4 February 2022

Review Body on Doctors' and Dentists' Remuneration 2022/23 pay round

Written evidence from NHS Providers

About NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community, and ambulance services that treat patients and service users in the NHS. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Our submission

We welcome the opportunity to submit evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) on behalf of NHS trusts and foundation trusts, to inform the 2022/23 pay round. For the purposes of this submission, we have drawn on several information sources, including:

- An annual survey of trust HR directors by NHS Providers[1]
- National workforce data
- NHS Providers' previous written submissions to the NHS Pay Review Body
- Other surveys and sources of feedback from trust leaders, including our *State of the Provider Sector* survey, *NHS Winter watch*, and our HR directors network meetings in 2021.

Key messages

- The majority of HR directors responding to our survey support a pay award of at least 3% for 2022/23, with 16% supporting a 5% uplift, and 11% supporting 4%, against the backdrop of increasing inflation, cost of living, and service demand in the NHS

[1] This online survey of HR directors in NHS trusts and foundation trusts was conducted from December 2021 to January 2022. Data is based on responses from 45 trusts, accounting for 20% of the provider sector, with all regions and trust types represented in the responses. This was a lower response rate than we have traditionally received, which was expected given the operational pressures which the NHS is currently under.

- Trusts and their staff are working at full capacity, with extensive and sustained operational pressure caused by COVID-19 infections, winter pressures, a nationwide vaccination campaign and a significant backlog in care
- Respondents to our survey did not support the targeting of pay between grades of medical staff, with 65% against the possibility. This is likely in reaction to last year's decision to not grant equivalent pay awards to junior doctors and SAS doctors on the new contracts
- We welcome indications from our survey that the new SAS contracts have been relatively straightforward to implement, but uptake remains low due to last year's 3% pay uplift on the 2008 contract and a new increase should be applied to remedy this in 2022/23
- 86% of HRDs responding to our survey said that reform to local clinical excellence awards (LCEAs) is very important or important, with several suggesting that LCEAs should be ended entirely
- Trust leaders are concerned about the possibility of partially funded pay uplifts, as trusts will have to make up any shortfall from existing budgets which have been allocated to ensuring service delivery. This will have operational impacts will affect patients directly
- We continue to reject the concept of a "direct trade-off" between more funding for pay or staff numbers. These are interdependent factors, as fair pay helps to attract high quality staff and supporting their retention
- The delays to the announcement of pay awards each year have a negative impact on staff morale, increasing uncertainty for staff and complicating trust financial planning. There is a specific recruitment and retention case for higher pay awards this year, as low morale and increased uncertainty from delays will be compounded by ongoing cost of living increases and a National Insurance rise
- It is welcome news that the Office for Students reports a record number of applications to medical and dentistry degrees for 2020/21 and 2021/22. However, trusts are clear that they would welcome the removal of the medical school cap, which is being reapplied for 2022/23 after being lifted previously due to the impact of COVID-19 on A-level examinations
- Flexibility can be built into the service both through the fuller utilisation of new roles and a focus on generalism, but also through the provision of flexible working options for staff. A fully costed and funded national workforce plan is needed to realise this, to build resilience into the system and to plan sustainably for future demand.

Remit

In his remit letter to the Chair of the Review Body on Doctors' and Dentists' Remuneration (DDRB),[2] the Secretary of State for Health and Social Care, Sajid Javid, repeatedly referenced the importance of affordability for the 2022/23 medical and dental staff pay awards given that "the NHS budget has already been set" until 2024/25. The message, repeated since 2019, continues to be that there is direct trade-off between "pay and staff numbers", with funding for both being taken from the current five-year funding settlement for the NHS.

The DDRB are invited to make recommendations on a pay award for: dentists employed by or providing services to the NHS; consultants; and SAS doctors who have chosen not to move onto the new national contracts which were agreed with the BMA in 2020. SAS doctors who have moved onto the new contracts, and doctors and dentists in training, are all covered by multi-year pay arrangements and therefore not in scope for recommendations from the DDRB. The remit letter invites "comments and observations" for doctors and dentists in training, but not for SAS doctors who have moved onto the new contracts. This submission will refer to all of the aforementioned staff groups and will give some early feedback from trusts on the implementation and effects of the new SAS contracts.

The remit letter does not reference the economic conditions surrounding the ongoing COVID-19 pandemic, including increased costs of living, but we would expect this to be raised to the DDRB by all stakeholders submitting evidence, including the government.

Pay decision for doctors 2022/23

Context

The 2021/22 pay award for consultant doctors and Speciality and Associate Specialist (SAS) doctors on the 2008 contract was 3%, backdated to April 2021, as recommended by the DDRB and accepted by Government. The DDRB recommended no uplift to consultant Clinical Excellence Awards (CEAs) until they are reformed, which the government also accepted. While NHS Providers welcomed the 3% pay award – which was a significant improvement on the 1% suggested by the Department of Health and Social Care (DHSC) in their written submission – its value was severely impacted by the sharp increase across all measures of inflation as the year went on. Similarly, medical staff under pre-agreed

[2] https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-remit-letter-2022-to-2023/review-body-on-doctors-and-dentists-remuneration-remit-letter-2022-to-2023

multi-year pay deals also saw a decrease in the value of their planned pay levels for this reason (these included SAS doctors who have moved onto the new contracts, doctors and dentists in training, and GP partners). The DDRB's 2021 report stated that "recognising the contribution [these groups of medical staff under pre-agreed multi-year pay deals] have made to the pandemic response in this context is extremely important, and we would urge ministers to consider this." Ultimately, the government gave no additional pay award to these staff groups.

In HM Treasury's January 2021 written submission to the pay review bodies, the possibility of such increases was not considered, and instead an emphasis was placed on staff coming off a "third consecutive year of pay awards in excess of inflation" in 2020/21. At the time of writing, it was not clear that inflationary pressures would reach current levels, however there was a sense that HMT was relying heavily on lower immediate costs of living caused by the winter lockdown and associated lack of economic activity as a precursor to a 1% proposal for staff pay in the next financial year. Ultimately, the government decision and announcement of a 3% pay award in July last year, came one week after CPI had risen beyond forecasted levels to 2.5%[3] and in the same month the OBR had raised the prospect of temporary or longer-term annual price rises of between 4-5% in their fiscal risks report.[4]

Trust leaders have repeatedly told us that they are concerned about the impacts of these cost of living increases on staff. Given the strength of inflationary pressures in the 2021/22 financial year – and given that the Bank of England expects inflation to reach 6% by Spring 2022[5] - we encourage the DDRB to carefully scrutinise further forecasts, analysis and assumptions around the value of proposed pay awards and their impacts on the cost of living for NHS staff in their deliberations this year.

Against a backdrop of increased and long-lasting demands on all staff during the pandemic, the curtailed value of the 3% pay award for eligible medical staff (and lack of any additional increase for medical staff under pre-existing multi-year pay deals) led to dissatisfaction and an increase in trade union activity in the latter half of 2021. The BMA expressed disappointment in the "real-terms pay cut" of the 3% award, the lack of any increase for LCEAs, and Government's decision not to provide

[3] Office for National Statistics, Consumer price inflation, UK: June 2021: https://www.ons.gov.uk/economy/inflationandpriceindices/bulletins/consumerpriceinflation/june2021

[4] Office for Budgetary Responsibility Fiscal Risks Report, July 2021, page 181-182: https://obr.uk/docs/dlm_uploads/Fiscal_risks_report_July_2021.pdf

[5] Bank of England, "Will inflation in the UK keep rising?" https://www.bankofengland.co.uk/knowledgebank/will-inflation-in-the-uk-keep-rising

additional pay uplifts to those covered by multi-year pay deals.[6] As such, it surveyed its consultant and junior doctor members to gauge their responses. 93.5% of junior doctors who responded to this survey said their morale had decreased as a result of only receiving their planned pay uplift of 2%.[7] The BMA's Junior Doctors Committee is retaining the option of balloting for industrial action by October 2022 "if change is not forthcoming."[8] Over 80% of consultants who responded to the BMA's survey believed that the 3% pay award was "inadequate" or "completely unacceptable".[9] The union's Consultants Committee decided not to engage with the DDRB process for this 2022/23 award round, "instead seeking urgent negotiations with the Government and the DDRB to reform the pay setting process."[10] The chair of the SAS Doctors committee stated that "despite the benefits that the new contracts bring, I would have hoped that the Government would have taken the opportunity to properly recognise the efforts of all SAS doctors during the pandemic, as this was outside the scope of these negotiations."[11]

At the time of writing this submission, the NHS is combatting the toughest winter on record, with increasing demand for care far outstripping capacity given that the service has almost 100,000 staff vacancies,[12] and large numbers of staff self-isolating from week to week due to the ongoing COVID-19 pandemic. Despite these constraints, in November 2021 there were record numbers of patients seen by a consultant following an urgent two-week GP referral, all activity in cancer care increased, and diagnostic activity reached the highest level since January 2020.[13] This is testament to the dedication of NHS staff.

It is in this context of uncertainty around national workforce budgets, severe, sustained pressure on medical staff, their dissatisfaction with the outcome from the 2021/22 pay round, and continuing cost

---

[6] BMA, doctor's annual pay review from DDRB: https://www.bma.org.uk/pay-and-contracts/pay/how-doctors-pay-is-decided/doctors-annual-pay-review-from-ddrb

[7] BMA, "Intensifying our junior doctor pay campaign": https://www.bma.org.uk/news-and-opinion/intensifying-our-junior-doctor-pay-campaign

[8] Ibid.

[9] BMA, "Consultants call on government to restore original pay review process": https://www.bma.org.uk/bma-media-centre/consultants-call-on-government-to-restore-original-pay-review-process

[10] Ibid.

[11] BMA, "The government's pay award is a deep disappointment for SAS doctors": https://www.bma.org.uk/news-and-opinion/the-government-s-pay-award-is-a-deep-disappointment-for-sas-doctors

[12] NHS Digital: NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics

[13] NHS Providers, blog, "We must keep recognising the extraordinary efforts of NHS staff": https://nhsproviders.org/news-blogs/blogs/we-must-keep-recognising-the-extraordinary-efforts-of-nhs-staff

of living increases, that the 2022/23 pay round begins. This context was cited by most of the HR directors we surveyed, with the general feeling that this year's pay round could be contentious.[14]

Our view

Over half (55%) of respondents to our survey said a 3% pay uplift would be needed for all doctors in 2022/23 to support their recruitment, retention, and morale. 16% of respondents supported an uplift of 5% or above, and 11% supported a 4% uplift.

There was a notable lack of support for the targeting of pay between grades of medical staff, with 65% of respondents against this possibility. This is likely in response to the reactions of medical staff last year, when junior doctors and SAS doctors on the new contracts did not receive equivalent pay awards to consultants and SAS doctors on the 2008 contract.

When asked to rate the impact of the new SAS contracts within organisations, respondents reported the most positive effect to be ease of contract implementation, with 44% saying the experience was very positive (7%) or positive (37%). This is an extremely welcome result. The response to the take-up among eligible doctors was less positive, with 30% of respondents saying there was a negative (21%) or very negative (9%) impact. In fact, there were repeated comments in our survey of HR Directors noting that many SAS doctors have chosen not to move across to the new contracts due to the immediate financial advantage of staying on old terms. Last year's 3% increase for SAS doctors was only applied to existing pay scales applicable to the 2008 contract. Some trusts have extended the time frame in which SAS doctors must decide whether to move across to the new contracts, but to encourage uptake, the DDRB could usefully recommend that the government applies an uplift to the new contracts which would make them financially equitable to the 2008 version.

Other effects of the new SAS contracts are yet to be made clear, as shown by the following findings in our survey:

- 71% of HRDs saw neither positive nor negative effects on SAS vacancies due to the new contracts; 17% saw a positive effect, 12% didn't know, and zero respondents reported a very positive or a very negative effect

[14] NHS Providers pay survey of HR directors, December 2021-January 2022. Unless stated otherwise, subsequent references to 'this year's' or 'our' pay survey refer to the same exercise. Please see a contextual note on responses at the beginning of this submission.

- 63% saw neither positive nor negative effects on workload due to the new contracts; 16% saw a positive effect, 9% reported negative effect and 2% very negative. No respondents reported a very positive effect, and 9% didn't know
- 57% saw neither positive nor negative effects on staff wellbeing due to the new contracts; 24% saw a positive effect, 12% didn't know, 2% saw a negative effect, and 5% very negative. No respondents reported a very positive effect.

We will include this question in next year's survey to track the effects of the new SAS contracts as the implementation period continues.

When asked how important possible changes to consultant terms and conditions are in 2022/23, a large majority (86%) of HR Directors said that reform of local clinical excellence awards was very important (58%) or important (28%). A smaller, albeit still significant, proportion (82%) said that a funded multi-year deal for consultant doctors was very important (26%) or important (56%). Many said that LCEAs should be ended entirely, with several highlighting that it is an "outdated" element of the consultant pay envelope. 9% of respondents also commented that LCEAs only applies to consultants and not the whole workforce which can be "damaging" and "divisive". There was support for reform and a full review of the criteria of the awards (should they continue), and we look forward to seeing how these elements are considered by the BMA, NHS Employers, and DHSC in their ongoing discussions on LCEA reform.

In response to the government's repeated assertion that there is a "direct trade-off" between more funding for pay or staff numbers, 69% of HRDs in our survey said that both aspects are equally important priorities for their trusts (a 19% increase on last year's responses to the same question). 27% prioritised more staff (33% last year), and 4% prioritised better pay for staff (18% last year). In their comments, most respondents who answered that both are equally important felt that these factors are interdependent, as good pay both attracts a high quality of staff and supports their retention. Respondents who prioritised "more staff" felt that there are more significant factors to recruitment and retention than pay, which would be enabled by having more staff in the service (including flexible working options, ensuring ability to take annual leave, and reducing staff relocation to new workplaces at short notice). Overwhelmingly, though, the message from respondents to this year's survey on this question was that it is vitally important that pay is not a reason for staff leaving the service, and investment in pay equates to investment in staff retention.

Implementation and affordability

It is important to state that if staff pay awards are not fully funded this year, there will be operational impacts. Trusts will have to make up any shortfall from existing funding which has already been allocated to ensuring service delivery. This would directly affect the quality of, and access to care for patients.

When asked how confident they were that funding for all doctors' pay rises will be fully costed and funded by central government to their trust in 2022/23, over one third (38%) of respondents to our survey were not at all confident (20%) or not very confident (18%). A smaller proportion (13%) were very (2%) or somewhat confident (11%), whereas over one third (36%) were neither confident nor not confident. 11% did not know. This level of uncertainty around funding is concerning and makes organisational financial planning far more difficult for trust leaders. We ask the DDRB to note this, and to call on the government to clarify the funding for this year's pay awards when it announces them.

When asked about the cost of the new SAS contracts to trusts, 20% of HR Directors said that this has had a positive effect. 56% reported neither a positive nor negative effect, 15% a negative effect, and 10% didn't know. No respondents reported very positive or very negative effects. We will provide evidence to the DDRB next year as information on the cost of implementing the new SAS contracts becomes clear, but it will be worth bearing in mind that contract reform is always a key workforce funding priority.

There have been delays to the announcement of pay awards for several years (always due by April, but usually announced early in the summer), and our survey asked trust leaders to report the effect this has on their organisations. 77% of respondents said it has a negative impact on staff morale, followed by 74% who said it brings uncertainty for staff. 64% referenced the increased administration work involved in arranging back payment of pay awards to staff, and 62% pointed to the difficulty delays cause to trust financial planning, given that it makes this element of spending fall out of step with the financial year.

Given the nature and prevalence of these concerns, there is a specific recruitment and retention case for higher pay awards this year. Low morale and increased uncertainty from delays are likely to be compounded by ongoing cost of living increases and a National Insurance increase which will come into effect on 1 April, before the pay award is announced and enacted. We are concerned about the potential for some staff in the remit group to feel demoralised and consider leaving the service as their take home pay loses value throughout the first half of this calendar year. While trusts will be working hard to ensure high levels of staff satisfaction and wellbeing in the coming months, a higher

annual pay award might mitigate the effects of broader economic conditions and tax policy changes in the early part of 2022.

Wider issues

Pay and reward must be viewed alongside the other workforce and operational challenges in the NHS. Improved pay offers will only make NHS careers more attractive and sustainable if they are accompanied by a considered programme of work to improve the recruitment, retention, wellbeing, and morale of doctors across the country.

Operational pressures and pandemic impact

The NHS and its workforce are currently under immense and sustained pressure, with winter sitreps showing a 91.9% acute and general bed occupancy rate in the week of 10-16 January 2022.[15] Data from December 2021 shows that A&E attendances were up 27% compared to the same time in the previous year and the elective waiting list has reached six million patients[16]. A combination of winter pressure, the impact of the Omicron variant and a backlog of care from the initial waves of the Covid-19 pandemic mean that the health service and its staff have been under enormous pressure for almost two years. Against this backdrop, however, there have been areas of increased activity, for example, November 2021 saw a record number of patients seen by consultants after an urgent two-week GP referral[17]. This demonstrates the immense effort by staff to continue to deliver for their patients, but NHS Providers and trust leaders have been clear that this pressure is unsustainable in the long-term and that a fully costed and funded workforce plan is urgently required to ensure increasing demand can be met without undue pressure on already burnt-out staff[18]. Trust leaders have been clear in telling us that they are extremely or moderately concerned about staff burnout across their organisations (94%), with staff availability over winter one of their largest concerns[19].

[15] NHS Providers, Winter Watch, week 7: https://nhsproviders.org/nhs-winter-watch-202122/week-7

[16] Ibid.

[17] NHS Providers, blog, "We must keep recognising the extraordinary effort of NHS staff": https://nhsproviders.org/news-blogs/blogs/we-must-keep-recognising-the-extraordinary-efforts-of-nhs-staff

[18] NHS Providers, press release, "The demands on NHS staff are unsustainable": https://nhsproviders.org/news-blogs/news/the-demands-on-nhs-staff-are-unsustainable

[19] NHS Providers, reports, "State of the provider sector 2021": https://nhsproviders.org/state-of-the-provider-sector-2021-survey-findings/key-findings

A high level of vacancies in the NHS was an issue prior to the Covid-19 pandemic, with close to 9,000 FTE medical posts unfilled in the early months of 2020.[20] The volume of medical vacancies, particularly those in shortage specialties, not only impacts on service provision but also on the experience of existing staff who are afforded less flexibility due a lack of resilience in the service. These issues are compounded by geographical factors, with those in rural communities heavily reliant on locum, bank and agency staff. In 2019/20 the NHS spent £6.2 billion on filling staffing gaps, with £3.8 billion spent on bank staff and £2.4 billion on agency staff[21]. Rural trusts find it particularly difficult to attract junior doctors in medical speciality training, in part due to a lack of financial incentives to assist with their relocation, however the recruitment of consultants and middle-grade staff in these communities also presents difficulties[22].

Workload is an area of significant concern, particularly its impact on morale, mental and physical wellbeing and ultimately on staff retention. The General Medical Council's (GMC) annual *State of Medical Education and Practice in the UK* report confirmed an increase in burnout and dissatisfaction in the medical workforce, with 59% working beyond their rostered hours at least once a week and 17% at high risk of burnout. Of great concern are the 23% of doctors surveyed who said they were planning to leave the profession, an increase from 19% in 2019. Doctors who had taken 'hard steps' to act on leaving the profession had increased from 4% in 2020 to 7% in 2021[23]. Of those doctors considering leaving the service, 13% were planning to move their practice abroad, with research showing that drivers for leaving the UK are poor working conditions compared to those overseas, a desire to leave the NHS for more training and development opportunities and a better quality of life[24].

The last annual NHS staff survey found 44% of staff reported feeling unwell as a result of their work (compared to 36.8% in 2016), while 55.2% of staff work additional unpaid hours on a weekly basis –

[20] NHS Digital: NHS Vacancy Statistics England April 2015 – September 2021 Experimental Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2021-experimental-statistics

[21] UK parliament, questions for Department of Health and Social Care: https://questions-statements.parliament.uk/written-questions/detail/2020-07-08/71059

[22] NHS Providers, report, "Challenges faced by trusts operating in rural areas": https://nhsproviders.org/trusts-operating-in-a-rural-environment/challenges-faced-by-trusts-operating-in-rural-areas

[23] GMC, "The state of medical education and practice in the UK (2021)": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

[24] GMC, "Drivers of international migration of doctors to and from the United Kingdom": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/drivers-of-international-migration-of-doctors-to-and-from-the-united-kingdom

this is a reduction on previous year, but still represents a majority of staff[25]. Furthermore, responses to the Royal College of Physicians' (RCP) member survey found that one in five doctors feel overwhelmed at work every day, while 69% feel overwhelmed at least once a week[26]. These findings demonstrate the immense pressure that the medical workforce is under, and how this sustained pressure is not only damaging to staff mental and physical wellbeing but risks creating further shortages in the health service as doctors increasingly assess options for leaving the service or changing their working patterns.

With access to training and development opportunities cited as a reason for doctors considering leaving the NHS, it is concerning that over two thirds of respondents (64%) to our annual member pay survey told us they were somewhat concerned that the pandemic had disrupted continual professional development and training for doctors, with 17% saying they were very concerned by this. While there have been opportunities to mitigate this disruption through innovation and remote learning, there has been disruption to networking opportunities for doctors as well.

Pensions

In previous submissions, we have shared with the DDRB our concerns regarding the design of the NHS pension scheme as it interacts with taxation reform affecting mostly higher earning members of the medical workforce over the past 4-5 years. The NHS pension scheme undoubtedly provides generous benefits to its members and compares favourably in many respects to other public and private sector schemes across the economy. However, changes to tax rules and pension growth allowance 'thresholds' in recent years have created well publicised issues for senior doctors and managers in particular. The impact has been caused most notably by large – and sometimes unexpected – annual tax bills resulting from salary increases, promotions and/or working of additional hours.

In 2019, we canvassed members extensively on the effects of pension issues and in our briefing reported the finding that in 60% of trusts, clinical staff were less willing to take on leadership roles, and in 37% of trusts fewer staff were seeking or accepting promotions due to annual allowance taxation specifically.[27] There was significant concern around the need to restore an incentive for

[25] NHS England and NHS Improvement staff survey results: https://www.nhsstaffsurveys.com/results/national-results/

[26] RCP, "One in five doctors feel overwhelmed at work every day": https://www.rcplondon.ac.uk/news/one-five-doctors-feels-overwhelmed-work-every-day

[27] NHS Providers, An Unnecessary Divide: The impact of NHS pension taxation on trust leaders: https://nhsproviders.org/media/689074/pensions-20-briefing-1a.pdf

doctors to work additional shifts, while 69% of clinical directors surveyed said they had either declined or considered declining additional work or responsibilities due to the impact of annual allowance taxation.

The situation has improved following the government's welcome changes to tax rules – which increased the annual allowance income 'taper' thresholds – in March 2020. At the time, the government estimated that 98% of hospital consultants would be taken out of the scope of the taper, however we are aware that some senior doctors are still affected by annual and lifetime pension tax issues given the decision to retain these limits on pension growth and the associated financial penalties. The extent of the current impact is not clear, though we have received isolated reports that challenges remain around the receipt of tax bills associated with promotions, and in reference to operational challenges caused by the ongoing disincentive for the highest earning senior doctors to work additional hours in some circumstances. Conversations with the BMA have further illustrated these ongoing challenges post the March 2020 policy change.

Recently, DHSC concluded a consultation on proposed changes to pension contribution tiers. Some elements of these proposals – including alignment of tiers to AfC pay uplifts and fairer contribution rates for less than full time staff – are positive, and we have sympathy with arguments questioning the large contribution rates for higher earners. But overall, we believe the central initiative to flatten the contribution rate structure and increase employee contribution levels for some lower and middle banded staff is ill-advised due to the impact on take home pay for lower and middle banded non-medical staff in the NHS, particularly given wider conditions affecting the value of their incomes.

In our survey, there was a fairly even split of HRDs against the proposed changes (34% disagreed or strongly disagreed), supportive (36% agreed or strongly agreed), or neutral (31% neither agreed nor disagreed, or answered 'don't know). A significant majority of respondents (85%) were somewhat concerned (58%) or very concerned (27%) about the potential for lower and middle banded staff to leave the pension scheme as a result of higher rates, with only one respondent expressing no level of concern. Our response to this consultation, submitted to DHSC last month, sets out in full our position on these proposed changes.[28]

[28] See supplementary evidence: NHS Providers submission to DHSC pensions contribution rate consultation

National workforce plans and funding

The 2021 autumn budget and spending review did not include a specific funding rise for the DHSC workforce budget, which sits outside the NHS England and NHS Improvement (NHSE/I) ringfence. It only stated that there will be "hundreds of millions of pounds in additional funding over the SR21 period (2021/22-24/25)" in order to build the workforce (noting the need to support training for medical and nursing students, meet the manifesto commitment for 50,000 more nurses, and create a new pipeline of midwives and allied health professionals).[29] This lack of clarity means that there is currently no confirmation over the size and nature of the Health Education England budget for 2022/23, or any indication that a multi-year settlement will be forthcoming. The HEE budget – £4.5bn in 2021/22 – has declined by around half a billion pounds in real terms since the arms-length body's first settlement in 2013/14, when there were significantly fewer staff in the NHS than there are now.

This has meant that the HEE training and workforce development budget is spread far too thin, and cannot adequately support either the size and nature of workforce expansion required, nor the training and development needs of the existing workforce. HEE is due to merge with NHSE/I in 2023, and while there are pros and cons to this shift, the most important factor going forward will continue to be ensuring appropriate investment in the development of the current workforce and future domestic pipeline of staff into the NHS, regardless of whether or not funding for HEE as an agency moves into the NHSE/I revenue budget ringfence. In other parts of this submission we have noted encouraging signs around student numbers, particularly in nursing, and it will be important to ensure this progress is effectively utilised and sustained in future years.

Trusts have been innovating to improve the employment offer for their staff and implement the NHS People Plan, however this is against the backdrop of 48% of respondents to our survey saying they had seen evidence of staff leaving due to early retirement, burnout and other impacts of working throughout the pandemic[30]. It is reassuring to see that trusts are confident that their organisations are progressing in implementing the People Plan. 89% of HRDs were very confident or confident in their progress, and that these actions are making a positive impact on staff (66% of respondents were confident or very confident in this).

---

[29] NHS Providers, on the day briefing, "Autumn Budget and Spending Review 2021": https://nhsproviders.org/media/692396/october-2021-budget-and-csr.pdf

[30] NHS Providers, report, "Providers deliver: recruiting, retaining and sustaining the NHS workforce": https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce

However, there remains uncertainty as to how this plan will develop, and whether a next 'phase' or new form of workforce plan through DHSC and NHSE/I might be forthcoming in the near future. HEE's Framework 15 update, formally the "Long-Term Strategic Framework for Health and Social Care Workforce Planning", is a welcome development overall, but the terms of reference and HEE officials have both made it clear that this work will focus on setting the foundations and principles for future workforce growth without any specific assessments or projections on required workforce numbers to meet demand for care in the short, medium or long-term.

We wholeheartedly support HEE's aim to grow the workforce through the inclusion of 'more and different' types of healthcare professionals but the omission of true workforce supply and demand projections from this work will greatly diminish its value to trusts and the sector as a whole. To meet current and future demand, trust leaders are clear that a fully costed and funded workforce plan is needed to ensure long-term stability and to offer greater flexibility to staff and the service[31].

This could be achieved on the back of legislative change, should parliament accept an amendment to workforce planning provisions in the Health and Care Bill in the coming months, which calls for a statutory requirement for the government to produce independently assessed workforce projections. NHS Providers has been working with a number of key stakeholders across the sector, including the RCP, BMA and AoMRC, to support the development of this amendment which has been tabled and supported by former Health and Social Care Secretary Jeremy Hunt, alongside other prominent parliamentarians.[32] The amendment has considerable support across all parties in both houses and has been signed by a coalition of 90 health and care bodies in the UK.[33]

Inequalities

The NHS People Plan 2020/21 is clear that a sense of belonging for staff in the NHS is crucial, and that this should be underpinned by changes to ensure the workforce reflects local, regional and national communities, and to remove biases in systems and processes at work. As part of this, staff must be empowered to speak up when they have concerns[34]. As the People Plan acknowledges, the COVID-19

[31] NHS Providers, blog, "Government must publicly acknowledge scale of NHS workforce problems": https://nhsproviders.org/news-blogs/news/government-must-publicly-acknowledge-scale-of-nhs-workforce-problems

[32] https://www.standard.co.uk/news/uk/jeremy-hunt-care-quality-commission-health-care-government-b973830.html

[33] Strengthening workforce planning in the health and care bill: coalition principles: https://www.rcplondon.ac.uk/guidelines-policy/strengthening-workforce-planning-health-and-care-bill-coalition-principles

[34] NHS Providers, on the day briefing, "NHS People Plan 2020/21": https://nhsproviders.org/resource-library/briefings/on-the-day-briefing-nhs-people-plan-202021

pandemic has renewed focus on disproportionate inequalities within our society, and in turn, within the NHS. Urgent, focused and long-term actions are required to address inequalities, particularly race inequality within the NHS workforce.

The medical workforce in the NHS is diverse, with 41.9% of medics and dentists in trusts and CCGs from minority ethnic backgrounds, compared to 14% of the population. However, a deeper look at the data highlights an underrepresentation of minority ethnic doctors within consultant grades, as well as in clinical and medical director roles. Medical Workforce Race Equality Standard (MWRES) data published by NHSE/I also shows an ethnicity pay gap, averaging 7% per year less pay for minority ethnic consultants compared to their white consultant colleagues. Disparity extends into the recruitment process, with 80% of white applicants shortlisted for open positions compared to 66% of minority ethnic candidates. Minority ethnic staff are more likely to be bullied or harassed by other staff members, particularly when they are in training, and are twice as likely to receive a complaint or referral to the GMC for investigation[35]. Research from the GMC shows Asian doctors reported feeling less supported by their immediate colleagues and less likely to feel part of a supportive team[36].

NHS Providers and trust leaders believe it is a critical priority for the NHS to both accept the existence of structural racism in the service, and work to dismantle it. We are working to support trust leaders in this goal through our member benefits and board development programmes. As part of our 2021 'Race and health equality survey', 72% of responding trust leaders told us that evidence-based case studies would assist in accelerating their pace of change, while 67% felt that best practice learnings from other sectors would be a significant aid. To date (particularly since 2020) trust leaders feel that the most progress has been made in increasing leadership focus on the importance of staff networks (85%) and staff wellbeing (77%). However, only 4% felt that race equality is fully embedded as a core part of the board's business, demonstrating that there is still significant work to be done in this area.

A diverse and inclusive workforce incorporates considerations of gender, sexuality, religion, disability and age, which all intersect with race. Data from the British Medical Association (BMA) shows there is a gender pay gap of 18.9% for hospital doctors. This figure is adjusted to account for reduced working hours, with women in the NHS often working fewer hours. The unadjusted gender pay gap

[35] NHS England and NHS Improvement, "Medical Workforce Race Equality Standard (MWRES)": https://www.england.nhs.uk/wp-content/uploads/2021/07/MWRES-DIGITAL-2020_FINAL.pdf

[36] GMC, "The state of medical education and practice in the UK (2021)": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

for hospital doctors is 24.4%[37]. With regard to disability, research from the GMC shows that disabled doctors are twice as likely to be dissatisfied in their career, at high risk of burnout, while struggling with their workload and ultimately taking 'hard steps' to leave the profession. These measures have worsened over time with the gap between disabled and non-disabled staff widening, particularly with their workload and risk of burnout[38]. Information on sexuality and religion is limited, but the available data is clear that there is still much work to be done to ensure inclusivity, as outlined in the People Plan and People Promise.

Integrated Care Boards

It is clear that integrated care boards (ICBs) will eventually become the principle organising function for workforce planning moving forwards, coordinating a "one workforce" approach across each system (as per the ambitions of the People Plan 2020/21).[39] ICBs[40] will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care) and will be expected to support and collaborate with those who provide wider community services, including in local government, other public services and in the voluntary sector. If undertaken with full input from constituent partners, the process of fulfilling this responsibility may be a very useful grounding – but not a replacement – for national-level health and social care workforce planning, as it should capture levels of local need and opportunities for collaboration. Given that ICBs are also mandated to have both a medical director and a nursing director, the input of frontline service leaders should be embedded in this work, which is welcome.[41]

However, there are many elements of workforce management and employment relations which are not entirely possible, nor desirable, to undertake at system level. Local providers, including trusts, remain the principal, and legal, employer of their staff, and therefore responsible for their wellbeing, satisfaction, performance and other aspects of employment. Consequently, whilst ICBs will hold responsibility for workforce planning and the deployment of skilled staff to parts of a local system

[37] BMA, "Review of the gender pay gap in medicine": https://www.bma.org.uk/pay-and-contracts/pay/how-doctors-pay-is-decided/review-of-the-gender-pay-gap-in-medicine

[38] GMC, "The state of medical education and practice in the UK (2021)": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

[39] NHS England and NHS Improvement, "We are the NHS: People Plan for 2020/21 – action for us all", 30 July 2020: https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

[40] We have described systems as ICBs for the purposes of this submission, although they will not officially transition from Integrated Care Systems in name and structure until the anticipated passage of the Health and Care Bill through parliament in 2022.

[41] NHS England and NHS Improvement, "Interim guidance on the functions and governance of the integrated care board", page 8: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf

where they are most needed, the constituent organisations within an ICB still have a significant role to play in attracting and retaining staff. National guidance continues to emphasise that systems will mature at their own pace, and the focus of evolving ICB workforce policy should therefore be on supporting structures which enable regional and system people boards to align in the correct way, with a mix of organisational representatives around the table, to input into the workforce planning process for their area.

New roles and workforce expansion

NHS Providers is a member of the implementation group working with Health Education England (HEE) to develop a medical doctor apprenticeship pathway to tackle barriers that prevent access to more traditional training routes. There is hope that diversifying routes into medical careers will increase diversity in the workforce and accessibility. Additionally, utilisation of this new route in the service will help ease workforce pressures on wider teams. Trust leaders have told us that additional funding and reform of apprenticeships is crucial to make this a reality, with 88% of respondents to our annual pay survey stating decisions on funding and regulation of apprenticeships are very important or important to their organisation. Respondents also felt that flexibility and amendments to the apprenticeship levy would be of benefit to trusts, while additional funding from the government is essential for the fuller utilisation of new roles (53%).

HEE's *Future Doctor* report, published in 2020, cited the importance of generalism as a key priority to ensure flexibility for both future doctors interested in a broader skills-mix and a non-linear career pathway, as well as for the service to respond with agility to future demand and pressures. A pilot 'school of generalism' in the East of England has been developed in response to this and is the first in the UK to embed a generalist development programme into foundation training. There are 30 posts for F1s to start in August 2022,[42] and we look forward to seeing the impact this programme has on service delivery in the longer term.

Trust leaders are clear they would support the removal of the cap on medical school places, in addition to increased funding to support this expansion. Research by the Royal College of Physicians (RCP) in January 2021 estimates a doubling of medical school places to 15,000 per year would cost £18 billion[43]. The wider impact of any changes to the medical school cap needs to be considered fully

[42] Health Education England, "The school of generalism": https://heeoe.hee.nhs.uk/foundation/training-programme/school-generalism

[43] RCP, "Double or quits blueprint expanding medical school places": https://www.rcplondon.ac.uk/projects/outputs/double-or-quits-blueprint-expanding-medical-school-places

to ensure foundation training placements are appropriately increased at the same time. Furthermore, it is key that a shift in this policy is recognised as a long-term solution, resulting in an increase in the number of new doctors in the medical workforce a number of years down the line once training timelines are factored in. Additionally, once new doctors are in the workforce it is then also crucial to ensure their working environment is optimised to ensure retention within the NHS. Planning should also recognise that increased medical school places may not fully translate into a bolstered workforce, given rates of student attrition. Data from the Office for Students (OfS) shows a confirmed intake for the 2020/21 academic year of 10,461 students to medical schools and 1,198 for dentistry. The cap was removed due to the impact of COVID-19 on A-level results and examinations in 2020/21. The summary intake for 2021/22 is 10,543 for medicine and 1,109 for dentistry, with the cap again updated to reflect the effect of the pandemic on exams[44]. However, the target intake for 2022/23 has reduced back down to 7,571 for medicine and 809 for dentistry. This is 2,972 fewer medical students and 300 fewer dentistry students than 2021/22.

The COVID-19 pandemic also saw flexibility in the earlier deployment of final year medical students in a newly created FiY1 interim year prior to F1 placement, which resulted in students undertaking a placement from mid-April instead of from August. The GMC's *State of Medical Education and Practice'* report 2021 found that students who had completed a FiY1 placement felt more prepared for their first F1 post (79%, compared to 57% of F1s who did not complete FiY1). Research also suggested there was a small protective element on wellbeing, with 15% of those who had completed a FiY1 placement at high risk of burnout compared to 18% of those who did not[45]. Further research by the GMC found that the FiY1 placement was attractive to students, helping their transition to F1 and acting as a quasi-apprenticeship[46]. Initiatives to increase workforce flexibility have benefits for the health service and the workforce, tackling inequalities while allowing the flexibility both trusts, and individual staff need to deliver services in a sustainable way. The use of new roles within teams will increase flexibility for all staff, improving resilience. 66% of respondents to our annual pay survey felt that greater workforce flexibility would be enabled by greater use of staff in 'new roles'.

[44] Office for Students, Health education funding – medicine and dentistry: https://www.officeforstudents.org.uk/advice-and-guidance/funding-for-providers/health-education-funding/medicine-and-dentistry/

[45] GMC, "The state of medical education and practice in the UK (2021)": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

[46] GMC, "2020 medical graduates: the work and wellbeing of interim Foundation Year 1 (FiY1) doctors' during COVID-19": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/2020-medical-graduates---the-work-and-wellbeing-of-interim-foundation-year-1-doctors-during-covid-19

Trust leaders are clear that additional funding and reform from the government for ethical international recruitment is required – 98% of respondents to our pay survey ranked this as their most important source of additional funding. GMC research has shown that barriers to international recruitment are found in immigration policies, the registration process and the perception that the healthcare service is a difficult one to enter[47]. The Health and Social Care visa has since been introduced, but the cost of international recruitment to trusts is significant and it is important that internationally recruited staff are supported to integrate into the service and develop their careers. NHS Providers are supportive of ethical international recruitment. There is concern in the sector that the application process for international applicants is burdensome, leading to a withdrawal of applications, while rural trusts or those outside of large cities struggle to attract international recruits or do not have the in-house expertise to navigate the administrative process of recruiting from abroad. A 'one workforce' approach could help share expertise across systems, as is already happening in some parts of the country.

In response to the DDRB's request for more information on community dentists, our survey asked HR Directors whether their organisations are affected by the potential shortage in this staff group. Under half of respondents to the question in total said the issue applied to them, and within that group (48%) reported that their organisation is either somewhat (37%) or significantly (11%) affected by a potential shortage. The findings were inconclusive on the whole, particularly given a considerable proportion of respondents (27%) to this question who felt this question was applicable to their organisations, but said they were neither affected or unaffected by the issue, or did not know.

Flexible working and productivity

NHSE/I published *'the future of NHS human resources and organisational development'* report in November 2021, which builds on the foundations laid out in the People Plan 2020/21 to improve flexibility and new ways of working in the health service. The report notes a shift to portfolio careers, increased importance of work/life balance and flexibility, and a need for flexible training offers[48]. Trust

[47] GMC, "Drivers of international migration of doctors to and from the United Kingdom": https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/drivers-of-international-migration-of-doctors-to-and-from-the-united-kingdom

[48] NHS England and NHS Improvement, the future of NHS human resources and organisational development: https://www.england.nhs.uk/wp-content/uploads/2021/11/B0659_The-future-of-NHS-human-resources-and-organisational-development-report_22112021.pdf

leaders have told us that they are seeing increased desire for flexibility from their workforce, with non-linear career pathways more common, as well as requests for flexibility as staff approach retirement[49].

However, data from the most recent NHS staff survey shows that only 38.4% of respondents agree that there are enough staff within their organisation to allow them to do their job properly, while 47.7% agreed they were able to meet the demands on their time at work[50]. Our *'Providers Deliver'* report, published in November 2021, showcases the efforts and best practice examples of trusts working to support their workforce and improve flexible working options[51].

Despite the actions laid out in NHSE/I's *'future of NHS human resources and organisational development'* report, and the efforts of trust leaders, attempts to implement meaningful, long-term flexibility are hampered by a lack of resilience in the service due to an overstretched workforce and a large number of open vacancies. Without both increased staffing capacity in the short-term and a fully costed and funded workforce plan that accounts for future demand on the service, it will be difficult to implement and maintain these flexible practices in a meaningful way. It is also crucial that there is a system level focus embodying the 'one workforce' approach – this will allow for equity across systems, while ensuring pressure is not exacerbated within those same systems.

As in past years, our survey of HR Directors this winter asked about interventions which could enable greater workforce productivity within trusts. Flexible working was a feature of the responses to this question, with 30% of trusts saying more flexibility to deploy staff across a system would be one of the three most beneficial interventions. The most selected responses, however, were improved use of technology (chosen by 85% of HRDs), greater use of staff in new roles (66%), and enhanced support for staff mental health and wellbeing (36%).

[49] NHS Providers, report, "providers deliver: recruiting, retaining and sustaining the NHS workforce": https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce

[50] NHS England and NHS Improvement, NHS staff survey results: https://www.nhsstaffsurveys.com/static/afb76a44d16ee5bbc764b6382efa1dc8/ST20-national-briefing-doc.pdf

[51] NHS Providers, report, "providers deliver: recruiting, retaining and sustaining the NHS workforce": https://nhsproviders.org/providers-deliver-recruiting-retaining-and-sustaining-the-nhs-workforce

Further information and contact

We would be pleased to supply any further supplementary information and respond to questions from the Review Body on Doctors' and Dentists' Remuneration. We look forwards to discussing the evidence further in our scheduled oral evidence session.

For more information, please contact NHS Providers' workforce policy advisor, Sarah White, via email at Sarah.White@nhsproviders.org