NHS Employers

NHS Employers' submission to the Doctors' and Dentists' Review Body 2025/26

25 November 2024

Contents

Key messages

Diagnosis: Darzi report

The Independent Investigation of the National Health Service in England report by Professor Lord Darzi sets out clearly the multiple challenges the NHS is struggling to manage. Lord Darzi describes rising demand, the effects of a decade of underinvestment (especially in capital) and the impact (and recovery) from the COVID-19 pandemic.

The report highlighted several key issues, most notably how much less capital is available for the NHS to invest in its essential infrastructure in terms of buildings, technology and equipment. It also states that previous structural reforms have removed management capacity that is essential in terms of achieving and delivering further productivity gains linked to the provision of services. Lord Darzi, in his letter to the Secretary of State, described a workforce facing profound challenges: -

‘There is also compelling evidence that, post-pandemic, too many staff have become disengaged, and there are distressingly high levels of sickness absence – as much as one working month a year for each nurse and each midwife working in the NHS.

The experience of the pandemic was exhausting for many and its aftermath continues to reverberate. NHS staff not only mourned deaths of their colleagues on the frontline but were at the sharp end of the Covid rules. They had to insist that mothers gave birth alone

and that elderly and other patients had to die without the comforting touch of their loved ones. The result has been a marked reduction in discretionary effort across all staff groups.'

Response: Ten-year plan

Employers in the NHS welcome the ambition and vision the government has set out in its response to Lord Darzi's diagnosis. They share the commitment to build a health and social care system fit for the future around three clear 'shift' priorities on the future delivery of care and services:

1. Hospital to home – so that more people can access care at home and in their local communities.
2. Analogue to digital – so that the workforce we need can have access to the technology to deliver the best care possible.
3. Treatment to prevention – with very clear moves made to a more prevention-based approach.

These will be significant and stretching changes to make. As part of our work within the NHS Confederation, the views of employers around the case for changes are set out in more detail in the following reports:

– Working Better Together in Neighbourhoods

– Paving a New Pathway to Prevention: Leveraging Increased Returns on our Collective Investment

– Raising NHS Capital Funds; Options for Government

Employers are ready to support the work needed to develop policy solutions that reflect the balance required between immediate priorities and the plans to deliver tangible and sustainable changes over the medium-to-longer term, and the priority actions that will need to be taken forward to implementation in local systems.

The new ten-year plan will, in turn, drive a refresh of the NHS Long Term Workforce Plan (LTWP). Employers will want to see that any refresh of the LTWP is matched with and supported by sustainable funding that builds on the investment to stabilise NHS finances announced in the October 2024 Budget. There will also need to be more explicit recognition of the role that pay and reward must play in the delivery of the three shifts and the attraction, recruitment, retention and morale and motivation of staff now and in the future.

Wider government policy

In addition to the ten-year plan and the refresh of the LTWP, the government's planned agenda to 'make work pay' places a new emphasis on enhancing workers' rights, with the aims to create a fairer and more equitable working environment for everyone. Key parts of the plan include the employment rights bill, day one flexible working rights and a genuine living wage for all. While many of the changes proposed by the government to take effect in 2026 are already part of the NHS employment in whole or large part, there are several areas where employers across the NHS will need to think through the implications due to the minimum standards changes being proposed for all workers across the UK.

Investment in headline pay awards

After the resolution of the medical workforce pay disputes and periods of industrial action, employers would like investment in headline pay award uplifts to be prioritised in the 2025/26 pay round.

Awards should be fully funded and sustainable, allowing employers to continue to prioritise workforce growth and improvements to services.

We do not recommend any targeted pay actions across the medical workforce staff groups. Any pay uplifts should be applied equally to all staff.

Impact of industrial action

- Employers welcome the conclusion of industrial action with the pay deals accepted by consultants, SAS doctors, doctors in training and their dental counterparts.

- Different pay award settlements between medical and non-medical staff groups and some dissatisfaction with the final position on pay deals continue to create industrial relations tensions. There is some anxiety that this could result in further industrial action. Employers are concerned that any progress they make to rebuild relationships, improve financial positions, reduce waiting lists and improve working lives could be hindered if periods of industrial action start to become a regular feature of annual pay rounds.

Doctors and dentists in training

- We will support employers by implementing the pay deal agreed between government and the British Medical Association (BMA), which includes a pay increase that covers 2023/24 and 2024/25. We will collaborate with the Department of Health and Social (DHSC) as it approaches reforms to the training and rotational placements system, in line with principles agreed as part of the pay deal. Exception reporting will be renegotiated to ensure doctors are compensated for all time worked above contracted hours in the future.

- Flexible pay premia (FPPs) are in place to incentivise working in certain specialties, such as general practice, psychiatry, and emergency medicine. However, there are ongoing issues with the application of FPPs that we wish to explore further with key stakeholders.

Specialty and specialist grade (SAS) doctors

- NHS Employers is supporting employers by implementing the pay deal agreed between government and the BMA, which includes reforms to address the imbalance between old and new SAS contracts. Three priority actions to support career progression for SAS doctors will also be taken forward, including developing advice and guidance, exploring national levers to establish specialist roles, and ensuring proper utilisation of the acting-up clause.

- The role of the SAS advocate, introduced with the 2021 SAS contracts, is crucial for maintaining engagement and collaboration among SAS staff. In organisations where this role has been fully supported, it has led to improvements in recruitment, retention and the overall wellbeing and morale of SAS doctors. Employers have noted positive experiences and increased visibility for SAS doctors with access to an advocate. Our shared intention with the BMA is to encourage all NHS organisations to appoint the role of a SAS advocate.

Consultants

- We are supporting employers by implementing the pay deal agreed between government and the BMA, which includes reforms to the consultant pay scale, pay progression processes and the introduction of shared parental leave provisions. Employers have raised concerns about the additional administrative work that will be necessary to support the new pay progression process.

- We are working with national stakeholders to resolve issues related to the reform of local clinical excellence awards (LCEA), particularly the interactions between pre-2018 LCEAs and National Clinical Impact Awards.

- No further funding is expected to be available for any further significant reform of the 2003 contract in the short-to-medium term. In the meantime, we will continue to seek to build a robust evidence base to inform any future contract reform discussions and to make the case for reform of this national contract as a longer-term priority.

- Following the end of the pay deal implementation work for each of the remit groups listed above, we will focus on re-establishing the respective joint negotiating committees (JNCs) to oversee and maintain the national terms and conditions of service (TCS).

Salaried primary care dentists

- Employers are facing significant challenges in recruiting entry-level salaried primary care dentists. This has resulted in prolonged vacancies, with some positions remaining unfilled for extended periods despite being widely advertised.

- The LTWP seeks further exploration of possible measures to encourage dentists to spend a minimum proportion of their time delivering NHS care in the years following graduation. This initiative is expected to necessitate changes to pay structures and terms and conditions of employment. We are actively seeking input from employers to ensure their views are considered in developing this plan.

- Salaried dentists have reported significant levels of verbal and physical abuse from patients, often stemming from frustrations related to access to care and long waiting times. This abuse has a detrimental impact on the health and wellbeing of these dentists, leading to increased stress and burnout and does not help to alleviate attraction, recruitment and retention pressures for this important staff group.

Locally employed doctors

- The rise in the number of locally employed doctors (LEDs) is partly driven by more less-than-full-time (LTFT) posts for doctors in training, gaps in training allocations, and increasing workload pressures. LEDs provide a stable workforce as they do not rotate like doctors in training.

- There is a growing focus on supporting LEDs in their education and career development. While LEDs are crucial for service provision, ensuring they have access to educational resources and career development opportunities can improve retention, patient safety, and support training programmes.

- We will continue to raise issues associated with LEDs as part of the work on the planned refresh of the LTWP.

Differences between and challenges presented by contract variations in different parts of the UK

- Divergence continues to emerge as the devolved nations agree on a variety of pay and non-pay solutions to support established collective bargaining arrangements and resolve pay disputes. We are unaware of any evidence suggesting that contractual variations between the devolved nations are significant enough to impact recruitment and retention in England.

Medical staffing teams

- Medical staffing teams provide essential operational people services to support the NHS's medical and dental workforce, with team structures varying across different NHS organisations.

- These teams face growing challenges due to complex medical contracts, recruitment and retention issues, increased workload arising from prolonged periods of industrial action, and managing the growing numbers of part-time and flexible working arrangements across the medical workforce.

- While some medical staffing teams feel supported by senior leadership, most feel under-recognised and under-resourced to deliver on a widening range of medical workforce initiatives to improve the working lives of doctors. Many have called for external accredited role-specific training to help deliver their responsibilities.

Digital infrastructure

- NHS organisations would like a national framework to validate pay and contract rules, supported by digital systems to reduce pay errors, legal challenges and manual processes, which would provide greater accuracy and consistency thereby improving staff morale and efficiency.

NHS Pension Scheme

- There have been several notable developments in the NHS Pension Scheme over the past year:

  – Partial retirement: introduced to the 1995 Section of the scheme from October 2023.

  – McCloud remedy process: ongoing efforts to address age discrimination in public sector pensions.

  – Member contribution structure: completion of planned changes.

  – Pension abatement and lifetime allowance: permanent removal.

- Some of these changes aim to aid retention and increase workforce capacity and are showing early signs of success. However, further evaluation is needed on the medium-to-longer-term benefits linked to these changes. Implementing these changes requires consistent commitment and resource allocation from employers to ensure equitable delivery across the workforce.

Pay body review processes and associated timetable

- As part of the pay deals, the government committed to reviewing and making changes to the operation of the DDRB process (considering the views of the BMA, British Dental Association (BDA), Hospital Consultants and Specialists Association (HCSA), other trade unions, and employers), with the intention that these changes be implemented so that they apply for the 2025/26 round.

- Employers welcome these first steps in returning to a timelier annual pay process. They would like this progress to continue to be prioritised in future pay rounds, enabling the return to prompt payment of pay award changes to be made at the beginning of the financial year. This would also help significantly in terms of budget and financial management processes.

Informing our evidence

We welcome the opportunity to submit our evidence on behalf of NHS-employing organisations in England. We recognise the Doctors' and Dentists' Pay Review Body's (DDRB) crucial role in offering expert insights and an impartial perspective on remuneration and broader employment issues concerning doctors and dentists.

By continuously engaging with a diverse range of NHS organisations, we have gathered our findings to understand and articulate their priorities.

Our interactions included engagement with:

- Employers, via a series of employer focus groups and a variety of established and time-limited engagement networks
- employer representatives, who sit on our joint negotiating committees for consultants, SAS, trainees, and dentists
- our regional guardians of safe working hours network (specific to doctors and dentists in training)
- our contracts experts' group (medical staffing leads) and the medical and dental workforce forum, a sub-committee of the NHS Employers policy board.

We act as a link between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies.

We are part of the NHS Confederation, the membership organisation that brings together support and speaks for the whole healthcare system. Our submission reflects employers' views on the challenges faced by the NHS regarding their medical and dental staff.

Section 1 - Context setting

Introduction

Employers have been facing significant and longstanding pressures since the recent period of industrial action affecting the NHS commenced in December 2022. Sustained strike action by medical and non-medical staff groups has taken place against a backdrop of sustained operational and financial pressures on the NHS, exacerbated by ongoing workforce shortages, care backlogs, and growing demand.

For many medical and dental staff, their concerns are not just about pay levels but also about their working conditions. High levels of vacancies and demanding workloads have a detrimental impact on staff wellbeing and morale.

There is an emphasis now on the need for more clinical activity while delivering financial savings by reducing workforce numbers. Factors affecting productivity include complex patient cases, increased sick leave, industrial action, social care workforce challenges and rising temporary staffing costs.

Employers have described those financial constraints and the need to reduce costs while maintaining or increasing service delivery, has become increasingly more challenging. The struggle to balance

quality improvement with operational demands can further impact productivity.

Industrial action

Employers welcome the conclusion of industrial action with the pay deals accepted by consultants, SAS and resident doctors.

- Consultants pay deal agreed on 5 April 2024.
- SAS pay deal agreed on 18 June 2024.
- Resident doctors pay deal agreed on 16 September 2024.

It has been noted that the language emerging from the BMA leadership and sections of their membership following acceptance of the agreement indicates an underlying dissatisfaction with levels of pay, which may result in further industrial action.

We are also aware of the government's plan to repeal the Strikes Act 2023, which may also influence and increase the risks associated with managing further industrial action. Employers remain concerned that any progress they can make to rebuild relationships, improve financial positions, reduce waiting lists and improve working lives could be hindered if they enter into and have to manage another period of industrial action.

The JNCs were suspended during the prolonged industrial action period. This has delayed activity associated with supporting the application and maintenance of nationally agreed terms and conditions of employment. We will be focused on rebuilding positive relationships with trade unions to reinitiate the JNCs once the pay deal packages are implemented.

Employers have felt the financial strain from the period of industrial action when maintaining safe rotas, paying for cover and

implementing contingency plans to maintain services. While the operational impact of the pay disputes became more manageable through experience, improved planning and the gradual resolution of disputes, the impact on elective backlogs has been significant, with employers under pressure to tackle them.

The prolonged industrial action has also strained local industrial relations, particularly where operational challenges have persisted.

Employers are describing difficulties in returning to pre-industrial action extra-contractual rates. The BMA rate cards have been removed as part of the pay deals. Where integrated care boards (ICBs) and other groups of employers collaborate on arrangements for securing extra-contractual consultant work, it has been agreed that this should be done in consultation with those employers' joint local negotiating committees. Affordability concerns are a real driver for employers when resetting local medical and non-medical staff rates. Still, employers report that the BMA repeatedly challenges them to enhance those rates for doctors.

Extra contractual work

Extra-contractual work is arranged by mutual agreement between the doctor and employer. The pay rate for extra-contractual work can vary across employers and could depend on factors such as the doctor's grade or when the shift occurs. During doctors' recent industrial action, the BMA published recommended minimum rate cards for doctors to use or consider when considering agreeing to extra-contractual work requests. As part of the pay deals for doctors and dentists in training, SAS and consultants, the BMA agreed to withdraw their rate cards in England immediately following each pay offer's acceptance.

Some employers are reviewing their bank and agency spending across their multidisciplinary teams as part of financial analysis. As part of the deals for SAS and consultant doctors agreed by the

government, it was agreed that in instances where integrated care boards (ICBs) and other groups of employers collaborate on arrangements to set new rates for securing extra-contractual work for doctors, this should be done in consultation with employers' joint local negotiating committees (JLNCs).

General practice collective action

GP practices are independent businesses contracted to provide services for the NHS. Staff working in general practice are usually employed directly by the GP practice and not by the NHS.

The BMA GP Committee England (GPCE) held a non-statutory ballot of its members, which resulted in collective action commencing on 1 August 2024. NHS England has asked that the public come forward as usual for care during collective action, as practices will still be open and see patients. However, some GPs may direct patients to other local services.

Despite employers not feeling the impact of collective action, there is a growing concern that this will soon start to be visible and if media attention on GPs increases, this could lead to further pressures on emergency departments through the challenging winter months.

Productivity challenges

Workforce leaders continue to be challenged to increase productivity levels. NHS England is driving the need for more clinical activity while asking employers to deliver financial savings by reducing workforce numbers through recruitment freezes and a review of roles created since the start of the pandemic.

Other factors affecting NHS productivity include impacts and recovery from the COVID-19 pandemic on main activity levels, patients presenting with more complex cases, increased sickness

absence, industrial action, the impact of social care workforce challenges on discharge and flow, and an increase in temporary staffing costs. Staff engagement and leadership experience have also been highlighted as influencing productivity, with workforce leaders keen to emphasise the importance of addressing these, too.

NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan (LTWP) was published on 30 June 2023. It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period and working in new ways to improve staff experience and patient care.

While the LTWP has clear goals for staff recruitment into the NHS, the range of measures needed to better retain existing staff have been more difficult to secure, with high vacancy rates continuing across the medical and wider NHS workforce.

While it seeks to improve staff working conditions, it is unlikely to provide immediate solutions to resolve current recruitment and retention challenges facing employers.

The government has signalled that it intends to develop a ten-year plan for health and care. This follows Lord Darzi's independent investigation that highlighted the significant pressures facing the NHS, as noted above. It is expected that the LTWP will then need to be reconsidered in light of this plan once published.

Autumn Budget – October 2024

The Chancellor has delivered a one-year budget (termed Phase 1) setting out both an updated 2024/25 spend and next year's planned funding. A longer-term Spending Review will follow in the 'late spring' (called Phase 2).

The health and social care revenue budget will increase to £200.5 billion in 2025/26 and its ring-fenced sub-budget for NHS England will increase to £192 billion. The NHS England increases are frontloaded to help fund pay deals and other immediate cost pressures.

The medical and dental workforce – key statistics

Workforce full-time equivalents (FTE)

Our 2024/25 DDRB evidence stated that in August 2023, there were 135,794 full-time equivalent (FTE) doctors and dentists. In June 2024, there were 140,745 full-time equivalent (FTE) doctors and dentists. This is an increase of 3.6 per cent.

Contract	FTE
Consultant	57,013
SAS	12,614
Resident doctors	70,303
Other / local grades	815
Total	140,745

Vacancy rates

NHS Digital data shows that in 2023/24*, medical vacancy FTE stood at 15,237, which is an increase of 2.0 per cent from the previous year.

See Annex A for further details on the medical vacancy rate since 2016.

*Due to the availability of data, the years specified in the data run from June-June.

The data in Annex A shows a slight growth in vacancies since 2016/17. There is a trough in the data from 2019-2021 but this can be accredited to the COVID-19 pandemic. Since 2022, vacancies have returned to usual levels.

Leavers

NHS Digital has reported that the total number of doctors leaving the UK workforce decreased between 2022/23 and 2023/24 by 1.6 per cent.

Annex A details the NHS Hospital and Community Health Services (HCHS) doctor leavers since 2010/11; HCHS doctor reason for leaving since 2011/12; and HCHS doctor total leavers since 2011/12.

The data shows that doctors in training consistently make up most of the total number of leavers yearly. This is due to how the data is recorded. For example, when a doctor or dentist in training changes placement and moves trust, they are recorded as leaving despite still being in the NHS. As a result, their unusually high leaver rate can be somewhat ignored.

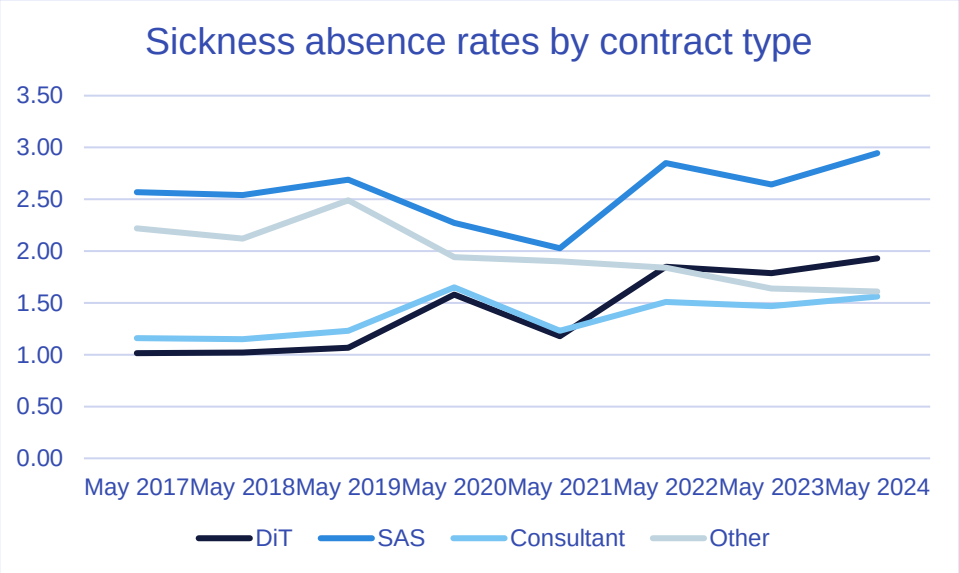
For the other three contract categories (consultant, SAS and other/local), the leavers numbers are fairly consistent each year, with only slight increases since 2010/11.

Doctor average sickness absence rates

The sickness absence rate is the percentage of working time that employees are absent from work due to illness.

The data below show that sickness absence rates have increased from the previous year for all contract types except ‘other’. (‘Other’ is all doctors who are not employed on one of the national contracts). SAS doctors have the highest sickness absence rates of all the categories, peaking at 2.95 per cent in May 2024.

Doctor	Average sickness absence rates (%)							
	May 2017	May 2018	May 2019	May 2020	May 2021	May 2022	May 2023	May 2024
Doctors and dentists in training	1.02	1.02	1.07	1.58	1.18	1.85	1.79	1.93
SAS	2.57	2.54	2.69	2.27	2.03	2.85	2.64	2.95
Consultant	1.16	1.15	1.23	1.65	1.23	1.51	1.47	1.56
Other	2.22	2.12	2.49	1.94	1.90	1.84	1.64	1.61



Safety at work

Sexual safety at work

Employers are taking significant steps to ensure sexual safety at work through the implementation of the NHS Sexual Safety Charter.

Employers have described creating local policies to ensure that all incidents of sexual harassment/assault are investigated and that all facts are recorded and reported. They are creating a culture in which everyone feels safe speaking up and raising concerns, as well as supporting those affected.

Workforce and racially motivated violence

We have heard from employers about how they are responding to the impacts of the recent riots and racist attacks on staff. Employers have condemned the racist violence, emphasising a zero-tolerance policy towards any form of discrimination or abuse against NHS staff. This stance is crucial in maintaining a safe and supportive working environment for all medical and dental staff.

In response to the civil unrest in summer 2024, we published guidance on how to deal with employees who may have been involved in racist or criminal activity, either physically, or on social media.

International recruitment

The NHS's continued reliance on the global workforce has been well documented. In our 2024/25 written evidence to the DDRB, we reported on the significant international recruitment activity in the NHS. These staff make up a large and growing proportion of the registered medical workforce and bring a range of positive benefits.

International medical graduates (IMGs) need specific support and induction when they join the NHS, and NHS Employers continues to promote the use of the national induction package Welcoming and Valuing International Medical Graduates. The Medical Workforce

Race Equality Standard report published in July 2021 also highlighted other issues affecting IMGs, such as the higher rate of referral to the GMC, and we are participating in ongoing work with other stakeholders to tackle this disparity. Many IMGs also work as locally employed doctors, which will be addressed further in Section 3 of this report.

NHS Staff Survey

The statistical results of the NHS Staff Survey provide invaluable insight into NHS staff's experiences. The most recent report, based on engagement with staff in autumn 2023, provides a snapshot of how people experience their working lives, gathered at the same time each year.

The NHS Staff Survey is considered key in helping national stakeholders monitor the delivery of the NHS LTWP.

The annual report is published in early spring each year, so it does not align well with the pay review body's evidence-gathering processes.

Rather than incorporating detailed findings from the 2023 report in our evidence submission, the key points we would like to highlight are set out below. Our response to the report provides a helpful summary of our thoughts on the findings.

- The rate of improvement around satisfaction with pay for medical staff did not improve at the same rate when compared with nursing staff and the overall average. The fall in satisfaction was broadly similar for all medical groups but the overall level of satisfaction was 39.30 per cent for consultants and only 13.60 per cent for doctors in training.
- Analysis of the eight key People Promise and staff engagement themes shows a similar pattern for the medical and dental workforce. While their scores did see an

improvement across the board, it was not at the same rate of improvement as for the other staff groups.
- 9 per cent of staff have experienced sexual harassment, with this figure rising to a quarter among ambulance staff.

In addition to NHS Staff Survey data on sexual harassment, a British Medical Journal report stated that nearly a third of female surgeons had been sexually assaulted by a colleague.

The data on sexual harassment in the NHS shows that there are issues to understand and address across all staff groups, not just the medical profession and the ambulance service, which is where a lot of the work has been progressing to date. In November we published guidance on creating safer workspaces, free from sexual harassment, misogyny and sexual misconduct.

The publication of the NHS Staff Survey 2024 report will be made available in March 2025 to help inform the DDRB's considerations for the 2025/26 pay round.

Medical staffing teams

The medical staffing profession provides operational people services to NHS organisations' medical and dental workforce. The makeup and name of medical staffing teams vary across the NHS, with some teams having several team members with different roles and responsibilities and others having one staff member who covers a range of responsibilities.

We recognise that the successful delivery of medical and dental workforce improvements and ensuring positive working experiences for doctors are contingent upon well-established and resourced medical staffing teams. This involves in-depth onboarding and training to build the knowledge and understanding of multiple complex medical contracts. Where medical staffing teams are well resourced and include experienced team members, doctors are more likely to have a more positive workplace experience.

Contract complexities

Existing contractual complexities, such as the application of a wide range of contractual safeguards and pay protection arrangements, alongside an increase in more flexible working patterns, increases the difficulties associated with effectively and efficiently deploying the medical and dental workforce. Our Medical Staffing Workforce Review described the challenges the medical staffing workforce faces in navigating these complexities. Recruitment and retention issues often arise due to the specialist knowledge needed to be effective in this role.

Workload

NHS England's letter to NHS trusts on improving the lives of doctors in training noted above, outlines actions to address the concerns of resident doctors who rotate. While responsibility for action will be held by boards, medical staffing teams will be tasked with much of the work required to make the necessary improvements. Employers have raised concerns about possible impact on capacity, workload, stress and burnout for this group of staff.

During the prolonged industrial action, medical staffing teams worked to plan staff rotas to ensure safe staffing levels were maintained. This increased their workload through the administration and deployment of locum cover. The pay deals agreed to resolve industrial action contain non-pay elements and medical staffing teams will have a central role in implementation of the new arrangements locally.

The pay deal arrangements have generated a considerable amount of manual work in order to implement the backdated pay uplifts. There were complexities around doctors and dentists in training who had rotated out of trusts, which also creates additional work. The backpay element of this particular deal may also impact on individual tax arrangements and employers will need to consider how best to support staff on managing this issue.

Employers have indicated that the new pay progression processes for SAS and consultant doctors have also created additional administrative tasks for medical staffing teams.

Due to the increase in part-time and flexible working for doctors and dentists, hospital headcount in the medical workforce has increased. This introduces greater degrees of complexity as medical staffing teams are required to create more bespoke rota patterns. These rota patterns often leave sporadic shifts unfilled, which are more challenging to fill. This has increased temporary staffing issues, displacing the medical staffing team's time and restricting their ability to progress initiatives to improve the working experiences of doctors. While accepting that some degree of contractual complexity is unavoidable, we are increasingly looking for more sustainable solutions to pay and contractual issues to help employers manage evolving service delivery challenges in line with contractual terms.

Specialist knowledge and support

Employers have described the recruitment and retention of medical staffing teams as consistently difficult. Vacancies caused by the departure of longstanding staff members can create a huge gap in specialist knowledge. Training new staff members to the appropriate level of knowledge takes a substantial amount of time, which then has an impact upon the delivery of business-as-usual tasks.

While medical staffing teams have stated that they are supported by chief people officers and senior leadership teams, official role-specific training with an option to become accredited with a medical-staffing-specific course would be welcomed.

We have created a medical staffing hub that highlights key resources and information associated with the national medical and dental contracts. This hub is a tool for employers to help onboard new medical staffing team members and provide a platform to

disseminate relevant medical and dental workforce news and updates.

Digital infrastructure

NHS organisations procure software solutions for contract and regulatory compliance and payroll calculations. Workforce deployment software systems include job planning, rostering, temporary staffing systems and ESR.

Employers have expressed a need for a national accreditation framework that provides validation of pay and contract rules for digital systems. This would help to ensure that pay is more consistently calculated in line with contractual entitlements, enable better interoperability between different software solutions and minimise the need for manual calculations. Suitable training and technical support would help onboard new systems and staff.

Employers continue to highlight numerous examples of staff making legal challenges in response to incorrect payments. Resolving payment discrepancies often consumes valuable time for medical staffing teams and doctors. Inconsistent or incorrect payments can decrease morale among staff and affect local industrial relationships.

Section 2 - The remit groups

Doctors and dentists in training

Pay deal

Resident doctors commenced strike action in March 2023. Industrial action continued through the remainder of 2023 and into 2024, with the longest period of five consecutive days of strikes taking place in July 2023. This prolonged period of industrial action damaged relationships and morale across the whole NHS workforce. A considerable amount of work will be required to build reconciliation and improve resident doctor's experiences in the workplace.

Health leaders have welcomed the successful resolution of the long-running pay dispute between resident doctors and government. The removal of the immediate threat of more strikes will allow better deployment of resources over what is expected to be a very difficult winter.

While there is still a long way to go to address all the issues raised by resident doctors, including their experiences of the quality of work, education and their rotational system, we hope that discussions can move forward now pay has been agreed.

We look forward to working with the BMA, the Royal Colleges, the General Medical Council (GMC) and NHS England to find resolutions

to these issues and to taking forward the non-pay parts of the agreement, including a revised approach to exception reporting.

Funding made available by government for the pay deal has been applied as follows:

- Pay for 2023/24: government investing an average of an additional 4.05 per cent into 2023/24 pay scales for doctors in training. Uplifts will be applied to the pay scales for the 2016 and 2002 contracts as well as to local pay scales which mirror those contracts. The effective date is 1 April 2023, with payment to reflect backpay.

- Pay for 2024/25: government accepted the recommendations of the DDRB and uplifted each nodal point by 6 per cent plus £1,000, on a consolidated basis, with an effective date of 1 April 2024.

Employers have highlighted the complexities arising from a pay deal in which arrears are paid as one lump sum in the current tax year that also includes back pay from a previous tax year. Amending returns and calculating each employee's tax can be an administrative burden for employers, which they will often voluntarily support on a case-by-case basis. Some employers have described not having the resources to support the work of this manual process for the whole of the affected workforce, so doctors will need to individually engage with HMRC processes directly.

As well as the investment in pay, additional measures aimed at improving the experiences of resident doctors have been agreed as part of the deal:

- Exception reporting: doctors must be paid/receive time off in lieu (TOIL) for all time worked above contracted hours subject to making an exception report. We will work with the BMA, DHSC and NHS England to revise the provisions applicable to exception reporting based on a number of jointly agreed principles.

- Rotational placements: DHSC will lead a partnership approach to reform the current system of training and rotational placements, and we will contribute to the discussions.

Introduction of the term ‘resident doctor’

The BMA wrote to NHS Employers to share that from 18 September 2024, it will no longer use the term ‘junior doctor’ but instead use ‘resident doctor’. Resident doctors include all doctors and dentists in training and those in comparable roles working alongside them as locally employed doctors. This wider definition means that we will continue to use the term ‘doctors and dentists in training’ where appropriate to do so, and use the term resident doctor in our communications, where we would previously have used junior doctor.

Actions to improve the trainee experience

Employers have shared that it continues to be difficult to dedicate time and resources on their own organisational work programmes related to trainee experience, due to the industrial action and associated capacity constraints.

Despite this, examples of good practice and progress continue to emerge, including a greater focus on engagement with doctors to understand what priority actions should be taken.

We are also aware of a range of other examples of making physical improvements to on-call rooms and out-of-hours facilities, alongside other positive developments in rota oversight and management (including explorations of technical solutions such as those that support self/preferential rostering approaches); providing greater access to health and wellbeing resources; and some are undertaking work to improve payroll functions for new trainees in an effort to ensure their basic pay and enhancements are correct before the first payroll.

On 25 April, NHS England issued a letter to all trusts outlining the importance of addressing issues that negatively impact the working lives of doctors in training. The letter outlined several requirements that organisations were asked to undertake against the following themes:

- Increase choice and flexibility: better rota management and deployment.
- Reduce duplicative inductions and pay errors: streamline and improve HR support.
- Create a sense of value and belonging for our doctors.

The initiatives were broadly welcomed by employers whose boards are now expected to take responsibility for this agenda. Further details on supporting resources for employers will be necessary to help prioritise the required activity locally.

Additional work will continue to contribute to pressure on medical staffing teams and may result in other priorities not being progressed.

Financial initiatives in place to incentivise working in particular areas or specialties - flexible pay premia in England.

The 2016 doctor and dentists in training TCS introduced a range of flexible pay premia (FPP) which intended to encourage recruitment in certain specialties. These specialties included general practice, psychiatry and emergency medicine. The premia are only payable to those on the 2016 TCS pay scale.

Values of the flexible pay premia are confirmed in version 5/2024 of the medical and dental pay and conditions circular.

Employers continue to report that the application of the FPPs causes confusion when aligned with different training pathways, and in the

application of any necessary pay protection provisions. There have also been reports from employers that some of the listed hard-to-fill specialties are no longer difficult to recruit to. We will discuss these issues once the JNC has been reestablished following conclusion of the current pay deal implementation phase.

Our expectation is that evidence will be provided to the DDRB in a future round (principally from NHS England, which manages the recruitment round fill rates) about hard-to-fill training programmes and other uses for FPP. This will allow the DDRB to review the use of the payments and make recommendations on their application and value.

General Medical Council's national training survey

The GMC's National Training Survey 2024 results was published in July 2024. It demonstrates issues within the postgraduate training system and underlines the priority of increasing the capacity of the trainer workforce.

Burnout remains a key factor in this year's report. Over a fifth (21 per cent) of doctors in training are at high risk of burnout, while 29 per cent of trainers are at moderate or high risk of burnout. Trainers reported struggling to complete their work and responsibilities within the time allocated.

Employers must work towards creating a safe and supportive working environment. This includes addressing issues of bullying and harassment, which, although slightly decreased, remain areas of concern.

However, overall satisfaction with doctors in training has improved. Many trainees reported positive experiences with their training programmes. The quality of support and supervision has improved, with many trainees feeling well supported by their trainers and educational supervisors.

Specialty and specialist grade doctors

Pay deal

In late 2023, SAS doctors voted in a ballot that resulted in an outcome in favour of taking strike action. While strike action didn't take place, the government and trade unions entered negotiations to resolve the dispute. An initial offer was rejected in March 2024.

The offer accepted by trade union members in June 2024 includes a pay scale reform to address the imbalance between old and new SAS contracts, as described in previous evidence submissions.

The targeted funding was applied as follows:

Contract	Pay uplift value
2021 contracts	between 6.1 and 9.2 %
closed pre-2021 contracts	£1,400 (pro-rated where appropriate)

The pay increases were paid in August 2024 salaries and backdated to 1 April 2024, as detailed in pay and conditions circular (M&D) 4/2024.

As part of the proposal to support career development for SAS doctors, the DHSC, NHS Employers, NHS England and the BMA are taking forward three priority actions:

- To develop advice and guidance specifically to support career progression for SAS doctors.
- Explore what national levers are available to encourage, establish and embed specialist roles in order to provide career development opportunities for SAS doctors

- Ensure that specialty doctors undertaking a specialist grade role are properly utilising the acting-up clause (Schedule 19 of the terms and conditions of service).

The national stakeholders are also working in partnership to form a programme of work reviewing how employers can create more specialist roles and agree to:

- promote job planning to take place to enable SAS doctors to work optimally with access to appropriate opportunities

- collaborate on a joint piece of work with the objective of helping SAS doctors to progress through the portfolio pathway.

Transition to 2021 contracts

Overall SAS headcount Jan 2024 - Aug 2024								
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
New contracts	6,627	6,770	6,854	6,978	7,083	7,177	7,244	7,693
Old contracts	6,255	6,196	6,134	6,064	5,980	5,937	5,889	5,930
Total	12,882	12,966	12,988	13,042	13,063	13,114	13,133	13,623

In our 2024/25 DDRB evidence we stated that our data showed that 48 per cent of the SAS workforce is on the new contracts, compared to 52 per cent on the old contracts. As of August 2024, 56 per cent of the SAS workforce is on the new contract.

This demonstrates that there is a continuous increase in new contracts, although it has been slower and lower than the rate that the original forecast predicted.

Employers have described a recent increase in requests from SAS doctors to transfer to 2021 contracts. Employers link this response to the SAS pay deal agreed in June 2024. The latest data shows an increase of 448 SAS doctors on new contracts between July 2024 and August 2024, compared to an increase of 67 between June 2024 and July 2024.

Employers have also reported supporting transfers but are currently unable to further promote transfers to the new contract due to capacity constraints. We will produce updated guidance to support employers with SAS doctors who wish to transfer to the new contract.

Specialists

Region	East of England	London	Midlands	North East and Yorkshire	North West	South East	South west
Specialist headcount	104	176	270	168	155	294	200

Total new specialist roles April 2021 – August 2024.

The midlands and the south continue to have the largest specialist contracts, while the east of England has seen the lowest creation of specialist contracts. Employers have reported that funding for specialist posts remains an issue due to current financial restraints.

SAS advocates

The role of the SAS advocate was introduced as part of implementing the 2021 SAS contracts. This role is key to maintaining strong engagement and collaboration among SAS staff, which benefits everyone including employers.

Giving SAS doctors access to an advocate shows the employer's commitment to improving their experience and allows the sharing of good practice. Employers have described a positive experience for

SAS doctors who have access to an advocate and an improvement in the health and wellbeing, morale and visibility of the SAS workforce within the organisation.

While there are no mechanisms for collecting data on the number of advocates in post, we are aware that many employers have not yet appointed SAS advocates. Those that have, and have appropriately resourced the role, noted improvements in recruitment and retention of their SAS doctors. SAS advocates also provide support by reviewing SAS doctor job descriptions and person specifications to ensure that the best candidates are appointed to SAS roles.

The role is an additional responsibility for an existing employee and is not intended to replace existing support for SAS doctors.

SAS Week 2024

SAS Week provides employers with the opportunity to celebrate the specialty and specialist doctor and dentist workforce (SAS) and raise its profile as a rewarding career and a much-valued part of the NHS workforce.

SAS Week has a theme for each day. For 2024, these included SAS as a career choice and SAS charter, specialist grade, SAS in extended roles and SAS development, Equalities and the Medical Workforce Equality Standard (MWRES), SAS advocates, and SAS wellbeing.

Initial evaluation of the week shows that engagement on social media was higher compared to previous years. There is evidence to suggest that there has been an increase in local events being planned during the week, with more national stakeholders also taking part and creating their own supporting content.

NHS Employers created SAS Week in 2022. Over the last three years it has grown and employer engagement has increased

substantially. Many employers have developed their own locally scheduled SAS Week, including award ceremonies, celebrations, showcasing of good practice and conferences in response to the successes of the national event. SAS Week is delivered in partnership with the BMA.

During the week, new resources are released each day to highlight the important work of the SAS doctors and dentists and resources that employers can use to support this workforce.

A series of webinars was held during the week, presented with stakeholders such as the Academy of Medical Royal Colleges. The College covered the topic of the specialist role, including empowering progression and tapping into the talent of the SAS cohort; strengthening the SAS workforce; and the SAS advocate role: the value it brings to SAS doctors and how to ensure your organisation appoints one.

SAS pay progression

A closed gateway pay progression process, which completed the five-pay point structure, came into effect on 1 April 2023, for those SAS doctors on 2021 contract terms.

The new pay progression system is intended to enhance and strengthen existing processes, underlining the employer and doctors' mutual obligations and will:

- enable doctors to reach the top of the pay structure more quickly
- allow doctors to progress to the next pay point after a minimum of three years
- introduce a closed gateway model of pay progression by incorporating a simple process between SAS doctors and their clinical manager and ensure that pay progression is achieved

where clinical managers are satisfied that the doctor has met the required standards.

However, many employers have raised concerns about securing the necessary additional capacity and buy in that will be required to deliver this more robust approach to managing pay progression gateways. We will continue to check in with employers on progress made in implementing the new arrangements as part of ongoing employer engagement activities.

Teaching, training and supervision capacity

Employers have described being concerned about the capacity of senior doctors to meet the demands of teaching, training and supervising doctors in training and any locally employed doctors, where this has been agreed locally. This is due to the increase in headcount, with more doctors opting to train/work LTFT. Many of the support mechanisms in place will be bespoke to the doctor and not a default response to the post.

As set out in the Academy of Medical Royal Colleges SAS as Educators report, SAS doctors and dentists are a diverse group of the medical workforce. Specialists and associate specialists have a minimum of ten years' experience and carry out work at a senior level. They are well placed to undertake educational roles with many already in roles as postgraduate and undergraduate educators.

NHS England's Educator Workforce Strategy has been designed to set out actions that lead to sufficient capacity and quality of educators across healthcare. SAS doctors and dentists should be considered for educator positions given their varied experience that they can apply to these posts.

Consultants

Pay deal

Consultants commenced strike action in July 2023, with the longest period of three striking days taking place in October 2023. The government and trade unions negotiated a deal, which consultants accepted in April 2024.

We are continuing to support employers in implementing the pay deal, including reforming the consultant pay scale, pay progression processes and the introduction of shared parental leave provisions.

Contract	Pay uplift value
2003 contract	Between 2.9% and 10.6%

The pay increases were paid in May 2024 salaries and backdated to 1 March 2024, as detailed in pay and conditions circular 1/2024.

The contractual entitlement to access an annual LCEA round ceased on 1 April 2024. The annual award round from 1 April 2023 to 31 March 2024, which was based on evidence before 1 April 2023, was the final LCEA round.

Pre-2018 LCEAs were retained and these awards remained pensionable and consolidated. The value of these awards was frozen. Pre-2018 LCEAs are awards granted prior to 1 April 2018 under local clinical excellence awards schemes in place as of 31 March 2018. The review process for these awards has been removed.

In May 2024, the consultant 2003 contract was re-published to include updates to the consultant pay scale and included the entitlement to shared parental leave.

It was agreed that an updated pay progression process would commence on 1 April 2025. Consultants reaching a pay point that results in a salary increase will attend a pay progression meeting with their clinical manager to determine if they have met the criteria to progress. Once the pay progression meeting has been completed and the doctor has met the criteria, the necessary action to open the pay point will be taken.

It will be the norm for consultants to expect to achieve pay progression and the intention is not to prevent those who are achieving expected standards from moving through the pay scale. Employers are concerned that this process will bring an administrative burden that will likely fall to medical staffing teams. Capacity challenges for clinical managers to participate in meetings has also been highlighted. Employers welcome the end to the dispute but are also concerned about the impact on capacity of clinical managers, given the additional administration work necessary to support the revised pay progression process.

Following the implementation of the pay deal, we will work with stakeholders and trade unions to plan a return to formal governance of the 2003 contract via JNC (consultants).

Local clinical excellence awards (LCEA)

We will continue to work with our national stakeholders to resolve residual issues associated with the reform of LCEA arrangements, primarily concerned with interactions between pre-2018 LCEAs and National Clinical Impact Awards.

Reform of the 2003 consultant contract

Due to the government's current financial challenges and its focus on fiscal prudence, no further funding is currently expected to be prioritised in the short-to-medium-term to invest in any significant reform of the 2003 contract.

Therefore, the JNC's priorities will remain focused on maintenance of the current contractual terms.

Alongside the planned contract maintenance agenda, we will revisit and refresh the evidence base for what employers would want from a reformed consultant contract, should the opportunity to do so arise in the future. Employers have described the 2003 contract as ‘outdated’, with its provisions making it challenging to deliver services that meet the needs of a more varied and complex range of working patterns that have developed since the contract’s inception.

Partial retirement

Employers have highlighted the complexities around applying partial retirement flexibilities for consultants, particularly those not seeking to reduce their total working hours while accessing the provisions.

We will continue to liaise with national NHS Pension Scheme leads to develop updated guidance on pension flexibilities to support the retention of experienced consultant staff.

Differences between and challenges presented by contract variations in different parts of the UK

We have sought views from trusts operating around England's borders to better understand any recruitment and retention challenges they are experiencing. While responses were limited, our assumption is the position represented in our evidence last year remains, and that this is not an issue for employers in England.

An analysis of the latest pay scale values (Annex B) across the medical contracts highlights that the pay scales remain relatively aligned regardless of the different annual pay awards applied across the devolved administrations.

The remit group divergence is clear to varying degrees across each contract. However, as a range of additional benefits are associated with their respective reward packages, a simple comparison of pay scales does not reveal significant financial push and pull factors affecting employers in England.

To illustrate the ongoing incremental divergence, the Welsh SAS committee recently confirmed acceptance of the 2023/24 pay offer for SAS doctors in Wales, which included a 4 per cent uplift to the 2023/24 pay award for associate specialists. In England's pay deal, associate specialists were awarded a consolidated pay uplift of £1,400. As part of the Welsh deal, the period covered by premium pay time for 2021 specialty doctor and specialist contracts has reverted to 7pm to 7am, from a previous alignment with the 2021 SAS contract (England) of 9pm to 7am.

Salaried primary care dentists

Salaried primary care dentists are a relatively small group of dentists spread across various providers within different sectors for which we maintain national terms and conditions. Community dentistry is generally referred to as a salaried service, a managed service in which dentists have a contract of employment to fulfil and service standards to meet.

We will aim to gather employer views to feed into dental activity emerging from the LTWP. The LTWP seeks to introduce a requirement for dentists to spend a period working for the NHS after training, which is likely to require changes to both pay and terms and conditions.

The LTWP highlights that the details of wider proposed changes to dentistry will be set out in a forthcoming dental plan. Our priority will be to engage and participate in this emerging work programme, securing evidence from employers as and when necessary to feed into discussions.

Employers are reporting continued difficulties in recruiting entry-level salaried primary care dentists. Salaries are no longer deemed competitive with wider remuneration levels across general dental practice or other areas of dentistry. They have described recruiting for band A roles as becoming increasingly more difficult, and vacancies remain unfilled for long periods. Although vacancies are advertised widely, employers often don’t receive a single application.

Abuse and violence remain a concern for salaried dentists. Salaried dentists have experienced verbal and physical abuse from patients. This is often due to frustrations around access to care and waiting times. This has significantly impacted salaried dentists' health and wellbeing, resulting in some requiring time off or leaving dental services altogether.

Section 3 - Locally employed doctors

Background

Locally employed doctors (LEDs) are those employed directly by trusts on terms different to those provided by national contracts and are excluded from the DDRB's remit.

All NHS employers can recruit staff on terms and conditions as they see fit, to respond to local needs as necessary.

Many LEDs work under terms based on national contracts, with the 2016 doctors in training contract being the most common. LEDs often hold similar seniority and work hours as doctors in training, although there are exceptions like postgraduate clinical fellowships. A significant number of LEDs are international medical graduates (IMGs) for whom this role represents their first work experience in the UK. Recently, there has been a trend of doctors in training temporarily or permanently transitioning into LED positions.

Contracts

Our message to employers is that the 2016 TCS is the most appropriate basis for local contracts for most LEDs. This is particularly the case where LEDs work directly alongside doctors in training, as it ensures parity in remuneration and consistency around safe working hours.

We have seen an increase in trusts moving to mirror the 2016 TCS in their local pay scales, away from local contracts that mirror closed grades. A key driver in this is to meet the expected rates of pay in the Certificate of Sponsorship (CoS) application process which is based on the 2016 pay scales.

Existing points of contention remain where the national contract may not correlate easily with a local contract, particularly around pay progression, study leave and access to the guardian of safe working hours. Many trusts will take local approaches to these points, which may lead to inconsistencies.

Data

Accessing accurate national data for LEDs remains a real challenge due to the lack of consistency in codes used within Electronic Staff Records (ESR). Our message to employers is that the pay codes MT01-05 should be used for LEDs employed on terms that mirror the 2016 national contract used for employment of doctors in training.

Many LEDs remain employed on closed pay codes (such as the MN37 pay code), which can be difficult to differentiate from doctors in training who remain on the same codes due to pay protection arrangements introduced with the 2016 contract.

Some employers have also created unique ESR codes to reflect bespoke local contracts where there isn’t (or had previously been) a suitable equivalent among the national contracts.

Providing accurate national data on the employment of LEDs is crucial in understanding this area of the workforce. However, it is likely to be a complex and time-consuming task for many employers.

Increasing numbers of LEDs

Numerous causes exist for the increase in LEDs in the NHS, most notably the increase in LTFT posts for doctors in training, gaps in training allocations and increasing clinical pressures.

Generally, the increase in LEDs is seen as neither positive nor negative by employers, but simply as a consequence of changing needs for medical staffing.

There are several aspects that make employing an LED attractive to employers. Employers have greater control over working patterns, and this ensures a more consistent and present workforce as there is no requirement to rotate. This is particularly the case with the frequency of rotations in some training programmes.

The obvious disadvantage is the lack of NHS England funding for such posts and as such any associated costs are covered by the employer.

Additionally, the majority of LEDs are IMGs. For many of these individuals an LED post is their first experience of working in the NHS, so additional support is often needed to ensure that they can work safely at the required level. This can include an extended period of induction or adjusted duties until the employer is satisfied that the LED is safe to work at the required level.

Education and career development

There is growing recognition of the need for better educational and career support for LEDs. While LEDs are crucial for service delivery their access to training is inconsistent, largely because their posts are trust funded without designated training budgets. Some employers offer support voluntarily, but this varies widely.

Many employers advocate for central funding to enhance LED development, which could improve retention, patient safety and the readiness of LEDs for training roles. However, there are concerns that supporting LEDs should not undermine the training of doctors in training. Some trusts have begun to designate LED tutors or leads to oversee their educational development.

Contract length

Concerns have been raised about the short-term contracts offered to LEDs, often as brief as four months, which creates insecurity and financial burdens especially for IMGs who need to reapply for work rights. Some employers have introduced 'rotational' LED roles, allowing for longer-term positions while providing varied experience.

Most LED roles last no longer than 12 months, with some transitioning to SAS posts. However, contracts shorter than two years have led to dissatisfaction among LEDs wishing for stability, as this may be a strategy to avoid granting full employment rights. Employers are encouraged to transition longer-serving LEDs to national contracts like the specialty doctor contract, although local contracts may still be used in specific contexts, particularly when working alongside training doctors.

Section 4 – NHS Pension Scheme

Introduction

In the past year, the NHS Pension Scheme has seen significant developments, including the introduction of partial retirement for the 1995 Section (starting October 2023), progress on the McCloud remedy process, updates to the member contribution structure, and the permanent removal of pension abatement and the lifetime allowance.

These changes aim to improve workforce retention and capacity, with early signs of positive impact. However, a thorough evaluation of their effectiveness is still needed. It's important to recognise that these changes require ongoing commitment and resources from employers, who manage the implementation and ensure fairness across the workforce.

Summary of the NHS Pension Scheme and opt-out data.

Scheme participation remains high, with 1.8 million active scheme members paying pension contributions into the NHS Pension Scheme (as at 31 March 2024). The NHS Pension Scheme accounts 2023-24 provide details of opt outs, new entrants to the scheme, deferred members who re-joined and the number of re-employed

pensioners in the year. Membership rates for doctors specifically remain stable, with no significant changes to report.

According to the most recent information about opt-out rates, the reasons given for more than half of opt-out instances are related to affordability: either ‘affordability’ or ‘temporary opt out due to financial priorities’. The latter has seen an increase from 34 per cent to 41 per cent in a 12-month reporting period. This highlights that NHS staff continue to find it difficult to prioritise paying into the pension scheme due to rising cost-of-living pressures. It should be noted that this isn’t necessarily just as simple as a scheme cost issue. It may also be influenced by individual behaviours and how they perceive saving for their future self, particularly as financial priorities can quickly change in their immediate day-to-day lives.

As we reported last year, membership flexibilities include the option to opt in and out of the scheme multiple times in any given year. Opt-out data suggests some members use this method to balance their personal finances or to manage their pension growth for pension tax reasons, but there is a danger that members opt out and then do not return, meaning that they will be missing out on the benefits of the scheme, such as death in service. We look at this option in our video on the benefits of continuing NHS Pension Scheme membership. The video explores the challenges for members balancing the cost of membership against other financial commitments and the benefits members receive in return.

We believe that introducing flexibilities that enable individuals to have control over what level of their pay is pensionable would enable more affordable access and a way for a member to manage their pension tax position. The NHS Pension Scheme offers additional valuable benefits such as life assurance, retirement flexibilities and ill-health retirement that are also lost if members choose to opt out. Our value of the NHS Pension Scheme poster supports employers to raise awareness of the key benefits and to promote the overall value of the scheme to all parts of their workforce.

Pension communications

Timely, clear and simple communication about the NHS Pension Scheme is crucial for member understanding especially given its complexities, including multiple sections, the McCloud remedy and tax considerations. Effective communication allows members to make informed financial decisions regarding their pensions. Delays in communications, particularly related to the McCloud remedy, could undermine trust in the scheme.

Recognising that the average reading age in the UK is nine, communications should be accessible and in various formats to accommodate all members. Many individuals avoid pension communications due to their complexity, which is a common issue beyond the NHS. To address this, there is a need for employers to enhance awareness and facilitate pension discussions within NHS organisations.

The availability of pension expertise varies across NHS organisations, complicating the support provided to staff. Employers are encouraged to direct members to resources like the NHS Pensions online member hub for tailored support. We also aim to use simple language in our communications and produce various resources to help. We collaborate with NHS Pensions to ensure consistency in guidance, particularly regarding flexible retirement and McCloud communications.

Flexible retirement

We know that the way society considers retirement is changing. There is no longer the expectation that retirement means leaving the workplace and employment completely or indeed permanently, or that full-time work should be replaced immediately with full-time retirement.

Our flexible retirement web page explains the options in more detail and provides examples to show how flexible retirement can support

staff to retire in a way that suits their individual circumstances. This year, existing flexible retirement options were extended to members of the 1995 Section:

- Partial retirement allows members to access from 20 to 100 per cent of their pension benefits while continuing to work in the NHS and continue contributing to the scheme.

- Members who retire and return may now rejoin the 2015 scheme to build up further pension benefits.

- The 16-hour rule was removed, allowing 1995 Section members to work without restrictions in the first month after returning from retirement, aiding capacity.

We have reported that retiring flexibly benefits and supports employees towards the end of their careers to achieve a healthy work-life balance, bridge the financial gap between taking their NHS pension and state pension benefits, and control their pension growth. Flexibilities come with a level of additional complexity and communicating flexible retirement clearly is incredibly important to overcome this complexity.

Greater flexibility enables employers to retain experienced staff for longer, aiding succession planning, workforce capacity and delivery of high-quality patient care. Experienced staff are also vital in supporting the development and supervision of apprentices and students. Supporting the health and wellbeing of employees approaching the end of their careers can also help to improve sickness absence rates and productivity, while reducing rates of stress, fatigue and burnout. Our flexible retirement guidance supports employers to discuss the options with staff and develop effective flexible retirement policies to improve retention.

The introduction of partial retirement in the 1995 Section of the NHS Pension Scheme in October 2023 has shown early positive uptake, indicating significant interest in balancing retirement with continued

work. The long-term impact on retention and workforce challenges will become clearer as data is collected on how long these partial retirees remain in service.

Employers are reporting difficulties achieving the 10 per cent reduction in pensionable pay required to access partial retirement, particularly for clinicians who do not wish to reduce responsibilities/capacity. We are advising that, in this instance, it may be better to use retire and return arrangements and that it is good practice to maintain the employee's pre-retirement terms and conditions in the new contract of employment.

McCloud

The review body is aware of the McCloud remedy, which aims to eliminate age discrimination in public service pension schemes, including the NHS Pension Scheme. However, the remedy increases scheme complexity, particularly regarding potential annual allowance tax charges that may affect long-serving clinicians already mindful of their pension tax liabilities. This complexity can hinder members' understanding and decision-making about their pensions and may lead to frustration for those who have already navigated their financial planning during the remedy period.

NHS Pensions is focused on improving communications to help members understand these complexities, prioritising quality over quantity to avoid overwhelming them with information. The McCloud remedy may allow some members to access higher-value benefits earlier than expected, potentially enabling earlier retirement without the need to supplement their pension income. While employers can promote flexible retirement options, the remedy might reduce the incentive for some members to continue working. The scheme's range of flexible options remains important for encouraging longer careers in the NHS.

Pension taxation

Last year our submission included reports of staff taking early retirement, reducing their work commitments, and a reluctance to apply for promotions or take on additional work and responsibilities due to the impact of pension taxation. As a result, workforce capacity, service delivery and patient care concerns were raised. Changes were announced in the 2023 Spring Budget and introduced from April 2023, to help to alleviate some of these pressures.

The removal of lifetime allowance (LTA) has had a positive impact on workforce capacity. Those who may have been affected will no longer need to decrease work commitments or retire early as a way of reducing their liability. Similarly, the uplift of the annual allowance and the thresholds for the annual allowance taper means that more senior clinicians can continue or increase their work commitments without being affected by the annual allowance.

An individual's decision to retire is based on many drivers, including personal, health, family and financial circumstances. Therefore, it is not possible to collate evidence to quantify the specific impact of the tax changes on retention, as this relates to behaviour change when previous intentions may have been unknown and are not recorded.

At the time of writing this submission, we do not have data to show how many members of the NHS Pension Scheme have pension growth exceeding the new annual allowance of £60,000 compared to how many members breached the lower annual allowance in previous tax years.

We know that some employers continue to offer locally implemented pension contribution recycling schemes. However, due to the pension tax changes, many employers are removing these as they feel they are no longer required.

Our pension tax guidance page provides employers with further information on pension tax and signposts to support for those who

may still be affected by pension tax issues. Our NHS Pension Scheme annual allowance ready reckoner supports members to assess their annual allowance liability to help manage their tax position.

Pension abatement

The government has extended the suspension of NHS pension abatement rules for special class status members until March 2025, with plans for permanent removal aimed at supporting workforce retention. While it is challenging to quantify the impact of this change on retention and workforce issues, the removal of abatement sends a positive message about the scheme, encouraging members to continue or return to work post-retirement. Although abatement historically affected a small number of members, its removal resonates broadly due to widespread confusion about its application.

April 2024 scheme changes

In April 2024, changes were made to the member contribution structure in line with the consultation outcome published by DHSC.

Indexation of member contributions

We were pleased to learn that changes included indexing uplifts to the member contribution structure each April, in line with the consumer price index (CPI) figure from the previous September. This change came into effect from April 2024 and has given certainty to members and to employer pension administration teams.

Member contribution rates for 2024-25

Tier	Pensionable pay (tier thresholds from 1 April 2024)	Contribution rate from 1 April 2024 based on actual pensionable pay
1	£0 to £13,259	5.2%
2	£13,260 to £26,831	6.5%
3	£26,832 to £32,691	8.3%
4	£32,692 to £49,078	9.8%
5	£49,079 to £62,924	10.7%
6	£62,925 and above	12.5%

The new contribution rates from 1 April 2024 are set out in the table above. The structure has moved from 11 original tiers to these six tiers, to flatten the contribution structure as the membership moves to be in the 2015 Career Average Revalued Earnings (CARE) scheme as opposed to the final salary 1995 and 2008 Sections of the scheme.

Employer contribution rate

From 1 April 2024 the employer contribution rate was increased to 23.7 per cent. This is up from 20.6 per cent for the period 1 April 2019 to 31 March 2024. The administration levy remains 0.08 per cent collected at the same time and in the same way as employer contribution rates. In practical terms this means employers are paying 23.78 per cent of pensionable pay.

Employers pay 14.38 per cent of contributions, while the remaining 9.4 per cent is centrally funded. While we welcome any increases to the employer contribution rate being centrally funded, we would welcome clarity on the future of this funding arrangement and mechanism.

It is important for employers to continue to see the value of the scheme contribution rate through impact on attraction, recruitment, motivation and retention of the workforce and for the administration levy to continue to provide value for money in terms of an effective scheme administration provision.

Looking to the future

Scheme flexibilities

The LTWP emphasises the need for actions to modernise the NHS Pension Scheme, particularly by introducing greater flexibility in contribution levels and benefit values. This flexibility could encourage more members to join and remain in the scheme, enhancing the overall reward package and improving workforce retention.

The proposal includes allowing members to choose lower contributions for reduced pensions, which could strengthen the scheme as a tool for reward and recognition. Additionally, exploring ways to combine flexible pension accrual with the recycling of unused employer contributions could benefit both staff and employers.

However, modernising the scheme will increase complexity for both members and employers, making it essential to ensure adequate resources for pension administration. Clear communication about these flexibilities is crucial to avoid overwhelming members and to help them make informed financial decisions.

Autumn Budget 2024

NHS leaders support the government’s ambitions to meet the rising complexity of patient need, hit performance targets and deliver the best possible care for patients. Employers recognise that investment

must come with reform and so will do everything they can to rise to the challenge so that the NHS can meet the government's expectations on productivity and performance improvements.

The funding will need to cover recently agreed pay deals for resident doctors and other NHS staff, meet growing demand, recover performance against key targets and transform the way local services are delivered. There will also be some big challenges ahead across mental health and community services, and primary care in particular, especially as winter approaches.

We hope that the government will use next year's Spending Review and ten-year strategy to continue to increase revenue spending and capital investment to give the NHS the long-term financial security it needs going forward. This budget is the start of a journey towards a sustainable future for the NHS, which will be delivered through the government's three shifts.

NHS Employers has summarised the key areas of the Budget that impact the NHS and its workforce.

The NHS Confederation has published a media statement on the Budget announcements and a more detailed member briefing with summary and analysis.

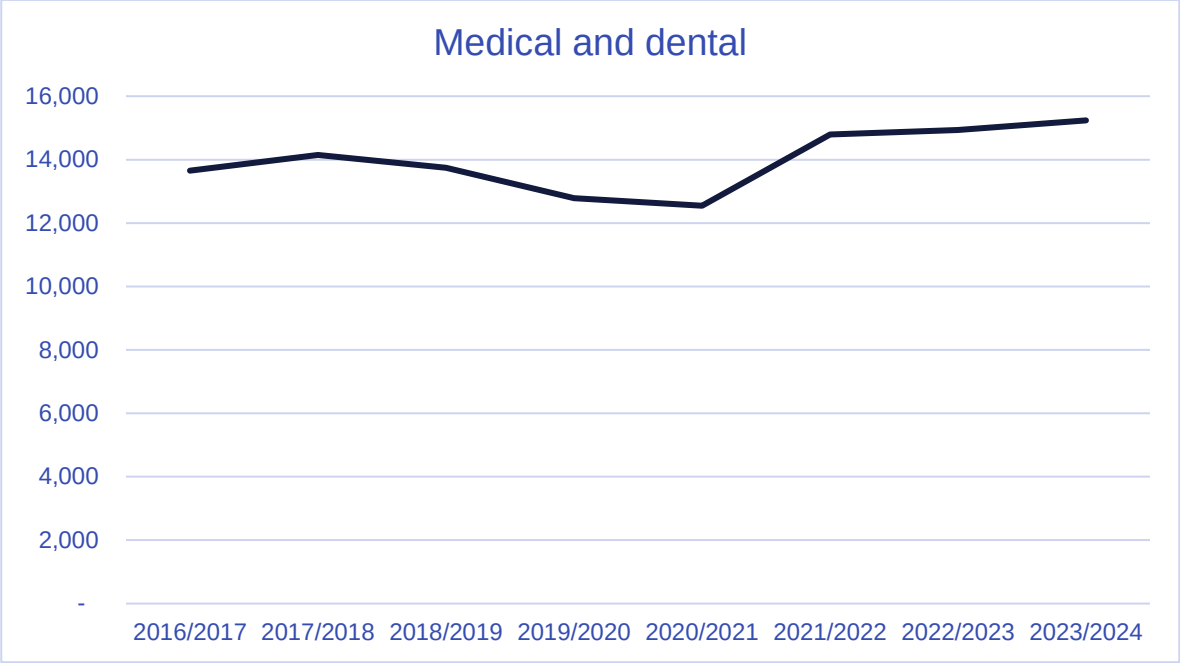
Annex A

Vacancy and leaver data

Vacancy data

(*Due to availability of data, the years are calculated from June-June)

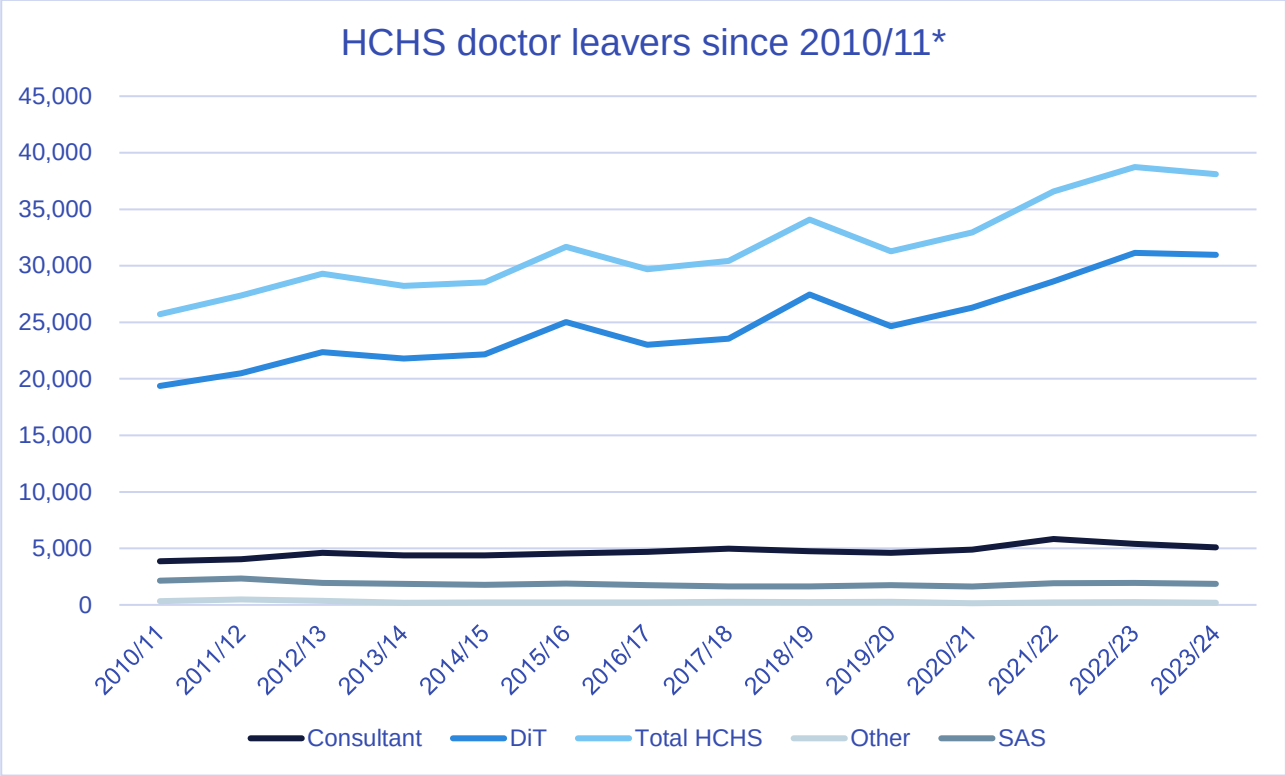
Year*	2016/17	2017/18	2018/19	20/19/2020	2020/21	2021/22	2022/23	2023/24
Medical and dental	13,650	14,143	13,742	12,781	12,547	14,798	14,939	15,237



Leavers Data

(Due to availability of data, the years are calculated from June-June)

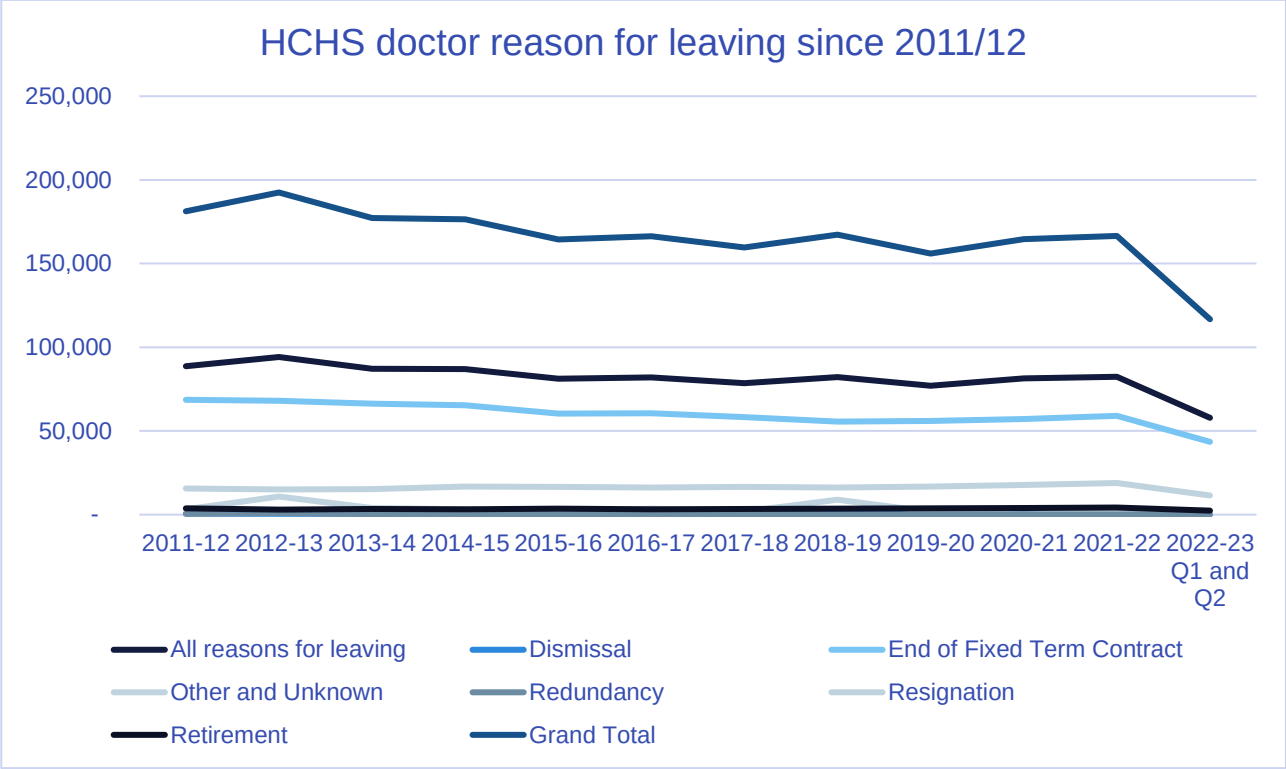
Contract Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Consultant	3,862	4,050	4,618	4,383	4,370	4,547	4,684	4,964	4,753	4,593	4,880	5,828	5,390	5,084
DiT	19,369	20,491	22,372	21,794	22,161	25,018	23,024	23,546	27,451	24,662	26,291	28,625	31,140	30,980
SAS	2,151	2,334	1,935	1,852	1,783	1,888	1,755	1,644	1,626	1,752	1,625	1,915	1,953	1,863
Other	334	482	360	188	220	230	229	276	241	270	146	208	248	180
Total HCHS	25,716	27,358	29,284	28,217	28,533	31,683	29,691	30,430	34,071	31,277	32,943	36,576	38,732	38,105


HCHS doctor leavers since 2010/11*
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2023/24
Consultant
DiT
Total HCHS
Other
SAS

Reason for leaving

The information in the table below is taken from NHS Digital data.

Year	All reasons for leaving	Dismissal	End of Fixed Term Contract	Other and unknown	Redundancy	Resignation	Retirement	Grand total
2011-12	88,765	660	68,615	3,205	620	15,560	3,775	181,200
2012-13	94,175	450	68,055	10,810	875	15,145	2,955	192,465
2013-14	87,180	515	66,400	3,930	370	15,310	3,460	177,165
2014-15	86,885	640	65,360	3,245	290	16,785	3,245	176,450
2015-16	81,160	590	60,445	1,770	265	16,665	3,610	164,505
2016-17	82,025	520	60,665	3,545	255	16,115	3,215	166,340
2017-18	78,630	485	58,185	1,950	290	16,625	3,390	159,555
2018-19	82,275	500	55,670	9,030	240	16,145	3,505	167,365
2019-20	77,085	450	55,925	1,720	200	16,865	3,800	156,045
2020-21	81,360	365	57,210	3,870	170	17,725	3,960	164,660
2021-22	82,385	400	59,055	1,480	95	18,895	4,250	166,560
2022-23 Q1 and Q2	57,865	255	43,505	1,135	115	11,480	2,405	116,760


HCHS doctor reason for leaving since 2011/12
250,000
200,000
150,000
100,000
50,000
-
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23 Q1 and Q2
All reasons for leaving
Dismissal
End of Fixed Term Contract
Other and Unknown
Redundancy
Resignation
Retirement
Grand Total

Annex B

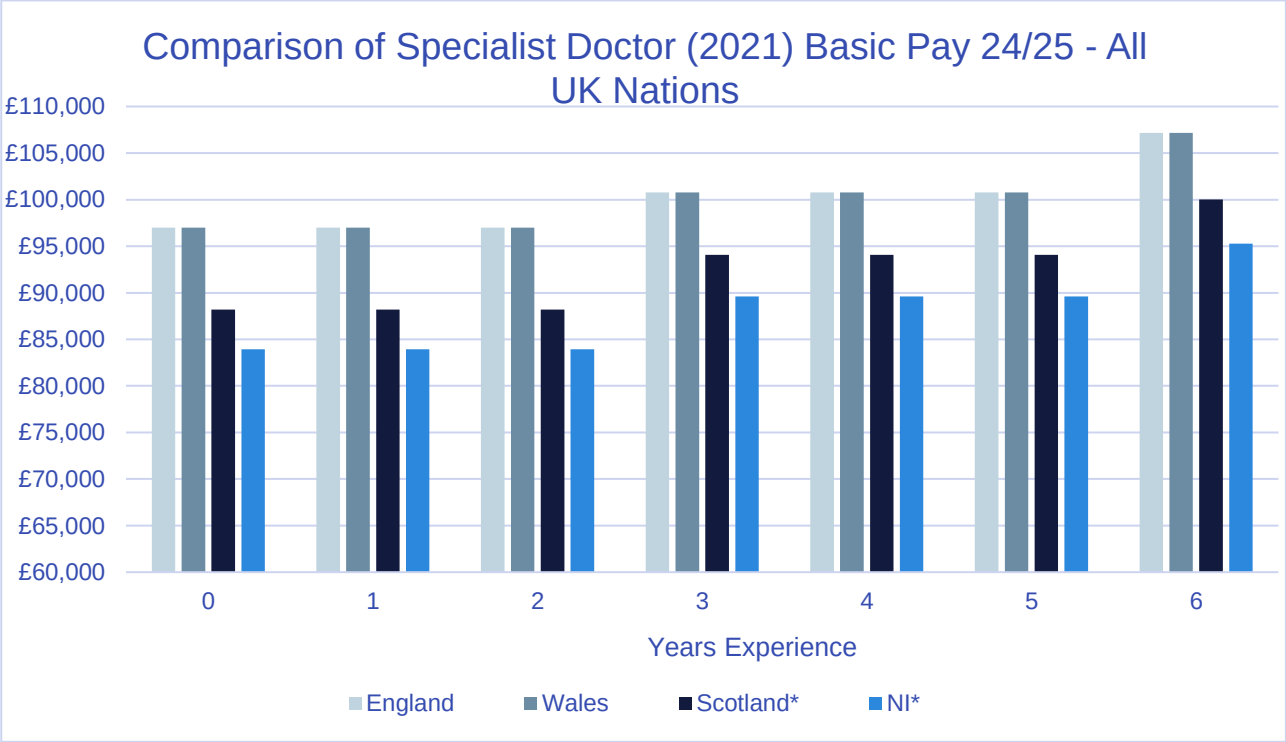
Comparison of medical and dental pay scales across the devolved nations

To note: a comparison of pay scales for doctors and dentists in training across the devolved nations remains under consideration, given the complexities of comparing the different contractual structures.

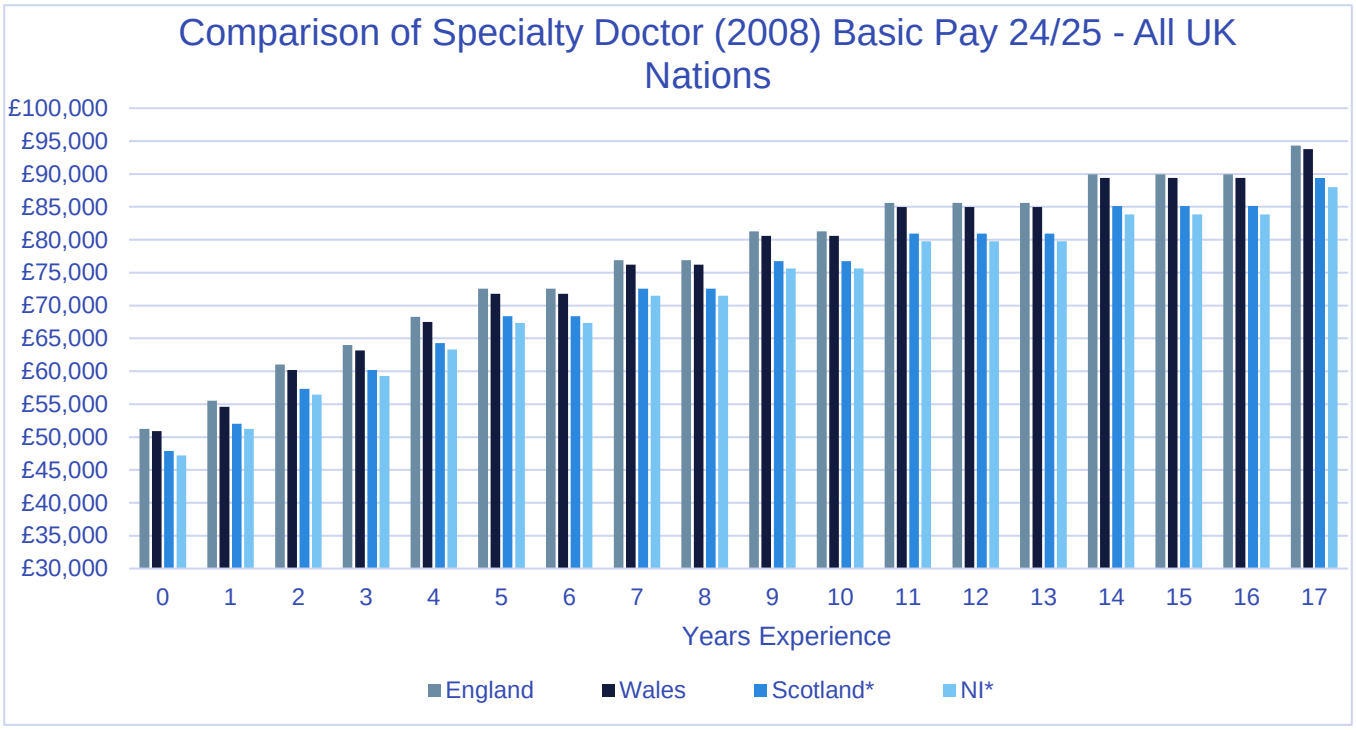
Consultants

Speciality doctor (2021)

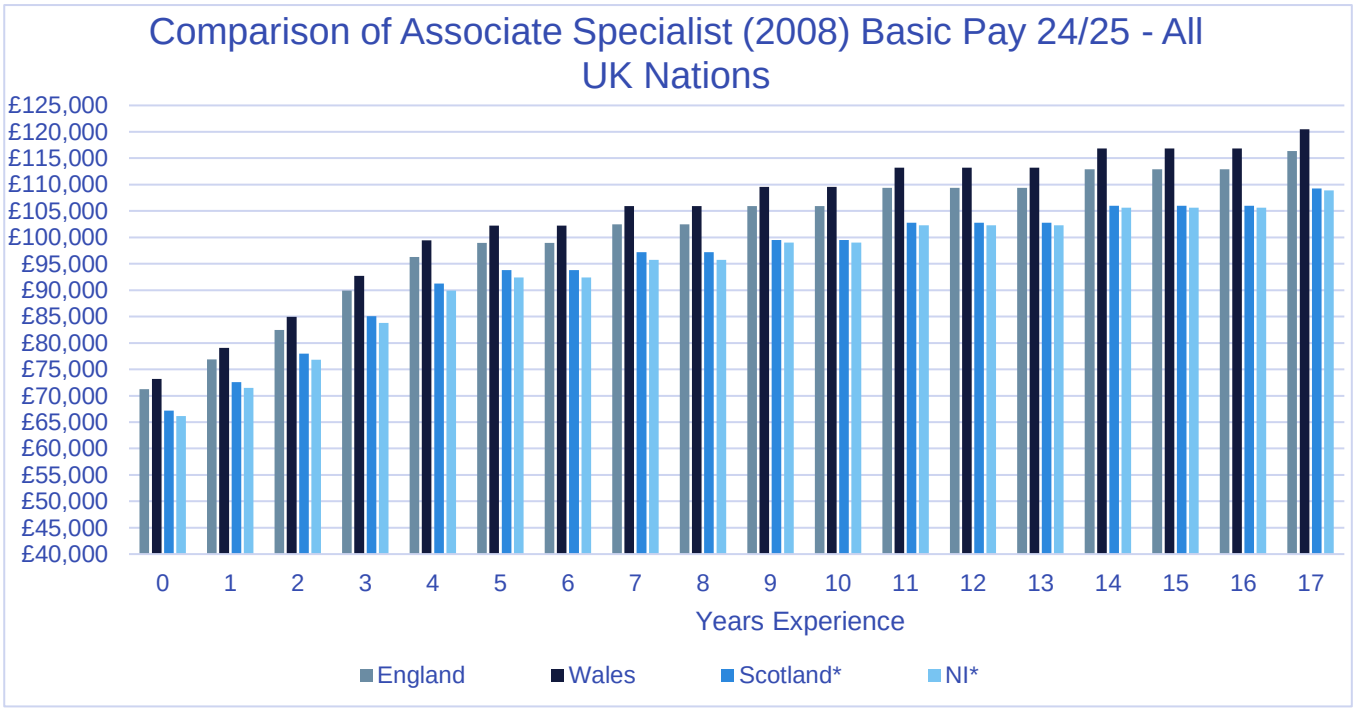
Specialist doctor (2021)



Specialty doctor (2008)



Associate specialist (2008)



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