsibility.
- 2.12. Following the decision of the British people to leave the European Union, it is clear the UK economy is experiencing some turbulence. Neither the Treasury nor the Office for Budget Responsibility have produced revised economic forecasts since the EU referendum. However, the latest comparison of independent forecasters shows that expected growth for 2017 has been cut from 2.1 per cent to 0.7 per cent in 2017 since the referendum. It is highly likely that the Office for Budget Responsibility will forecast growth of less than 1 per cent on a 4 quarter-on-4 quarter basis which will trigger the requirement for the Treasury to review the fiscal targets.
- 2.13. The Chancellor of the Exchequer has been clear that in light of the referendum result the Government will no longer pursue a surplus in 2019-20. He has also been clear that reducing the deficit remains a core priority for the Government. The Government's fiscal position will be set out at the Autumn Statement in the normal way once the Office for Budget Responsibility have produced a revised economic and fiscal forecast.

Labour market

- 2.14. The labour market has performed strongly in recent years. While there is still uncertainty about the future of the labour market, the latest data (April – June 2016) show continued strength in the headline figures, with employment up by 606,000 over the year, to a record level of 31.7m. At 74.5 per cent the employment rate is the highest on record. The quality of employment has been strong, with the majority of employment growth over the year being among full-time workers (62 per cent) and among high and medium-skilled occupations (87 per cent).
- 2.15. Unemployment fell by 207,000 over the year to a level of 1.6m, with the rate falling to an 11 year low of 4.9 per cent. Over 60 per cent of the fall in unemployment over the year came from the decrease in long-term unemployment (unemployment of 12 months or more), which was down by 130,000 over the year.
- 2.16. Youth unemployment (16-24) was down by 105,000 over the year to April - June 2016, to a level of 626,000. The youth unemployment rate stood at 13.7 per cent, down 2.1 percentage points on the year. Excluding people in full-time education, there were 418,000 unemployed 16-24 year-olds, with a corresponding unemployment rate of 12.1 per cent.
- 2.17. The claimant count in July fell by 8,600 over the month and by 27,100 over the year, with the claimant count rate at 2.2 per cent.
- 2.18. The number of vacancies in the three months to July stood at 741,000. While this reflects a fall on the quarter, this is consistent with recent trends in vacancies and remains up on the same period last year.
- 2.19. Wage growth was fairly stable in the first half of 2016. In April -June total pay was up 2.4 per cent on the year in nominal terms and by 2.1 per cent in real terms. This marks the 21st month that average earnings have outstripped inflation, continuing the longest period of real wage growth since 2008. Table 2.1 summarises these statistics:

Table 2.1: Labour market statistics summary (Levels in 000s, rates in %)*

	2011	2012	2013	2014	2015	Apr-Jun 2016
Employment level, 000s (All aged 16 and over)	29,376	29,696	30,044	30,757	31,296	31,750
Employment rate % (All aged 16-64)	70.3	71	71.5	72.9	73.7	74.5
Unemployment level, 000s (All aged 16 and over)	2,593	2,572	2,474	2,026	1,781	1,641
Unemployment rate % (All aged 16 and over)	8.1	8.0	7.6	6.2	5.4	4.9
Youth unemployment level, 000s (All aged 16-24)	996	1007	967	782	685	626
Youth unemployment rate % (All aged 16-24)	21.4	21.4	20.9	17.1	14.9	13.7
Claimant Count	1,534.4	1,585.6	1,421.8	1,037.1	798.7	763.6**

Source: UK Labour Market: August 2016, ONS

* The latest public and private sector employment figures available are for the first quarter of 2016. These show that private sector employment rose by 55,000 on the quarter and was up by 485,000 over the year. This more than offset the fall in public sector employment which was up by 1,000 on the quarter but down by 24,000 over the year. Since Q1 2010 over 6½ private sector jobs have been created for every public sector job lost. These series exclude the effects of major reclassifications where large bodies employing large number of people have moved between the public and private sectors.

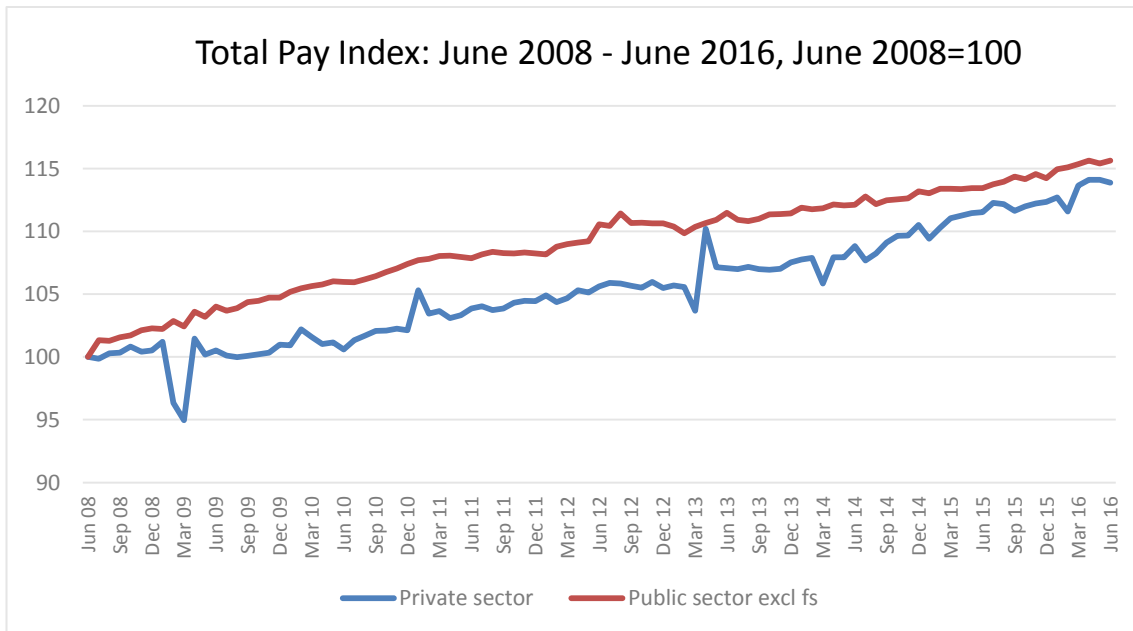
** Monthly data used (July 2016)

Public sector pay and pensions

2.20. IFS and ONS analysis has shown, on average, higher pay growth in the public sector when compared to workers with similar characteristics in the private sector. While the public-private pay differential is narrowing, the overall remuneration of public sector employees when taking employer pension provision into account continues to be above that of the market.

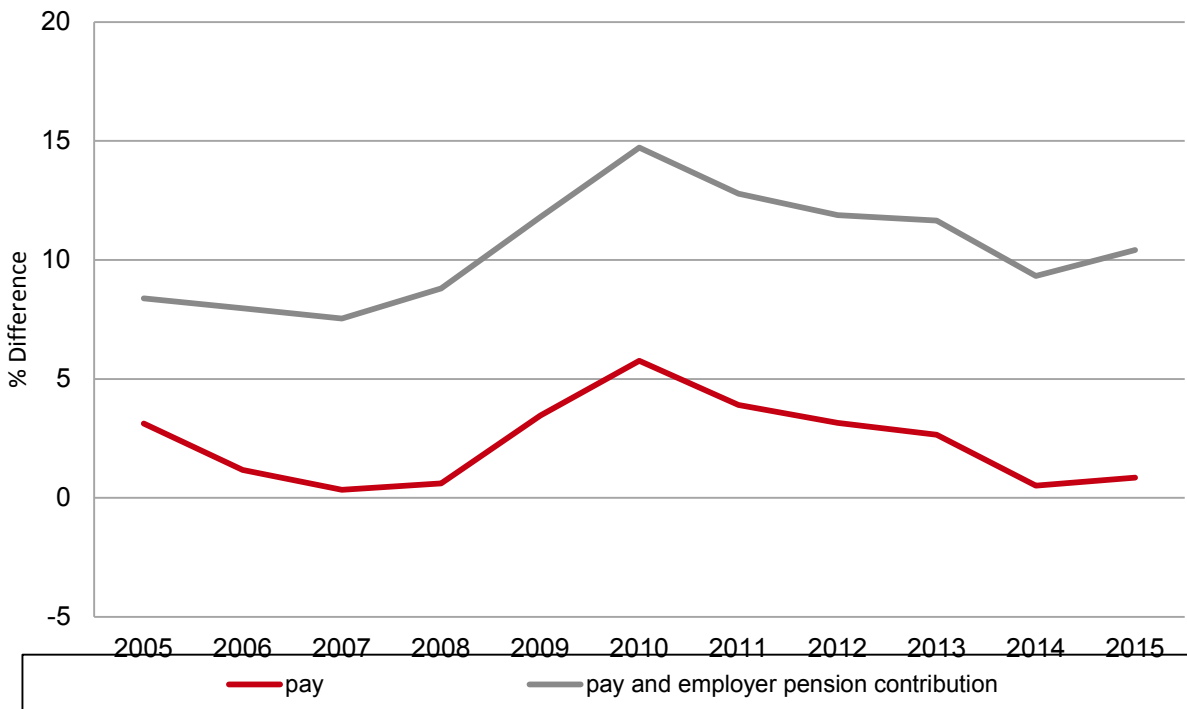
- 2.21. In the three months to June 2016, private sector total pay growth (including bonuses) stood at 2.5 per cent, while private sector regular pay growth (excluding bonuses) stood at 2.4 per cent. Although low inflation has helped boost real wages, nominal private sector wage growth remains below rates seen before the recession (about 4-5 per cent per annum).
- 2.22. Public sector total pay growth (including bonuses) was 1.9 per cent in the three months to June 2016. Regular earnings (excluding bonuses) grew by 1.7 per cent over the same period. These rates stood above the rate of inflation in this period (0.5 per cent) but still below the pre-recession average growth rate, as in the private sector.
- 2.23. Historically, public sector wages tend to fall and recover at a slower pace during economic cycles than private sector wages – there can be a delay between a recession occurring and public sector wage adjustment. Since July 2014, private sector earnings growth has been faster than growth in public sector wages, but this follows on from sustained public sector wage growth in the years immediately following the recession. From the three months to June 2008 to the three months to June 2016, total average public sector earnings increased by 15.6 per cent, while those in the private sector have increased by 13.8 per cent. The overall level of public sector average weekly wage remains above that of the private sector, as shown in Table 2.2 which compares the growth in average public and private sector weekly earnings since 2008.

Table 2.2: Total pay comparison



2.24. When considering changes to remuneration, it is important to consider other elements of the total reward package. Including employer pension contributions to pay and bonus, recent HMT analysis finds that on average public sector workers benefit from a 10.4 per cent premium compared with their private sector counterparts as can be seen in Table 2.3. This is supported by the IFS (October 2014 paper), who found that a 4.6 per cent pay premium continues to exist in favour of public sector workers and that the premium increases significantly if one incorporates pension payments in the analysis. This premium is driven by a number of factors including higher pay for women, and protection for the low paid in the public sector. Table 2.3 shows the comparison of average hourly earnings for public and private sector workers with similar characteristics across time.

Table 2.3 : Estimated public-private hourly pay differential



2.25. This Government wants to build an economy that works for everyone, and wants to do this in a fair way by ensuring that low wage workers take a greater share of the gains from growth. An essential part of this is the introduction of a new National Living Wage (NLW).

2.26. In April 2016, the NLW was introduced at £7.20 for workers aged 25 and over, marking an increase in pay for over a million workers across the UK. Estimates indicate that approximately 200,000 public sector workers have directly benefitted from the policy.

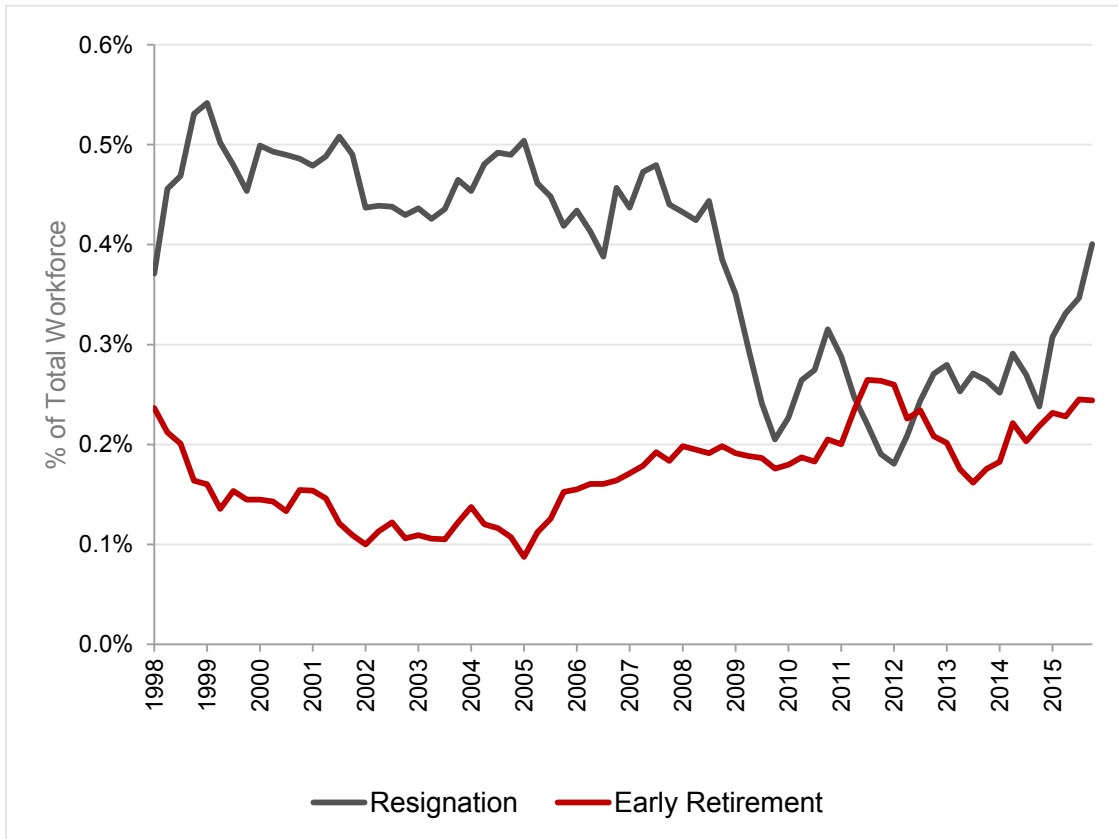
Pension reforms

- 2.27. One major factor in the overall reward package is pension provision. The design and scope of private sector occupational schemes has changed significantly in the last 25 years. Participation in private sector schemes fell from 6.5m active members in 1991 to 2.8m in 2013, whereas participation in the public sector increased over the same period. Private sector participation rates are now increasing, following the phased introduction of mandatory workplace pension savings, but this growth is in defined contribution schemes where the employee rather than the employer bears the investment risk. The average employer contribution to private sector pensions was around 7 per cent of pay in 2014, compared to average employer costs of around 14 per cent of pay in the reformed public service pension schemes.
- 2.28. Where private sector defined benefit provision exists, the employer contribution towards the costs is broadly similar to the cost of providing the reformed public sector schemes, however fewer private sector employees have access to such arrangements. The average employer contribution to private sector career average schemes was 12.7 per cent of pay in 2014. There were 1.6m active members of defined benefit schemes in the private sector in 2014.
- 2.29. Public service pension schemes continue to be amongst the best available and significantly above the average value of pension provision in the private sector.

Recruitment and Retention

- 2.30. Across the whole economy there is evidence that the labour market is performing strongly with strong growth in employment. However, there is limited evidence of widespread recruitment and retention issues within the public sector. Table 2.4 shows recent resignation and early retirement rates in the public sector.

Table 2.4: Resignation and Early Retirement Rates (up to Q4 2015)



- 2.31. The rate at which people are resigning from the public sector remains substantially below pre-recession levels. Within the public sector, the resignation rate was relatively constant prior to the recession, in the region of 0.4 – 0.5 per cent. From the middle of 2008 this rate fell sharply to 0.2 – 0.3 per cent, potentially relating to opportunities outside the public sector becoming scarcer. Since then it has made little sustained recovery. Resignation rates over the last year have increased but remain below pre-recession levels. The early retirement rate figures have fluctuated since 2010.
- 2.32. The CIPD Labour Monthly Outlook, Spring 2016, indicates that amongst all private sector firms, where pay has increased by 2 per cent or more, only 28 per cent of those cases were set at that level to address recruitment and retention issues.

3. NHS Finances

Funding Growth

- 3.1. This chapter sets out the financial context for the NHS.
- 3.2. Between 1999/2000 and 2010/11 NHS revenue expenditure increased by an average of 5.7% in real terms. In the following five years, 2011/12 to 2015/16, NHS revenue expenditure increased by an average of 1.9% per year in real terms. Table 3.1 shows
- outturn NHS revenue expenditure figures from 1999/2000 to 2015/16
 - Revenue Departmental Expenditure Limits (RDEL)

Table 3.1 NHS Revenue Expenditure: England - outturn 1999/2000 to 2015/16 and plan 2016/17 & 2017/18

Year		Revenue Net NHS Expenditure, £bn (4)(5)(6)	% Increase	% Real Terms Increase (7)
Resource Budgeting Stage 1 (1)				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	6.5
2001/02	Outturn	47.3	10.8	9.4
2002/03	Outturn	51.9	9.8	7.4
Resource Budgeting Stage 2 (2)				
2002/03	Outturn	56.9	-	-
2003/04	Outturn	61.9	8.7	6.3
2004/05	Outturn	66.9	8.1	5.3
2005/06	Outturn	74.2	10.9	8.0
2006/07	Outturn	78.5	5.8	2.7
2007/08	Outturn	86.4	10.1	7.5
2008/09	Outturn	90.7	5.0	2.3
2009/10	Outturn	97.8	7.8	6.4
Resource Budgeting - Aligned (3)				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	1.4
2011/12	Outturn	100.3	2.9	1.5
2012/13	Outturn	102.6	2.3	0.2
2013/14	Outturn	106.5	3.8	2.1
2014/15	Outturn	110.6	3.8	2.2
2015/16	Outturn	114.7	3.8	3.7
2016/17	Plan	117.3	2.2	0.7
2017/18	Plan	120.4	2.6	0.8

(1) Expenditure figures from 1999/2000 to 2002/03 are on a Stage 1 resource budgeting basis.

(2) Expenditure figures from 2003/04 to 2009/10 are on a Stage 2 resource budgeting basis.

(3) Expenditure figures from 2010/11 are on an aligned basis following the government's Clear Line of Sight programme. Expenditure in 2009/10 has been restated.

(4) Expenditure figures over time are not consistent due to changes in government accounting and this should be noted when making comparisons between years.

(5) Revenue is quoted gross of non-trust depreciation and impairments; prior to September 2007 revenue was quoted net of non-trust depreciation and impairments. This brings DH in line with HMT presentation of the statistics.

- (6) Expenditure excludes NHS (AME).
 (7) GDP as at 30th June 2016.

Share of Resource Going to Pay

3.3. Table 3.2 shows the proportion of the increased funding that has been consumed by the HCHS paybill over time. Note that the HCHS workforce comprises staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

Table 3.2 Increases in Revenue Expenditure and the Proportion Consumed by Paybill

Year	Increase in Revenue Expenditure	Increase in HCHS Provider Paybill	Proportion of Revenue Increase on Paybill	Increase in HCHS Paybill due to Prices		Increase in HCHS Paybill due to Volume	
	(£bn)	(£bn)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.3	1.6	4.5	0.9
2002/03	4.6	2.4	51	5.2	1.3	5.4	1.2
2003/04	6.5	2.6	41	5.4	1.4	5.2	1.3
2004/05	5.0	4.5	91	11.9	3.8	4.4	1.2
2005/06	7.3	2.5	34	4.7	1.6	3.2	1.0
2006/07	4.3	1.3	30	5.3	1.9	-1.4	-0.5
2007/08	7.9	1.3	16	4.1	1.5	-0.5	-0.2
2008/09	4.4	2.6	60	3.2	1.3	3.8	1.4
2009/10	7.1	2.7	39	1.9	0.8	5.0	2.0
2010/11	3.3	1.6	49	2.9	1.3	0.9	0.4
Average	5.5	2.4	44	5.3	1.6	2.8	0.9
2011/12	2.8	-0.5	-17	-0.1	-0.1	-1.0	-0.4
2012/13	2.3	0.7	31	1.5	0.6	0.2	0.1
2013/14	3.9	1.1	28	0.7	0.3	1.9	0.8
2014/15	4.1	1.0	25	0.2	0.1	2.2	1.0
2015/16	4.2	1.2	29	0.7	0.3	2.1	0.9
Average	3.5	0.7	21	0.6	0.2	1.1	0.5

(1) Revised 2010/11 to 2012/13 following accounts restatements and exclude inter-company eliminations.

(2) Excludes ALB and DH core staff expenditure.

(3) Excludes GPs.

(4) Volume & Price estimates changed method in 2010/11 to make use of a more detailed staff group breakdown from ESR.

(5) Figures may not sum due to rounding.

3.4. On average, between 2011/12 and 2015/16, increases to the HCHS paybill have consumed 20.6% (£0.7bn out of £3.5bn) of the increases in revenue expenditure. Of these 20.6 percentage points, pay effects have consumed around 7.1 percentage points and volume effects around 13.5 percentage points.

3.5. HCHS pay is the largest cost pressure, on average it has accounted for around 38% of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next year.

Pressures on NHS Funding Growth

- 3.6. Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories
- baseline pressures
 - underlying demand
 - service developments
- 3.7. Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand or increased levels of activity, which may arise due to demographic pressures or medical advances. Service developments are new areas of activity which arise due to new policies or ministerial commitments.
- 3.8. HCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Financial Balance

- 3.9. In recent years the NHS budget has represented an unprecedented challenge to the service to deliver quality care with limited resources. Although the Department, in comparison to other Government Departments, received a generous settlement, the position in 2017/18 is tight because of the requirement to recover the provider net deficit position.

Provider Deficits

- 3.10. The NHS faces a significant financial challenge in 2016/17. This is why we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year. Whilst NHS providers delivered an overall net deficit in 2015/16, offsetting savings throughout the rest of the system were achieved and financial balance against all spending controls was delivered. With the financial controls package and help from system leads, we expect to deliver financial balance against the overall spending controls in 2016/17.
- 3.11. In 2017/18 we expect trusts to balance their books, but it will still be challenging due to increasing demand for health services as a consequence of the ageing and growing population, and new drugs and treatments.

Productivity in the NHS

- 3.12. 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.
- 3.13. 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 2013/14 NHS outputs were 89% higher than in their base year of 1998/99, while volume of labour input was 41% higher. This suggests an average growth in labour productivity of 2.0% per annum

Table 3.3 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
Average Annual Growth	4.3%	2.3%	2.0%			

- 3.14. 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 2013/14 NHS outputs were 89% higher than in the base year of 1998/99. However, the total volume of factor inputs increased by 82% over the same period, resulting in a moderate growth of 0.2% per annum in total factor productivity.
- 3.15. 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 the GDP deflator, this would have a negative effect on technical efficiency.

Table 3.4 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
Average Annual Growth	4.3%	4.1%	0.2%			

Efficiency Savings

- 3.16. The NHS Five Year Forward View anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if there were no further efficiencies. To fill this gap we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year, along with £22 billion of efficiency savings (equivalent to 2% - 3% efficiency per annum). This is challenging but as the above shows is in line with average growth in labour productivity of 2.0% per annum in recent years.
- 3.17. The Department of Health is working with the health service, partners and patients to develop key elements of the programme required to achieve the efficiency savings. The five main areas of focus are:
- 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 some NHS costs by limiting pay increases and improving purchasing;
 - increasing income to the NHS through charges and commercial opportunities; and
 - reducing system overheads by reducing NHS management costs.
- 3.18. Lord Carter’s recent review into productivity and how hospitals buy goods and services found that the NHS could save up to £5 billion a year, by making better use of staff, medicines and deploying its vast buying power more effectively, so every penny possible can be spent on patient care. Lord Carter’s review says that increasing staff efficiency by

just one per cent, through better planned rotas and shifts could save hospitals £400 million a year.

Conclusion

- 3.19. The NHS faces a significant financial challenge over the next five years. The NHS Five Year Forward View anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if there were no further efficiencies. To fill this gap we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year.
- 3.20. This will require the NHS to meet the challenge of finding £22 billion of efficiency savings by 2020/21. Meeting this 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. Economy-wide, medical practitioners' earnings have grown less than other high-earning occupations, but medical practitioners remain one of the very highest-earning groups, despite being the only such group to include junior trainees.
- 4.2. Overall earnings per person have increased slightly year-on-year since 2011/12. Part of this increase reflects change in grade mix: the number of consultants has grown faster than other groups, and because consultants earn more on average than other groups, this has increased the average.
- 4.3. A longitudinal study shows that the total earnings of HCHS doctors increased by an average of 3.3% per year between 2010 and 2015.
- 4.4. As described in Chapter 2, there are signs of wider labour market recovery. Unemployment is down, employment is up, and private sector pay growth has accelerated after a period of low growth. NHS recruitment and retention prospects need to be considered in the context of this wider recovery.
- 4.5. Chapter 2 suggests a pay premium remains for the public sector as a whole, and that public sector pay has grown faster than that of the private sector in the period since the financial crisis, though not since July 2014. Comparison of recent earnings growth for doctors compared with other high-earning occupations shows that doctors remain one of the very highest-earning occupations in the UK, but economy-wide medical practitioners' earnings have grown less than other high-earning occupations.
- 4.6. The leaver rate increased slightly in 2015/16, but medical and dental capacity continued to increase, and there are robust workforce planning arrangements in place.
- 4.7. The use of recruitment and retention premia has historically been very low and this has not changed.
- 4.8. Agency costs have continued to increase, particularly in the south-east, but the figures include all staff groups, not just medical and dental.
- 4.9. Morale, as indicated by the Engagement Index and sickness absence, appears not to have changed significantly in recent years.

Economic Context

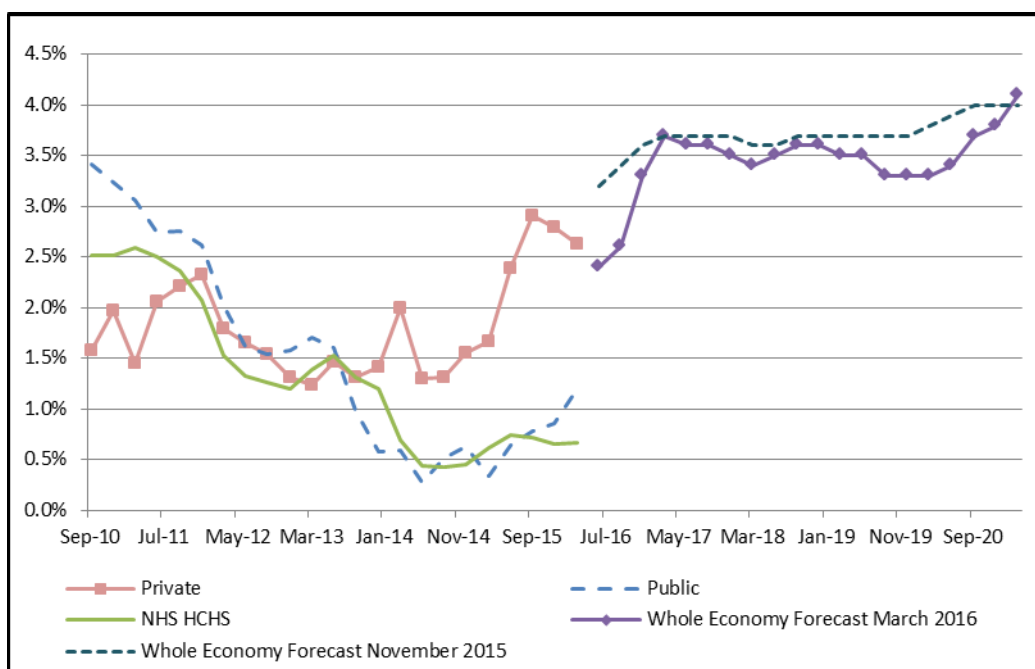
Summary

- 4.10. Chapter 2 suggests a pay premium remains for the public sector as a whole, particularly when pension benefits are included, and that public sector pay has grown faster than private sector over the period since the financial crisis. However HCHS average earnings growth has been lower than the private sector average for the last two years, and the gap is expected to continue to widen, although uncertainty about the wider economic impact of the UK decision to leave the EU may alter this. Viewed together with improved employment prospects in the wider economy, this represents a potential recruitment and retention risk to the NHS.

Earnings growth

- 4.11. Chapter 2 shows that public sector pay has grown faster than private sector over the period since the financial crisis. Recent NHS pay awards have been below the wider public sector pay awards cap. Furthermore, absolute comparisons of pay across industries and sectors are notoriously difficult. Capturing differences in pressures and working patterns is particularly complicated. The material below shows that recent NHS pay growth has fallen behind that of the private sector, and the risk is that this will continue.
- 4.12. The Office for National Statistics (ONS) publishes earnings statistics for the economy based on their Weekly Earnings Survey. These statistics show that private sector earnings growth has been higher than all public sector earnings growth since 2013. HCHS earnings statistics, which are based on staff pay records in the NHS Electronic Staff Record, also show lower growth than the ONS private sector figures. The private-public earnings differential has returned to around the pre-crisis level. Latest Office for Budget Responsibility (OBR) forecasts, published in March, expected economy-wide earnings to continue to grow significantly in 2016-17.

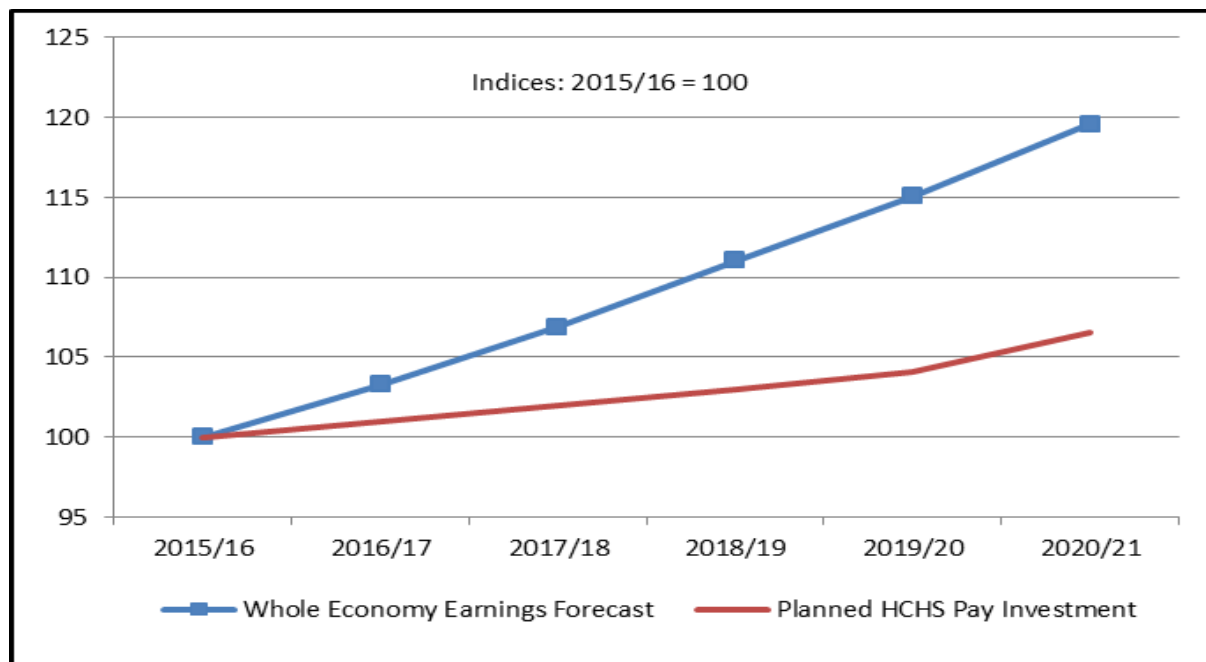
Table 4.1: Average Earnings Growth by Sector and HCHS: Time Series and Forecasts



Sources: Collated Summary Outputs: HCHS Headline Paybill Metrics; ONS AWE; OBR

- 4.13. Planned investment in HCHS pay is 1% per year for the next three years. This is significantly lower than the OBR forecasts of whole economy earnings growth. Note that the next set of forecasts may be affected by the vote for the UK to leave the EU.

Table 4.2: Planned Investment in NHS Pay and Forecast Whole Economy Earnings Growth

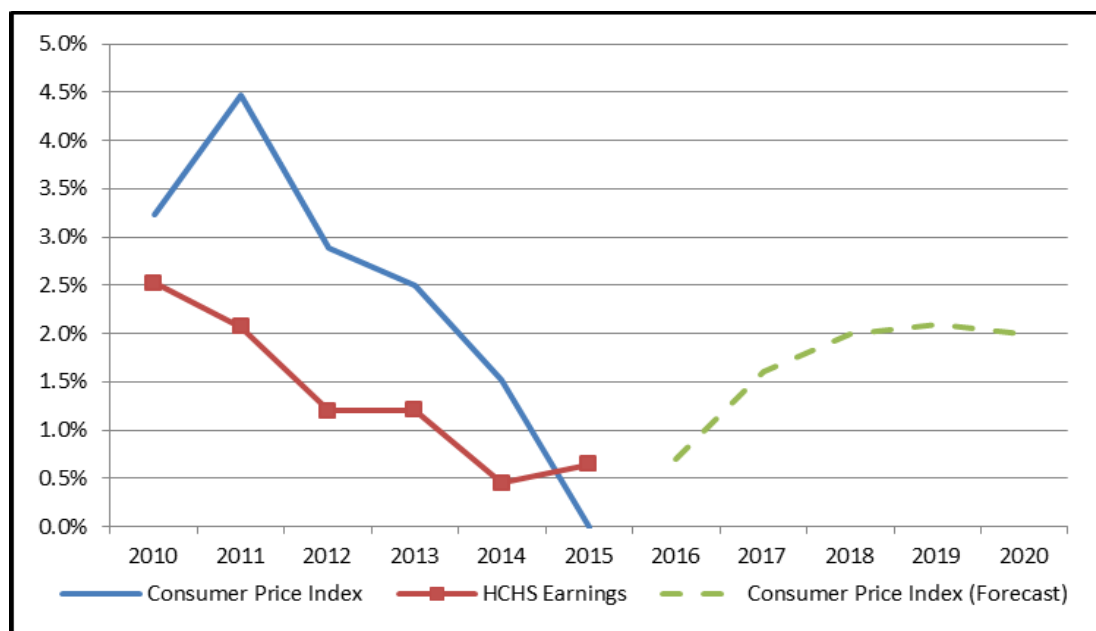


Source: Office for Budget Responsibility

Inflation

4.14. HCHS average earnings growth was below inflation between 2010 and 2015, and slightly above inflation in 2015-16, when inflation fell to 0%. The latest OBR forecast (March) anticipated inflation rising over the next two years to 2%. Again, note that UK exit from the EU may alter these forecasts.

Table 4.3: Average HCHS Earnings Growth and Inflation: Times Series and Forecasts



Sources: Collated Summary Outputs: HCHS Headline Paybill Metrics: ONS CPI Table; OBR Table

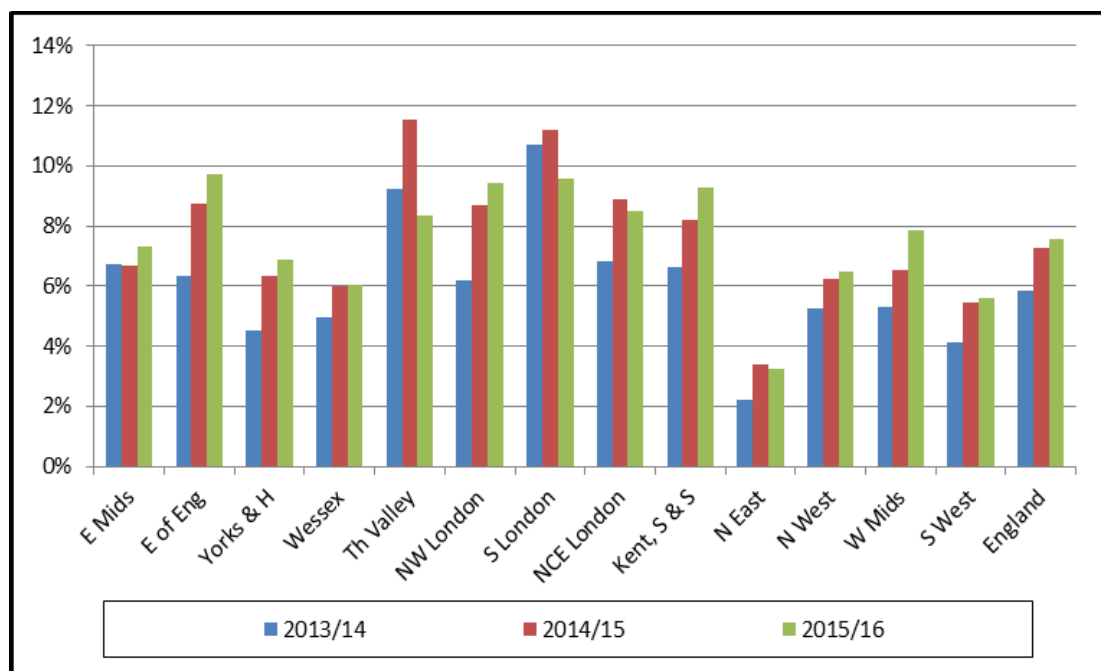
Employment

4.15. As described in Chapter 2 Table 2.1, unemployment has fallen and employment has grown.

Agency Use

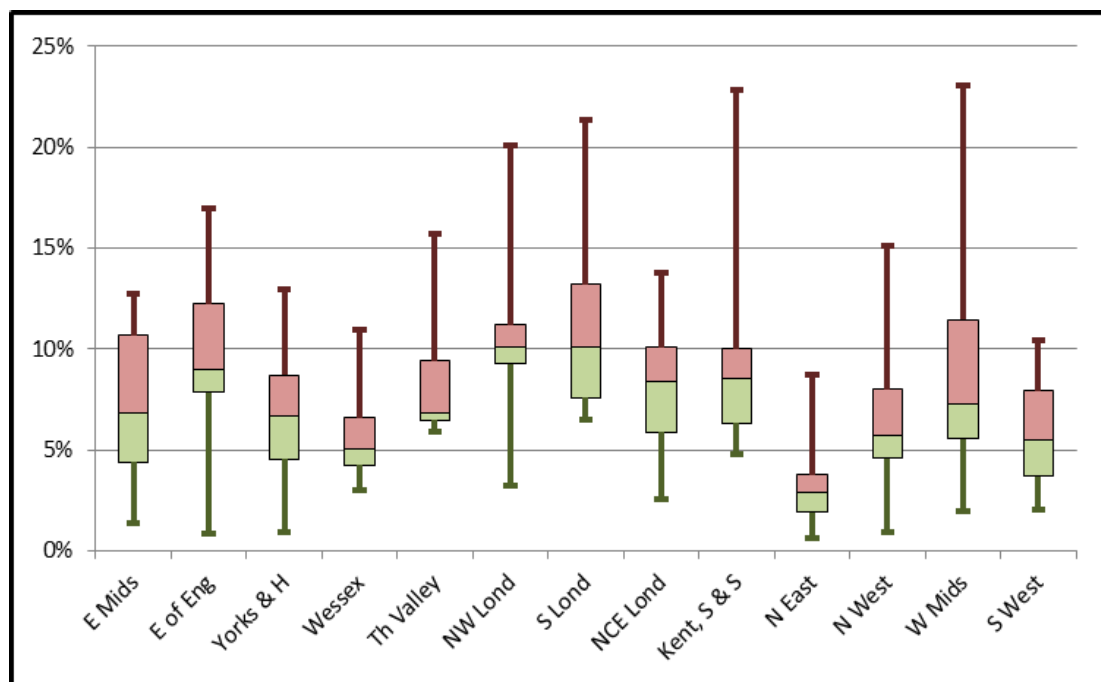
4.16. A range of financial controls to limit spending on high cost agency staff has been introduced since last summer as part of the wider effort to stem unaffordable growth in total workforce costs. These controls comprise caps on the prices paid to agencies, ceilings on agency spend and use of approved frameworks for the procurement of agency workers. The controls are intended to reduce the cost of agency staffing to the NHS from £3.7bn in 2015/16 to around £2.5bn in 2016/17 which is needed to control costs and ensure our workforce is sustainable

Table 4.4: Agency Expenditure Rate by Region, 2013/14 to 2015/16



Source: NHS Improvement

Table 4.5: Variation in Agency Expenditure Rate, by Region: 2015/16



Source: NHS Improvement – Trust Financial Accounts

Note: The chart shows the 5 quartile Trust agency values for each region. For example, in East Midlands, the lowest agency expenditure by a Trust was 1.4% of staff costs, the highest was

12.7%, and the median average was 6.8%. The upper and lower limits of the box are the 25% and 75% points: 25% of Trusts had agency expenditure more than 10.7% and 75% spent more than 4.4% of staffing expenditure on agency.

4.17. Agency expenditure is highly variable between Trusts. Variation between Trusts within regions is far greater than variation in the average between regions. In 2015-16 the regional median average varied between 2.9% and 10.1%, and the Trust rate ranged from less than 1% to 23% of staff costs. This suggests that agency expenditure is driven principally by individual Trust-specific factors.

Summary

4.18. Agency expenditure for HCHS staff overall has increased significantly in most regions, though the figures cover all HCHS staff, not just DDRB remit group

4.19. The increase is widely believed to have resulted from unexpected increase in recruitment beyond planned levels, primarily to achieve safer staffing levels. This level of demand could not be met in the short term by the supply of newly qualified graduates. Aggregate regional rates are generally higher in London and the south-east than in the north and south-west, but variation between Trusts within regions is much greater than variation between regions, suggesting that costs are driven by individual Trust-specific factors.

Controlling Agency spend

4.20. A range of financial controls to limit spending on high cost agency staff have been introduced since summer 2015 as part of the wider effort to stem unaffordable growth in total workforce costs. These controls comprise caps on the prices paid to agencies, ceilings on agency spend and use of approved frameworks for the procurement of agency workers. The controls are intended to reduce the cost of agency staffing to the NHS from £3.7bn in 2015/16 to around £2.5bn in 2016/17 which is needed to control costs and ensure our workforce is sustainable

4.21. The number of hours of agency and bank staff in acute trusts increased from c1.2m in December 2012 through to over 1.9m in December 2014, as hospitals increased their staffing following the publication of the Francis Report in February 2013. Spending on agency staff has risen by £2.5bn (from £1.7bn in 2010/11 to £3.7bn in 2015/16. On 13 October 2015, the Government announced a series of radical measures to address the cost of agency staff employed in the NHS with the intention of significantly reducing

spending. The financial controls introduced by NHS Improvement¹⁰ which are now in place include:

- A requirement for all trusts to stay within annual expenditure ceilings;
- mandatory use of approved frameworks for procurement; and
- hourly price caps limiting the amount a trust can pay to an agency.
- Annual Expenditure Ceilings

4.22. NHS Improvement set ceilings on the total amount individual NHS Trusts and Foundation Trusts can spend on agency staff in 2016/17. The ceilings were calculated based on a Trust’s Q1 to Q3 (April to December) 2015/16 spend on agency as a percentage of total staff spend (Table 4.6).

Table 4.6 Agency Spend Ceilings for NHS Trusts and NHS Foundation Trusts

Current Agency Spend as a Percentage of Total Staff Spend	Required Reduction in Agency Spend
Above 4.6%	35%
3% - 4.6%	0 - 35%
At or below 3%	0%

Mandatory Use of Approved Frameworks

4.23. As of 1 April 2016 all NHS Trusts and NHS Foundation Trusts are required to use frameworks approved by NHS Improvement when procuring agency staff. Price caps are being embedded into framework agreements and will be fully embedded by late October 2016. As such agencies will be incentivised to comply on price so that their staff can be procured through mandatory frameworks.

Hourly Price Cap

4.24. In November 2015, price caps were introduced limiting the amount a trust can pay to an agency for temporary staff.

¹⁰ <https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/>

4.25. The price caps were introduced gradually and in a phased approach, having initially been set at a higher level to enable NHS Trusts and Foundation Trusts time to adapt. Table 4.7 shows the phasing of the price caps.

Table 4.7 Phasing of Hourly Price Caps for Temporary Staff

	Junior Doctors	Nurses & Other Clinical Staff (including Consultants)	Other Staff
23 Nov 2015	150%	100%	55%
1 Feb 2016	100%	75%	55%
1 April 2016	55%	55%	55%

4.26. Price caps for all staff from 1 April 2016 are calculated at 55% above basic pay rates. This takes into account holiday pay (annual leave and bank holidays), employer National Insurance contributions, a nominal employer pension contribution and a modest agency fee. Further information and reference tables are available on the NHS Improvement website¹¹.

4.27. The controls are having an impact on spending. From April 2016 to July 2016 the NHS spent £188m less than in the same period in 2015 (Spending is £555m less than projected spending before controls were introduced). We recognise there is more to do and we are working in partnership with NHS Improvement to deliver a number of measures to strengthen controls and drive further spending reductions.

Medical and Dental Staff Earnings Growth

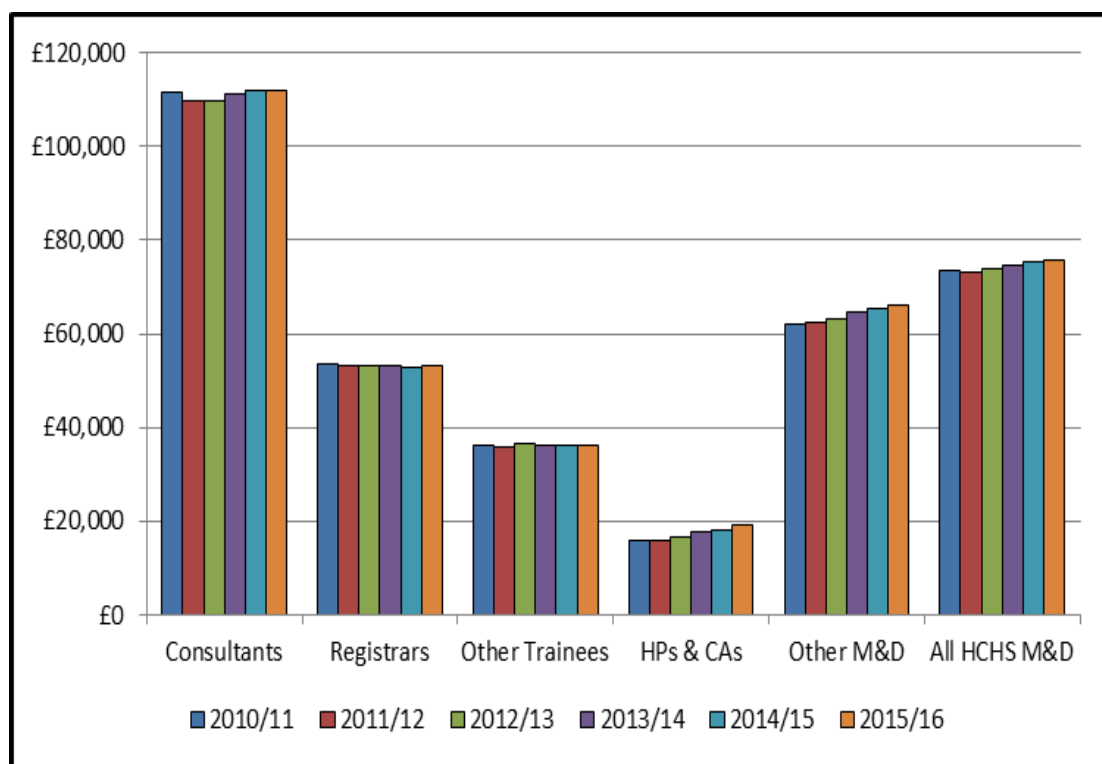
4.28. Overall earnings per person have increased slightly year-on-year since 2011/12. Part of this increase reflects change in grade mix: the number of consultants has grown faster than other groups, and because consultants earn more on average than other groups, this has increased the average.

4.29. NHS Digital publishes NHS Earnings Statistics based on information about payments in the NHS Electronic Staff Record. Average earnings growth since 2010/11 has been almost flat for the Registrar and Other Trainees groups. The Consultant group average fell slightly in 2011/12 and increased in 2013/14 and 2014/15. There has been increase in each of the last four years for the Hospital Practitioners & Clinical Assistants and Other Medical & Dental groups.

¹¹ <https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/>

These figures do not represent the earnings growth experienced by staff employed within one group throughout the five-year period. (We have undertaken separate analysis on this which is included at Annex B, and which shows that the total earnings of HCHS doctors increased by an average of 3.3% per year between 2010 and 2015). 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. Only 12% were on the top point of their pay scale in 2015/16. A new longitudinal analysis of earnings growth experienced by doctors employed in the HCHS at the beginning and end of the last 5-year period is included at Annex B.

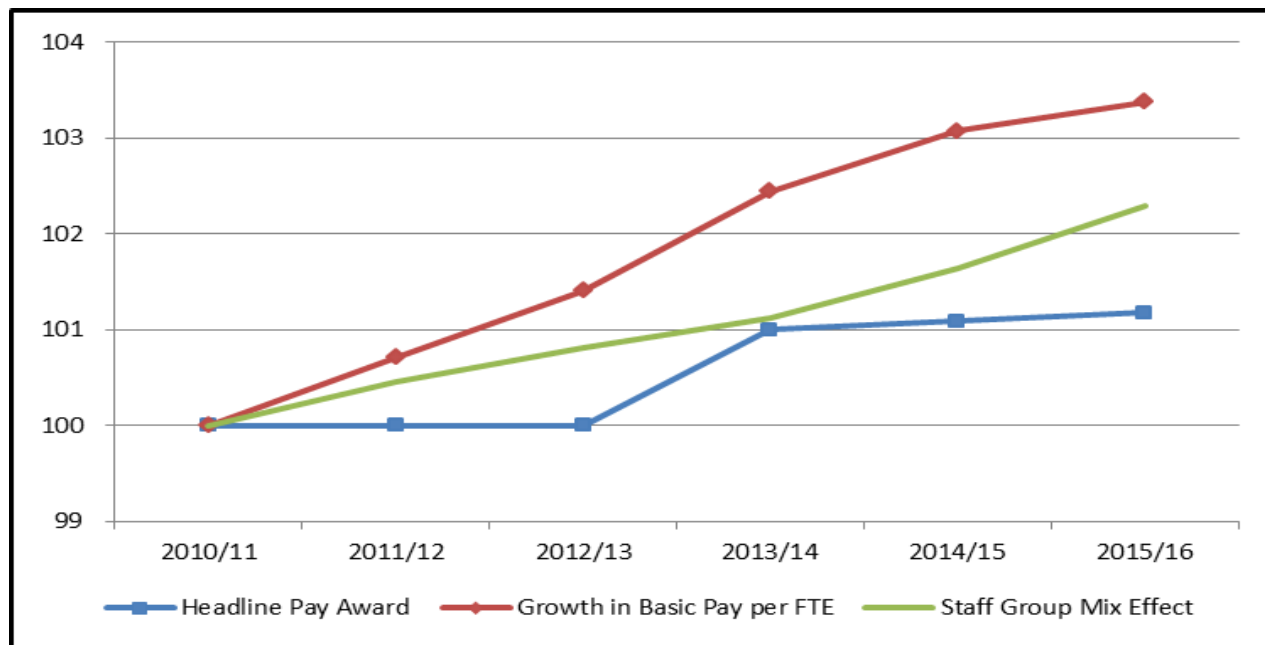
Table 4.8: HCHS Medical & Dental Staff Average Earnings per Person by Grade Group: Time Series



Source: NHS Digital – NHS Earnings Statistics

4.30. The effect of headline pay awards was about 1.2% between 2010/11 and 2015/16, and average basic pay per FTE increased by 3.4%. There was a significant effect of 2.3% from change in grade group mix.

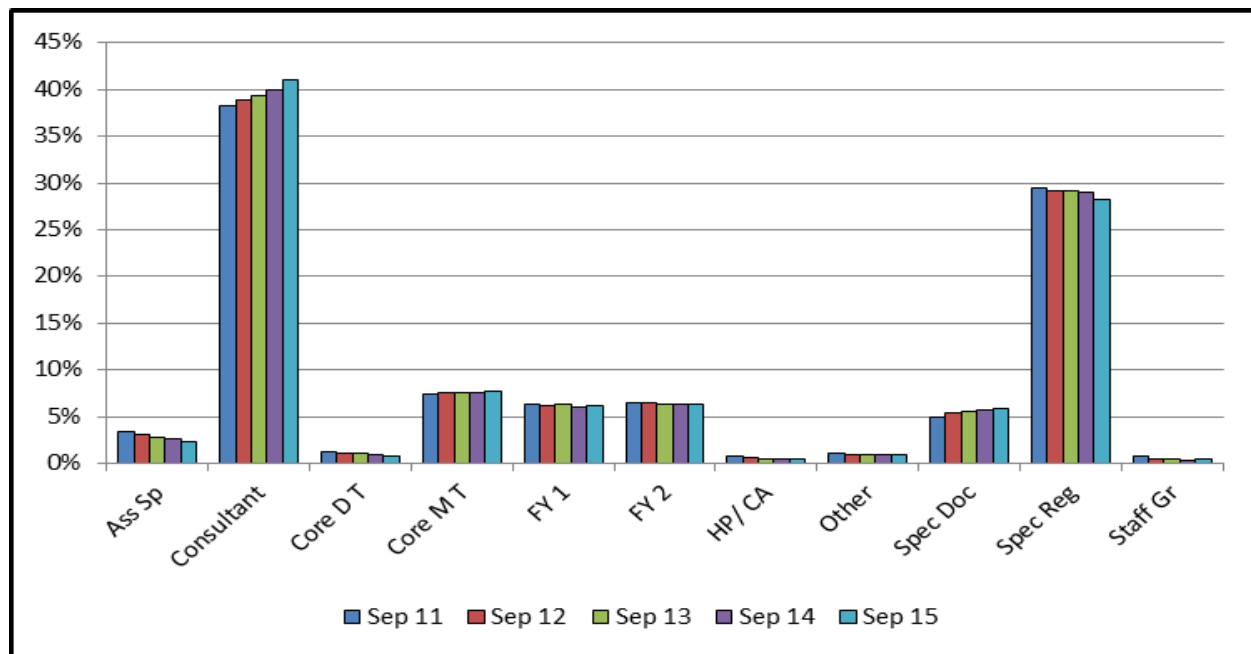
Table 4.9: Pay Awards and Average Basic Pay Growth for HCHS Medical & Dental Staff: Time Series Indices



Source: Collated Summary Outputs: HCHS Headline Paybill Metrics

4.31. The grade mix effect has arisen from year-on-year increase in consultants' representation in the Medical & Dental (M&D) workforce. Average earnings are affected because consultants earn more on average than other groups. Table 4.10 shows for each year the representation of each grade group in the medical and dental workforce. For example, in 2011 consultants represented 38% of the M&D workforce, and this increased to 41% in 2015.

Table 4.10: Distribution of HCHS Medical & Dental FTE Between Grade Groups: Time Series



Source: NHS Digital Workforce Statistics

The Effect of Pay Restraint on Doctors’ Earnings Compared with Other High-Earning Occupations

- 4.32. 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 2015
- 4.33. 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 overstate any erosion of pay differentials as a result of, for example, sample effects.
- 4.34. 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.

Analysis

4.35. The tables below show that the annual pay of Medical Practitioners has broadly maintained its rank position relative to the other high-earning occupations between 2011 and 2015. Table 4.11 includes each 4-digit occupation code group with a published median annual gross pay figure higher than £55,000 for 2011 and a published median figure for 2015, and also the average for all employees. This Table shows that in both years the median for Medical practitioners was 4th highest amongst the 2011 top six, after Chief executives & senior officials, Aircraft pilots & engineers, and Marketing & sales directors, and more than 2.9 times the average for all employees in the UK, despite the fact that Medical Practitioners is the only group in the Table to include junior trainees.

Table 4.11: Median Annual Gross Pay for High-Earning Occupations in 2011 and 2015

Occupation	Median Annual Gross Pay		Number of jobs (thousand)
	2011	2015	
Chief executives and senior officials	£71,515	£80,871	67
Aircraft pilots and flight engineers	£66,810	£84,592	10
Marketing and sales directors	£64,515	£68,338	144
Medical practitioners	£62,621	£65,843	164
Information technology and telecommunications directors	£57,924	£61,082	29
Senior police officers	£56,903	£61,841	11
All employees	£21,100	£22,487	21,634

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2011 and 2015 – Gross Annual Pay by Occupation (4-digit SOC 2010)
<http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashtable14>

4.36. Table 4.12 includes each 4-digit occupation code group with a published 70th percentile annual gross pay figure higher than £70,000 for 2011 and a published 70th percentile figure for 2015, and also the average for all UK employees. This Table shows that in both 2011 and 2015 the 70th percentile pay figure for Medical Practitioners was in the top three occupation groups and around three times the figure for all UK employees. Note that although the ASHE figures for Medical Practitioners show a decrease in the 70th percentile, the HCHS M&D figures published by NHS Digital show an increase from £113,000 in 2012 to £116,500 in 2015. (These statistics were not published for 2011.)

Table 4.12: 70th Percentile Annual Gross Pay for High-Earning Occupations in 2011 and 2015

Occupation	70th Percentile Gross Annual Pay		Number of Jobs (thousands)
	2011	2015	
Chief executives and senior officials	£109,746	£115,114	67
Medical practitioners	£94,911	£92,991	164
Marketing and sales directors	£89,267	£89,756	144
Aircraft pilots and flight engineers	£85,211	£96,780	10
Information technology and telecommunications directors	£81,566	£74,494	29
Financial managers and directors	£74,361	£80,020	238
All employees	£29,849	£31,495	21,634

Source: Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) for 2011 and 2015 – Gross Annual Pay by Occupation (4-digit SOC 2010)
<http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/occupation4digitsoc2010ashtable14>

Recruitment and Retention

4.37. 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. (Some of this is also covered in Chapter 5).

The Use of Recruitment & Retention Premia

4.38. This analysis is performed by NHS Employers and included in their evidence to avoid duplication. Consistency with the Headline Pay Bill Metrics figures is ensured by sharing data. The latest figures show that the previous very low percentage of medical and dental staff receiving an RRP payment has continued. There is no evidence of an increase in the use of RRP to address R&R problems.

Agency Expenditure

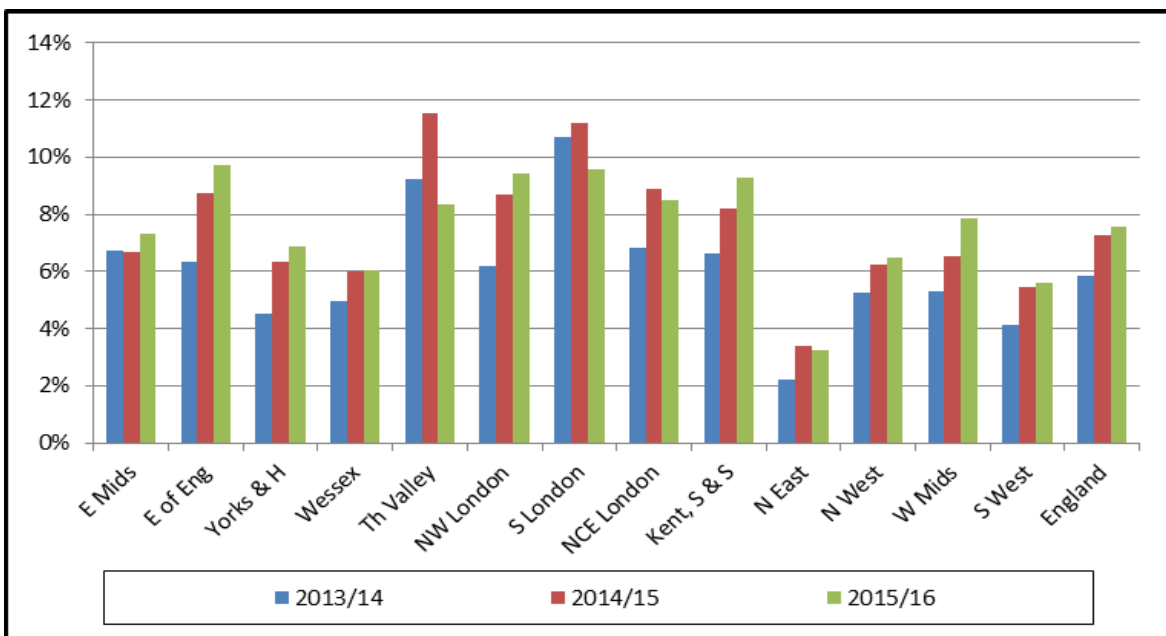
4.39. Agency expenditure has increased significantly, in most regions, though the available national figures cover all HCHS staff, not just medical and dental. The increase is widely believed to have resulted from unexpected increase in recruitment beyond planned levels, primarily to achieve safer staffing levels. This level of demand could not be met in the short term by the supply of newly qualified graduates. Aggregate regional rates are generally higher in London and the south-east than in the north and south-west, but variation between Trusts within regions is much greater than variation between regions, suggesting that costs are driven by individual Trust-specific factors.

Analysis

4.40. The available national expenditure figures do not separate non-medical from medical staff. They include all expenditure on off-payroll staffing, including agency, self-employed contractors and externally-managed banks.

4.41. Total expenditure on off-payroll staffing has increased significantly, from £2.6bn in 2013-14 to £3.7bn in 2015-16. At region level, the expenditure rate (agency as a percentage of total staff costs) is generally higher than average in London and the South-East and relatively low in the North and South-West. The level of change in the last two years has not followed a clear geographical pattern. There have been decreases in Thames Valley and South London; and the largest increases were in East of England; North West London and Kent, Surrey & Sussex.

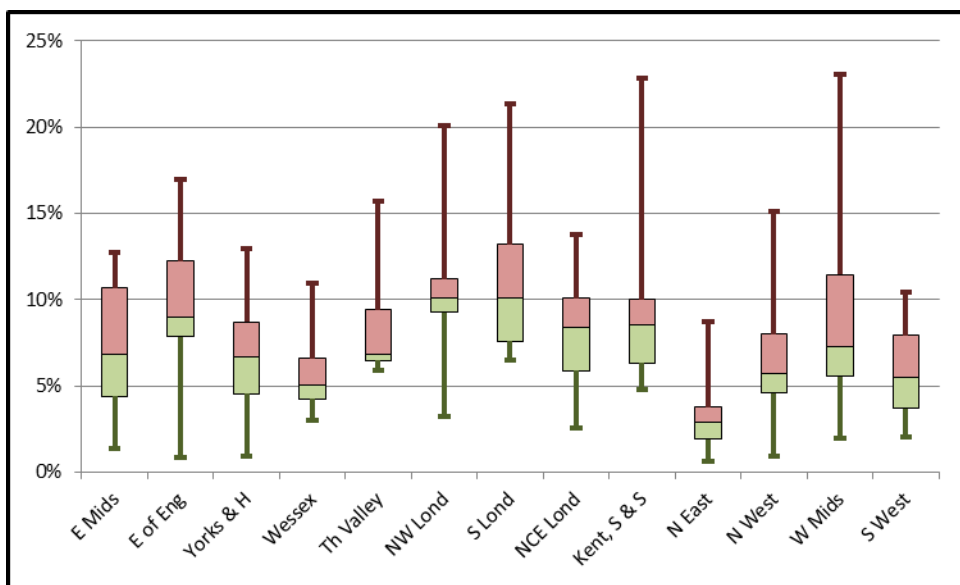
Table 4.13: Agency Expenditure Rate by Region, 2013/14 to 2015/16



Source: NHS Improvement

4.42. Agency expenditure is highly variable between Trusts. Variation between Trusts within regions is far greater than variation in the average between regions. In 2015-16 the regional median average varied between 2.9% and 10.1%, and the Trust rate ranged from less than 1% to 23% of staff costs. This suggests that agency expenditure is driven principally by individual Trust-specific factors.

Table 4.14: Variation in Agency Expenditure Rate, by Region: 2015/16



Source: NHS Improvement – Trust Financial Accounts

Note: The chart shows the 5 quartile Trust agency values for each region. For example, in East Midlands, the lowest agency expenditure by a Trust was 1.4% of staff costs, the highest was 12.7%, and the median average was 6.8%. The upper and lower limits of the box are the 25% and 75% points: 25% of Trusts had agency expenditure more than 10.7% and 75% spent more than 4.4% of staffing expenditure on agency

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.
- 5.2. The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system ("workforce supply") and 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 through recruiting and training new staff and retaining productive and experienced existing staff, and by increasing the efficiency and productivity of the workforce through better use of technology and changing the skill mix.
- 5.3. HEE has a clear remit to lead workforce planning and education commissioning across the health system to secure the future supply of workforce, based on local plans which are affordable and take full account of national policy requirements including integration and 7-day services.
- 5.4. Effective workforce planning requires reliable and accurate workforce information at both national and local level. HEE's National Workforce Plan for England is underpinned by national data collected by NHS Digital and a comprehensive local workforce planning process. This process involves local health communities across the country working in partnership to ensure that plans for the future workforce reflect the needs of local service users, providers and commissioners of healthcare in both acute and community settings within the available resources.
- 5.5. 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

- 5.6. Reliable and accurate workforce 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 the quality and coverage of published workforce information. Last year the DDRB and the NHSPRB asked for more consistent evidence and data covering vacancies, attrition/turnover by staff group and geography The Department's analytical team is

Recruitment, Retention, Motivation and Medical Workforce Planning

working closely with the Review Body secretariat to bring together data and information from a range of sources that will provide a reliable single source for all parties and address some of these issues.

Published Workforce Information

- 5.7. NHS Digital publishes workforce statistics monthly, bi-annually and annually. The annual publication provides the best means of viewing medium and long-term trends in workforce numbers and provides detailed information on staff working in the NHS in England at 30 September each year, including information on doctors working in general practice and primary care. This annual publication provides a more detailed breakdown of the HCHS information already published in the monthly workforce statistics and is the only source of long term time series covering the entire NHS workforce.
- 5.8. The monthly statistics provide a time series back to September 2009 for the HCHS trusts and CCGs. The time series provides the opportunity to see the impact of seasonal variation such as the effects of the training cycle. Medical students graduate in the summer and take up employment between July and August. Normal turnover results in a gradual decline in numbers over the rest of the year.
- 5.9. The monthly data provides headcount and FTE staff in post statistics includes turnover and is drawn from the HR and Payroll system for the NHS - Electronic Staff Record (ESR). It does not include staff working in general practice or those providing NHS funded services in organisations that do not use ESR, such as the independent sector, local authorities and some social enterprises, as well as two NHS organisations that do not use ESR.

Improvements to published workforce information

- 5.10. Following substantial consultation in 2015, NHS Digital implemented changes to the methodology for collecting and reporting workforce statistics. This resulted in a more accurate count of staff numbers and changes to the publication of workforce information to include separate publications covering independent sector staff and those working in NHS central bodies and support organisations. These changes came into place in the published statistics on 30 March 2016 covering HCHS and independent sector staff providing NHS funded services. The revised time series takes into account the main structural changes from the Health and Social Care Act 2012 to enable a historical comparison with previously published statistics.

Impact:

HCHS – trusts and CCGs

- 5.11. The new methodology showed a difference of 69,317 FTE at September 2015 between the old and new methodology for HCHS NHS staff. Of this number:
- 26,798 are now included in the HCHS support organisations and central bodies statistics;
 - 17,854 previously included in the HCHS monthly statistics but reflect staff working in community interest companies and social enterprises are now included in the independent sector organisations publication;
 - 25,095 are not receiving pay for activity and therefore have not been included
 - 189 are now included in the GP workforce statistics; and
 - 212 have a non-service contract (the following contract types; Honorary; Non-Exec Director/Chair; Prof Exec Committee; Retainer Scheme, and Widow/Widower) and therefore have been removed from the statistics.
- 5.12. NHS Digital also publishes additional quarterly data on HCHS staff in trusts and CCGs, including reasons for leaving, staff movements and redundancy data, as well as data on earnings and sickness absence. On a quarterly basis, NHS Digital publishes data on HCHS Central Bodies and Support Organisations which includes for example NHS England, HEE, NHS Digital, and Public Health England.
- 5.13. As part of the consultation, NHS Digital sought users' views on the introduction of a publication of bank staff numbers to provide additional information on the flexible workforce. As a result of feedback, NHS Digital has undertaken some initial work to investigate the NHS staff earnings data to identify bank staff, with the intention of developing a new publication to show these new analyses and provide a time series by staff group.
- 5.14. The Department has worked with NHS England, HEE and NHS Digital on the design of the workforce information architecture for the new education and training system, developed, piloted and now rolled out a workforce Minimum Data Set (wMDS) to be collected from all providers of NHS funded care, to support the workforce planning process.
- 5.15. The wMDS is an expanded data collection that now covers all HCHS and general practice staff, and is collected bi-annually. The wMDS also includes information on absences and vacancies. For general practice, the data will also include more detail on

Recruitment, Retention, Motivation and Medical Workforce Planning

joiners and leavers (including if available, the source of recruitment, reason for leaving and destination).

- 5.16. The general practice data will be published by NHS Digital in September 2016 and will reflect the staff in post numbers as at 31 March 2016. The general practice absence and vacancy data which will be included for the first time will cover the six month period from September 2015 to March 2016.
- 5.17. All wMDS data items will assist planners in understanding workforce demographics and in developing strategies and plans to ensure the appropriate education commissioning, education and learning strategies and whole system changes to provide a future workforce with the required skills and competencies.

Vacancy data

- 5.18. Vacancy rates are an important element of workforce planning at local and national levels. NHS Digital consulted on the publication of administrative data taken from NHS Jobs to provide some vacancy data. The feedback generated continues to inform the development of the publication with the third and most detailed in the series published on 25 August 2016. This publication follows a similar but enhanced methodology and format, which will continue to develop and provide more meaningful information and trends of advertised vacancy per FTE by staff group, area of work, occupational group, region and organisation cluster group.
- 5.19. The data derived from NHS Jobs reflects the FTE that is advertised for each vacancy, taking into account adverts that offer more than one post. However an advert might cover multiple vacancies or an ongoing recruitment programme. Whilst the processing of the data has been improved, in particular with regards to ensuring only jobs in the NHS are included, adverts can be placed by NHS sub-contractors and local authorities so not all adverts will be for jobs in the NHS.
- 5.20. The publication on 25 August covered the period 1 February 2015 to 31 March 2016 (inclusive) and breaks down the FTE advertised vacancies each quarter by staff group and area of work. This publication of “experimental” data differs again in that the timescales have changed. This is the first time the data has been displayed in four quarters. Due to these methodological changes it is not possible to directly compare the figures covered by the three publications and NHS Digital are discouraging users from attempting to draw any conclusions from this data at this time.
- 5.21. The data shows that the FTE number of advertised vacancies in England in each month between February 2015 and March 2016 varied between around 23,000 and 29,500.
- 5.22. There are other definitional and data quality issues relating to the NHS Jobs information and NHS Digital continues to drive forward improvements in data quality. Over time, the

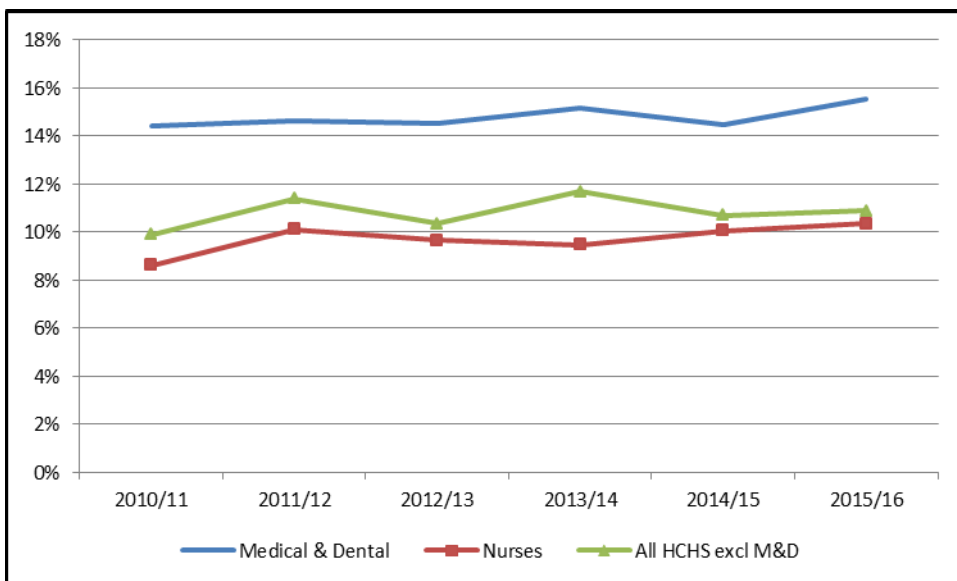
time series will allow comparison to be made relating to the advertised vacancy FTE, which may provide a more useful indicator or proxy measure related to recruitment within the NHS.

- 5.23. NHS Digital continues to investigate other sources for vacancy information to build on the information extracted from NHS Jobs, potentially including data derived from the ESR system even though not all organisations use ESR to record establishment and vacancies. The intention is to both help define what more meaningful data may be possible to extract from different systems, and improve the quality and completeness of data in those systems, including both in ESR and in NHS Jobs.
- 5.24. Information on vacancies is also gathered by HEE and NHS Improvement and used to inform workforce planning and monitoring of the health and care system.

Turnover

5.25. NHS Digital produces turnover statistics based on information in the NHS Electronic Staff Record. The leaver rate is the percentage of the workforce leaving their staff group in the HCHS in a year. It excludes staff moving between Trusts, but includes people moving from the HCHS to e.g. general practice. The leaver rate for HCHS medical & dental staff was around 14.5% per year in 2010/11 to 2012/13. 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. Note: the figures include junior doctors, some of whom leave the HCHS as part of their training, for example into primary care, as part of their rotation.

Table 5.1: HCHS Staff Leaver Rates: Time Series



Source: NHS Digital (ad hoc request)

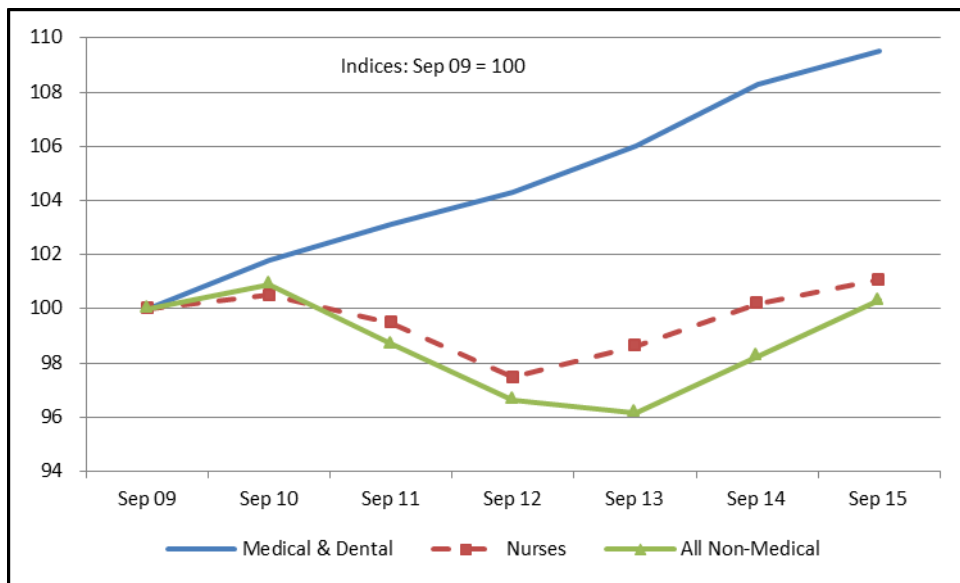
Workforce Planning

- 5.26. Effective workforce planning is critical to the delivery of affordable, high quality care. Workforce planning requires an understanding of the external and internal environment, business vision and strategy and current workforce. It also requires forecasted information taking into account the impact of turnover, retirements, recruitment and continuing professional development on workforce demand and supply. The recent National Audit Office report¹² and the Migration Advisory Committee report into nursing shortages¹³ has highlighted concerns about workforce planning in the NHS in the context of continuing shortages of key staff groups.
- 5.27. The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system (“workforce supply”). In conjunction with HEE and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff and to increase the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.
- 5.28. The government continues to make a significant investment in educating, training and recruiting doctors. This has resulted in a 10 per cent increase in the medical workforce since 2010. HEEs National Workforce Plan for England for 2016-17 forecasts an increase in the available supply of doctors to the NHS workforce by 2020 of 14.6% above 2015 figures. The Department has mandated HEE to lead a process of improved workforce planning to ensure sufficient staff are trained with the right skills in the right locations to enable healthcare providers to deliver their commissioning plans within their available budgets.
- 5.29. There has been an increase of over 24,000 more professionally qualified staff working in the NHS since May 2010 and with over 50,000 doctors in training, the government will continue to make sure there are sufficient staff available to give patients high quality, safe and sustainable care 24 hours a day, seven days a week.
- 5.30. Workforce Statistics published by NHS Digital show that the medical and dental workforce in trusts and clinical commissioning groups grew by 9.5% between 2009 and 2015, while the rest of the HCHS workforce increased by just 0.3%.

¹² <https://www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/>

¹³ <https://www.gov.uk/government/news/migration-advisory-committee-mac-report-on-nursing-shortage>

Table 5.2: HCHS Workforce FTE Growth: Time Series Indices

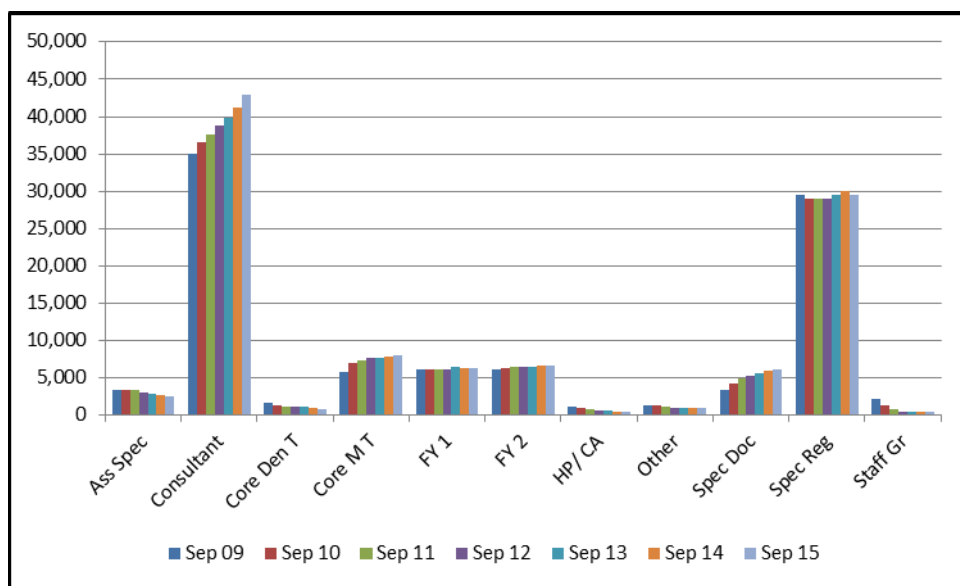


Source: NHS Digital Workforce Statistics

Note: The analysis looks at September figures, because these are mid-pay year and therefore most coherent with the pay figures which are on a pay year basis (April to March). The latest published FTE figures are for April 2016. These are not directly comparable with September figures because of seasonality, driven by the education year. As at 30 April 2016 there were 103,869 M&D FTE in Trusts and CCGs, an increase of 2.2% from April 2015.

5.31. Within the medical and dental workforce, there has been year-on-year FTE growth for consultants and speciality doctors. The number of registrars has changed little, and there have been decreases for associate specialists, staff grade, and hospital practitioners/ clinical assistants.

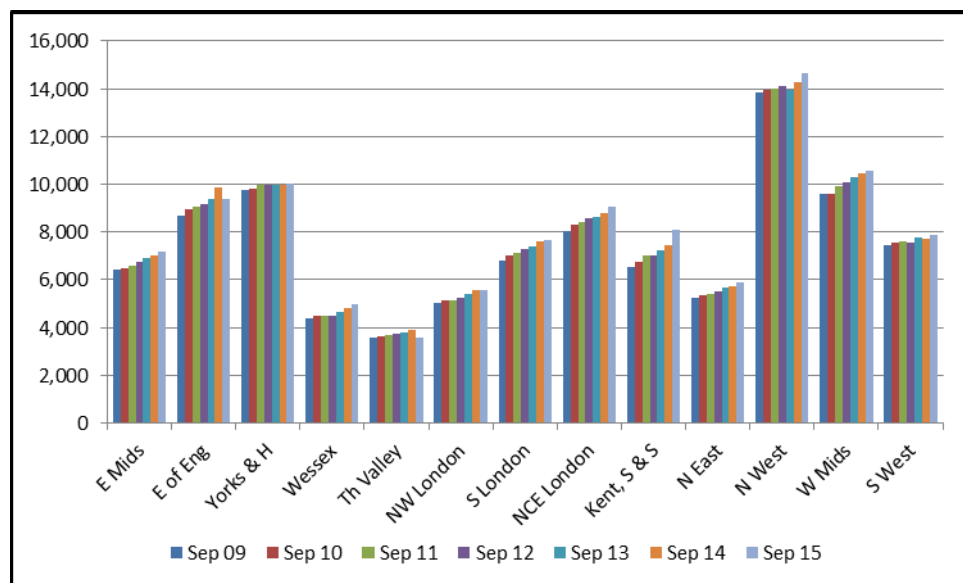
Table 5.3: HCHS Medical & Dental Workforce FTE, by Grade Group: Time Series



Source: NHS Digital Workforce Statistics

5.32. The North West is the largest region in terms of the medical and dental workforce and Thames Valley is the smallest. There was steady year-on year growth in the HCHS medical and dental workforce between 2009 and 2015 in most regions. Exceptions to this were a flat trend in Yorkshire & Humber since 2011, and a temporary spike in 2014 in East of England. Growth between 2014 and 2015 was less consistent between regions: there was notably high growth in North West and Kent, Surrey & Sussex; and a decrease in Thames Valley.

Table 5.4: HCHS Medical & Dental Workforce FTE by Region: Time Series



Source: NHS Digital Workforce Statistics

Skill Mix

- 5.33. The Department is working with HEE to consider how skill mix changes such as the development of physicians associates and nursing associates can help address workforce shortages and how the new model of apprenticeships can play a role in recruiting and developing the future health and care workforce in line with public sector apprenticeship targets with funding from the apprenticeship levy.
- 5.34. Physicians associates (PA) increase the medical workforce by acting in an enabling role, helping to reduce the healthcare team's workload. They bring new talent to the NHS and add to the skill-mix within teams. PA offer continuity of care for patients, as well as institutional memory for the team in which they work.
- 5.35. 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 PA 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.

International Recruitment

- 5.36. The government is committed to moving towards self-sufficiency and, as set out above, has increased training numbers and significantly increased the workforce. However, the size and diversity of the workforce and the time taken to train qualified healthcare professionals – especially doctors - means that there are always likely to be shortages caused by unexpected fluctuations in demand. Overall, the proportion of non-British staff in the NHS workforce has remained fairly stable. However, over the past six years, the number of non-EU nationals has decreased and they have been replaced by EU nationals. This reflects changes in the immigration rules to reduce migration and the increased mobility of EU citizens compared to those from outside the EU.
- 5.37. Following the outcome of the referendum the government will be entering negotiations with the EU on a range of issues including migration policy. Under current policy where there are particular pressures inclusion on the Shortage Occupation List makes international recruitment from non-EU states easier. Medical specialties currently on the Shortage Occupation List are:
- Consultants: clinical radiology, emergency medicine, old age psychiatry
 - CT3 trainee and ST4 to ST7 trainee: emergency medicine, core trainee in psychiatry
 - Staff grades: emergency medicine, old age psychiatry, paediatrics

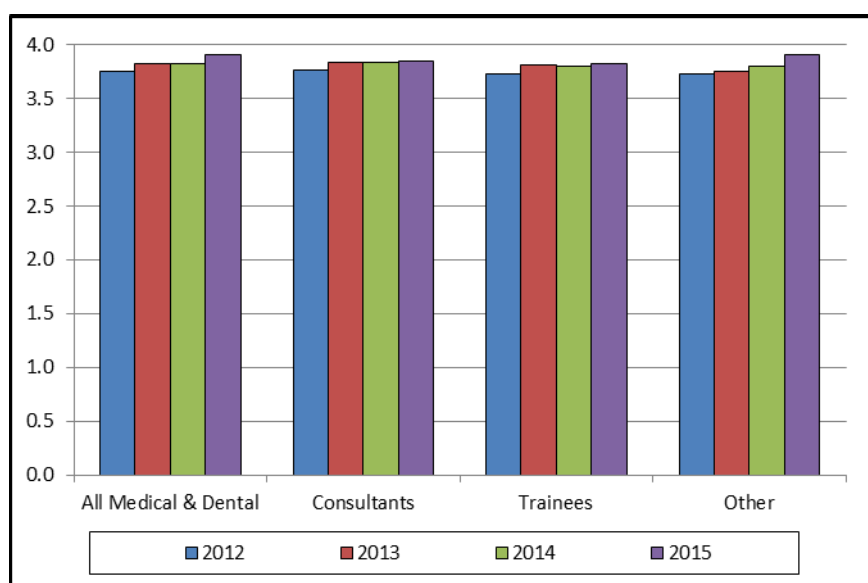
Recruitment, Retention, Motivation and Medical Workforce Planning

- 5.38. Other doctors from outside of the EEA can continue to enter into the UK to take up posts in the NHS through the Tier 2 (skilled migrants) route of entry. Whilst a small number of doctors were denied entry due to the Tier 2 allocation limits being reached in mid-2015, this has not occurred since, although it remains a risk particularly to roles at CT/ST 1 level and to a lower degree at CT/ST 2 level.

Staff Engagement

- 5.39. The Department is committed to developing and improving the data available to employers that will help them improve their staff experience. This includes the annual NHS Staff Survey, the Staff Friends and Family Test (FFT), sickness absence statistics and network groups, which complement local information. Staff engagement is improving with an overall increase across the NHS from 3.71/5 in 2014 to 3.78/5 in the 2015 Staff Survey results
- 5.40. The Engagement Index shows improvement for doctors, and sickness absence has remained at its trend low level. Morale, as indicated by these measures, appears not to have changed significantly in recent years
- 5.41. The Index results from the last four surveys show that for HCHS Medical & Dental Staff overall and for consultants and other Medical & Dental staff excluding trainees, the Engagement score improved year on year. For trainees the score improved in 2013 and fell back marginally in 2014 and improved again in 2015.

Table 5.5: Engagement Score for HCHS Medical and Dental Staff: 2011 to 2015



Source: NHS Staff Survey

- 5.42. There is a complex relationship between overall pay and levels of staff engagement, morale and motivation. Staff engagement is crucial to create the right culture and to develop an environment where staff want to work. At a national level we encourage local organisations to develop their own local initiatives as they are best placed to do so. Work continues with NHS Employers on raising the importance of staff engagement highlighting other factors that impact on staff engagement such as interaction with line managers, employee voice and the handling of organisational change. There is a complex relationship between overall pay and levels of staff engagement, morale and motivation. The 2015 NHS Staff Survey¹⁴ score for overall staff engagement of 3.78/5 for “all trusts” remains reasonably high despite the pressures on NHS staff. We measure morale through the NHS Staff Survey using staff engagement scores. For medical and dental consultants the score was 3.91/5 in the 2015 up from 3.84/5 in 2014 and 2013, for doctors and dentists in training it was 3.85 in 2015 up from 3.81/5 in 2014 and 2013.
- 5.43. A NHS Staff Survey measure for motivation was introduced in 2009. Staff motivation as it is used within the NHS Staff S Survey is defined as “the extent to which staff look forward to going to work, and are enthusiastic about and absorbed in their jobs.” The trend for motivation as measured by staff motivation at work has been fairly stable with overall NHS scores (for all organisations) of 3.72/5 in 2013, 3.85/5 in 2014 and 3.93/5 in 2015. Scores for both groups of medical and dental staff are higher than average with consultants at 4.01/5 in 2014 and 4.05 in 2015 and doctors and dentists in training 3.98/5 in 2014 and 4.01 in 2015.

¹⁴ <http://www.nhsstaffsurveys.com/Page/1010/Home/NHS-Staff-Survey-2015/>

Recruitment, Retention, Motivation and Medical Workforce Planning

- 5.44. Published research¹⁵ has shown that good staff support and engagement is directly related to patient experience, safety and quality of care.
- 5.45. A further test of staff engagement is the extent to which employees would advocate their trust as a place to receive care and a place to work, and whether they consider that their trust has care of patients as its top priority (advocacy). This is reflected via the FFT for staff and patients and given greater impetus as NHS England has introduced a Commissioning for Quality and Innovation (CQUIN) payment for NHS organisations to support implementation of the staff FFT.
- 5.46. The Staff FFT was introduced in April 2014 and is carried out quarterly by NHS England. It allows staff to give their feedback on NHS services helping trusts locally understand quickly what is working well and what areas need attention. The Staff FFT asks whether staff would recommend their organisation as a place to work and whether they would recommend their organisation as a place to receive treatment¹⁶. Although there is wide variation across the service the overall trend is positive with Q4 2015/16 indicating that 62% of staff said that they would recommend their organisation as a place to work; and 79% of staff said that they would recommend their trust as a place to receive treatment (up from 76% in Q1 2014/15).
- 5.47. The annual NHS Staff Survey records advocacy through the key indicators “staff recommendation of the(ir) trust as a place to work or receive treatment”. Scores for DDRB’s remit group include, for example, medical and dental staff overall recording 3.75/5 in 2014 with an increase to 3.82/5 in 2015, consultants 3.71/5 (2014) increasing to 3.81/5 in 2015. The score for medical and dental staff in training increased from 3.80/5 (2014) to 3.84/5 in 2015.
- 5.48. In terms of the Pay Review Body’s comments about how regulatory frameworks can address the issues of staff engagement, we would like to cite the CQC’s regulatory regime¹⁷ which also uses measures of staff engagement as part of the Chief Inspector’s assessment of the organisational health of providers. Changes to the way CQC regulates, inspects and monitors care include a vision of a “well-led” service, with effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from other people’s views and experiences to make improvements. Inspections encompass an assessment of aspects of governance, leadership and culture to assess whether a service is “well-led”. The CQC reports provide information on the range of staff engagement activity across the NHS to enable benchmarking and monitoring of progress.

¹⁵ West, M. Culture and Behaviour in the English NHS (2013)

¹⁶ <https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/>

¹⁷ <http://www.cqc.org.uk/content/how-we-inspect-and-regulate-guide-providers>

- 5.49. The DDRB future evidence requirements mentioned the poor levels of well-structured appraisals. The NHS Survey questions relating to appraisals in 2014 asked how many have received an appraisal, annual review, development review or Knowledge and Skills Framework development review before going on to ask how it helped them to do the job. The NHS staff survey question for 2015 asked specifically about the quality of appraisals. The overall score across the NHS was 3.08/5. It was higher for doctors and dentists in training at 3.24, but lower for medical and dental consultants at 3.00.
- 5.50. In his review of leadership in the NHS, Lord Rose¹⁸ identified that whilst staff received an appraisal the quality was poor “The 2013 NHS staff survey results stated that 84% of staff had received an appraisal while only 38% said that their appraisal had been well structured. This resonates with what this Review heard”. He made a series of recommendations aimed at improving the rate and quality of appraisals in the health service. The National Leadership Development and Improvement Board (LDIB) is developing a package of measures which will respond to these recommendations; details will be published in October 2016.
- 5.51. It is vital that employers engage with their staff on issues which affect them and the way they work. The Department supports this through the NHS Constitution Staff Pledges which state that “the NHS is committed to engage staff in decisions that affect them and the services they provide, individually through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families”. Employers are best placed to decide how they can most effectively improve engagement locally, whilst making the most of the partnership arrangements and good practice. The NHS has a comprehensive range of data as well as good practice advice and guidance to help trusts plan how they can improve staff engagement locally.
- 5.52. There is clear evidence that staff engagement is being encouraged through the new models of care being developed across the NHS in England as a result of the Five Year Forward View and the development of Vanguards (sites for the new model of care programme)¹⁹ and includes:
- Northumberland Primary and Acute Care System (PACS) where staff engagement has been embedded from the start. Trade Unions are engaged in the work of the Vanguard via a local partnership forum. Effective staff engagement means there is a collective will to work together to ensure the best results for their patients. This

¹⁸ <https://www.gov.uk/government/publications/better-leadership-for-tomorrow-nhs-leadership-review>

¹⁹ <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

organisation also has an engagement platform in place around service improvement which enables the identification of more effective ways of delivering care. The involvement of staff in the development of these new ways of working have been key in obtaining support.

- Following a move out of special measures in 2015, Bolton NHS Foundation Trust launched a scheme reassessing its values to boost the staff morale and engagement amongst its 5,000 employees. It was an opportunity to see how the organisation might move forward in the context of the Greater Manchester devolution. Four key values were identified by the staff: compassion; excellence; openness; and integrity - all key elements of an engaged workforce. A further survey will be undertaken in September 2016 to enable the staff engagement team to identify whether there are any gaps to bridge and whether more work needs to be undertaken to strengthen workplace culture.
- The Northern Devon Healthcare NHS Trust was rated fourth in the country for staff satisfaction in 2014. However, the organisation required reconfiguration as care moved closer to the patient-home and the trust needed to be sure that all staff, especially those geographically difficult to reach, were kept up to date on developments. An electronic solution was identified to ensure more frequent staff engagement opportunities and an on-line platform produced with the agreement of staff. The platform enables staff to run polls; extract health and wellbeing information; share good practice and encourage innovations through the sharing of ideas. There are plans to develop the platform further towards the end of the year enabling staff to raise areas of concern anonymously and there are plans to introduce live chat forums with the senior management team.

5.53. The NHS Confederation have collated good practice examples accessible on their website²⁰:

5.54. The Department has been highlighting the importance of staff engagement including, for example, most recently, supporting events with NHS Employers to raise the profile and its importance in the service including support for the government's "Engaging for Success Taskforce"²¹. The Department has commissioned NHS Employers to develop staff engagement resources. Examples include a staff engagement toolkit²² to support trusts and, following the Francis report²³ to help line managers foster staff engagement and better understand what it means to be an engaging manager in the NHS.

²⁰ <http://www.nhsconfed.org/resources/2016/06/new-care-models-and-staff-engagement>

²¹ <http://engageforsuccess.org/>

²² <https://www.google.co.uk/#q=nhs+employers+staff+engagement+toolkit>

²³ <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/>

- 5.55. The Department commissioned NHS Employers to work with the NHS Leadership Academy to develop “Do-OD” – the first national Organisational Development (OD) resource for the NHS which supports the service to be more effective in leading organisational and culture change enabling system transformation²⁴.
- 5.56. The focus of this work links with the Leadership Academy’s programmes’ aims. It supports trusts in delivering culture change, improving staff engagement, and helping the development of a more open, supportive and inclusive culture in which, for example, reporting incidents can be done with confidence, and in which the risk of bullying can be reduced. As the NHS undergoes changes on numerous levels and as the needs of patients change, new approaches to delivering care are also needed. The work of Do-OD acknowledges the complexities and helps equip OD practitioners with knowledge and skills to enhance their practice. Do-OD will support practitioners to think differently and to make changes which take a more transformational rather than transactional approach to their practice.
- 5.57. NHS Improvement are working with the King’s Fund on a two-year programme to help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality compassionate care. The programme provides practical support to help trusts diagnose their cultural issues, develop collective leadership strategies to enable them to address these issues and make the necessary changes.
- 5.58. NHS Improvement are looking at existing resources and programmes of work, such as the Carter review and, where they add value, building them into the programme of work. To ensure that the programme is relevant and has a lasting benefit for providers, three pilot sites have been identified to help, develop and tests all aspects of the support.
- 5.59. The importance of staff engagement is also being promoted by the NHS Leadership Academy²⁵ in their refreshed version of ‘the Healthy NHS Board’²⁶. This sets out what boards need to put in place to help them develop a responsive insightful approach to issues in their organisations, including advice on effective staff engagement. The Academy is also developing and implementing a leadership development offer that places strong emphasis on shaping positive cultures and engaging staff.
- 5.60. The Academy provides a suite of leadership development programmes that represent the first national approach to leadership development in the NHS , designed to develop outstanding leaders for every tier across the healthcare system, ‘from frontline to board’.

²⁴ <http://www.nhsemployers.org/campaigns/organisational-development>

²⁵ <http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/engaging-the-team/>

²⁶ <http://www.leadershipacademy.nhs.uk/resources/healthy-nhs-board/>

- 5.61. The evidence of West et al found a significant reduction in patient standardised mortality rates in organisations with high staff engagement (in turn associated with high levels of effective and engaging leadership) so the Academy's leadership development programme contain components of the values and behaviours required in a new integrated health care system. These are focused around the needs of the patients, carers and service users in ways which liberate, engage and motivate staff to provide compassionate and personal health care. These behaviours are congruent with NHS values and uphold the NHS Constitution, which states; "Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported".
- 5.62. The Pay Review Bodies imply that a more centrally directed approach to staff engagement may be more appropriate. However, evidence from the NHS Staff Survey does show an improvement in the overall staff engagement scores. Of course, there is no room for complacency given wide variation across NHS organisations and staff groups and the continuing pressures facing the NHS, which is why we continue to commission NHS Employers to support local organisations to develop their own bespoke staff engagement strategies.

Staff Health and Wellbeing

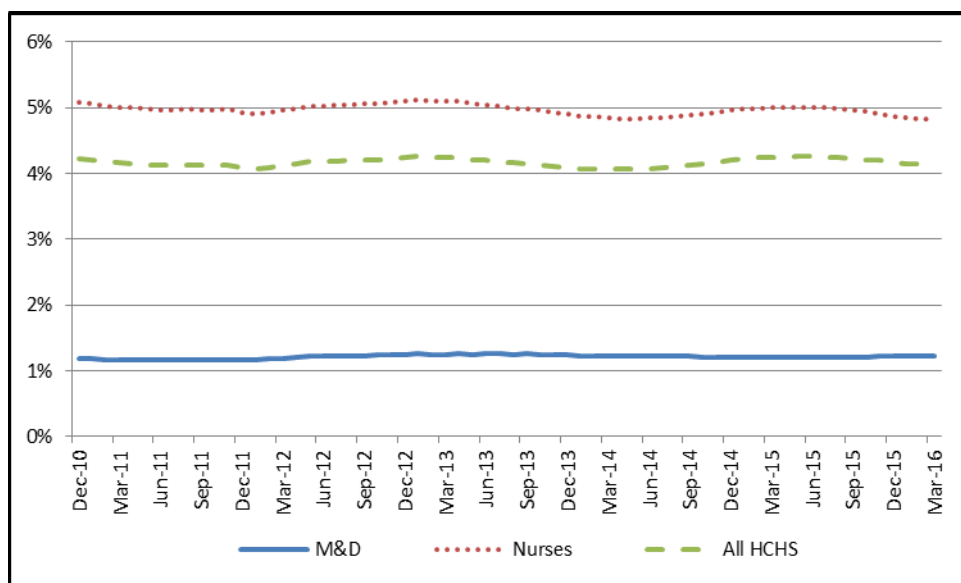
- 5.63. The Department continues to commission NHS Employers to support trusts in their responsibility for improving the health and wellbeing of their staff in line with the NHS Constitution pledge "provide support and opportunities for staff to maintain their health, wellbeing and safety"
- 5.64. Improving staff health and wellbeing can help NHS organisations increase productivity and make efficiency savings, as well as improve the experience of patients and staff.
- 5.65. In terms of wellbeing, key staff survey indicators show small changes compared with results from 2014:
- Staff working extra hours has risen in 2015 to 73% up from 72% in 2014
 - 85% for medical and dental staff (83% in 2014);
 - 89% for consultants (88% in 2014); and
 - 89% for doctors and dentists in training (80% in 2014)However we do not know if this is paid or unpaid or whether it is a choice to boost income.
 - In 2015 37% of staff reported suffering work related stress in the last 12 months compared to the previous year's score of 38.9%.
 - medical/dental consultants 33% in 2015 and 2014; and
 - for doctors/dentists in training 34% in 2015 up from 31% in 2014.

Staff feeling pressure in last three months to attend work when feeling unwell decreased in 2015 to 59% whereas 2014 figures reported 61%. Overall sickness levels have dropped slightly for 2015/16, to 4.15%, a decrease of 0.10% from 2014/15, which stood at 4.25%

Sickness Absence

5.66. 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. The rate of sickness absence for doctors is much lower than for other HCHS staff groups, at 1.2% compared with around 5% for nurses. Sickness absence is subject to month-to-month variation, and some of this is seasonal. Table 5.6 shows the 12-month average, which removes seasonal variation. There are no signs that the rate for doctors is changing.

Table 5.6: Sickness Absence Rates for HCHS Staff: 12-month moving average



Source: NHS Digital – NHS Sickness Absence Rates statistics <http://digital.nhs.uk/searchcatalogue?topics=1%2fWorkforce%2fStaff+management&sort=Relevance&size=10&page=1#top>

(<http://digital.nhs.uk/searchcatalogue?productid=21177&returnid=1907>) and 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 Report²⁷

²⁷ <http://www.nhshealthatwork.co.uk/health-work-wellbeing.asp>

- 5.67. In response to the NHS Staff Survey and following the Francis report, the Department placed a stronger emphasis on Mental Health and Wellbeing, commissioning NHS Employers to develop a behaviour change toolkit to support individuals and teams to make changes which will influence their emotional wellbeing²⁸ and the quality of care they deliver. Their toolkit “How are you feeling NHS?” was launched in early 2015 and in April 2016 NHS Employers report that it had had over 3,000 hits on the website.
- 5.68. In 2014 the Department commissioned NHS Employers to develop “Healthier Staff, higher quality care”- a pledge to work to improve the health and wellbeing of staff who work in the NHS which was signed by ministers, senior DH officials and NHS Leaders²⁹.
- 5.69. The Staff Experience Summit followed, hosted by NHS Employers, which brought together senior NHS leaders to sign a pledge to continue to improve the health and wellbeing of staff who work in healthcare. The summit and pledge focussed on staff experiences in their own organisations and plans to improve staff experience internally and across the system.
- 5.70. The Department has updated the 2015/16 commission of NHS Employers to support NHS England’s initiative in improving the staff health offer, engaging the NHS health and wellbeing networks and supporting the 12 pilot organisations. This complements the support NHS Employers continue to provide organisations in improving their staff health and wellbeing which includes:
- Informing: keep employers up to date on the latest developments regarding health and wellbeing of the current NHS workforce;
 - Engaging: engage with employers on issues relating to the health and wellbeing of the existing workforce;
 - Influencing: Represent the views of employers to the Department of Health and key stakeholders. Influence national policy and national initiatives and exert influence on the future of health and wellbeing work; and
 - Supporting improvement and leading the way: Supporting employers across the NHS to improve the health and wellbeing of their staff by helping leaders to develop robust wellbeing programmes that deliver measureable outcomes, with a particular focus on emotional wellbeing (mental health) across the NHS. This includes encouraging trusts to use the “How are you feeling NHS?” with individuals, teams and professionals to encourage open, and supportive conversations about emotional wellbeing.
- 5.71. NHS Employers are working with NHS England and Public Health England on the £5 million initiative announced in September 2015 to improve the health and well-being of

²⁸ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/protecting-staff-and-preventing-ill-health/taking-a-targeted-approach/emotional-wellbeing>

²⁹ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/copy-of-leading-the-way/whats-happening-nationally/our-commitment>

health service staff. NHS organisations will be supported to help their staff stay well, including serving healthier food, promoting physical activity, reducing stress and providing health checks covering mental health and musculoskeletal problems³⁰.

- 5.72. Other initiatives introduced by NHS Employers include the development of an interactive on-line tool that enables organisations to track their progress against the Boorman Review recommendations. The tool enables organisations to reflect on their local strategies by developing work and initiatives against progress being made on a national level³¹.
- 5.73. NHS doctors remain highly committed to their jobs in the face of undoubted pressures on the service. Despite concerns over issues such as pay restraint and workload, doctors and dentists remain broadly satisfied with their jobs and levels of satisfaction remain higher than average weighted scores. Motivation has been affected by current challenges but remains high.
- 5.74. The level of staff engagement has not changed over the past two years for consultant and doctors and dentists in training. The Department recognises the pressures facing the service and the importance of employers maintaining staff motivation. Progress has been made although much remains to be done and the degree of variation is too wide.

³⁰ <https://www.england.nhs.uk/2015/09/improving-staff-health/>

³¹ <http://www.nhsemployers.org/news/2016/06/what-progress-has-been-made-since-boorman>

6. The Aims of Contract Reform

- 6.1. A key aim of the Government's public sector pay policy is to reform and modernise the terms and conditions of public sector workers, developing more affordable, sustainable pay systems. That includes ending the systems of automatic pay rises based on time-served, as the Government announced in June 2013, and strengthening the link between pay and performance.
- 6.2. Over the past few years, there have been discussions and negotiations on reforming NHS national terms and conditions across all staff groups. The drivers for change have differed in some respects. For the medical staff groups:
 - the contract for doctors and dentists in training was considered to be in need of reform from as early as 2008, with all parties being of the view that the balance of earnings needs to shift so that proportionately more sits in fixed, basic pay;
 - a review of consultant clinical excellence awards (by the Review Body) highlighted the need to look at the totality of the reward package for consultants and a report by the Public Accounts Committee recommended linking pay to outcomes;
 - improvements to the GMS contract are made annually to support improvements in out of hospital care more widely, a new voluntary Multispecialty Community Provider (MCP) contract will be offered from 2017;
 - the Government is committed to reforming the current dental contractual framework - the reformed approach will move away from the current activity-driven system to one that includes a clinical approach focussed on prevention and measurement of quality and outcomes.
- 6.3. The principles informing the approach to reform, however, are consistent with those that apply across the public sector: contracts must provide value for money to the NHS and the taxpayer and staff must be rewarded fairly for their contribution. Across the NHS, contracts must work better for staff and patients, with pay closely related to the amount and quality of the work that staff do for patients.
- 6.4. For consultants, the ambition is to develop a better contract that: rewards them more fairly; includes appropriate safeguards to support patients and doctors; engages consultants as senior decision makers in the NHS; and better supports seven day service provision.
- 6.5. For doctors and dentists in training, the aim is to ensure: fairer pay, with earnings tied more closely to level of responsibility and actual work done, including during unsocial hours; stronger safeguards on working hours; improved training (including appropriate consultant support at weekends); and a contract that supports a seven day NHS.
- 6.6. The Review Body has given its views on these aims over a number of years, including in its 2015 report on contract reform.
- 6.7. The following chapters provide updates on the progress of negotiations with the trades unions and next steps. For doctors and dentists in training the reforms involve

fundamental restructuring of the pay systems. This structural redesign takes account of recruitment and retention in the broadest sense – ensuring fair reward by tying pay more closely to level of responsibility and work done. It also includes an element of targeting to address specific current recruitment and retention issues – with flexible pay premia for doctors and dentists in hard-to-fill training programmes.

6.8. Similarly for consultants, the parties continue to engage in constructive discussions that aim to agree changes to the existing contract that builds on observations from the independent Review Body and will help to support recruitment and retention and facilitate improvements to patient care.

In light of:

- ongoing pay system reform, which includes (for juniors) pay premia targeted to training programmes for specialties with recruitment and retention problems;
- a lack of robust evidence that any further targeting would make a material difference to recruitment, retention and motivation (and the risk that further targeting would exacerbate industrial relations and increase resistance to contract reform implementation);
- the fact that the progression pay systems for trained doctors mean that the majority will receive an annual increase of between 3-10%; and
- the rate of inflation remaining low

our proposal is that, for 2017/18, a 1% increase should apply for these staff groups and independent contractors.

6.9. The following chapters provide updates on the progress of negotiations with the trades unions and next steps.

7. Doctors and Dentists in Training - New Contract

- 7.1. Following publication of the Review Body's report on contract reform in July 2015³², the government invited the BMA to return to negotiations on reforming the consultant contract and the juniors' contract. In August 2015, the BMA's Junior Doctors' Committee decided not to re-enter negotiations. (Negotiations with the BMA's Consultants Committee began in September 2015.)
- 7.2. Based on the Review Body's recommendations, a 'firm, not final' offer for juniors was published on 4 November 2015³³. The offer included transitional protection provisions: cash pay protection for juniors in the early stages of training; with more senior juniors remaining on existing pay terms (protecting their expectations) whilst moving onto the new contract in all other regards. The following day, the BMA balloted junior doctor members on industrial action and a series of strikes was subsequently announced, to commence on 1 December 2015.
- 7.3. Discussions under the auspices of ACAS led to an agreement on 30 November 2015 that the BMA, NHS Employers and the Department of Health would enter negotiations. A Memorandum of Understanding set out the scope of negotiations³⁴ and the strike action was suspended.
- 7.4. Negotiations began in December 2015. On 4 January 2016, the BMA left negotiations and announced a series of dates for strike action. Details of what had been on offer were published³⁵ by the Department and a letter was sent to all juniors³⁶. The Secretary of State asked Sir David Dalton, the Chief Executive of Salford NHS Foundation Trust, to lead resumed negotiations. On 10 February, Sir David advised the Secretary of State that, whilst the parties had agreed on many elements of a new contract, a negotiated solution was not possible.

³² <https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week>

³³ <https://www.gov.uk/government/news/junior-doctors-contract-offer>

³⁴ <http://www.acas.org.uk/index.aspx?articleid=5557>

³⁵ <https://www.gov.uk/government/publications/summary-information-from-letter-to-all-junior-doctors/summary-detail-on-safety-training-and-pay>

³⁶

<http://www.nhsemployers.org/~media/Employers/Publications/Junior%20doctors%20letter%2007%2001%2016%20final.pdf>

- 7.5. On 11 February, the Secretary of State announced that a new contract would be introduced from August 2016. He also announced a review of non-contractual measures that could be taken to improve juniors' morale³⁷. On 31 March, the Department published an Equality Analysis of the new contract, together with a Family Test³⁸, and NHS Employers published the terms and conditions and a model contract.
- 7.6. In early May, the Academy of Medical Royal Colleges called for a pause in the introduction of the new contract and on further industrial action, and for the parties to return to negotiations. Negotiations under the auspices of ACAS, led for the NHS by Sir David Dalton, took place over ten days, resulting in an agreement on 18 May³⁹.
- 7.7. NHS Employers published the proposed new terms and conditions on 27 May and the Department published an equality statement⁴⁰. A further version of the proposed terms and conditions was published on 16 June with some amendments and minor clarifications⁴¹, including additional pay during transition for less than full time trainees who would be in receipt of cash pay protection during transition.
- 7.8. The BMA held a referendum of its members between 17 June and 1 July. On 5 July, the BMA announced that 58% of eligible members, on a 68% turnout, had voted against the contract.
- 7.9. The Secretary of State announced on 6 July 2016 that the contract negotiated and agreed with the BMA would be introduced in a phased rollout with new terms starting to

³⁷ <https://www.gov.uk/government/speeches/jeremy-hunt-updates-parliament-on-the-junior-doctors-contract>

³⁸ <https://www.gov.uk/government/publications/junior-doctors-contract-equality-analysis-and-family-test>

³⁹ http://www.acas.org.uk/media/pdf/l/p/ACAS_FINAL_AGREED_NHS_Emp_BMA_DoH_Package_180516.pdf

⁴⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526623/Equalities_statement.pdf

⁴¹ <http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-contract>

Doctors and Dentists in Training - New Contract

apply from October 2016⁴² (for new appointments and as contracts of employment expire as juniors move through training). NHS Employers published final terms and conditions, a pay circular and associated material in July 2016, together with a timetable for implementation⁴³.

- 7.10. In his statements, the Secretary of State also announced a series of non-contractual measures, with commitments to:
- a review of how best to allow couples to apply to train in the same area and to offer training placements close to home for those with caring responsibilities;
 - a review to inform a new requirement on trusts to consider caring and other family responsibilities when designing rotas;
 - recognition of prior training when switching training path;
 - improved rostering practices;
 - improving the working lives of junior doctors
 - addressing the particular concerns of foundation year doctors who often feel most disconnected in that period of their training before they have chosen a specialty;
 - an independent review of the gender pay gap in the medical profession.
- 7.11. In statements on 6 July and 5 September, he also made clear that the door remained open to the BMA both to be involved in this work and to discuss how the new contract is implemented and maintained.

Features of the new arrangements

- 7.12. The new contractual arrangements are designed to be fairer and safer and to be better for juniors and for patients. They redistribute pay whilst maintaining average earnings; they include stronger limits on working hours and patterns; and they better support training. NHS Employers' evidence will detail the terms and conditions, which are also annexed to this Evidence. Some of the key points of the new contractual arrangements, and of related initiatives, are covered in this chapter.
- 7.13. The new arrangements are designed to be cost-neutral per full-time equivalent, resulting in no change in the junior doctor pay bill or in average earnings (for a given size of junior doctor population). As set out in the Heads of Terms for negotiations (July 2013), the

⁴² <https://www.gov.uk/government/speeches/jeremy-hunt-updates-parliament-on-junior-doctors-contract>

⁴³

<http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Implementation%20timeline%20July%202016.pdf>

cost of additional employer pension contributions arising from increased basic pay sit outside this envelope. Those costs – and the costs of transition – will fall within the overall medical pay bill of over £9bn.

Pay

- 7.14. The system of banding payments is replaced by a new pay structure which places a greater proportion of earnings into basic, pensionable pay - something that the BMA and the Review Body had long wished to see. The new structure relates earnings more directly to work done – i.e., hours worked, unsocial hours and intensity of on-call commitments.
- 7.15. Basic pay (for a basic 40 hour week) increases by 10-11% and is on a nodal point pay system that links basic pay to level of responsibility (stage of training). Negotiations with the BMA resulted in a both a flattening of the nodal pay point structure (with fewer points) and a frontloading which distributes earnings so that juniors earn more earlier on in their career (compared with previous proposals).
- 7.16. Other key elements of pay are:
- Pay for additional hours worked (at the prevailing rate depending on when worked)
 - An enhancement of 37% on the hourly rate for work at nights: hours between 9pm and 7am (and for hours worked up to 10am for shifts that begin after 8pm and no later than 11.59pm and are of more than eight hours in duration)
 - A weekend allowance paid where weekend working is at a frequency of 1 in 8 or more – a sliding scale allowance of between 3% and 10% of basic salary, depending on frequency of weekend working
 - An on-call availability allowance (in addition to payment for work undertaken as a result of being on-call) based on 8% of full-time basic salary for the grade
 - Flexible pay premia for:
 - general practice training (payable during the practice-based period of GP specialty training) to replace the GP training supplement which has been used, under the existing arrangements, 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.
 -
 - A 'senior decision maker' allowance (from October 2019)
 - Pay protection on switching into a hard-to-fill training programme

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- Pay protection for those switching training programmes for reasons linked to disability or caring responsibilities
- Additional provisions on maternity pay to benefit doctors returning from approved periods out-of-programme – by defining the reference period as the doctor's last period of paid employment in the previous training placement immediately prior to commencing the period of time spent out of programme
- Pay for hours worked beyond the work schedule in exceptional circumstances to secure patient safety
- 'Penalty' payments for hours worked in excess of: the 48 hour weekly average; the 72 hour absolute weekly limit; or where the minimum rest requirement of 11 hours has been reduced to less than eight hours. From a penalty payment at four times the hourly rate, 1.5x will be paid to the doctor and the balance will be a fine paid to a Guardian of Safe Working Hours (see below) to be used to benefit the education, training and working environment of juniors.

Work schedules

- 7.17. There will be work schedule for each post, mapped to the curriculum and setting out both the training opportunities and the service commitments of the post. Work schedules will be personalised to each postholder, taking account of individual training experience, competencies and needs, and will be reviewed regularly and also on request.

Safeguards on working hours and the role of the Guardian

- 7.18. The limits in the contract (see Schedule 3 of the 2016 Terms and Conditions of Service) go beyond those in the old contract and those in the Working Time Regulations. A Guardian of Safe Working Hours for each organisation will be responsible for protecting these safeguards, ensuring issues of compliance are addressed, and providing assurance to the trust board (or equivalent) that juniors' working hours are safe.
- 7.19. At 23 September 2016, 215 out of 217 trusts had appointed a Guardian or had interim arrangements in place. The remaining two trusts are currently exempt because they will not employ any junior doctors until early 2017.

Transitional provisions

- 7.20. There are two types of transitional protection.
- 7.21. Juniors at Specialty Training Stage 3 (ST3) and above will remain on the existing pay terms (whilst moving onto the new contract in all other respects), continuing to receive increments and banding payments (up to the level of Band 2A). This protects the

expectations of this group of juniors. Whilst it is envisaged that the majority of juniors, including those training less than full time or taking time out, would be able to complete training whilst on the current pay system, a contract review in 2018 will look at whether this is likely to be achieved by 2022 and if not, we would be prepared to extend transition beyond 2022 for those working less than full time.

- 7.22. Those below ST3 will receive cash pay protection if their salary on the new terms is below a 'cash floor' of: basic pay immediately prior to moving onto new terms; plus the level of banding supplement that applied on 31 October 2015 to the post that they are in immediately prior to moving onto new terms. In addition, a flexible pay premium of £1,500 a year will be paid to those in this group who are training less than full time (who are likely to have been in training longer than others at ST3 and below, and thus to have had similar expectations as those above ST3).
- 7.23. Pay will be protected as described above either until: the doctor exits the training programme or four years of continuous employment have elapsed from first being appointed on the new terms; or until August 2022 - whichever is sooner (but see para 7.21 above).

Equalities aspects

- 7.24. These new pay arrangements are based on the principle of equal pay for work of equal value – both in replacing automatic increments with nodal points for basic pay, and in linking additional pay more closely to actual work done.
- 7.25. As mentioned above, the flattening and front-loading of the nodal pay structure was agreed with the BMA, to deliver higher basic pay earlier on, minimising the potential impact (e.g. on those who take time out or train part-time) of moving away from a system of annual incremental pay progression.
- 7.26. Other measures to improve equality of opportunity include:
- The 'accelerated training support' to help returners catch up with colleagues.
 - Pay protection for those who switch career path because of caring responsibilities or as a result of disability.
 - The basis on which the on-call and weekend allowances are designed and calculated for those working less-than-full-time.
 - Elements of pay protection during transition, including the pay premium for less-than-full-time trainees who move onto the new pay terms.
- 7.27. The Equality Analysis and Equality Statement (referenced at paragraphs 7.5 and 7.7) covers the equalities issues in detail.

Supporting seven day services

7.28. The new contract:

- establishes the principle that any doctor who works less than an average of one weekend day a month (Saturday or Sunday) should receive no additional premium pay, being compensated by an increase in basic pay of between 10 and 11%;
- reduces the marginal cost of employing additional doctors at the weekend by about a third;
- supports all hospitals to meet the four clinical standards most important for reducing mortality rates for weekend admissions by establishing a new role for experienced junior doctors as 'senior-clinical decision makers' able to make expert assessments of vulnerable patients who may be admitted or staying in hospitals over weekends; and
- removes the disincentive, identified by employers, to roster sufficient numbers of doctors at weekends by replacing an inflexible banding system with a fairer system that values weekend work by paying actual unsocial hours worked, with more pay to those who work the most.

7.29. It was recognised in the 2013 Heads of Terms for negotiations that both service delivery and training will continue to take place throughout the seven day week. The new contract does not mean that the same workforce will be expected to provide an additional contribution – the limits on working hours remain (and are strengthened) and average earnings remain the same. The change brought about by the contract is to differentially distribute those earnings, to relate more closely (than under the banding system) to work done.

7.30. Seven day services is not a cost-neutral policy, but will be funded out of the additional £10 billion provided to the NHS this Parliament. The changes to the junior doctors contract are cost neutral meaning that the contract cannot in anyway be used to save money – our commitment maintains the current spend for the current number of full-time equivalent doctors working the current average working week. The BMA acknowledged this commitment and communicated it to its junior doctor members before the vote on the contract.

2017/18 pay round

7.31. As set out in the previous chapter, this contract represents a fundamental redesign of the pay structure, which takes account of recruitment and retention in the broadest sense – ensuring fair reward by tying pay more closely to level of responsibility and work done. It also includes an element of targeting to address specific current recruitment and retention issues – with flexible pay premia for doctors and dentists in hard-to-fill training programmes.

- 7.32. As part of the ACAS agreement with the BMA on a new contract for doctors and dentists in training, it was envisaged that the values of the pay points in the new arrangements would be increased by at least 1% in 2017/18. (Therefore any increase above 1% would need to be funded by a less than 1% uplift for other staff groups). Despite the lack of a collective agreement on the new contract, we consider that an uplift of 1% is the right approach given that the restructuring of the pay system redistributes earnings in a way that more fairly links to work done, and also incentivises shortage training programmes.
- 7.33. In future rounds, the Review Body will, as it recommended in its 2015 report, be able to review, retrospectively, the use of flexible pay premia and make recommendations where appropriate.

8. Consultants - New Contract

- 8.1. As senior doctors and clinical leaders, consultants are ideally placed to identify and realise opportunities to improve patient care. Consultant lead many of the changes required to support NHS productivity growth and other system priorities, including work to ensure that urgent and emergency care is of a consistently high standard across the week.
- 8.2. Our ambition for consultant contract reform is to ensure that as the consultant workforce continues to grow, consultants have access to fair, modern terms that support, recruit and retain consultants while facilitating the very best patient care.
- 8.3. Negotiations on consultant contract reform between NHS Employers and the BMA have been ongoing in some form since 2013, but paused in October 2014 when the BMA withdrew from discussions. Negotiations recommenced in September 2015 following the publication of the DDRB' report 'Contract reform for doctors & dentists in training – supporting healthcare services seven days a week'. The report took into account evidence from a number of organisations including the Royal Colleges and the BMA. It made a number of observations on changes to the consultant contract which were accepted by the government.
- 8.4. Building on these observations, the renewed discussions with the BMA have been constructive and are continuing.

9. Speciality Doctors and Associate Specialists

- 9.1. Last year, NHS Employers reported that, following the publication of a Charter for SAS doctors in December 2014, work had been undertaken to identify any barriers to career progression and to find solutions to effective development, opportunities for SAS leadership roles, and the development of good practice.
- 9.2. The Department is not aware of any specific issues, including relating to the contracts, for SAS doctors; and would expect the BMA to raise any issues through the Joint Negotiating Committee (SAS) with NHS Employers.
- 9.3. It is likely, however, that we would wish to review the current contractual arrangements, and consider any case for change, once reforms have been made to the contracts for consultants and doctors and dentists in training. The SAS contracts include incremental pay scales, though progress through these is linked to meeting specified criteria, with additional criteria at Threshold One and further additional criteria at Threshold Two. There might be a case for some alignment of arrangements, for example, unsocial hours periods and the payment structure for work at those times.
- 9.4. In the absence of any evidence of pressing concerns, or any recommendation from the Review Body that immediate changes are needed to the contractual arrangements, our intention is to consider this once we have agreed and begun to implement changes for consultants and for doctors and dentists in training.

10. Contract Reform - General Medical Practitioners

- 10.1. 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 has been provided separately by NHS England.

Developments in General Practice

- 10.2. In last year's evidence, the Department updated the Review Body on the vision of general practice set out in the NHS Five Year Forward View. This is one in which general practice sits at the centre of strengthened out of hospital care services, with improved care for people with complex ongoing needs and a greater focus on prevention. As part of this, the NHS Five Year Forward View acknowledged the need to stabilise and support general practice services. Since last year's evidence, significant steps have been taken towards implementing that vision.
- 10.3. The NHS Planning Guidance, issued in December 2015, makes addressing the sustainability and quality of general practice one of nine 'must dos' for local areas. In particular, local Sustainability and Transformation Plans (STPs) will be expected to address workload and workforce issues in general practice.
- 10.4. In April 2016, NHS England published the General Practice Forward View⁴⁴. This is a package of support for general practice, to help improve patient care and access and invest in new ways of providing primary care. It contains measures on workload and workforce, which are covered in more detail below.
- 10.5. The General Practice Forward View also signalled the changing nature of general practice. Increasingly, many practices are choosing to work at scale by forming networks and federations. They are finding that this is a way both to spread innovation and deliver a wider range of services to their patients.
- 10.6. GP Access Fund sites are testing improved and innovative access to GP services. Across the two waves of the Fund, there are 57 schemes covering over 2,500 practices, and over 18 million patients – a third of the population – have benefited from improved access and transformational change including evening and weekend appointments.

⁴⁴ <https://www.england.nhs.uk/ourwork/gpfv/>

- 10.7. NHS England will provide over £500 million by 2020/21 to enable clinical commissioning groups (CCGs) to commission and fund extra capacity across England to ensure that by 2020, everyone has access to sufficient routine appointments at evenings and weekends to meet local demand, alongside effective access to 24/7 urgent care services.
- 10.8. To support further integration of primary and community health services, a new voluntary MCP contract will be introduced in 2017. NHS England published the framework for the MCP contract on 28 July 2016.

2016/17 GP Contract and progress on expenses

- 10.9. Negotiations between NHS Employers (on behalf of NHS England) and the General Practitioners Committee (GPC) of the BMA reached an agreement on the GP contract for 2016/17 outside of the DDRB process.
- 10.10. The agreement increased investment of £220 million to deliver a 1% pay uplift for GPs and to reimburse rising practice expenses, including higher Care Quality Commission fees.
- 10.11. Other key elements of the deal included an end to the dementia enhanced service, with a transfer of resources to core funding, and an increase to the vaccination and immunisation item of service fees from £7.64 to £9.80.
- 10.12. As part of the 2015/16 contract agreement, NHS England and the GPC agreed to undertake work in 2016/17 to look to determine an agreed methodology on expenses. NHS Employers has convened a working group on this issue, with representatives from NHS England, the BMA and the Department, which met for the first time in July. The intention is that the output of this work will be presented to the parties to inform 2017/18 contract negotiations. The Department will keep the Review Body updated.
- 10.13. The General Practice Forward View set a commitment to address rising indemnity costs, which are considered an expense for GPs. Funding for expenses has increased via the contract, and an additional £33m was included in 2016-17 specifically to reflect indemnity inflation rises in the last year. However, GPs have reported that they feel they have been subject to unsustainable, above-inflation rises in the amount that they must pay to buy indemnity cover.
- 10.14. Following an eight week review by the Department and NHS England, on 28 July, NHS England announced a new Indemnity Support Scheme for practices⁴⁵. The scheme will

⁴⁵ <https://www.england.nhs.uk/ourwork/gp/v/gp-indemnity/>

run for an initial period of two years and will seek to cover the inflationary rises of indemnity costs for practices.

Investment in General Practice

- 10.15. Total spend on general practice has increased in nominal terms every year since 2003/04 (the first year that data was available).⁴⁶ The biggest increases were in 2004/05 (19%) and 2005/06 (12%), the first two years of the new GP contract.
- 10.16. Taking into account inflation⁴⁷, total investment in general practice was on a declining trend from 2005/06 to 2012/13. However, the last two years' data both show a real increase in expenditure. Total real expenditure in 2014/15 was 18.9% higher than 2003/04 levels (representing average real growth of 1.7% per year).
- 10.17. The General Practice Forward View committed to increasing investment in general practice by £2.4billion a year by 2020/21 compared with 2015/16.
- 10.18. The latest data from NHS Digital shows that the average income before tax in 2014/15 for a contractor GP was £103,800 compared to £101,900 in 2013/14.
- 10.19. Table 10.1 shows the change in contractor GP income in England since 2003/4 in real terms (2014/15 prices). Please note that this combines data for GPs in GMS and PMS practices and is an average based on headcount not FTE.

⁴⁶ There was a change in the way the data was collected from 2006/07, meaning that the figures before this are not strictly comparable (although rough comparisons are reasonable).

⁴⁷ <https://www.gov.uk/government/collections/gdp-deflators-at-market-prices-and-money-gdp>

Table 10.1

Year	Gross Earnings	Total Expenses	Income before tax
2003/04	£267,775	£160,907	£106,868
2004/05	£296,860	£169,711	£127,149
2005/06	£307,999	£172,138	£135,861
2006/07	£302,648	£173,162	£129,486
2007/08	£301,553	£176,744	£124,809
2008/09	£302,400	£181,500	£120,900
2009/10	£302,600	£183,500	£119,100
2010/11	£302,400	£187,300	£115,100
2011/12	£299,700	£187,900	£111,800
2012/13	£298,600	£190,200	£108,500
2013/14	£295,400	£191,900	£103,500
2014/15	£302,600	£198,800	£103,800

10.20. For salaried GPs, the average income in England in 2014/15 was £53,700 compared to £54,900 in 2013/14. As for contractors this is based on headcount data so will not take account of part time working.

GP Workforce

10.21. The Review Body noted in its last report the growing proportion of salaried GPs in the workforce. The Government would value the DDRB's analysis of the trend towards GPs working on a sessional basis.

10.22. At March 2016, there are 7,613 practices in England down from 8,451 practices in 2005 (9.9% decrease). The average number of patients registered per practice is 7,521 up from 6,250 in 2005 (20.3% increase).

10.23. As set out in Chapter 4, the workforce data on general practice is improving through the Workforce Minimum Dataset. This was published for the first time on 27 April 2016 and

Contract Reform - General Medical Practitioners

included more granular information on the staff working in general practice as at 30 September 2015. It also included GP locums for the first time. It was published for the second time on 27 September 2016 and included information on the staff working in general practice at 31 March 2016. It also included data on joiners/leavers, vacancies and absence for the first time.

- 10.24. It showed that there are approximately 35,000 GPs (FTE) in 2016 in England, of which 19,034 were stated as GP providers and 6,687 stated as salaried/other GPs. 601 were stated to be locums.
- 10.25. The data published in April and September are not fully comparable with previous workforce census publications. However, prior years' data shows an increasing proportion of salaried GPs in the workforce. The number of salaried GPs increased by 30% between 2009-14 whilst the number of partners fell by 6.4%.

GP Recruitment and Retention

- 10.26. In considering recruitment and retention pressures in general practice, the Review Body will wish to consider the wider context of action already underway.
- 10.27. The General Practice Forward View announced a package of measures to redouble the rate of growth in the GP workforce. These measures build on the actions already in place as part of Building the Workforce a ten point plan published in January 2015 by NHS England, HEE, the Royal College of GPs and the BMA's General Practitioners Committee.
- 10.28. Specific interventions set out in the General Practice Forward View are targeted towards areas where it has historically been difficult to recruit GPs. NHS England and HEE have introduced financial incentives of £20,000 in areas that have found it hardest to recruit GP trainees. Additionally, NHS England has introduced a targeted scheme to help recruit doctors returning back into general practice. The scheme offers £8,000 relocation allowance, a £2,000 educational bursary, and £2,000 support for the practices.
- 10.29. There are some signs that this work is having an impact. There has been an increase in the number of doctors applying to return to general practice, with an increase of 40% in 2015/16 compared to 2014/15. The first round of recruitment to specialty GP training for 2016 saw an increase in total accepted filled posts of 7% compared with 2015.
- 10.30. As set out in the Department's evidence last year, a considerable proportion of practice income is based on a weighted capitation formula. The Department has significant concerns as to how any differential uplift to contracts would interact with the operation of that formula, which is currently under review by NHS England, and the Review Body will wish to take this into account in its deliberations.

11. General Dental Practitioners

11.1. The Government has extended the public sector pay policy of 1% for the rest of this Parliament. The Government’s view is that this policy should extend to all employees and those individuals or groups indirectly funded via the public sector. We would expect the DDRB recommendation for General Dental Practitioners to be considered within this wider context.

General dental Practitioners: earnings and expenses

11.2. The average taxable income for all dentists in 2014/15 was £70,500, down from £71,700 in 2013/14. This reflects a fall in the average gross income to £152,500 in 2014/15 from £155,100. The level of expenses to gross income (“the expenses ratio”) has remained at 53.8%. The expenses ratio remains towards the lower end of the range seen during the last ten years. Table 11.1 has details for the last eleven years.

Table 11.1: Gross income, expenses and taxable income for all dentists from 2004/05 to 2014/15

	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%

<http://digital.nhs.uk/searchcatalogue?topics=1%2fPrimary+care+services%2fDental+services&ort=Relevance&size=10&page=1#top>

- 11.3. In England, the earnings of a dentist are dependent on whether they are a Providing-Performer dentist (has a contract with NHS England Area Team/Local Health Board (LHB) and is also performing dentistry) or a Performer only dentist (working for practice owner, principal or limited company). In 2014/15, Providing-Performer dentists had an average taxable income of £117,400 up from £115,200 in 2013/14. In contrast, a Performer only dentist saw their average taxable income fall to £59,900 in 2014/15 down from £60,600 in 2013/14.
- 11.4. 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 and in the balance between NHS and private sector work; the shift in the make-up of the dentist population with relatively fewer Provider-Performers and more Performer only dentists and the evolving nature of practice business models and the rise of incorporation.

General dental Practitioners: Recruitment and retention

- 11.5. NHS Digital (previously the HSCIC) publishes data on the number of dentists who have delivered NHS dentistry in any given financial year. This is based on data for NHS Business Service Authority who processes the payment forms. Figures are shown in Table 11.2

Table 11.2: 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

<http://digital.nhs.uk/searchcatalogue?topics=1%2fPrimary+care+services%2fDental+services&sort=Relevance&size=10&page=1#top>

- 11.6. 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. This suggests that while individual practices may have difficulty in attracting and retaining performer dentists, there does not appear to be a general problem across England.

General Dental Practitioners: Motivation and Morale

- 11.7. The Dental Working Hours: Motivation and Morale 2012/13 & 2013/14 report was last published by NHS Digital in August 2015. No date has been set by NHS Digital for publication for the latest motivational analysis which will add data from 2014/15 to the previous time series. It is unlikely to be available before the end of the year.
- 11.8. Motivation is regarded as the internal drive of an individual, e.g. inspiration or enthusiasm. The results from the previous report show that in 2013/14 more Performer only dentists answered 'strongly agree' or 'agree' to the motivation questions. Performer only dentists appear to have higher morale than Provider-Performers. This is shown in the table below.

Table 11.3: Average motivation results; Average morale results 2012/13, 2013/14

	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

Average of 'strongly agree' or 'agree' responses to the motivation questions

Percentage of dentists who recorded their morale as 'very high' or 'high'

- 11.9. In 2013/14, Performer only dentists responded more positively than Provider-Performer dentists with a 48.8% 'strongly agree' or 'agree' response compared to 45.7%.
- 11.10. Morale generally relates to comfort and satisfaction. 42.7% 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 27.2% of Provider-Performer dentists.
- 11.11. Comparing the data published by NHS Digital relating to 2012/13 and by British Dental Association Business Trends Survey relating 2012, the BDA data reports a higher motivation score for provider –performers (58%) than the NHS Digital published survey (47.5%). 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 doing private only work. 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.

Targeting

11.12. 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

11.13. The Government is committed to reforming the current dental contractual framework including a period of prototyping a potential new contract (see below). This commitment, originally made in 2010 and reaffirmed by the current Government, is intended to increase access to NHS Dentistry and implement improvements in oral health. The reformed approach will move away from the current activity-driven system to one that includes:

- A clinical approach focussed on prevention as well as treatment
- Measurement of quality through a Dental Quality and Outcomes Framework (DQOF)

11.14. Piloting commenced in 2011 to test a new clinical approach and gather the learning needed to design a new remuneration system. In 2014 the Government announced the proposed new approach to remuneration which will reflect activity, quality and capitation.

Community Dental Services

11.15. 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.

11.16. 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, which identifies the level of dental need for a particular community and which will pay particular attention to access to local dental services and the dental health of the local population.

11.17. The Department of Health 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.

General Dental Practitioners

- 11.18. 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.
- 11.19. The terms and conditions for salaried dentists directly employed by the NHS are negotiated by NHS employers on behalf of the NHS.

12. Ophthalmic Practitioners

- 12.1. The Department of Health 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 the NHS England. Discussions are to take place with representatives of the professions on fees for 2017/18.

Background

- 12.2. 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.
- 12.3. 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>

13. Pensions and Total Reward

Introduction

- 13.1. The NHS Pension Scheme remains a valuable part of the total reward package available to NHS doctors and dentists. 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 income, with the rate paid by the lowest earners being 5% and the highest is 14.5% for those earning £111,377 or above.
- 13.2. 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).
- 13.3. 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.
- 13.4. A junior doctor commencing employment and membership of the 2015 scheme from August 2016 (retiring at 68) can expect a pension of around £66,000 p/a if s/he progresses to be a full-time consultant⁴⁸. A similar junior doctor progressing to be a part-time consultant can expect a pension of around £54,000 p/a. Junior doctors progressing to be GPs can expect a pension of around £68,000 p/a⁴⁹.

⁴⁸ These figures assume the full-time junior doctor joins the scheme aged 24, is promoted to consultant aged 35 and receives 3 CEAs during their career. The part-time consultant also joins at 24 and is promoted at 35; but takes a 2 year career break aged 38, then works part-time for 10 years at 0.6WTE before returning to full-time employment until retirement.

⁴⁹ This figure assumes that a junior doctor, joining the scheme aged 24, becomes a self-employed GP after 5 years' service and that 95% of their career earnings are pensionable.

Review of Access

- 13.5. HM Treasury's non-statutory policy "The Fair Deal for Staff Pensions"⁵⁰ sets out how pension issues are to be dealt with when staff are compulsorily transferred from the public sector to independent providers delivering public services. The guidance applies to tenders involving compulsory transfers of staff who were transferred out under the previous Fair Deal policy - which required the provision of "broadly comparable" pension schemes. Under the guidance there will continue to be protection where staff are subsequently transferred to a new employer.
- 13.6. Changes to the NHS Pension Scheme from 1 April 2014 allowed independent providers (IPs) of NHS clinical services with an Alternative Provider Medical Services (APMS) contract, an NHS Standard Contract or local authority public health contract, to enrol eligible employees in the NHS Pension Scheme. This builds upon HM Treasury's reformed Fair Deal policy and has extended access to the NHS Pension Scheme for approximately 20,000 staff delivering NHS clinical services since 2012.
- 13.7. The provisions allowing eligible employees of IPs access to the scheme were reviewed during 2015, after their first year in force, to ensure they were delivering the policy aim of a fair playing field (in relation to pensions) for providers competing for NHS contracts. The Department consulted with IPs, their staff, as well as those who unsuccessfully applied for access to the NHS Pension Scheme and reported to HM Treasury in late 2015. The review found that the policy aims are largely being met, but that clearer guidance and a shorter application process would improve the operation of the provisions. The review found that changes to the way contracts are awarded and service delivery structured, with an increasing use of sub-contractors, meant that some changes to the regulations may be desirable to recognise this.
- 13.8. The Department is working with HM Treasury on the review's recommendations.

Contracting Out & New State Pension

- 13.9. The introduction of the new 'single tier' state pension from 6 April 2016 has led to an increase in national insurance contributions for members of the NHS pension scheme and their employers. This is due to the withdrawal of the 'contracting-out' rebate. Contracting out is where an individual contributes to an occupational pension scheme (e.g. the NHS pension scheme) instead of building up second state pension rights. A lower national insurance rate is paid as a result. The new state pension abolished the second state pension (and therefore contracting-out) meaning that employers and employees pay 'full rate' NI contributions from April 2016.

⁵⁰ Fair Deal for staff pensions: staff transfers from central government, HM Treasury (October 2013)

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- 13.10. This additional cost relates to the accrual of new state pension rights, and not the NHS pension scheme. It is effectively an increase in the cost of employment and a reduction in take home pay for individuals who were contracted-out:
- 3.4% increase in employer NI on individual's earnings between £8,000 and £40,000.
 - 1.4% increase in employee NI for earnings between £8,000 and £40,000.
- 13.11. In terms of effect, the higher NI contributions do not appear to have led to an increase in individuals opting out from the NHS pension scheme. Annex B

Pension Scheme Contributions

- 13.12. Employee contribution rates remained the same in 2015-16 as they were in 2014-2015, and have been 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.
- 13.13. Even with the increases in employee contribution rates, implemented across three years from 2012/2013, the NHS Pension Scheme remains an excellent investment for retirement. The Government Actuary's Department calculate that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.
- 13.14. High earners are likely to benefit from higher rate tax relief on their pension contributions. This meant that before contributions were raised in April 2012, members with full-time earnings over £60,000 actually paid a contribution rate that was lower than colleagues who earned half that amount, once tax relief had been taken into account.

Table 13.1: Employee contribution rates

WTE Pensionable Earnings	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%

Pension scheme membership

- 13.15. The Department continues to monitor changes in scheme membership using data from ESR. Annex B presents the position as of May 2016, and shows the percentage point change over the previous month, the last 12 months and from October 2011
- 13.16. Membership amongst employed doctors is high. 92% of employed doctors are members of the pension scheme (May 2016). This is an increase of 0.4% compared to May 2015, and 0.6% higher than the Oct 2011 position.
- 13.17. Increases to member contributions in recent years, and the increase to employee National Insurance resulting from the abolition of contracting out, do not appear to have led to significant numbers leaving the scheme in net terms. However there is evidence of an increasing trend for high earning individuals to opt-out of the scheme or leave NHS employment.
- 13.18. Table 13.2 gives indication of this trend, based on scheme valuation data as of 31 March 20

Table 13.2: Opt-out and leaver trends for GPs, consultants and other high earners

	All members with final WTE pay over £110k		GPs only	
	Opted out	Left service	Opted out	Left service
2008-09	9	349	10	322
2009-10	15	294	9	291
2010-11	14	334	19	352
2011-12	236	433	115	395
2012-13	149	497	97	532
2013-14	961	670	663	605
2014-15	357	731	246	636

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- 13.19. The trend 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 have reduced:
- The lifetime allowance is now £1m (reduced from £1.25m). It 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.
- 13.20. 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.
- 13.21. 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.
- 13.22. We are reviewing recruitment and retention of GPs and consultants, of which pensions tax changes will be a factor. We will explore what if any mitigation might be appropriate in the context of total reward.

Contract reform

- 13.23. The Department's approach to contract reform is influenced by the interaction between pay and pensions. By increasing basic pay for junior doctors, this will be more beneficial to the growth of their annual pension than the previous pay arrangements. This is because the CARE method used by the reformed pension scheme factors the level of pensionable earnings in each year of membership. A higher proportion of pensionable pay earlier in career will therefore lead to a better pension outcome.

Total Reward

- 13.24. As a concept, 'total reward' is both the tangible and intangible benefits that an employer offers an employee. In addition to financial benefits, it includes training, career development opportunities, culture and working environment. It is a means of explaining to employees the total value of their employment package. The Department considers the reward concept central to the ability of NHS employers to recruit and retain staff.

13.25. The context of continued pay restraint means that NHS employers should look to be creative and willing to explore more flexible approaches to employee reward packages. To this end, the Department's approach to reward policy is to create the right environment in which NHS organisations can develop the appropriate capability and capacity to:

- fully utilise the NHS employment package to attract, motivate and retain the staff they need;
 - implement local reward strategies that are aligned with their organisational objectives and meet the needs of their workforce; and
 - ensure employees understand the full value of their reward package (the tangible and intangible benefits) and the flexibilities within it.
- 13.26 Our objective is to develop a coherent approach to reward that will help the NHS deliver workforce productivity improvements by supporting employers in ways that will:
- help NHS organisations recruit, retain and motivate the staff they need to deliver excellent services to patients;
 - enable staff to understand the value of their reward package and have access to opportunities to maximise its value for them at different stages in their career;
 - contribute to improved patient and staff experience (engagement; health and wellbeing);
 - improve local management of the NHS paybill and support wider NHS productivity gains;
 - support and empower employers across the NHS to adopt and develop innovative pay and reward solutions that meet local need and enable them to compete for the best staff;
 - be in the vanguard of public sector approaches to reward; and
 - focus on reversing dissatisfaction with pay as evidenced by NHS staff survey results by improving staff perceptions of the value of their NHS reward package. In 2015 satisfaction with pay increased 4 percentage points to 37% compared to 2014 results, though this is still below the 38% level reported in 2013.

13.26. Since last year, we have continued to develop the NHS total reward policy by commissioning NHS Employers to continue building the business case for the NHS. NHS Employers are working on the strategic context, improving understanding of TR and developing communications and benchmarking through:

13.27. We are working with NHS Employers to develop the business case, strategy and plans for bringing forward new approaches to reward during this Parliament. This will be achieved through:

- the Total Reward Engagement Network (TREN) which meets regularly in London and Leeds and through which awareness of reward as a retention and recruitment tool is being raised and staff encouraged to engage more with strategic reward in their organisation;
- commissioning of research into the relationship between total reward and employee engagement, and analysis of the results;

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- identify reward and workforce priorities - helping NHS employers to use reward to recruit and retain particular groups of staff;
- ensuring the NHS has access to reward expertise and is kept up to date with latest developments and leading edge practice supported by a range of products, such as checklists for job advertisements, info-graphics on multi-generational workforces and guidance for line managers on reward as a recruitment and retention tool;
- influencing a change in employer behaviour to embrace reward approaches and share learning, for example, through encouraging wider use of NHS Employers' Reward Strategy toolkit⁵¹ - designed to lead trusts through planning, developing and implementing their reward strategies; and
- ensuring that our reward approach influences and is influenced by ongoing pay and contractual changes.

13.28. There are indications that more organisations are working with their staff on alternative reward offers to address recruitment challenges and we plan to continue developing good practice and encourage innovative use of pay and pensions flexibilities.

Features of Total Reward Packages for Employed Doctors and Dentists

13.29. Components of the TR package for medical and dental staff employed directly by the NHS, updated where appropriate from last year, include:

- for consultants, incremental progression of almost 7% of basic salary;
- competitive starting pay for doctors in training;
- a defined benefit pension scheme with a 14.3% employer contribution and flexible early retirement options from 55 years old;
- immediate life assurance of twice an employee's annual pay and generous death benefits for spouses and dependent children;
- for consultants, between 40 and 42 days holiday (inclusive of Bank Holidays) compared with the 28 days statutory minimum;
- sick pay of up to six months full pay and six months half pay compared with statutory sick pay of £88.45 per week for up to 28 weeks;
- redundancy pay of up to two year's salary with a minimum of 24 years reckonable service (using a notional £23,000 minimum and £80,000 maximum earnings for the purpose of calculating benefits) compared with the statutory half to one and a half week's pay for each full year of service depending on age. The Enterprise Act 2016 provides that a cap of £95,000 may be introduced on the value of exit payments for public sector workers, will be introduced following secondary legislation;
- HM Treasury has consulted⁵² on further reforms to public sector exit payments to ensure greater consistency between public sector redundancy compensation

⁵¹ <http://www.nhsbsa.nhs.uk/3798.aspx>

⁵² <https://www.gov.uk/government/consultations/further-consultation-on-limiting-public-sector-exit-payments>
<http://www.legislation.gov.uk/ukpga/2016/12/section/41/enacted>

schemes. Its response was published on 26 September 2016. The Government's expectation is that individual workforces will negotiate these changes with trade unions over the coming 9 months. We will work with NHS trade unions in the coming months to determine how the proposals will apply to the NHS, taking into consideration the savings already made from changes made to agenda for change redundancy terms in April 2015⁵³

- maternity pay of eight weeks full pay, 18 weeks half pay, 13 weeks statutory maternity pay (SMP) and an optional extra 13 weeks unpaid leave compared with the statutory entitlement of six weeks at 90% of average gross weekly earnings and 33 weeks at the lower of either £139.58 or 90% of average gross weekly earnings;
- paternity leave of two weeks starting twenty weeks after the child is born as well as an additional two to 26 weeks if the mother has returned to work. Fathers are also entitled to receive additional paternity pay if the mother has not exhausted her SMP when she returns to work; and
- the nationally recognised values, diversity and reputation of the NHS including, for example, excellent opportunities for flexible working, career breaks etc. and other local initiatives.

Total Reward Statements

13.30. Total Reward Statements ("TRS") were first introduced in the NHS during 2014 and are made available annually to most NHS employees. TRS are designed to help improve communications with employees, help them understand their complete benefits package and highlight the value of their employment and NHS pension benefits in one place.

13.31. A TRS is a personalised summary that shows employees their reward package, including:

- basic pay;
- allowances; and
- pension benefits (for NHS Pension Scheme members).

13.32. Organisations using the NHS Electronic Staff Record ("ESR") can also add information about local benefits allowing employers to showcase the positive benefits of working for their trust. Local benefits could include:

- health and wellbeing programmes;
- learning and development;
- flexible working opportunities;
- childcare vouchers; and
- cycle to work scheme.

⁵³ <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook/nhs-redundancy-arrangements>

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- 13.33. Evidence, for example, from NHS workshops suggests that employees do not understand the full value of their reward package with many unaware that they receive a 14.3% employer contribution towards their pension package. TRS should help resolve this and feedback from pilots confirmed that:
- the concept appears to be understood by staff and well supported;
 - the quality of statements is regarded as good; and
 - there is further work to be undertaken with NHS employers to support the local customisation of statements thus ensuring that the project's benefits are fully realised.
- 13.34. TRS are accessed by employees via the TRS portal and ESR employee self-service for organisations that use the facility. TRS have been developed and delivered by the NHS Business Services Authority ("NHSBSA") in partnership with the NHS Electronic Staff Record programme to support staff retention and motivation by giving NHS staff details on the overall value of their employment package. Staff in organisations not using ESR instead receive an annual benefit statement.
- 13.35. TRS content is refreshed annually for each eligible employee. NHSBSA carried out a Year One Evaluation in April 2015. Their findings show that TRS/ABS has been welcomed by NHS staff and viewed as a tool that provides valuable information. A national roll out of TRS started in 31 August 2015, with 2,197,616 statements now available.

Annex A

Chairs:

NHS Trusts

NHS Foundation Trusts

Clinical Commissioning Groups

Cc' ALB Chairs (for info)

Dear Colleague,

Keeping control of the paybill while ensuring we can recruit and retain high quality staff is a crucial part of meeting the efficiency challenge. Reforming the way we pay for NHS staff is a very high priority and must include a review of the pay of the most senior staff in the NHS (Very Senior Managers – VSMs) – chief executives and executive directors. Although these staff do important jobs and deserve to be fairly rewarded, it is vital that we do not lose sight of the need to ensure that executive pay remains proportionate and justifiable. More junior staff subject to tight restraint over their pay have the right to expect this as do the public more widely.

Although we have reduced the number of senior managers across the NHS by over 1,800 the latest figures still suggest that more than half of all directors in provider trusts are paid between £100,000 and £142,500 with more than one fifth paid amounts over £142,500. At a time of financial pressure, it is right to question the need to pay so many NHS staff more than the Prime Minister. The overall reward package is not just about pay, but also includes deferred pay in the form of NHS pensions. It cannot be right to treat pension benefits as though they are entirely separate from the employment offer.

I am therefore writing today to outline the following:

- Firstly, to urge you all to urgently review your policies on executive remuneration and consider whether the amounts paid are necessary and publicly justifiable.
- To advise you that I shall extend to NHS Trusts the current requirement for ambulance and community NHS Trusts, to first seek the approval of the Chief Secretary to the Treasury for appointments above the Prime Minister's salary of £142,500.
- I am also requesting that all FTs and CCGs seek the views of ministers via Monitor and NHS England respectively before making appointments to Boards/ Executive Boards with a salary higher than the Prime Minister's. In addition, that you advise me of those current salaries which are higher than the Prime Ministers and your justification.

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- To highlight particular attention to the pay of interim Board members and ensure that you follow the relevant HMT guidance on interim appointees paid on an “off-payroll” basis. Treasury guidance on such appointments states very clearly that Board members should be on the payroll of the organisations they lead unless in exceptional, short-term cases. The same rules apply to senior officials filling roles with significant financial responsibility. Can you please ensure that HMT’s guidance on “off payroll” appointments is rigorously followed.
- In addition, I believe the daily rates paid for such appointments amount, on an annual basis, to pay which is excessive and indefensible. Can you please ensure that where there are exceptions, the daily rates involved do not normally exceed what would be paid to substantive appointments.
- Clamping down on “retire and return” to ensure that very senior staff cannot gain financially, from this at a cost to the taxpayer. I have concerns that very senior staff use the retire and return provisions of the NHS pension scheme to access their full pension and lump sum and then continue in full-time work. The provisions were not designed for senior staff to gain financially. I will look to extend existing rules so employees’ new salaries plus their pension on returning to employment cannot be more than the original salary prior to retirement. It is unacceptable, particularly for VSMs leading organisations receiving additional tax payer support, to be better off by taking their pension and returning almost immediately to the NHS.
- To set out my expectation that the new redundancy terms for NHS staff in England apply to all newly appointed VSMs (unless staff are on statutory redundancy terms) and existing VSMs where section 16 is referenced in their contracts. The new redundancy terms for NHS staff in England are now more effective than before and it would be wholly unacceptable to have very senior staff leaving on significantly better compensation packages than more junior colleagues.

The last Government legislated for the “claw back” of contractual redundancy benefits on return to public sector employment for staff earning £100k or more. The new law will be in place in April 2016. This Government will introduce an overall contractual redundancy cap of £95k. Alternative employment where ever possible must be the priority so we retain valuable skills. Redundancy should be the very last resort.

I have also considered options for better control of VSM pay across the system, and will be taking these forward in the coming weeks. These include the following:

- introducing a national VSM pay framework with benchmarked rates for executive roles, and a more effective approach to transparency and disclosure (e.g. central publication of VSM pay rates for each organisation alongside the benchmarked rate). If these measures cannot be implemented effectively on a voluntary, “comply or explain” basis, I will strongly consider taking additional legal powers. In addition,

it is important that the new pay framework is informed by any relevant recommendations following publication of The Rose Review.

I recognise that effective leadership is crucial if we are to improve outcomes for patients. Getting this right is a team effort, and my expectation is that there should be no significant difference in the terms and conditions of senior leadership teams and those working on the front line. I do not believe it is acceptable that some senior managers experience the high levels of pay, with year on year increases, as a matter of course.

By the end of June I would very much welcome your plans and thoughts on:

- reviewing your policies on executive remuneration and whether the amounts paid are necessary and publicly justifiable;
- to note that NHS trusts will be required to seek the approval of the Chief Secretary to the Treasury on VSM pay which is more than the PM's - £142,500 - before making any appointments;
- via Monitor and NHS England, that FTs and CCGs should mirror the process in the rest of the NHS for appointing VSMs paid more than the PM;
- providing me with details of your current VSM salaries that are higher than the PM's and your justification;
- the introduction of a national pay framework for executive roles and how appropriate rates can best be benchmarked;
- assuring me that Board members and those filling roles with significant financial responsibility paid "off payroll" all meet the Treasury guidance and where they do not, the action you plan to take to rectify the situation.

In addition, I ask that you confirm to me in writing that you will personally scrutinise and approve any new VSM appointments in your organisation.

My officials will make contact with you as quickly as possible to provide further guidance about the information I have requested and will provide standard templates for your colleagues to complete.

I look forward to receiving your conclusions in June and continuing to work with you on this crucial aspect of the financial challenges we have to address.

JEREMY HUNT

Annex B

Earnings change for HCHS Doctors 2010-2015 – a longitudinal study.

Summary

A longitudinal study shows that the total earnings of HCHS doctors increased by an average of 3.3% per year between 2010 and 2015. This is the annualised median increase in the earnings of doctors with a record of payment on the NHS Electronic Staff Record system at both March 2010 and March 2015. Doctors who were not in post at both these points in time were excluded from the analysis. This increase is higher than the average increase over the same period in average earnings of all doctors, including those who may have joined or left the NHS over the period, which was 0.5% per year. This confirms that doctors joining the NHS tend to be lower earners, but progress over subsequent years. The average annual CPI figure over the same period was 2.4%.

The Analysis

Analysis has been undertaken of the total earnings of doctors as reflected on their Electronic Staff Record. Specifically, the analysis looks at the total earnings of those doctors with a record of payments made in both the months of March 2010 and March 2015. The analysis is based on the records of 60,500 doctors which represent around 60% of all doctors employed at March 2010. There is no presumption of continual service between the two points in time – so, in the interim, some doctors may have left and re-joined. The age and gender profiles of this analysis group and how they compare with those of all doctors is discussed later in the paper.

This analysis only includes payments to doctors on permanent contracts and excludes locums.

Changes in earnings are associated with career progression, pay uplift, geographical movement and changes in personal working patterns. The analysis controls for changes in earnings due to changes in working patterns by adjusting each doctor's earnings to a full time equivalent based on their recorded contracted hours. This adjustment has little impact on the median increase (as indicated at Table 2), but has a more significant effect towards the extremes of the distribution.

Key Findings

There is significant variation in the extent of change in earnings of doctors over the period. The one fifth of doctors seeing the greatest increase benefited from at least a 49% rise, equivalent to over 8.3% per year. However, the one fifth of doctors benefiting least had increases of less than 0.71% over the five years, equivalent to an average of less than 0.14% per year. Half of doctors saw an increase of at least 17.6% over the period, equivalent to 3.3% per year. Table 1 expands on the distribution of the changes in total earnings.

Table 1: Range of total earnings change, adjusting for changes in contracted hours, March 2010 to March 2015.

	20th centile	40th centile	Median	60th centile	80th centile
Change over five years	0.71%	11%	17.6%	26%	49%
Annual equivalent	0.14%	2.1%	3.3%	4.7%	8.3%

The average (median) increase compares favourably with both the Consumer Price Index (CPI) and the increase in average earnings of doctors as a whole over the same period. The latter is drawn from comparisons over the same time period of the mean earnings of all doctors – not just those who were employed at the start and the end of the period – published by NHS Digital. Table 2 put the findings of this study in the context of other changes over the same period, including figures for the longitudinal analysis without adjustment for part time contracted hours, which are more comparable with the increase seen in mean earnings of doctors published by NHS Digital.

Table 2: Comparisons of increases of doctors' earnings and prices.

	March 2010 – March 2015	Annual equivalent
Median change adjusted for FTE hours	17.6%	3.3%
Median change with no FTE adjustment 1	16.6%	3.1%
Published change in average earnings 2	2.4%	0.5%
CPI 3	12.4%	2.4%

Methodology

This analysis looks at the total earnings change for all permanent doctors with records on ESR in both March 2010 and March 2015. It only compares payments made in these two months and does not take into consideration what has happened to doctors between these two months, e.g. a doctor could have left the NHS and returned. Total earnings is the sum of all payments made in the month, including basic pay, additional programmed activities, additional standard time, band supplements, geographic allowance, etc.

Data is taken from the Electronic Staff Record (ESR) Data Warehouse. The ESR Data Warehouse is a monthly snapshot of the live ESR system, which is the HR and Payroll system used by all but two Hospital and Community Service (HCHS) organisations. The robustness of this data is subject to local coding practices and is not centrally validated. However, for this analysis, a number of constraints have been introduced, and records have been excluded where any of the following criteria were met:

- The doctor's contract is non-permanent, such as bank or honorary contracts

Pensions and Total Reward

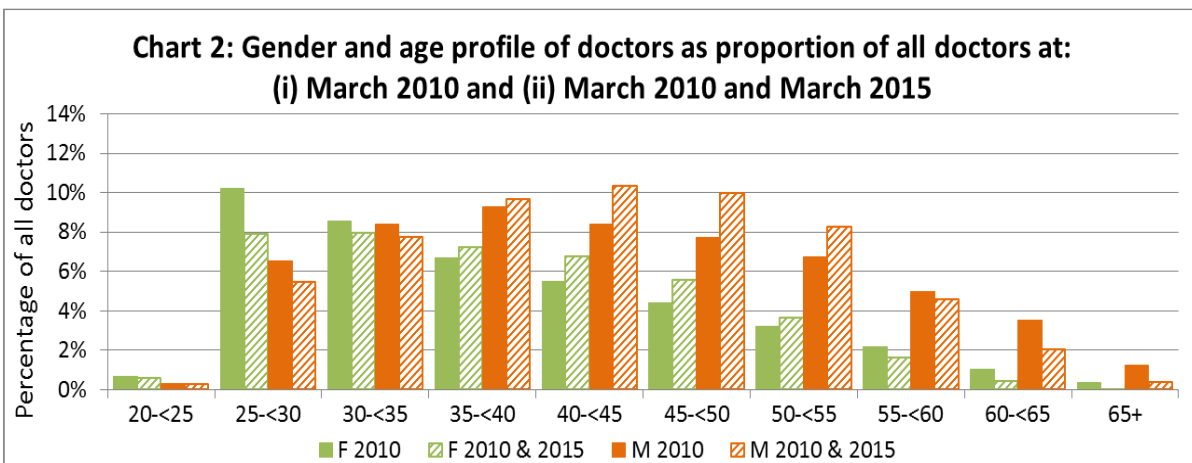
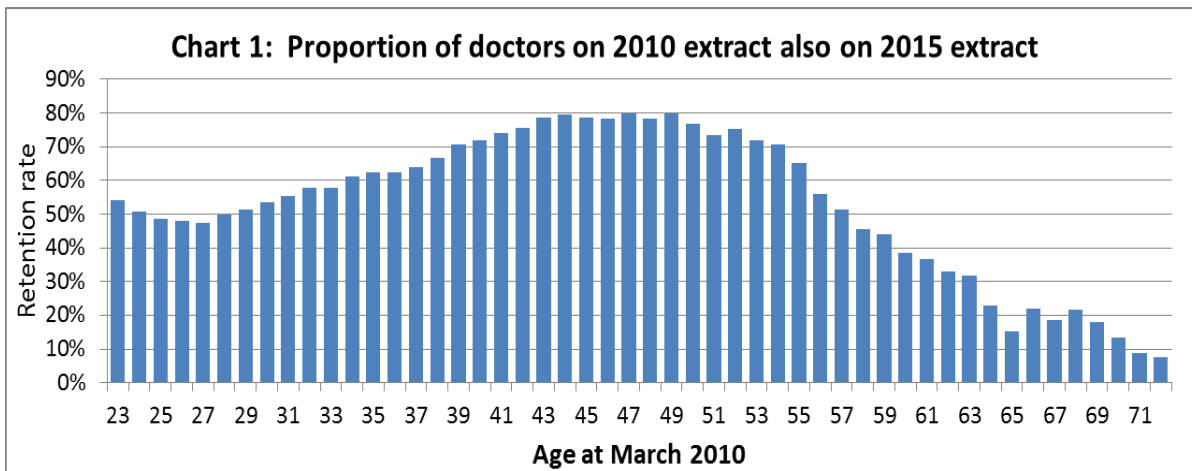
- The level of recorded basic pay is not consistent with the recorded job role.
- Total earnings are less than £100.
- Employment was not for the full month.

Where a doctor holds more than one contract, earnings for each contract are summed.

Limitations of the analysis

Earnings of individuals are likely to fluctuate across any given period, due to changes in working patterns (such as overtime), timing of progression pay or external circumstances. For certain individuals, the two months chosen may not be representative of their long term earnings change.

The cohort of staff with a record on the March 2010 and a record on the March 2015 extracts only makes up around 60% of all those employed in 2010, and so cannot be considered to be representative of the entire workforce; they will have different characteristics to the full cohort of doctors with a record on any one of the extracts. This is highlighted at Chart 1 which shows that the proportion of those on the 2010 extract who also appear at 2015 starts to reduce markedly for those aged over 50 in 2010, which means the analysis underrepresents the earnings patterns of older staff. Chart 2 shows in more detail the age and gender profile of the analysis group with that of all employees in 2010, showing that the analysis particularly over-represents males between 40 and 55, and under-represents women under 30.



Annex C

NHS Pension Scheme membership rate and trends

	FTE	% with pension contributions	% point change		
			May 2016	Apr 2016 and May 2016	May 2015 and May 2016
All	1,027,100	89%	0.3%	0.9%	4.5%
Staff Groups					
Doctor	104,048	92%	0.4%	0.1%	0.6%
Qualified nursing, midwifery & health visiting staff	306,851	91%	0.4%	0.6%	3.2%
Qualified Scientific, therapeutic and technical staff	129,085	93%	0.3%	0.3%	2.3%
Qualified Ambulance Staff	18,395	95%	-0.2%	-0.8%	-0.3%
Support to Clinical Staff	305,280	87%	0.4%	1.6%	7.7%
Central Functions & Hotel, Property & Estates	129,320	84%	0.3%	1.6%	6.9%
Managers	30,103	91%	0.0%	-0.4%	-2.0%
All Non-Medical	923,052	89%	0.3%	1.0%	4.9%

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.