Department of Health

Review Body on Doctors' and Dentists' Remuneration

Review for **2007**

Written Evidence from the Health Departments for Great Britain

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October 2006

SCOTTISH EXECUTIVE

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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EXECUTIVE SUMMARY

1. Public sector pay makes up about a quarter of Government expenditure, with an annual cost of over £130 billion. Pay Review Body (PRB) workforces make up about 40% of this total, with a combined pay bill of around £50 billion per annum. The pay bill for this Review Body alone amounts to over £8 billion every year.

2. Therefore, the recommendations made by this Review Body make a significant impact on the overall Government pay strategy, public finances, the ability for Government to meet other spending pressures, and the level of inflation in the wider economy. The evidence will demonstrate a strong recruitment and retention position, the difficult current financial position of the NHS, recent and on-going high levels of earnings growth, all of which point to the current pay arrangements being more than adequate. That is why the Government is putting forward evidence to support a general pay uplift of 1.5% this year.

3. Evidence is provided in **Chapter One** of the UK economic position within which we would ask the Review Body to make recommendations. Evidence is brought forward to provide a background for the Review Body on the economic context, the fiscal context, recent improvements in pay levels and the importance of total reward. High employment, low stable inflation and strong GDP growth has meant the Government has been in a position to invest in public services.

4. The Chancellor wrote to all Review Body Chairs on 13 July 2006 setting out his view that in order to prevent converting temporary inflation increases into a permanent increase pay settlements should be based on the achievement of the Bank of England's inflation target of 2%.

5. In **Chapter Two** detailed evidence on the financial position of the NHS is provided. Pay costs are met from general NHS allocations; there is no separate financial provision for pay costs within the NHS. As around two thirds of NHS revenue spending is on pay, even a small change in pay levels has a substantial impact on the funds available to deliver services. Evidence is also provided on the pressures facing the NHS as a result of a £512 million deficit in 2005/06. The NHS is working towards achieving financial balance in 2006/07 and maintaining that position in 2007/08 onwards. It is clear already that balance will only be achieved by some reduction in posts.

6. As all pay uplifts are met from general allocations, the Review Body is asked to remember that high pay uplifts will cause cost pressures at a time when the NHS is facing financial challenge. Evidence is given to illustrate that the pay bill is growing steadily as a percentage of HCHS revenue spend (excluding purchase of healthcare from non-NHS bodies). Together with the fact that the Department of Health Departmental Expenditure Limit cannot be breached, the Review Body is asked to remember that additional funding for the NHS will not be available to meet additional cost pressures caused by high and unaffordable pay uplifts.

7. Therefore, affordable pay uplifts are imperative otherwise, PCTs and NHS Trusts will inevitably need to make decisions on potential job losses and/or service disinvestment. The exact decisions will be made at a local level, but evidence is provided that demonstrates every 0.5% of pay uplift for this remit group will add around £43m onto the pay bill. This equates to around 1,200 qualified nurses or 440 doctors or 18,700 elective procedures. It is the Governments' position that should the pay uplift be more than 1.5%

then the NHS would face hard decisions including, reducing overtime, reducing staff numbers, delaying service changes and/or reductions in existing services.

8. The Review Body is also presented with evidence in **Chapter Three** of the improvements in pay and conditions of service for employed doctors and dentists in the NHS. The Government continues to believe that the Review Body cannot fulfil the remit in relation to affordability and the inflation target without taking into account the level of earnings and earnings growth in the NHS. Therefore, detailed pay metrics are provided that show the effects of the investment of consultant pay, the banding supplements for doctors in training and the incremental progression built into the pay system. This illustrates that the pay bill increased from £4.6 billion to £8.1 billion from 2001/02 to 2006/07 (a 76% increase) and the growth in average earnings across all medical staff groups (on average around 3.8% growth per head in 2006/07).

9. Comparisons of pay and earnings for doctors in training and other comparable professions remains favourable, with graduate starting salaries remaining higher than those for accountants and lawyers, with only investment bankers earning more.

10. **Chapter Four** provides evidence of the strong recruitment and retention position within the employed medical and dental staff within the NHS. We are in a position where domestic supply meets demand. We now have more than 117,000 doctors working in the NHS - 27,400 more than in 1997 - as well as record levels of doctors in training in UK medical schools and we do not need to rely on overseas doctors as much as we did in the past. We are now moving away from year-on-year growth in the NHS workforce to more of a steady state where there is a closer match between demand and supply.

11. The recent announcement that, subject to consultation, the NHS will retain a defined benefit final salary pension scheme, based on 14% employer contributions, means that the NHS will remain very competitive with most external employers. The value of this and other non-pay benefits, including leave and opportunities for flexible working will continue to make the NHS a very attractive career option.

12. Vacancy levels continue to fall with the three-month vacancy levels in March 2006 standing at 1.9%. This compares with 3.3% in March 2005 and 4.4% in March 2004.

13. It is the Governments' contention that pay levels are at appropriate levels to maintain the current good position on recruitment and retention. The Review Body is asked to note this strong recruitment and retention evidence when considering an appropriate and affordable pay uplift.

14. Detailed evidence on the position for NHS dentistry is provided in **Chapter Five**. Information is given on the contractual changes for general dental services. PCTs are currently facing no significant difficulties in expanding services and indeed are able to commission additional services at improved levels of value for money, strongly suggesting that dentists and corporate bodies are attracted by the new contractual and remuneration packages available for NHS work.

15. **Chapter Six** identifies the position on Ophthalmic Medical Practitioners. A review of General Ophthalmic Services is being undertaken by the Department of Health and is due to be completed by the end of 2006. Future evidence to the Review Body will take into account any implications for remuneration arising from the review.

16. Detailed evidence from the National Assembly for Wales is included in **Chapter Seven** and from the Scottish Executive Health Department in **Chapter Eight**.

17. **Chapter Nine** provides conclusions and pay proposals for 2007/08. In particular, the chapter brings together the total arguments of a healthy recruitment and retention position, evidence of good earnings growth and the need for affordable pay uplifts laid out in the chapters preceding it and makes the case for a 1.5% pay uplift for this remit group. It remains the Government's contention that if pay uplifts were to be higher than 1.5% the NHS would experience additional cost pressures that would inevitably lead to local discussions about job losses and the effect on service provision.

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION
THIRTY-SIXTH REVIEW

WRITTEN AND STATISTICAL EVIDENCE
FROM THE HEALTH DEPARTMENTS

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STATISTICAL TABLES

CHAPTER 1: GOVERNMENT EVIDENCE ON THE GENERAL CONTEXT

Introduction

1.1 Public sector pay makes up about a quarter of Government expenditure, with an annual cost of over £130 billion. Pay review body (PRB) workforces make up about 40% of this total, with a combined paybill of around £50 billion per annum. Therefore PRB recommendations make a significant impact on the overall Government pay strategy, public finances, the ability for Government to meet other spending pressures, and the level of inflation in the wider economy.

1.2 This chapter covers a broad, public-sector wide view on the:

- economic context;
- fiscal context;
- recent improvements in pay levels; and
- importance of total reward.

Economic Context

1.3 The UK economy stands in a sound position. It has grown for 55 consecutive quarters, the longest unbroken economic expansion on record. It has benefited from its longest period of sustained low and stable inflation since the 1960s and shown greater stability and stronger GDP growth than the majority of its competitors. Low inflation has, in turn, provided the platform for record employment levels, higher investment, productivity and economic growth. Labour market conditions continue to be favourable, as despite record employment levels and high oil prices we are not seeing any significant upward pressure on wages.

1.4 Recent increases in inflation rates have in large part been due to the temporary impact of higher oil prices. Once the impact of oil (and other goods with volatile prices) is stripped out, underlying or "core" inflation has remained consistently below 2%. However, in recent months goods price inflation has picked up as a result of these temporary price increases. The Chancellor feels strongly that we should remain vigilant to the risk of higher pay settlements feeding through into higher inflation going forward, which would undermine hard won stability.

1.5 The Chancellor wrote to the PRB Chairs on 13 July setting out his view that pay awards should be based on the achievement of the Bank Of England's inflation target of 2%. To do otherwise would risk converting a temporary increase in inflation into a permanent increase. Further information on inflation is included in **Annex A**.

Fiscal Context

1.6 Against a background of record increases in public investment there is a strong desire to get the most out of available resources by embedding ongoing efficiency improvements into Departmental planning. Public service delivery remains the Government's bottom line. That is why the Government has placed such a strong emphasis on using efficiency savings to reallocate resources to the front line. Given the fiscal constraints, there remains a premium on gaining the maximum value for money from the public sector pay-bill.

1.7 The period covered by the forthcoming PRB awards covers the final year of the 2004 Spending Review and the PRBs will wish to make recommendations based on current

resource allocations in the context of wider Government objectives. Moreover, the pay awards arising from this round will set the baseline for the forthcoming Comprehensive Spending Review, covering the years 2008/09 to 2010/11 (CSR07), and so this year's awards will have much longer-lasting affordability implications.

1.8 In recent years, spending on pay has grown in line with overall high growth in public spending. Over CSR07, rate of growth in budgets is set to slow substantially. Therefore, given the necessary fiscal tightening over CSR07, recent growth rates in pay are unsustainable if Departments are to fund their spending priorities.

1.9 More information on the affordability of awards for the DDRB's remit groups is contained in chapters 2, 7 and 8.

Improvements in Pay

1.10 Overall pay bill in the public sector has increased by around 6% a year in nominal terms since 1997, due to a combination of expansion in workforce numbers and growth in average pay levels (workforce expansion accounts for growth of around 2% a year and an increase in pay per person for the remaining 4% a year). Furthermore, looking over the past two Spending Review periods, average public sector pay increased more rapidly than in the private sector. The main driver of this increase has been workforce reforms, particularly reforms of pay structures.

1.11 For the HCHS medical workforce an illustration of the combined effects of growth in average pay and in workforce numbers is contained in **Annex B**.

1.12 In a large number of areas, effects of some of these reforms are still feeding through and for some workforce groups we expect to see further reforms in the future. Future drivers of pay for doctors and dentists are set out in chapters 3-8.

1.13 For reasons of affordability, and in the interests of rebalancing the pay levels between the public and private sectors, settlements need to be off-set against other drivers of paybill. When determining settlements, it is critical that all factors that will increase earnings are taken into account, such as:

- payments arising from the restructuring of pay systems;
- targeted payments to aid recruitment and retention;
- local pay;
- the net effect of progression payments; and
- bonus payments.

1.14 Therefore we are keen that PRBs consider the impact of the headline award on:

- **paybill per head growth,** which gives an indication of resulting changes in average earnings; and
- **paybill growth,** which reflects the total cost to the employer.

Total Reward

1.15 Pay is only one element of the total reward package on offer to the workforces covered by the PRBs. Government is moving in the direction of placing far more emphasis on total reward, which covers a wide range of areas such as pay, pensions, annual leave, flexible working and work / life balance, career development, and access to training. It is the entire total reward package that allows employers to recruit, retain and motivate their workforces, and deliberation on the level of the overall pay award should be carried within this context.

1.16 Information on what the Government sees as the most effective reward mechanisms to achieve their performance objectives for doctors and dentists are set out in chapters 3-8.

1.17 Within the total reward package, pay increases should be at levels which are affordable and are necessary to respond to the particular circumstances of the group involved, where the outcome would be to improve service delivery by supporting recruitment, retention and motivation within the workforce. For the medical and dental workforce, more detailed information on these areas is contained in chapters 3-8.

Summary

1.18 Government relies on PRBs to recommend affordable pay awards leading to levels of pay that are sufficient to recruit, retain and motivate key public sector workers. In addition, PRB recommendations have knock-on effects across the public sector, setting the scene for pay awards in other services.

1.19 In recent years we have seen major growth in workforce numbers and a great deal of modernisation of pay structures, necessary to deliver key public services. This has led to significant increases in both average salaries and in the overall pay bill of public sector workforces.

1.20 As we are entering a period of tighter spending growth, it is important that pay growth is restrained and the right balance between public and private sector pay levels is restored.

CHAPTER 2: NHS FINANCES

Introduction

2.1 This chapter sets out the financial context for our recommendation, including the Department of Health's Departmental Expenditure Limits (DELs) for 2005/06 until 2007/08 as announced in the Chancellor's 2005 Budget Statement.

2.2 Around two thirds of health service spending is on pay, so even very small changes in pay have a substantial effect on the ability of Primary Care Trusts (PCTs) to manage the substantial non-pay spending pressures that the health service faces.

2.3 The annual pay bill increases as staff numbers increase, however, there are other reasons for the increase; the annual settlement, an element of pay reform and pay drift. The table below shows that the pay bill for medical and dental consultants increased at a much higher rate than the number of staff over the same period. The Review Body will wish to note that the cost of pay reform for consultants was £90 million more than planned so the benefit to consultants has been higher than expected.

	2002/03	2003/04	2004/05	2005/06
Paybill	2,538m	3,114m	3,681m	4,111m
Staff Numbers WTE	24,756	26,341	28,141	29,613
% Increase in Paybill		22.70%	18.23%	11.66%
% Increase in Staff Nos		6.40%	6.84%	5.23%

Source: Paybill reference: 060712

Key Challenges Ahead

2.4 The key challenges are:

- **Financial Pressures** Last year we reported that a significant minority of NHS organisations were continuing to struggle to achieve financial balance, and that it was likely that a number would again finish 2005/06 in deficit. The issue of deficits was a real problem and in oral evidence we informed the Review Body that some NHS trusts were imposing recruitment freezes and some threatening redundancies. We asked the Review Body to take this into account in their recommendations.

  The Review Body's 35th Report discounted this evidence, saying that they did not consider that the pay settlement for the remit group should bear the brunt of financial difficulties that are attributable to a range of sources, though they did acknowledge that it should play its part. The Report went on to say that it was not evident to the Review Body how they could factor into their consideration the funding problems of a minority of organisations when considering the level of a national pay recommendation, and that they had paid particular attention to NHS Employers' evidence on the views of the majority of employers.

  In the event the NHS ended 2005/06 with over 170 organisations in deficit (around 30%), compared to 159 organisations in 2004/05. In addition, the net deficit increased from £259 million in 2004/05 to £512 million in 2005/06. After the first quarter of 2006/07, there are still 120 NHS trusts and PCTs forecasting a deficit. Although the NHS as a whole is forecasting a return to net financial balance, there is a large amount of risk. There is still a lot of further progress

needed before the NHS financial position is fully stabilised. There will be significant suppressed inflation from costs deferred into the next financial year, rather than avoided. A significant number of NHS trusts now have financial recovery plans in place, and we have seen announcements of planned reductions in staffing by NHS trusts.

It is important to realise that because the NHS has a duty to achieve financial balance overall, the effect of deficits in a minority of trusts is a national rather than a local problem, with other organisations required to run surpluses in order to release resources and cash to assist those organisations which are struggling.

These difficult decisions reflect the determination of the NHS to achieve overall financial balance this year. However, the overall balance will continue to include a significant minority of trusts with deficits. For these trusts, financial recovery plans will extend into 2007/08 and therefore the level of pay award will be a crucial factor in determining whether there are more or fewer redundancies in these organisations and whether other organisations can use surpluses to drive planned service improvements. Both of these issues will be of concern to staff, and we believe that as was beginning to be the case last year, concern about job security will be a significant issue for the DDRB's remit group.

- **NHS Reforms** On top of these existing challenges the NHS will be introducing system reforms such as Payment by Results, Patient Choice, Foundation Trusts and practice-based commissioning. Their ability to manage this will be helped by having stability in pay rates during this period of rapid change. For organisations operating Payment by Results in 2007/08, the affordability of any pay settlements will be largely determined by the level of tariff increase. For 2006/07, the tariff increased by an average 1.5% over the previous year. For 2007/08, HM Treasury will need to approve any increase in the national tariff and ensure this is in line with the Chancellor's policies on public sector inflation.

- **Pay Drift** The recent rapid increase in recruitment will have resulted in a large number of staff joining the NHS at the bottom of pay and career scales. This will generate a considerable pressure on earnings and paybill over the next few years until the pay systems stabilise. For example, the number of junior doctors in the NHS has risen faster than the number of senior posts, putting pressure on the service to accommodate their career aspirations. The workforce growth figures show that over the last five years the average annual increase in number of consultants has been 5.9% and junior doctors 6.8%. Over the last three years growth has accelerated and these figures are 6.2% and 8.5% respectively.

- **Resource implications going forward** In 2002, the Chancellor accepted Derek Wanless's "fully engaged" spending recommendation for the five years to 2007/08, which was for annual average spending growth of 7.1%. By 2007/08 the Government will have achieved its aim of bringing UK health spending up to the European average. No decisions have yet been taken for the comprehensive spending review which will allocate resources for the period from 2008/09 to 2010/11. Historically (since 1948) average spending growth on health has been at a rate of 3.1%.

  Furthermore, 2007/08 is the final year of the 2004 spending review and will form the baseline year for the forthcoming comprehensive spending review. High awards now will give high baseline for the future and may adversely affect the delivery of longer-term strategy, such as the remainder of the NHS Plan; and

create unrealistic expectations on future pay affordability. In the light of the likely slowdown in overall NHS funding from 2008/09, it is even more important to be cautious in terms of additional spending commitments imposed on the NHS.

- **Pension Liabilities** - The NHS pension package is now an attractive element of the overall staff remuneration package. However, it should be noted that any increase in salary has an equivalent impact on the cost of pension provision to the NHS. Employer contributions are currently around 14% of salary.

The Health Departments' and the Government's Plans for Spending Limits

(NB: The figures quoted here are for England only, see later chapters for Wales and Scotland respectively)

2.5 In addition to recruitment and retention issues, the Review Body's remit includes the need to consider the Health Departments' DEL limits when recommending appropriate pay levels. Therefore, pay awards for NHS staff must be set within a framework that considers:

- The Department of Health's spending limits set by the Chancellor in his Budget statement;
- The achievement of financial balance by the end of 2006/07 and continued sustainability;
- The effect of the Government's challenging plans against a range of output targets for the delivery of services including those of the Public Service Agreement (PSA) and the NHS Plan;
- The Government's aim of achieving 2.0% Consumer Price Index inflationary target.

2.6 Pay costs are not funded separately by the Department of Health. The pay bills are met at PCT level from the overall funding for PCTs which is made available in the unified allocation. This allocation covers around 70% of the total DEL (69% in 2005/6). Any large increases in pay will inevitably have an affect on the amount available for PCTs to spend on commissioning new services. Pay is an integral part of the total cost of any patient service and PCTs routinely need to make decisions on what services to commission based upon patient need. Currently, approximately 60% of a Trusts' budget is spent on pay

2.7 If higher than proposed pay awards are agreed, there would be an inevitable impact upon the cost of the patient services delivered by NHS providers. The PCT commissioners would have to consider the impact of such increased costs when determining their commissioning strategies. Higher costs could mean the PCTs not investing in some service areas.

2.8 Exactly what areas would be at risk from a large pay deal is impossible to say as decisions would be made locally. However, it is clear PCTs would need to consider slowing down some priorities and changing others. Therefore, it is realistic to assume that in the event of high pay awards creating cost pressures, NHS trusts and PCTs will consider where savings could be made. Such savings would be a mixture of disinvestment in existing services (e.g. reducing the number of elective procedures), less investment in new services (e.g. not opening a new community based clinic) and

reducing the number of staff in post (e.g. redundancies). Therefore, the Review Body should note that higher than proposed pay awards could result in posts being cut and/or planned service investment cancelled.

2.9 For example, each additional 0.5% increase in pay for the DDRB's remit group adds around £43 million onto the pay bill. That additional cost would need to be met from allocations and locally this would translate as a major cost pressure. We know that nationally £43 million would fund 1,200 qualified nurses, or 440 doctors or 18,700 elective procedures. Therefore, at a local level, PCTs and NHS trusts faced with this cost pressure would need to look at the cost of elective services and staffing.

2.10 The DELs for 2003/04 to 2007/08 are shown in the table below.

Departmental Expenditure Limits [(1)]

	NHS DEL (£m) (3)	Cash Growth (£m)	Cash Growth %	GDP Deflator (2)	Real Terms Growth
2003/04	64,183	-	-	-	-
2004/05 (4)	69,306	5,123	8%	2.72%	5.1%
2005/06	77,847	8,541	12.3%	2.12%	10.0%
2006/07	84,387	6,540	8.4%	2.44%	5.8%
2007/08	92,173	7,786	9.2%	2.66%	6.4%

Notes:
1. Figures are consistent with the 2006 Department of Health Report
2. GDP deflator as at 30 June 2006
3. NHS DEL figures now include technical adjustment for Trust depreciation
4. Includes a technical adjustment in 2004/05 for provision of £-1,497m

2.11 These increases are not a benchmark for pay settlements. Moreover, the growth in revenue funding, to fund pay amongst other things, is less than the overall average growth of 6.7% real terms over the 5-year period (2003/04 to 2007/08). Average real terms growth in revenue is 6.3% per year and capital is 21.4% per year over the 5-year period (2003/04 to 2007/08). The use of the overall DEL also needs to be considered against the Government's ongoing commitment to the modernisation of the NHS, in particular the objectives set out in the NHS Plan including PSA Targets and the impact of underlying demand pressures such as clinical negligence, European Economic Area (EEA) medical costs, access to NHS dentistry and NHS Connecting for Health.

2.12 As all pay uplifts are met from general allocations, the Review Body is asked to remember that high pay uplifts will cause cost pressures at a time when the NHS is facing financial challenge. Given that the Department of Health DEL can not be breached, the Review Body is asked to remember additional funding for the NHS will not be available to meet additional cost pressures caused by high and unaffordable pay uplifts.

2.13 There are a range of commitments (many of which are demand led) that need to be funded from overall NHS growth, and could be put at risk of delivering if a higher pay award was agreed:

- Delivery of the standards and targets set out in the NHS Plan, Public Service Agreements and National Service Frameworks;

- Implementation of NICE appraisals and guidelines

- The increasing demand for services supplied by GPs and dentists.

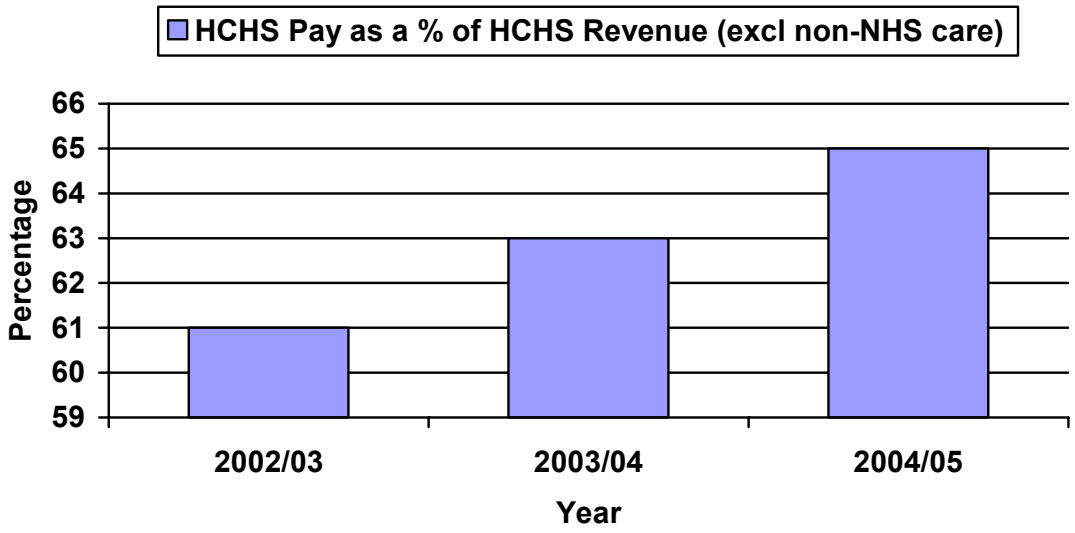
- The year-on-year rises in demand for hospital services shown by the increases in emergency admissions and attendances at A&E departments; attendances at A&E departments increased by 8% from 2003/04 to 2004/05 and a further 5.2% in 2005/06. This growth includes NHS Walk in Centres, which saw a 30% increase in attendances in 2005/06. The number of emergency admissions increased by 8% from 2002/03 to 2003/04, a further 12% in 2004/05 and 5% in 2005/06.

- The cost and demand for drugs; 2005/06 growth is limited due to a number of initiatives such as the Pharmaceutical Price Regulatory Scheme (PPRS) agreement, which limited increases in 2004/05 and 2005/06. The long run trend, which is expected to continue in 2006/07 and beyond, remains at about 8%. In 2005/06 approximately 13% of annual DEL was spent on the FHS and HCHS drugs bill.

- The costs of providing training opportunities, medical school places and training and career development opportunities.

- The resources to meet demand in terms of capital investment for new hospitals and equipment, the IT infrastructure; and training and development for the growing NHS workforce.

2.14 Pay as a percentage of revenue spend on Hospital and Community Health Services (HCHS) continues to rise. With pay accounting for around 65% of HCHS revenue the result is that if pay levels continue to rise there will be less revenue spend available for investment in services. The table below illustrates this trend using the latest available data.



2.15 In 2007/08 we anticipate considerable investment in drugs and new treatments based on NICE guidelines. This investment will consume a higher proportion of the increase in resources than pay. Costs will also increase rapidly due to the revenue consequences of capital investment in infrastructure and IT.

2.16 A broad breakdown of NHS expenditure and pressures besides pay is at **Annex C**. This shows that, over the last two years, before any pay increases, NHS trusts and NHS foundation trusts faced cost increases of around 3.0%.

2.17 The increase in NHS resources until 2007/08 provides a fixed funding envelope for the NHS. There will be no resources over and above this to fund any excess costs arising from pay settlements. It is therefore crucial that pay increases are no more than necessary to meet the recruitment and retention needs of the NHS, in order to ensure resources are available to deliver growth in capacity, service improvements, pay modernisation and maintaining financial balance.

Public Service Agreement (PSA) Targets and the New Planning Framework

2.18 In line with the cross-Government timetable attached to the 2004 Spending Review, a Department of Health PSA was agreed which covers the financial years 2005/06 to 2007/08. This PSA, which is set out at **Annex D**, forms the basis for the national targets for the NHS and social care which were issued in July 2004 in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08.* The Planning Framework describes the vision for services over the three-year period, and identifies the national priorities and targets which NHS organisations will build into their local plans.

2.19 The Planning Framework:

- Sets out a focused set of national priorities, reducing the number of national targets from 62 in the last planning round to 20 for years 2005/06 to 2007/08;
- Includes a framework for local target setting. Fewer national targets create more headroom for local targets set in response to local population needs; and
- Incorporates the *Standards for Better Health*, which were published after a three-month public consultation. The standards set out the levels of quality and safety that all NHS patients can expect from the services they receive. They also set the agenda for continuous improvements in quality and safety across the full spectrum of NHS healthcare.

2.20 An analysis of progress against the Department's PSA targets is contained in the sixteenth annual *Departmental Report*[1] published on 11 May 2006. Further information on progress in service improvement is set out in the 2006 *Chief Executive's Report to the NHS*[2].

Links Between Pay and Output Targets

2.21 Output targets provide a clear focus for planning and delivery and for measuring the return on the unprecedented levels of investment the Government is committing to such improvements. The targets form part of the wider context within which the Review Body considers its recommendations and the Review Body's remit requires it to have regard to the Health Departments' output targets for the delivery of services, as well as the funds available within DELs, and the need to recruit, retain and motivate doctors.

2.22 Affordability, and the other cost pressures, are crucial factors in any consideration of the links between pay and output targets. If the extra resources which have been

[1] Available on the Department of Health website at http://www.dh.gov.uk
[2] Available on the Department of Health website at http://www.dh.gov.uk

committed by the Government are diverted into unnecessarily large pay increases the service improvements necessary to meet output targets cannot be delivered. However, as we have previously reported, the link between pay and output targets is multi-faceted and we do not believe it is possible to quantify in any precise way the impact which the DDRB's recommendations on pay in one year will have had on the achievement of output targets in the next. Nor would it be meaningful to attempt to do so given the complex factors at play.

Summary and Conclusions

2.23 The Government is committed to modernising services for patients and improving the working life of NHS staff, including modernising the pay system. Although the headline figures show large growth in the DELs, a responsible approach to pay is crucial if we are to achieve all the objectives set out in the NHS Plan and maintain financial balance. The Government's commitments to the modernisation of the NHS and the range of additional cost pressures set out above mean that there is significantly less money available than may first seem.

CHAPTER 3: HCHS AND GMS PAY AND CONDITIONS OF SERVICE

INTRODUCTION

3.1 This chapter updates the Review Body on pay and conditions of service for doctors and hospital dentists in England. It outlines the affects on average earnings growth of incremental progression and investment in pay reform for this remit group.

3.2 In last years' report, the Review Body did not accept the need to take into account the effects of earnings growth and incremental progression when making recommendations for annual uplifts.

3.3 The Government continues to believe that the Review Body cannot fulfil the remit in relation to affordability and the inflation target without taking into account the level of earnings and earnings growth in the NHS. While it is true in theory that the NHS could deal with other drivers of earnings growth by negotiating changes to pay systems, in practice such changes can rarely be agreed without net investment (pushing up earnings growth further). This means, de facto, that pay settlements have to be the balancing item when concerns about affordability or inflationary pressures begin to arise.

3.4 As noted in paragraph 1.15, pay is only one element of the total reward package which staff receive. Other key elements include pensions, annual leave, opportunities for flexible working and work/life balance, career development and access to training.

NHS PENSION SCHEME

3.5 NHS staff reward is not limited to current pay. The NHS Pension Scheme (NHSPS) is a valuable part of the reward package for staff. We are dealing with pensions issues in some detail this year because of the proposed changes in pension arrangements. Overall, these represent an improvement in the value of NHS pensions, once longevity is taken into account, which is why it is proposed that staff contributions should increase to pay for these improvements.

3.1 We are not arguing that pay should be reduced on account of these changes, because higher staff contributions are a form of saving for the future rather than an increase in remuneration. The total value of deferred remuneration in the form of employer contributions is proposed to be unchanged at 14.0% (though with provision for a possible increase to 14.2% until 2016 if scheme experience is unfavourable). NHS pensions are, however, a very valuable benefit, and the continued announcements of the closure of defined benefit schemes by other employers means that the overall NHS employment package is becoming more competitive, and the Review Body may wish to take this into account in assessing pay levels needed for purposes of recruitment and retention.

3.2 Most employees contribute 6% of their pensionable pay, but the net payment is 3-4% after tax-relief. NHS employers pay 14% of pensionable pay towards the benefits package, which includes:

- Index-linked pension for life from age 60, of up to one-half pensionable pay at retirement
- Unreduced pension from age 55, for many health professionals in post before 1995

- One-off tax-free lump sum equal to 3x annual pension
- A range of family benefits, and for mental health officers
- Double pension after 20 years, so that 40 years service can be accrued in 30 years

NHS Pension Scheme review

3.3 A review of the NHSPS, led by a partnership of NHS Employers and NHS Staff Side, was nearing completion, at the time of this report. Following agreement in the Public Services Forum (PSF) that existing scheme members will remain free to retire with unreduced pension from age 60, NHS staff are expected to enjoy the following benefits from late 2007.

3.4 Existing members will:

- Retain their 1/80ths final salary pension and 3x pension lump sum
- Retain their normal pension age (NPA) of 60 (55 for health professionals and mental health officers in post before 1995)
- Retain their current minimum pension age (MPA) of 50
- Gain the facility to commute further pension (up to a total of 25%) at the rate of £12 lump sum for each £1 foregone
- Gain the ability to nominate non-married / civil partnership partners for survivor pension cover for membership from 1988. Surviving partners will be able to retain their current pensions, for life even if they enter into new partnership.

3.5 New entrants will:

- Retain their index-linked, final salary pension, with 1/60ths accrual
- Have pensionable pay based on the best 3 consecutive years in the members last 10 before retirement, revalued by RPI, so they can choose to 'step-down' without pension loss
- Have a NPA of 65 and a MPA of 55
- Gain the facility to take up to 25% of their pension as a tax-free lump sum, at the rate of £12 for every £1 of pension foregone
- Gain lifetime survivor pensions for nominated partners
- Gain the ability to draw-down part of their pension whilst continuing to work and build-up further pension

3.6 The new arrangements will maintain a high quality, defined benefit, final salary scheme as an integral of the NHS reward package. The employer contribution will be no more than 14% from 2016, but may rise to 14.2% after 2008. In future, both existing and new entrant employees will pay tiered contributions according to their pay level to reflect the proportionally greater benefits that higher paid staff receive in a Final Salary pension scheme.

Comparability of the NHS Pension Scheme

3.7 ***Public Sector***: According to the 2006 Government Actuary's Department Survey, the NHSPS, prior to review, is in the middle of comparable public sector arrangements. On a 'net of member contributions' basis, this means the NHSPS is relatively less valuable than the civil service 'premium' scheme but broadly equal to the 'classic' scheme and to the teacher's pension scheme. However, the local government pension scheme is less valuable than any of these schemes, except for members who enjoy a normal retirement

age of 60. After review and the effects of NHS pay modernisation, the NHSPS is expected to move closer to the upper end of the comparable public sector arrangements.

3.8 Contribution rates in the teachers scheme are currently the same as the NHS Scheme (14% of pensionable pay from employers, and 6.0% from employees). Employer contributions to the Local Government Scheme are set locally and vary by local authority, but currently average around 11-12% of pensionable pay plus significant additional contributions being paid to address accumulated deficits. Employee contribution rates are also set at 6.0% of pensionable pay.

3.9 Under the proposed new NHS scheme, new and existing staff will pay tiered contributions on their whole salaries depending on their full time equivalent pensionable income. The proposed rates will be 5.0% for staff earning up to £15,107, 6.5% for staff earning £15,108 to £60,880, 7.5% for staff earning £60,881 to £100,000 and 8.5% for staff earning £100,001 and more. This is to reduce the effective subsidy of higher paid members by lower paid staff.

3.10 ***Private Sector:*** In April 2005, the NHSPS compared favourably with private sector schemes. Employer contributions to defined contribution (DC) schemes averaged at 6.0% of pay with employer contributions to open, defined benefit (DB) schemes similar to the NHSPS averaging at 13.9% of pay. However, it should be noted that the latter figure could well include significant additional contributions being paid by private sector employers to address accumulated deficits, a situation which does not apply in the case of the NHS Scheme. It is therefore likely that the underlying cost of benefits accruing in the private sector is materially less than 13.9%. Care should also be taken when comparing contribution rates in that the rates will vary according to the funding methodology and actuarial assumptions adopted. Also, the proportion of defined benefit schemes available to private sector staff continued to decline, to around one third, so that two thirds of members now face all investment risks in defined contribution arrangements. Corresponding employee contribution rates were 2.7% (DC) and 4.9% (DB) respectively, with the private sector trend generally upwards.

REGIONAL AND LOCAL DIMENSIONS

3.6 In last year's evidence we reported on the findings of the research we had commissioned from Aberdeen University into the effectiveness of regional pay to help address localised recruitment and retention issues for various NHS staff groups. The research suggested that doctors operate in a national labour market and found no evidence that greater pay differentiation would be appropriate in tackling comparative recruitment and retention difficulties. As the Review Body is aware, under the 2003 consultant contract there is provision for employers to pay a recruitment and retention premium of up to 30% of normal starting salary under certain circumstances. We are not seeking any further regional/local differentiation in doctors' pay for 2007/08.

3.7 London weighting is paid to HCHS doctors and dentists, GMP Registrars and salaried GMPs. The Review Body's 35th Report commented that on labour market grounds there was no case for London weighting to be increased. Statistical Tables 17 and 18 show the latest information on the distribution of medical and dental consultants and on the geographical and specialty variations in medical and dental vacancies. We can see no case for London weighting to be increased in 2007/08 and we would ask the Review Body to agree that the rates of London weighting (£2,162 for non-resident staff and £602 for resident staff) should continue to be held steady in cash terms.

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

3.8 The Review Body is reminded that in addition to the annual pay uplifts awarded following Review Body recommendations, doctors on incremental pay scales who are not yet at the top of their pay scale have the opportunity to progress up the pay scale. For example, excluding the annual pay award, the pay of a specialist registrar who is not yet at the top of the scale increases by between 4.2% and 5.3% per annum (depending on the point they are on in the pay scale). The table at **Annex E** illustrates the combined effect of incremental rises and Review Body awards on individual doctors' pay by taking some hypothetical examples over a five-year period.

CONSULTANTS

3.9 Existing consultants are employed on either the old pre-reform contract (a five point incremental scale rising to £75,404) or the new post-October 2003 consultant contract which has eight pay thresholds ranging from £69,991 to £94,706. All new consultants are appointed on the new contract. The national survey undertaken by the Health and Social Care Information Centre, published in July 2006, showed that, as at 29 October 2005, fewer than 13% of consultants remained on the old contract. They have the opportunity to transfer to the new contract if they wish to do so.

3.10 The Review Body is reminded that the job planning process is key to the new contract. It provides a stronger, unambiguous framework of the consultant's contractual obligations enabling consultants to better manage their workload. This should have a positive impact on morale and retention. The 2003 contract is based on a full-time working week commitment of 10 programmed activities (PAs) each of which has a timetable value of four hours (with the exception of work done in premium time). Additional PAs can be arranged by agreement between the consultant and the employer. The national survey showed that, as at 29 October 2005, the average number of PAs in agreed job plans was 10.83.

3.11 The 2003 contract was designed to provide, over time, a 15% average increase in a consultant's career earnings. As **Annex B** highlights, average earnings per head for consultants has increased significantly in recent years. We would expect to see continued high growth in average earnings per head as consultants progress through their thresholds towards the new maximum. For example, if consultants are awarded a 1.5% uplift in 2007/08, we forecast that average earnings per head for consultants will rise by 4.3%.

3.12 In last year's evidence to the Review Body, the BMA expressed concern about the changing pay differential between consultants and GMPs following the implementation of their respective contracts.

3.13 We do not believe that comparing the pay of GMPs and consultants is comparing like with like. GMPs have a greater opportunity than NHS-employed consultants to flex their pay in the context of profit-sharing between partners. We agree that it is not possible to establish a measure of average GMP remuneration under the new GMS contract. The contract has been designed as a practice-based contract. This means that the practice as a whole receives funds to provide service to patients and all associated running costs. We do not believe that it is appropriate within this model, to try to determine the relative job weightings of GMPs and consultants. Allocation of work within practices, including utilisation of skill mix, is determined by that individual practice.

Clinical Excellence Awards

3.14 Consultants on either contract with at least one-year's service are eligible to apply for Clinical Excellence Awards (CEAs) which can increase their basic salary by between £2,817 (CEA level 1) and £72,210 (CEA level 12). The CEA scheme is now in its third year. It replaced the previous consultant reward schemes – discretionary points (DPs) and distinction awards (DAs) – though awards made under these previous schemes remain in payment until award holders retire or are awarded a CEA. All levels of CEA, DA and DP are pensionable. The Advisory Committee on Clinical Excellence Awards have reported that in March 2006, 58.5% of eligible consultants held an award (CEA, DP or DA) and 13.6% of consultants held a CEA at or above level 9 or a distinction award.

NON-CONSULTANT CAREER GRADES

3.15 In January 2005 the Department of Health asked NHS Employers to enter into negotiations with the BMA for new contractual arrangements for Staff and Associate Specialist doctors. It was hoped that a new deal could be in implemented from April 2006.

3.16 However, we understand that negotiations continued beyond April 2006. The Department await full joint proposals from NHS Employers and the BMA for consideration. We will update the Review Body of developments at the supplementary evidence stage.

3.17 As we reported in last year's evidence, these national negotiations related only to doctors working on national terms and conditions of service. The Review Body asked if data is available showing the breakdown of SAS doctors working on national and local contracts. The workforce census data collected centrally does not differentiate between staff employed on national contracts and those employed on local contracts – the census data is collected by pay band. The basic pay and terms and conditions of employment of trust grade doctors on local contracts are determined locally but are normally broadly similar to comparable doctors in training grades.

HOSPITAL DOCTORS AND DENTISTS IN TRAINING

3.18 The introduction of the New Deal contract in 2000 provided a financial incentive to NHS Trusts to reduce the working hours of junior doctors. The contract uses banding supplements, paid in addition to basic salary, to reward doctors for the frequency and duration of their out-of-hours work. The banding multipliers are now free-standing and reviewed annually by the Review Body. For posts which comply with the New Deal, the banding supplements are currently: Band 1C – 20%; Band 1B - 40%; Bands 1A and 2B – 50%; Band 2A – 80%. Doctors in non-compliant posts are paid a Band 3 supplement of 100%.

3.19 Compliance with the New Deal is monitored by NHS Employers and Tables 9 and 10 give an analysis of the March 2006 returns showing compliance by grade and by specialty. Since March 2005, 98% of doctors in training have been fully compliant compared with 88% in March 2004 and 71% in 2001.

3.20 As we reported last year, whilst total duty hours for doctors in training have fallen considerably since the introduction of the New Deal contract, for many doctors from a

maximum of 72 to 56 per week, there has not been a corresponding drop in average earnings.

PRHO Pay – 2001 to 2006

Date	Basic Salary	Multiplier	Typical Pay	Increase on 2001
	£17,935	1.56	£27,962	
April 2002	£18,585	1.57	£29,214	4.48%
April 2003	£19,185	1.74	£33,373	19.35%
April 2004	£19,703	1.71	£33,616	20.22%
April 2005	£20,295	1.60	£32,537	16.36%
April 2006	£20,741	1.57	£32,517	16.30%

(The multiplier is the average of that for all full-time first year trainees in post)

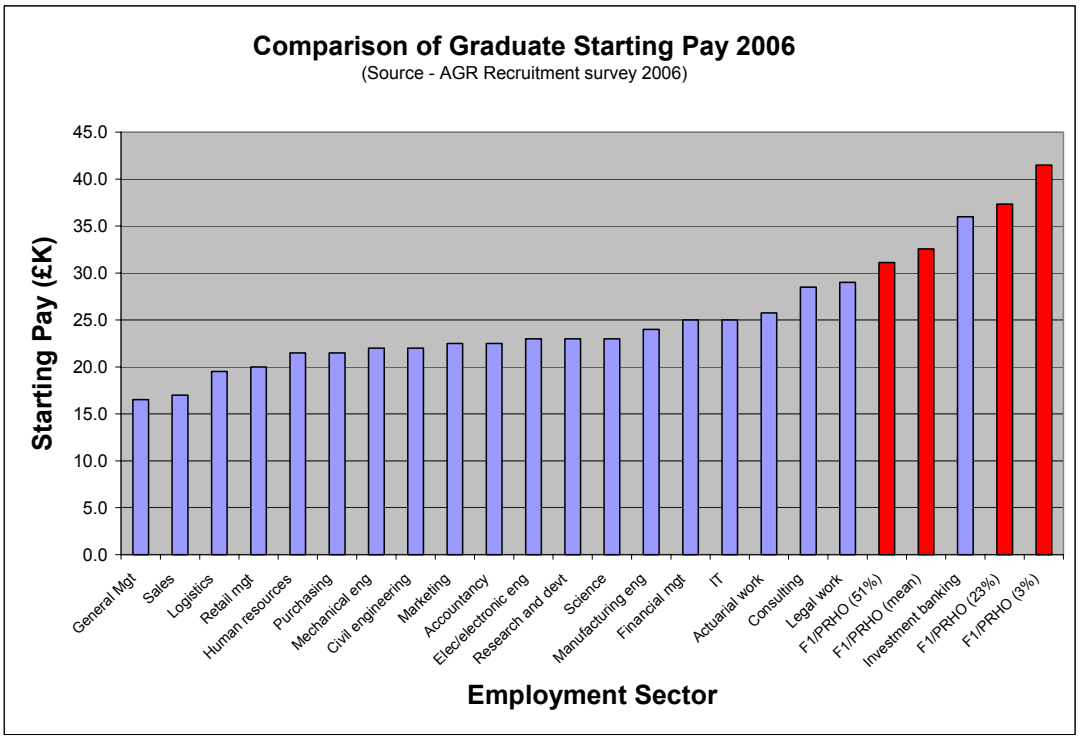
3.21 The table shows the movement of PRHO pay since the implementation of the new contract. In that period, basic salaries have risen by 15.6% and typical overall pay by 16.3%, against inflation of 14.1% (using HM Treasury GDP deflator figures). The reduction in typical pay since 2004 results from the reduction in working hours as the New Deal and Working Time Directive impact on working patterns. We expected doctors' earnings to fall with hours as a result of the New Deal, as the disincentive to higher hours in the form of high multipliers took effect. These reductions in total pay must be weighed against the benefits of reduced hours and a more family-friendly working environment. By 2009, all doctors in training should be working no more than 48 hours a week and will as a consequence receive a maximum supplement of 50% of basic salary. We are pleased that working hours and average multipliers are falling and would not want to see any adjustment to a system which is working as intended.

Salary comparisons with other professions

3.22 For graduates entering their first PRHO post, salaries remain very competitive. A recent survey by the Association of Graduate Recruiters[1] reported that between 2005 and 2006 40% of the employers surveyed had either kept pay static or reduced it. A further 39% had raised pay by between 1.0% and 4.0%; 20% had raised pay by between 5.0% and 9.0%.

3.23 Two thirds of employers questioned in the AGR's survey expected graduate starting salaries in 2007 either to remain static or to rise by no more than the cost of living.

1 Recruitment Survey Summer 2006, Association of Graduate Recruiters



3.24 The above chart, using data taken from the survey, shows a comparison between the pay of junior doctors in their first post and the pay of graduates entering other professions. The four columns for Medicine, as in previous years' evidence, show the range of actual starting pay for PRHOs (ignoring the value of accommodation currently provided free in the pre-registration year). The chart shows the percentage of doctors on each of the three main pay bands in addition to the average, which for PRHOs in 2006 is £32,563, with 26% earning £37,334 or more. This continues to compare favourably with other professions, exceeding even the starting salary for investment banking.

3.25 We are concerned to ensure an adequate supply of training places for the increasing number of students leaving medical school and would ask the Review Body to take into account the NHS need to be able to fund adequate training places in setting pay particularly at PRHO level.

Banding Multipliers

3.26 The banding multipliers for compliant bands are set at a level that fully reflects the relativities that the Health Departments and the BMA agreed in 2000 to reward different patterns of work intensity and out of hours commitment. We remain firmly of the view that these relativities are fair and they provide an appropriate financial incentive for Trusts and trainees to manage the workload of doctors in training.

GENERAL MEDICAL PRACTITIONER SERVICES

GMP Registrars

3.27 The supplement paid to GMP registrars is intended to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged in relation to hospital doctors in training. As the average banding supplement paid to hospital

doctors has fallen to 56% in England, it would seem appropriate to reduce the GMP registrars' supplement from its current level of 65% of basic salary. We would ask the Review Body to reduce the GPR supplement to 55% for 2007/08.

GMP Trainers

3.28 The flat rate grant paid to GMP trainers is currently £7,179. In its 34th Report, the Review Body recommended a £750 supplement should be paid to GMP trainers to boost their continuing professional development. In last year's evidence to the Review Body we said that whilst the supplement would be paid in 2005/06, we had some reservations about the recommendation and planned to carry out a broader review of the role and remuneration of GMP trainers.

3.29 An independent review of GP trainers' pay was completed in June 2006 incorporating views from the Department of Health, the BMA and other stakeholders. The recommendations and conclusions of the report are attached at **Annex F**. Ministers in England have accepted the recommendations of the report.

3.30 The main conclusions were that the approach and methodology used for remunerating GP training should be changed, but that recommendations on appropriate levels of remuneration could not be proposed until the results of further research and evaluation were known. We agree this work should be taken forward as soon as possible with a view to introducing the new system and agreeing levels of remuneration, although we think this will not be possible within this reporting period. As a result, despite our reservations about the supplement, the £750 will be paid for a further year in 2006/07.

3.31 Until the required further information is available and implementation of the new arrangements agreed, we would ask the Review Body to uplift the GP trainers grant by no more than the increase we are seeking for other salaried doctors.

GMP Educators

3.32 A GP educators' payscale was introduced in 2003/04 following agreement between the Department of Health, the Committee of General Practice Education Directors (COGPED) and the BMA's General Practitioners' Committee. In response to the Review Body's request for evidence on the recruitment and retention position for this group, we sought independent advice from COGPED. COGPED reported that the overall picture is that posts are being filled but from a smaller applicant list. At Director and Associate Director level there are no long term vacant posts. At Course Organiser level posts are being filled but often from reduced applicant lists. There are some vacancies at GP tutor level, although it was reported this was due to pressures on SHA budgets rather than levels of remuneration. We would ask the Review Body to uplift the GP educators payscale by no more than the increase we are seeking for other salaried doctors.

Salaried GMPs

3.33 As we reported last year, the salary range for salaried GMPs employed by Primary Care Organisations, which was agreed in May 2003, was designed to be wide enough to cover the range of possible roles that salaried GMPs might be required to undertake, with starting pay, progression and review determined locally. The model terms and conditions of service for salaried GMPs are intended to be the minimum, with employers free to offer more favourable terms to reflect local needs and circumstances.

The salary range for 2006/07 is £50,332 to £76,462. The Department of Health has seen no evidence to suggest that the current salary range is inappropriate.

Independent contractor GMPs

3.34 We do not expect the Review Body to make recommendations on remuneration for independent contractor general medical practitioners (GMPs) for 2007/08. Negotiations are about to begin on a review of the GMS contract between the BMA's General Practitioners' Committee and NHS Employers on behalf of the Department of Health.

3.35 The first phase of the Global Sum Formula Review is now complete. This involved initial assessment of all the factors in the existing formula and of factors which could be included in a revised formula.

3.36 The Global Sum Formula Review Group expects to present its final report to the NHS Employers-General Practitioners' Committee Plenary at the end of Summer 2006. The outcomes will be discussed as part of the negotiations.

3.37 As part of the original contract negotiations, it was agreed that NHS Employers, the GPC and the four health departments would review the contract for 2006/07. The aims during negotiations were to ensure that the contract was better for patients, was fair on the profession and delivered good value for public money.

3.38 The revised contract came into effect from 1 April 2006. The changes secure:

- greater value for money – service improvements are being funded through recycled efficiency savings as well as additional funding for new work that supports government priorities
- no cost of living or inflationary increases for GPs for 2006/07
- an ongoing commitment to deliver efficiencies and productivities in the future.

3.39 Highlights of the revision:

- The revised Quality and Outcomes Framework (QOF) includes seven new disease areas. The inclusion of new areas was made possible through the release of 138 points from the previous QOF. (We removed: points from holistic care payments and quality practice payments, points associated with disease registers, a number of organisational indicators, points from asthma and mental health indicators)
- Practices will benefit from extra payments for involvement in practice based commissioning
- There is investment to support practices in installing new technology, including choose and book, electronic transfer of prescriptions and GP to GP records transfer
- A patient experience survey will be introduced during 2006/07. This will measure and validate standards in access to services and choice of secondary care referral.

3.40 Looking across all three years of 2003 GMS contract agreement, in England, the final cost of providing Primary Medical Care Services over the three years 2003/04 to 2005/06 will be £1.6 million (8.0%) more than the 36% increase originally guaranteed to GPs. This is a cumulative (not recurrent) figure, and we believe that the recently negotiated deal has gone some way to realign the value for money of the contract.

3.41 Based on 2004/05 achievement data, quality scores hit 958 points on average (out of 1050) ie over 91% achievement. High levels of achievement in QOF are a good thing. It shows we have a system in place that motivates general practice to provide high quality evidence-based clinical care. Research carried out by the National Primary Care R&D Centre (NPCRDC) in 2004 shows that significant health gains could result over time from achieving the quality targets in QOF. Introduction of the QOF has also led to an accurate clinical database, unparalleled anywhere else in the world, on the majority chronic disease sufferers in this country. This can act as the basis of better commissioning - a significant plank in demand management.

3.42 We have continued to see strong growth in GP numbers in the past two years – though many of these are flexible workers and salaried GPs rather than partners.

3.43 The NPCRDC 2005 GP job satisfaction survey (not yet published) shows that job satisfaction has increased and job pressure reduced following the introduction of the new GMS contract. GPs had more positive views on the new contract than were indicated before its introduction, particularly in relation to their pay and quality of care for their patients.

Seniority payments

3.44 In last year's evidence to the Review Body, the BMA sought an increase in the value of seniority payments to help retain senior GPs in the workforce. The Review Body's 35th Report recommended that seniority payments should remain unchanged in 2006/07. We propose that seniority payments should remain at current values in 2007/08. We have no evidence to suggest that GPs are less likely to stay working or to return to general practice after drawing their pension based on the value of their seniority payments. This issue was not raised in the context of the latest round of GMS contract negotiations, where we would expect any concerns to be raised and dealt with. In addition, given that projections for GP earnings show a likely profit increase well in excess of the intended 36%, there seems no good reason to increase seniority payments at this time.

CHAPTER 4: THE MEDICAL WORKFORCE CONTEXT

Introduction

4.1 This chapter sets the context for consideration of issues around remuneration of doctors including progress on the reform of postgraduate medical training, implementation of the Working Time Directive and evidence on recruitment, retention and motivation.

4.2 The investment in NHS staff and reforming medical training to build up workforce capacity has been successful. We are in a position where domestic supply meets demand. We now have more than 117,000 doctors working in the NHS - 27,400 more than in 1997- as well as record levels of doctors in training in UK medical schools and we do not need to rely on overseas doctors as much as we did in the past.

4.3 These successful strategies are mirrored in the recommendations and objectives set out in the 2006 annual World Health Organisation (WHO) report which this year focussed on Human Resources for Health and was launched by Rosie Winterton on 7 April 2006. The UK is committed to an ethical approach to recruiting healthcare professionals from overseas. As such, the Code of Practice for NHS employers involved in the International Recruitment of Healthcare Professionals was published in October 2001. In its report WHO calls for all developed countries to build their own healthcare workforce capacity so as not to destabilise the infrastructures in the developing world. At the same time it set out a challenging agenda for developing countries to implement, with support, the types of HR strategies for training, recruitment and retention that the UK has already implemented successfully.

Workforce strategy

4.4 The NHS has seen unprecedented levels of investment and a period of expansion in the workforce since 1997 in order to reduce waiting times, improve access to services and ensure high quality treatment and care. We are now moving away from year-on-year growth in the NHS workforce to more of a steady state where there is a closer match between demand and supply.

4.5 There will be a shift of staff from the acute sector into the primary care sector as more care is undertaken in a community setting in order to deliver this goal. The training and recruitment of doctors, as for all staff groups, is driven by local health organisations and local health needs. The White Paper presents a number of opportunities for staff, including doctors, and more freedom to consider innovative approaches to care, whether that is through focussing more on prevention or changing the way they work with the people they care for so that it is a partnership.

4.6 There is more that the NHS can do to improve efficiency in terms of strengthening frontline capacity through increases in productivity and skill mix and reducing spend on agency staff. In some cases, productivity gains may mean that fewer staff are needed to deliver the same service outcomes.

4.7 In last year's evidence we reported that two interim statements on the workforce strategy have been issued[1]: *Delivering the NHS Improvement Plan: The Workforce Contribution*, published in November 2004; and *A Workforce Response to Local Delivery Plans: A Challenge for NHS Boards,* released in August 2005. The essential

1 Available on the Department of Health website at http://www.dh.gov.uk

message in these statements is that NHS employers should place emphasis on working differently and more productively. A combination of good human resources practices with a focus on high impact service delivery changes will provide the best means for meeting the challenging demands facing the NHS.

REFORM OF POSTGRADUATE MEDICAL TRAINING

4.8 In evidence last year, the Department outlined two ongoing, key initiatives in postgraduate medical training - Modernising Medical Careers (MMC) and the establishment of the Postgraduate Medical Education and Training Board (PMETB). An update on progress is included below.

Modernising Medical Careers

4.9 MMC is a major reform of postgraduate medical education that aims to improve patient care by delivering a modernised and focused career structure for doctors.

4.10 As reported last year, we successfully introduced Foundation Programmes (covering the previous PRHO year and first year of SHO training but with a new unified curriculum) in August 2005. Although these are now well-established, development of the Foundation programme is continuing through new national recruitment arrangements and competency-based assessment tools which are subject to continuing evaluation and refinement. The Foundation curriculum is also subject to continual review to ensure it is fit for purpose and an updated version is planned for introduction in August 2007. All aspects of the Foundation Programme will be evaluated thoroughly.

Specialist Training

4.11 We will introduce newly structured specialist training programmes from August 2007. We explained in last year's evidence how this provides an opportunity to organise specialist training to best meet the needs of patients and the NHS.

4.12 There has been extensive consultation with all stakeholders and much debate within the profession and the service on the most appropriate way to for it to be organised. As a result, a new medical training and career structure has been agreed and published (see the MMC website www.mmc.nhs.uk).

4.13 Training for specialist and GP roles will follow directly after the Foundation Programme and from August 2007 doctors at this stage of training will be recruited into:

- the new specialty registrar grade undertaking specialist/GP training programmes designed to deliver the curricula approved by PMETB; or

- Fixed Term Specialty Training Appointments (FTSTAs) – at Specialist Training 1 (ST1) and Specialist Training 2 (ST2) level.

4.14 New titles for the training grades within this structure have been agreed by the four UK Health Departments, NHS Employers and the BMA as follows:

- trainees in Foundation Programmes - Foundation House Officer 1 and 2 (FHO 1 and 2)

- trainees in specialist training programmes - Specialty Registrar (StR)

- trainees undertaking FTSTAs - Fixed Term Specialty Registrars (FTStR)

- trainees in general practice training programmes – GP Registrars (GPRs).

However, whilst these are the titles that will be used for pay and contractual purposes, we will encourage common usage of the more patient-friendly 'Foundation doctor' and no separate labelling of fixed term specialty registrars.

Transition

4.15 The new training structure means that the current Senior House Officer (SHO) and, over time, the current Specialist Registrar (SpR) grades will be managed out of existence, as from August 2007, entry to the SHO grade and all SpR training programmes will be closed. However, all SpRs currently in programmes will complete training in those programmes, subject to satisfactory progress - but will have the option, in discussion with their local Deanery Training Committee, to access the new curricula in full (Type I trainees) or in part (Type II trainees) in completing their programmes.

4.16 At the same time, doctors part way through their SHO training will have to compete to enter training in the new structure. This will be at a level appropriate to their skills and experience to enable fair competition between trainees in their peer groups to take place.

4.17 A significant and challenging agenda of work is being taken forward to develop the arrangements and ensure a smooth transition from the current structure. However, this also provides an opportunity to reconfigure existing SHO and equivalent posts in August 2007 to best meet training and service requirements. This is a complex process as, in order to help optimise workforce planning, deaneries will need to consider with service colleagues, Clinical and College Tutors, Specialty Training Committees (STCs) and College Specialty Advisory Committees (SACs) how these posts might best be deployed. Most of this work is taking place at deanery and NHS trust level and in consultation with the Royal Colleges and PMETB (as educational approval for new programmes will ultimately need to be agreed by PMETB). The Workforce Review Team (see paras 4.42 – 4.44) will provide a national overview of the evolving plans.

4.18 A key element of transition will be to address issues of pay and terms and conditions, and preliminary discussions have taken place between NHS Employers and the BMA. However, it is clear that with a competency-based training and career structure it will be possible to map remuneration to defined levels of competence. For the time being, however, the new structures can be run by adapting existing pay and grading arrangements.

Non-consultant Career Grades (NCCGs)

4.19 A key strand of MMC is parallel reform of the NCCGs. Through the Government's approval of the recommendations of *Choice and Opportunity*, we are committed to providing greater opportunities for NCCG doctors. Work is underway to consider how these recommendations should be taken forward.

4.20 At the same time opportunities for NCCG doctors have increased as a result of the PMETB assuming its full statutory responsibilities from 30 September 2005. Since that date, NCCG doctors have been able to apply to PMETB to have their qualifications, training and experience recognised as sufficient to be placed on the Specialist or GP

Register (see below), or to be prescribed the "top up" training required to reach that level.

Postgraduate Medical Education and Training Board (PMETB)

4.21 The Government established PMETB in October 2003. It has replaced the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) as the competent authority for postgraduate medical training in the UK. It assumed its full statutory responsibilities on 30 September 2005.

4.22 The new arrangements give greater involvement for patients and the NHS in setting the standards and approving the curricula for postgraduate medical education and training. The new organisation has also brought together the arrangements for general practice and specialist training in one organisation.

4.23 For the first time, the system will deal properly with doctors training outside the European Economic Area (EEA), giving them a route to apply for registration which will take account of their qualifications, training and experience, wherever gained. This will also be of benefit to some NCCG doctors as they too are now able to submit evidence of their experience, training and qualifications to be considered together by PMETB.

4.24 If the PMETB assessment decides that the sum of the doctor's experience, training and qualifications is equivalent to the standards required to obtain a CCT in the UK, then the doctor will be entered on to the Specialist or GP Register. A new facility, in order to meet current standards and not compromise patient safety, will be the power to prescribe a short period of "top-up" training in order to overcome any perceived deficiency. There will clearly be implications for workforce planning as a result of these developments as there will be an extra supply of fully-trained doctors (consultants and GPs) as non-consultant career grade doctors and international medical graduates gain direct entry to the Specialist and GP Registers.

WORKING TIME DIRECTIVE

4.25 The Review Body asked to be kept in touch with developments on the Working Time Directive (WTD). The Finnish Presidency of the European Union has said that resolving the problems from the SiMAP and Jaeger Judgments is a priority for them. We will continue to press for changes to the WTD in relation to the SiMAP and Jaeger judgements but there are no guarantees that a deal will be reached. The NHS should be planning for full implementation of the WTD for doctors in training based on current WTD interpretations.

4.26 The need for the NHS to be planning for WTD 2009 implementation has been emphasised via the national WTD Conference and the NHS Employers Bulletin. National Workforce Projects (lead NHS organisation for supporting WTD implementation) have reinforced this message via the *Calling Time* magazine and by briefing their Chief Executive network.

4.27 The Review Body also asked to be kept informed of independent research looking at the impact of changing working patterns on medical training. This work is being led by the University of Sheffield. The study aims to identify and examine models of effective post graduate medical training in the context of reduced working hours and changes in working patterns. This first phase includes a detailed and systematic review of available

literature as well as an analysis of individual and group interviews with key stakeholders.

4.28 This phase is due for completion by the end of the summer. The findings will be presented to an expert group of postgraduate deans before sharing the findings of the interim report more widely.

4.29 The Department of Health works collaboratively with colleagues leading on other initiatives such as MMC. An awareness and understanding of the WTD has been crucial in the development of MMC. It would not be possible to implement the WTD without a reform of medical training and therefore the Department of Health believes it is best to be addressing both these two changes at the same time.

4.30 Stakeholders are working together at a national level to support implementation and to maintain links with related areas such as MMC. For example, the National Stakeholder Group, which was established July 2005, has approved a number of work strands to support the full implementation of the WTD for doctors in training. These include a number of WTD 2009 pilots and a Royal College of Physicians Working Group which has published guidance on working the night shift for junior doctors, and will be publishing advice on rota design in the Autumn.

4.31 Further information on the WTD pilots (including the Hospital at Night project) can be found on the workforce portal at: www.healthcareworkforce.nhs.uk

AN INTEGRATED ROLE FOR COMMUNITY HOSPITALS

4.32 As the Review Body is aware, the White Paper, *Our health, our care, our say: a new direction for community services* (Cm 6737) sets out a vision for more care to be provided in local and convenient settings. Central to this vision is ensuring that the necessary infrastructure is in place to support this shift in services. Community hospitals and related smaller facilities will form an important part of this infrastructure. In its 35th Report, the Review Body urged the Health Departments to maintain strategic oversight of community hospitals and to look for any early warning signs that problems might be developing with service delivery because of funding issues.

4.33 The Department of Health recently published its vision for the future of community hospitals in a follow up document: *Our health, our care, our community: investing in the future of community hospitals and services*. This document also announces a £750 million capital investment programme and sets out a strategic role for the Department to oversee delivery of the programme.

Early warning mechanism

4.34 The White Paper makes clear that community hospitals currently under threat of closure should not be lost in response to short-term budgetary pressures that are not related to the viability of the community facility itself. To that end, the Department of Health wrote to Strategic Health Authorities (SHAs) on 16 February 2006 about the need for SHAs to assure themselves that all Primary Care Trust (PCT) proposals for changes relating to community hospitals are consistent with the long-term strategy of the White Paper to move care closer to patients' homes and that local people are properly consulted.

4.35 In addition, the Department held meetings with SHAs during March 2006 to ensure that any plans locally to reconfigure community services:

- fit with the commitment to invest an increasing proportion of NHS resources in providing care in community settings;
- support the White Paper principles of providing modern health and social care in more local and community settings;
- fit with the White Paper vision of a new generation of community hospitals, for example, giving scope for the provision of specialist care more locally such as diagnostics, day-case surgery and outpatients; and
- are consistent with the White Paper goal of reducing unnecessary bed occupancies, e.g. for providing step-down rehabilitation beds in community hospitals.

4.36 Ultimately, however, the configuration of healthcare services in a particular area is a decision that needs to be taken at a local level. PCTs, with their perspective across hospital, community and primary care, are best placed to take such decisions. They have a responsibility under Section 11 of the Health and Social Care Act 2001 to involve and consult people for whom services are being or may be provided on both the development and consideration of proposals for changes in the way those services are provided and consult them on decisions to be made affecting the operation of those services.

4.37 Furthermore, Local Authority Overview and Scrutiny Committees have the power to review and scrutinise health services from the perspective of their local populations. NHS bodies are under a duty to consult Overview and Scrutiny Committees on any plans to make substantial variation to NHS services. Those committees have the powers to refer any proposal to the Secretary of State if they believe the plans are not in the interests of the health service.

RECRUITMENT, RETENTION AND MOTIVATION

4.38 The Healthcare Commission's staff survey, conducted in October 2005, found that staff were 'generally satisfied with their jobs' with evidence of sustained improvement in key areas such as training, learning and development, access to flexible working, support for staff with dependents and staff safety at work. This is despite the challenging times faced by the NHS. All 570 NHS trusts and 25 Strategic Health Authorities in England took part in the survey. A total of 209,124 NHS employees responded, which is 58% of those staff who were invited to take part in the survey. The occupational group distribution of respondents to the survey was broadly similar to that of the NHS workforce in England as a whole.

4.39 The Review Body will wish to note the creation of the Medical Training Application Service (MTAS) - a UK-wide service for recruitment of junior doctors to Foundation and GP/Specialty training programmes which will modernise and focus doctors' career structures whilst also improving patient care. MTAS will streamline the process and will:

- Support MMC reforms to postgraduate medical training
- Enable UK-wide joined-up, fair and transparent approach to recruitment
- Provide an online, user-friendly application service accessible via the world-wide web
- Provide a robust service for recruitment to Foundation and specialty training places (including GP)
- Simplify and clarify recruitment processes for employers and applicants
- Maximise filling of posts with suitable applicants
- Reduce the need for applicants to complete multiple application forms for training programmes

4.40 For Foundation programmes, the service will be live by October 2006 for recruitment into programmes commencing August 2007. For Specialty training, the service will go live in January 2007 for programmes commencing August 2007.

Workforce planning

4.41 As we reported in our evidence last year, in England, NHS workforce supply is no longer driven by nationally set targets. Historical levels of investment in the NHS coupled with extra investment in training, have resulted in a steady state where there is a closer match between demand and supply, and a move away from year-on-year growth in the NHS workforce. Local Delivery Plans now set out the workforce requirements needed to achieve service objectives.

4.42 The Workforce Review Team (WRT) works at national level on behalf of the NHS in England. It is an expert group that considers national and local priorities to determine local workforce development. WRT works closely with SHAs, National Workforce Projects, Skills for Health (the sector skills council for health) and the Department of Health. It also draws information from a range of sources, including professional bodies and education providers.

4.43 In line with the move away from central control, the Department of Health has devolved responsibility for making commissioning recommendations to the WRT. WRT make annual recommendations about training levels and other factors that influence workforce supply, taking into account national priorities (such as long term conditions and shorter waiting times). NHS organisations are responsible for their own workforce planning taking account of the WRT recommendations and their local circumstances.

4.44 Further detail about the WRT can be found at www.healthcareworkforce.nhs.uk

4.45 Despite the move away from nationally set targets, there will be occasions when the Department of Health will need to use national levers at a strategic level. Recent changes to the immigration rules affecting junior doctors and dentists in postgraduate training, are a case in point. Medical training programmes and the needs and structure of the NHS have changed considerably.

Immigration changes

4.46 The Home Office amended the immigration rules in July 2005 to reflect the changes to the training structure for doctors which came into effect last year (MMC). The changes to the immigration rules ensured that overseas doctors coming to the UK to undertake one of the new Foundation Programmes could be granted leave for the duration of this programme, rather than having to apply for an extension of stay part-way through the programme. The Home Office also used the opportunity to formalise the role of the postgraduate deans, who supervise the training of doctors and dentists.

4.47 Through their new formalised role in the application process for permit-free training, the postgraduate deans became aware the rules had not been applied consistently throughout the NHS. They began the process of tightening up the criteria for permit-free training and in doing so it clarified which posts are recognised training posts and which are in fact service delivery posts.

4.48 In April 2006, the regulations were amended again, this time to end the category of permit-free training for postgraduate doctors. An exception was made for doctors with a UK medical degree who can be granted up to three years permit-free training to complete a Foundation Programme. In order to work and train in the UK all other overseas post-graduate doctors (known as International Medical Graduates or IMGs) must now meet the requirements of an employment category of the Immigration Rules, such as the work permit requirements. Work permits will normally only be granted where there are no suitable UK or EEA applicants.

4.49 Subsequently, larger numbers of IMGs started to apply to the Highly Skilled Migrant Programme (HSMP) - an individual immigration route which allows applicants to seek entry to work in the UK without having a prior offer of employment. The Department of Health issued guidance stating that as there was no guarantee that doctors with limited leave to remain (such as those on the HSMP) would be granted an extension of their leave it was possible to exclude them from the first sift for interviews for training posts where their leave did not cover the entirety of the programme for which they were applying. This advice is currently the subject of judicial review. The hearing is due to take place in early December 2006.

Workforce numbers: headline figures

4.50 The statistical tables provided by the Information Centre for Health and Social Care show we are moving towards a period of greater self-sufficiency in the medical workforce. The increased investment resulting in increased intakes in recent years and reforming postgraduate medical training in order to build up NHS capacity has produced a significant increase in both UK-qualified and non-UK doctors. There were further increases in the numbers of doctors and hospital dentists and GMPS doctors in England in 2005:

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 3,634 (headcount) or 4.2% and 4,106 (FTE) or 5.2%;

- Consultant numbers increased by 1,343 (headcount) or 4.4% and 1,471 (FTE) or 5.2%;

- Associate specialist numbers increased by 260 (headcount) or 11.3% and 231 (FTE) or 11.4%;

- Staff grade numbers increased by 60 (headcount) or 1.1% and 18 (FTE) or 0.4%;

- Numbers in the registrar group (mainly specialist registrars) increased by 1,183 (headcount) or 7.0% and 1,202 (FTE) or 7.5%;

- Senior house officer and equivalent numbers increased by 1,023 (headcount or 5.1% and 1,053 (FTE) or 5.2%;

- Foundation programme year 1 and pre-registration house officer numbers increased by 390 (headcount) or 9.1% and 386 (FTE) or 9.1%;

- GP numbers – excluding GP retainers and GP registrars – increased by 1,215 (headcount) or 3.9% and 940 (FTE) or 3.3%.

- GP registrars increased by 2 (headcount) or 0.1% and the full time equivalent figure decreased by 19 or 0.8%.

4.51 The Review Body will have noted reports in the media about financial pressures and redundancies in the NHS coupled with reports of reduced career prospects for junior doctors. Contrary to the claims that have appeared in the media, there are not widespread redundancy exercises across the NHS. Where NHS trusts are reducing posts they are largely doing so through expected turnover, vacancy freezes, reducing the use of agency staff and redeploying staff in different ways. Compulsory redundancies are a last resort.

4.52 A minority of NHS trusts are experiencing significant financial problems and they will need to make some difficult decisions as they strive for financial balance. However, these NHS trusts are working extremely hard to keep any compulsory redundancies amongst medical staff to an absolute minimum. Furthermore, intelligence gathered by SHAs and NHS Employers suggests that most posts affected by reductions are those in management, administration and clerical roles, not medical roles. The Review Body will need to be aware this is an evolving situation as NHS trusts finalise their restructuring plans and we will provide an update at oral evidence where appropriate.

4.53 The employment opportunities for junior doctors need to be understood separately. SHAs oversee the distribution of funding for medical education to ensure that the number and type of trainee posts on offer best serves the needs of patients, both now and in the future. Due to the distinct funding stream for junior doctor training, we are confident that the majority of junior doctors, including those who have just left medical school, will be able to secure posts. We value highly those doctors in whose education and training we have invested heavily. We want these doctors to progress and develop their careers in the NHS, delivering modernised patient-centred services.

4.54 The overall intention is to deliver a situation where the NHS has the right number of both educationally-approved training posts and service posts to produce the right number of doctors, as identified by the NHS, to meet patient needs. Recruitment will be managed through the new Medical Training Application System (MTAS) which will support UK wide recruitment. This will reduce both the number of applications a doctor has to submit to secure a post, and the number of applications that have to be assessed by each panel. The level of competition will vary considerably between foundation schools and specialties. Doctors may therefore need to be more flexible than in the past about their future career options. Linked to the development of MTAS, the Department of Health is working with NHS Employers and CoPMeD on the provision of improved career management for junior doctors.

4.55 The Review Body asked to see evidence on how changing roles in the NHS and the growth in workforce capacity is affecting both hours of work and the workload of doctors. Measuring doctors' workload is very difficult. One simple measure is to compare changes in doctor related cost weighted activity with staff inputs over time. Both the number of doctors and activity have increased significantly from 1999 to 2005. Analysis suggests that, if productivity is used as a proxy for workload, then the workload of doctors has decreased since 2002. This measure should be treated with some caution as there may be many factors that influence activity that are unrelated to doctor numbers. For example, technology, changing skill mix, changing working hours or working practices could all increase or decrease activity independently of numbers of doctors.

Entry to the medical workforce

4.56 The provisional English medical school intake figure in autumn 2005 was 6,298. This is 68% more than in autumn 1997. The planned English autumn 2006 intake was exceeded in both 2004 and 2005.

4.57 We would stress again that there are no problems in attracting new recruits of the right quality into medicine. Medicine and dentistry remain very attractive careers and continue to attract high quality candidates with average tariff points considerably higher than the average for all subjects. For 2005 entry, the average UCAS tariff points of accepted applicants to medicine and dentistry were 413 and 381 respectively compared with 409 and 375 for entry in 2003.

4.58 Table 3 shows that the number of UK applicants to study medicine at UK universities has increased again over last year. The number of UK applicants to medical schools has risen more rapidly than the number of available places with, in 2005, an average of 2.4 applicants for every medical school place. In 2005, 58% of UK accepted applicants were female compared with 60% in 2004 and 62% in 2003. As at 15 October 2005, the number of UK applicants to medical schools for 2006 entry was 1.5% higher than at the same point in the cycle in the previous year.

Langland's Report – Gateway to the Professions

4.59 The Department is a member of the Inter-Departmental Group that has been set up to implement Gateway recommendations around widening participation, improving information for potential and existing students and ensuring that students have access to sources of financial advice to help manage their affairs if they get into difficulty.

4.60 This work is being supported by a development fund which is overseen by the Gateways to the Professions Collaborative Forum. Bids for this financial year - including one from the General Medical Council to develop opportunities for people with disabilities and from disadvantaged backgrounds, will be finalised by October 2006.

4.61 The process and priorities for 2007/08 are presently under consideration by the Collaborative Forum

Pre-Registration House Officers (PRHOs)

4.62 In the light of the increase in medical school graduates resulting from the increased intakes in recent years, funding was provided for an extra 319 Foundation Programme

Year 1 (PRHO) posts in England in 2005/06 and an additional 354 in 2006/07. A Foundation Programme Standing Committee is overseeing the creation and distribution of the appropriate number of Foundation Programme Year 1 and Year 2 posts that will be needed in England over the coming years, amongst other responsibilities.

Senior House Officers (SHOs)

4.63 Between 1997 and 2005 the number of SHOs and equivalents employed by the NHS increased by 6,636 (44.2%), from 15,006 to 21,642. In the period 2004 to 2005 the figure increased by 1,041 (5.1%).

4.64 Competition for entry into SHO training posts remains extremely high, particularly in popular areas such as London and in popular specialties. There are also a significant number of trust doctor and other non educationally-approved posts at SHO equivalent level with locally employed terms and conditions, which are included in the SHO figures quoted in this evidence, for which competition is also high.

4.65 In the longer term, we are also progressing with the implementation of MMC.

Registrar Group Doctors

4.66 Between 1997 and 2005 the number of Registrar Group Doctors employed by the NHS increased by 6,097 (51.2%) from 11,909 to 18,006. In the period 2004 to 2005 the figure increased by 1,183 (7.0%). These are the doctors training to be consultants.

GPs and GP Registrars

4.67 In September 2005 the number of GMS other and PMS other (salaried) GPs had increased by 2,552 (301.7%) from 846 to 3,398 since 1997, of which all but 239 of this increase has occurred since September 2002. This compares with growth in the number of contracted GPs of 2,140 (7.9%) in the same period. In aggregate these two groups have provided an increase in GPs (excluding retainers and registrars) of 4,692 (16.7%) between 1997 and September 2005. GMS Other and PMS Other (salaried) GPs represent 10.4% of the GP (excluding retainer and registrar) workforce, compared with 3.0% in 1997.

4.68 Between 1997 and 2005 the number of GP Registrars employed by the NHS increased by 1,221 (91.0%) from 1,343 to 2,564. In the period 2004 to 2005 the figure increased by 2 (0.1%) from 2,562 to 2,564.

4.69 Our intelligence on whether general practice continues to be an attractive career choice for new doctors, is from the studies of cohorts undertaken by the Medical Careers Research Group (MCRG) at the University of Oxford (http://www.uhce.ox.ac.uk/ukmcrg). This group has studied doctors' careers since 1975, focussing on career choices and reasons for them.

4.70 Briefly, interest in general practice as a career choice is not increasing and the percentage of men choosing general practice is now approximately half that of women. However, there is a strong view in very recent surveys undertaken in 2005 that general practice is now a more attractive career choice than hospital practice. Study of written comments suggests that many doctors, and particularly women, view general practice as having more flexible arrangements for part-time working and training, more supportive training, and better pay than hospital practice.

4.71 MCRG's research confirms that general practice is the most popular career choice for women in medicine. When doctors are asked about their reasons for opting for particular specialties there are very few differences in the responses of men and women, responses clustering round wanting to follow a specialty and interests. Money is always very low on the list. However the main area where men and women differ in their responses as to the factors affecting their career choice is that of working hours/ working conditions/work-life balance/ opportunities for part-time working. These things being rated as more important by women compared to men doctors.

4.72 The Review Body's last report reminded Health Departments to keep incentives schemes under review to ensure the schemes support recruitment and retention cost effectively. In line with devolved workforce planning, the management and funding of recruitment and retention schemes such as the Flexible Careers and Returners Schemes has been devolved to SHAs. Empowering employers to target the use of schemes will ensure cost effective use of funding. Similarly, the Primary Care Development Scheme established in April 2005, to improve recruitment to the primary care team, is overseen by a lead PCT and is subject to review at the end of 2007/08.

Associate Specialists and Staff Grades

4.73 Between 1997 and 2005 the number of Associate Specialists employed by the NHS increased by 1,203 (89.0%) from 1,351 to 2,554. In the period 2004 to 2005 the figure increased by 260 (11.3%).

4.74 Between 1997 and 2005 the number of Staff Grade doctors employed by the NHS increased by 2,970 (116.2%) from 2,557 to 5,527. In the period 2004 to 2005 the figure increased by 60 (1.1%).

4.75 There is no evidence of any general recruitment and retention problems in these grades. The introduction of MMC will offer these doctors more opportunities to undertake further training and progress their careers.

Consultants

4.76 Between 1997 and 2005 the number of Consultants employed by the NHS increased by 10,519 (49.0%) from 21,474 to 31,993. In the period 2004 to 2005 the figure increased by 1,343 (4.4%)3.

The Impact of Part-time Working

4.77 Table 16 shows the change in the number of part-time medical and dental staff by grade since 1995. As we reported in our evidence last year, the effects of part-time working are taken into account in the national workforce models. In general, this is done by assessing the current ratio of FTE to headcount and using analysis of historical data and judgement about future trends to determine how this ratio will change over time. The current short-term workforce projections for consultants and junior doctors assume that the 2002 ratio is held for the next six years. This assumption is based on evidence that the ratio has been stable in recent years. The table below shows the FTE to headcount ratio for consultants since 1999. Across the whole of the HCHS sector in England, the ratio between FTE and Headcount in 2005 was 0.91.

FTE to headcount ratio for Consultants in England

Year	Headcount	FTE	Ratio
1999	23,321	21,410	0.92
2000	24,401	22,186	0.91
2001	25,782	23,064	0.89
2002	27,070	24,756	0.91
2003	28,750	26,341	0.92
2004	30,650	28,141	0.92
2005	31,993	29,613	0.93

4.78 More generally, the national workforce models for the whole medical workforce take into account the age profile and grade structure. By modelling different joining and leaving rates for these factors, the models implicitly take into account the effect of changes in participation rates, for example amongst staff in their 30s and 40s.

Vacancy rates

4.79 Table 18 shows the latest three-month vacancy rates for HCHS doctors (excluding doctors in training) by specialty and Table 19 summarises the available vacancy data by specialty over the period 2002 to 2006. The March 2006 mean three-month vacancy rate for medical and dental consultants was 1.9%. This compares with 3.3% in March 2005 and 4.4% in March 2004.

Turnover and wastage

4.80 The Review Body asked that we give consideration to collecting data on turnover and wastage. NHS staff are employed by individual NHS employers. Doctors can be expected to move between NHS employers as they progress their NHS careers. Information on turnover rates is not collected centrally**.** An analysis of the latest available data on retention and retirements is at **Annex G.**

Productive Time

4.81 Staffing is the most expensive and important NHS component (more than 60% of the NHS budget is spent on its workforce) so it is essential that the workforce providing NHS care is employed in ways that "deliver quality and value" to patients.

4.82 As we have previously reported to the Review Body, as part of the spending review 2004, the Department of Health committed to achieving annual efficiency benefits in England of at least £6.5 billion by 2007/08 up to £2.9 billion of which are expected to come from making better use of staff time (Productive Time).

4.83 In last year's evidence we re-stated that both the Department of Health and the NHS are committed to improving efficiency in health care provision. A significant proportion of these savings, to be reinvested in patient care, will come through improving the 'productive time' of front-line staff, using initiatives to increase the time spent by health care professionals (clinicians, managers and administrators) on activities related to better patient care. Improving productive time includes encouraging NHS organisations to focus on the characteristics of high performing clinical systems,

processes and practices by providing benchmarking information and promotion of benchmarking as a technique for continuous service improvement.

CHAPTER 5: DENTISTRY

GENERAL DENTAL PRACTITIONERS

Overview

5.1 Our evidence this year is presented six months into the implementation of fundamental reforms to NHS dental services. The early evidence shows that PCTs are successfully using their new local powers to commission new and expanded dental services. In doing so, PCTs are not facing difficulties in finding dentists keen to expand or establish new services, indicating a healthy recruitment position. It is too early to measure the impact on net remuneration, but there are strong reasons for supposing that expenses will reduce (as a proportion of gross remuneration) as dentists carry out simpler courses of treatment. Over the next two years, dentists will also be benefiting from our £100 million capital investment programme.

5.2 From 1 April 2006, PCTs have been responsible for commissioning primary dental services within their areas. The budgets devolved to PCTs for this purpose represent around £2.4 billion of gross expenditure (including forecast income from patient charges) – one-third higher than three years ago (£1.8 billion in 2003/04).

5.3 In the transition to the new arrangements, the early priority was to agree contracts with dentists and corporate bodies previously providing General Dental Services (GDS) or Personal Dental Services (PDS) pilots. The new contracts signed by these dentists and corporate bodies represented around 96% of previous service levels. Around 35% of contracts were signed with some terms still in dispute or under discussion, but around 41% of disputes had already been settled by the end of July – with the vast majority (c.98%) resulting in the contractor remaining with the NHS.

5.4 One of the major advantages of the new arrangements is that PCTs have the financial resources and commissioning powers to replace any capacity lost through dentists retiring, leaving the area or reducing their NHS practice. This has been vividly demonstrated in the last six months. The additional services commissioned since 1 April already exceed the 4% of capacity temporarily lost through dentists choosing not to take up the new contracts. Our evidence includes examples of the tender exercises carried out by PCTs, the overwhelming degree of interest by dentists and corporate bodies in providing new or expanded services, and the improvements in access and value for money that PCTs are securing in this process. This constitutes strong evidence that dentists and corporate bodies are attracted by the contracts and remuneration packages on offer.

5.5 The new arrangements have been designed to deliver additional benefits for patients, both by encouraging simpler courses of treatment (where appropriate) that free up more time for prevention and by introducing a simpler, more transparent system of patient charges. It is too early to provide a meaningful assessment of the impact on patients, but our evidence reports on further work being undertaken with the NHS and the profession to support sustained improvements in the quality and responsiveness of services.

5.6 It is likewise too early to judge the full effects of the new arrangements for dentists. The indications, however, are that the new arrangements should certainly support dentists, as intended, in carrying out simpler courses of treatment. As well as being more clinically appropriate for patients, this will reduce workload and (all other things

being equal) reduce expenses as a proportion of gross remuneration. The effect of the 5% reduction in the number of courses of treatment (i.e. the reduction in units of dental activity - UDAs - required under the new contract compared to the previous GDS workload) itself reduces expenses and increases gross remuneration by around 0.75%. On top of this, we have an expected reduction in the complexity of treatment, which will have a further downward effect on expenses.

5.7 The Department has established an Implementation Review Group comprising representatives of patients, dentists, PCTs and other stakeholders to monitor the impact of the reforms and identify any changes that may be needed to improve their effectiveness.

5.8 In the short term, the evidence on recruitment and retention – and the likely impact of the new arrangements on expenses – justifies in our view an increase of around 1.5% in gross contract values for 2007/08, in line with the recommendation being sought for other professional groups. Taken together with the 5% reduction in courses of treatment, a 1.5% award would effectively mean a 2.25% increase in remuneration, assuming expense costs rise by 2.25%. If, as expected, there is also a significant reduction in the complexity of treatment, the increase in remuneration would be even higher.

Overall dental strategy

5.9 The Government's high-level objectives for dental services and dental public health are to support the NHS and the professions to:

- deliver further improvements in oral health and reduce oral health inequalities
- improve access to NHS dental services
- promote high-quality NHS dental services.

5.10 Over the last few years, targeted investment and workforce initiatives have resulted in significant access improvements in areas of the country that traditionally suffered from low levels of dentistry. The reforms introduced on 1 April now provide a much more stable platform for supporting further improvements, through a combination of:

- more effective use of existing financial investment and workforce, using the opportunities opened up through the dental reforms to improve commissioning and promote better compliance with NICE guidelines on patient recall intervals,
- continued investment;
- maintaining a healthy position on workforce supply, including a greater use of skill mix in delivering services.

5.11 Sustainable improvements in access rely on keeping these three factors in balance. There is clear evidence – set out below in the section on recruitment and retention – that workforce supply does not currently present any barrier to expansion of services, and that this position is set to continue for many years to come as significantly increased numbers of dental students graduate from 2009 onwards.

5.12 Our main focus, therefore, is in supporting NHS commissioners, working with the profession, to ensure that the reforms are implemented and their benefits realised in ways that facilitate steady improvements in local access. This in turn will provide a more stable platform on which PCTs can make local decisions about further financial investment in services.

Recruitment and retention

Data from transition to new contracts

5.13 As of March 2006, there were 21,111 dentists working in NHS primary care services, a 6.6% increase on the previous year and 28% higher than in 1997. This reflected, among other factors, the success of the Department's programme to recruit the equivalent of an extra 1,000 whole time dentists between April 2004 and October 2005. As reported in last year's evidence, this target was exceeded with the recruitment of the equivalent of over 1,450 whole time dentists.

5.14 However, as demonstrated by the transition to new NHS dental contracts in April 2006, the key measure in terms of recruitment and retention is not the number of dentists in itself, but the level of NHS dental services that they provide. It is for this reason that the Review Body has in the past sought data on whole-time equivalent rather than headcount numbers. The system of NHS dentistry has never lent itself to WTE data, given it is based predominantly on approval for providing dental services (rather than individual employment contracts) and the dentists providing those services carry out a varying mix of NHS and private work. But the move to the new contracts has enabled us for the first time to have a consistent contractual currency – units of dental activity commissioned from dentists – for tracking changes in NHS dental workforce capacity.

5.15 **Annex H** sets out evidence on the contracts offered to dentists in the run-up to 1 April in each former Strategic Health Authority area and the proportion of these contracts signed, including the proportions signed in dispute. The key point to note is that, although just over 1,000 contract offers were not taken up, the service levels (i.e. units of dental activity) associated with these contract offers were a small proportion (4%) of the total. This is likely to indicate both that the rejected contracts were for fewer dentists than the signed contracts and that many of the dentists who chose not to take up new contracts had previously provided a relatively low level of NHS services.

5.16 Since 1 April, PCTs have made major progress in commissioning new or expanded services, both to replace the 4% of capacity associated with rejected contract offers and to expand services further. In the first four months of 2006/07, PCTs commissioned 3.5 million units of dental activity, likely to be equivalent to services for some 1.1 million patients. This already exceeds the service levels associated with rejected contract offers.

5.17 As one would expect, workforce capacity (as represented by the total units of dental activity now commissioned) also exceeds levels of capacity last year. One cannot calculate with absolute precision the equivalent units of dental activity provided before 1 April, for instance because we do not have data on some of the activity underpinning child capitation in the former GDS. But our best estimate is that courses of treatment in 2005/06 equated to some 76.7 million units of dental activity, compared with the 78.5 million units of activity now commissioned.

5.18 The information on dental contracts does not tell us how many individual dentists are working under new contracts, because a contract can be for a single dentist or for a group of dentists within a practice. The NHS Information Centre will, however, be publishing data on numbers of dental performers (amongst other areas) in October. We will comment on this in our supplementary evidence, but we expect it to show a reduction in overall numbers compared with March 2006. This would be consistent with the pattern of dentists with relatively small levels of NHS commitment ceasing to

provide services and provision increasingly shifting to dentists who devote proportionately more of their time to NHS work.

5.19 The other short-term indicator that is relevant to recruitment and retention is the outcome of contracts signed 'in dispute'. The transitional arrangements included provision for contracts to be signed 'in dispute' so that, where PCTs and contractors had not yet reached full agreement on some terms, the contractor could continue providing services to patients and receive payment whilst these outstanding issues were resolved, either through local agreement or (if necessary) a determination by the NHS Litigation Authority. Around 35% of signed contracts fell into this category.

5.20 Based on data to the end of July, the dispute resolution process has already been concluded in 41% of these cases. Most importantly, the evidence so far shows that dentists are overwhelmingly staying with the NHS at the end of the process. By the end of July, 98% of disputes so far settled had ended with the dentist staying with the NHS.

5.21 This fits with the more impressionistic evidence gathered by Local Dental Committees from their own members. Their survey in May 2006 indicated that 38% of their members in dispute regarded the dispute as settled and nine out of ten reported positive working relationships with their local PCT.

Responses to local commissioning

5.22 The experience of PCTs in commissioning new services provides a further measure of recruitment and retention. So far, there is clear evidence from recent tender exercises that the supply side remains very healthy, with high levels of competition for new NHS work.

5.23 **Annex I** sets out in more detail examples of some of the tenders recently undertaken by PCTs, the level of interest from dentists and corporate bodies in the services being offered, and the improvements in service levels and value for money (i.e. the units of dental activity commissioned for a given level of contract value) that PCTs have secured through these processes.

5.24 In Lincolnshire, for example, three PCTs issued a tender worth some £3.1 million to bring significant new services into a traditionally under-dentisted area. Nationwide advertising for extra services resulted in 33 expressions of interest from which twelve new contracts were agreed. What is more, the contractors were able to put forward proposals that delivered a 12% increase in service levels (for a given level of contract value) compared with the previous average for General Dental Services in the area. In other words, dentists and corporate bodies are not just keen to provide new and expanded services, but are sufficiently confident in the contractual terms and remuneration package available to be able to offer improved levels of service for NHS patients.

5.25 This supports our view that the key factor in expanding levels of dental services is no longer recruitment and retention, but growing services at a pace that protects value for money and is consistent with local investment priorities.

The future workforce supply

5.26 In the medium term, the position on workforce supply will be further enhanced by the 25% increase in undergraduate training begun in October 2005 and the fourfold increase in training places for dental therapists, as set out in our evidence last year.

5.27 It is difficult at this stage to update the conclusions of the 2003 workforce review to assess the optimum level of future workforce supply. If sustained, the levels of interest among existing dentists in undertaking additional NHS work and the continued ability of practices and corporate bodies to benefit from overseas recruitment, will have significant implications for our workforce strategy.

5.28 In order to update our workforce assumptions, we will also need to assess the impact of the new contractual arrangements on levels of patient access, which will hinge on a range of factors including the value for money secured through new contracts and the frequency of patient recall.

Impact of new arrangements for patients

5.29 As indicated above, the Department's high-level aims in relation to dentistry are to improve oral health, improve access to NHS dental services, and promote high-quality dentistry.

5.30 The new commissioning and contractual arrangements are designed to support all three objectives. In terms of oral health and clinical quality, the key point is that the abolition of the fee-per-item system is designed to support dentists in carrying out simpler courses of treatment, with fewer intensive interventions. This should not only be more in line with best clinical practice, but free up time for dentists to spend more time with patients and give more preventative health advice.

5.31 We are aware that a number of dentists continue to question these assumptions, on the grounds that there are no explicit incentives (i.e. no specific remunerative advantage) for offering preventative advice or for treating patients with higher-than-average oral health needs. Our view has always been that it will take time for practices that have grown used to a fee-per-item system to adapt to new ways of working, to see for themselves how these can free up time and capacity, and to recognise the crucial importance of 'averaging', i.e. that some courses of treatment will inevitably be more complex and costly than others but that – on average – the courses of treatment carried out over the year will be less complex and less costly than under the traditional GDS system.

5.32 We recognise that this is one of the key aspects of the reforms that will have to be closely tested. This was part of the reason for establishing an Implementation Review Group, bringing together representatives of patients, dentists (including orthodontists), SHAs/PCTs, dental laboratories and the NHS Business Services Authority to ensure that the different stakeholders can jointly assess how far the reforms are delivering their intended benefits for patients, for dentists and for the NHS. We hope to publish a report after the first twelve months of the reforms, based on the evidence reviewed by the group and any ideas put forward by the group for making improvements to the new systems.

5.33 In the meantime, we have undertaken further work to support the NHS and the profession in working jointly to address oral health and clinical quality. We and NHS Primary Care Contracting have published a Clinical Governance Framework for

primary care dentistry which is available on the PCC website for PCTs to use in liaison with their local practitioners. We have also commissioned an e-learning resource aimed at promoting prevention and dental public health within the new dental contract. A copy of the CD ROM will be sent to every dental practice in England.

5.34 In terms of patient access to services, progress in the run-up to the reforms was (as reported above) highly encouraging. The Information Centre for Health and Social Care bulletin "*NHS Dental Activity and Workforce Report England 31 March 2006*" published on 23rd August, showed an increase of more than half a million registrations between March 2005 and March 2006.

5.35 The reforms provide a number of advantages that should support PCTs in making further sustained increases in patient access, building on this progress. In particular, PCTs now have dedicated financial budgets and the commissioning tools to replace services when a dentist retires or leaves the area. The evidence so far from re-commissioning, as set out above, is that when re-commissioning services in this way PCTs are typically able to secure better value for money, with a greater level of patient services commissioned for the same level of investment. The other key point is that dentists are now under a contractual duty to follow the NICE guidelines on patient recall intervals, which in our view is likely to mean less frequent recalls for some dentally healthy patients – thereby freeing up capacity for new patients to be seen.

Impact of new arrangements for dentists

Total reward package

5.36 The NHS has an excellent reward package for dentists which we believe will have been significantly improved by the introduction of the new contracts. This includes:

- a pension for all performers;
- the stability and security of an agreed annual NHS contract value guaranteed at current levels for at least three years;
- the old "treadmill" of drill and fill removed;
- a 5% reduction in overall activity (defined by weighted courses of treatment) for GDS dentists for the same remuneration package;
- the opportunity to reduce workload and expenses further through carrying out simpler courses of treatment
- maternity, paternity and sick pay arrangements; and
- a new £100 million capital investment programme.

5.37 The new dental contract provides dentists with the long-term financial security they did not have under the old item of service system. General Dental Services (GDS) contracts are open-ended and allow dentists to agree their services and delivery pattern with PCTs along with any necessary variation to allow for staff changes etc. This provides a regular income stream every month, a month in arrears: a major improvement on the previous system where claims had to be submitted and agreed after the conclusion of the course of treatment with payment taking another four weeks on average. This improves cash flow and financial planning and significantly reduces the cost of working capital. It also allows agreed activity to be planned across the financial year to allow for holidays, training etc.

5.38 Although the transition period for the new contract and the associated guarantees for dentists and ring fencing arrangements for PCT dental budgets were set at three years, we do not expect any major changes to take place at the end of this period. PCTs and their dental providers should be building up long term, mutually beneficial working

relationships. PCTs are highly unlikely to sever service contracts, provided there has been no serious breach of contract requirements or service standards. The main significance of the three-year period is that, during this period, money from contracts that lapse through retirement, dissolution of practices, etc has to be used by the PCT to re-provide more dentistry. This gives real stability; neither before nor after the transitional period can a PCT unilaterally reduce the remuneration given to a provider

5.39 We will also be continuing to supply dentists with details of their regular patients: those seen by them in the previous 24 months and not subsequently seen by another practice. This "practice list" will enable dentists to keep track of their patients and demonstrate the size of the practice if they wish to sell, helping to maintain the "goodwill" value of the practice. The list will be generated and maintained by the dental practice division of the NHS Business Services Authority at no cost to the dentist.

5.40 On the pension scheme, dentists have a generous NHS pension: they accrue the equivalent of 1.4% of their net superannuable NHS earnings each year, which is uprated to keep pace with subsequent pay increases until the point of retirement, so a pension for dentists with 40 years service and a high NHS commitment should be around £40,000 in today's prices. This is inflation proofed and would be very expensive to fund privately.

Expenses

5.41 We will not have firm statistical evidence this year on the effect of the new contract. However, we believe there is little doubt that dentists will be carrying out simpler courses of treatment, which must on the face of it mean lower expenses (as a proportion of gross remuneration) and therefore higher net incomes (or profits).

5.42 The expected reduction in the frequency and complexity of treatment is desirable and forms part of the expected benefits of the reforms. The reduced complexity allows dentists to spend more time with patients and give more preventative advice. In addition, the consumables and appliances used are expected to reduce, especially for complex restorative treatments: significantly reducing costs.

5.43 Consumables and lab costs make up around 30% of dental expenses. A 5% reduction in the UDA expectation – as implemented in the new contract - therefore means that a 1.5% increase in pay translates into a 2.25% increase in net income (assuming other expenses rise by 2.25%).

5.44 We believe that on top of this 5% UDA reduction there will also be a notable reduction in complexity within each treatment band. The evidence from Personal Dental Services pilots is that abolishing the fee-per-item system reduced the complexity of courses of treatment by some 20-30%. The fact that PDS pilots were not based on units of dental activity is irrelevant in this context: units of dental activity are simply a weighted count of courses of treatment, so carrying out fewer items within a course of treatment does not affect the achievement of the annual agreed UDAs. If the average complexity of courses of treatment is reducing by 20%, then a 1.5% increase in net pay translates into a 8.6% increase in net income (if expense inflation is 2.5% and allowing for lower expense volume from the 5% reduction in UDAs) .

5.45 The new arrangements for NHS dentistry now allow, and indeed encourage, PCTs, to take specific account of any local factors, which may influence expenses in the main contract value for each provider. This might include local high costs for practice staff, rents, property or specific recruitment issues in the area (for example persuading

dentists to come and work in less desirable or remote areas). This means that there is no need to include such factors in the general, national contract value uplift as they are best dealt with at local level by the commissioners of the service. Including a national uplift factor would reduce the money available to target at such "hot spot" areas and would significantly reduce flexibility to increase access in areas of highest needs.

Access to NHS capital funding

5.46 Health minister Rosie Winterton announced in May 2006 that NHS dental practices and their patients will benefit from a programme of capital investment. £100 million of capital investment has been made available to the NHS, through SHAs, over the next two years to take forward infrastructure improvements for NHS primary dental care services. This builds on the £80 million capital investment already going towards modernising dental education establishments and supporting the 25% expansion in dental training places. This direct access to additional capital funding (PCTs can already use their normal capital allocations to invest in primary care dentistry) will further reduce pressure on practice expenses, particularly where practices are planning large scale investments.

DDRB expenses formula

5.47 The formula used in the 2005 DDRB report set out to model the change in the level of dental expenses. For staff costs, the formula used in the 2005 report was based on the increase in dental nurses' earnings. In the 2006 report, it was based instead on pay increases for staff employed in the Healthcare and Related Personal Services (HRPS) sector, which was higher than the increase in dental nurses' earnings for that year.

5.48 We consider that whatever increase is chosen for use in a fixed formula there will always be year-to-year variations in recorded pay increases. If a formula is to be used, we consider that it should use the most relevant pay information, which is for dental nurses. We do, however, continue to have reservations about the use of a formula in this manner. Many of the expenses in the dental system are driven by the rate of increase in gross dental remuneration with the size of the dental review body determination setting their own increases.

5.49 The major changes to the dental contract now mean that it is essential to undertake a new workforce and expenses survey. This has been discussed in the Dental Working Group and we would ask this group to set out the necessary remit for such a survey.

Conclusion

5.50 Following the introduction of the new dental contracts there will need to be a new workforce and expenses survey. The two key factors in improving access (see above) are reforms to how services are delivered (through better commissioning and better use of NICE guidelines) and steady, sustained growth in local investment. Additional spend on gross remuneration will directly reduce the money available locally for improving access**.** Each additional 0.1% on pay costs £2.4 million, which would otherwise purchase some 120,000 UDAs (allowing for additional patient charge revenue), which corresponds to some 40,000 patients.

5.51 We consider that an increase in gross remuneration of 1.5% would also fairly reflect the likely reduction in expenses flowing from the new contract arrangements, together with the strong evidence on recruitment and retention. PCTs are currently facing no significant difficulties in expanding services and indeed are able to commission additional services at improved levels of value for money, strongly suggesting that

dentists and corporate bodies are attracted by the contractual and remuneration packages available for NHS work.

5.52 We recommend a simple percentage uplift of 1.5% which can be applied to the GDS dental contract values. We would expect most PDS agreements to have a similar uplift applied but the specialist nature of some of the services commissioned, e.g. for orthodontics, mean that PCTs need to have more flexibly in uplifting contract values for this group.

5.53 Allowing for a 5% fall in expenses volume from the reduction in GDS units of dental activity, this would mean personal pay growth and increase in expense costs of 2.25%. Allowing for a 20% reduction in expense volume because of the likely reduction in complexity of courses of treatment, it would mean a rise in net income of 5.25% if expenses have increased in line with net income (as is often the case following DDRB awards) or a rise in net income of 8.6% if expenses have increased by 2.5%.

SALARIED PRIMARY DENTAL CARE SERVICES

5.54 Salaried primary dental care services (SPDCS) continue to be an important and valued part of the dental workforce available to Primary Care Trusts (PCTs). We reported last year on progress with the review of these services undertaken under the leadership of the previous Chief Dental Officer, Professor Raman Bedi and that, following extensive consultation with salaried dentists, patients and the NHS, we were inviting NHS Employers to take forward negotiations on new pay, terms and conditions with the BDA.

5.55 Following detailed consideration of the consultation responses we were able, on 14th March 2006, to publish both a summary of those responses, and the Department's considered view of the way forward on each of the fourteen proposals which had been set out in *Creating the Future - Modernising Careers for Salaried Dentists in Primary Care*. We confirmed that we were asking NHS Employers to work in partnership with the BDA to develop changes based on the proposals in *Creating the Future* that would support the modernisation of careers, support high quality patient care, and give a 10% increase in the pay budget for salaried dentists. We asked that the negotiations be taken forward with a view to the new terms and conditions of service being introduced from 1st April 2007. We anticipate that NHS Employers and the BDA, as the parties to the negotiations, will be reporting directly to DDRB on progress.

5.56 Pending the outcome of those negotiations, we believe it would be appropriate to uplift existing salary scales and allowances for all grades of salaried dentists by the percentage uplift applicable to other groups of salaried doctors and dentists working in the NHS.

5.57 As part of the wider modernisation process for NHS dentistry, and consistent with the vision for salaried primary care dental services set out in *Creating the Future*, we also published in March 2006 Directions to PCTs which should ensure that by October 2006 all salaried dental services are being provided on a common basis, and one which is consistent with the framework for services commissioned from independent contractors. In support of those changes, we published a factsheet for PCTs about salaried primary dental care services.

5.58 We reported last year on the national organisational development programme commissioned for all salaried dentists in England. This programme was designed to equip salaried dental services for the changes to NHS dentistry due to be introduced

from 1st April 2006. The contract was let to a consortium of NHS Partners and Capita Consulting and was largely complete by the end of March 2007. By its final conclusion the programme had been provided to 107 of the 113 salaried dental services in England and involved 3,084 staff, 944 of whom were salaried dentists. Of the six non-participating services, four had already undertaken significant OD work and did not feel the necessity to enter this programme. The programme was evaluated and the response from participants was extremely positive.

DENTAL PUBLIC HEALTH STAFF

5.59 We reported last year that we hoped to publish shortly an Oral Health Plan for England. "*Choosing Better Oral Health*" was published in November 2005 and as part of the Choosing Health family it sets out the Government's strategy for improving oral health and reducing oral health inequalities. In the section on workforce we state that "PCTs will firstly wish to consider the advice that they receive on meeting the oral health needs of their residents and that Consultants in Dental Public Health are trained specifically to assess oral health needs and provide advice on how these needs should be met".

5.60 Dental public health staff will play an important part in helping SHAs and PCTs realise the benefits of the NHS dental reforms, particularly in commissioning services to improve oral health. These staff are employed on terms and conditions of service which are exactly comparable with their counterparts in hospital medicine and dentistry and in public health medicine. We have been in discussion with the BDA for a number of years about the desirability of fully incorporating those staff in the main hospital medical and dental/public health medicine terms and conditions of service, in order to ensure that these staff experience no delay in receiving the benefits of changes to pay, allowances, and other terms of service. Regrettably, the BDA seem unable to conclude consideration of this issue from their side.

5.61 We consider that dental public health consultants and training grade staff should receive exactly the same uplift to pay and allowances as their hospital medical and dental staff/public health medicine counterparts in order to maintain parity and ask the DDRB to so recommend.

CHAPTER 6: OPHTHALMIC MEDICAL PRACTITIONERS

Summary

6.1 The Department of Health is currently negotiating the 2006/07 sight test fee with the Optometric Fees Review Committee, which represents optometrists and ophthalmic medical practitioners (OMPs). These negotiations are also covering the payment for loss of earnings associated with undertaking continuing education and training.

6.2 We remain firmly of the view that there should be a common sight test fee for optometrists and OMPs. Optometrists continue to carry out some 97% of NHS sight tests, and we believe the DDRB's previous recommendations about the joint negotiation of a common fee continue to be relevant for this and future years.

Background

6.3 Between 31 December 2004 and 31 December 2005, the number of OMPs who held contracts with Primary Care Trusts in England and Local Health Boards in Wales to carry out NHS sight tests decreased from 592 to 477, and the number of Optometrists increased from 8328 to 8522. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

6.4 In 2005/06, 11.0 million sight tests were paid for by PCTs in England and LHBs in Wales. This was 2.1% more than in 2004/05. Within these figures, the proportion of sight tests carried out by OMPs was 2.6% in 2005/06.

6.5 The surveys which we have conducted into the working patterns of optometrists and OMPs show that the majority of OMPs practise part-time. The sight tests volume and workforce survey 2003/04 showed that 46% of practising OMPs in Great Britain also held appointments as hospital doctors.

6.6 The Department is currently working with the professions, the NHS and other stakeholders to review the General Ophthalmic Services. The review is looking in particular at the scope for enhancing the role of primary care professionals in diagnosing and managing eye conditions, in order to reduce pressure on secondary care and support the wider objective of providing care closer to home for patients. The review is due to be completed by the end of 2006.

CHAPTER 7: EVIDENCE FROM THE NATIONAL ASSEMBLY FOR WALES

SUMMARY

7.1. This chapter has been prepared by the Health and Social Services Department and reflects the views of NHS Wales. It complements the evidence from the other Health Departments and draws attention to any policies that are distinctive to Wales.

Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century

7.2. The Welsh Assembly Government's 10-year strategy for health and social care services was published in May 2005 and outlines a vision of high quality health and social care for the future. It includes:

- a 10 year ambition to cut to the minimum avoidable death, pain, delay, helplessness and waste in Wales
- a process for a transformation in services moving the focus to the prevention of problems and to earlier intervention, shifting services out into the community and breaking down artificial barriers at all levels
- the first of a series of three-year action plans, based around tough targets, to drive the improvements that are needed
- a recognition of the crucial role of local government in developing its own service contribution and in working with the NHS, in bringing about the service changes and improvements needed

7.3. In the immediate next phase, *Designed to Deliver,* the focus is on six major streams: regional reconfiguration, commissioning, quality improvement, clinical engagement, waiting times reduction and chronic conditions management.

Workforce Strategy

7.4. *Designed to Work* is the workforce and people management strategy to support *Designed for Life* to ensure that we have the right staff with the right skills doing the right jobs in an efficiently planned and managed service.

7.5. It has three key themes:

- develop a new approach to role redesign and innovative work systems to meet patients' needs;
- create an organisational and workforce development planning system to deliver service change;
- develop a modern people management, human resources and organisational development service for the delivery of innovation.

7.6. This marks a new beginning with the establishment of the Workforce Development Education and Contracting Unit in the National Leadership and Innovation Agency for Healthcare (NLIAH). This will have a key role in helping to create the vision of the future workforce that we need and thus ensuring that we train, recruit, retain and develop these roles for NHS Wales.

7.7. A partnership approach to the implementation of *Designed to Work* will be adopted directly with staff, trades unions and professional bodies, heads of professions, NHS managers and the public.

7.8. The future workforce will:

- be designed around patients, care pathways and service needs
- work across traditional professional boundaries
- work across organisational boundaries
- work in managed clinical networks where care is needed
- reflect a shift from secondary to primary care provision
- evolve and develop in innovative ways as service needs change
- be developed with the full engagement of clinical leaders
- be developed around career pathways and the KSF
- be regulated and accredited within new arrangements
- be involved directly in the development of roles

7.9. All organisations will have workforce modernisation strategies, maximise pay modernisation benefits to support the transformation of service delivery and role development and work with NLIAH and the Deanery to promote service redesign and innovation.

7.10. The benefits created by pay modernisation – the revised consultants' contract and consultant outcomes indicator system, the new General Medical Services and Dental Contracts and hopefully the new contract for non-consultant career grades will be maximised to support the transformation of service delivery and role development. Modernisation demands the development of an innovative whole health economy approach to workforce planning which will require close collaboration with clinicians to provide safe effective services within available resources.

7.11. All healthcare organisations will ensure that they have appropriate workforce modernisation strategies in place to develop innovative recruitment and employment models to attract and retain under-represented groups such as the economically inactive and disadvantaged and minimise the use of agency staff.

Total Reward

7.12. Pay levels, pensions, annual leave, flexible working, career development and access to training are part of a generous package to offer existing and potential employees in NHS Wales. These should also be considered when deciding on a recommendation on an annual pay uplift, especially given we are looking for a low uplift this year.

7.13. For graduates entering their first PRHO post, salaries remain very competitive. Figures produced by the Higher Education Statistics Agency (HESA) show that the starting salary in typical graduate-level jobs for medicine and dentistry are the highest.

8.1	Clinical medicine (doctor/surgeon/GP)	£31,074

8.2	Clinical dentistry (dentist)	£27,870
8.3	General engineering (engineer/IT pro)	£23,219
8.4	Economics (business/finance)	£22,761
8.5	Clinical veterinary medicine (vet)	£22,505
8.6	Aerospace engineering (engineer)	£21,366
8.7	Building, construction (architect/planner/ surveyor)	£21,257
8.8	Mechanical engineering (engineer)	£21,231
8.9	Social work (public/social services)	£21,162
8.10	Software engineering (IT professional)	£20,884
8.11	Physics (business/statistics)	£20,865
8.12	Mathematics (business/finance/teaching)	£20,805
8.13	Civil engineering (engineer)	£20,473
8.14	Electronic, electrical engineering (engineer)	£20,336
8.15	Nursing (nurse)	£20,275
8.16	Information systems (IT professional)	£20,088
8.17	Medical technology (healthcare)	£19,901
8.18	Computer science (IT professional)	£19,898
8.19	Teacher training (teaching)	£19,588
8.20	Business studies (sales/admin/business)	£19,346

Source: HESA 2004/05

Workforce Numbers: Headline Figures

7.14. There were further increases in the numbers of doctors and hospital dentists and GMPS doctors in Wales in 2005:

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 144 (headcount) or 3.1% and 64 (FTE) or 1.2%;
- Consultant numbers increased by 85 (headcount) or 5.3% and 81 (FTE) or 5.1%;
- Associate specialist numbers increased by 2 (headcount) or 1.4% and 4 (FTE) or 3.0%;
- Staff grade numbers decreased by 9 (headcount) or 1.9% and 17 (FTE) or 3.6%;
- Numbers in the registrar group (mainly specialist registrars) increased by 26 (headcount) or 3.2% and 36 (FTE) or 4.5%;
- Senior house officer and equivalent numbers increased by 68 (headcount) or 5.7% and 65 (FTE) or 5.5%;
- Pre-registration house officer numbers increased by 10 (headcount) or 4.1% and 11 (FTE) or 4.5%;
- GP numbers – excluding GP retainers and GP registrars – increased by 33 (headcount) or 1.8% and 28 (FTE) or 1.7%;
- GP registrars decreased by 12 (headcount) or 10.4%.

7.15. The annual medical student intake has nearly doubled (190 to 375) from 1998 to 2005 with 305 places available at Cardiff and a further 70 on offer at the Graduate Entry

Scheme at Swansea. There are over 2,200 doctors in training in Wales of which 811 are Specialist Registrars working in all specialty areas to gain the Certificate of Completion in Training (CCT) to enable them to apply for consultant posts. The Deanery is currently going through a process of reorganising these posts along with 1,100 SHO posts to develop run-through training under the auspices of Modernising Medical Careers with a start date of entry of August 2007.

Pre-Registration House Officers

7.16. There are currently 282 posts for graduates. From 2007 an additional 30 F1 posts are being created, which are being advertised in October for commencement in August 2007. This increase is to meet the number of graduates from Welsh Medical Schools.

Senior House Officers (SHOs)

7.17. Between 1997 and 2005 the number of Senior House Officers and equivalents employed by the NHS in Wales increased by 241 (23.4%), from 1,028 to 1,269. In the period 2004 to 2005 the figure increased by 68 (5.7% from 1,201 to 1,269.

Registrar Group Doctors

7.18. Between 1997 and 2005 the number of Registrar Group Doctors employed increased by 253 (41.3%) from 613 to 866. In the period 2004 to 2005 the figure increased by 26 (3.2%) from 613 to 866.

Associate Specialists and Staff Grades

7.19. Between 1997 and 2005 the number of Associate Specialists employed increased by 59 (51.3% from 115 to 174. In the period 2004 to 2005 the figure increased by 2 (1.4%) from 172 to 174.

Between 1997 and 2005 the number of Staff Grade doctors employed increased by 189 (62.4%) from 303 to 492. In the period 2004 to 2005 the figure decreased by 9 (1.9%) from 501 to 492.

Consultants

7.20. Between 1997 and 2005 the number of Consultants employed increased by 540 (40.8%) from 1,322 to 1,862. In the period 2004 to 2005 the figure increased by 85 (5.3%) from 1,777 to 1,862.

7.21. The table below shows the FTE to headcount ratio for consultants since 1999. Across the whole of the HCHS sector in Wales, the ratio between FTE and Headcount in 2005 was 0.90.

FTE to headcount ration for consultants in Wales

	Headcount	FTE	Ratio
1999	1,433	1,270.6	0.89
2000	1,496	1,299.8	0.87
2001	1,528	1,361.0	0.89
2002	1,578	1,420.7	0.90
2003	1,596	1,431.5	0.90
2004	1,777	1,591.2	0.90
2005	1,862	1,672.6	0.90

Source: Annual Medical & Dental Staff census, National Assembly for Wales

Pay and Conditions of Service

Consultant Vacancies

7.22. The following tables show how the three-month vacancy rate for medical and dental consultants has changed over the last 12 months.

The number of vacant consultant posts has fallen from 119.3 to 102.3 between March 2005 and March 2006. The breakdown by specialty is as follows:

	31/3/2005	30/9/2005	31/3/2006
A&E	5	3.4	5.4
Anaesthetics	8	8.6	8
Clinical oncology	2	-	
Dental Group		1	
General Surgery	6	2	3
ENT			
T&O	6	9	7
Ophthalmology			
Urology		1	1
Cardio-thoracic surgery			
Plastic Surgery			
Pathology		1	
Haematology	4	3	5
Histopathology	7.5	6.5	9.6
Medical Microbiology	2	2	1
Blood Transfusion	0.8	-	
Paediatrics	6	5	4
General Medicine	32	25	20.5
Obstetrics & Gynaecology		1	
Community Health	7.4	4.6	
Psychiatry	18	28	28.4
Radiology	14.6	10.8	9.4
	119.3	111.9	102.3

The vacancies were spread over the NHS Trusts in Wales as follows:

	31/3/2005	30/9/2005	31/3/2006
Bro Morgannwg	5	8	9
Cardiff and Vale	9	6	8
Carmarthenshire	8	6	4
Ceredigion & Mid Wales	6.1	3.3	2
Conwy & Denbighshire	10	9	9
Gwent Healthcare	16	12	11
North East Wales	4	7	9
North Glamorgan	9	9	9
North West Wales	18	17.4	13.9
Pembrokeshire & Derwen	13	18	18.4
Pontypridd & Rhondda	2	1	2
Powys LHB	3.4	3.2	
Swansea	7	8	7
Velindre incl NPHS	8.8	4	
	119.3	111.9	102.3

Consultant Contract

7.23. The amended consultant contract in Wales became effective on 1 December 2003. Trusts have been undertaking their second round of job planning during the past 12 months, when emphasis has shifted during the year from basic implementation of the contract to commencing benefits realisation. During this time a formal structure for development and implementing Consultant Outcome Indicators (COIs) has also been put in place.

7.24. The aims of the amended consultant contract were to improve the consultant working environment, to improve consultant recruitment and retention, and to facilitate health managers and consultants to work together to provide a better service for patients in Wales. It was seen by all parties as an integral part of the modernisation of NHS Wales.

7.25. Virtually all Trusts have seen a reduction in the level of additional sessions being paid. Over 80% of previously unrecognised additional sessions have either been converted into planned sessions worked on a prospective and agreed basis, or are no longer required to be worked. The remaining sessions, which currently attract an escalator premium payment, will further reduce substantially by Autumn 2006. No Trusts in Wales are paying consultants at premium rates for work done, apart from the remaining sessions attracting an escalator payment, or any genuine 'badged' Waiting List Initiative payments.

7.26. The average number of DCC sessions worked by consultants overall has reduced by just over 0.5 sessions per week, but he potential for loss of activity is more than compensated by the increase in the numbers of consultants employed, quite apart from the effects of changes in clinical practice and service delivery. Indeed only one Trust has reported any loss of activity. There has been a small increase in the average level of SPA sessions which, combined with the increase in consultant numbers, means a considerable additional investment in service quality. Trusts appear to have

management processes in place to link job planning with their overall service modernisation agenda.

7.27. Trusts entered into contractual arrangements for the delivery of COIs with CHKS during 2005, funded by the Assembly, and have developed project management arrangements for their implementation. An all-Wales Steering Group was established in late 2005, and a User Group of Trust Project Managers and CHKS and Assembly representatives is now meeting regularly. Work on the development of COIs, however, is likely to take a further 2 to 3 years before producing information that can effectively inform individual job planning, service commissioning, and performance management.

7.28. The average number of hours worked by consultants per week in December 2003 was 46.3 hours per week (according to retrospective job plans), with those in many specialties working considerably in excess of these, in part to cover vacancies. Trust Annual Reports identify that average working hours had reduced by March 2006 to 44.3 hours per week, a reduction of 2.0 hours per week since the amended contract was introduced.

7.29. Vacancy rates for consultant posts in Wales were running at 9.5% in September 2003 (based on the all-Wales 6-monthly vacancy surveys of posts unfilled for 3 or more months), with problems accentuated in particular specialties such as psychiatry and radiology, and geographically, particularly in rural parts of West Wales and certain Valleys communities. By March 2006, the vacancy rate had fallen to 5.4% despite a considerable expansion in the number of consultants employed in Wales during this period of 1,596 in September 2003 to 1,862 in September 2005.

7.30. Overall a total of 2,901 additional sessions were being paid across Wales as at March 2006. This is an overall reduction of 284 sessions over the level being paid based on retrospective (2004) job plans. As the total number of consultants employed has increased in this period from 1,596 to 1,862, the average number of additional sessions has fallen from 1.83 to 1.57 per consultant, including any additional non-clinical or management responsibilities. This included both Assembly-funded additional clinical sessions, and locally funded additional clinical, non-clinical, and management sessions.

7.31. The escalator premium rate (time and a quarter) for continuing previously unrecognised additional sessions, effective from December 2005, was still being paid on about 530 sessions across Wales at the end of March 2006. Three Trusts had identified that they were in the process of eliminating the need for any escalator payments this year by, respectively the end of June, end of July and autumn. This would reduce the total number being paid to about 130 sessions.

Designed to Comply – Doctors in Training

7.32. The compliance rate with the New Deal has increased to 95.8% in March 2006 compared to 89.3% in March 2005. Nine out of the 14 Trusts in Wales are 100% compliant.

7.33. In July, the Assembly published an evaluation report to provide an overview of the compliance of junior doctors with the EWTD. As of March 2006 compliance with the 2004 requirement of 58 hours was 96% and based on current working patterns this would result in a compliance of approximately 29% with the 48 hour target for 2009.

7.34. The report advocated four areas to assist NHS Trusts to achieve compliance:

- Rota management – this provides an opportunity to place suitable numbers if needed on appropriate rotas for local service delivery and consists of 4 components, work intensity, numbers on rotas, workforce planning and training considerations;

- Hospital at Night – involves structuring rotas to provide demand led care in the out of hours period based on competency rather than specialty and grade;

- Remodelling the medical workforce to assess which member of staff is best suited to provide the level of care needed for the patient;

- Reconfiguration – involves the re-allocation and design of services on a local and national level and will support the requirement to achieve EWTD compliance for 2009.

General Medical Services

7.35. The growth in GP numbers is shown in the table below.

ALL MEDICAL PRACTITIONERS – BY SEX AND AGE [(a)]

Number	**2001**	**2002**	**2003**	**2004**	**2005**
MALES AGED:					
Under 30	7	10	7	7	6
30 – 39	275	253	247	209	186
40 – 49	505	510	484	490	481
50 – 59	399	394	403	410	419
60 – 64	63	67	83	79	92
65 or over	27	24	21	24	24
All ages	**1,276**	**1,258**	**1,245**	**1,219**	**1,208**
FEMALES AGED:					
Under 30	8	11	11	16	19
30 – 39	214	216	210	209	218
40 – 49	218	230	248	253	271
50 – 59	78	78	93	104	115
60 – 64	13	14	11	10	14
65 or over	-	1	4	5	4
All ages	**531**	**550**	**577**	**597**	**641**
ALL PRACTITIONERS AGED:					
Under 30	15	21	18	23	25
30 – 39	489	469	457	418	404
40 – 49	723	740	732	743	752
50 – 59	477	472	496	514	534
60 – 64	76	81	94	89	106
65 or over	27	25	25	29	28
All ages	**1.807**	**1,808**	**1,822**	**1,816**	**1,849**

Source: Health and Social Care Information Centre
[(a)] At 30 September. Excluding GP Registrars, GP Retainers and locums

7.36. Between 1997 and 2005 the number of GPs (excluding retainers and registrars) employed increased by 70 (3.9%) from 1,779 to 1,849. In the period 2004 to 2005 the figure increased by 33 (1.8%) from 1,816 to 1,849.

7.37. Between 1997 and 2005 the number of GP Registrars employed increased by 8 (8.4%) from 95 to 103. In the period 2004 to 2005 the figure decreased by 12 (10.4%) from 115 to 103.

7.38. The GMS Contract is a UK contract and the formula used to calculate Global sum is applied consistently across all four countries. Regional differences in earnings occur because of a variety of factors including the age, sex profile of patients and lower Welsh list sizes. It should be noted that prior to the introduction of the new GMS Contract there always were differences between Wales and England in levels of intended earnings reported by the DDRB.

7.39. We are working on implementing a primary care database for Wales and may contract Professor Keith Hurst to populate the database using the same model commissioned by Department of Health.

7.40. The report on GP Recruitment and Retention published by the CMO in 2005 indicated that initiatives to improve recruitment and retention should be devised locally to take account of specific local circumstances. A decision was taken to remove the Golden Hello scheme. It was not encouraging doctors to work in the areas where they were needed most. However, the funding for Golden Hellos was not removed from LHB allocations hence they now have more flexibility in utilising the money in connection with recruitment initiatives.

Community Hospitals

7.41. The issue of GPs remuneration for working in community hospitals has been left to individual Trusts and LHBs to resolve. In a number of instances, in return for increased remuneration, GPs have agreed to modernise the way they work, adopt more flexible admissions, adhere to a more formal work pattern and participate in clinical governance requirements.

GENERAL DENTAL SERVICES

Workforce and Uptake

7.42. There has been a 13% increase in the number of dental undergraduates in Cardiff since 2004. There are 1,087 dentists in general dental practice / pilot PDS in Wales (at 31 March 2006) compared to 975 when the National Assembly for Wales was established (figure at 30 June 1999). Information provided by Local Health Boards and the NHS Business Services Authority indicate that 97% of these dentists signed up to the new contract and are continuing to provide NHS dental services. Contracts signed by these dentists account for a little over 95% of NHS dental services being provided prior to 1 April. The loss of some 74,000 places is of course disappointing but it should be seen against the 206,000 additional places provide by PDS pilots and the schemes currently underway in order to improve access.

New Contractual Arrangements - Differences between Wales and England

7.43. In Wales a 10% reduction in overall activity (defined by courses of treatment) for the same remuneration package; maternity, paternity and sick pay arrangements. There is also a tolerance level of 5% in Wales.

7.44. Vocational Training and Clinical Audit and Peer Review will both remain centrally funded, governed and administered in Wales and not be devolved to local level. This has the full support of the Welsh Central Assessment Panel, the Welsh General Practitioner Committee, and the Department of Dental Postgraduate Education, University of Cardiff.

Community Dental Service and other salaried primary care dental services in Wales.

7.45. *Bridges to the Future*, the Welsh Assembly Government's consultation, on salaried primary care dental services in Wales closed on 31 December 2005. The Welsh Assembly Government issued its response 18/7/06.

7.46. In summary :

- In view of the general support for the proposals related to career development linked to a single pay-spine and the Department of Health's decision to allow NHS Employers to enter into negotiations with the BDA on a new pay structure and associated terms and conditions, the Welsh Assembly Government has secured observer status at the English negotiations. The outcome of the English negotiations will be assessed for their suitability for introduction in Wales. The Welsh Assembly Government will continue to discuss this issue with the profession through the Wales Joint Negotiating Forum.

- Regarding the organisational reform, we wish to see a phased approach addressing, as a priority, the areas where CDS services have been in decline. All or most of the salaried primary care dental services in Wales could be re-organised within a regional framework by 2010. This is in line with the philosophy of *Design for Life* and would generally create sustainable and better commissioned services. The proposed structures will provide an opportunity for improving services to patients including the ability to increase the range of services provided in a managed salaried dental service.

7.47. The reform of the organisation of CDS services in Wales is not a rationalisation exercise, rather it should be viewed as stabilising the present provision, including workforce, and then building on that base. In view of the need to improve access to dental services we do not wish CDS clinical & non clinical vacancies frozen while LHBs and Trusts work on the merger plans.

Facts on Funding the GDS/PDS

7.48. Funding of the new contract will result in an additional £30 million being invested in NHS dentistry from 2006/07 onwards and this represents an increase in the net spend in dentistry of over 89% since the Assembly was established in 1999 and some 35% over the forecast expenditure for 2005/06.

7.49. In June, it was announced that £3 million of a centrally held fund was being made available to help LHBs in areas where access was still difficult.

NHS W ales Staff Survey 2005

7.50. The results of the Survey were published in March of this year and although based on the questionnaire widely used in England, was tailored for the NHS Wales workforce. Over 80,000 forms were distributed and there was a 33% response rate.

7.51. In terms of job satisfaction for the medical and dental staff:

79% agreed that they have clear, planned goals and objectives
80% agreed that they always know what their responsibilities are
67% agreed that they can decide on their own how to go about doing their work
52% agreed that their job had become more interesting over the last year
34% agreed that changes to their job in the last year had led to better patient care

7.52. In addition:

59% were satisfied with the recognition they get for good work
87% with the amount of responsibility they are given and
78% the opportunities they have to use their abilities.

7.53. There are a number of themes emerging from the Survey which will be the subject of particular attention from the Welsh Partnership Forum over the next 12-18 months:

- Communication – improving communication between different parts of the organisation and between management and staff;
- Staff involvement – improving staff involvement in the way the organisation is run, consultation before decision making or making changes that affect their work;
- Feedback to staff – improving the numbers of staff receiving appraisal and clear feedback on performance;
- Workload – improving staff resources and ensuring the right people are doing the right work;
- Work/Life balance – improve awareness of choice of flexible working options;
- Injury/feeling unwell at work – reduce the levels of work related stress and other injuries;
- Physical violence, harassment, bullying and abuse – increase efforts to reduce the number of incidents against NHS staff by patients and relatives;
- Thinking of leaving – use the survey data as a key predictor for recruitment and retention.

7.54. The task of monitoring, evaluating and taking forward the issues raised is being undertaken by the Employment Practices sub-group and is a reflection of the importance attached to the views of staff in assisting the WAG to make the changes necessary to improve and revitalise services and to improve the working lives of those responsible for organising and delivering the service.

Designed for Working Lives Standard

7.55. The Assembly has been considering the benefits of achieving the IWL Standard quoted by NHS Employers and the Department of Health.

7.56. The task in Wales would be to re-model IWL within parameters that can be resourced. Standards could be built to support the Corporate Health Standard and Investors in People, and look at a system of prior accreditation.

7.57. IWL has improved recruitment and retention (turnover rates/costs reduced), Staff Survey results are positive, the workforce are motivated, and sickness rates have reduced significantly in England – 4.7% average.

7.58. IWL would allow Wales to set national NHS Standards for employment practices, and provide an audit assessment process and in addition allow identification of best practice and the establishment of Best Practice Guidelines.

7.59. It is possible to remodel IWL by significantly reducing and re-designing the assessment and validation processes, by synergising procedures already in place and by making the most of partnership structures.

7.60. NHS Wales has agreed that there is clear opportunity to capitalise on the best that IWL has to offer.

Electronic Staff Record (ESR)

7.61. Trusts and LHBs will be committed to realising the benefits of the ESR system through modernising systems and developing shared services.

7.62. Organisations will be measured and accredited against a standard which will scope the people management elements from Investors in People, the Welsh Risk Management Standards, Health Inspectorate Wales reviews, the bi-annual staff survey results and assessments to be development for measuring partnership working effectiveness and staff involvement.

7.63. The Designed for Working Life Standards – to which employers must commit – will be accredited and monitored by the Employment Practices sub-group of the Partnership Forum. These standards of excellence will ensure that organisations can attract, retain, involve and develop staff.

Financial Strategy

7.64. NHS Wales continues to face a difficult financial outlook in 2007/08. NHS organisations are currently forecasting deficits equating to approximately 1.5% of their 2006/07 allocation - £63 million. This is due, in part, to the costs of pay modernisation and the full-year effect of last year's pay awards. It is probable that at least 1% will not be managed out before the end of this year, and so will continue to create a financial pressure in 2007/08.

7.65. Based on the Chancellor's expectation of public sector pay increases announced in Autumn 2005, an across the board pay settlement of 2% had been planned for during the 2006/07 Assembly Budget Planning Round. The actual effect of the 2006/07 pay awards works out at an average of 2.4% taking account of the 2.5% pay award for Agenda for Change staff and the lower award for consultants

7.66. The cost of a 1% pay increase for hospital and community NHS staff is approximately £23 million. This is equivalent to the cost of approximately 650 qualified nurses or the capital charges on approximately £170 million capital equipment (with expected life of 10 years).

7.67. The Assembly Government expects to have to provide further funding for pay modernisation in 2007/08 of:

- an additional 0.6% funding on hospital and community allocations for the costs of incremental increases of Agenda for Change;
- 0.2% funding for the non-consultant career grade contract (full-year effect).

7.68. The Assembly Government has no flexibility to manage NHS pay awards in 2007/08 above a 2% planning figure. The main financial priority is to meet the costs of UK-wide negotiated primary care contracts and to generate further reductions in waiting times.

7.69. Since April 2003 the maximum of the consultants scale has increased by 26% from £70,715 to £89,368 with some consultants benefiting in an increase in pay of 38% in the same period. Consultants will continue to enjoy high growth in paybill per head as a result of the revised contract. Those consultants who were aged between 51 and 56 at the time of the introduction of the new contract will automatically receive a consultant award of £3,088 in December 2006 and those aged between 43 and 50 a similar increase in December 2007.

7.70. This coupled with the fact that the average number of hours worked by consultants has fallen from 46.3 hours in December 2003 to 44.3 hours in March 2006 means that there are no reasons for requesting a higher uplift than the one requested last year for consultants i.e. 1.5%.

7.71. The following figures are from the Assembly's draft Budget tables and must be taken as provisional until the Assembly votes its final Budget for 2007/08 in December.

	Health DEL £m	**Cash Growth £m**	**Cash Growth %**	**GDP deflator [(1)]**	**Real Terms Growth**
2003/04	3,982				
2004/05	4,279	289	7.5	2.72	4.6
2005/06	4,628	349	8.2	2.12	5.9
2006/07*	4,983	356	7.7	2.44	5.1
2007/08*	5,332	348	7.0	2.66	4.2

** Figures at final Budget State – November 2005*
[(1)] GDP Deflators as at 30 June 2006

7.72. Employers in Wales have been surveyed about their wishes for the 2007/08 pay round. There was a high degree of agreement on:

- the level of pay uplift should be in line with or below inflation.

- the same level of uplift was desirable for both Medical and Dental and Agenda for Change staff.

CONCLUSION

7.73. Taking all factors into account, especially the continuing financial pressures within the NHS, we recommend an uplift of no more than 1.5% for this remit group for 2007/08.

CHAPTER 8: EVIDENCE FROM THE SCOTTISH EXECUTIVE HEALTH DEPARTMENT (SEHD)

SUMMARY

8.1 This chapter has been prepared by the Scottish Executive Health Department (SEHD) to complement evidence from the Department of Health in England and the National Assembly for Wales. It sets out where circumstances, initiatives and policies within NHS Scotland (NHSS) are distinct from elsewhere in Great Britain (GB) and confirms SEHD's endorsement of evidence given elsewhere that represents a GB position.

8.2 The evidence sets out:

A The Scottish context
B Specific information about individual staff groups
C Pay and Workforce Strategy
D Working Time Regulations
E Efficient Government
F Regional Pay
J NHS Finance in Scotland
H Conclusion

A. THE SCOTTISH CONTEXT

Background

8.3 The Minister for Health launched *Delivering for Health*, his action plan for NHS Scotland on 27 October 2005.

8.4 *Delivering for Health* sets out the vision of a health service which provides "anticipatory care" to those at greatest risk of ill-health; targeted and integrated care in the community for those with long term conditions; a system in which planned and emergency care are separated when feasible; shorter waiting times; and a stratified unscheduled care system based on treatment in local Community Casualty Units when possible, and in Emergency Centres when necessary.

Key actions

WHAT? **WE WILL…**	**HOW?** **BY…**
reduce the health gap (the inequality in life expectancy across Scotland)	• developing and delivering anticipatory care for those 'at risk' wherever they live • increasing health care services delivered in disadvantaged communities
enable people with long-term conditions to live healthy lives	• increasing support for self care • anticipating the needs of vulnerable people • identifying those people at greatest risk of hospital admission and providing them with earlier care to prevent deterioration of health and reduce emergency admissions
establish new health and social care services in communities	• prioritising investment in local services, including Community Health Centres that deliver diagnostic and day-care [should be day case]treatment • developing practitioners with extended roles

	• fully utilising the skills of all professionals through stronger teamwork in Community Health Partnerships
accelerate improvements in mental health services	• identifying priorities for investment in a delivery plan that builds on our *Framework for Mental Health in Scotland*
build on recent progress on waiting times	• delivering our waiting time commitments for 2007
ensure that wherever people need care, their medical history is available to the service provider	• implementing a national information and communication technology system, including an Electronic Health Record
streamline unscheduled (emergency) hospital care	• delivering services locally in Community Casualty Units when it is safe to do so, and in well-resourced Emergency Centres when it is necessary to do so
separate planned from unscheduled care	• aiming to make day case surgery the norm
remove bottlenecks in diagnostic services	• delivering on our diagnostic waiting time commitments for 2008 • increasing the range of locally available diagnostic services
apply a systematic approach to decisions regarding the concentration of specialist services	• basing our decisions on National Framework recommendations
strengthen health care in remote and rural areas	• establishing the Scottish Centre for Telehealth • identifying what services can be safely delivered in Rural General Hospitals • educating and training health care professionals with specialist skills for practice in those hospitals
decide where national specialist services such as neurosurgery and neuroscience and tertiary paediatric services should be provided	• aiming to make the best use of valuable specialist skills, and delivering services of the highest quality

8.5 The Executive has made clear that we expect NHS Boards to develop service change proposals in line with the National Framework for Service Change. "*Delivering for Health*" makes sure that change happen by providing specific actions for named bodies for which they will be held to account.

8.6 On 28 February 2006 NHS Boards were provided with a Health Department letter – HDL(2006)12 offering guidance on the implementation of the action plan set out in *'Delivering for Health'*. This described what needs to be done, by whom and when. It identifies the major milestones, defines responsibilities for the tasks and describes how the accountability arrangements for the performance of NHS Boards will be utilised to ensure that momentum is maintained.

8.7 The Health Department has set up a new Delivery Group to:

- Ensure a renewed and explicit focus on key objectives, targets and measures across the health portfolio
- Strengthen performance management between each NHS Board and the Scottish Executive by introducing local delivery plans of agreed, sharply focussed, quantified local actions

- Work with more timely and reliable management data enabling accurate tracking of Boards' performance
- Making specific interventions to support and improve performance where the need arises

8.8 For some of the commitments in *Delivering for Health* there will be public performance measures in the local delivery plans (e.g. extent of day case surgery). More generally the Delivery Group will monitor implementation of the full set of commitments in the document.

B. STAFF GROUPS

Hospital Consultants

8.9 This section updates progress on the implementation of the new consultant contract in NHS Scotland.

8.10 The number of consultants on the new contract in NHS Scotland as at September 2005 is 97%. The average number of programmed activities agreed in NHS Scotland at September/October 2005 is 11.5.

8.11 The implementation of the new contract has required significant cultural change for consultants and their managers. This is an on-going process. However, there is clear evidence that job planning is aligning individual consultant job plans to corporate requirements and that individual service benefits are flowing from the discussions and negotiations at the annual job planning stage.

8.12 From the last round of job plans in March 2006 there is evidence that there are emerging changes and pattern of service redesign.

8.13 As far as benefits emerging from the new contract are concerned, NHS Boards in Scotland significantly describe benefits of the new contract as directly contributing to, amongst other things, the delivery of in-patient and out-patient waiting targets; increased day case rates; increased theatre utilisation and a reduction in the average length of stay.

8.14 As was the case last year, NHS employers in Scotland have agreed that recruitment and retention premia for consultants should only be applied on a collective basis across Scotland to ensure a consistent and fair application. To date, no application has been received from any NHS employer in Scotland to apply this premia.

8.15 SEHD remains fully committed to maximising the number of consultants in post by September 2006 and ensuring NHS Scotland has the staff it needs to fulfil its commitment to the people of Scotland to improve health and reduce health inequalities. Work is ongoing with NHS Boards to achieve this and several initiatives have been introduced to assist NHS Boards in their ability to recruit consultants. It has to be recognised, however, that the NHS has moved on since the numeric target of 600 was set. Both *Delivering for Health* and *Modernising Medical Careers* will influence our future demand for consultants and were not around when setting the original target.

8.16 For these reasons, it was announced on 30 March 2006 our intention to step aside from the numeric target and use our robust workforce planning arrangements to give a clearer picture of future requirements. NHS Boards have been asked to use their workforce plans to consider what their future requirements for the workforce will be, taking into

account the above policy changes. Key stakeholders, including BMA Scotland, were made aware of this decision in advance.

Review of Distinction Awards and Discretionary Points

8.17 Over the next year, SEHD will carry out a review of the consultant Distinction Awards and Discretionary Points schemes. Ministers have agreed a number of parameters for this review, which is aimed at modernising the existing schemes in a way which meets the aspirations of the doctors involved and the overall needs of NHS Scotland. The review aims to achieve a significant change of emphasis both in the way the schemes operate and in the philosophy which underpins them. Key to this is the shift towards locally-determined awards, reflecting local service priorities as well as the Executive's policy priorities. It is intended that local management will be at the heart of the new processes. We also wish to build on the good work done by the Scottish Advisory Committee on Distinction Awards (SACDA) in improving the distinction awards process over recent years by giving them an overall monitoring role across Scotland. This will also be aimed at ensuring consistency across the country. The review will be led by Dr Harry Burns, the Chief Medical Officer. SEHD is currently setting up the Review Body. It is anticipated that it will begin work early this autumn and will complete its deliberations by the end of the 2006.

Staff and Associate Specialist (SAS) Doctors

8.18 SEHD has been participating in the on-going negotiations for the new contract for Staff and Associate Specialist (SAS) doctors. SEHD considers that the proposed new contract represents a genuine attempt to address many of the issues that this group of doctors have raised over the years and will also give this group of doctors an increase in pay of between 7% and 9% as part of the agreed funding envelope. The Department is pleased to note that the UK BMA SAS Committee have decided to put the proposed contract to their members for ballot.

New General Medical Services Contract

<u>Current Golden Hello Arrangements</u>

8.19 There is an incentive under the new General Medical Services Contract for GPs to join NHS Scotland. Any full-time or part-time GP starting out in their first eligible post is given a standard Golden Hello payment of £5,000 providing they satisfy a time commitment of at least 50%. Part-time appointments with less than 50% commitment qualify for a standard payment of £3,000.

8.20 Incentives are available to enable NHS Boards to recruit and retain GPs in remote and rural areas as well as areas of Health Boards where practices service deprived sectors of the community.

8.21 The incentives include a supplementary Golden Hello payment of £5,000 to every GP taking up post in a practice in a remote and rural area. Practices in rural and remote areas often have to continue to provide General Medical Services due to their isolation and this incentive is in recognition of the commitment to retain services.

8.22 A supplementary Golden Hello averaging £5,000 is also payable to every GP taking up a substantive post in one of the 40% most deprived practices in Scotland. These practices have been defined using information held centrally which shows the level of deprivation payments to each practice. Payments are made on a sliding scale between

£2,500 and £7,500 ensuring that practices in the most deprived areas receive the highest payment.

Community Hospitals

8.23 The Community Hospital Strategy proposes that the quality of services provided in community hospitals should be assessed as part of each NHS Board's arrangements for consideration of clinical quality, risk management and patient safety and not seen as "stand alone" entities. Standards would be monitored through the usual arrangements eg NHS Quality Improvement Scotland (NHSQIS) and SEHD performance framework. Should professional issues arise these would be dealt with through the usual HR procedures and professional bodies.

Doctors in Training

8.24 In the monitoring period to February 2006, 97.2% of junior doctors in Scotland were fully compliant with the New Deal contract. All FY1s are now compliant and only 138 doctors in SHO and SpR grades remain non-compliant. A number of these work in small specialties, like neurosurgery, where radical service redesign has been proposed (in the Kerr report) and implementation is being planned.

8.25 The regional New Deal Implementation Support Group (ISG) teams were transferred to the three regional workforce networks as New Deal Support Officers on 1 September 2005 as part of the review of the ISG which was started in 2003 with the York report. A review has just been carried out of these interim arrangements to support the New Deal and that report is being considered at present.

Junior Doctors

Banding Supplements

8.26 Despite average banding supplements having reduced in recent years, significant investment is still being made in supplements which are illustrated in the table below. The table shows the average supplement paid to all grades of hospital trainees for the August 2005 to January 2006 monitoring period is 60% of basic salary, a higher average than in England. NHS Scotland is working to reduce this as it moves towards further reducing hours for doctors-in-training.

	All Grades	Specialist Registrar	Senior House Officer	House Officer
August 2005 – January 2006	60.0%	60.4%	63.2%	65.8%
February 2005 – July 2005	66.2%	64.0%	65.7%	70.6%
August 2004 – January 2005	68.8%	67.4%	68.6%	72.2%
February 2004 – July 2004	75.8%	73.2%	76.0%	79.3%
August 2003 – January 2004	76.3%	72.9%	77.3%	78.7%
February 2003 – July 2003	81.7%	76.1%	84.6%	81.8%

FY1/FY2 Pay Circular

8.27 *Modernising Medical Careers* introduced a foundation programme for junior doctors and as a result, SEHD have issued a circular outlining the new pay scales that are to be

used for all new appointments to these grades. This follows discussion at the UK Joint Negotiating Committee (JNC(J)) for Hospital, Medical and Dental staff where agreement was reached on new pay scales to be used when employing trainees on the Foundation Programme.

Numbers

8.28 The headcount figure for doctors in training at September 2005 was 5223. The table below breaks down by grade those doctors in training that are compliant with the New Deal. The percentage of those compliant with the New Deal as at September 2005 was 97.2%.

	All Grades	Specialist Registrar	Senior House Officer	House Officer	Other
August 2005 – January 2006	4,955	1,322	2,480	840	313
February 2005 – July 2005	4,864	1,276	2,477	807	304
August 2004 – January 2005	4,910	1,306	2,511	798	295
February 2004 – July 2004	4,891	1,296	2,481	791	323
August 2003 – January 2004	4,882	1,315	2,492	777	298
February 2003 – July 2003	4,751	1,406	2,551	794	x

x - Prior to January 2004 these grades were included with the specialist registrar, senior house officer and house officer categories.

Proposed Foundation Doctor Contract

8.29 Over the last year discussions have been ongoing between NHS employers, the Department and the BMA to agree a National Foundation Doctor Contract with the BMA. While there were many areas of agreement between the parties in terms of the shape of such a contract, it did not ultimately prove possible for an agreed version to be implemented. The Management Steering Group of NHS Scotland employers have therefore decided to continue with the present practice of issuing staff with four month contracts for the year to August 2007, at which point a new one year contract for junior doctors will come into operation across Scotland.

PRHO/FY1 Accommodation

8.30 Last year the DDRB were advised that NHS Greater Glasgow had taken a decision to withdraw the provision of free accommodation for PRHOs. Following ongoing discussion between SEHD, NHSS Employers and the BMA Scottish Junior Doctor Committee, Glasgow agreed to stop the practice of charging for the accommodation available and to refund charges that had been made. Although the practice has now ceased, Glasgow are still of the view that they are not required to provide free accommodation to all FY1 doctors.

8.31 It has been agreed that the arrangements around the provision of this accommodation are a matter that should be resolved locally in Glasgow and discussions in relation to this are currently ongoing.

GP Registrars

8.32 The average banding supplement for hospital doctors in training in Scotland was 60% in the monitoring period to February 2006. This suggests that this might be an appropriate time to consider reducing the banding supplement for GP Registrars. Recruitment of

GPs does not appear to be a problem since the introduction of the new GP contract and the Golden Hello scheme is available to deal with any problem areas which are identified. SEHD would suggest that the supplement might be reduced to 55% for all new GP Registrar contracts.

Dental Services

Action Plan for Improving Oral health and Modernising NHS Dental Services in Scotland 2005

8.33 The consultation on *Modernising NHS Dental Services in Scotland* (2003) resulted in the launch of policy proposals in the form of a three-year *Action Plan*. The measures outlined in the *Action Plan* are designed to address Scotland's poor oral health record, provide better access for patients to NHS dental services and provide an attractive package for professional staff who are recruited to, and remain within, the NHS. The *Action Plan* can be viewed at: http://www.scotland.gov.uk/library5/health/apioh-00.asp

8.34 The first year of the *Action Plan* is now complete and 18 out of 19 milestones contained within this timeframe have been met or are on schedule to be completed. A table is attached at **Annex J** giving details of these achievements.

8.35 SEHD is committed to investing an additional sum of £150 million over three years in order to achieve the goals. This amounts to £45 million in 2005/06, £100 million in 2006/07 and £150 million in 2007/08. Cumulatively, this amounts to £295 million over three years. Of this, £237 million will go to primary care dental services. A breakdown of the funding for NHS dentistry for 2005/06 is provided below:

Funding – 2005/06

Forecast spend of £225.2m on general dental services
£3.4m Rent re-imbursement interim payment
£5m Practice Improvement Funding
£2m Emergency Dental Services
£4m Oral Health
£5m Education & Training
£1.07m Scottish Dental Access Initiative
£0.51m Vocation training golden hellos

Fees

8.36 SEHD would welcome DDRB reporting on an uplift to fees as in previous years.

Total Number of NHS Dentists in Scotland

8.37 The table below shows the headcount of dentists in Scotland by service sector as at 30 September 2005 for the years 1995 to 2005.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005[5]
NHS Dentists[1,2]											
General Dental Service	1,865	1,871	1,913	1,955	1,999	2,002	2,048	2,078	2,112	2,156	2,267
Non salaried	1,826	1,833	1,877	1,918	1,952	1,954	1,992	2,015	2,040	2,070	2,100
Principals	1,722	1,721	1,747	1,789	1,827	1,823	1,856	1,881	1,903	1,919	1,933
Assistants	31	37	48	45	44	39	40	36	38	41	46
Vocational Trainees	80	82	89	94	93	101	104	109	111	122	136
Salaried[3]	42	41	39	39	48	50	60	67	77	93	187
Hospital Services	298	309	311	325	338	327	337	328	336	315	329
Community Dental Service	282	266	276	284	280	296	287	343	329	349	363
Dentists working in more than one sector											
Hospital/Community	2	2	2	3	4	3	3	10	6	6	3
Hospital/General	86	87	87	90	96	82	90	76	74	65	65
Community/General	48	34	49	60	53	67	69	92	87	107	185
Hospital/Community/ General	1	0	2	0	1	4	3	2	2	2	5
Total	137	123	140	153	154	156	165	180	169	180	258
Total NHS Dentists[4]	2,307	2,323	2,358	2,411	2,462	2,465	2,504	2,567	2,606	2,638	2,696
Annual Change		+16	+35	+53	+51	+3	+39	+63	+39	+32	+58
Annual % Change		+0.7%	+1.5%	+2.2%	+2.1%	+0.1%	+1.6%	+2.5%	+1.5%	+1.2%	+2.2%

Source: ISD Scotland/NES

Notes
1. Consists of those dentists registered to provide NHS treatment at 30 September.
2. These data vary from those prevously published. This is a result of ongoing work to improve quality and completeness of data.
3. Due to improvements in the collection of information on GDS salaried dentists, figures for September 2005 include some GDS salaried dentists not previously recorded.
4. Total across all sectors taking into account those who work in more than one sector. Dentists who work in all three sectors require to be subtracted from the total twice.

8.38 The total number of dentists registered to provide NHS treatment has consistently risen at a similar rate. Increases have occurred in the General Dental Service (GDS) and the Community Dental Service (CDS).

8.39 It should be noted that SEHD's target for an annual increase of at least 50 dentists has been met in 2005, and this is a trend which is expected to continue as a result of the increased incentives that are contained in the *Action Plan*.

8.40 In 2004, the number of dentists in the hospital service fell due to a combination of more leavers and fewer joiners, but in 2005 the number rose to levels similar to those seen in earlier years.

8.41 It should be noted that SEHD have now eliminated the problem of double counting of dentists who work in more than one sector, which has enabled us to make accurate calculations of the shortfall within NHS dentistry in Scotland.

Comparison of Supply and Utilisation Model Outputs

8.42 *An Update on the Analysis and Modelling of Dental Workforce in Scotland* report was published by NHS Education for Scotland(NES)/Information Services Division (ISD)

Scotland in June 2006. The report includes detailed supply and utilisation models for Scottish Dentistry and can be viewed at:
http://www.nes.scot.nhs.uk/docs/publications/analysisand modelling.pdf

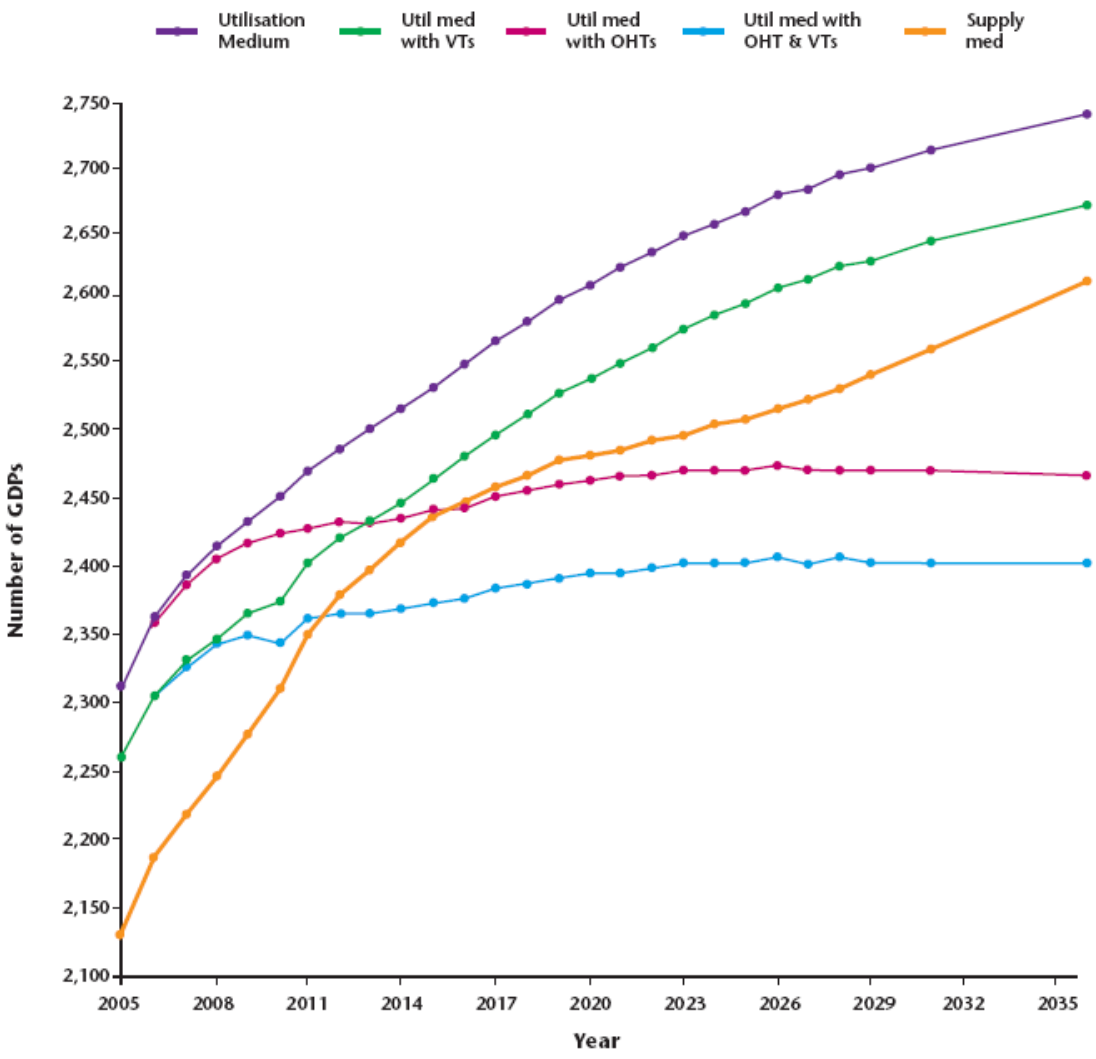
8.43 The General Dental Service utilisation model estimates the numbers of GDPs required to service the population based on levels of utilisation of the GDS derived from the most up to date data. The model has been populated with the new treatment data and revised population projections.

8.44 The utilisation model is based on observed characteristics of utilisation, with inputs from projected trends in demographics, oral health, and the structure of the dental workforce. As such, it can be thought of as a proxy for demand, in that estimates of workforce requirements are made relative to changes in these areas.

8.45 The model suggests that for 2006, 2,367 GDPs are needed and this requirement will increase to 2,616 in 2020. When account is taken of the additional VTs and OHTs (Oral Health Therapists), the model suggests that 58 fewer GDPs are required (2,309) in 2006 and 216 fewer dentists (2,400) in 2020.

8.46 Comparison of supply and utilisation model outputs provides an indication of the number of GDPs required to provide a level of service as shown by historical data, and whether the availability of GDS provision is expected to improve with time.

8.47 The chart below shows how the principal (medium) supply model output compares against the utilisation model outputs described above:



8.48 The chart shows the supply model output as the bold yellow line. The other lines represent the various utilisation model outputs described. The purple line is the standard medium utilisation model output, and shows a shortfall of 177 GDPs in 2006. While the supply never matches this utilisation model output, the difference between the two nevertheless decreases until about 2014, suggesting an improving situation in terms of dental service provision.

8.49 The green line shows the result of accounting for the contribution of VTs only, with a shortfall of 120 GDPs in 2006. The red line shows the effect of accounting for the contribution of OHTs only, with the initial gap of 177 GDPs disappearing by 2016. The light blue line represents the utilisation model output accounting for the contribution of both VTs and OHTs. This suggests the shortfall compared to the supply will reduce very quickly over the next five years and would disappear by 2012.

8.50 All of these results show that the projected supply is increasing at a rate higher than that of the utilisation requirements. This points to the current provision of GDS in Scotland improving with time, although there is currently a shortage of GDPs compared to what would be required to provide service at historical levels.

Allowances for Independent General Practitioners

Vocational Trainee (VT) Golden Hellos

8.51 Vocational Trainees are defined as trainees in a contract of employment as an assistant to a trainer whose name is on a Dental List or is under a contract of service with a Health Board. This allowance is a one off payment of £3000, which is available to all VTs with an additional payment of £3000 to VTs who take up a post in a designated area.[1]

8.52 There have been 126 claims from VTs in 2005/06, of which 24 claims were from designated areas and 102 from non-designated areas. This is an increase from 123 last year. The total VT allowance paid was £505,934, an increase from last year of £49,434 *(9.9%)*.

8.53 In 2004/05, there was a 20% increase in the number of VTs claiming this allowance in a designated area, giving a total extra payment for the designated allowance of £87,000. The take-up of the allowance in designated areas has fallen slightly this year and the total extra payment for 2005/06 is £72,000.

8.54 Data on the Scottish dental school output shows an annual increase in the number of dental graduates taking up posts in Scotland. In 2004, 86% of the total Scottish graduates were registered for VT in Scotland, rising to 90.5% in 2005 and 91.5% in 2006.

8.55 The number of graduates from Scottish Dental Schools is predicted to rise over the next five years as follows:

Expected Graduation Date	Total Number Expected Graduates
July 2006	137
July 2007	127
July 2008	135
July 2009	156
July 2010	184
July 2011	157

8.56 Intakes are expected to stabilise at around 155. The total number of dental students in the Scottish Dental Schools is now higher than at any time in the recent past.

8.57 The number of dental VT places in Scotland continues to build steadily. The total cohort size and breakdown into country of qualification between 2000 and 2005 is shown in the table below:

[1] Designated areas are classified as Borders, Dumfries and Galloway, Fife, Grampian, Highland, Orkney, Shetland and the Western Isles NHS Boards.

NUMBER OF VTs BY THE COUNTRY IN WHICH THEY QUALIFIED – source ISD Scotland (2 Feb 2006)					
		COUNTRY OF QUALIFICATION			
VTCohort Year	**Number in Cohort**	**Scotland**	**Other UK**	**Abroad**	**Unknown**
2000	100	77	11	1	11
2001	94	78	14	-	2
2002	101	89	7	-	5
2003	101	90	8	1	2
2004	113	88	15	6	4
2005	126	95	15	15	1

8.58 In 2006, the size of the cohort is 146 wte (headcount of 150 with 8 doing VT part-time over 2 years).

8.59 The number of VT numbers issued has steadily increased each year, demonstrating the positive effects of the recent initiatives on recruitment. The figures are provided in the table below:

VT Numbers Issued (2001 to 2005)				
Year	**2001/02**	**2002/03**	**2003/04**	**2004/05**
Total VT Numbers Issued	126	131	146	150

Golden Hellos

8.60 In this financial year, SEHD has paid £80,000 to dentists who have joined the list of a NHS Board in Scotland for the first time or on re-entry to a dental list in Scotland after a break of 5 years. The payment to each dentist is £5,000 over two years or £10,000 over two years for designated areas.

8.61 SEHD has also paid £675,000 to dentists who have joined a NHS Board dental list within 3 months of completing their training. This allowance was paid to 61 dentists in 2004/05 rising to 71 dentists in 2005/06. The payment to each dentist is £10,000 over two years or £20,000 over two years for designated areas.

General Dental Practice Allowance

8.62 This allowance can be claimed by a practice and is based on the gross NHS practice earnings by dentists within the practice.

8.63 The allowance is to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.

8.64 The total practice allowance paid in 2005/06 was £15,422,380 rising from £4,068,375 in 2004/05. However, it should be noted that the amount payable per practice has been increased this year to 6% of accumulative gross practice earnings. Those practices who meet the new definition of NHS commitment are entitled to receive an additional 6% of accumulative gross practice earnings for each quarter that they meet the conditions of entitlement to payment. In the last quarter of the financial year 2005/06, 69% of dental practices qualified for this allowance.

Remote Area Allowance

8.65 The allowance is paid annually in a lump sum to each qualifying dentist. Payments are subject to abatement on a sliding scale related to NHS earnings. The definition of a 'remote dentist' was extended with effect from 1 April 2006 to provide that those dentists who provide general dental services (GDS) in areas which have less than 0.5 persons per hectare would be entitled to receive the remote area allowance. The definition has been further amended to provide that those dentists who provide for the first time on or after 1 April 2006 GDS on islands in Scotland will be entitled to receive the remote area allowance, provided the dentist provides the greatest proportion of GDS in a remote area.

8.66 There has been an increase in the total amount of allowance paid between 2004/05 and 2005/06 from £323,700 to £448,500. However, it should be noted that this allowance has been increased from a maximum of £6000 in 2004/05 to a maximum of £9000 in 2005/06.

8.67 The total number of claims has fallen slightly from 65 in 2004/05 to 59 in 2005/06. The change in criteria from 1 April 2006 is intended to address this downward trend. In addition, this figure does not take into account the number of claims from salaried dentists. Allowance to salaried dentists is paid locally and as such the information on uptake is not held centrally.

Sedation Allowance

8.68 This allowance is paid to a practice which provides a minimum amount of both types of sedation and is subject to abatement related to percentage NHS earnings.

8.69 The total allowance paid in 2004/05 was £77,000 which decreased to £63,000 in 2006/07. This is the second year running that the total sedation allowance paid has decreased. To address the decrease in claimants a review of the terms of the allowance has been undertaken. As a result the allowance has been increased and the minimum number of sedation treatments under GDS which a practice requires to undertake in order to receive the allowance has been reduced from 50 to 40. These changes came into effect on 1 April 2006 and any increase as a result should be apparent by 2007/08.

Rent Reimbursement

8.70 In January approximately 70% of dental practices in Scotland who met the new NHS commitment criteria received an interim payment of £3.4 million for notional rent reimbursement. A further £1.7 million for 2005/06 was paid in August.

Recruitment and Retention Allowance

First Included on a Dental List within 3 months of completing Training

8.71 This allowance is available to all new dentists when their name is first included on a dental list within 3 months of completing their training. Recipients must undertake to provide the full range of general dental services to all categories of NHS patients during each of the 3 years following receipt of the first payment.

8.72 A total of 70 new claims were received in 2005/06, as compared to 69 in 2004/05. The total amount paid was £370,000. However, this figure does not take into account the number of claims from salaried dentists. Allowance to salaried dentists is paid locally and as such the information on uptake is not held centrally.

First Included on a Dental List or Return to a List after a 5-year Break Allowance

8.73 This allowance was introduced in 2004/05 for eligible dentists joining a dental list in Scotland for the first time, or those returning to a list after a minimum 5-year break. A one-off payment of £5,000 is paid over a two-year period. There is an additional £5,000 available over a two-year period if the dentist is in a designated area. Recipients must provide NHS Dental Services at a rate of 80% of total earnings for three years in exchange for the allowance.

8.74 The total number of claims in 2004/05 was 27, with a total amount paid of £87,500. The total number of claims in 2005/06 has fallen this year to 10, and the total amount paid was £27,500. However, this figure does not take into account the number of claims from salaried dentists. Allowance to salaried dentists is paid locally and as such the information on uptake is not held centrally.

Scottish Dental Access Initiatives (SDAI)

8.75 SEHD has paid over £1.2 million to NHS Boards under the Scottish Dental Access Initiative Scheme to general dental practitioners who are willing to make a sustained commitment to the NHS, and who wish to establish a new practice or extend existing practices in areas where general dental service availability is poor. For new practices SEHD pays up to £100,000 and up to £50,000 to expand existing practices.

Review of Salaried Services

8.76 DDRB has requested evidence on the outcomes of negotiations for the review of salaried services. The current salaried services operate as follows:

Community Dental Services (CDS)

8.77 The Community Dental Services (CDS) is a directly managed service in which staff are remunerated by salary. The CDS has a Public Health function to include screening, health promotion and preventive public health programmes for children and adults with special needs. The service undertakes annual inspections of children's oral health as part of the National Dental Inspection Programme. The second function is the treatment objective of the service, providing a complementary service to the GDS by identifying special needs groups. More recently there has been an increased commitment to act as a safety net treatment service for those patients who do not obtain treatment from the GDS. Between 1980 and 2004 the number of Whole Time Equivalent Community Dental Officers in Scotland reduced from 278 to 192. In contrast, the number of Senior Dental Officers, who have greater experience and skills in the complex management issues associated with Community Care, has risen from 6.5 WTE to 37.2 WTE in the same period. The activity in the CDS has changed markedly over the last couple of decades with a reduction in staffing levels, a concomitant reduction in patient numbers, and within that an increase in the proportion of adults being seen and a greater emphasis on clients with special needs. The remit of the CDS has changed over the last 20 years as it has responded to the need to provide a complementary service to the independent contractor GDS. The 'Action Plan for improving oral health and modernising NHS dental services in Scotland' document has recognised the need to concentrate on prevention in dentistry, whilst also maintaining a treatment service.

8.78 The CDS has adapted to meet the demands of patients with special needs, primarily those with complex clinical conditions and/or challenging behaviour. Consequently,

there has been a reduction in numbers of routine child patients treated by the CDS, the extent of which varies from area to area. There has been a rise in the number of adult patients treated, with a concentration on the client groups who have special needs. The dental public health role has been maintained and, with the recent introduction of the National Dental Inspection Programme, this has strengthened.

General Dental Services (GDS)

8.79 The remit of the Salaried General Dental Services (GDS) is the same as that of overall GDS (ie the main primary care dental service), except that salaried GDPs are remunerated on a salaried basis, rather than item of service and are managed as part of the Salaried Dental Services. Recent figures indicate that there are currently 81 salaried GDP posts established in Scotland. Due to recruitment difficulties, not all these posts are filled. There is no recognised appropriate level of dentist to population ratio across Scotland so levels of salaried practitioners will depend on local circumstances, influenced by demand and need. The provision of GDS is often driven, in the main, by market forces and will, therefore, encourage dentists to provide services in areas with dense population levels. Consequently, when there is a shortage of dentists, remote areas, with low population density, are likely to be adversely affected. The availability of NHS GDS has decreased over time and, in an attempt to meet demand, there has been an increase in the numbers of salaried GDPs, particularly in rural areas. In some areas the demand for such services has given rise to long waiting times.

8.80 SEHD have undertaken a review of the salaried services which is currently with Ministers for consideration. Further details will be forwarded to the DDRB when the report is published.

Dentists from Overseas

8.81 Responsibility for the overall provision of NHS dental services in an area rests with the NHS Board. Where an NHS Board considers that the existing NHS general dental service provision is insufficient to meet the demands of the local population, and no independent general dental practitioner is available to fill the gap, the Board can appoint salaried dentists. NHS Boards already employs a number of salaried dentists and are aware that they can appoint additional salaried posts to address further gaps in provision.

8.82 Forty dentists from Poland are being recruited to work within the NHS in Scotland. This is one way of increasing the salaried service. They will work in all areas of Scotland from Shetland in the North to Dumfries in the South and will provide dental services for between 50,000 and 100,000 patients

8.83 The first group of the dentists from Poland arrived in Scotland at the end of January and are already providing treatment for hundreds of patients in Fife, Forth Valley and Argyll and Clyde. The second group have now finished their training and have taken up their positions with their respective NHS Boards. The final group of dentists from Poland arrived in September and it is anticipated that they will be employed in Grampian, Highland, Lothian, Tayside and Shetland.

8.84 The total number of dentists from EC/EEA who have been recruited to an NHS Board between 1 January 2005 and 22 June 2006 is 67, an increase of 570% for the same period the previous year (10 overseas dentists between 1 October 2004 and 22 June 2005).

C. PAY AND WORKFORCE STRATEGY

8.85 The Department's objective is to protect, promote and improve the health, quality of life and wellbeing of people in Scotland by working with NHS Scotland to build a world-class workforce for NHS Scotland. SEHD is working on five key areas to achieve this aim:

- Improving NHS Scotland workforce planning to ensure that the right workforce is in the right place delivering the right care;
- Expanding health-care related education and training to develop a workforce that is appropriately skilled and eager to learn;
- Stepping up recruitment and improving NHS Scotland's reputation so that we can attract the best workforce in an increasingly competitive world;
- Implementing better employment practice so that NHS Scotland can retain a workforce that is keen and proud to work for the organisation;
- Enhancing rewards and developing capability to demonstrate NHS Scotland commitment to a workforce that is flexible, motivated and driving change.

The steps that are being taken to achieve these objectives are outlined in the following sections.

Improving NHS Scotland's workforce planning to ensure that the right workforce is in the right place delivering the right care

8.86 The *National Workforce Planning Framework* was published in August 2005, establishing a new annual workforce planning cycle more closely linked with service and financial planning. Within this cycle, NHS Boards will publish workforce plans each April, the three Regional Planning Groups will publish workforce plans each September, and the Scottish Executive will publish a national workforce plan each December.

8.87 Within their plans, NHS Boards and Regions are to project their future demand for each staff group to meet their anticipated needs for delivering services. This look ahead is for the short term (3 years), medium term (5 years) and longer term (10 years). In projecting their future workforce requirements, Boards and Regions must take into account the range of drivers for change in the way that services and workforce are configured.

8.88 The Scottish Executive will use NHS Board and Region assessments of future staffing requirements to inform supply planning. Analysis of the first round of plans is underway and will inform decisions about the number of medical training places in Scotland for August 2007. The *National Workforce Planning Framework* is available online at www.scotland.gov.uk/Resource/Doc/927/0017088.pdf.

Medical Workforce Supply

8.89 In determining the number of GP and specialty training places for Scotland, the basic principle is to ensure that the number of trainees in a given specialty reflects future demand for "trained doctors" in that specialty. Demand comprises replacement of

leavers as well as expansion of establishment, and is determined by NHS Boards in the context of service and financial planning to meet patient need.

8.90 Over the next few years, we are operating in the context of MMC implementation and the dissolution of the SHO grade. In determining the number of specialty training places for Scotland for August 2007, two further, interdependent principles will therefore be factored in: that service delivery can be sustained during the transition, and that there are sufficient opportunities for existing SHOs who are eligible, to continue their training in Scotland. This is likely to mean that, during the period of transition, the number of specialty training posts will be inflated artificially above that required for future demand (as currently projected).

Improving Data

8.91 Development of the Scottish Workforce Information Standard System continues, to establish a comprehensive system to collect and store information describing the NHS workforce in Scotland. Collection of information on qualifications and posts is the next phase of implementation. In addition, a specification for an operational system to support HR functions has been developed. These systems will support decision-makers to take informed decisions on future workforce needs.

Expanding health-care related education and training to develop a workforce that is appropriately skilled and eager to learn.

Postgraduate Medical Training - Modernising Medical Careers

8.92 In February 2003 the four UK health Ministers launched *Modernising Medical Careers* (MMC) - their response to consultation on *Unfinished Business: Proposals to Reform the Senior House Officer Grade*, which set out proposals for the fundamental reform of postgraduate medical training.

8.93 The MMC policy was further developed in April 2004 through publication of *The Next Steps*, the UK strategy statement which took forward arrangements for the MMC training reforms and commissioned for new foundation programmes from August 2005.

8.94 Since then there has been considerable activity at UK and Scottish levels to deliver the foundation programmes for years 1 and 2. Preparations are now underway for the implementation of run-through specialty training in August 2007.

A Review of Basic Medical Education in Scotland

8.95 Professor Sir Kenneth Calman led a review of basic medical education in Scotland, which the Scottish Executive responded to in June 2005. Key proposals of the Executive's response include:

- providing an additional 100 medical graduates in Scotland, achieved by providing additional clinical training places across the four Scottish clinical medical schools for those students who enter St Andrews university for their medical education;
- support for Sir Kenneth's proposals for universities to review their selection processes and to widen access to medical education;
- support for the introduction of a fast-track graduate-entry medical degree course in Scotland;

- support the establishment of a Board of Medical Education for Scotland, to co-ordinate activity across the five medical schools in line with Sir Kenneth's recommendations.

8.96 Implementation of the Executive's response to Sir Kenneth's review would increase Scotland's output of medical graduates from approximately 800 to around 900 each year, an increase of 12.5%. SE, SFC and Scottish universities are working together with the newly established Board of Academic Medicine to support the delivery of these proposals in the coming years.

<u>Stepping up recruitment</u> and improving NHS Scotland's reputation so that we can attract the best workforce in an increasingly competitive world.

8.97 At 30 September 2005, there were 153,996 staff in NHS Scotland. The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland increased by 219 WTE or 2.3% in 2005. This represents changes across the medical and dental grades as follows:

- Consultant numbers increased by 136.6 WTE (4.1%)
- Staff and Associate Specialist grade numbers increased by 11.1 WTE (1.8%)
- Specialist Registrar numbers increased by 36.3 WTE (2.3%)
- Senior House Officer numbers increased by 28.3 WTE (1%)
- Pre-Registration House Officer numbers decreased by 36.3 WTE (4.5%)
- GP numbers (excluding Registrars) increased by 58.4 WTE (1.6%)
- GP Registrar numbers increased by 23.7 WTE (8.9%)

8.98 More detailed workforce data are presented in **Annex K**.

8.99 NHS Scotland is Scotland's largest single employer and therefore subject to trends in the wider labour market as well as changes specific to NHS Scotland. Scotland's ageing and declining population also impacts upon both the labour supply and on demand for services. In a shrinking labour market, attracting staff into the NHS in the face of competing sectors will become increasing important.

8.100 In recognition of this, SEHD launched and is currently running, an active media campaign aimed at raising awareness of a career in NHSScotland for all grades. The media campaign was launched by the Minister for Health and Community Care on 2 March 2006 and TV commercials went on air from 6 March to 29 May. An independent evaluation of the campaign is currently underway and initial results are very positive showing that the key objectives of the campaign are being met.

8.101 More detail of the work involved can be found under the following section.

Staff Retention

8.102 Retaining trained staff is important for all organisations. It reduces recruitment and training costs which can be used to promote better health care for patients and improved workforce balance initiatives for staff. Many of the reasons that encourage people to apply for or train for jobs in the NHS in the first place are that we operate good employment practices. We have good balanced working lives policies *(2006 Survey evidence*), which enable many staff to work at the time that suits them and fits around family commitments. This is evidenced by the fact around 40% of the NHSScotland workforce is part time (*ISD September 2005*).

8.103 Good career prospects associated with personal development plans and access to continuous professional development that enables our staff to maintain their skills and knowledge base and provide better care to patients clearly plays a part in helping to retain staff. How we treat our staff is also important and proper application of Partnership Information Network policy guidance on dealing with employee concerns and dignity at work is essential. There does however have to be a recognition that managers need to be able manage, but this has to done fairly and consistently.

8.104 In the past, we have adopted a rigid age 65 retirement policy, and due to the new age discrimination regulations this is now illegal, unsustainable and unnecessary. SEHD has made clear to NHS Boards that they should treat requests from older workers to work beyond age 65 seriously and develop policies which encourage this to happen. This is in line with Healthy Working Lives and future pension policy which is likely to see the development of retirement policies across Scotland aimed at encouraging the older worker to remain in work for as long as they feel able to do so with policies such as phased retirement and "step down" arrangements towards retirement being introduced.

Vacancies

8.105 Numbers of consultant vacancies have been increasing year on year since 1999. In headcount terms, numbers increased by 43 (17.5%) between 2003 and 2004 and slowed to an increase of 19 (6.6%) between 2004 and 2005. SEHD is not aware of any specific reason for such an increase but are not complacent either. Actions being taken to ensure consultant numbers continue to increase involve the specific targeting of consultant vacancies and ensuring NHS Boards take all steps to reduce such vacancies.

8.106 NHS Boards have submitted business plans to SEHD which specifically target the filling of consultant vacancies. To assist NHS Boards in this process SEHD allocated an additional £2.5 million to NHS Boards in January 2006. NHS Board general allocations also include funding for consultant expansion. SEHD has also taken the following steps:

- A scheme has been introduced from 1 April 2006 which will identify the career aspirations of specialist registrars approaching their Certificate of Completion of Training (CCT) and match these to current and possible future vacancies. This is an information sharing strategy which will help retain more specialist registrars in Scotland as they become qualified consultants by alerting them to the jobs available;

- £1 million has been made available for the introduction of an advanced appointment scheme. The scheme allows specialist registrars, once they have obtained their CCT, to take up a consultant position where the consultant currently in post has not yet retired or left. The scheme funds 50% of the new consultant's salary and allows both

consultants to work in tandem for a period of up to six months. The scheme will help keep new consultants in Scotland where previously they may have left due to there being no existing vacancies in place.

- SEHD has also taken out an advert in the British Medical Journal promoting Scotland as a good place to work as a consultant and referring the reader to the Scotland's Health on the Web vacancy database where we are encouraging all NHS Boards to place all current consultant vacancies.

8.107 Currently, no information is available on associate specialist, staff grade or GP vacancies.

Implementing better employment practice so that NHS Scotland can retain a workforce that is keen and proud to work for the organisation.

8.108 A key aim of NHS Scotland is to become an exemplary employer. SEHD has been working with this aim in mind for the last few years and our policies and strategies are reflective of this aim.

Partnership Working

8.109 The open and transparent way NHSScotland works with staff, employee directors are on all our NHS Boards, and their representatives and develops its strategies in partnership plays a major part in our current success and industrial harmony in NHSScotland both locally and nationally. We reviewed the partnership process last year and streamlined it to make it more productive and less onerous. Currently the Staff Governance Standard which is enshrined in legislation is being reviewed. This is expected to remain much as it currently is. Staff can expect to be:

- Well informed;
- Appropriately trained;
- Involved in decisions which affect them;
- Treated fairly and consistently; and
- Provided with an improved and safe working environment.

8.110 The Staff Governance Standard is about how NHSScotland employers are expected to provide consistency of treatment for staff across Scotland. It is underpinned by the 12 policy guidelines which range from Managing Health at Work to Managing Dignity. NHS employers are required to adopt the policy guidelines. The Standard is monitored through the Self Assessment Audit Tool and the Staff Survey.

Staff Survey

8.111 The latest staff survey (a census rather than a sample survey) took place earlier this year and achieved a 33% response rate. Key strengths are: high level of intention to remain working for the NHSScotland in 12 months time; their job makes good use of their skills and abilities; staff are clear about what they are expected to achieve in their job; staff are very positive about the support they get from work colleagues; satisfaction with the overall benefits package; and feel that performance reviews accurately reflect performance and help staff focus on improving their performance.

8.112 Opportunities for improvement exist to improve communication, particularly the way change is managed. Staff wish greater involvement in decisions and have a negative perception of how open and honest communication is from senior management and the

Board and to whether senior managers are focused on meeting patients/clients needs. There appear to be issues with how staff feel they are treated with low levels of satisfaction on treating staff with dignity and respect and offering equality of opportunity; NHS Boards taking staff safety during their journey to work seriously and the level of violent/aggressive incidents and bullying, harassment and discrimination experienced.

8.113 The Scottish Workforce and Staff Governance Committee, which is a partnership committee comprising trades unions, professions, NHS Employers and SEHD, have considered the outcomes from the staff survey and are devising a work plan which will seek to address the negative issues and further build on the positive elements.

Healthy Working Lives

8.114 Key to tackling many of these issues in NHSScotland is through the Healthy Working Lives concept. Healthy Working Lives is about the integration of all polices and processes which impact on the health and well-being of the workforce. A working group will be set up shortly to develop the process to deliver Healthy Working Lives to NHSScotland staff. Funding has been put aside to take this forward. The Department has recently completed a review OHSS services and will shortly be announcing the outcomes. The results of the review are predicated on delivery of the Healthy Working Lives agenda for both NHSScotland staff and for the NHS to contribute to its wider delivery to the Scottish workforce. This links directly to the Government's commitment to rehabilitation and getting claimants off benefit and back into work and to enabling the workforce to work for as long as they are able.

8.115 **OHSXtra**, an important part of the Healthy Working Lives agenda, is a dedicated service for NHS staff currently being piloted in NHS Fife and NHS Lanarkshire. It provides quick access to physiotherapy, occupational therapy and counselling services with the aim of improving staff health and morale and contributing to the Government's aim of reducing sickness absence to 4% in the NHS by March 2008 and to enabling staff to remain in work for as long they are able. Evidence from the National Audit Office has indicated that quick access to physiotherapy alone can have a spend to save ratio of seven pounds for every pound spent. The pilots are only a few months in but are gaining new client numbers every week. It is intended to review available evidence in September this year to determine initial success. If this is favourable, it is our intention to fund OHSXtra in other Boards. £750,000 has been set aside for further development of OHSXtra in 2006/07 and 2007/08.

8.116 SEHD is working with NHS Greater Glasgow and Clyde and Vielife on a health promotion project with around 100 staff. This provides health screening at the start and end of the project and is for a year. The remainder of the project is around healthy living and lifestyle improvements and involves access to an online system enabling the individual to input their own lifestyle information and to get a personal and private response on how to improve it. Senior Management receive an overall monthly report which indicates the overall level of health of those taking part. Early indications are that it will provide a good evidence base for further work on Healthy Working Lives.

Safer Workplace

8.117 SEHD is working with NHSScotland and the trade unions and professions to reduce violence to NHS staff. We recognise more needs to done to change attitude and culture of the public and to getting them to appreciate that being abusive or violent does not help anyone. As part of our commitment to changing the culture, the Scottish Executive has delivered on the Emergency Workers Act. This provides legal protection for doctors, nurses and midwives working in the hospital setting and anyone assisting them. It also provides legal protection for other emergency workers, including ambulance workers. Since the Act came into force in May 2005, some 290 charges are known to have been raised.

8.118 The Scottish Executive have also conducted the "Bang out of order" raising awareness poster and TV campaign. This featured a nurse. In addition we have issued zero tolerance posters. Further posters are in hand for issue later this year aimed particularly at GP practices. Some £1 million has been spent over the last few years on funding projects aimed at reducing violence and aggression. Developmental work is in process on an evidence based violence and aggression training passport aimed at bringing some collective order to training. Future work is expected to include a Framework for Tackling Violence and Aggression with good practice.

8.119 As part of our drive to make the workplace safer and to specifically help reduce musculoskeletal injuries and ensure training is evidence based, we are working with NHS Employers, NHS and the HSE to develop an evidence based manual handling training passport. Work is also being taken forward on stress and mental health well-being.

<u>Enhancing rewards and developing capability</u> to demonstrate NHS Scotland's commitment to a workforce that is flexible, motivated and driving change

8.120 The implementation of pay modernisation through the new consultant and GMS contracts and *Agenda for Change* represents a major investment in our NHS workforce. These three strands share a common goal – to reward, motivate, and free up staff to deliver re-designed and improved services to patients. SEHD expects delivery of these contracts to link closely with the Department's overall policy objectives for NHS Scotland with a particular focus on improved productivity, enhanced services to the public, service re-design around the needs of patients, improved recruitment and retention and improved management and development of staff.

8.121 Pay modernisation is a toolkit which helps and supports systems to deliver on a wide range of key NHS priorities in securing sustainable, safe, and effective changes to service provision. It is also a driver for positive culture change in the NHS in behaviours, attitudes, and ways of working which will be of long-term benefit to both staff and patients. Health Boards are required to provide Pay Modernisation Benefits Realisation Plans which will demonstrate how they are using the new contractual arrangements to support both the delivery of key targets and *Delivery for Health.* This planning process, which requires updates every six months, is now well established.

8.122 The new consultant contract was introduced from 1 April 2004 and the majority of consultants now have agreed job plans. There is now emerging evidence through the Pay Modernisation process of positive change flowing from the job planning processes associated with the contract, including more efficient use of consultant resource for the benefit of patient care.

8.123 The n-GMS contract was also fully introduced from 1 April 2004. The new contract encourages recruitment and retention in the GP workforce through better management of GP workload, investment in primary care infrastructure, and by transferring responsibility for out-of-hours services to Health Boards.

8.124 This contract also links GP payments to the quality of care that they provide for patients, through the Quality and Outcomes Framework (QOF). This Framework is realising significant benefits for patient care and clinical outcomes in the primary care sector. General Practitioners in Scotland have showed a high level of achievement in the provision of quality care to patients across Scotland, a reflection of considerable improvements made by practices over the previous year.

8.125 The contract is reviewed on a UK-wide basis, and a revised set of arrangements were put in place from April 2006. Some further changes are anticipated in 2007/08, which need to be anticipated in the 2007/08 budget.

8.126 Pay modernisation provides financial incentives to join and stay in the NHS and also offers a number of non-financial incentives such as flexible working conditions; and the opportunity for self-development through quality training and learning.

8.127 Other incentives available for recruiting staff in NHS Scotland include "Golden Hello" payments to incentivise GPs to join NHS Scotland and a number of programmes for dentists aimed at encouraging them to take up posts in Scotland and provide NHS services.

8.128 The national Staff Governance Standard, which seeks to make NHSScotland an exemplar employer, provides for the high standards of employer practice which support retention of staff. Staff governance measures include 12 Partnership Information Network (PIN) publications, which prescribe mandatory minimum standards of employment practice for NHS Scotland employers, and the Occupational Health and Safety Strategy "*Towards a Safer Healthier Workplace*".

8.129 With its strong medical school/teaching hospital base, Scotland generates a healthy supply of doctors in training. However, many training grade doctors are England-domiciled and therefore look south of the border when they reach consultant grade. There is thus a continuing challenge to retain doctors when they gain consultant status, particularly in some shortage specialties. Work is ongoing to improve retention rates in support of the Executive's Partnership Agreement commitment to aim to increase the consultant workforce by an extra 600 consultants.

Pensions

8.130 The NHS Pension Scheme is an integral and valuable part of the NHS remuneration package. It compares very well with other occupational pension schemes, and is an invaluable recruitment and retention tool. For example, many private sector employers have closed their final salary schemes, while the NHS will be retaining it both for new and existing staff.

8.131 In common with other public service pension schemes, the NHS Pension Scheme in Scotland is under review. Agreement has been reached by the Scottish review partners on a set of proposals for reform. These proposals, which mirror the agreement in England and Wales agreement as outlined Chapter 3, represent reform which will

modernise and improve the scheme, sustain its long term financial sustainability and help NHS Scotland in its stated aim to be the employer of choice.

8.132 SEHD also expects the current UK-wide review of the NHS Pension Scheme to aid recruitment and retention by introducing the possibility of more flexible recruitment and retirement options. One of the aims of the review is to ensure that the NHS Pension Scheme meets the needs of a modern NHS and its staff by making benefits more appropriate for today's workforce. The review recognises the importance of the scheme in supporting the recruitment and retention of staff and encouraging those staff who have left to return to the NHS.

8.133 Consultation on the reform options for NHS Scotland is due to be launched in early October.

Reward package

8.134 Pay modernisation provides financial incentives to join and stay in the NHS and also offers a number of non-financial incentives such as flexible working conditions; and the opportunity for self-development through quality training and learning.

8.135 It is important to stress that, although the financial aspects of pay modernisation are obviously of great importance to staff, it is the whole reward package including pay, pensions, training, education, career development, and support in delivering a high level of care to patients that will allow NHS Scotland to recruit retain and motivate its workforce.

8.136 To that end, the wide range of targeted workforce initiatives alluded to in Section B, along with the measures in put place by NHSScotland to achieve exemplar employer status, must also be taken into account when looking at any future pay proposals.

D. WORKING TIME REGULATIONS (WTR)

Junior Doctors

8.137 NHS boards in Scotland continue to implement appropriate aspects of the Hospital at Night (H@N) approach. A self-assessment tool used by National Workforce Projects in England has been adapted to allow Scottish boards to assess their progress towards implementing this approach. Over 99% of junior doctors are compliant with the current WTR limits and around 40% of them are already working 48 hours or less a week. We are supporting and working with boards to design rotas down to 48 hours now wherever possible so that efforts can concentrate on the smaller units and specialties which will have the greatest difficulty in meeting this target by 2009.

8.138 SEHD have a virtual network of contacts in NHS boards with responsibility for WTR/H@N with whom we share information and good practice examples. Our WTR adviser has visited all boards at least once to discuss progress in meeting the requirements of the WTR for junior doctors. Our regional New Deal Support Officers have been given training in the requirements of the WTR and provide a source of expertise for boards, particularly in relation to rota design.

Consultants

8.139 In responding to a survey by Audit Scotland, a majority of consultants said they were still working over 48 hours a week. However, information published by ISD shows only three NHS boards which declare that they have consultants working more than 12 PAs a week who have signed the opt out from the WTR. Concerns had also been raised about consultants who did private work for their boards or for other employers as well as their work in the NHS. They are required by their contract to notify their employer about any private work they do and also have a professional responsibility to be fit to work. NHS employers in Scotland have been approached about this and reminded that any employees who work more than 48 hours a week should sign the opt out.

E. EFFICIENT GOVERNMENT

8.140 SEHD continues to make a significant contribution to the Efficient Government Efficiency Programme. In 2005/06, the Health Department had identified efficiency savings of £525 million by 2007/08. For 2006/07, the contribution has increased to £531 million, which equates to over a third of the overall Scottish Executive target for 2007/08. The majority of these additional savings will be delivered through improved procurement processes which are now embedded across the service. All savings will continue to be retained within individual board areas and will be ploughed back into the NHS to supplement announced spending.

8.141 Two targets which may be of particular interest to the Review Body are to reduce the sickness absence rate in NHS Scotland to 4% by 31 March 2008 and to increase consultant productivity by 1% over the next 3 years.

F. REGIONAL PAY

8.142 The position on regional pay has not changed markedly since last year and we are not therefore currently considering any further measures on this front. Given that the delivery of pay modernisation is still at an early stage, SEHD are not yet able to measure the effect of new pay systems on pay differentials in addressing local recruitment and retention pressures. The new consultant contract in Scotland does allow for recruitment and retention premia to be applied if it is felt there is compelling evidence to provide extra incentives over and above base pay.

G. NHS FINANCE IN SCOTLAND

8.143 A substantial and sustained injection of new resources has been invested in health services in Scotland. It is clearly vital that NHSScotland recruits and retains well-trained and motivated staff which this additional investment should allow. Staffing costs account for about 60% of total expenditure on health in Scotland and clearly a substantial portion of the additional funding is going towards staff costs. This reflects the very significant investment made in staff pay in recent years. The costs of pay awards for NHSScotland staff have to be set within a framework which considers:

- The totality of funding set for the Scottish Executive Health Department;
- The achievement of financial balance at the end of 2006/07 and continued sustainability;
- The Scottish Executive's commitment to deliver the key national priorities and other standards set out in *Building a Better Scotland*; and

- The Government's inflation target for the economy.

8.144 There is no doubt that the recent significant increases in staff pay have had a major impact on NHS boards' budgets and that excessive pay uplifts on top of these would have an opportunity cost on the ability of boards to develop and extend responsive to patients. The cost of a 1% increase in the paybill would be equivalent to the average cost of treating 21,550 in-patients or 87,000 day cases or 510,600 out-patients in all acute specialties or the cost of employing 1,600 nurses or 520 doctors for a year. The cost of a 1.5% increase in the paybill would be equivalent to the average cost of treating 32,325 inpatients or 130,500 day cases or 510,600 out-patients in acute specialties or the cost of employing 2,400 nurses or 780 doctors for a year. The cost of a 2% increase in the paybill would be equivalent to the average cost of treating 43,100 in-patients or 174,000 day cases or 1,021,200 out-patients in all acute specialties or the cost of employing 3,200 nurses or 1,040 doctors for a year. The cost of any excessive pay uplift would restrict the ability to take forward key priorities such as health improving, tackling health inequalities, providing the most efficacious drugs or reducing waiting times, although it is not possible to say which areas would be specifically affected as decisions would be taken locally.

8.145 The SEHD's provision for 2006/07 and 2007/08 are set out in the following table:

	2006-07	**2007-08**
Total (£m)	9513	10261
Cash Growth (£m)	699	748
Cash Growth (%)	7.93%	7.86%
GDP Deflator	2.44%	2.66%
Real Terms Growth	5.36%	5.07%

8.146 These increases cannot be seen as a benchmark for pay settlements. The use of the overall provision needs to be considered against the Scottish Executive's ongoing commitment to the modernisation of NHSScotland, in particular the priorities set out in *Building a Better Scotland* and the impact of underlying demand pressures. These include, among other things:

- Meeting growing demand for health services – providing fairer access to more services locally and adopting medical advances;

- Developing, improving and meeting the additional costs associated with the demand led primary care services;

- Expanding diagnostic capacity and throughput and reduce waiting times for outpatient, inpatient or day case treatment;

- Improving the quality of NHS services to better meet the needs of patients, with particular priority to cancer, coronary heart disease, stroke and mental health;

- Growth in the number of prescriptions and the prescribing of new drugs. Although growth in drugs costs in 2005/06 was limited due to a number of initiatives such as Pharmaceutical Price Regulation Scheme (PPRS) renegotiation, in the long run costs are expected to continue to rise by around 10% per year, which will account for around £90 million per year;

- Securing a more flexible workforce – equipping them to deliver a more patient-focused service;

- Resources to meet demand for capital investment for new hospitals and equipment, the IT infrastructure, and training and development of the NHSScotland workforce.

8.147 NHS boards have been allocated revenue allocations for 2006/07 comprising a standard increase of 6.75% with an average increase of 7.25% and a maximum increase of 8.14%. NHS boards have been notified of an indicative standard increase of 6% for 2007/08.

8.148 The Scottish Executive is committed to improving health and revitalising the NHS and community care services in Scotland. New initiatives are being developed to create a step change in improving health. Pay clearly plays an important part in this process but it is only one element. The increase in NHS resources until 2007/08 provides a fixed envelope for the NHS in Scotland. There are no resources over and above this to fund any excess costs arising from pay settlements. It is therefore crucial that pay increases are no more than necessary to meet recruitment and retention needs of the NHS in Scotland in order to ensure resources are available to deliver growth in capacity, service improvements, pay modernisation and financial balance.

8.149 The level of any pay award being considered should take account of:

- The totality of funding available to the Scottish Executive Health Department;
- The Department's ongoing commitment to the modernisation of NHSScotland;
- Affordability and the competing demands for investment;
- The Government's inflation target of 2%.

H. CONCLUSION AND PAY PROPOSALS

8.150 We would assert that in general, the picture on a wide range of workforce issues within NHSScotland is positive and improving. Our objective of trying to build a world-class workforce for NHSScotland is challenging for the Department, NHSScotland management and staff, and their representatives. However, the evidence above suggests that we are collectively facing up to this challenge and trying to move forward in effecting change for the benefit of all those who either work in the NHS or are treated by it.

8.151 In relation to doctors, numbers are up in almost all categories, and although there are vacancies for consultants, the rate at which these vacancies are increasing is declining. As outlined above, there are numerous measures in place to effect a reduction in the number of consultant vacancies. Any rise in the number of vacancies also needs to be seen in the context of a workforce which has been expanding.

8.152 The position on dentist numbers is healthy, in terms of both the numbers practicing and the future supply of dentists when compared to the numbers that we estimate will be needed. SEHD continues to fund a wide range targeted initiatives aimed at both retaining existing dentists, recruiting more, and ensuring that an acceptable level of service provided to residents in all parts of the country, whether urban, or remote and rural. A full account of the measures we are to achieve these objectives is included above.

8.153 We also sought the views of Scottish employers on the recruitment and retention position in their areas. In the vast majority of cases employers reported a stable position in this area, with the perennial difficulty of recruiting in remote and rural areas remaining an issue. Scottish employers have not to date been minded to use recruitment and retention premia, wither under the consultant contract or Agenda for Change which indicates that recruitment and retention remains fairly healthy in Scotland.

8.154 On morale and motivation, 33% of NHSScotland staff took the time to respond to the annual staff survey and, as well as some opportunities for improvement, a number of positive outcomes were recorded. For example, a high proportion of the staff surveyed indicated that they expected to continue working for the NHS over the next year and felt that good use is made of their skills and abilities. The picture in this area is therefore also fairly positive, with feedback indicating that the majority of staff are satisfied with the overall benefits package they receive as NHS employees.

8.155 As well as the factors mentioned above, we feel that the 2007/08 pay award should take account of:

- The totality of funding available to SEHD;
- The Department's ongoing commitment to the modernisation of NHSScotland;
- Affordability and the competing demands for investment.

8.156 SEHD supports the Health Department's recommendation of a general uplift of 1.5% which we believe is fair and affordable and balances the need to meet the recruitment and retention needs of NHS Scotland, the need to ensure that resources are available to deliver both growth in capacity and service improvements, and the need to maintain financial balance.

CHAPTER 9: CONCLUSIONS AND PAY PROPOSALS

9.1 In the preceding chapters, we have outlined the overall economic climate within which all public sector pay uplifts must be considered along with the specific issues relating to this remit group within the NHS. The UK economy remains in a sound position with a sustained period of economic expansion. It has benefited from the longest period of sustained low and stable inflation since the 1960s and shown greater stability and stronger GDP growth than the majority of our competitors. Recent increases in inflation have been in large part due to temporary impact of high oil prices but, removing the impact of this (and other) temporary factors, the underlying or "core" inflation has remained consistently below 2.0%. The Chancellor wrote to all Review Body Chairs on 13 July 2006 setting out his view that in order to prevent converting temporary inflation increases into a permanent increase, pay settlements should be based on the achievement of the Bank of England's inflation target of 2.0%.

9.2 It is clear from our evidence that pay restraint in the next financial year is key to the continued healthy growth in the economy as a whole. It is also clear that in 2006/07 the NHS is facing a challenging year when an overspend of £512 million is to be repaid and financial balance is to be restored and maintained in future years.

9.3 We have provided evidence of the pressures on the NHS financial position. This pay year (2007/08) is the final year of the 2004 spending review and will form the baseline for the next spending period. As yet, we do not know what the exact levels of investment will be for 2008/09 and beyond, but it is clear that spending will slow substantially. Therefore, we would urge the Review Body to remember that high pay awards this year will have a long lasting effect on NHS finances and may adversely affect the delivery of long-term improvements and financial stability.

9.4 In its 35th Report, the DDRB discounted our arguments about taking the deficit issue into account when making recommendations on affordable pay uplifts. It remains the Government's contention that this is a major issue in determining affordability. It is the combination of headline pay increases and the strong underlying growth of medical earnings which are causing NHS employers to examine very carefully the replacement and creation of senior medical posts. It is important to remember that if the NHS as a whole is to achieve and maintain financial balance overall, the effects of deficits in a minority of NHS employers is a national rather than a local problem.

9.5 The Government remains committed to improvements in the NHS. Investment has been substantial and we will start to see the benefits of that investment over the next spending review period. In this next period, growth in spending is set to slow substantially and therefore we all need to recognise the need for affordable pay uplifts.

9.6 Annex B provides detailed information on the increases in medical pay and earnings levels since 1997/98. The pay bill has increased from £4.6 billion to £8.1 billion from 2001/02 to 2006/07, a 76% increase in that period. We continue to see a high level of average earnings across all medical staff groups, on average around 3.8% growth per head in 2006/07. This demonstrates the effect of investment in pay modernisation for consultants in 2003, the banding supplements for doctors in training and the incremental progression built into the pay system.

9.7 The Government awaits joint proposals from NHS Employers and the BMA for new contractual arrangements for Staff and Associate Specialist doctors. The intention is to update the Review Body on this issue at supplementary evidence stage.

9.8 We have also brought forward evidence to demonstrate the healthy recruitment and retention picture amongst the remit group. We are in a position where domestic supply meets demand. This demonstrates our long-term commitment to securing and retaining the best workforce for NHS patients. We are clear that recruitment is not a problem and, in fact, in some cases we are seeing a re-balancing of the workforce with some NHS trusts reducing the number of posts in their compliment. This demonstrates the fine line the NHS needs to tread in order to ensure that costs can be contained at the same time as services are improved at a time of financial prudence.

9.9 High pay awards would bring added cost pressure to NHS trusts, which would inevitably lead them to consider if they could sustain their current staff numbers and services offered.

9.10 In the light of the good recruitment and retention position, low vacancies and against the background of the financial pressures facing the NHS, we believe it is vital that an affordable pay settlement is reached for the NHS. With a stable rate of inflation on target at 2.0% and a lower rate of growth in spending, it is sensible to seek a realistic pay settlement for this remit group.

9.11 Taking all factors into account, especially the financial pressures on the NHS, we believe that an affordable level of pay uplift for this remit group for 2007/08 is 1.5%. Such an uplift for 2007/08 we believe will lead to an increase in average earnings for HCHS doctors of 2.2% (detailed in Annex B). The Government believes that current pay arrangements are more than adequate for a 1.5% pay uplift not to have an adverse impact on retention or future recruitment.

9.12 The Review Body will be interested to know that we have put forward evidence to the Nurses and Other Health Professions Pay Review Body seeking a similarly affordable award for all NHS staff.

ANNEX A

EVIDENCE ON INFLATION FOR THE PAY REVIEW BODIES

1. Each year the Treasury provides the Pay Review Bodies (PRBs) with evidence on the economic situation to inform the assessment of pay settlements for public sector workers. This paper provides advance analysis of recent trends in inflation, a key issue in assessing pay awards, especially in the context of significant rises in oil prices seen over the past two years. The paper updates the analysis provided by the Treasury to the PRBs in November 2005.

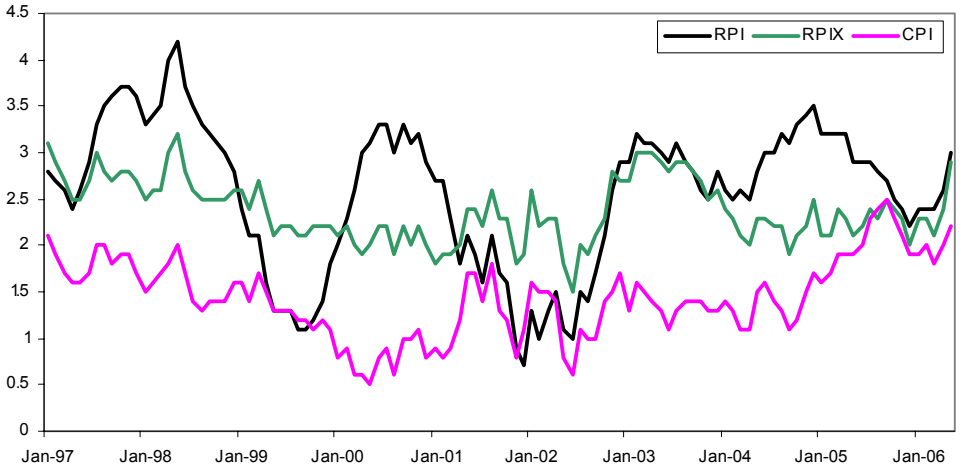
2. The paper begins by examining recent movements in inflation as shown by the different measures of inflation. It then considers the causes of these changes, the extent to which they are temporary, and the implications for wage-setting in the public sector.

3. Since the Government established its monetary policy framework in 1997, the UK has benefited from its longest period of sustained low and stable inflation since the 1960s. For example, whereas inflation as measured by the Retail Prices Index (RPI) averaged 6.5% between 1979 and 1997, it has averaged 2.6% since 1997. As a consequence of this low inflation environment, interest rates have also been at record lows. Having averaged 12% between 1979 and 1997, mortgage interest rates have been 7% on average since 1997 and currently stand at under 6.5%. These low interest rates have benefited millions of public sector workers as well as households in the rest of the economy.

4. Against this background of historically low inflation and interest rates, Consumer Price Index (CPI) inflation increased last year to reach a peak of 2.5% in September 2005. Since then it has dropped back, and stood at 2.2% in May 2006. Other measures of inflation, such as RPIX, have risen less quickly over the same period. Headline RPI inflation actually fell throughout 2005, as house prices eased and mortgage interest payments (excluded from CPI and RPIX) were reduced as a result of the Bank of England's base rate cut in August 2005.

5. All three measures of inflation have picked up slightly in recent months. This can largely be attributed to a temporary increase in the rate of inflation for goods with volatile prices, such as oil and seasonal foods.

Chart 1: UK inflation



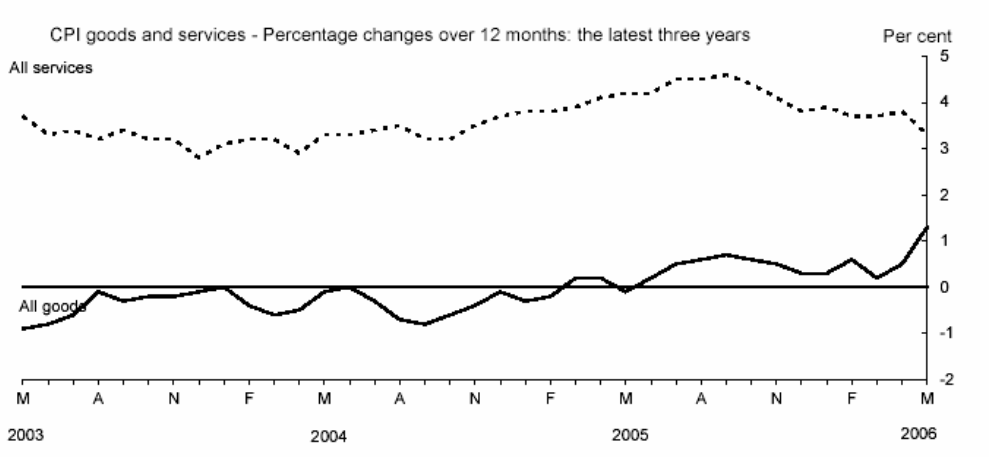
6. Increases in the prices of petrol, energy and food have resulted in a pick up in goods price inflation. Over the past 15 years services inflation in the UK has consistently outpaced goods inflation. For much of the past 7 years goods inflation has in fact been negative or around zero,

whilst services inflation has hovered around a 4% annual growth rate. But with goods and services inflation each accounting for roughly half of the total CPI basket (goods: 55%; services 45%) this scenario has proved consistent with the maintenance of the headline CPI inflation rate around its 2% target.

7. As Chart 2 shows, goods price inflation picked up to 1.3% in May as a result of these temporary price increases. Although this has been accompanied by a slight decline in inflation in the service sector (in which wages represent a higher proportion of total costs), service sector inflation remains significantly higher than goods prices inflation. Overall CPI inflation has remained broadly stable around the Government's 2% inflation target.

8. Recent higher goods price inflation means it is important to remain vigilant to the risk of higher pay settlements feeding through into higher service sector inflation. In order to avoid a permanent increase in inflation going forwards, discipline in pay settlements will need to be continued, through pay awards that are consistent with the achievement of the Government's CPI inflation target of 2%.

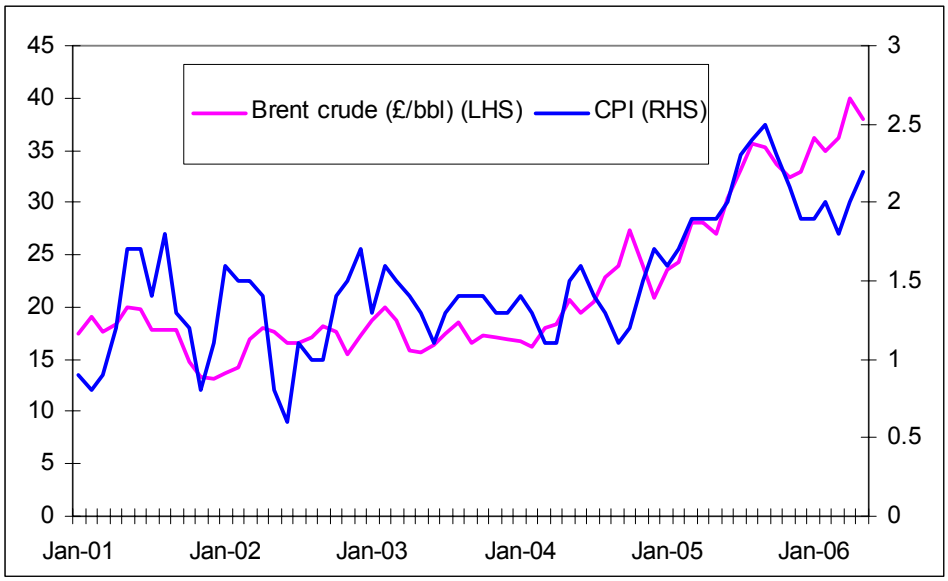
Chart 2: CPI goods and services inflation



The price of oil

9. One of the main reasons for the increase in the rate of CPI inflation since the start of 2005 is the sharp increase in crude oil prices. Oil prices have increased by more than 75% since the beginning of 2005, and recently reached a new record high in May 2006.

Chart 3: Sterling oil price and UK headline inflation



10. Chart 3 shows the oil price against CPI inflation. The increase in oil prices in 2005 had a direct impact on CPI inflation, as a result of increases in the price of petrol and other fuels. These increases have added around 0.4 percentage points to the current annual rate of CPI inflation, accounting for nearly 20% of current inflation by this measure.

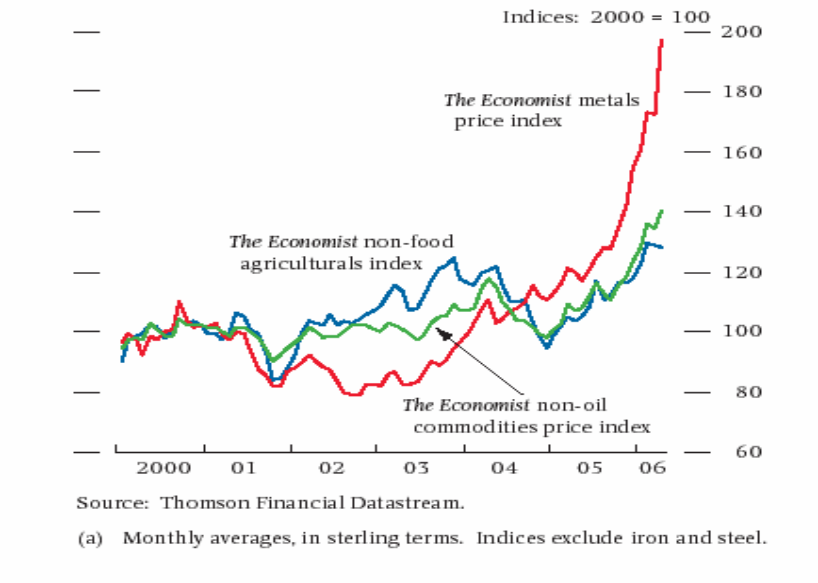
11. Increasing energy prices as a whole have had an even greater impact on inflation, accounting for half of the current rate of CPI inflation, or 1.1 percentage points.

12. Throughout 2005, the impact of higher oil prices on the RPI and RPIX measures of inflation was offset by easing house price inflation, and additionally by a reduction in mortgage interest payments for the RPI. However, in recent months RPIX and RPI inflation have picked up alongside the CPI measure, as these 'offsetting' factors have declined and higher energy prices have consequently fed through into higher headline inflation.

Other commodity prices

13. The increase in global commodity prices has not been limited to crude oil. In recent years a number of other commodity prices have been subject to considerable price rises. Chart 4 shows that *The Economist* non-oil commodities price index has risen by around 45% in sterling terms over the past 18 months; whilst the increase in metals prices has been of the order of 80% over the same period.

Chart 4: Global commodity price inflation



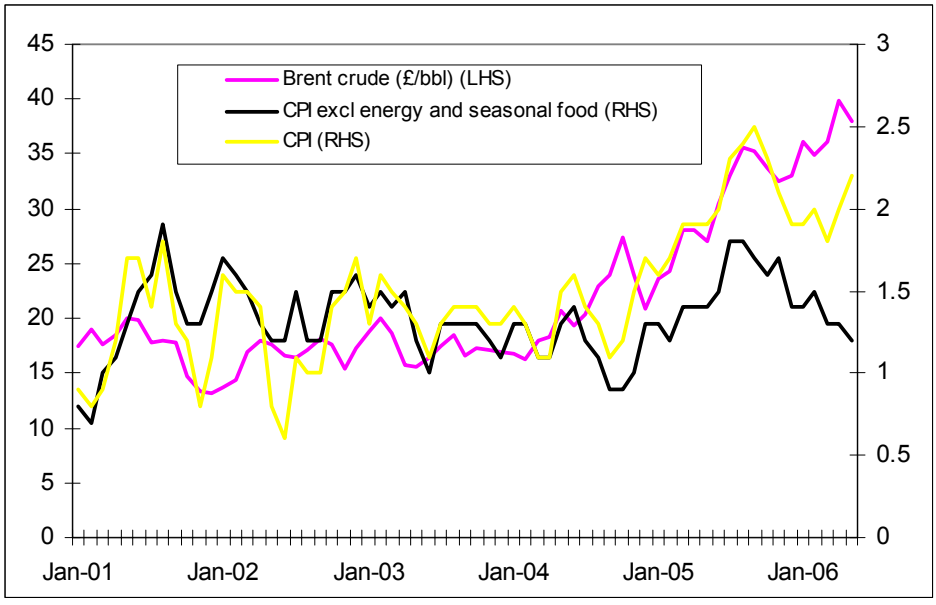
Source: Thomson Financial Datastream.

(a) Monthly averages, in sterling terms. Indices exclude iron and steel.

'Core' inflation

14. It is possible to abstract from the effects of volatile price changes by looking at measures of 'core' inflation. These measures exclude certain items from the CPI basket whose price effects might be considered to be temporary and/or volatile: examples include energy prices and seasonal food prices. As such these measures, which are intended to give a measure of 'underlying' inflation in the economy, are more likely to reflect the balance of the pressures of demand on supply and thus should be taken into account when pay settlements are determined.

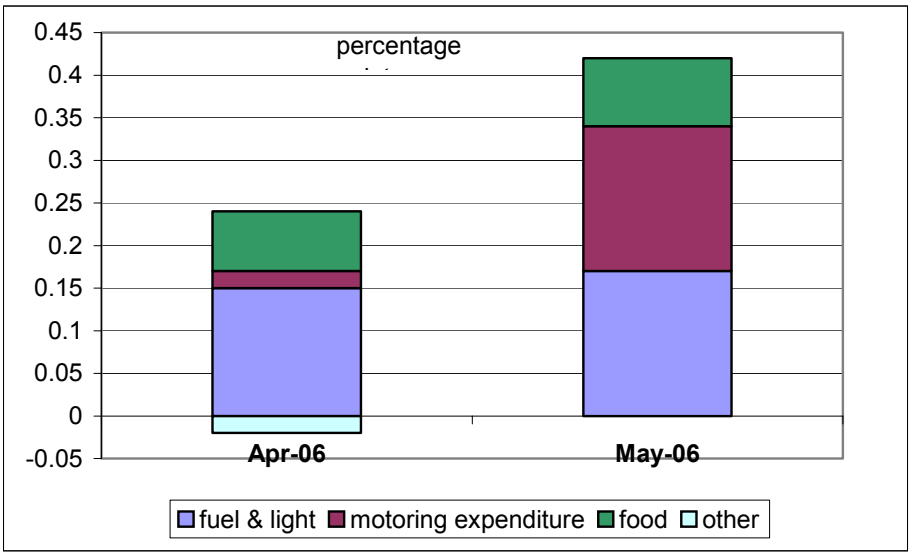
Chart 5: Oil price and UK 'core' inflation



15. Chart 5 shows the oil price against total CPI inflation and CPI inflation excluding energy and seasonal food. It shows that oil prices rose sharply over 2005, driving up headline CPI inflation. However, it also makes clear that once these temporary volatile factors are stripped out, underlying or 'core' inflation has remained below 2% and has been falling steadily since August 2005.

16. As Chart 6 shows, the pick-up in RPI inflation in April and May 2006 can also largely be attributed to a temporary increase in the rate of inflation for energy, oil (increases in the price of petrol are reflected in an increased contribution from the motoring expenditure category) and seasonal foods.

Chart 6: Main contributions to the month's change in the annual RPI rate



17. With core CPI inflation stable below 2% and falling back since August 2005, and with headline CPI inflation having fallen back from the peaks seen in 2005, this shows that, so far, higher oil prices have not resulted in a more general rise in prices. This is in part due to pay growth restraint. However, recent higher goods price inflation means it is important to remain vigilant to the risk of higher pay settlements feeding through into higher service sector inflation going forwards. In order to avoid a permanent increase in inflation going forwards, this discipline will need to be continued, through pay awards that take account of underlying inflation and are consistent with the achievement of the Government's CPI inflation target of 2%.

Conclusion

18. In conclusion, this paper has shown that the recent increase in headline inflation rates is in large part due to the temporary impact of higher oil prices. Measures of inflation which strip out the impact of oil and give a measure of 'underlying' inflation in the economy are much lower. However, there are signs that these temporary price increases are feeding through into higher goods price inflation. This means it is important to remain vigilant to the risk of higher pay settlements feeding through into higher service sector inflation going forwards.

19. So far there has been no evidence of higher headline inflation rates feeding through into higher pay settlements in the private sector. Because of the discipline of wage-setters, this has also been the case in the public sector. However, it will be important to continue to ensure that public sector pay increases do not contribute to inflationary pressures in the economy going forwards. To do so would risk converting a temporary increase in inflation into a permanent increase. The Pay Review Bodies should therefore base their pay settlements on the achievement of the inflation target of 2%.

ANNEX B

PAY METRICS

Historical Pay Metrics

Historic pay metrics in this annex are estimated on the basis of data from the financial returns and foundation trust annual reports, together with staff numbers from the workforce census. These cover all staff and salary costs, including employers' NI and pension contributions. The paybill figures do not include the cost of Agency staff.

High increase for junior doctors in 2001/02 were the result of the new junior doctors contract. Similarly, the high increase for consultants in 2003/04 resulted from the new consultant contract. Decrease in 2004/05 for junior doctors was related to decrease in hours required by the EWTD.

Projected Pay Metrics

Workforce projections are central to paybill forecasting. The paybill forecasts use projections of workforce supply produced by the Workforce Review Team. Workforce projections currently use census 2004 data as a baseline, and represent full time equivalent staff numbers. Pay metrics will be updated when revised supply projections (using a 2005 baseline) are available. Projections for key workforce groups are modelled individually, taking into account information such as past trends, international recruitment, flow through grades, return to practice, retirement and other leavers.

Projected pay metrics are shaded in grey. The base year for projections is 2004/05, this is the most recent year for which financial returns are available. To project forward, assumptions on workforce numbers (see above), pay settlement, pay reform, employer NI and pension contributions and pay drift are applied to the baseline data. Projections are produced on a year on year basis. Forecasts for 2005/06 and 2006/07 use the agreed settlement figures for the respective years. The effects of different levels of settlement in 2007/08 are shown in the forecasts.

Paybill and Earnings per head (FTE)

Paybill per head (FTE) is derived using full-time equivalent staff numbers. Paybill figures include the "on-costs" of employment. On-costs are estimated using figures in financial returns (these are not broken down by staff group or grade). These costs are then stripped out to give an estimate of average earnings per head (FTE).

Pay Metrics

HCHS Paybill by staff group (£million)[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5**[2]	***2005/6***[3,4]	***2006/7***[3,4]	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	1,432m	1,581m	1,773m	2,024m	2,278m	2,538m	3,114m	3,681m	4,111m	4,212m	4,403m	4,424m	4,446m	4,468m	4,490m
Other Career Grades	185m	233m	271m	327m	395m	477m	546m	635m	679m	818m	877m	882m	886m	890m	895m
Registrars and Senior Registrars	480m	522m	574m	639m	765m	865m	1,026m	1,161m	1,285m	1,336m	1,336m	1,342m	1,349m	1,356m	1,362m
SHOs and HOs	629m	671m	728m	794m	934m	1,073m	1,240m	1,370m	1,494m	1,497m	1,644m	1,652m	1,660m	1,669m	1,677m
Other Hospital Medical Grades	207m	199m	212m	214m	216m	208m	217m	229m	214m	237m	229m	231m	232m	233m	234m
Total Medical staff	2,933m	3,207m	3,558m	3,997m	4,589m	5,161m	6,142m	7,077m	7,783m	8,100m	8,489m	8,531m	8,573m	8,615m	8,658m

Growth in HCHS Paybill[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5**[2]	***2005/6***[3,4]	***2006/7***[3,4]	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	6.6%	10.4%	12.1%	14.2%	12.6%	11.4%	22.7%	18.2%	11.7%	2.5%	4.5%	5.0%	5.6%	6.1%	6.6%
Other Career Grades	9.2%	25.9%	16.2%	20.8%	20.8%	20.6%	14.5%	16.3%	6.9%	20.5%	7.2%	7.8%	8.3%	8.8%	9.3%
Registrars and Senior Registrars	7.9%	8.7%	10.0%	11.2%	19.8%	13.1%	18.5%	13.2%	10.7%	3.9%	0.0%	0.5%	1.0%	1.5%	2.0%
SHOs and HOs	1.9%	6.7%	8.4%	9.0%	17.8%	14.8%	15.6%	10.5%	9.0%	0.2%	9.8%	10.4%	10.9%	11.5%	12.0%
Other Hospital Medical Grades	28.4%	-3.9%	6.5%	0.8%	1.0%	-3.6%	4.3%	5.7%	-6.5%	10.8%	-3.2%	-2.8%	-2.3%	-1.8%	-1.3%
Total Medical staff	7.2%	9.3%	11.0%	12.3%	14.8%	12.5%	19.0%	15.2%	10.0%	4.1%	4.8%	5.3%	5.8%	6.4%	6.9%

HCHS Paybill Per FTE (£)[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5**[2]	***2005/6***[3,4]	***2006/7***[3,4]	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	72,820	77,394	82,813	91,224	98,788	102,509	118,213	130,819	138,820	144,751	148,830	149,566	150,302	151,038	151,774
Other Career Grades	52,452	55,252	57,890	62,498	71,689	74,773	82,617	90,994	93,928	100,966	101,887	102,392	102,896	103,401	103,906
Registrars and Senior Registrars	42,354	45,158	47,524	52,352	60,576	66,414	73,325	72,085	74,247	75,881	75,881	76,260	76,640	77,019	77,399
SHOs and HOs	34,487	36,229	39,526	41,755	48,228	51,333	55,323	55,837	57,512	58,777	58,777	59,071	59,365	59,659	59,953
Other Hospital Medical Grades	47,884	49,632	56,467	61,563	62,065	65,049	74,473	85,185	87,932	94,520	95,382	95,855	96,327	96,800	97,272
Total Medical staff	51,373	54,583	58,965	64,367	71,636	75,604	85,000	90,199	94,266	97,846	98,516	99,005	99,494	99,983	100,472

Growth in HCHS Paybill Per FTE[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5[2]**	***2005/6[3,4]***	***2006/7[3,4]***	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	0.9%	6.3%	7.0%	10.2%	8.3%	3.8%	15.3%	10.7%	6.1%	4.3%	2.8%	3.3%	3.8%	4.3%	4.9%
Other Career Grades	-4.7%	5.3%	4.8%	8.0%	14.7%	4.3%	10.5%	10.1%	3.2%	7.5%	0.9%	1.4%	1.9%	2.4%	2.9%
Registrars and Senior Registrars	2.0%	6.6%	5.2%	10.2%	15.7%	9.6%	10.4%	-1.7%	3.0%	2.2%	0.0%	0.5%	1.0%	1.5%	2.0%
SHOs and HOs	-3.2%	5.0%	9.1%	5.6%	15.5%	6.4%	7.8%	0.9%	3.0%	2.2%	0.0%	0.5%	1.0%	1.5%	2.0%
Other Hospital Medical Grades	33.2%	3.7%	13.8%	9.0%	0.8%	4.8%	14.5%	14.4%	3.2%	7.5%	0.9%	1.4%	1.9%	2.4%	2.9%
Total Medical staff	1.8%	6.2%	8.0%	9.2%	11.3%	5.5%	12.4%	6.1%	4.5%	3.8%	0.7%	1.2%	1.7%	2.2%	2.7%

HCHS Earnings Per FTE (£)[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5[2]**	***2005/6[3,4]***	***2006/7[3,4]***	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	65,799	69,934	74,007	80,684	86,477	89,846	103,246	109,728	116,429	121,398	124,819	125,435	126,050	126,666	127,281
Other Career Grades	47,395	49,926	51,838	55,387	62,850	65,627	72,268	76,432	78,896	84,791	85,572	85,994	86,416	86,838	87,260
Registrars and Senior Registrars	38,270	40,805	42,618	46,452	53,161	58,328	64,182	60,622	62,442	63,818	63,829	64,146	64,464	64,781	65,098
SHOs and HOs	31,162	32,736	35,503	37,120	42,395	45,160	48,515	47,038	48,450	49,518	49,529	49,775	50,021	50,266	50,512
Other Hospital Medical Grades	43,268	44,848	50,572	54,564	54,459	57,137	65,181	71,575	73,883	79,402	80,133	80,529	80,924	81,319	81,714
Total Medical staff	46,420	49,321	52,794	57,033	62,804	66,353	74,342	75,767	79,179	82,182	82,753	83,162	83,571	83,980	84,389

Growth in HCHS Earnings Per FTE[1]

											2007/8[3,4]				
	1997/8	**1998/9**	**1999/0**	**2000/1**	**2001/2**	**2002/3**	**2003/4**	**2004/5[2]**	***2005/6[3,4]***	***2006/7[3,4]***	**0.0%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**
Consultants	1.0%	6.3%	5.8%	9.0%	7.2%	3.9%	14.9%	6.3%	6.1%	4.3%	2.8%	3.3%	3.8%	4.3%	4.8%
Other Career Grades	-4.6%	5.3%	3.8%	6.8%	13.5%	4.4%	10.1%	5.8%	3.2%	7.5%	0.9%	1.4%	1.9%	2.4%	2.9%
Registrars and Senior Registrars	2.1%	6.6%	4.4%	9.0%	14.4%	9.7%	10.0%	-5.5%	3.0%	2.2%	0.0%	0.5%	1.0%	1.5%	2.0%
SHOs and HOs	-3.1%	5.1%	8.5%	4.6%	14.2%	6.5%	7.4%	-3.0%	3.0%	2.2%	0.0%	0.5%	1.0%	1.5%	2.0%
Other Hospital Medical Grades	33.3%	3.7%	12.8%	7.9%	-0.2%	4.9%	14.1%	9.8%	3.2%	7.5%	0.9%	1.4%	1.9%	2.4%	2.9%
Total Medical staff	1.9%	6.3%	7.0%	8.0%	10.1%	5.7%	12.0%	1.9%	4.5%	3.8%	0.7%	1.2%	1.7%	2.2%	2.7%

DAT Paybill Reference 060831.

Notes:

1. Figures for NHS Staff only & exclude agency
2. Includes estimates for Foundation Trusts
3. Figures are projections and are subject to change. Actual paybill outturn figures for 2005/06 are not yet available
   Current workforce projections from 2006 onwards are supply projections, using 2004 Census FTE as a baseline.

ANNEX C

NON-PAY COST INCREASES IN THE NHS

The table below sets out the cost pressures faced by NHS Trusts, net of pay increases and any efficiency improvements they are able to deliver.

Goods and services - Inflation on goods and services is assumed to be 2.7% in 2005/06 and 2006/07 in line with the GDP deflator.

Clinical negligence costs - Clinical Negligence Scheme for Trusts contributions by the NHS are assumed to rise by £135m in 2005/06 and £141m by 2006/07.

Secondary care drugs - The underlying growth in secondary care drugs is assumed to be around 10% in each year. This does not include the cost of NICE appraisals which are accounted for separately.

Capital Charges

- Revenue cost of capital - Based on the price element of the capital charge estimates provided by the NHS and the unitary charge for PFI schemes

- **Volume growth in capital charges -** Based on estimates from the NHS, the volume growth in capital charges is estimated to be £156m in 2005/06 and £103m in 2006/07

Efficiency savings - Efficiency savings have been assumed that are equivalent to 1.7% in 2005/06 and 2.5% in 2006/07.

NICE technology appraisals and clinical guidelines - This comprises the estimated cost of new technology appraisals and clinical guidelines from NICE. The estimate includes the cost of faster appraisal of some technology appraisals.

Implementation of the National Programme for IT - The average costs assumed in 2006/07 for the following:

- PACs – implementation costs are estimated to be a net £25m costs in 2006/7
- Patient administration system conversion to spine technical and data quality compliance standards (required for PBR, full Choose and Book compliance and implementing LSP solutions) - £55m in 2006/7.
- Standardisation and integration of critical departmental systems (Pathology, pharmacy, theatres, radiology and maternity) required for results, order communications and clinical resource management - £63m in 2006/7.
- Warranted IT environments and enhanced information governance/registration procedures - £20m in 2006/7.

The total is approximately £163m in 2006/7.

Technical adjustments

- **revaluation of the NHS estate -** The revaluation of the NHS estate in 2005/6 resulted in a £115m increase to the tariff in 2005/6.

NON-PAY COST INCREASES – BASED ON 2006/07 TARIFF UPLIFT

	2005-06 (over 2004/05 baseline)		2006-07 (over 2005/06 baseline)	
	£m	**%**	**£m**	**%**
Baseline	**46,162**		**49,806**	
Increase in prices	***619***	***1.3***	***898***	***1.8***
Non-pay inflation (prices)	257	0.6	253	0.51
Clinical Negligence Costs	58	0.1	141	0.28
Secondary care drugs	199	0.4	287	0.58
Revenue cost of capital	105	0.2	218	0.44
Reform and quality	***511***	***1.1***	***394***	***0.8***
NICE appraisals and clinical guidelines	327	0.7	291	0.58
Investment in new capital	184	0.4	103	0.21
Connecting for Health	0	0.0	163	0.3
Technical adjustments	***134***	***0.3***	***0***	***0.0***
Revaluation of NHS estate	134	0.3	0	0.0
	Overall	***2.7***	***Overall***	***2.9***

ANNEX D

SPENDING REVIEW 2004 PUBLIC SERVICE AGREEMENT

The aim of the Spending Review 2004 Public Service Agreement is to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

The objectives of the SR2004 Public Service Agreement are:

Objective I: Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

1. Substantially reduce mortality rates by 2010:
    - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
    - from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
    - from suicide and undetermined injury by at least 20%.

2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

3. Tackle the underlying determinants of health and health inequalities by:
    - reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
    - halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport; and
    - reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. Joint target with the Department for Education and Skills.

    Note: Figures will be reviewed following publication of the Public Health White Paper later in 2004

Objective II: Improve health outcomes for people with long-term conditions

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective III: Improve access to services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

Objective IV: Improve the patient and user experience

7. Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:

    - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
    - increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

ANNEX E

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

The table below illustrates the combined effect of incremental rises and Review Body awards on individual doctors' pay by taking some hypothetical examples of HCHS grades over a five-year period.

Column (a) shows the actual basic pay for a doctor at 1 April each year from 2002. An individual doctor would progress incrementally each year as well as receiving a pay award based on Review Body recommendations and the figures include both elements.

Column (b) expresses the total annual increase as a percentage. (The DDRB headline award is also shown)

Column (c) shows the cumulative percentage increase over basic pay at 1 April 2002.

For example, a new consultant starting on 1 April 2002 on the minimum of the scale would have received basic pay of £52,640. Having progressed up the consultant scale, and assuming transfer to the new consultant contract, by 1 April 2006 the doctor's basic salary would have increased to £76,658 - an increase of 45.6% over 4 years. The basic salary of a consultant with thirty years seniority who transfered to the new contract has increased from £68,505 in April 2002 to £94,706 in April 2006 – an increase of 38.2%. A consultant who was on the maximum of the scale on 1 April 2002 and who chose to remain on the pre-2003 contract has had a salary increase of 10.1% over 4 years.

GRADE	YEAR	(a) ACTUAL BASIC SALARY £	(b) ANNUAL % INCREASE (of which DDRB headline award)	(c) CUMULATIVE % INCREASE
SHO	1 April 2002 (minimum)	23,190		
	1 April 2003 (point 1)	25,545	10.1 (3.225)	10.1
	1 April 2004 (point 2)	27,884	9.2 (2.7)	20.2
	1 April 2005 (point 3)	30,418	9.1 (3.0)	31.2
	1 April 2006 (point 4)	32,822	7.9 (2.2)	41.5
SpR	1 April 2002 (point 2)	28,540		
	1 April 2003 (point 3)	30,825	8.0 (3.225)	8.0
	1 April 2004 (point 4)	33,337	8.1 (2.7)	16.8
	1 April 2005 (point 5)	36,067	8.2 (3.0)	26.4
	1 April 2006 (point 6)	38,628	7.1 (2.2)	35.3
Staff Grade	1 April 2002 (minimum)	28,150		
	1 April 2003 (point 1)	31,440	11.7 (3.225)	11.7
	1 April 2004 (point 2)	34,734	10.5 (2.7)	23.4
	1 April 2005 (point 3)	38,377	10.5 (3.225)	36.3
	1 April 2006 (point 4)	41,882	9.1 (2.4)	48.8
Consultant (with transfer to new contract)	1 April 2002 (minimum)	52,640		
	1 April 2003 (new contract)	65,035	23.5 (3.225)	23.5
	1 April 2004	68,196	4.9 (3.225)	29.6
	1 April 2005	73,699	8.1 (3.225)	40.0
	1 April 2006	76,658	4.0 (1.0)	45.6
Consultant (30+ years seniority on transfer to new contract)	1 April 2002 (maximum)	68,505		
	1 April 2003 (new contract)	78,195	14.1 (3.225)	14.1
	1 April 2004	85,780	9.7 (3.225)	25.2
	1 April 2005	93,768	9.3 (3.225)	36.9
	1 April 2006	94,706	1.0 (1.0)	38.2

Consultant	1 April 2002 (maximum)	68,505		
(15 years	1 April 2003 (new contract)	73,290	7.0 (3.225)	7.0
seniority on	1 April 2004	75,654	3.225 (3.225)	10.4
transfer to	1 April 2005	78,094	3.225 (3.225)	14.0
new contract)	1 April 2006	78,875	1.0 (1.0)	15.1
Consultant	1 April 2002 (maximum)	68,505		
(remaining on	1 April 2003 (maximum)	70,715	3.2 (3.225)	3.225
pre-2003	1 April 2004 (maximum)	72,483	2.5 (2.5)	5.8
contract)	1 April 2005 (maximum)	74,658	3.0 (3.0)	9.0
	1 April 2006 (maximum)	75,404	1.0 (1.0)	10.1

ANNEX F

RECOMMENDATIONS AND CONCLUSIONS OF THE REVIEW OF GP TRAINERS' PAY

An independent review of GP trainers' pay was completed in June 2006 incorporating views from the Department of Health, the BMA and other stakeholders.

Terms of reference

The review had the following terms of reference:

In the light of the implementation of Modernising Medical Careers and the changing role of those GPs engaged in training to consider:

- An appropriate method of remunerating GPs and/or GP practices who undertake the training of GP and Foundation trainees
- Assuming an agreed method of remuneration, to make proposals on the level(s) of that remuneration when introduced
- To make recommendations to ensure the agreed continuing professional development needs of GPs participating in training are met.

In the light of the findings of the review, to consider what further evidence might be available or could be commissioned to inform the future development of trainers or training practice remuneration. Further to consider the role of GP practices in the education, training and development of health care staff more generally.

Recommendations

The report made the following nine recommendations:

An appropriate method of remunerating GPs and/or GP practices

1. Remuneration for training should become practice based as opposed to GP trainer based.

2. There should be a move towards a more explicit recognition of:
   - the net service contribution of doctors in training in general practice
   - the opportunity costs to training practices (e.g. premises, the GP trainer's time for teaching and supervising doctors in training, GP trainer's own training and CPD time and costs, general administrative costs and involvement of other staff in training)

   in calculating the remuneration to training practices.

3. In order to optimize the use of educational and training resources in a training practice, it would be helpful if deaneries endeavour to ensure there is a consistent flow of doctors in training through the practice to maintain a consistent level of service provision. These doctors will be at different points in their postgraduate training, depending on the training profile of the practice.

4. For funding purposes, it is proposed that doctors in training in general practice be divided into bands, reflecting the level of experience. In developing the number of bands it will be necessary to balance simplicity versus equity. Initially, it is suggested that two bands are considered but this may need to be increased in number as more evidence of the variation in

service delivery becomes available. Band one would comprise F1 and F2 doctors and band two all GPRs from months 1 to 12 (and potentially eventually 18).

5. An equitable and transparent mechanism based on defined educational needs should be put in place for funding those GPRs who require further periods of training in primary care beyond the standard period. There is a recognised need for practices willing to train GPRs who require remedial training. The amount of extra workload this type of training places on a practice should be the topic of further audit and review.

6. Practices that train doctors should be encouraged to be training practices for other health professionals but not at the expense of the quality of uniprofessional training. This will be facilitated by a move to funding training practices to develop as a learning environment instead of a focus on individual GP trainers. By developing a teaching and learning culture throughout the primary health care team, practices will develop resources and skills to offer multiprofessional education. The funding for these activities may be at marginal cost or may be on a *quid pro quo* basis, with professionals 'hosting' trainees from other disciplines as well as their own.

Levels of remuneration

7. Payments for GP training should be revisited in the light of the outcomes of:
    - The MPET review
    - The audit of the levels of educational activity and service contribution of doctors in training in primary care. Professor Ruth Chambers and colleagues at the University of Staffordshire are currently undertaking an audit of time spent on service commitment and other activities by doctors in training in general practice.
    - PMETB decisions on the proposed new GP curriculum
    - Further work on the other issues identified by the GPC (Recommendation 9)

Ensuring agreed continuing professional development needs are met

8. It is recommended that there should not be a separate payment of educational CPD in 2006/7 or in future years, but that the costs of education and professional development for those involved in training within the practice should be reflected in the training practice grant.

Further evidence required

9. In addition to the work highlighted at recommendation 7, four further areas of work are recommended:
    - To evaluate the success of COGPED initiatives to develop training practices in under doctored and deprived areas.
    - To evaluate the relationship between numbers of training practices in hard to recruit areas and recruitment and retention of GPs.
    - To determine the workload practices undertake for those GPRs requiring remedial training beyond the usual 12 month FTE period.
    - To determine the impact of undertaking multiprofessional training in a general practice.

Conclusion

The report concluded:

"The Terms of Reference for this review outlined three issues for consideration:
- An appropriate method of remunerating GPs and/or GP practices who undertake the training of GP and Foundation trainees

- Assuming an agreed method of remuneration, to make proposals on the level(s) of that remuneration
- Ensuring agreed continuing professional development needs of GPs participating in training is met.

We consider that we have made significant progress in addressing the first issue, while recognising that further work is required to review the work of practices with GPRs requiring remedial support. Recommendations 1-6 outline a framework for recognising the contribution of, and remunerating those engaged in, GP training that is fit for purpose in the post-MMC, multi-professional environment of the future. We feel the proposals will be fair to both GPs and their practices whilst meeting the needs of the NHS.

We have not made similar progress with the second issue. We felt it was not possible to recommend levels of remuneration within the proposed new framework at this stage as the outcome of a number of current initiatives and the result of ongoing research are required to make informed decisions. We recognise, however, the urgent need for this issue to be addressed in the light of the required information and hope that this will be taken forward as soon as possible.

We have addressed the third issue at recommendation 8.

We have also highlighted at recommendation 9, further areas of work required to inform this ongoing review".

ANNEX G

RETENTION AND RETIREMENTS

1. As set out in previous years' evidence, the Department of Health has a number of means for monitoring retirement and retention trends and these mechanisms form an integral part of our workforce planning assumptions and models. The available evidence is consistent with the workforce planning assumptions we have made.

2. We remain of the view that, whilst there are some indications of a small shift towards early retirement, the numbers involved are small and would have only a marginal impact on total numbers overall and the retirement rates are not expected to change.

3. Future patterns in working behaviours will be monitored. Part time working is expected to become more commonplace, due in part to the feminisation of the workforce. However, this behaviour is not expected to have a significant impact on net retirement rates in the near future. The Department has put in place a range of measures to encourage higher rates of retention.

How are retirement rates modelled?

4. Workforce modelling for the Department of Health is now performed by the NHS Workforce Review Team (WRT)[6], hosted by the South Central SHA. The WRT comprises an expert team of professional advisers, workforce modellers, information analysts and project managers, who provide insightful and independent advice and modelling to the Department on workforce issues.

5. WRT modelling of consultant retirements is done for each individual specialty by WRT analysts. A consultant retirement across all specialties is then the sum of the individual specialty consultant retirements.

6. The starting point for WRT modelling of consultant retirements is the NHS Workforce Census, in particular the age-profile. WRT hold discussions with the Medical Royal Colleges to estimate a retirement age for each specialty. These are applied to each specialty's consultant workforce and age profile, such that an estimate of retirements can be made for future years.

7. Historical consultant leaving rates in each specialty are considered when estimating the average retirement age. In certain specialties, actual numbers can be estimated with a reasonable degree of accuracy. In others, suitable data is not available and numbers of retirements by year are averages.

8. The consultant retirement rate, across all specialties, is currently estimated to be 2.5%, using this methodology. This is expected to remain fairly constant over the foreseeable future.

New data on early retirement intentions

9. The Medical Careers Research Group (MCRG) has now provided final results from a study, from data collected in late 2004 and early 2005, of the retirement intentions of doctors approaching the age when some of them might to start to consider early retirement. The MCRG have sought views from those doctors, who qualified in 1977 and had a median age of 51 years at the time of the survey. This study follows the format of a previous MRCG study, relating to the 1974 cohort, and provides a view on emerging trends in retirement intentions.

[6] NHS Workforce Review Team website: http://www.hiowwdc.nhs.uk/workforce_review_team/index.htm

10. The latest MRCG study found that 17% of NHS doctors who qualified in 1977 had a definite intention to retire early. This compares to 25% of NHS doctors in the 1974 cohort, when surveyed in 1998 at a similar stage in their careers. Initially, these figures seem quite high, although the results of the 1977 survey do show an improvement. A total of 37% of NHS doctors among the 1977 respondents said they would definitely not or probably not stay on to retirement age. Again this compares favourably with the survey of the 1974 cohort in which 51% were of this opinion.

11. These results need to be viewed with caution. They do suggest a reduction in the level of intentions to retire early. However, the key point to bear in mind is that early retirement intentions are not the same thing as actual retirements. It is common in many professions for early retirement intentions to be overstated. The survey of the 1974 cohort suggested very high rates of early retirement, but the reality is that this has not produced any significant shift in actual retirements so far.

12. The evidence so far suggests that early retirement intentions overstate likely outcomes, but it is not possible yet to prove this analytically. In the meantime, the situation needs to be monitored carefully, although the evidence we have so far is consistent with a situation in which early retirement intentions are consistently quite high, but levels of actual retirement are consistently moderate, reasonable and manageable.

13. We will continue to use the MCRG data to monitor trends in stated early retirement intentions over time. We will also consider with MCRG whether it is possible to follow these cohorts of staff (for 1974 and 1977) to later stages in their careers to see how intentions change over time. Alongside this, we will continue to use existing methods to monitor numbers of actual retirements. These mechanisms will ensure that we are well placed, if necessary, to respond to any shifts in real retirement patterns.

Data from the NHS Business Services Agency Pensions Division

14. Table 1 below shows the number of consultants who received a pension award, from the NHS pension scheme, in each of the financial years 1996/97 to 2004/05, by category of retirement. (Final data to year end 31 March 2006 is not yet available).

15. The table replaces the evidence provided in previous years by the NHS Pensions Agency. This data is now held by the NHS Pensions Division, part of the newly formed Business Services Agency[7]. The data is presented in a slightly different format to previous years' evidence, which accounts for the small differences between this series and that shown in the previous evidence[8].

16. As with previous years' evidence, the figures relate to England and Wales as it is not possible to separate Welsh data for this calculation. It should also be noted that the retirement data held by the NHS Pensions Division is used primarily to record membership of the scheme. The data recording system manages over 1.2 million active records most of which are subject to regular updates year on year. Retirement data will therefore represent a "snapshot" at a given period, which will be subject to change over time.

Table 1: Consultant Retirements and Reasons for Retirement – England & Wales

Year end 31 March	Age	Ill-health	Deferred Pension	Redundancy	Unknown	Total Pension Awards

[7] NHS Business Services website: http://www.nhsbsa.nhs.uk/index.htm

[8] Refined data cleaning has amended some previously presented figures. Numbers of voluntary early retirements cannot be identified separately.

			Benefits			
1997	258	58	31	27	32	406
1998	295	52	30	19	34	430
1999	275	57	22	18	37	409
2000	295	55	21	11	23	405
2001	338	66	34	11	26	475
2002	358	66	26	8	24	482
2003	327	60	16	7	30	440
2004	367	57	22	14	34	494
2005	363	46	20	9	36	474

17. The total number of pension awards has increased over the period as the size of the workforce has increased. The number of age retirements is higher now than it was in the late 1990s, but this reflects the age profile of the current workforce rather than any change in retirement rates. Voluntary early retirements are still included in the unknown category, but, if we look at unknowns and early retirements together, the figures suggest no systematic increase.

18. These data need to be considered alongside existing evidence on retirement trends. In previous years' evidence we have quoted findings from the 1979-1984 actuarial investigation of the NHS Pension Scheme by the Government Actuary's Department (GAD). This projected an average age of retirement for male hospital doctors of 63.9 years. It should be noted that this average was identified for a staff group that contained male hospital doctors, but was fully defined as "non-manuals administrative, executive, clerical officers, including hospital medical and dental officers and male nurses". The retirement patterns of hospital doctors could not be separated out from the other members within this group. The corresponding figure in their latest valuation (for 1989 to 1994, completed in October 1998) is 63.3 years, indicating a small change over a ten-year period. GAD stated, however, that it was likely that the average doctor retirement ages were probably lower than the rest of the group; this is because doctors are more likely to be able to afford to retire than clerical workers.

19. The grouping of pensions valuation data has now changed, and male and female hospital doctors are included groups (one male, one female) defined as "Hospital Medical Staff and part-time specialists", including nurses who joined the scheme after March 1995. The assumed average retirement ages from these groups (for the valuation for 1999-2004) are 63.4 (males) and 62.4 (females). These data continue to include information on non-doctors, and as such may overstate the retirement ages of doctors. However, the retirement ages do not vary significantly from previous reported ages and indicate little change in retirement behaviours since the previous valuation.

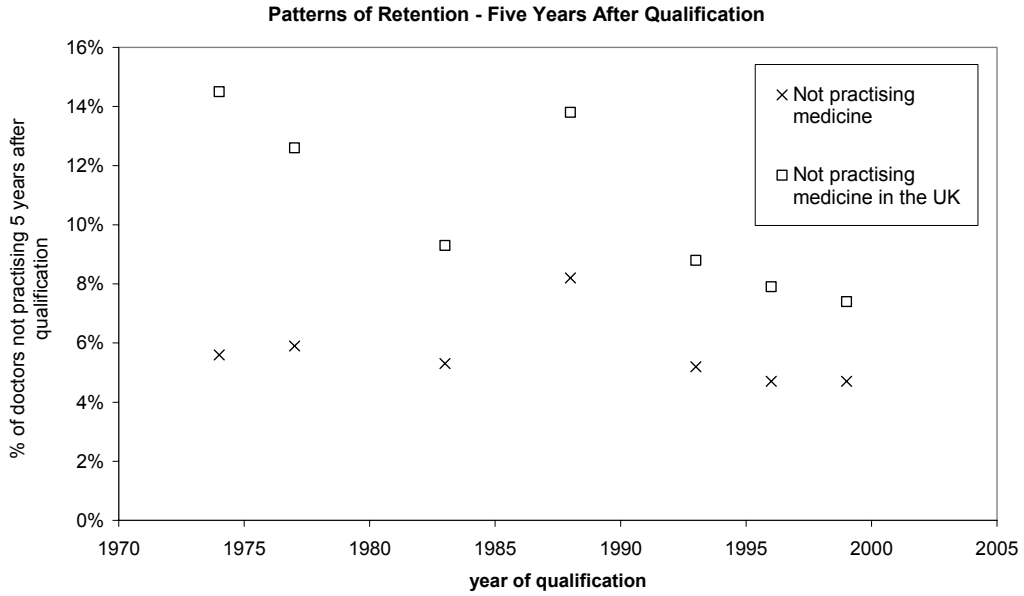
20. For this year's evidence we have updated the usual analysis from the Medical Careers Research Group (MCRG) on overall wastage rates 5 years after qualifying. Table 2 below shows the MCRG's estimates of numbers of doctors not practising medicine, and numbers not practising medicine in the UK, five years after qualification. The figures are minimum estimates, because they exclude non-respondents who are registered as doctors in the UK.

21. The percentage of graduates not practising medicine after five years has remained quite low for all cohorts, remaining fairly stable over time. The percentage of 1999 graduates not practising medicine in 2004 was 4.7% compared with 4.7% for the 1996 graduates and 5.2% for the 1993 graduates at the same stage of their career (2001 and 1998 respectively). The percentage not practising medicine in the UK was 7.4%, compared to 7.9% for the 1996 cohort. There is no clear trend, but in both cases the proportions not working in UK medicine are smaller than for previous cohorts. (see chart 1).

Table 2: Patterns of Retention – Five Years After Qualification

Year of Qualification	Cohort size	Not practising medicine		Not practising medicine in the UK	
		Number	%	Number	%
1974	2344	131	5.6	339	14.5
1977	3130	184	5.9	395	12.6
1983	3841	204	5.3	357	9.3
1988	3731	307	8.2	514	13.8
1993	3639	188	5.2	322	8.8
1996	3836	182	4.7	302	7.9
1999	4180	195	4.7	308	7.4

Chart 1:



New Analysis of HCHS Census Data

22. To ensure that we are assembling as complete and up to date a picture as possible of any emerging trends in retention patterns, we have also updated the analyses of our own HCHS census data. The latest available figures show leaving patterns in the year to September 2005.

23. The analysis provides details of consultants who have left the NHS between 2004 and 2005, but without taking into account the small numbers that flow to other sectors, such as GMS, so the wastage rates may be slightly overstated[9]. The wastage rate for hospital medical consultants between 2004 and 2005 was 5.0%. This is in line with previous wastage rates, which have remained almost unchanged since 1995, with gross wastage at between 5% and 6%. In the last 4 or 5 years there was a slight upward trend in the number of consultants appointed from outside the NHS (including rejoiners) and as a result the net wastage rate fell from a 2% loss to a 1.1% gain between 2002 and 2003. This trend has now slowed with net

[9] It should also be noted that wastage rates will include (a) doctors from overseas who did not intend to stay in the NHS for long periods, (b) doctors on maternity leave and research programmes.

wastage results for the whole of the hospital consultant workforce showing a 0.1% gain between 2004 and 2005.

24. As expected, there is a variation by age. The gross number of leavers in the 55 to 59 age group has previously been about 250 to 300 each year – about 8% or 9% of staff in that group; between 2004 and 2005 there were 227 in this age group that left the NHS, equating to 5.7%. When taking into account the number of staff in this age group newly appointed from outside the NHS between 2004 and 2005 (101), the net wastage in this age group currently stands at 2.0%. This is a lower rate of wastage compared to the rate in previous years' evidence (4% between 2002 and 2003).

25. As well as assessing retirement rates, we also need to take into account the age profile of the current workforce. Doctors recruited during the expansion of medical school places in the late 1960s are now nearing retirement age, and an increase in the numbers retiring is only to be expected. However, it leads to only a marginal increase in the projected numbers of retirements, and does not have a significant impact on retirement rates and our workforce projections.

26. It must be noted that the use of historical information as a guide to future trends is limited, particularly in light of changing attitudes to working patterns. For example, the number of females in the medical workforce is increasing. This group tend to work less hours per week but provide a longer length of service, i.e. better retention. Also, the idea of having a retirement 'date' and to retire fully is likely to reduce, increasing numbers of doctors choosing instead to work part-time later in their careers. Currently, these behaviours are not expected to have a significant impact on net retirement rates.

27. We will continue to monitor these patterns and behaviours as part of our workforce planning.

ANNEX H

CONTRACTS OFFERED TO DENTISTS IN THE RUN-UP TO 1 APRIL 2006

	Contracts signed		Contracts still in discussion		Contracts rejected			Contracts signed				
SHA	A: Number	B: Approximate UDA value	C: Number	D: Approximate UDA value	E: Number	F: Approximate UDA value	% UDAs from rejected contracts to all UDAs	G: Number signed without dispute	H: Number signed in dispute	% disputes	% contracts rejected	% UDAs from signed contracts and contracts in discussion
AVON, GLOUCS & WILTSHIRE	334	2,932,488	0	-	103	202,996	6.5%	225	111	33.2%	**23.6%**	93.5%
BEDS & HERTS	324	2,370,157	0	-	30	84,681	3.4%	162	162	50.0%	**8.5%**	96.6%
BIRMINGHAM & BLACK C	397	4,069,268	0	-	26	134,825	3.2%	220	177	44.6%	**6.1%**	96.8%
CHESHIRE AND MERSEYSIDE	368	4,452,930	8	55,131	18	132,230	2.8%	280	88	23.9%	**4.6%**	97.2%
COUNTY DURHAM & TEES V	156	2,036,999	0	-	10	62,281	3.0%	123	33	21.2%	**6.0%**	97.0%
CUMBRIA & LANCASHIRE	320	3,000,454	8	105,419	22	78,390	2.5%	255	65	20.3%	**6.3%**	97.5%
DORSET & SOMERSET	227	2,056,284	0	-	40	73,852	3.5%	184	43	18.9%	**15.0%**	96.5%
ESSEX	243	2,447,810	7	32,691	25	51,881	2.0%	166	77	31.7%	**9.1%**	98.0%
GREATER MANCHESTER	483	4,528,026	0	-	56	169,288	3.6%	251	232	48.0%	**10.4%**	96.4%
HAMPSHIRE & ISLE OF WIGHT	278	2,115,492	1	952	60	238,355	10.1%	194	84	30.2%	**17.7%**	89.9%
KENT & MEDWAY	253	2,032,775	0	-	40	154,712	7.1%	147	106	41.9%	**13.7%**	92.9%
LEICS, NORTHANTS RUTLAND	258	2,252,013	0	-	9	7,050	0.3%	140	118	45.7%	**3.4%**	99.7%
NORFOLK, SUFFOLK & CAMBS	358	3,513,288	0	-	52	145,505	4.0%	270	88	24.6%	**12.7%**	96.0%
NORTH CENTRAL LONDON	265	1,811,434	0	-	31	30,468	1.7%	143	122	46.0%	**10.5%**	98.3%
NE YORKS & N LINCS	211	2,325,571	1	4,400	63	153,179	6.2%	181	30	14.2%	**22.9%**	93.8%
NORTH EAST LONDON	235	2,172,750	0	-	14	59,038	2.6%	136	99	42.1%	**5.6%**	97.4%
NORTH WEST LONDON	384	2,694,363	0	-	41	27,945	1.0%	297	87	22.7%	**9.6%**	99.0%
NORTHUMB, TYNE AND WEAR	199	2,616,964	0	-	12	89,879	3.3%	155	44	22.1%	**5.7%**	96.7%
SHROPSHIRE & STAFFORDSHIRE	399	2,205,529	0	-	38	49,202	2.2%	236	163	40.9%	**8.7%**	97.8%
SOUTH EAST LONDON	245	2,204,647	0	-	11	6,325	0.3%	122	123	50.2%	**4.3%**	99.7%
SOUTH WEST LONDON	251	1,541,988	0	-	35	67,909	4.2%	194	57	22.7%	**12.2%**	95.8%
SOUTH WEST PENINSULA	269	2,358,462	0	-	41	72,648	3.0%	217	52	19.3%	**13.2%**	97.0%
SOUTH YORKSHIRE	196	2,282,457	0	-	6	23,992	1.0%	74	122	62.2%	**3.0%**	99.0%
SURREY AND SUSSEX	503	3,057,545	11	32,922	50	108,889	3.4%	369	134	26.6%	**8.9%**	96.6%
THAMES VALLEY	363	2,265,121	2	3,653	62	102,165	4.3%	232	129	35.5%	**14.5%**	95.7%
TRENT	337	4,062,284	0	-	28	112,789	2.7%	224	113	33.5%	**7.7%**	97.3%
WEST MIDLANDS SOUTH	224	2,365,920	0	-	87	232,994	9.0%	151	73	32.6%	**28.0%**	91.0%
WEST YORKSHIRE	297	3,273,661	0	-	41	145,788	4.3%	145	152	51.2%	**12.1%**	95.7%
TOTAL	**8,377**	**75,046,680**	**38**	**235,168**	**1,051**	**2,819,256**	**3.6%**	**5,493**	**2,884**	**34.4%**	**11.1%**	**96.4%**

Notes:

Provisional management estimates on the number of signed and rejected contracts is provided in the spreadsheet. The information on signed contracts is broken down to show contracts signed in dispute and those not signed in dispute.

The table also sets out the estimated level of NHS services associated with accepted contracts compared with that of rejected contracts, based on weighted courses of treatment (or 'units of dental activity').

A contract may be for either a practice or an individual dentist.

ANNEX I

EXAMPLES OF DENTAL TENDERS UNDERTAKEN BY PCTs

BLACKBURN with DARWEN

The Issue
This area experienced access pressures which had been exacerbated by dentists leaving the area/ the NHS and consequently significant losses in access to NHS dental services(>21,600 de-registrations) in 2003/4.

They undertook a large scale re-commissioning exercise which resulted in two large new providers opening practices in the area together with some smaller PCT-run services. However, there were further losses as a result of the introduction of the new contract. The PCT therefore needed to stabilise the position of NHS dentistry and replace the losses.

The Solution
The PCT decided that as it had already carried out significant re-provision work that it did not need to go through a further large scale tendering exercise, and instead opted to carry out a local tender involving existing providers.

The size of the tender was £299,850. The average UDA costs for the newly tendered service compared to the existing PCT average UDA costs turned out to be:

Average PCT GDS UDA cost	£23.29
Average PCT PDS UDA cost	£27.96
Average tendered UDA cost	£19.67

Outcome
Five initial expressions of interest led to four formal applications.

Of the four applicants one contractor was awarded a commission for 3,250 UDAs and the other for 12,000 UDAs.

LINCOLNSHIRE (West Lincolnshire PCT, East Lincolnshire PCT, Lincolnshire South West PCT)

Issue
Following contract negotiations a number of practices chose to leave the NHS to practice private dentistry. This resulted in a significant reduction in access to NHS dental services.

In response to this situation as well as the issues regarding access that had been identified in the Dental Action Plan the PCTs jointly carried out a significant procurement process for additional dental capacity across Lincolnshire.

Solution
Because Lincolnshire has been traditionally a difficult area to which to recruit, with a falling supply of NHS dentistry. The PCTs therefore decided to test the local market and open the area up to new providers. They issued an external tender for the new provision

The size of the tender was £3,128,514. The average UDA costs for the newly tendered service compared to the existing PCT average UDA costs turned out to be:

Average PCT GDS UDA cost	£20.23
Average PCT PDS UDA cost	£24.10
Average tendered UDA cost	£18.08

Outcome
Nationwide advertising for extra services resulted in 33 expressions of interest from which 12 contracts were signed for a total of 174,040 UDAs with services expected to be in place by the autumn in Lincoln, Louth, Spalding, Boston, Skegness Holbeach and Grantham.

These contracts will result in several new surgeries and some expansion of existing practices.
Services have been commissioned from a range of providers including bodies corporate, independent contractors and a social enterprise body corporate.

MILTON KEYNES

Issue
Milton Keynes Area of rapid population growth, with none of the existing 35 practices accepting new adult NHS patients. PCT priority was therefore to improve access to general dentistry

Solution
PCT decided to attract a new provider into the area to provide a new, single site practice in one of the high need areas identified in their oral health needs assessment. They therefore put out an external tender.

The size of the tender was £500,000. The average UDA costs for the newly tendered service compared to the existing PCT average UDA costs turned out to be:

Average PCT GDS UDA cost	£25.08
Average PCT PDS UDA cost	£29.26
Average tendered UDA cost	£17.90

Outcome
The tender was awarded for single site practice to deliver >28,000 UDAs, to come on stream by 1 October 2006. As the new practice was sited adjacent to, not in, the area of high need, the PCT has stipulated that all patients are to be taken from the PCT access database, and no advertising for new patients is to be undertaken without the PCT's prior consent.

ANNEX J

IMPROVING ORAL HEALTH AND MODERNISING NHS DENTAL SERVICES IN SCOTLAND

1. **Oral Health and Prevention: (a) Children & Adults**			
Target Groups: Pre-school and School Children			
Actions	**Milestones 2005/06**	**Status**	**Comments/Information**
Implement comprehensive programme for 0-2 yrs initially in areas of greatest need thereafter to the rest of Scotland	Health Visitor referral scheme starts in areas of greatest need	Achieved	Demonstration Project Initiated. Pilot now running in West of Scotland with 69 General Dental Practices + participating in Childsmile pre-school oral health promotion programme in West of Scotland
Implement nursery and schools preventive programmes	Nursery and school expansion programme starts in areas of greatest need	Achieved *2006 target for nursery children achieved.	Nursery toothbrushing programme in place. 70% of nurseries nationwide are toothbrushing daily – over 90,000 children involved daily.
Implement changes to children's services in general dental services	New children's allowances	Partly achieved	Piloting of child friendly practice payment in place. Fissure sealants introduced. Registration period extended from 15 months to 36 months.
Changes to structure of dental services for adults including extending registration	Phase one of programme	Achieved	Increases in adult capitation payments have been introduced. Registration period extended from 15 months to 36 months.
Oral examinations free for those 60 and over	60+ Free examinations	Achieved for all NHS patients	Free exams for NHS patients of all ages introduced. Oral health assessment for those aged 60+ piloted
Additional achievements			
Oral health targets 5 & 11 year olds	Continued improvement in oral health	Achieved	- 50% 5yr olds no obvious dental disease - 53% 11yr olds no obvious dental disease

2. Workforce: (a) Dentists and PCDs			
Target Group: Dentists and Professionals Complementary to Dentistry			
Actions	**Milestones 2005/06**	**Status**	**Comments/Information**
Increase number of dentists by at least 200 over present number, at an average rate of 50 per year	Allocate new salaried posts to boards	Achieved	NHS Boards have authority to appoint salaried dentists directly. 56 additional dentists working in NHS dentistry over 12 month period to September 2005. 40 dentists in varying stages of recruitment from Poland.
Vocational training posts for all dental graduates	135 posts funded	Achieved	135 posts funded 143 posts available this year (2006) 135 graduates expected 2006
Increase PCD (therapists/hygienists) student numbers	30 student intake	Not yet achieved.	2005 intake only 20 rather than target of 30. The Edinburgh conversion course will produce 4 additional therapists this year with the new Edinburgh therapist course which is currently being finalised producing additional students.
Expand dental nurse training to 250/year	National dental nurses teaching pack for 150	Achieved	Over 250 new dental nurses recruited and receiving standardised teaching pack
Develop outreach training in Aberdeen and other locations	Outreach in Community clinics Aberdeen, Glasgow and Argyll and Clyde	Achieved/ on schedule	Outreach in Aberdeen being developed for target date of Autumn 2006. Outreach already in operation in Arbroath, Kirkcaldy, Greenock and Glasgow
Additional Achievements			
Dental Student increase	Students increased to meet graduate target of 135	Achieved	Student numbers are such that there are likely to be at least 135 dental graduates this year
General Dental Practitioner increase	Recruitment from European Union	Achieved	40 dentists in varying stages of recruitment from Poland.

3. Modernising Dental services: (a) NHS Dental System			
Target Group: Patients, Dental Professionals, NHS Boards			
Actions	**Milestones 2005/06**	**Status**	**Comments/Information**
Implement new remuneration system for dental practices	New reimbursements for premises, IT and services. Changes to general dental practice allowance	Achieved except for IT see below*	Premises re-imbursements introduced General dental practice allowance modified and substantially increased to NHS committed practices. Clinical waste collections and re-imbursement introduced. IT connections to NHS net being piloted in 40 practices
Programme of premises improvements	New reimbursement scheme to meet rental or equivalent costs New improvement grant scheme	Achieved	Re-imbursement scheme introduced and backdated to 1 April 2005.
Implement programme of IT improvements	Connection of practices to NHS net Specification of approved clinical systems	*Work in progress *Work in progress	40 Practices already connected to NHS Net in pilot Work currently in progress to specify approved clinical systems.
Improve access for patients to routine and emergency care	Increased funding to Boards to provide out-of-hours services. Revised dental access scheme. NHS Boards given authority to support salaried practitioners. Boards provide help-line for local people	Achieved	Substantial additional funding issued to independent general dental practitioners committed to providing NHS general dental services. Funding provided to NHS Boards for emergency dental services. NHS Boards given authority to appoint additional salaried practitioners. Help lines in all NHS Board areas for emergency services. Revised dental access scheme being finalised.
Implement quality improvement programme for dental services	Develop accreditation scheme with support practices	Work in progress	Initial piloting being undertaken in NHS Forth Valley. All dental practices inspected 3 yearly.
Introduce new system of patient charges	Review current system	Work in progress	Working group established. Further work to link with modernisation and simplification of statement of dental remuneration.

ANNEX K

Additional Workforce Information: NHS Scotland

HCHS Medical and Dental Staff by staff group

	REGION				
Hospital, Community and Public Health Medical and Dental Staff Headcount at 30 Sept 05	Scotland [8]	East [4]	North [5]	West [6]	Other [7]
All Staff	10,876	2,532	2,766	5,483	118
Consultant [1]	3,724	902	895	1,873	69
Registrar group [2]	1,695	480	481	727	7
Senior house officer	2,761	594	602	1,556	9
House officer	767	164	223	380	-
Associate specialist and Staff Grades [3]	797	192	195	398	12
Other	1,158	204	374	564	21

Source: ISD Scotland

[1] Consultants includes Directors of Public Health

[2] Registrar group includes Senior Registrars, Registrars and Specialist Registrars

[3] Associate Specialist and Staff grade group includes Senior Clinical Medical Officers and Clinical Medical Officers

[4] East Region includes Borders, Fife and Lothian.

[5] North Region includes Grampian, Highland, Orkney, Shetland, Tayside and Western Isles.

[6] West Region includes Ayrshire & Arran, Argyll & Clyde, Forth Valley, Greater Glasgow, Lanarkshire and Dumfries & Galloway.

[7] Other includes National Bodies and Special Health Boards includes State Hospital, Golden Jubilee, Scottish Ambulance Service, NHS24, NHS National Services Scotland (formerly CSA), NHS Education for Scotland, NHS Health Scotland and NHS Quality Improvment Scotland

[8] Note sum across the regions /grade may not equal the Scotland total as some individuals work in more than one region /grade

Proportion of HCHS medical staff who are employed part-time, by grade

Part-time headcount as percentage of total staff in post, at 30th September

	1999	2000	2001	2002	2003	2004	2005
All staff [1]	**20.8%**	**21.1%**	**20.5%**	**19.3%**	**18.4%**	**17.8%**	**17.5%**
Consultant [2]	17.1%	17.1%	16.8%	16.5%	16.6%	16.9%	16.5%
Associate specialist & Staff grades	41.9%	41.8%	41.0%	39.1%	40.6%	39.4%	37.6%
Registrar group [3]	16.0%	16.7%	14.2%	13.8%	13.2%	11.1%	10.0%
Senior house officer	1.8%	2.2%	2.5%	2.4%	2.8%	2.5%	2.5%
House officer	0.3%	0.1%	0.1%	0.0%	0.1%	0.0%	0.3%
Other	98.5%	99.1%	99.2%	98.6%	99.1%	98.9%	96.7%

Source: ISD Scotland

Notes

1 Maximum part-time staff are included as full time

2 Consultant includes Director of Public Health

3 Registrar group includes Specialist Registrars, Senior Registrars and Registrars **Source: ISD Scotland**

Turnover of Hospital and community medical staff [1, 2]

	2002/03	2003/04	2004/05
Consultants [3]	4.3%	4.1%	4.4%
Doctors in training [4]	24.9%	24.0%	23.9%

Source: ISD Scotland

1 'Turnover' is defined as the number of 'leavers' divided by the average number of staff in post in the year concerned.
The denominator is calculated as: (staff post at 30 Sept yr(n) + staff in post at 30 Sept yr(n+1))/2.

2 Data on staff working in oral and maxillofacial surgery is included.

3 Comprises consultants and directors of public health

4 Comprises House Officers, Senior House Officers and Registrar grades.

Turnover of Dentists [1]

	2002/03	2003/04	2004/05
All NHS dentists	**7.4%**	**8.1%**	**7.7%**
Hospital	21.4%	23.0%	13.4%
GDS	7.3%	8.0%	8.8%
Community	19.0%	13.0%	13.8%

Source: ISD Scotland

1 Many dentists work in more than one sector. For the purposes of this table a leavers has been counted in each sector but only once in the total.

General Medical Practitioners

Whole time equivalent at 30th September

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Change 04-05	Average annual change 95-05
General medical service [1, 2]	**3,712.6**	**3,697.2**	**3,740.0**	**3,802.5**	**3,832.3**	**3,876.3**	**3,941.3**	**3,941.9**	**3,991.3**	**3,991.7**	**4,073.8**	**2.1%**	**0.9%**
Performer	3,399.6	3,432.9	3,464.8	3,485.1	3,504.0	3,504.0	3,536.3	3,532.1	3,551.1	3,525.6	3,546.1	0.6%	0.4%
Performer registrar	270.7	224.6	230.4	263.0	272.6	250.6	271.7	272.6	270.6	266.9	290.6	8.9%	0.7%
Performer salaried	42.2	39.7	44.8	54.4	55.7	64.0	69.8	73.0	98.9	126.8	165.0	30.2%	14.6%
Performer retainee [2]	-	-	-	-	-	57.8	63.6	64.2	70.7	72.4	72.1	-0.5%	x

Source: ISD Scotland

Notes:

1 WTE information for GPs is no longer available. Data for this table has been estimated for 2005 using the relationship between WTE and headcount in previous years.

2 Performer retainees were collected (and included in the total) for the first time by ISD Scotland in 2000.

Headcount at 30th September

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Change 04-05	Average annual change 95-05
General medical service [1, 2]	**3,880**	**3,877**	**3,942**	**4,026**	**4,073**	**4,254**	**4,346**	**4,360**	**4,448**	**4,456**	**4,538**	**1.8%**	**1.6%**
Performer	3,532	3,581	3,632	3,667	3,703	3,710	3,761	3,769	3,805	3,782	3,804	0.6%	0.7%
Performer registrar	282	234	240	274	284	261	283	284	281	282	307	8.9%	0.9%
Performer salaried	66	62	70	85	87	99	109	114	155	189	246	30.2%	14.1%
Performer retainee [2]	-	-	-	-	-	184	196	194	209	208	207	-0.5%	x

Source: ISD Scotland

Notes:

1 The sum of the components does not necessarily adds up to the General Medical Service total as double counting (e.g.where a GP works in 2 categories) has been excluded.

2 Performer retainees were collected (and included in the total) for the first time by ISD Scotland in 2000.

General Medical Practitioners by age group

Headcount at 30th September 2005

	Total	Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
General medical service [1, 2]	**4,538**	**-**	**3**	**207**	**556**	**700**	**891**	**835**	**662**	**502**	**182**
Performer	3,804	-	1	41	347	566	772	798	639	480	160
Performer registrar	307	-	1	143	104	36	16	5	1	1	-
Performer salaried	246	-	1	19	55	35	47	22	21	21	25
Performer retainee [2]	207	-	-	4	57	68	63	13	2	-	-

Source: ISD Scotland

Notes:

1 The sum of the components does not necessarily adds up to the General Medical Service total as double counting (e.g.where a GP works in 2 categories) has been

2 Performer retainees were collected (and included in the total) for the first time by ISD Scotland in 2000.

General Medical Practitioners by age group

Headcount as % at 30th September 2005

	Total	Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
General medical service [1, 2]	**100.0%**	**-**	**0.1%**	**4.6%**	**12.3%**	**15.4%**	**19.6%**	**18.4%**	**14.6%**	**11.1%**	**4.0%**
Performer	83.8%	-	0.02%	0.9%	7.6%	12.5%	17.0%	17.6%	14.1%	10.6%	3.5%
Performer registrar	6.8%	-	0.02%	3.2%	2.3%	0.8%	0.4%	0.1%	0.0%	0.02%	-
Performer salaried	5.4%	-	0.02%	0.4%	1.2%	0.8%	1.0%	0.5%	0.5%	0.5%	0.6%
Performer retainee [2]	4.6%	-	-	0.1%	1.3%	1.5%	1.4%	0.3%	0.04%	-	-

Source: ISD Scotland

Notes:

1 The sum of the components does not necessarily adds up to the General Medical Service total as double counting (e.g.where a GP works in 2 categories) has been

2 Performer retainees were collected (and included in the total) for the first time by ISD Scotland in 2000.

All GP performers [1] by age group; As at 30 September 2005

number and percentage

	Number			Percentage	
Age Group	**1995**	**2005**	**Age Group**	**1995**	**2005**
20-24	3	3	**20-24**	0.1	0.1
25-29	314	207	**25-29**	8.1	4.6
30-34	676	556	**30-34**	17.4	12.3
35-39	777	700	**35-39**	20.0	15.4
40-44	696	891	**40-44**	17.9	19.6
45-49	592	835	**45-49**	15.3	18.4
50-54	406	662	**50-54**	10.5	14.6
55-59	273	502	**55-59**	7.0	11.1
60+	142	182	**60+**	3.7	4.0
All ages	**3,879**	**4,538**	**All ages**	**100**	**100**

Source: ISD Scotland

[1] Excludes Performer locums.

Source: 2005 data: GP contractor database (GPCD). 1995 data: GMP database, ISD Scotland.

General Dental Practitioners

	Headcount at 30th September										
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
General Dental Practitioners (GDPs) [1, 2]	**1,785**	**1,789**	**1,824**	**1,861**	**1,906**	**1,901**	**1,944**	**1,969**	**2,001**	**2,034**	**2,131**
Principals	1,722	1,721	1,747	1,789	1,827	1,823	1,856	1,881	1,903	1,919	1,933
Assistants	31	37	48	45	44	39	40	36	38	41	46
Salaried dentists [3]	42	41	39	39	48	50	60	67	77	93	187

Source: ISD Scotland

Notes:

1. GDPs take into consideration General Dental Service minus Vocational Trainees.
2. Information is not collected on the working hours of dentists in the GDS. This data show the number of dentists in post (headcount), not the whole-time equivalent.
3. Due to improvements in the collection of information on GDS salaried dentists, figures for September 2005 include some GDS salaried dentists not previously recorded. There are a number of cases where a salaried post will be recorded under a generic name and not under the name of a specific dentist. Numerous dentists may work in this post at any given time. For years prior to September 2005 it was assumed that, since there was no named individual recorded, a permanent dentist was not in post. As a result, all posts recorded without a named individual were previously excluded from GDS salaried dentist counts. However, information is now available on the individuals who fill these posts. These dentists can now be included in the GDS salaried dentist count, which has resulted in a significant increase in the number of salaried dentists.

STATISTICAL

TABLES

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Entry to the Professions

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General Medical Practitioners

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