

NHS Employers evidence to the pay review body on doctors' and dentists' remuneration

2010/2011

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NHS Employers 2010/11 key messages to the review body

- Employers believe that a flat rate increase on all pay points for employed doctors and dentists should be recommended.
- An increase of £450 on all points, for example, would maintain graduate entry pay to medicine and dentistry while avoiding unacceptable and unaffordable cost pressures at more senior levels.
- Employers believe that, in the light of known pressures on finances, an uplift of up to 1% in overall cost would be affordable for directly employed doctors and dentists, dependant on a corresponding increase in the tariff for 2010/11.
- Employers believe that there should be uplift to the gross contract values of no more than 0.21% in general dental services
- In relation to the general medical services, NHS Employers will submit evidence shortly.
- Employers want an award that is fair to staff but also recognises the need for organisations to achieve financial balance.

Employers' views are based on three key areas:

- financial considerations, linked to the tariff
- recruitment and retention
- staff morale.

Recruitment and retention continue to be generally stable in relation to doctors and dentists, suggesting that the pay system is largely fit for purpose and needs only limited changes.

Employers feel strongly that any unfunded increases in earnings would lead to cost savings elsewhere, leading to a possible loss of jobs and significant detrimental impact on patient services and care, jeopardising the local delivery of the overall NHS strategy.

The whole reward package must be considered - including pensions, tangible and non-tangible rewards - with regard to its effectiveness in enabling the NHS to recruit the correct number of staff, the correct skill mix of staff and the correct application of those skills, to do all the things required of the service.

Our evidence is representative of the views of employers in the NHS. Views gathered through hundreds of employer engagement activities across the past year, regional HR networks, focus group activity and a questionnaire, responded to by over 300 separate employers, our medical workforce forum and NHS Employers' policy board.

1. NHS Employers

Who we are

- 1.1 NHS Employers is the voice of NHS organisations in England. We also deliver a range of services to other UK countries in respect of the NHS. NHS Employers is the part of the NHS Confederation with responsibility for workforce and employment issues. NHS Employers has its own distinct governance arrangements, director and policy board.

About our evidence

- 1.2 NHS Employers aims to provide authoritative and comprehensive evidence on issues related to the remit of the Doctors' and Dentists' Review Body (DDRB). The evidence is based on information collected from employers in the NHS. We have used a questionnaire, designed to provide evidence for DDRB, completed by employers. We also gather evidence from many hundreds of contacts each year with the NHS through our networks, reference groups, our own governance structure and dealing with queries and advice directly with the service.
- 1.3 This evidence particularly addresses the issue of affordability. The UK economy officially entered recession during January 2009. This, and related matters, led Government to agree significant extra public spending in other (non-Health) sectors of the economy in addition to its original comprehensive spending review allocations. This has put significant cost pressures on to public spending. Those cost pressures are expected to intensify from April 2011 such that tough decisions will be needed to be acted upon during 2010/11 if the NHS is to be prepared for the cost pressures predicted for 2011 onwards.
- 1.4 It is this that dominates the thinking of employers in the NHS this year. This evidence describes the way in which the economy affects NHS funding, the pressures that this causes and the need for significant efficiency savings, and why this makes affordability the key theme of NHS Employers' evidence on behalf of the NHS in England.
- 1.5 This has led us to conclude that medical and dental pay cost increases will need to be below 1% for 2010/11. Even that will only be affordable if the increase in the tariff is sufficient to cover such a pay cost increase.
- 1.6 The evidence has been endorsed by the NHS Employers policy board.

2. General

Impact of the economic climate

- 2.1 The NHS is facing a severe contraction in its finances in the three years from 2011. The NHS will not survive the impending spending squeeze unchanged so courageous decisions are needed to re-shape the service and this is reflected in the large reduction in capital allocation in 2010/11.
- 2.2 The full extent of the pressures on the NHS will only become clear when decisions on public sector funding are made. Various commentaries estimate the funding shortfall. One is the NHS Confederation publication Dealing with the Downturn. Commenting on the leadership challenges faced by the NHS it highlights:
- the Department of Health (DH) has assumed 0.5 % extra efficiency savings for PCT providers
 - efficiency savings in the pricing scheme for drugs
 - an over-provision for the costs of pandemic flu preparations
 - the impact of further falls in the pound may have an adverse impact on the prices of goods and services from the Eurozone and the USA
 - pay and price increases will be greater than the uplift in the tariff
 - cost pressures for commissioners including managing the impact of the move to the tariffs based on Healthcare Resource Group
 - a requirement to make an even greater surplus in 2010/11 as a buffer against future cost pressures.
- 2.3 PCTs previous planning assumptions were for an increase in their centrally allocated revenue resource limits of 3.5% for 2008/09 onwards. The comprehensive spending review proposed an increase in NHS spending by an average of 4% above inflation each year through to 2010/2011.
- 2.4 The planned allocations up to 2010/11 increase PCT allocations in England by 5.5%¹, and 10.2% over two years, is 0.7% less than the uplift in the pre budget report.

Financial position in the NHS

- 2.5 The draft accounts for the end of year 2008/09 show that the NHS (excluding foundation trusts) is reporting an overall year end surplus of just over £1.7 billion. The surplus sits within NHS organisations. It is a small proportion of total NHS resources, at just over 2%. The surplus is also in line with 2008/09 forecasting, the overall NHS financial strategy and the NHS operating framework for 2009/10². It is key to achieving the financial stability and flexibility needed to deliver plans for service development, sustainability and

¹ Dealing with the Downturn: The NHS Confederation

² The Quarter, Quarter 4 2008/09 – an update from the Director General for NHS Finance, Performance and Operations

enhancement over the next decade, which have been set out by staff and clinicians involved in the Next Stage Review.

- 2.6 Monitor³, the independent regulator of foundation trusts, reported on the finances of the 115 authorised foundation trusts to 31 March 2009. It reported a combined net surplus (excluding exceptional items) over the twelve month period of £522 million. Nevertheless, Monitor has told foundation trusts they will need to have robust plans in place to implement efficiency savings before the financial pressures arise in 2011 and thereafter.
- 2.7 Foundation trusts believe they can manage within their annual earnings by keeping pay costs down. However, Monitor has warned that their predictions “may prove to be optimistic” given likely NHS investment cuts. Their Chief Operating Officer has been reported as saying, “As funding begins to tighten, areas of financial weakness may start to appear in some trusts”.⁴
- 2.8 Surpluses are non-recurrent. They have generally been achieved through short-term measures which will not generate such savings year-on-year. Examples include the postponement of essential investment through temporary delays to patient care initiatives. Such measures cannot be repeated each year due to the longer-term and permanent impact they would have upon patient care and activity/waiting list targets.
- 2.9 Non-recurrent savings are not therefore available for investment in recurrent areas of expenditure, such as staff pay. To do so would generate un-funded recurrent commitments for future years.
- 2.10 The financial management of the NHS has continued to improve. According to draft accounts six organisations were facing a cumulative deficit at the end of 2008/09 of £58 million. This compares to five organisations with an overall deficit of £125 million reported in 2007/08.

Efficiency savings

- 2.11 The comprehensive spending review announced that the minimum expected annual efficiency saving was being increased from 2.5% to 3% with an expectation of further value for money reforms realising annual net cash-releasing efficiency savings of at least £8.2 billion by 2010/2011. The NHS will need to make further efficiencies to help return the economy to balance as identified in the pre-budget report. The ambition is to begin to achieve these significant efficiency savings during 2010/11.
- 2.12 Money within the NHS budget is not specifically allocated to spend on annual pay increases. The pay bill at PCT level is met from the overall allocation of funding for PCTs. Resources for trusts arise from the pre-budget report tariff.

³ Monitor, NHS Foundation Trusts: review of 12 months to 31st March 2009

⁴ Health Service Journal, 13 August 2009

As the greatest element of NHS expenditure, pay cost pressures form a significant risk to the employing organisation. Typically pay represents 65 – 70% of expenditure within provider trusts, the employers of the majority of the DDRB remit group.

2.13 Any pay increase not reflected in PCT allocations or tariff will inevitably have a detrimental impact on services. Employers stress that affordability is dependent on an appropriate increase in the tariff for 2010/11.

2.14 Factors identified as creating particular cost pressures during 2010/11 include:

- The continued achievement of waiting time targets, such as the 18 week referral to treatment target and 2 week cancer waiting time targets, and maintaining financial stability;
- Continued roll out of the new specialty doctors and associate specialists contract - the new contract was introduced on 1st April 2008. Money has already been provided for the implementation but uptake has been slow, therefore during 2010/11, organisations will face delayed back pay costs;
- Pay progression – individuals are awarded annual increments over and above their annual pay award. Most organisations recognise that this effect will only last until the effect of staff turnover and “churn” offsets the cost of annual increments being awarded. However, the introduction of new contracts during 2003 and 2004 for most NHS staff, including Consultants, means that this process is still being felt;
- European Working Time Directive (EWTD) – some provider organisations pointed to cost pressures from the impact of the EWTD upon junior doctors’ hours;
- Large reductions in capital allocation in 2010/11, an over-provision for the costs of pandemic flu preparations;
- The impact of further falls in the pound may have an adverse impact on the prices of goods and services from the Eurozone and the USA;
- Pay and Price increases will be greater than the uplift in the tariff;
- Agenda for Change multi-year deal, year 3 arrangements – 2.5% cost pressure on the NHSPRB pay bill due to agreed 2.25% uplift to the pay scales in addition to the removal of the minimum point on the pay scale and additional increases to pay points in bands 5 and 6.

2.15 These interactions have also been referred to by The King’s Fund and the Institute of Fiscal Studies in their recent report, *How Cold Will It Be? – Prospects for NHS funding 2011-17*⁵. They find that, after significant real growth in NHS funding since 2000 (averaging nearly 7% per year in England up to 2010/11), future prospects are poorer. They remark that, *“As ever policy choices have to be made over public spending. But the consequences of the current financial crisis on the state of the public finances have meant that making these will require difficult trade-offs.”*

⁵ http://www.kingsfund.org.uk/research/publications/how_cold_will_it_be.html , published on 20 July 2009

- 2.16 They analyse possible funding futures for the English NHS from 2011/12 to 2016/17 and the consequences for the NHS, other spending departments and taxation. Over the next spending review period – 2011/12 to 2013/14 – the budget across all spending departments, including the NHS, could reduce in real terms by an average of 2.3% per year. However, if the NHS were to be protected to a greater or lesser degree, other departments could face greater cuts.
- 2.17 They conclude that, *“The NHS in England faces significant challenges if it is to sustain the improved staffing levels, improved access to service and reduced waiting times.”*
- 2.18 NHS Employers conclude from all of this that only limited funds will be available for wage increases.

Affordability

- 2.19 NHS Employers recognise that the definitive sources of evidence on the economic context and affordability are HM Treasury and the Health Departments. In advance of the PCT allocations being announced for 2010/11 and the NHS tariff being published, employers will have to take a view on the affordability of their workforce. A key national guidance paper supporting local operational and financial planning for 2010/11 and beyond is expected to be published by the Department of Health during the autumn of 2009.
- 2.20 The key points of the 2009/10 operating framework were summarised in a member briefing by the NHS Confederation, including reference to the challenging financial circumstances facing NHS trusts:
- The uplift of an average of 5.5%, 10.2% over two years, is 0.7% less than the uplift in the pre budget report;
 - The size of the tariff uplift next year and in subsequent years, the size of the efficiency requirement and the potential cost pressures mean that the environment for providers will be very challenging;
 - Whilst the pre budget report and operating framework both make reference to sources of efficiency it is important to stress that these seem to relate to top-down modelling exercises and assumptions about operational efficiency, procurement, the use of assets, length of stay, shifting work out of hospital, etc;
 - History suggests that these often have limited relationship to the reality experienced on the ground. Organisations and health communities will have to find their own route to these challenging targets which might be as great as 5% by 2010/11, followed by an increase in employers National Insurance in 2011/12.
- 2.21 The existing operating framework⁶ (published December 2008) includes provisional 2010/11 targets which state:

⁶ The Operating Framework for the NHS in England 2009/10

The operating framework for 2009/10 sets no new national targets. The challenge is to invest additional resources wisely in order to prepare to make substantial efficiency savings in 2010/11 and for a tighter financial climate thereafter. It means investing prudently in high quality care. The intention is to deploy the current surplus in a planned and managed way, reducing the overall surplus by £800 million during 2009/10 and 2010/11.

Providers were advised to assume that the tariff uplift for 2010/11 would not exceed 1.2% in making their financial plans.

2.22 During 2009/10 and continuing into 2010/11 PCT allocation and revenue will benefit from:

- The new formula for PCT allocation of resources, which builds on and improves the previous formula;
- An average PCT allocations growth of 5.5%, with a minimum floor growth of 5.1%. This represents a total increase in PCT direct funding of £4.4billion over 2010/11.

2.23 It is important to consider the impact of both current and future inflation on affordability of any earnings growth. The RPI⁷ (Retail Price Index) inflation measure indicated deflation of 1.3% in the year to August 2009. Private pay settlements are reflecting the downward trend in RPI.

2.24 The preferred Government measure - CPI (Consumer Price Index) – has remained more stable, increasing by 1.6% in the year to August 2009 (down from 2.3% in the year to April 2009) according to the Office for National Statistics.

The potential impact of a higher than forecast pay award

2.25 The majority of NHS health care providers' income is determined by agreements with their purchaser, much of which is under the nationally set tariff. Such organisations face a significant risk if future pay awards for NHS staff are higher than accounted for in their plans. A large additional cost pressure would be created.

2.26 Significant increases to future pay awards would therefore require reviews of operational financial plans and potentially jeopardise direct patient care, service quality or nationally set access targets. In this respect, as an indication only, a 1% variation in anticipated pay awards would predominantly absorb many trusts' total operating contingencies and working capital reserves without any consideration for other in-year financial risks.

2.27 For PCTs the level of financial exposure associated with annual pay awards varies. Direct pay costs only account for approximately 10% of a typical

⁷ <http://www.statistics.gov.uk/pdfdir/cpinr0909.pdf>

commissioning PCT's expenditure baseline. PCTs with a provider arm will have a greater exposure against direct pay costs.

- 2.28 Nonetheless, affordability has this year become a significant issue for employers as a result of the interaction of the prevailing wider economic circumstances in the UK and public expenditure. The NHS Confederation's report *Dealing with the Downturn*⁸ refers to this in some detail.

The key points made are:

- The NHS is facing a very severe contraction in its finance with an £8–10 billion real terms cut likely in the three years from 2011.
- The need for strong leadership and radical quality and efficiency improvement is therefore greater than ever.
- History tells us that letting waiting lists grow, diluting quality and structural change should be avoided.
- The NHS will not survive the impending spending squeeze unchanged.
- Courageous decisions are needed now to reshape services and help us prepare for the most significant leadership challenge the NHS is ever likely to face.

The reward package

- 2.29 The purpose of the reward package in the NHS, as for any employer, is to ensure the recruitment and retention of the appropriate numbers of staff, the appropriate skill and knowledge mix among the staff and the correct quality of application of that skill and knowledge at the correct place and time, to provide the services required.
- 2.30 Reward is not only about pay rates. It is also about tangible and non-tangible non-pay rewards. It encompasses pensions – deferred wages; conditions of service, such as annual leave, sick pay, enhancements for work out of hours and payments for additional duties; and how staff are managed. It is about the total reward. In effect, this evidence is about what people do, what they are paid and how they are managed.
- 2.31 While economic conditions have effects on the labour market and on affordability, any recommendations of the DDRB need to reflect the purpose of the reward strategy in the NHS – that is, to recruit, retain and motivate the appropriate numbers, skill mix and quality of medical and dental staff.
- 2.32 In comparison to other professional jobs in the economy, doctors and dentists are in an occupation on which prevailing economic circumstances have a more limited effect since the employment and contracting of doctors and dentists is largely within the NHS. In the UK, only 3%⁹ of doctors receive

⁸ (http://www.nhsconfed.org/Publications/Documents/Dealing_with_the_downturn.pdf)

⁹ http://www.ic.nhs.uk/webfiles/publications/workforce/NHS%20Staff%20Earnings/staffearnaprjun09/NHS_Staff_Earnings_Estimates_April_to_June_2009_Bulletin.pdf

their primary income from other sources, such as academic work. Competition with the wider labour market and the wider economic circumstances are not thought to be the primary factors in the recruitment and retention of doctors and dentists.

NHS medical and dental workforce earnings

- 2.33 The NHS Information Centre produces a quarterly publication of NHS Staff Earning Estimates which show medical workforce earnings by staff group, taken from the Electronic Staff Record (ESR). Roll out of the ESR is now complete and the most recent data covers every NHS organisation, except two foundation trusts which have not joined ESR.
- 2.34 Changes in the average earnings by staff group arise from actual increases in individuals' pay due to pay awards, back pay and incremental progression or changes in the composition of the workforce due to pay reforms and/or the impact of new organisations joining the sample. A separate analysis of earnings has shown that some of the changes in earnings arise from changes in the sample rather than true changes in average salary.¹⁰
- 2.35 The figures which follow are taken from the NHS Staff Earnings Estimates in June 2009. They give basic pay and total pay for April to June 2009 and comparisons are made with the same quarter of 2008 in Table 1.
- 2.36 Doctors in foundation year 1 (FY1) receive an average basic salary of £22,500 and their average total earnings are £32,300. These figures show an average additional earnings equivalent to £9,800 or 44% of basic pay. Their average basic pay has increased by 1.8% since the previous year with the average total earnings remaining the same. We refer later to the continuing work to scope the effectiveness of the current doctors in training contract.
- 2.37 Doctors in foundation year 2 (FY2) receive an estimated basic pay of £29,600 and total pay of £43,300. These figures equate to average additional payments of £13,700 or 46% of basic pay. This shows a decrease of 1% in basic pay and a 2% reduction in total pay.
- 2.38 Specialty registrars earn an average basic salary of £38,000 and an average total salary of £58,000. The estimated average additional earnings for this group add 52% to their basic pay. These figures are 2.4% and 1% more than the 2008 figures for basic and total pay respectively.
- 2.39 Apparent reductions in the average salaries of FY2/senior house officers (SHOs) and registrar grades are not the result of real reductions in earnings. Implementation of the Modernising Medical Careers (MMC) programme has resulted in most staff transferring from the SHO to the registrar pay scales.

¹⁰http://www.ic.nhs.uk/webfiles/publications/workforce/NHS%20Staff%20Earnings/staffearnaprjun09/NHS_Staff_Earnings_Estimates_April_to_June_2009_Bulletin.pdf

The resultant effect of this has been to reduce the average earnings of both the FY2/SHO group and registrar staff groups in the earnings estimates. A better indication of individual increases received by doctors in training is given by the annual pay awards and increments received.

- 2.40 Associate specialists have a mean basic salary of £79,300 and a mean total pay of £87,600. This figure shows that additional earnings add 11% to basic pay or an average £8,300 p.a. The median salary is lower than the mean basic and total pay suggesting a positive skew in associate specialist earnings. Their average basic pay has increased by 5% since the previous year whilst total earnings have increased by 6%. Staff grades earn a basic salary of £61,500 and an additional 11% in additional pay. Their average total annual earnings are £68,300. Their average basic pay has increased by 6.2% since the previous year whilst total earnings have increased by 6.9%.
- 2.41 There are two types of contractual arrangements for consultants, referred to as the '2003 contract' and the 'pre-2003 contract'. Of consultants, 95% are paid on the 2003 contract. The mean total earnings of consultants are estimated at £121,800 for those on the 2003 contract and £104,800 for those on the pre-2003 contract, this includes clinical excellence awards. These figures are payments received from NHS organisations and exclude private earnings or earnings of consultants paid by universities. For those on the new contract, the total earnings have increased by 2.2% over the year from the second quarter of 2008 to the same period in 2009, reflecting the pay award and increments.

Analysis shows that the figures presented are a true reflection of the increase in earnings and are not skewed due to changes in the ESR sample. The increase in earnings exceeds the pay award because of incremental progression.

Table 1 below summarises the earnings data.

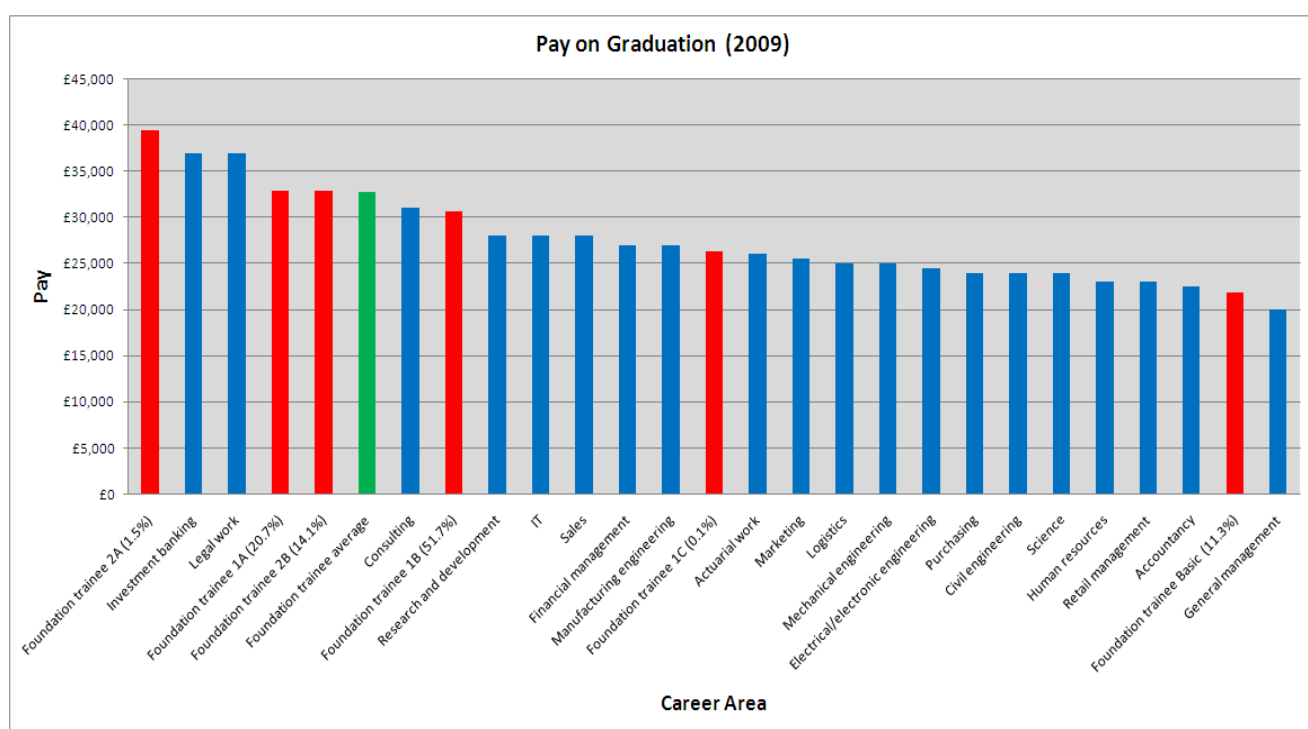
Table 1: Medical and dental basic and total earnings by grade in June 2008 and June 2009. The table also shows the percentage change over the course of the year.

STAFF GROUP	APR - JUN 09				APR - JUN 08				AVERAGE % ANNUAL CHANGE FROM LAST YEAR IN BASIC PAY	AVERAGE % ANNUAL CHANGE FROM LAST YEAR IN TOTAL PAY
	MEAN BASIC SALARY PER FTE	MEAN TOTAL EARNINGS PER FTE	MEAN ADDITIONAL EARNINGS	MEAN % ENHANCEMENT TO BASIC PAY	MEAN BASIC SALARY PER FTE	MEAN TOTAL EARNINGS PER FTE	MEAN ADDITIONAL EARNINGS	MEAN % ENHANCEMENT TO BASIC PAY		
	APR - JUN 09	APR - JUN 09			APR - JUN 08	APR - JUN 08				
Consultants: Old Contract	£87,200	£104,800	£17,600	20.2%	£85,500	£102,400	£16,900	19.8%	2.0%	2.3%
Consultants: New Contract	£90,900	£121,800	£30,900	34.0%	£89,000	£119,200	£30,200	33.9%	2.1%	2.2%
Foundation Yr 1 / HO	£22,500	£32,300	£9,800	43.6%	£22,100	£32,300	£10,200	46.2%	1.8%	0.0%
Foundation Yr 2 / SHO	£29,600	£43,300	£13,700	46.3%	£29,800	£44,100	£14,300	48.0%	-0.7%	-1.8%
Registrar Group	£38,000	£58,000	£20,000	52.6%	£37,100	£57,400	£20,300	54.7%	2.4%	1.0%
Associate Specialist	£79,300	£87,600	£8,300	10.5%	£75,800	£82,700	£6,900	9.1%	4.6%	5.9%
Staff Grade	£61,500	£68,300	£6,800	11.1%	£57,900	£63,900	£6,000	10.40%	6.2%	6.9%

National Statistics (Year to Jun-09)									AVERAGE % ANNUAL CHANGE FROM LAST YEAR IN BASIC PAY	AVERAGE % ANNUAL CHANGE FROM LAST YEAR IN TOTAL PAY
National Average									2.5%	2.5%
Private Sector Only									2.1%	2.1%
Public Sector Only									3.7%	3.7%

- 2.42 Doctors earnings were compared to national levels of pay across the private and public sectors and across other professional groups in the DDRB 38th Report, 2009. Doctors' and dentists' remuneration compared favourably with other professional groups, excluding actuaries (and legal and tax and accountancy for associate specialist equivalent) who were considered a special case due to their financial services sector involvements. It was also noted that the lowest spine point for consultants is in the top 5% of the national pay distribution.
- 2.43 Earnings for foundation doctors in training at the start of their postgraduate medical careers are illustrated in Graph 1. They compare favourably with those of graduate recruits in other sectors.

Graph 1: Median earnings across various sectors; the green bar is the median and average for FY1 pay, the red bars the actual pay values for the various bands. (Sourced from Graduate Recruitment Survey 2009 Summer review, published by the Association of Graduate Recruiters).



- 2.44 The Office of National Statistics reports national average earnings, including bonuses, rose by 2.5% in the year to June 2009, up from the April rate of 0.9%. Average earnings excluding bonuses, or regular pay, rose by 2.5% in the year to June 2009, down from the April rate of 2.7%.
- 2.45 The Office of National Statistics indicated that, in the year to June 2009, pay (excluding bonus payments) grew nationally by 2.1% in the private sector compared with 3.7% for the public sector. This gap has grown and was only 1% in May 2009. Including bonuses the growth in the private sector was 2.1% compared with 3.7% in the public sector.

Increments

- 2.46 Incremental progression in the pay structures continues to make a noticeable contribution to earnings growth for doctors and dentists employed in the NHS.
- 2.47 For newly appointed consultants increments are worth an average of 4% of basic pay, excluding any clinical excellence awards.
- 2.48 In the financial year 2010/2011, specialty doctors and associate specialists on new contracts will have access to incremental progression every year or once every two or three years, depending on their position along the pay spine.
- 2.49 Doctors in the new contract SAS grades benefit from average increments of between 3 and 10% of basic pay.
- 2.50 Doctors in training grades receive annual incremental increases of between 4 and 8%.
- 2.51 Employers in the NHS believe these additional increases in basic pay and earnings should be factored into decisions about the recommended level of pay increase.

NHS medical and dental workforce

- 2.52 In 2008 the overall NHS workforce increased by 2.8% compared to 2007. In England, the total headcount increase was 37,585. It is the first increase experienced since 2005 and increased the workforce headcount to a ten year high. Of 1.28 million hospital and community health services staff employed in the NHS, 98,703 are doctors, making up 8% of the workforce.
- 2.53 Against this background, the medical and dental workforce continued to grow significantly during 2008 and at a much faster rate than in previous years. There was 91,586 full time equivalent hospital and community health services medical and dental staff in September 2008, compared to 87,533 in 2007. These figures show an increase of 4,053 full time equivalent or 4.6% compared to 1.8% the previous year. Since 1997, the number of full time equivalent hospital and community health services medical and dental staff has increased by 60% from 57,099.
- 2.54 The 34,910 consultants is the highest figure ever. The growth rate for 2006/07 was 2.4% and for 2007 to 2008 was 3.7% - the highest yearly increase since 2005. The number of doctors in training increased significantly by 5.1% compared to 1.1% in the previous year. This growth exceeds the average rate of 4.5% over the preceding ten years.

- 2.55 Over the ten years to 2009, the number of associate specialists and staff grades has increased by an annual average of 8% and 7% respectively. In 2007, associate specialists increased by 5.4% and staff grades fell by 2.1%. The reduction in growth in the associate specialist workforce and fall in staff grades against previous years is offset by the introduction of the new specialty doctors' contract.
- 2.56 Excluding consultants and doctors in training and equivalents the number of other doctors has increased by an annual average of 2.8% over the last ten years. The 4.6% increase from 2007 to 2008 the highest increase since 2000.

Vacancies

- 2.57 The three month vacancy¹¹ rate (vacancies as at 31 March that have remained open for three months or more and which trusts are actively trying to fill) for medical and dental staff, excluding training grades, was 1.5%. Despite having increased from 0.9% in 2008 the rate remains very low.
- 2.58 The three month vacancy rate for consultants was 1.1% and increased from 0.9% in 2008. It is the first time since 2004 that increases in vacancies have been reported. Specific pockets of high vacancy rates are apparent by specialty at a regional level.

Staff Group	Total vacancy rates to 31st March each year (per cent)						per cent change in 2008
	2004	2005	2006	2007	2008	2009	
All medical and dental staff	4.3	3.1	1.8	1.1	0.9	1.5	0.6
Consultants	4.4	3.3	1.9	1.2	0.9	1.1	0.2
Other doctors and dentists (excluding training grades)	4.1	2.6	1.7	0.7	1.0	3.0	2.0

Table 2: Vacancy rates of medical and dental staff

- 2.59 Vacancies in the non-medical staff groups were lower. Qualified and unqualified nursing had vacancy rates at 0.7% and 0.4% respectively. In the economy at large vacancy rates are higher than those in the NHS at 1.6 vacancies per 100 employee jobs for July 2009.

¹¹ NHS Vacancy Survey England – 31 March 2009. Vacancy rate is the ratio of FTE vacancies to the number of FTE staff in post plus the number of vacancies. The rate is expressed as a percentage.

- 2.60 Pay specialists Incomes Data Services report that median pay settlements in the UK in the three months to July dropped to 1% from the 2% that had prevailed for several months in the early part of 2009, the lowest figure since its records began in 1994. Figures before that time are unlikely to have been lower given the prevailing higher pay and price inflation experienced in the UK during the 1980s and 1990s. Thus it is likely that the current rate of pay rises is the lowest seen in the UK for three decades. Nearly half of the pay settlements in the three months to July 2009 were pay freezes.
- 2.61 At the same time unemployment has grown by about 750,000 to nearly 2.5 million over the past year.
- 2.62 The contrast with public sector pay is stark despite the looming financial restrictions facing the NHS in the next 18 months. Doctors and dentists' employment and earnings have been largely immune to the economic effects we have noted.
- 2.63 This has led NHS Employers and its member organisations to conclude that any recommendation will need to be significantly less than last years award, while taking account of these matters:
- balancing affordability
 - acceptability to the public purse
 - the need for continued improved service delivery
 - maintaining the morale and commitment of doctors and dentists

3. Employer views

- 3.1 More employers than ever before have engaged with the review body process by responding to our questionnaire (Annex B). About 75% of employers of doctors and dentists in the NHS submitted evidence in this way. The high response rate suggests the continued commitment of employers to engage through NHS Employers in the work of pay review. The sample represented an appropriate proportion of all types of trusts, and is considered representative of employer opinion. NHS Employers confidence in this has been bolstered by the many hundreds of employer engagement contacts, more formal employer focus groups held on the subject of pay and the endorsement of this evidence by NHS Employers' Policy Board.
- 3.2 Employers in the NHS in England considered the most important factors for assessing pay recommendations should be:
- affordability (98% of the respondents cited this as the main issue for consideration, far in excess of any previous figure on this measure)
 - recruitment and retention
 - staff morale (about a third of respondents mention this – down from previous years)
- 3.3 Employers are very clear that any cost pressure through unfunded pay increases would have an adverse affect on services. Most employers indicated that an unaffordable pay increase would lead to necessary cost savings elsewhere. Of our sample 97% offered a view on the likely consequences of an unaffordable pay increase:
- effects on service capacity and quality – with all respondents citing one, or a combination of, delays to planned service extensions, reductions to service capacity and quality and/or reductions in the quality of care
 - reductions in the number of posts - with 96% of those who responded saying they would suffer one of, or a combination of, reductions in the number of posts, increased levels of unfilled posts or redundancies
 - over half of the respondents also referred to failing to meet Trust Board objectives and government targets.
- 3.4 Affordability is linked to the level set for pay in the tariff. Employers must be able to meet commissioned levels of service and national targets without compromising patient care or financial balance. Similar financial constraints apply at PCTs and some mental health services even though they are mainly not covered by the tariff prices. Affordability of pay awards can be compromised by assumptions of efficiency gains which may be more difficult to achieve in some places rather than others.

- 3.5 As referred to in the previous chapter, the pressure on finances are widely reported to be more extreme than ever before for the NHS.¹²
- 3.6 Employers reported recruitment and retention difficulties faced during the past year, the grade and speciality involved, and whether any difficulties were severe or not. About two thirds (compared to half last year) of the trusts responding to the questionnaire reported recruitment and retention difficulties in relation to doctors and dentists, over the year to August 2009, and 36 separate trusts reported a total of 61 doctors and dentists recruitment difficulties as 'severe'. Most common among the specialty areas involved in those 61 severe examples were paediatrics (13 examples), accident and emergency (8 examples), anaesthetics (7) and medicine (7). Other specialties were mentioned in fewer than 5% of the examples.
- 3.7 It is believed that the severe difficulties were mainly related to labour shortages. Among the severe impacts on patient care, half were said to relate to SAS doctors with roughly a quarter related to each of consultants and doctors in training. The proportion of severe difficulties among dental staff was halved compared to the previous year. It is thought that the pressure on SAS doctor roles may reflect the impact of reducing hours for doctors in training. It also suggests that the introduction of the new salaried dental contract during 2008 has proved successful in reducing the number of recruitment difficulties being experienced in the service.
- 3.8 Pay was not cited at all in the severe difficulties reported by employers.
- 3.9 The most common approaches reported as in use by employers to solve recruitment and retention problems were:
- the use of locum cover (both from external agencies and internal arrangements) (85% of respondents)
 - job plan changes (24%)
 - skill mix changes (20%)
 - overseas recruitment (16%)
- 3.10 Under 3% of respondent employers reported the use of local labour market supplements. Of those, only two examples correlate with reported recruitment and retention issues with severe impacts on patient care. We believe this means the market supplements are being used appropriately at local level and are not being used in areas where there are labour supply side issues. Such labour supply side issues will need to be addressed by service redesign, reconfiguration and longer term workforce planning solutions, rather than increased employee income which churns the labour market and poaches staff from other trusts without benefiting the overall delivery of the NHS objectives for the quality and quantity of patient care.

¹² See in particular the example of the NHS Confederation's recent report Dealing with the Downturn (http://www.nhsconfed.org/Publications/Documents/Dealing_with_the_downturn.pdf).

- 3.11 The use of temporary medical staffing in the NHS remains a key area of workforce expenditure which employers are seeking to control. While temporary staff are essential for delivering flexibility, and for dealing with short term capacity fluctuations, costs can be high. Thus, prolonged or excessive usage is not cost effective. Employers' responses to our questionnaire indicate that the use of locums (from both internal and external sources) is a common measure for dealing with recruitment difficulties or for filling short term service gaps such as maternity cover.
- 3.12 NHS Employers published updated guidance during December 2008 on the effective management of temporary staffing.¹³ This set out a range of measures to help contain costs. In the wake of European Working Time Directive (EWTD) implementation for doctors in training, there is a reported resurgence of interest in the use of electronic rostering to support local workforce planning. Regional initiatives, such as the London Procurement Project and the West Midlands' Healthcare Purchasing Consortium, promote collaborative working in the procurement of medical and non-medical agency staff. Better use of internal staff banks, development of NHS Professionals' services, and adherence to the Purchasing and Supplies Agency (PASA) framework agreements for commercial agencies all help sustain more cost-effective use of temporary and locum staffing.
- 3.13 Despite better control mechanisms, since 2007 there has been a steady recorded rise in agency costs for locum medical staff, largely as a result of the drive to achieve and maintain compliant rotas under the Working Time regulations from August 2009, and the need to cover for absences amongst doctors in training. The scope for immediate reduction is limited and expenditure may stabilise at current levels, although we will work with trusts to promote procurement savings where possible.
- 3.14 NHS Employers' medical workforce team's pre-evidence survey of employers revealed difficulties recruiting locum staff, particularly for short term assignments and for cover amongst the middle grades. Key supply or demand reasons given include:
- reduced availability of International Medical Graduate (IMG) doctors, reportedly discouraged from working in the UK by uncertainty and misinformation over the UK Border Agency's Points Based System for migrant workers and the impact on entry routes
 - competition from other overseas healthcare systems
 - some increased demand for doctors as reductions in hours of work to meet European Working Time Directive (EWTD) requirements take effect and additional posts are created coupled with locums working fewer hours themselves under the EWTD

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http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical_Education_and_training/Specialty-and-GP-training/Managing-medical-vacancies/Pages/Managing-medical-vacancies.aspx

- a small degree of mismatch between the doctors available and the specialties and levels at which locum cover is sought - this is being addressed centrally through better information on competition ratios but will take time to work through at trainee level
- controls on costs (via the NHS procurement framework) have made working as a locum less lucrative or attractive.

3.15 Despite these difficulties, employers are not reporting that difficulties in securing temporary medical staff are having serious implications for service delivery. Initiatives such as the relaunched Medical Training Initiative should help alleviate this further.

3.16 In efforts to aid recruitment and retention employers in the NHS continue to use non-pay measures, such as:

- flexible hours working
- flexible retirement arrangements
- childcare support
- career breaks schemes
- annualised hours
- term time only working
- return to practice arrangements

Clinical excellence awards

3.17 Employers in the NHS believe that clinical excellence awards are sufficient to reward excellence and the individual value of awards should not be increased.

London weighting

3.18 London trusts were asked whether the level of London weighting was adequate. Of those 75% thought that it was adequate, compared to 66% of London based trusts last year.

Multi-year settlements

3.19 We did not ask employers this year to comment on the perceived benefits or otherwise of multi-year settlements. As we said in last year's supplementary evidence, any such award could only be accommodated within the limits of public sector pay policy. Progress on multi-year deals, in any event, would have to emerge in parallel with the review body processes, in discussion with the British Medical Association (BMA) / British Dental Association (BDA) and the Department of Health.

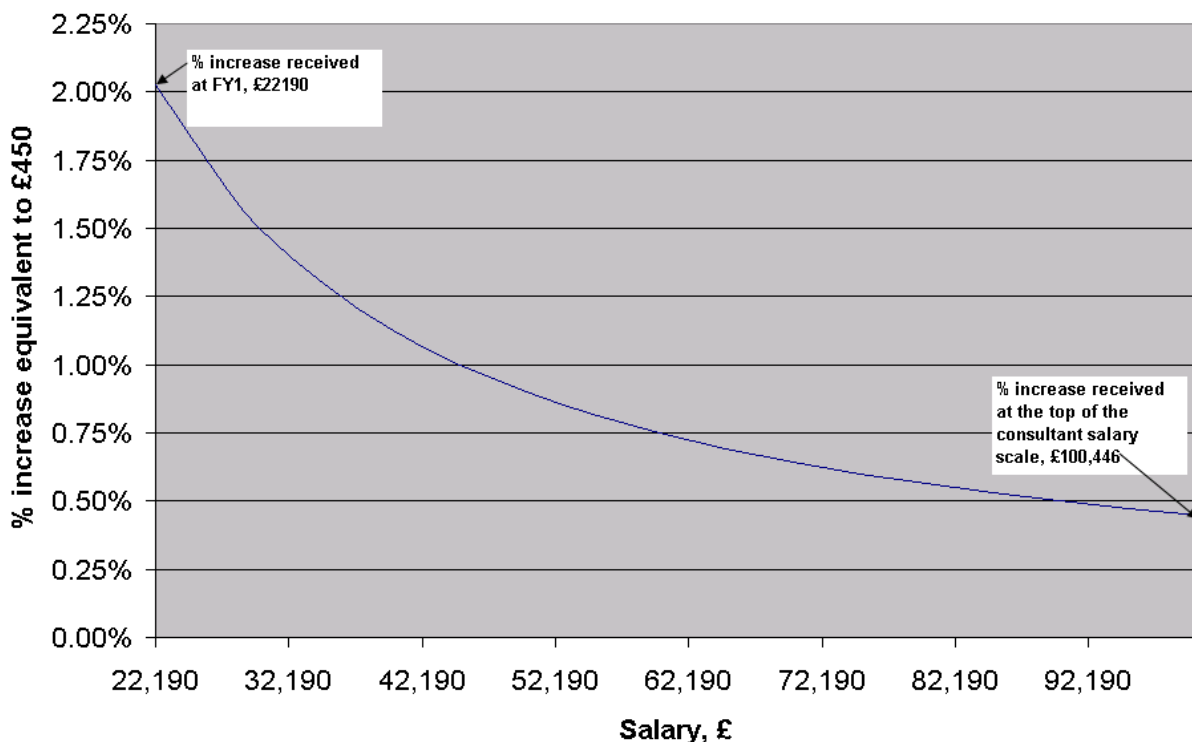
Structure of award

3.20 Many employers have indicated that they would prefer the same award for all categories of dental and medical staff, saying that they do not believe extra pay should be targeted at any particular medical or dental groups. Others favoured different awards for different categories, with doctors in training being mainly favoured for a higher award. Furthermore, some have questioned the acceptability of significant rewards for higher earners in the current economic climate.

3.21 Arising from this diversity of opinion there is a question of how any award should be structured. For example, £450 on each point on the pay scales delivers increased costs of just under 1% of the total wage bill for employed doctors and dentists. Such a sum if distributed equally to the profession would lead to increase as follows:

Graph 2: Illustration of effect of a flat rate pay uplift on percentage increases at different salary rates.

A table showing the data for the graph is given at annex C.



- 3.22 Such an approach could potentially assist with keeping a fair graduate entry pay for medicine and dentistry while avoiding unaffordable cost pressures at more senior levels, pending any long term changes that might emerge as a result of the current scoping exercise on the efficacy of the doctors in training contract.
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- 3.23 The employer support for such an approach has been tested through consultations with CEOs, HRDs and finance directors at a selection of trusts in different geographical regions.

Conclusion

- 3.24 Employers in the NHS want a fair and reasonable national pay award that recognises the need for local employers to achieve financial balance. Any award should:
- be consistent with the resources available to the NHS
 - reflect the 2010 tariff uplift.
- 3.25 Assumptions on tariff uplift, from the operating framework for the NHS, suggest to employers that an overall increase of more than 1% would not be affordable. The views of employers, the UK economic position and the outlook for public spending, suggest that above this level there would be unacceptable pressure on services and jobs.
- 3.26 However, NHS Employers believes that the overall increase could be distributed as the same flat rate for all employed doctors and dentists. As illustrated above, a £450 increase on all pay points for employed doctors and dentists would increase costs by just less than 1%. This would enable some account to be taken of reduced earnings of doctors in training arising from the introduction of EWTD compliant rotas from 1 August 2009, pending the outcome of a scoping study on the efficacy of the current contract for doctors in training. It would also be affordable and acceptable at more senior levels of the structure.

4. Workforce development

Staff satisfaction and attitudes

- 4.1 An element of the effectiveness of the pay rates and pay systems is reflected in the staff satisfaction and attitudes and how that affects staff morale as a key driver of the motivation of staff.
- 4.2 The Department of Health published research, as part of the Next Stage Review, looking at what affects staff in the NHS. Based on surveys and group discussions, the research identified factors that matter to staff. Crucial among these were involvement, including being treated with trust, being listened to, understanding the big picture and working together. In effect, what matters to staff is having a worthwhile, supported, resourced job with opportunities. The research is no longer accessible directly. A reference to it can be found at on **Ipsos MORI's website**.
- 4.3 The factors that are important to staff are linked to better patient and public satisfaction, and enhancement of the reputation of the NHS – key priorities in the NHS operating framework for 2009/10¹⁴.
- 4.4 Improving staff satisfaction is a key requirement of the 2009/10 NHS operating framework. An NHS staff survey has been carried out annually since 2003 enabling changes in the reported levels of job satisfaction to be seen. This provides a survey-based measure of job satisfaction for NHS staff. A more satisfied workforce is likely to be more sustainable and provide better patient care. Motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public. The 2009/10 NHS operating framework expects that employers in the NHS help staff understand their role in delivering a better NHS and encouraging staff to participate in the NHS staff survey and act on the findings. Data extracted from the 2008 survey, the most recent, have been used in this evidence. The complete data is available from the Care Quality Commission.¹⁵
- 4.5 The 2008 staff survey was reported in March 2009. It reflected the renewed focus on the NHS as an employer arising from the publication of the NHS Next Stage Review in July 2008 and the NHS Constitution¹⁶ in January 2009.

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445

¹⁵ <http://www.cqc.org.uk> The CQC took over responsibility for the survey from the former Healthcare Commission on 1 April 2009.

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419

- 4.6 The four pledges in the NHS Constitution includes set out for the first time, what the NHS expects from its staff and what staff can expect from the NHS as an employer.

NHS staff satisfaction survey

- 4.7 The latest NHS staff survey indicates that doctors and dentists remain more likely than their colleagues in other occupations to report that they are satisfied or very satisfied with their level of pay. When compared to their colleagues doctors and dentists are more satisfied with their pay, less likely to be planning to leave their trust, more satisfied with their jobs, healthier, get better access to training and learning, and are safer and less stressed. They report experiencing a poorer quality of life than the average for all NHS staff. The measures of work-life balance for doctors and dentists, while being poorer than other occupations, have improved since the previous survey.
- 4.8 The average score for job satisfaction (ranging from 1 for very dissatisfied to 5 for very satisfied) was 3.55 - a rise on the figures of 3.44 in 2007 and 3.40 in 2006. Consultant medical/dental staff scored 3.59.
- 4.9 Doctors and dentists generally scored higher than average on individual questions related to job satisfaction: 77% were satisfied with the support they received from colleagues compared to 75% of all staff; 80% were satisfied with the amount of responsibility they were given which is a rise of 3% on last year (71% for all staff); 74% were satisfied with the opportunities they had to use their skills (67% for all staff); 51% were satisfied with their level of pay (34% for all staff). All of these figures show an improvement on the last survey.
- 4.10 A further measure of job satisfaction is provided by the three questions relating to the intention to leave current jobs or search for new positions. The responses for doctors and dentists show a significantly lower level of intent to leave than the all staff average. In response to the statement "I often think about leaving this trust", 23% of doctors and dentists agreed compared with 30% of all staff. Asked if they would be looking for a new job within the next 12 months, 17% answered yes compared to 21% of all staff - a reduction of 2% on last year. Only 10% of doctors and dentists agreed with the statement, "As soon as I can find another job I will leave this trust" compared to 15% of all staff showing another 2% fall. 23% of consultants and of SAS doctors have 15 or more year's service at their current employer suggesting stability in the workforce compared to other NHS occupations.

Health and well-being

- 4.11 When asked if they have suffered "work related stress" in the preceding 12 months, 22% of all medical and dental staff say they had, a reduction of 4% on last years figures, compared to 33% of nursing staff.

- 4.12 In relation to work-life balance, doctors and dentists responses indicate that job flexibility and the opportunity to balance their working and home lives are not always as accessible as for other colleagues. 37% – a rise of 3 compared to the previous survey - felt their employer was committed to helping staff balance work and home life compared to 44% of all staff; 43% felt their line manager helped them to find a good balance (55% of all staff) and 52% felt they could approach their line manager to talk about flexible working (64% of all staff). All of these figures show a rise of one or 2% over the previous year.
- 4.13 Last year we reported an agreement to review the future of the Improving Working Lives (IWL) initiative in England and similar initiatives elsewhere in the UK. We said then:

“It is recognised that in a modern NHS improving the working lives of staff contributes directly to better patient care through improved recruitment and retention – and because patients want to be treated by well-motivated fairly rewarded staff, and the NHS Staff Council has:

- *recognised that modern health services require modern employment conditions*
- *understands that staff work best for patients when they can strike a healthy balance between work and other aspects of their life outside work*
- *encouraged joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff*
- *encouraged the valuing and support of staff in the contribution they make to patient care and meeting service needs*
- *encouraged personal and professional development and training opportunities that are accessible and open to staff irrespective of their working patterns*
- *encouraged the development of a range of policies and practices that enable staff to manage a healthy balance between work and their commitments outside work”*

- 4.14 The NHS Staff Council has now approved a new Improving Working Lives Framework document.¹⁷ This aims to be a reference point for all healthcare organisations in the UK who are committed to the principles of an employer of excellence. It is a practical tool, providing examples of good practice that can be used as a checklist locally. It provides references to further information. Employers can use it to:

- measure performance of their organisations
- develop joint action plans
- identify areas for improvement to support them in becoming a model employer

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http://www.nhsemployers.org/SiteCollectionDocuments/Improving%20working%20lives_af080709.pdf

- develop good human resources policies, to improve the working lives of staff, and lead to improved outcomes for service users
- assist them in meeting standards laid down by the Department of Health and regulatory bodies such as the Equality and Human Rights Commission and the Care Quality Commission.

4.15 Work continues with employers, the Health and Safety Executive and other NHS organisations on reducing reported levels of stress, bullying and harassment and violence to staff. This year's staff survey shows improvements in most of the areas of concern and we hope to be able to maintain this momentum.

4.16 A sub group of the NHS Staff Council – the partnership for occupational safety and health in healthcare - has completed work on the development of occupational health and safety standards for the NHS in England.¹⁸

4.17 Compared to the 2007 survey more doctors and dentists report receiving personal development plans. Satisfaction with the levels of pay has improved at all levels. Stress is reported less in line with the general staff response. Levels of job related training are slightly down. Doctors and dentists felt that there were more opportunities to develop their potential at work (56% compared to 45% of all staff) and 85% had received relevant training, learning and development in the previous 12 months, compared to 81% of all staff. 74% had received an appraisal (compared to 65% of all staff), and 69% had been appraised with personal development plans (57% of all staff). In relation to their own role within the organisation, 43% of medical and dental staff agreed that they understood their role and where it fitted in (46% of all staff) and 67% felt that they were able to contribute towards improvements at work.

4.18 Selected indicators from the survey are given at Table 4. Overall, the 2008 survey shows high and rising levels of job satisfaction, with:

- 94% of doctors and dentists agreeing with that their role makes a difference to patients
- 73% felt satisfied with the quality of work and patient care they were able to deliver, compared to 60% of all staff
- 90% of doctors and dentists felt valued by their work colleagues (86% for all staff)
- 89% agreed that they had an interesting job (81% for all staff).

4.19 Additionally, the NHS continues to be seen as a desirable place to work. A 2008 study by NHS Careers and Skills for Health – joint sponsors of the Health Learning and Skills Advice Line - showed that healthcare was the third most desirable sector to work in. It was surpassed only by the creative and cultural sector and the broadcast, film and video industries.

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<http://www.nhsemployers.org/Aboutus/Publications/Documents/Occupational%20health%20and%20safety%20standards.pdf>

- 4.20 The attraction of the NHS for careers in medicine and dentistry was emphasised by a study reported in [bmj.com](http://www.bmj.com) on 15 December 2008, and reported by Health Workforce Bulletin.¹⁹ This shows that most British medical graduates from British medical schools practise in the NHS for many years. Of home-based doctors, 88% of men and women worked as doctors in the NHS two years after qualification. The corresponding values were 87% of men and 86% of women at five years; 86% of both men and women at 10 years; 85% and 84% at 15 years; and 82% and 81% at 20 years. Attrition from the NHS had not increased in recent cohorts compared with older ones at similar times after graduation. The study concludes that the majority of British medical graduates from British medical schools practise in the NHS in both the short and long term.
- 4.21 The continuing attractiveness of medicine as a career in the UK is seen from the number of applications to study medicine at university rising by 1.3% in the 2009 round of applications to just over 70,000.²⁰

¹⁹ <http://www.health-workforce.com/htm/w20090608.127539.htm>

²⁰ http://www.ucas.ac.uk/website/news/media_releases/2009/2009-07-09

Selected Staff	% satisfied with	% agree	% appraised	% receiving	% suffering	Work	%satisfied	Staff job	%
Survey Data	quality of	role makes	and	job related	work related	pressure	/very	satisfaction	satisfied/very
2008	work and	a difference	having	training in	stress in	felt by	satisfied		opportunities
	care they are	to patients	a PDP	last 12	last	staff	with		to use my
	able to deliver			months	12 months	I low:5	own pay		skills
						high			
All NHS Staff	60	90	57	81	28	3.09	36	3.51	67
All Medical/Dental	73	94	69	85	22	3.06	51	3.55	74
Staff M&D (Consultants)	68	93	76	87	21	3.25	64	3.59	77
M&D (Training)	74	90	68	84	21	2.88	44	3.52	73
M&D (Other)	79	93	58	83	24	2.88	35	3.51	71

Table 4: Selected reports from the Health Care Commission NHS Staff Survey 2008

5. Pensions

- 5.1 Pay is only one element of employment reward. It also encompasses tangible and non-tangible non-pay rewards. Pensions have always been a valuable part of the reward package for doctors and dentists in the NHS. The value of the NHS Pension Scheme is an increasingly important element of the NHS reward package. We believe it compares well to pensions offered to comparable occupations outside the NHS. The past year has seen acceleration in the trend in the private sector to end final-salary defined-benefit pension schemes. Private sector employers often contribute less to employees' pension savings. Increasingly they make those contributions to less attractive defined contribution pension schemes.
- 5.2 Employers and NHS Trade Unions regard pensions as deferred pay. They recognise that the employer contribution is a significant part of earnings for NHS Pension Scheme members.
- 5.3 The contributions made by employees reflect the benefits structure and the cost of providing benefits. The tiered contribution arrangements are a method of sharing those costs between members more equitably in future. The contribution rates reflect a balance between current pay and deferred pay.
- 5.4 NHS Employers believe there is an increased awareness of the importance of pension provision and the value of public service pension schemes, within and outside the service. A "choice exercise" for all staff has started, where members of the 1995 section of the NHS Pension Scheme will decide whether to transfer their accrued benefits to the 2008 section of the scheme, with its higher normal retirement age of 65. This will further raise awareness about the value of the pension scheme to staff. It is expected that the impact of the NHS Pension Scheme on recruitment and retention will improve.
- 5.5 The number of final salary schemes open to new members continues to fall and at an increasing rate. Barely one-sixth of schemes were accessible to newcomers, according to research reported by Aon Consulting during August 2008, down from about a quarter during 2007 and about half five years ago. This means that those employers, such as the NHS, which still have defined benefit schemes should have a better impact on retaining staff. Access to final salary pension scheme arrangements has continued to decline throughout 2008/09, and where schemes remain they are often closed to fresh accrual of benefits or open only to existing scheme members.

- 5.6 During August 2009, Aon again reported²¹ on pension provision having surveyed more than 8000 employers' provision of final salary schemes. They report that a steep rise in the cost of providing final salary pension schemes in the private sector has pushed the long term bill above £1 trillion. They quote the effect of rising life expectancy, and declining annuity rates interacting with falling bond yields on driving up the cost of providing pensions. As a result they found that more employers are expected to close their schemes to staff in coming months as the cost of providing pension guarantees increase.
- 5.7 These findings were reinforced by the Association of Consulting Actuaries.²² They found that 87% of defined benefit schemes are now closed to new entrants. 18% of those are also closed to future accruals for current scheme members. They also report that 39% of employers with continuing defined benefit schemes responding to their survey say they were considering changes to future accrual and benefits structures.
- 5.8 A recent report by Hymans Robertson²³ suggests that public sector pension scheme members do not fully value their pension in contrast to the alternatives. More than half of those surveyed (54%) thought that private sector workers have the same working and retirement benefits or are better off. This emphasises the importance of communicating the value of the NHS Pension Scheme to those that benefit from it. They also found that 21% of public sector workers chose a public sector career for better pension provision. Despite the pension being an influence on career choice less than 40% of public sector workers in Hyman Robertson's survey know what their final pension will look like.
- 5.9 The NHS Pension Scheme continues to be a high quality final salary pension scheme. It costs around 20.5 % of pay. NHS Employers believes it is important that awareness of the value of this important reward should be raised and should be explicit in the assessment of the correct recommendations of the review body. 14% of pensionable pay, as a contribution by the employer toward income in retirement, is a significant part of the reward package of doctors and dentists. This often contrasts favourably with such provision in the wider economy. It should not be ignored.
- 5.10 Members of the pension scheme prior to 1 April 2008 retain their current normal pension age (60 in most cases) and a 1/80th final salary pension with a 3/80th lump sum. They have the option to commute pension for additional lump sum up to 25 % of the value of the pension. New scheme entrants since 1 April 2008 have a final salary scheme with 1/60th accrual (worth around 6 % more in actuarial terms) and with lump sum of up to 25 % of pension. However, their normal pension age will be 65.

²¹ Aon consulting press release 1 September 2009

<http://aon.mediaroom.com/index.php?s=43&item=1682>

²² Association of Consulting Actuaries, Twilight or a new dawn for Defined Benefit Schemes, 2009 Pension Trends Survey, September 2009

²³ Public Sector Pensions – A Frontline Perspective: A Change is Coming: Workers Willing to Retire at 70; Hymans Robertson, Jul7 2009

- 5.11 Employee contribution rates vary depending on pay rates. From 1 August 2009 those on rates up to £68,393 contribute 6.5% of pensionable earnings. Those on rates between £68,393 and £107,846 contribute 7.5% of pensionable earnings. Those over £107,847 contribute 8.5% of pensionable earnings. These figures are based on 2008/09 salary levels and will be updated annually.
- 5.12 Differential contributions reflect higher paid staff tending to enjoy significantly higher earnings from career progression. Modelling of career patterns show that higher paid staff would otherwise pay significantly less in contributions per pound of pension than lower paid staff. However, high earners have benefited from the removal of the earnings cap (£108,600 in 2006/7).
- 5.13 If the increased contribution rates of higher paid scheme members, being fairer to the generality of scheme members, are simply offset by higher pay awards for higher paid employees, the general advantages of such reforms could be lost. It would simply increase the cost of past accruals rather than making the benefits and contribution structure fairer for all.

Impact of cost sharing

- 5.14 The cost sharing agreement that underpins the pension arrangements provides for a cap on employer contributions of 14% from 2016 with an interim cap of 14.2% until then. The current contribution rate is 14%.
- 5.15 The basic principle behind the design and application of cost sharing and capping, is that factors that change the expected value of members' benefits, as assessed by the scheme actuary, should be taken into account.
- 5.16 A partnership group, of representatives of employers and staff, with expert advice, operates under the auspices of the NHS Staff Council. It considers the emerging valuation work (prepared by the Government Actuary) at each valuation. The first valuation that will take place in the context of the cost sharing regulations is the funding valuation with a valuation date of 31 March 2008. Funding valuations will then take place every four years. Any approved recommendations emerging from that work will take effect from 1 April 2012.

Ill health retirement benefits

- 5.17 Ill health retirement (IHR) benefits are an integral part of the NHS pension scheme. These may be paid to members, and some former members, who retire early because they are unable to carry out their duties due to permanent ill health.
- 5.18 A tiered approach applies to the determination of ill health retirement benefits. This recognises that the different levels of benefits for members should be dependent on the severity of their condition and the likelihood of them being able to work again.

5.19 These IHR arrangements provide high quality benefits. They are part of a comprehensive pension package to support recruitment and retention initiatives in the NHS.

6. Consultants

- 6.1 The number of consultants employed by the NHS in England in 2008 was nearly 35,000 – the highest figure ever. The most recent data from the NHS workforce vacancy survey shows a further decrease in the vacancy rate for consultants.
- 6.2 Employers continue to report that non-pay solutions to local challenges remain as effective or more effective, than increases to pay. Staff satisfaction continues to improve for consultants, including their satisfaction with their pay levels. On most measures consultant satisfaction is better than other staff.
- 6.3 The contractual provisions that underpin annualised hours and flexible working contribute to improvements to consultant morale and motivation. Employers find the provision within the consultant contract for the payment of recruitment and retention premia is still used only infrequently and for limited periods. The current provisions for the local level design and use of recruitment and retention premia continue to be deemed satisfactory by employers, and no change is sought to these arrangements.

The consultant contract programme

- 6.4 In November 2008 NHS Employers published a briefing²⁴ highlighting some of the findings, successes and learning arising from the large scale workforce change programme which ended its work in June 2008. Its aim was to support trusts and consultants to identify, describe and deliver service improvements through the effective implementation of the consultant contract.
- 6.5 The majority of the trusts reported that they are now implementing the contract more effectively by working with consultants to work together to agree changes which have the most impact on patient care.
- 6.6 A further workshop took place at the 'Leading workforce thinking' NHS Employers annual conference on the 4 November 2008 entitled 'Delivering improvements through the consultant contract'. This provided advice to the service on devising individual consultants' objectives in line with the organisation's objectives. It also gave guidance on how supporting professional activities programmed activities could be better used and planned.
- 6.7 NHS Employers has agreed with the BMA to undertake some joint work to further improve local job planning training in order to strengthen the links between work undertaken and the delivery of high quality local services. We are currently exploring how this could be done most effectively to assist the service and its doctors.

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<http://www.nhsemployers.org/Aboutus/Publications/Documents/Consultant%20contract%20programme.pdf>

Contract maintenance and guidance

6.8 NHS Employers has issued to issue a pay circular²⁵ confirming an agreement reached with the BMA on the starting salary to be paid to those Associate Specialists who have been paid in their previous appointment at a rate higher than or equal to the rate at which they would be paid on taking up their new consultant appointment. This will be fixed at the threshold in the basic pay scale next above that previous rate of basic pay.

Summary

6.9 Employers in the NHS are content that the 2003 contract continues to work well and see no current need for further revisions.

6.10 No difference is sought in the approach to increases awarded for those employed on the pre 2003 and those on the post 2003 contracts.

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http://www.nhsemployers.org/Aboutus/Publications/PayCirculars/Documents/Pay_circular_MandD_2-2009_aw.pdf

7. Staff grades and associate specialists

- 7.1 The new contracts for specialty doctors and associate specialists (SAS), introduced from 1 April 2008, are not fully implemented throughout the service. Assimilation to the new arrangements has taken longer than expected. We hope soon to issue, with the BMA, agreed joint guidance to help speed up the implementation process.
- 7.2 Close working between the relevant secretariats resulted in a set of jointly agreed documents being published, including frequently asked questions which continue to be developed as necessary, flowcharts and guidance, to support the implementation of the new arrangements.
- 7.3 With the introduction of the 'specialty doctor' (SD) grade from 1 April 2008, the associate specialist (AS) grade closed to new entrants after 31 March 2009. In parallel, a new contract was introduced for associate specialist posts.
- 7.4 Figures, taken from the Electronic Staff Record (ESR) in June 2009, show that there were 3729 doctors on the new contracts. Of those 2526 were specialty doctors and 1209 were associate specialists. This represents approximately 35% of all SAS doctors.
- 7.5 The uptake to the new contract has been slower than expected. NHS Employers have asked employers about their experiences of implementing the new contract and any reasons for delays. All responses cited the length of time taken to complete the job planning process as the key reason for any delays. Other causes for delay were the complexity of the assimilation/transition arrangements; insufficient support to trusts for implementation; and workforce capacity issues in medical staffing departments. However, all report that these have been overcome and the key remaining reason for any delay is the time taken to complete the job planning process. Proper job planning is essential and it would not make sense to get quicker uptake at its expense.
- 7.6 Employers recognise that the new contract is a positive step. It brings the SAS doctors into line with other medical contracts. Employers are using the documentation and processes already available for the consultant contract (on which the SD and AS contracts are based) in the implementation of the new contracts.

Pay implications of the new SAS contract

- 7.7 It is anticipated that the transfer from the old contract will continue to during this financial year and beyond. With the slower than expected progress many of the costs of assimilation are still to affect trusts' finances. In moving to the new contract arrangements, doctors receive an assimilation increase of one annual increment, between 4% and 15% of basic salary, delivered in two stages, effective from 1 April 2008 and 1 April 2009. Under the new contract, specialty doctors have access to

incremental scales, worth 5 to 10 % and associate specialists 3 to 9 %, in addition to the increases received effective from 1 April for the first two years from the implementation arrangements.

- 7.8 The latest NHS workforce census statistics published March 2009 indicate that as at September 2008 there were over 3,000 associate specialists, approximately 6,000 staff grade doctors and over 3000 hospital practitioners and clinical assistants. Although it is not possible to say how many were new recruits or transfers to the new contract the 6000 staff grades includes 445 speciality doctors on the new contract.

8. Doctors in training

Modernising Medical Careers

- 8.1 NHS Employers represents service interests in reviewing the strategic direction of Modernising Medical Careers through the new Medical Education England (MEE), the Medical programme Board (formerly the MMC Programme Board), which holds responsibility for detailed aspects of medical recruitment and training, and their related working groups.
- 8.2 Work continues to consolidate and deliver the core principles of modernising medical careers in relation to medical recruitment and career pathways. NHS Employers seeks to influence service planning, workforce planning and training at national policy level, SHA level and local health economy level. It is important that decisions on these matters should not be left solely to the medical profession to resolve.
- 8.3 Employers and the medical profession have a shared aim of ensuring that the best candidates are appointed to training places and that fair processes are used throughout. We have tested service views on a range of proposals such as:
- best recruitment and selection practice at foundation and specialty level
 - changes to the recruitment timetable
 - planning the future supply of trainees within each specialty
 - changes to specialty curricula
 - establishing newly-recognised specialties
 - maintaining the quality of training within a reducing working week.
- 8.4 Patients need the best doctors with the highest quality training. Employers report the appointment of many excellent trainees under the present recruitment system. They also work to ensure that future person specifications continue to meet service and patient requirements as well as the individual career aspirations of applicants.
- 8.4 We support incremental change within a “mixed economy” of specialty-specific improvements, whilst retaining and consolidating the key structures required for providing a high quality training environment. This aims to provide a clear career pathway for trainees to progress towards the certificate of completion of training (CCT).
- 8.5 We have pressed for improved flexibility so that trainees can obtain transferable competencies and continue their professional development by moving more easily between specialties, or follow alternative career pathways through the specialty doctor route and other senior appointments.

Having the right doctors in the right jobs best suited to their knowledge, skills and general competencies, benefits both patients and the profession. NHS Employers will continue to support the service in achieving that objective.

- 8.6 Worries about the longer term morale of doctors arising from the 2007 MTAS-led recruitment exercise appear to have diminished. The 2009 recruitment rounds for foundation programme trainees and specialty registrars have passed without undue difficulty. We are rebuilding consensus about the way postgraduate medical education and training should work and develop, and closely monitor the outcome of the annual Postgraduate Medical Education and Training Board (PMETB) trainees' surveys²⁶ which records satisfaction levels amongst trainers and trainees alike with the quality of training under the new curriculum standards.
- 8.7 However, some specialties and some geographic areas face difficulties in filling vacancies with suitably qualified applicants or in locating additional staff to cover for short or medium-term gaps in medical staffing. As stated in chapter 3 above, employers have reported where difficulties of recruitment can be said to have a severe effect on patient care. Such vacancies do not appear to be related to pay as such, as suggested by the very limited use of recruitment premia at local level reported by employers.

Foundation training

- 8.8 NHS Employers continued to help to shape the national rules and processes that governed the successful recruitment of almost 7,000 graduates into foundation training beginning in August 2009. Once again nearly all applicants to the available programmes were appointed to their first-choice foundation school, using a centralised electronic system and supported by helpful guidance from the UK Foundation Programme Office. Employers generally favour national recruitment arrangements and are satisfied that it is producing good quality trainees capable of undertaking the foundation programme curriculum.
- 8.9 We also believe that the two-year foundation programme is working well, but support continued improvements to careers advice during undergraduate training and within the programme itself. Further work is also needed to ensure that competencies gained through foundation training are consolidated in the revised specialty curricula.
- 8.10 NHS Employers has contributed to the current review led by the Medical Schools Council into potential changes to eligibility and selection processes. We broadly support the current selection methodology arrangements, which suit what is essentially an allocations process based on current undergraduate numbers. Changes in future years may be needed if graduate numbers continue to grow.

²⁶ <http://www.pmetb.org.uk/index.php?id=traineesurvey>.

8.11 Foundation doctors were included in the 2008 PMETB trainees' survey and results show that they are broadly satisfied with their training²⁷.

Specialty training

8.12 NHS organisations support the key principles of improved training and robust competency assessment procedures through the new training arrangements heralded by modernising medical careers. Since the well-publicised problems associated with the 2007 recruitment exercise, NHS Employers helped shape the essential changes agreed for future recruitment rounds with a return to a mix of national rules and processes in designated specialties led by the colleges and local, deanery-based recruitment.

8.13 Specialty recruitment for 2009 has been concluded for the majority of training posts beginning during August 2009. The provisional average fill-rate 2009 to specialty training exceeds 90%, an improvement on the same stage last year. This will have subsequently increased before the start date. However, national figures may mask some localised variations by geography and specialty.

8.14 The number of applications, as at April 2009, exceeded 45,000 from over 14,700 applicants for over 8,800 posts advertised. This compares favourably with 2008 and shows that applicants have a reasonable expectation of successful appointment to a specialty training programme subject to overall competition ratios, which vary by speciality and location.

8.15 Employers can experience difficulties if they receive late notification of the allocation of recruited doctors within rotations and late changes where doctors withdraw to take posts elsewhere and this can lead to service disruption. To help minimise service difficulties, NHS Employers has worked with the MMC team to tighten up on the offers arrangements to meet service as well as applicant needs.

8.16 NHS Employers believes that the current training arrangements are providing opportunities for doctors to experience high-quality structured in-programme training and this is good for their morale and motivation and better for patient care. The PMETB surveys of medical trainees and trainers conducted during 2009 can be viewed on a trust-by-trust and specialty-by-specialty basis via a web-reporting tool at <http://reports.pmetb.org.uk>.

Future of the medical workforce

8.17 Reforms to training and continuing professional development linked to the service delivery recommendations in A High Quality Workforce will have significant implications for employers.

²⁷ <http://www.pmetb.org.uk/index.php?id=traineesurvey>

They need to understand the impending changes to postgraduate medical training and service configuration, their effect on the structure of the junior medical workforce, and how these changes might impact upon service delivery.

- 8.18 There is general agreement that investment in specialty training needs to be rebalanced in line with the future demand for trained doctors and the expectation set out in A High Quality Workforce that GP training programmes would expand so that in future at least half of doctors going into specialty training will be training as GPs. The resultant medical workforce planning assumptions have been discussed at the Medical Programme Board and the Department of Health-led workforce availability planning and policy implementation group (WAPPIG). There is an immediate need to determine the level of specialty training commissioned in 2010 and to ensure that the decisions implemented are consistent with the current medical workforce planning assumptions.
- 8.19 NHS employing organisations are anticipating significant changes over the next 10 to 20 years in the way in which some NHS services are delivered, and will need a medical workforce capable of adapting to this change. Key points in approaching this challenge include:
- there should be a modular approach to training with defined step-points ('credentialing') that provide for a range of attractive and fulfilling career pathways whether in training or service posts, in community based healthcare, or otherwise
 - medical training and services should be aligned to the needs and expectations of patients
 - there should be an appropriate balance between service delivery and creating a supportive environment for learning
 - workforce planning should be multi-disciplinary, based on the needs of health service provision, with more refined tools and systematic engagement with employers
 - a small planned oversupply in the medical workforce is desirable to improve quality and allow for a flexible response to changing demographics and service needs
 - we need to review training capacity and the quality of training delivery to cater for the increasing numbers of current UK students about to graduate
 - clear and transparent decisions about future medical graduate numbers are needed, including whether we continue to incorporate international medical graduates into our medical training plans.

The effect of modernising medical careers on pay scales

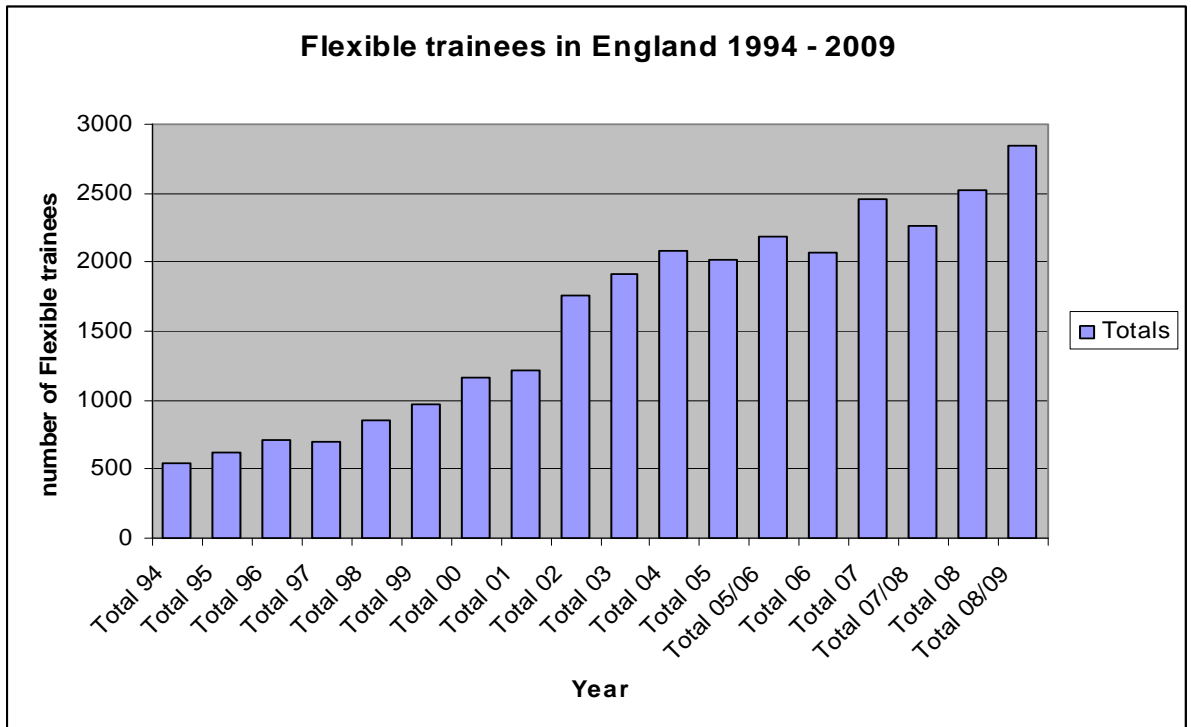
- 8.20 Last year we reported that a new pay scale for core specialty training (CT) was successfully introduced in 2008 enabling the identification and separation in payroll and HR records of the two training regimes.
- 8.21 Arrangements for the assimilation of SHOs into the new specialty registrar grade are generally complete. There remain a small number of trainees who were in SHO posts in August 2007 and who continued in that post and grade until 2009, probably for pay purposes only (i.e. they are not educationally approved trainees). It was expected that all SHOs in accredited training posts will have transferred to the new grade by August 2008.

Less than full-time (flexible) training

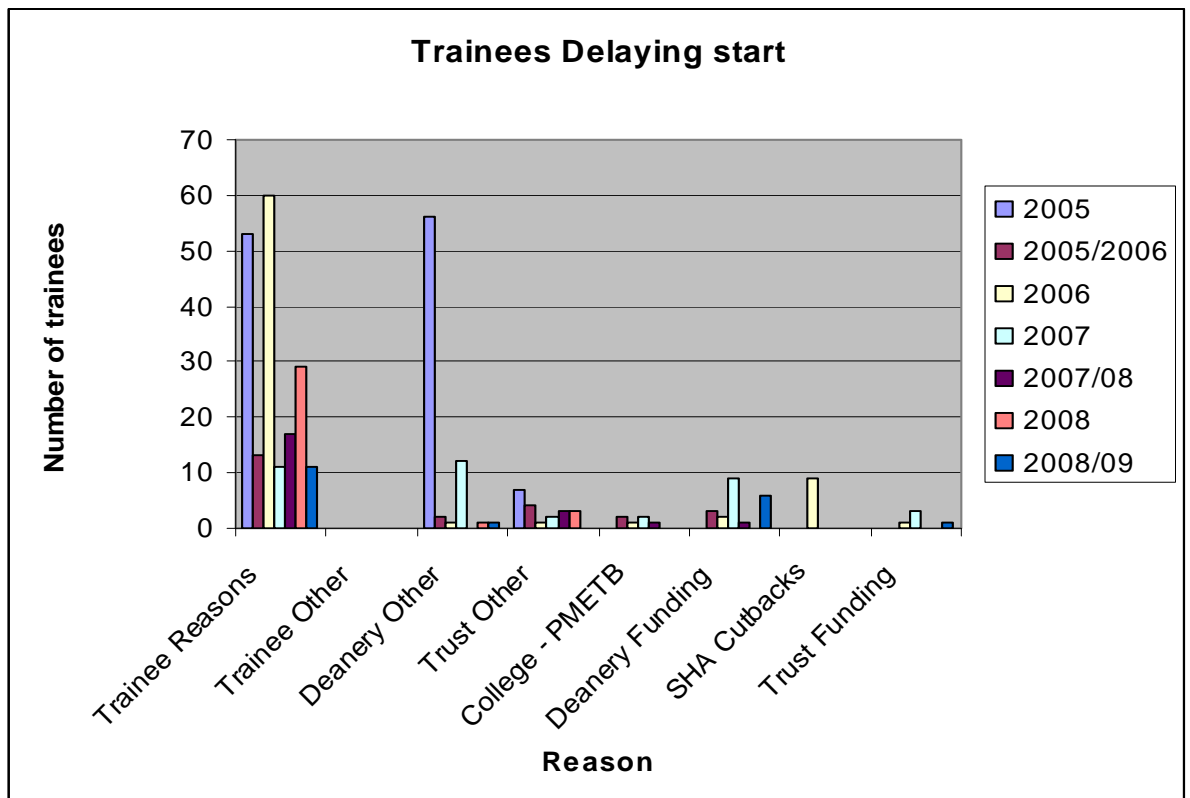
- 8.22 The number of flexible trainees continues to rise. November 2008 to April 2009 figures show that there were 2838 flexible trainees. This represents around 6% of the doctor in training workforce. Six-monthly data²⁸ from postgraduate deaneries in the UK, suggests that in general the trainees seeking flexible working arrangements are able to access them. Graph 3 shows the number of Flexible trainees has continued to rise in the 2008/09 financial year. Since 2005, when the principles underpinning flexible training were introduced, the number of flexible trainees has increased by 45%.
- 8.23 In 2008/9, 19 trainees had the start of their flexible training delayed. In 2007/2008, 23 trainees were delayed. This suggests that access to flexible training is improving. The major reason for delay in each year came from the trainee. In 2008/9 only 3 trainees applications for flexible training were rejected – an improvement on 2007/8. Graph 4 illustrates the decline in delayed starts reported.

²⁸ Bi-annual deanery survey of less than full time training, May to October 2008

Graph 3: Flexible Trainees in England 1994 - 2009



Graph 4: Trainees delaying start



- 8.24 The 2005 changes in equitable pay for flexible medical training have made it practical to employ two trainees in a full-time slot. In the past this would have been too expensive. Placing flexible trainees in full-time slots allows for services to be enhanced at little additional cost. Cost savings, compared to supernumerary employment, can be achieved without impact on services or training opportunities. This alone has encouraged employers to recruit flexible trainees. Flexible training opportunities are particularly important with the proportion of female doctors in the workforce increasing. The Royal College of Physicians²⁹ highlighted the need for flexible working in its report, *Women and Medicine: the future*.
- 8.25 There has been virtually no feedback about difficulties experienced by trainees wishing to access flexible training. Employers have not reported problems in seeking to accommodate them. This suggests that the current arrangements work.

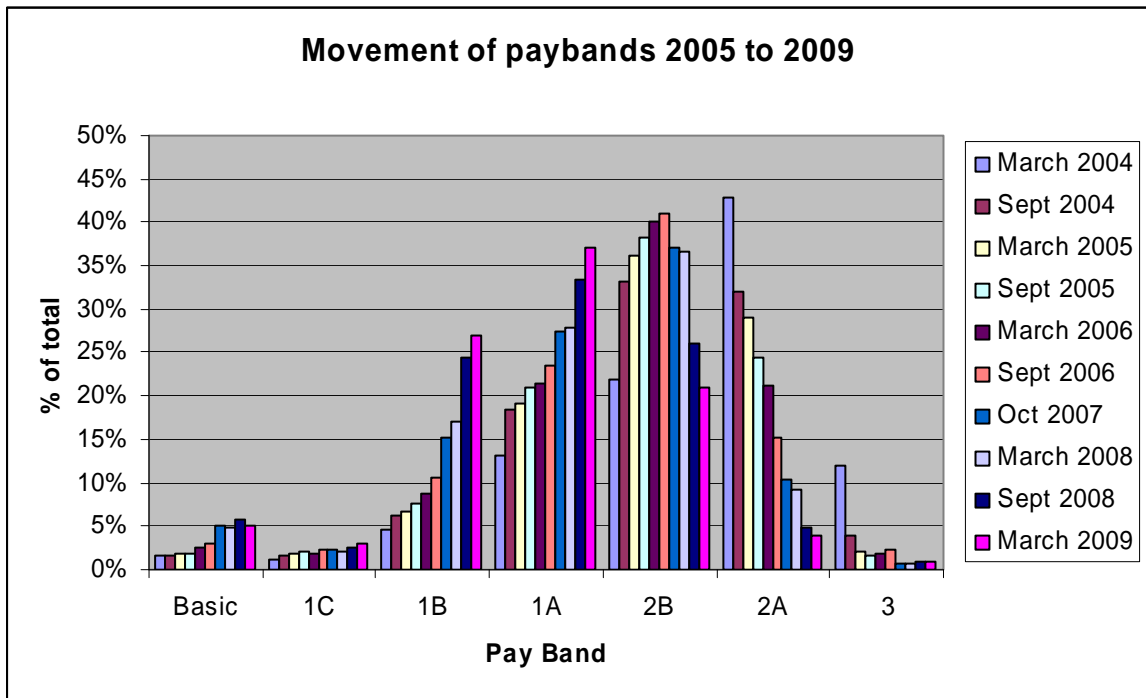
A joint NHS Employer and BMA group was organised to review flexible training; this has met twice already and a report is being drafted.

Pay supplements

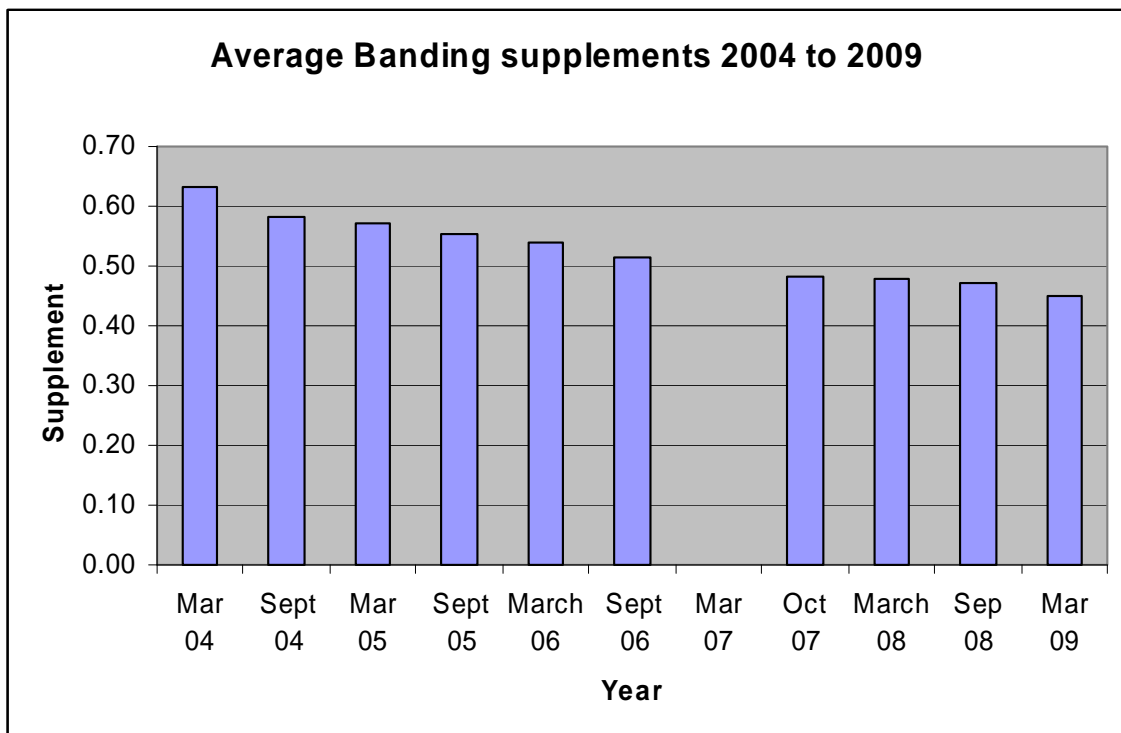
- 8.26 The pay supplements are intended to reflect the amount of work done and appropriately reflect the unsocial hours worked. Outside of the scoping exercise being undertaken for the four UK health departments described below, employers continue to see no reason to revisit the general value of banding supplements or their relationship to basic pay.
- 8.27 The most recent monitoring data, from March 2009, indicates an average supplement for compliant posts (some 99 % of doctors in training), of almost 48 %. This is based on reported working patterns. It takes no account of pay protection. This will be a significant element of pay for many doctors. The movement in pay bands since 2005 are illustrated at graph 5.
- 8.28 The average supplement in payment should continue to decline in August 2009. However the rate of decline in supplement values is slowing. It is not expected to fall significantly below 45 %. Graph 6 illustrates the decline in the average.

²⁹ <http://www.rcplondon.ac.uk/professional-Issues/workforce/Workforce-issues/Pages/Women-in-medicine.aspx>

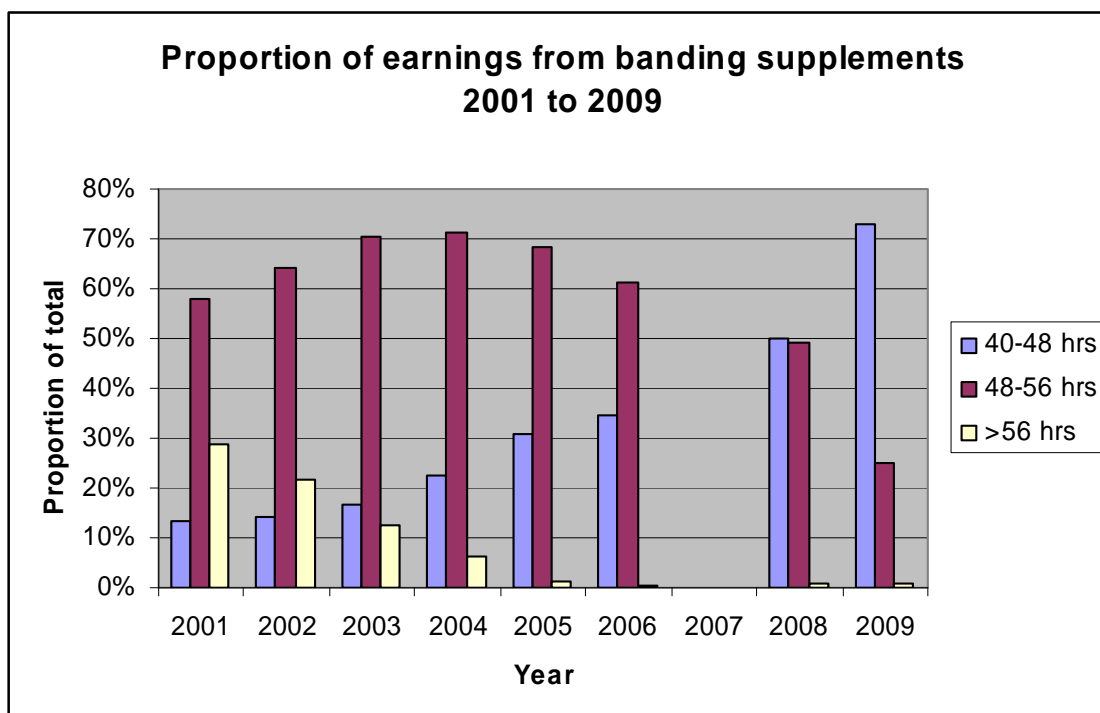
Graph 5: Movement of pay bands 2005 – 2009



Graph 6: Average banding supplements 2004 – 2009



Graph 7: Proportion of earnings from banding supplements 2001 – 2009



8.29 Medical and dental salaries, particularly overall pay on graduation, remain competitive and attractive. Annual increments add around 4 - 8 % to basic pay. Employers remain of the view that this should be recognised in any recommendation.

GP specialty registrars

8.30 There appears a general consensus amongst those responsible for GP training that the employment arrangements for this group of trainees should be aligned with those of hospital trainees. This would facilitate the movement of trainees from trust to GP practice and vice versa. It would lend itself to the use of single lead employers to cover all phases of training.

8.31 The supplement for GP specialty registrars (GP StRs) was originally set at 65 % of basic salary. This was to be recruitment instrument to reflect the average supplement then payable in a hospital training post. It was designed to provide an incentive to hospital trainees considering a move into general practice. It did not reflect the working arrangements of the post, as it would for a hospital trainee. It was introduced when GP recruitment was weak. Today, recruitment to GP training programmes continues to be strong. The argument for a recruitment payment for GP StRs is therefore weakened.

8.32 Progress towards aligning the contractual arrangements will take time. To pay GP StRs on the same basis as a hospital trainee would see the supplement reduce from its current level of 45 % to between 20 % and 40 %. In the case of those few GP StRs undertaking little or no out-of-hours work it

would be eliminated. Parity should be the longer term aim. With strong recruitment to GPR training it is appropriate to reduce the GPR supplement further. NHS Employers believes it could be reduced to 40 % for those entering GPR training placements after April 2010.

Scoping study to evaluate the effectiveness of the current contract for doctors in training

8.33 NHS Employers, in collaboration with the Health Departments and employers in Scotland, Wales and Northern Ireland, were commissioned by the four Health Departments to undertake a scoping study to evaluate the effectiveness of the current contract for doctors in training.

8.34 We are working with employers to consider:

- the current contractual arrangements for doctors and dentists in hospital training (the New Deal Contract introduced in 2000), identifying issues, strengths and weaknesses with clear evidence of all findings
- evidence on the financial and other consequences of keeping the current contractual arrangements in place, and amending them
- an appraisal of possible changes to the contractual arrangements, including a full assessment of all related costs, including pension costs for both employer and employee, and the cost of reform itself (which should begin from the assumption that any changes should be achieved with overall cost neutrality)
- a full assessment of the value-for-money gain of any potential reform in both cost and productivity terms
- the interface with contractual arrangements for doctors and dentists in the practice/community settings of GP or dental vocational training.

8.35 As part of this scoping study NHS Employers has been actively engaging with employers in the NHS and other key stakeholders. We have attended networks, forums and meetings of human resources directors, medical directors, medical staffing personnel and interviewed individuals to canvass employer views. Meetings with other stakeholders have also been utilised as opportunities to survey their views.

8.36 NHS Employers organised several focus groups and an email reference group to canvas the opinions of employers.

8.37 The British Medical Association and the British Dental Association are also engaged in this work. After initial meetings to discuss how we could engage with them, NHS Employers organised specific events to discuss the issues, strengths and weakness of the current contract and what a new contract may look like with the BMA and BDA.

8.38 The remit set out the expectation that we would report to the Health Departments in November. Work is progressing well and the BMA and BDA continue to be engaged in the work; Modelling work and reporting is on-going and we hope to finalise the study following the completion of the consultation exercise.

9. Salaried general medical practitioners

- 9.1 The salary range for salaried general medical practitioners employed in primary care organisations is between £53,247 and £80,354, with starting pay, progression and review determined locally. Demand for this group of staff continues to be high; the majority of employers continue to report that the pay range is appropriate and that there are no recruitment problems.
- 9.2 NHS Employers has continued to press the BMA's general practitioners committee to enter into discussions on updating the salaried general medical practitioners model offer letter and terms and conditions of service. Revised documents cannot, therefore, be issued.
- 9.3 NHS Employers is seeking an increase to the pay range consistent with that for other directly employed doctors.

10. General medical services

NHS Employers evidence in respect of the General Medical Services earnings will follow shortly.

11. Salaried primary care dental services

Acceptance and implementation of new contractual arrangements

- 11.1 Last year we reported that negotiations on revised terms and conditions and pay scales for this staff group had been completed, and that the new contract had been implemented following a positive ballot from those affected by the new arrangements.
- 11.2 NHS Employers continues to publish the summary agreement and terms and conditions of service, appraisal guidance and guidance on job planning, and a number of frequently asked questions which have been agreed with the BDA/DH and which are developed on an ongoing basis.
- 11.3 Appointments made after 4 February 2008 have been to the new arrangements; indications from employers and staff side are that overall implementation continues smoothly. There have been localised discussions regarding the rate of implementation, the application of extended competency points and appointment to Band C posts, but in general the process continues without major concerns.

Change to negotiating forum and contract maintenance

- 11.4 NHS Employers assumed responsibility from the DH to run the negotiating machinery for England and to provide secretariat support for the employers negotiating team in England. A new negotiating forum with the BDA has been established, an initial team appointed, and the new joint negotiating committee for salaried dentists met formally for the first time in April 2009 following informal meetings between the parties. A further formal meeting took place in September 2009.

Salaried dentist numbers and retention

- 11.5 There are about 1,300 salaried dentists, mainly employed by about 120 PCTs.
- 11.6 Historically, PCTs have experienced difficulties in recruiting to salaried dental services (SDS) due to a combination of pay, in competition with the general dental services, and applicants not meeting the requirements of the job specification. SDS has often been seen as an under resourced Cinderella service, with less investment and leadership, and poorer premises than in the general dental service.
- 11.7 The new contract, for community dental officers, senior dental officers, assistant clinical directors and clinical directors, is designed to improve recruitment and retention among such posts. As well as increased pay, the contract provides for very important non-pay aspects of the employment contract, such as job planning, which has been seen in comparable medical employment contracts as beneficial to staff and patients; and rewards clinical as well as managerial roles. Employers also report continued growth in spending on dental services, which has the potential to remedy some of the non-pay barriers to recruitment.

- 11.8 Only four PCTs reported experiencing difficulties over the preceding 12 months in recruiting salaried dentists, in response to our questionnaire. Just one of those reported the difficulty as being severe in relation to its impact on patients. This suggests that the situation may have been improved by the new contract, although we feel it is too early to be conclusive. PCTs reported at a series of focus groups in relation to general dental services that they have not seen any significant improvement in the recruitment difficulties faced.
- 11.9 The total costs of the contract were expected to increase the pay bill for salaried dentists by £2.5m in year one, increasing to £7.5m by year five. It provided salaried dentists with increases of between 2 % and 19 % in basic pay on moving to the new contract and access to annual increments worth between 2 % and 11 %. Table 5 shows the old grade, the new grade, percentage increases received on transfer to the new contract and the annual increments available.
- 11.10 The full impact of the contract is yet to emerge. NHS Employers have been overseeing its introduction. Its benefits realisation for patients, employers and staff are still at a relatively early stage. The implementation and use of the contract continues to be subject to discussion with the British Dental Association.
- 11.11 We believe that the same award should be applied to this staff group as to other directly employed doctors and dentists.

Old grade	New grade	Increase received on transfer to the new contract, %	Annual increments received, %	New salary, £ (2009 rates)
Community Dental Officer	Salaried Dentist A	4 to 12	4 to 11	37,344 to 56,016
Senior Dental Officer	Salaried Dentist B	3 to 19	2 to 5	58,091 to 67,946
Assistant Clinical Director	Salaried Dentist B* (for Assistant Clinical Directors only)	2 to 7	3	69,502 to 73,651
Clinical Director	Salaried DentistC	1 to 7	3	69,502 to 79,875

Table 5: Salary ranges, annual increments and increases received on transfer from previous salaried dentists grades to the new contract grades.

12. General dental services

Introduction

- 12.1 Following the implementation of the new general dental services (GDS) contract in 2006, primary care trusts (PCTs) have been successfully expanding NHS dental capacity through a variety of means: tendering for new provision and increasing capacity in existing providers both temporarily and on a permanent basis.
- 12.2 NHS Employers has previously submitted evidence to the DDRB based on the outcomes of PCT completed questionnaires. For the first time last year, NHSE commissioned NHS Primary Care Commissioning to conduct a focus group comprised of PCT commissioners, finance and dental leads to capture the views and opinions of PCTs on the 2008/09 and 2009/10 pay awards.
- 12.3 Given the positive response received from the DDRB to this approach, NHS Employers has once again used a focus group approach to capture the views of the NHS in relation to the 2009/10 and 2010/11 pay awards. A broad cross section of 15 PCTs was represented in 2 separately organised focus groups that took place during August and September 2009, and the views of the groups have been used to inform this evidence.

NHS Employers recommendations

- 12.4 Based on the feedback received from the focus groups, we recommend an uplift to gross contract values of no more than 0.21% for 2010/11.
- **employers believe that there should be 0.21% uplift to the gross contract values in general dental services**
- 12.5 That any consequent net pay award delivered by the uplift to gross contract values should be less than last year's award (which saw a 1.5% increase to net pay delivered through a 0.21% gross uplift to contract values).
- 12.6 In determining their recommended uplift to gross contract values, DDRB should take into account the:
- **affordability concerns** of PCTs who are very concerned that if DDRB were to recommend a large uplift in 2010/11, this could severely inhibit their ability to invest in new and additional services, and in responding to the needs of patients

- **opportunities that will likely be available to general dental practitioners (GDPs) during 2010/11 to earn significant additional income** from locally negotiated contracts
- **ability of dental practice to deliver cash releasing efficiencies.** Past experience demonstrates that contract holders have the ability to achieve a significantly higher increase to net pay than was intended by recent DDRB recommendations.

12.7 In order to ensure that any uplift is affordable to the NHS, NHS Employers recommends that practices should be required to make an efficiency saving of 1%. Taking this into account, NHSE believes an award of 0.2% to gross contract values, would deliver a 1% increase in GDP net pay.

12.8 The application of the DDRB formula should not result in a negative award. PCTs reported that a negative award would result in poor morale and would risk the delivery of the dental access programme.

2009/10 award

12.9 PCTs generally welcomed the 2009/10 award and reported to NHSE that, unlike the 2008/09 award, it did not have a detrimental affect on commissioning plans.

12.10 Consistent with last year, PCTs also reported that they would prefer less national prescription, allowing them more local flexibility in the provision and management of services. It was felt that the 2009/10 award provided PCTs with the flexibility to commission services according to local need.

Management of historic contracts

12.11 Some PCTs continue to report difficulty in managing contracts with existing providers. Many PCTs have inherited contracts with a wide range of units of dental activity (UDA) values for what is essentially the same service as a result of the implementation of the new contract.

12.12 The strong view from the focus groups is that blanket pay awards do not help this position as it restricts the ability of PCTs to successfully renegotiate contracts that ensure efficiency savings are made, access targets are met and the quality of services are improved.

12.13 A low recommendation for 2010/11 will better enable PCTs to manage contracts more effectively and locally invest in providing additional and improved services in ways that are more responsive to local requirements.

Impact on planned investment in services

12.14 The lead time for the commissioning of new services is approximately four to five months to allow for the tendering process to be completed. This means that PCTs often put in place commissioning plans well before the DDRB award is announced. The affordability of the 2009/10 award allowed PCTs to continue to implement their commissioning plans.

12.15 PCTs are confident that an uplift to gross contract values of less than 0.21% would allow PCTs to invest in areas of deficiency as identified locally, and ensure that patient need continued to be at the heart of decisions on investment in dental services.

Access to dental services

12.16 NHS Employers is pleased to report that PCTs are successfully tendering for new services and improving access to NHS dentistry.

12.17 Current contract values are already attracting very high interest from providers and there is an apparent willingness across a range of providers to provide NHS services. There seems to be no evidence to suggest that the value of these contracts should be increased in order to attract more providers.

12.18 Bids are being received from a range of types of provider including:

- existing contract holder
- local performers keen to become providers
- dental bodies corporate
- independent providers who since the introduction of the current contract in 2006 have begun to build up large businesses with multiple contracts.

12.19 The Department of Health's dental access programme has led to a significant increase in investment to improve access to dentistry, both through the tendering of new contracts and offering existing practices the opportunity to expand their services.

Opportunities to expand services

12.20 The Department of Health recently extended the ring-fence on PCTs' dental budgets until the end of the 2011 financial year. Coupled with the large national increase in the dental budget (there was an 8.5% increase in ring-fenced budgets in 2009/10, taking the total spend to £2.275bn), this presents significant opportunities for contractors to bid for new work and provide additional services.

- 12.21 However, PCTs are very concerned that if DDRB were to recommend a large uplift in 2010/11, this could severely inhibit the ability of many PCTs to invest in new and additional services, and in responding to the needs of patients.
- 12.22 There is also a concern amongst PCTs that a large uplift could lead to a decrease in the number of providers tendering for new work. They believe that a large award would create little incentive for providers to improve the quality, or increase the range, of services provided, since they would receive increased funding for existing services regardless of improved efficiency, quality or access.
- 12.23 Evidence from PCTs show that they are commissioning an increased level of UDAs at a lower rate than existing contracts. This has been experienced in several PCTs including in Westminster and North East Essex. Essex reported that they had 48 attendees for an event for a £330k contract.
- 12.24 PCTs believe that these new contracts still provide the opportunity for providers to make profits despite being set at a lower level than historic UDA values. This supports the view that providers are already making an acceptable level of profit from existing contracts.
- 12.25 PCTs have reported that whilst they are able to commission new services and expand the UDA levels of existing contracts, they are not experiencing any reduction in quality where new UDA values are negotiated at a lower level. Many of these new contracts contain additional quality markers which are being met.
- 12.26 NHS Hertfordshire report that local contractors have “under-cut” existing UDA rates (both their own and those of other local practices) when tendering for short-term activity.
- 12.27 NHSE understands that 2010/11 might be the last year the dental budget is “ring-fenced”. Given the current financial climate and in particular the general uncertainty that surrounds PCT budgets, PCTs believe it important that they be permitted to spend this ring-fenced budget in ways that more readily respond to identified local need rather than funding a general pay uplift.

General Dental Practitioner earnings

- 12.28 The average net profit (before income tax) for provider-performer dentists in 2007/08 was £126,807³⁰ (based on a population of 5,225 dentists) compared to £65,697 for performer only dentists (based on a population of 7,172 dentists).
- 12.29 This compares to the 2006/07 published figures that show average net profit (before income tax) for provider-performer dentists was £117,083.
- 12.30 Whilst it is difficult to compare year on year figures, this suggests an increase in average net profit in 2007/08 of over 8%.

Recruitment and retention

- 12.31 PCTs are still reporting difficulties in attracting dentists to work in rural areas. They believe this is often due to lower rates of pay. Rather than a blanket pay award to address the levels of pay, PCTs would rather this was left to local discussion to resolve.
- 12.32 PCTs are not persuaded that there is a strong link between the level of the DDRB award and the recruitment and retention of staff. Practices that experience difficulties in recruiting or retaining staff are sometimes reported to be out-dated or practices where there has been little investment. Staff are more likely to be attracted to innovative practices where there has been some level of investment. There is therefore no requirement for DDRB to make a high award to improve recruitment or retention.
- 12.33 A gross uplift to contract values recommendation of no more than 0.21% for 2010/11 would allow PCTs to offer appropriate premia, via the normal local contracting processes, in areas where it has been historically difficult to recruit and retain GDPs

Impact on salaried primary care dental services

- 12.34 PCTs have reported that they have not seen any significant improvement in the recruitment difficulties faced by the salaried primary care dental services (SPCDS). A large award to the GDS contract would only exacerbate this situation further.

³⁰ Dental Earnings and Expenses, England and Wales, 2007/08, The Health and Social Care Information Centre.

- 12.35 PCT provider services are working hard to deliver high quality services that offer value for money, often in deprived areas, but are not operating on a level playing field. General dental practice is perceived as a relatively easier and better paid option, with no requirement for generating the efficiency savings required of other NHS providers.
- 12.36 PCTs believe that the high turnover in SPDCS is due to the high levels of unscheduled care work (which is believed to impact on job satisfaction), and the low earnings (in the early years) relative to general practice.
- 12.37 Despite the investment made by PCTs in SPCDS, a significant increase in GDS earnings would further serve to discourage dentists from working in this area.

Passing on pay increases

- 12.38 PCTs continue to report that practices are not always passing on pay increases to their staff. This is a matter of concern and creates a perception that GDS contractors are using the awards to maintain and improve profits.

Practice expenses

- 12.39 The current expenses to earnings ratio (EER) as reported by the NHS Information Centre for providing-performer GDS dentists (financial year 2007/08) is 64.4%.
- 12.40 Due to the changes in the contract and the classification of dentists, it will be several years until it is possible to measure the trend in expenses through The NHS Information Centre's data. However, it is expected that due to the reportedly large drop in expenses since 2007/08, this ratio will have reduced.
- 12.41 PCTs expressed a view that practice expenses do not rise automatically year-on-year. PCTs report having seen no evidence of any increase in expenses at present. However, anecdotally, contractors have highlighted increased costs to PCTs in a number of areas this year. Many of these require an initial capital investment.
- 12.42 One area in which there may have been an increase in expenses is the costs associated with meeting the new decontamination and infection control standards. Many PCTs have reported that they have invested extensive capital monies to support practices in meeting the increased standards, examples of which are included in the table below.

Any inclusion of an amount of capital costs in the DDRB award would risk contractors receiving duplicated payments. There is a slight increase in the revenue costs associated with the improvements.

12.43 It was noted in the PCT focus groups that new practices, set up as a result of competitive tender exercises, are meeting the highest standards and still often cost less per UDA than contracts with existing providers. PCTs concluded that current UDA rates should more than cover any increase in cost related to the running of the new equipment.

12.44 A low award by DDRB allows PCTs to invest in practices following a local assessment of the requirements. For DDRB to take into account increased expenses in these areas might result in practices being reimbursed twice.

PCT	Investment
Liverpool	£292k for washer/disinfectors and running a nurse training course on fluoride varnishing which is available to all practices.
Cumbria	£600k capital investment in decontamination
Leeds	£580k in decontamination. They have also invested £1.1m towards improved IT, improved access to patients with disabilities and improved facilities. They have offered CPD verifiable washer disinfectant training for dental nurses in practices in contract with the PCT. Additionally they have committed £200k to assist practices in becoming BDA Good Practice Award Holders, and in demonstrating verifiable clinical governance standards have been met.
Essex	£1.1m investment for digital radiography and decontamination.

12.45 There has been no evidence that there has been any increase in laboratory fees. NHS Employers are pleased that the dental working group are in discussions with the British Dental Trade Association (BDTA) and the Dental Laboratories Association (DLA) to explore the prospects of including further data on dental expenses.

12.46 The requirement for dental nurses to be registered has caused a marginal increase in expenses for some practices. Whilst some practices have met the cost of training, it was acknowledged that this has not been universal.

12.47 NHS Hounslow reported that it had invested £20k in practice staff training. Stockport PCT has invested funds to support the training and development of Dental teams. The PCT also has a dental staff network which they sponsor.

12.48 Registration delivers many benefits to practices including a level of efficiency and productivity gained through having better trained staff. PCTs believed that this often off-sets any increase in practice costs and is therefore cost neutral.

12.49 PCTs recommended that for the majority of expenses, especially capital, IT and training, PCTs should be allowed to invest in response to local need, as demonstrated by the decontamination examples above, rather than they form part of a DDRB recommendation.

Efficiencies

12.50 PCTs felt that the DDRB award should take account of the requirement to make efficiencies. The rest of the NHS is expected to make significant year on year cash releasing efficiencies and the focus groups did not see any reason why dentistry should be exempt from the same requirement.

12.51 NHS Employers would want to work with the DDRB, the Department of Health and the BDA to examine and assess the components of a formula approach, in particular to investigate the possibility of taking in into account other factors, such as expected efficiencies.

Annex A

NHS Employers: who we are

NHS Employers provides advice and support to employers, sharing information and best practice, in order to help the NHS provide better care for patients. NHS Employers helps employers in the NHS to recruit, retain and develop the numbers and skill mix of staff required to deliver excellent services, treatment and care, while improving the working lives of staff working in the NHS. NHS Employers has four key roles:

- negotiating on behalf of employers
- representing employers
- supporting employers
- promoting the NHS as an employer of excellence.

Workforce and employment issues are of key importance to the overall strategy of the NHS and form an intrinsic part of wider service issues. NHS Employers was set up to ensure that the service itself drives the workforce agenda, and so Employers in the NHS drive the work of NHS Employers. We represent the views of employers within the NHS in England, including Foundation Trust, and act on their behalf in relation to:

- pay and negotiations
- planning the workforce
- workforce productivity
- employer of excellence
- HR policy and practice
- The workforce implications of system and structural reform.

The Department of Health remains responsible for developing policy standards for the health and social care workforce, setting the broad policy framework for the service within which NHS Employers operates.

NHS Employers also provides the 'machinery' for negotiations on a UK basis by way of a secretariat. The Department of Health in England may have an observer at pay negotiations while the devolved administrations each attend as negotiating members.

Annex B

NHS Employers annual pay review survey 2010/2011

NHS Employers annual pay review survey 2010/2011

1. Your details

* Name

* Telephone

* Email

* Job title

* Name of organisation that this evidence is submitted on behalf of

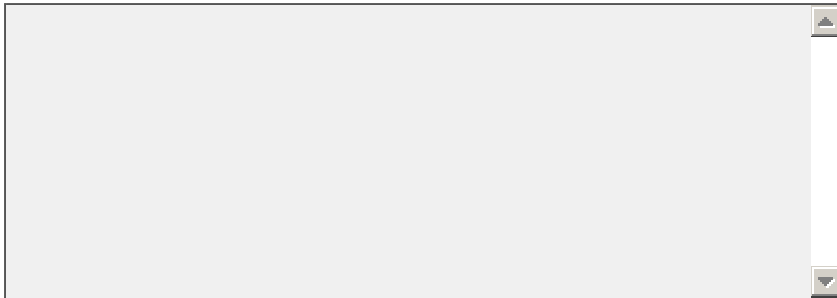
SHA region

Organisation type

NHS Employers annual pay review survey 2010/2011

2. Agenda for change i.e. staff other than doctors, dentists and certain very ...

The multi year agreement provides for a general uplift of 2.25% plus some structural changes in 2010/11. The NHS Pay Review will consider information in relation to recruitment and retention, and wider economic and labour market conditions. Please provide your views on the recruitment and retention outlook faced by your organisation.



NHS Employers annual pay review survey 2010/2011

3. Doctors and dentists

What are the 3 most significant priorities in assessing pay levels for doctors and dentists for 2010/2011?

- Recruitment
- Retention
- Staff Morale
- Affordability position of the organisation
- Other

If "other" please give details

What are the 3 most likely consequences of a higher pay award for doctors and dentists than you believe affordable?

- Reduction in service capacity
- Delayed planned expansion of service provision
- Reduction in quality of service
- Reduction in quality of care
- Reduction in the number of posts
- Increased unfilled vacancies
- Redundancies
- Failure to meet targets set by government
- Failure to meet business objectives set by your Board
- Other

If "other" please give details

Should any pay increase by the same percentage for all grades of directly employed doctors and dentists?

yes

no

NHS Employers annual pay review survey 2010/2011

If "no", which doctors or dentist should receive a higher award compared to their colleagues?

- Consultants
- Doctors in training
- SAS doctors
- Salaried dentists
- Salaried GPs

4. Doctors and dentists

During the last 12 months, has your organisation encountered difficulties in recruiting or retaining doctors and dentists?

Grade where difficulty encountered

Specialty

Severity of difficulty in relation to patient care

mild

moderate

serious

Other grades where difficulties encountered

Grade

Specialty

Severity of difficulty in relation to patient care

mild

moderate

serious

Other grades where difficulties encountered

Grade

Specialty

Severity of difficulty in relation to patient care

mild

moderate

serious

Other grades where difficulties encountered

Grade

Specialty

Severity of difficulty in relation to patient care

mild

moderate

serious

NHS Employers annual pay review survey 2010/2011

Other grades where difficulties encountered

Grade

Specialty

Severity of difficulty in relation to patient care

mild

moderate

serious

Please indicate whether any of the following solutions have been used at your organisation to resolve any recruitment and retention problems in relation to doctors and dentists

- Use of locums from NHS professionals
- Use of locums from other agencies
- Use of internal locum cover
- Job Plan Changes
- Skill mix changes
- Local labour market supplements i.e. R and R Premia
- Overseas recruitment
- Other

If "other" please state the solution involved

For London Trusts Only:

Is the current level of London Weighting for doctors and dentists adequate?

Yes

No

NHS Employers annual pay review survey 2010/2011

5. Primary care organisations

If you directly employ Salaried General Practitioners does the current pay range meet your requirements?

Yes

No

If no, please explain any difficulties with the current pay range

6. All respondents

Please add any further comments on your organisation's views on the pay and reward of doctors and dentists

Annex C

Example of distribution of flat rate to doctors in employment with percentage increase at each pay point.

				Flat cash increase	Monetary increase corresponding to %age increases					% increase from 07/08 to 09/10 including flat cash
		2008/09 basic, £	£ 450	2009/10 basic, £	2.25%	1.50%	1.00%	0.75%	0.50%	£ 450
FY1	F1 min	22,190	2.0%	22,640	£ 499	£ 333	£ 222	£ 166	£ 111	5.8%
	F1 1	23575	1.9%	24,025	£ 530	£ 354	£ 236	£ 177	£ 118	5.7%
	F1 2	24960	1.8%	25,410	£ 562	£ 374	£ 250	£ 187	£ 125	5.6%
FY2	F2 min	27523	1.6%	27,973	£ 619	£ 413	£ 275	£ 206	£ 138	5.4%
	F2 1	29323	1.5%	29,773	£ 660	£ 440	£ 293	£ 220	£ 147	5.3%
	F2 2	31122	1.4%	31,572	£ 700	£ 467	£ 311	£ 233	£ 156	5.2%
Specialty Registrar	StR min	29,411	1.5%	29,861	£ 662	£ 441	£ 294	£ 221	£ 147	5.3%
	StR 1	31,211	1.4%	31,661	£ 702	£ 468	£ 312	£ 234	£ 156	5.2%
	StR 2	33,724	1.3%	34,174	£ 759	£ 506	£ 337	£ 253	£ 169	5.1%
	StR 3	35,244	1.3%	35,694	£ 793	£ 529	£ 352	£ 264	£ 176	5.1%
	StR 4	37,077	1.2%	37,527	£ 834	£ 556	£ 371	£ 278	£ 185	5.0%
	StR 5	38,911	1.2%	39,361	£ 875	£ 584	£ 389	£ 292	£ 195	4.9%
	StR 6	40,745	1.1%	41,195	£ 917	£ 611	£ 407	£ 306	£ 204	4.9%
	StR 7	42,578	1.1%	43,028	£ 958	£ 639	£ 426	£ 319	£ 213	4.8%
	StR 8	44,412	1.0%	44,862	£ 999	£ 666	£ 444	£ 333	£ 222	4.8%
Specialty Doctors	SD Min	36443	1.2%	36,893	£ 820	£ 547	£ 364	£ 273	£ 182	5.0%
	SD 1	39559	1.1%	40,009	£ 890	£ 593	£ 396	£ 297	£ 198	4.9%
	SD 2	43610	1.0%	44,060	£ 981	£ 654	£ 436	£ 327	£ 218	4.8%
	SD 3	45781	1.0%	46,231	£1,030	£ 687	£ 458	£ 343	£ 229	4.8%
	SD 4	48909	0.9%	49,359	£1,100	£ 734	£ 489	£ 367	£ 245	4.7%
	SD 5	52025	0.9%	52,475	£1,171	£ 780	£ 520	£ 390	£ 260	4.6%
	SD 6	55211	0.8%	55,661	£1,242	£ 828	£ 552	£ 414	£ 276	4.6%
	SD 7	58399	0.8%	58,849	£1,314	£ 876	£ 584	£ 438	£ 292	4.5%
	SD 8	61586	0.7%	62,036	£1,386	£ 924	£ 616	£ 462	£ 308	4.5%
	SD 9	64772	0.7%	65,222	£1,457	£ 972	£ 648	£ 486	£ 324	4.5%
Associate Specialists	AS Min	51095	0.9%	51,545	£1,150	£ 766	£ 511	£ 383	£ 255	4.6%
	AS 1	55202	0.8%	55,652	£1,242	£ 828	£ 552	£ 414	£ 276	4.6%
	AS 2	59308	0.8%	59,758	£1,334	£ 890	£ 593	£ 445	£ 297	4.5%
	AS 3	64731	0.7%	65,181	£1,456	£ 971	£ 647	£ 485	£ 324	4.5%
	AS 4	69432	0.6%	69,882	£1,562	£1,041	£ 694	£ 521	£ 347	4.4%
	AS 5	71381	0.6%	71,831	£1,606	£1,071	£ 714	£ 535	£ 357	4.4%

	AS 6	73926	0.6%	74,376	£1,663	£1,109	£ 739	£ 554	£ 370	4.4%
	AS 7	76471	0.6%	76,921	£1,721	£1,147	£ 765	£ 574	£ 382	4.3%
	AS 8	79015	0.6%	79,465	£1,778	£1,185	£ 790	£ 593	£ 395	4.3%
	AS 9	81560	0.6%	82,010	£1,835	£1,223	£ 816	£ 612	£ 408	4.3%
	AS 10	84106	0.5%	84,556	£1,892	£1,262	£ 841	£ 631	£ 421	4.3%
Consultants	Con Min	74504	0.6%	74,954	£1,676	£1,118	£ 745	£ 559	£ 373	4.4%
	Con 1	76837	0.6%	77,287	£1,729	£1,153	£ 768	£ 576	£ 384	4.3%
	Con 2	79170	0.6%	79,620	£1,781	£1,188	£ 792	£ 594	£ 396	4.3%
	Con 3	81502	0.6%	81,952	£1,834	£1,223	£ 815	£ 611	£ 408	4.3%
	Con 4	83829	0.5%	84,279	£1,886	£1,257	£ 838	£ 629	£ 419	4.3%
	Con 5	89370	0.5%	89,820	£2,011	£1,341	£ 894	£ 670	£ 447	4.3%
	Con 6	94911	0.5%	95,361	£2,135	£1,424	£ 949	£ 712	£ 475	4.2%
	Con 7	100446	0.4%	100,896	£2,260	£1,507	£1,004	£ 753	£ 502	4.2%

Estimate of % increase on pay bill

Staff group	FTE Sept 08	Average basic pay Jan - Mar 09	Average total pay Jan - Mar 09	Approximate average % increase to basic pay with flat cash increase
				£ 450
FY1	6,025	22100	31800	2.04%
FY2/SHOs	8,001	29100	42400	1.55%
Registrars	34,272	37200	56700	1.21%
Staff grades and specialty doctors	5,653	59600	65800	0.76%
Associate specialists	2,803	77400	84900	0.58%
Consultants (including Directors of public health)	32,679	89100	119200	0.51%
Total FTE	89,433		Average	0.99%

NHS Employers

supporting • promoting • representing

NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. The NHS workforce is at the heart of quality patient care and we believe that employers must drive the workforce agenda. We work with employers to reflect their views and act on their behalf in four priority areas:

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

NHS Employers is part of the NHS Confederation.

Contact us

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