Review Body on Doctors’ and Dentists’ Remuneration 2018/19 pay round

Written evidence from NHS Providers

About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 98% of all trusts in membership, collectively accounting for £74 billion of annual expenditure and employing more than one million staff.

Our submission

We welcome the opportunity to submit evidence to the Doctors’ and Dentists’ Remuneration Review Body, on behalf of NHS trusts and foundation trusts to inform the 2018/19 pay round. For the purposes of this submission, we have drawn on two key information sources:

- A survey of HR Directors in November 2017. We received responses from 64 member trusts, 28% of the sector. The survey results are in Annex A.
- Our report, There for us: a better future for the NHS workforce, from November 2017. In this we drew on qualitative and quantitative evidence about the key workforce challenges facing the sector and provided some recommendations for how the government and national bodies could start to address these.

Key messages

- Workforce now surpasses the financial challenge facing the provider sector. In a recent survey of trust leaders, two thirds (66%) of provider trust chairs and chief executives reported that workforce is the most pressing challenge to delivering high-quality healthcare at their trust.

- We recognise the need to appropriately and fairly reward doctors, to support recruitment and retention and help create a motivated medical workforce. However, in the absence of additional funding from the government, an end to pay restraint for doctors would be unaffordable for provider trusts.
• The funding pressures facing the sector require a balance between the need to increase the number of staff with the need to address the factors contributing to the workforce challenges for frontline staff and employers. We would strongly urge that the review body takes account of the affordability of any pay award in making its recommendations.

• In a scenario where the pay review bodies recommend a pay award greater than 1%, less than half of HR Directors (45%) support targeting, and 42% are not supportive. The most common reason for opposing targeting was concern that it would be divisive and result in industrial relations disruption.

• Provider trusts have been working with their junior doctors over the last 12 months to address legitimate concerns voiced during the junior doctor contract dispute. Improving and rebuilding junior doctor engagement and morale continues to be a key priority.

• We would welcome a public update on the status of the consultant contract negotiations. If there is no realistic prospect of a successful conclusion, consideration should be given as to the best way forward, recognising the need to reform NHS pay, terms and conditions for consultants. Ongoing uncertainty over the status and outcome of the negotiations is not conducive to longer term planning at the local level.

• The need for a more strategic and coherent approach to workforce strategy, planning, and policy remains a priority. We have welcomed the government’s recent publication of a draft health and care national workforce strategy consultation document, which proposes a constructive start to addressing the workforce challenges facing the sector. The draft strategy helpfully provides a ten year time frame, recognising that the reforms required to address the workforce challenges facing the NHS will require a longer term horizon.

Remit for 2018/19

We note that the government has confirmed to the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) that it has adopted “a more flexible approach to public sector pay, to address any skills shortages and in return for improvements to public sector productivity” and that “review bodies should continue to consider affordability when making their recommendations”.

We also note that the DDRB has been asked to “make recommendations in relation to the employed medical workforce about targeting funding to support productivity and recruitment and retention”, considering the flexible pay premia within the existing junior doctor contract, Health Education England’s (HEE’s) views on hard-to-fill training programmes, and discussions between NHS Employers and the BMA on reform of the consultant contract.

Following the outcome of the November 2017 budget, we understand that the government has committed to fund an end to pay restraint for NHS staff on the Agenda for Change contract but not for
doctors and dentists. This would mean that should DDRB recommend an above 1% pay rise, this would need to be funded from existing NHS budgets, which is not currently built in to funding and contracts for 2018/19.

Our views on the 2018/19 pay award

Workforce is the top concern for NHS trusts across the country, with staffing challenges as pressing as the financial challenge.

Pay restraint is one of a range of factors impacting recruitment, retention and staff morale in the health service. This is confirmed in a recent survey of trust leaders of chairs and chief executives, which found that pay and reward is now one of the three biggest challenges impacting recruitment and retention in the NHS: 93% cited staff supply shortages, 60% work pressure, and 38% pay and reward.¹

We need to recognise that doctors’ pay has not kept pace with the wider economy and inflation. For example, the Health Foundation reports that between 2008/09 and 2015/16 the basic pay of doctors has fallen by 8% in real terms². For 2017, the Office of Budget Responsibility’s inflation estimates are 2.7%, when measured by consumer price index (CPI), and 3.6%, when measured by retail price index (RPI)³, whereas doctors received a pay award for 2017/18 of 1% in line with the government’s public sector pay policy.

However, we recognise that pay and reward can only be one part of the solution. For example, doctors could be given an above inflation pay rise for 2018/19 but, in the absence of action to address the work pressures staff face and long running staff shortages, trusts would most likely continue to struggle to have the medical workforce they need.

At the same time, improving pay and reward without additional funding could exacerbate the deep financial challenges already facing the sector. It is therefore unfortunate that in the November 2017 budget the government did not commit funding to end pay restraint for doctors as it did for Agenda for Change staff (subject to reform of terms and conditions). While we want to see an end to pay restraint for doctors to support recruitment and retention, in the absence of additional funding from the government, this would be unaffordable for the provider sector: 93% of HR directors in our latest survey told us a pay award above 1% for doctors from their trusts existing budget is “very” or “fairly” unaffordable⁴.

As one HR director put it, “While we support an increase in pay awards there is a concern about where the funding is coming from and the expectation that this is met within existing trust budgets, which puts huge cost pressure on already stretched budgets.”

¹ NHS Providers (November 2017), https://nhsproviders.org/a-better-future-for-the-nhs-workforce
³ http://budgetresponsibility.org.uk/faq/where-can-i-find-your-latest-forecasts/ [accessed 13 December 2017]
⁴ Survey of NHS Providers member trust HR directors undertaken during November/December 2017. 64 responses were received from HR directors across 28% of provider trusts.
We would therefore strongly urge that the DDRB take account of the affordability of any pay award in making its recommendations. Difficult decisions will need to be made and it is particularly important that such decisions are made with rigour and careful thought. Provider trusts support the pay review body mechanism as the best way to ensure this.

Targeting of the pay award

Last year we suggested to the DDRB that a national decision should not be made about targeting a 1% pay award. We argued that in the industrial relations climate at the time, this would have proved divisive and would not have taken account of differing local recruitment challenges.

In a scenario of a pay award of more than 1%, there is arguably more scope for targeting of the pay award and so we have sought to explore this.

When we asked HR directors whether, if the pay award is greater than 1%, they would support nationally agreed targeting of part of the pay award for doctors, almost as many (42%) told us they would not be supportive as would be supportive (45%).

The most common reason for opposing targeting was concern that it would be divisive and result in industrial relations disruption. Some HR directors also pointed out that for junior doctors the new contract includes provision for flexible pay premia and that these should be the means of pay targeting rather than a new mechanism.

In a scenario where a targeted pay award for doctors is nationally agreed, HR Directors suggested that doctors in specialities with the most difficult recruitment and retention, followed by junior doctors, should be the staff groups prioritised. If targeting is pursued, we need to recognise the scale of the communications and engagement task that this presents.

As indicated by our survey results, there are very mixed views across the sector as to the impact and benefit of targeting the pay award. Therefore any targeting of the pay award would need to follow consideration of all costs and benefits, be based on robust and up to date data, and be clearly placed in the context of other mechanisms such as flexible pay premia.

Our assessment of the other workforce pressures facing the NHS

Pay and reward should be viewed alongside the other workforce challenges facing the sector.

In November 2017, we published a report, *There for us: a better future for the NHS workforce*. The report was informed by a survey of provider trust chairs and chief executives.

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5 NHS Providers (November 2017), https://nhsproviders.org/a-better-future-for-the-nhs-workforce
Two thirds (66%) of provider trust chairs and chief executives told us that workforce is the most pressing challenge to delivering high-quality healthcare at their trust.

**Recruitment**

The medical consultant “shortfall data” provided by HEE to the DDRB last year demonstrates that some specialties have significant shortages – for example emergency medicine, psychiatry, and cancer services – and that there are also notable regional differences, with the north and, to a lesser extent, east and midlands, generally facing higher shortfalls than London and the south east and the south.

Similar regional and specialty patterns can be seen in the medical training “fill rates” which HEE also provided to the DDRB last year, and in the analysis by the BMA of specialty training fill rates since 2013.

It is unfortunate that “shortfall data” and “fill rates” are not made public on a more regular and timely basis to enable a shared understanding of the medical workforce recruitment challenges and informed debate about how to address them. The data submitted by HEE to the DDRB last year is still the most comprehensive and authoritative available and yet it is now more than two years old.

**Retention**

National data on retention shows that across staff groups there is a common trend of rising leaver rates from 2010/11 to 2015/16. For doctors as a whole the leaver rate was 14.4% in 2010/11 and 15.5% 2015/16.

Publically available leaver data does not, however, distinguish between staff who leave one NHS organisation to work in another and those who leave the NHS altogether. It also does not support breakdown by region, though the Health Foundation has done analysis using a bespoke cut of data from NHS Digital which demonstrates significant variation across England and concludes that “there is great scope to improve retention”.

Limitations of the publically available data on retention hamper efforts to develop a shared understanding of medical workforce challenges and how to address them.

Provider trusts have had a sustained focus on making their organisations great places to work. NHS Employers has a programme to support trusts to improve retention and has recently launched a new

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6 Survey of NHS Providers member trust chairs and chief executives undertaken 17-20 October 2017. 149 responses were received from leaders across 51% of all provider trusts.


toolkit⁹. NHS Improvement is also running a programme to improve retention, including a series of “retention masterclasses”¹⁰.

**Staff experience**

Between 2012 and 2016 the NHS Staff Survey shows an increase in the proportion of staff who would recommend their organisation as a place to work from 55% to 60%, reflecting provider trusts focus on making themselves great places to work¹¹ and better engagement with staff. There remains much more for provider trusts to do, notably tackling bullying and adapting the employment offer for new generations of staff with different expectations of the workplace.

At the same time, there are critical factors affecting staff experience which are largely outside of provider trusts’ control, notably the work pressure created by the fundamental mismatch between what the NHS is being asked to do and the resources made available and several years of pay restraint. While the November 2017 budget provided welcome additional funds for the NHS, it was unfortunately less than the NHS needs to deal with rising demand, fully recover performance targets, consistently maintain high quality patient care, and meet the NHS’s capital requirements¹².

Between 2012 and 2016 the NHS Staff Survey shows an increase in the proportion of staff who worked extra unpaid hours from 57% to 59%¹³. Similarly data from NHS Digital shows that “work-life balance” is now the fastest growing reason for voluntary resignations of NHS staff. It may be reasonable to ask staff to occasionally work extra hours, but to ask them to do regularly do so as at present is not sustainable. As one trust leader put it, “The NHS is significantly dependent on the ‘heroic’ efforts of clinical and non-clinical colleagues in responding to increasing service demand within an environment of ever-challenging financial constraints (including pay/reward controls) that compromises work/life balance, learning and development and overall job satisfaction”¹⁴.

**Junior doctor engagement and morale**

Last year we told DDRB that successfully implementing the new junior doctor contract and rebuilding junior doctor engagement and morale is a key priority for provider trusts, following the contract dispute.

We consider that junior doctors raised a number of legitimate concerns during the dispute and provider trusts have been working with their junior doctors to address these over the last 12 months.

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¹¹ NHS Providers (November 2017), https://nhsproviders.org/a-better-future-for-the-nhs-workforce
¹³ NHS Providers (November 2017), https://nhsproviders.org/a-better-future-for-the-nhs-workforce
¹⁴ Ibid
In October 2017, together with the Faculty of Medical Leadership and Management and NHS Improvement, we published *Eight high impact actions to improve the working environment for junior doctors*\(^{15}\). The resource sets out actions trusts can take immediately and examples of solutions.

There are also initiatives led by the arm’s length bodies. Health Education England (HEE) has taken forward its enhancing junior doctors’ working lives programme\(^{16}\). NHS Improvement now monitors trusts adherence to the publication of rotas 6 weeks prior to start date, as delayed release has a major impact on doctors’ work-life balance, and has made available a collection of case studies on how provider trusts have improved engagement with junior doctors\(^{17}\). The General Medical Council has provided greater flexibility for less than full time trainees wishing to do locum work\(^{18}\) and HEE has set out ten commitments to support junior doctors to return to training after time out\(^{19}\).

While it is still relatively early days, we expect that over time these initiatives should support the rebuilding of junior doctor engagement and morale, and this is a key priority for trusts.

**Consultant contract reform**

Last year we told the DDRB we would like to see a successful conclusion to negotiations to reform of the consultant contract. While we recognise that these negotiations had been prioritised during the junior doctor contract dispute, we now wish to see a successful conclusion to negotiations to reform the consultant contract.

These reforms are still crucial, and previously we have made the case to DDRB for reform of the contract, arguing that the right to decline non-emergency work outside of core hours must be removed, the link between pay and performance must be strengthened, and that more hours in a day and more days of the week need to be defined as core hours.

We are not directly involved in the negotiations. However, we are aware of reports that the sticking point that has prevented more rapid progress is the absence of additional funds to support a transition to a new contract, and that it is now unlikely that new contract would be implemented before 2019\(^{20}\). We are also clear that there is no appetite among provider trusts for a new contract to be introduced without agreement from medical unions.

\(^{15}\) Faculty of Medical Leadership and Management, NHS Providers, NHS Improvement (October 2017), [https://improvement.nhs.uk/resources/eight-high-impact-actions-to-improve-the-working-environment-for-junior-doctors/](https://improvement.nhs.uk/resources/eight-high-impact-actions-to-improve-the-working-environment-for-junior-doctors/)


We would welcome a public update on the status of the negotiations and the prospects of a successful conclusion. If there is no realistic prospect of a successful conclusion, consideration should be given as to the best way forward, recognising the need to reform NHS pay, terms and conditions for consultants. Ongoing uncertainty over the status and outcome of the negotiations is not conducive to longer term planning at the local level.

**NHS national workforce strategy**

Last year we told the DDRB that there was a need for a more strategic and coherent approach to workforce policy, including workforce planning.

This remains a priority issue. 90% of provider trust chairs and chief executives have told us they are “worried” or “very worried” about the Department of Health and its arms length bodies approach to workforce strategy, planning, and policy\(^21\). This is deeply concerning. As one trust leader put it, “Sustainable staffing is the greatest challenge facing my organisation. I have no real sense that the scale of the challenge is truly understood nationally.”

We set out in our report *There for us: a better future for the NHS workforce* what we think needs to happen to support provider trusts to recruit and retain the staff they need to deliver high quality care for patients.

We have welcomed the government’s recent publication of a draft health and care national workforce strategy consultation document\(^22\), *Facing the facts, shaping the future*\(^23\). This is a vital opportunity for the Department of Health and its arm’s length bodies to respond to the scale of the workforce challenges facing the NHS and care sectors, and adopt a coherent and credible approach which supports organisations to recruit and retain the staff they need. The draft strategy helpfully provides a ten year time frame, recognising that the reforms required to address the workforce challenges facing the NHS will require a longer term horizon.

We will be responding to the consultation that is now underway. The final strategy must make clear who is responsible for what at the national level and recognise the roles of provider trusts as employers. The system will need to fully work through the obvious consequences of these proposals, including the linked financial and funding requirements.

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\(^21\) NHS Providers (November 2017), https://nhsproviders.org/a-better-future-for-the-nhs-workforce


\(^23\) As the national workforce strategy consultation document was published on 13 December 2017 we have not been able to include a more developed response in our written evidence to the DDRB. We would welcome the chance to discuss this further with the DDRB at an oral evidence session.
Further information

We would be pleased to respond to supplementary questions from the DDRB and would welcome the opportunity to discuss our evidence further at an oral evidence session.

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Annex A – summary of trust HR directors survey results

NHS Providers survey results – November 2017

In November 2017 NHS Providers surveyed HR Directors/Leads at member trusts to understand their views on the 2018/19 pay award. We received responses from 64 NHS trusts and foundation trusts – 28% of all NHS secondary care providers in England. All trust types and regions were represented in the survey responses. The following responses were received with regard to doctors.

Q. How affordable financially is it for your trust to implement a pay award above 1% for doctors for 2018/19 from your trusts’ existing budget?

93% of respondents think implementing a pay award above 1% for doctors from their trusts existing budget is ‘very’ or ‘fairly’ unaffordable.

Q. If the pay award is greater than 1%, would you support nationally agreed targeting of part of the pay award for doctors?

Almost the same proportion of respondents would support targeting of a pay award for doctors as would not (45% vs 42%).

Q. If part of the pay award for doctors had to be targeted by national agreement, please rank the following as criteria for targeting.

The staff group prioritised most by respondents was doctors in specialities with the most difficult recruitment and retention (weighted ranking 328), followed by junior doctors (weighted ranking 273).