Review Body on Doctors’ and Dentists’ Remuneration

Review for 2009

Written Evidence from the Health Departments for the United Kingdom

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EXECUTIVE SUMMARY

Background and context

Our priorities – transformation of the NHS and delivery of the Next Stage Review

1. In identifying what pay award to recommend to the Review Body, the Government has considered:

   • the strategy for the delivery of health services in the future which is set out in the report of the Next Stage Review, *High Quality Care for All*;
   • the workforce implications of that strategy, including the considerable expansion that has taken place in recent years and our more modest growth plans for the future;
   • the significant investment that we have already made in pay reform and the benefits that this has delivered, including our current strong recruitment position;
   • the total value and competitiveness of the current reward package, which includes not only pay but also generous pension, other benefits and development opportunities;
   • the pay levels needed to recruit, retain and motivate this staff group to deliver the strategy.

2. As we set out in our evidence last year, the NHS is part-way through a major transformation which has three stages. The first stage started with the publication of the NHS Plan in 2000. At that time, capacity was limited, vacancies were high, waiting lists were long and waiting times were unacceptable. We consulted the public and they made it clear that they wanted increased capacity with more staff, paid better. The Government, therefore, invested considerable additional resources in the NHS; it increased capacity and reformed and increased pay. This has worked well. Recruitment is buoyant and, despite significant growth in medical and dental workforce requirements, vacancies are at or near record lows and the number of high quality applicants outstrips demand in most areas.

3. The second stage of the transformation of the NHS has been to introduce a series of reforms to give patients and staff the levers to create a more responsive NHS. These reforms have included the introduction of a more pluralistic health service, offering greater patient choice, supported by robust quality assurance, improved information and payment by results.

4. We have recently entered the third and most difficult part of the NHS transformation that requires us to bring together these reforms with our investment in extra capacity to deliver real benefits for patients. Our vision for how we will achieve this was set out in The NHS Next Stage Review Final Report: *High Quality Care for All*. This strategy places quality of care at the heart of everything the NHS does: empowering patients and staff to secure effective and personalised healthcare.
5. Alongside *High Quality Care for All* was published *A High Quality Workforce*, which outlines changes to workforce planning, education and training. This proposes a new devolved workforce planning system based on greater clarity of accountability, roles and responsibilities at all levels. Workforce plans will be built up from local commissioners’ priorities based on the needs of patients. A Centre of Excellence will be created to provide robust, objective analysis, advice and support for the whole system. And specific to the workforce covered by the DDRB, an independent advisory non-departmental body, Medical Education England, will be established to improve key aspects of workforce planning for doctors and dentists and take forward recommendations from the Tooke Inquiry into Modernising Medical Careers published earlier this year.

**The macro-economic context**

6. It is important to note that the macroeconomic context for this year’s pay decisions is substantially changed from last year. The unprecedented twin global effects of the credit crunch and the rapid rise in food and energy prices have hit all the world’s major economies, including the UK. In the 2008 Budget, economic growth was forecast to slow below trend in both 2008 and 2009.

7. These challenging times should be seen in the context of strong GDP and employment growth over the past decade. Nevertheless, decisions taken in the next year or so by individuals, businesses, unions, the Government, and the Bank of England will be critical in determining how, and how well, the UK responds to these adverse conditions. With GDP growth slowing, responses across the economy will determine both how quickly the UK economy recovers, and who bears the inevitable cost of the adjustment. Increases in world commodity prices are feeding through into significant increases in inflation. It is important that decisions taken in response to the current above target inflation do not feed into domestic wages, permanently locking in temporarily high inflation and limiting the Bank of England’s ability to cut interest rates and promote jobs and growth.

8. In terms of what this means for the Government’s pay policy, the fundamental objectives remain unchanged, to recruit and retain high quality workforces; pay awards that are affordable and provide value for money for the tax payer; and consistency with achievement of the Bank of England’s inflation target.

**The funding position and an optimal, cost-effective pay settlement**

9. The growth in funding available for the NHS in 2009/10, at 3.4% in real terms, is the lowest since 1998/99. This makes it even more important to determine the optimal, ie the most cost effective, balance between higher levels of pay and investment in improving services. This is difficult, but the factors that need to be taken into consideration are the medical workforce demand and supply position, the recruitment and retention situation and their pay and pension relative to the wider labour market. As explained in Chapter 9, pay awards above the appropriate level will be at the cost of service improvements.
to benefit patients. Each 0.5% increase in settlement for this group costs some £50 million – equivalent to two-thirds of the Department’s investment in the national obesity strategy ‘Healthy Weight, Healthy Lives’.

How are the DDRB staff groups doing?

10. The recruitment, retention, motivation and morale of doctors, dentists and other NHS staff are key to delivering the challenging Next Stage Review agenda. During the first stage of the NHS reform journey, our priority was to increase the number of staff and improve their pay to tackle problems of recruitment and retention thereby creating the capacity to address long waiting times and reduce the impact of major killer diseases such as heart disease, cancer and strokes. We have achieved this, introducing a series of pay and pensions reforms, and now have more than 128,000 hospital and community health services (HCHS) doctors and General Medical Practitioners (GPs), 38,000 more than in 1997. In aggregate, the balance of demand and supply for doctors as a whole suggests that the number of doctors coming through Medical School and Foundation Programmes is at about the right level to deliver the service expectations set out by the Next Stage Review. In light of the increasing demand for primary and community care services, GP training needs to expand so that in future at least half of doctors going into post Foundation programmes will be training as GPs.

11. Workforce reform has delivered successfully the following for this group:

- healthy competition for all levels of specialty training with, on average, 8.9 applications per place overall and even higher in some specialties, such as 18.4 per place for ophthalmology.
- medical vacancies at a record low level of 0.9% in 2008.
- doctor and dentist groups as a whole are one of the most satisfied occupation groups; according to the NHS Staff Survey, 48% were either satisfied or very satisfied with their pay compared with 30% for the NHS as a whole. Doctors and dentists also reported higher levels of job satisfaction, scoring 3.49 (on a scale of 1-5) compared to the NHS as a whole at 3.44.
- increased staff engagement on NHS developments, for example, through the process of drawing up the Next Stage Review.

12. Furthermore, this group has done very well in pay terms over recent years. Since 2000 average public sector earnings have risen by 40.3%; average private sector earnings by 37.3%; and average earnings across the directly employed staff in the remit group have risen by an estimated 50.2% (based on average HCHS medical earnings from the Pay Metrics at Annex A).

13. For individual doctors the Review Body is reminded that the existence of progression up incremental scales, combined with pay reforms, means that most HCHS medical staff see their earnings increase significantly above the level of the headline award each year. We estimate that average earnings per consultant increased by 38% in the first six years of the new contract (to 2008/09) and we would expect to see continued growth in consultants’ average
earnings, at a rate of about 1% above the headline settlement, as consultants progress towards the new maximum. Consultants in their first five years receive year on year increases of around 3% in addition to the headline settlement.

14. As they progress, more experienced consultants have access to Clinical Excellence Awards (CEAs), worth a minimum £2,900, on top of basic salary, with some 68% of consultants having CEAs or awards under the previous schemes and 13% having CEA level 9 or equivalent worth between £35,000 and £74,700.

15. Earlier this year we began the introduction of a new contract for specialty doctors and associate specialists. This will give specialty doctors (formerly staff grades) who move to the new contract (this process is ongoing, managed by individual NHS trusts) average pay increases of 5.2% in 2008/09 and 5% in 2009/10; and associate specialists increases of 1.8% in 2008/09 and 2009/10. Many doctors in these grades will also receive an incremental award which typically range from 4% to 7% as they progress up the pay scales, all in addition to any pay uplift awarded.

16. The average earnings of junior doctors in their first post (£31,453) continues to stand up well against the starting salaries in other professions. After two years, most of these new doctors will have progressed to the specialty registrar scale with average earnings at the minimum of the scale of £43,464 (some 38% higher than first post as a junior). Excluding the annual pay award, the pay of a specialty registrar who is not yet at the top of the pay scale increases by between 4.1% and 8.1% per annum.

17. This pay and earnings progression needs to be considered in the wider economic context. According to the Bank of England’s latest inflation report, the overall labour market situation is expected to deteriorate. The unemployment rate has already started to climb and will likely increase further due to the cyclical slowdown in output, reducing pressure on wages in the private sector.

18. In this environment, the very healthy medical recruitment and retention position, demonstrated by declining vacancy rates, and the package of workforce reforms for doctors and dentists, that have significantly improved their overall reward, including highly valued pension arrangements, strengthens the relative attractiveness of the public sector as an employer.

Our detailed evidence

19. The following paragraphs summarise the key parts of the detailed evidence we are submitting this year. We have this year tried to make our evidence more streamlined and set a clearer narrative for what the key developments in the NHS are seeking to deliver.

20. We start the evidence with a new Introduction chapter which summarises the key ambitions from the NHS Next Stage Review (NSR) and the specific NSR
document ‘A High Quality Workforce’. This outlines how the creation of a Centre of Excellence will support the improvement of our workforce planning, education and training strategy; the creation of an independent body, Medical Education England (MEE); rebasing the funding arrangements for the Multi-Professional Education and Training (MPET) budget to allow funding to follow the student or trainee; and how we want to work together with all the key stakeholders to develop a more effective postgraduate training pathway for doctors.

21. **Chapter 2** goes on to look at the workforce planning context. Overall the medical workforce numbers continued to grow to September 2007 against an overall small fall in NHS staffing. The outcome of the most recent medical workforce modelling shows the balance of demand and supply overall is at about the right level in relation to planning for the NHS Next Stage Review, which sets out the strategy for the NHS over the next 10 years. Overall three-month vacancy rates remain very low – and fell for hospital doctors and dentists for the fifth year running to just 0.9% in 2008 (as against 4.7% in 2003).

22. **Chapter 3** examines the position on entry to undergraduate training for medical and dental schools. This shows continuing strong numbers with 2.3 applicants for every medical school place and 2.5 for every dental school place. The quality of successful applicants is also good with Universities and Colleges Admissions Service (UCAS) tariff scores of 417 for medicine and 391 for dentistry, similar to 2006/07 and above preceding years. With 53% increase in medical school and 46% increase in dental school intakes since 1997, careers in medicine and dentistry remain very attractive. Graduate starting pay also remains attractive and this is against a backdrop of only a 1.8% increase in median starting salaries among all graduates paid by members of the Association of Graduate Recruiters in the year to 2008.

23. In **Chapter 4** we bring the DDRB up to date with progress on modernising medical careers and how the Tooke report and related work has fed into the NSR report ‘A High Quality Workforce’. The expansion of the number of doctors in training has continued in 2007 (now up some 47% since 2000) – with very high demand for posts in the most popular specialties and localities – and early indication of similarly high overall demand in 2008, with 8.9 applications per place, but with some changes in the regional variation.

24. We go on to show how the NHS is moving to deliver the requirements of the European Working Time Directive. In particular how the NHS is progressing towards the August 2009 target for all doctors in training to be working no more than 48 hours. Half of all doctors in training have already moved to become compliant with the Directive and this has not led to any major problems. We will continue to monitor the recruitment and retention picture as the remainder comply over the coming 12 months. This improvement in work/life balance is the major change in the circumstances of doctors in training over recent years. Finally, we highlight the latest NHS Staff Survey results for 2007 that continue to show doctors and dentists in training as one of the most satisfied NHS staff groups, particularly with respect to their level of
pay and other indicators eg work-related stress – falling some way below overall NHS figures.

25. In Chapter 5 we note the continuing expansion of specialty doctor (staff grade) group - up 2.1% in full time equivalents (FTEs) between 2006 and 2007 - and associate specialist numbers - up 6.2% - and we report on the impact of the new contract which was introduced from April 2008 after being accepted following a BMA ballot. To support the development of Specialty and Associate Specialist (SAS) doctors, further funding (some £12 million) is also being provided for support, training and continuing professional development (CPD) and additional guidance ‘Employing and supporting specialty doctors: A guide to good practice’ was jointly published by DH and NHS Employers in April 2008.

26. Chapter 6 sets out the strong position on recruitment and expansion of the number of consultants in the NHS which we have summarised above. We also draw the review body’s attention to proposals in the Next Stage Review to increase the transparency of the Clinical Excellence Awards scheme and to link the awards more strongly to quality and leadership.

27. Our evidence on General Medical Practitioners will be submitted later in the light of the current negotiations with the BMA.

28. Evidence on the position for NHS dentistry is provided in Chapter 7. Information is given on the growing success of the new contracts for primary dental services. PCTs are currently facing no notable difficulties in expanding local services with no shortage of dentists, either individual practitioners or corporate bodies, tendering for new services enabling best value for money to be achieved. For example, Devon PCT recently received 28 expressions of interest in response to an invitation to establish a large general dental practice, and the PCT was able to select a contractor after interviewing a final shortlist of 6 tenderers. Nationally, the number of dentists providing NHS services increased by 655 or 3.2% in 2007/08 and the Government’s investment in expanding undergraduate dental education is likely to further improve the availability of dentistry.

29. It is also now clear that the significant changes in treatment patterns resulting from the more preventive approach encouraged by the new contracts have reduced overall treatment complexity. Dentists are now providing courses of treatment which involve 33% fewer complex items such as crowns and bridges, and about 20% fewer other treatments such as fillings, than in 2003/04. This led to a reduction in dental practice expenses of about 8% during that period.

30. Our evidence on Ophthalmic Medical Practitioners is at Chapter 8. Around 1.7% of sight tests are carried out by OMPs and we believe the Review Body’s previous recommendation about the joint negotiation of a common sight test fee for OMPs and Optometrists continues to be relevant. In line with this we are currently negotiating the 2008/09 sight test fee with the Optometric Fees
Review Committee who represent optometrists and OMPs. We will report back on these discussions in due course.

31. *Chapter 9* explains the current position with NHS finances and sets out how a high award would both reduce the level of funds available for deployment in improved health care services and store up future pressures. The chapter looks at short and longer run medical workforce demand and supply which shows that these are in balance on existing participation rates of just under 90% for consultants over the next two years. Longer term, on current projections, we expect a small surplus of consultants to materialise in 2011/12. The high earnings of doctors, their job security and pension arrangements relative to the wider labour market, makes it unlikely that participation or morale, already relatively high, will fall below current levels. In the medium term the supply of consultants exceeds demand. A high level of pay award would then be at the expense of service developments in the short run and would feed excess supply in the longer run. An analysis of previous spending patterns is used to demonstrate the short run trade-off between pay and service developments.

32. *Chapter 10* refers to the excellent total reward package available to this remit group which, apart from pay offers an excellent pension scheme with, for the great majority, a normal retirement age (NPA) of 60 as well as other benefits including extensive holiday (35 days rising to 40), post graduate training leave entitlement (up to 30 days), generous sick pay (6 months full pay, 6 months half pay) and good opportunities for flexible working. Although the introduction of a new NHS Pension Scheme has seen NPA rise to 65 for new entrants, the final salary pension available to NHS staff is becoming relatively more valuable as the private sector increasingly moves away from such defined benefits arrangements.

33. *Chapter 11* describes the current macroeconomic context, outlining the current inflation situation, the government's fiscal position including affordability and also the general labour market picture incorporating average earnings growth and total reward.

**Conclusion**

34. Taking account of the strong position on recruitment, retention, morale, relative pay and recent pay increases, and the need to balance NHS aspirations for service improvements, staff morale and wider economic conditions, the Government would support a headline pay award of 2% for directly employed groups. For dentists, the Government would support a simple increase in gross contract values of 1%. We believe this would strike the right balance between ensuring the NHS has a well rewarded professional medical and dental workforce, and maximising the funding available to deliver improvements in healthcare and the reforms set out in the Next Stage Review reports. Awards above these levels would, we believe, unnecessarily reduce the funding available to meet the NHS’s objectives.
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CHAPTER 1: INTRODUCTION

1.1 Our strategies and policies for the NHS are aimed at improving the health and well-being of the population. Lord Darzi’s NHS Next Stage Review, ‘High Quality Care for All’, put clinicians at the forefront of developing local visions to meet local patient needs based on eight areas of clinical care. It is this vision which sets the context within which we are providing evidence to the Pay Review Body for 2009/10. The report, published on 30 June 2008, sets out ambitious plans to raise the quality of healthcare throughout the NHS.

1.2 As we reported to the Review Body last year, the NHS is on a journey of transformation and change which started with the publication of the NHS Plan in 2000. Our current strategy is to transform the NHS on two levels:
- from a monolithic provider of care to a more plural and open system;
- to move more of the care for patients out of hospital settings and into the community.

The aim is to develop a healthcare system that meets the growing needs and expectations of patients whilst ensuring equitable access and affordability.

1.3 The NHS reform journey has involved three stages. In the first stage, we needed to build capacity in the system. NHS funding was increased dramatically – the past decade has seen a trebling of the NHS budget – which has enabled investment in more staff, pay modernisation, new facilities and equipment. At the same time, high profile and ambitious targets were imposed to drive down waiting times and improve treatments for patients with the biggest killers such as cancer and heart disease. In the second stage, we introduced reforms such as patient choice, practice based commissioning, payment by results, foundation trusts and independent treatment centres, giving patients and staff more levers to create a more responsive NHS.

![Inpatient and outpatient waiting times 1997 - present](image)
There are now more than 1.3 million people employed in the NHS in England, an increase of over 272,000 since 1997. There have been substantial improvements in waiting times, as demonstrated by Figure 1.1 above, with those patients needing treatment now having a choice of providers to deliver their care within 18 weeks of seeing their GP. We have also seen substantial reductions in deaths from heart disease, cancers and cerebrovascular diseases.

We are now at the third and most difficult stage in the NHS reform journey – using the investment and capacity, together with the reforms, to transform services, driving up quality and delivering real benefits for patients. This has been articulated in the Next Stage Review.

**NHS Next Stage Review: High Quality Care for All**

The challenge for the Next Stage Review (NSR), was to “help local patients, staff and the public in making the changes they need and want for their local NHS.” It has first and foremost been a local process. *High Quality Care for All* is about enabling and supporting improvements that have been developed and agreed locally.

The Review has been led locally by clinicians in each NHS region. Seventy-four local clinical working groups, made up of some 2000 frontline clinicians, have developed improved models of care, from maternity to end-of-life, for their communities. These are based firmly on the best available clinical evidence and extensive engagement with local patients, staff and their wider communities to ensure that they reflect the needs and preferences of local users.

Each Strategic Health Authority (SHA) in England has now published its long-term vision for improving health and healthcare in its region based on the work of these groups. These visions will now be turned into practical actions locally and delivered on the ground.

*High Quality Care for All* sets out wide-ranging proposals that place quality of care at the heart of everything the NHS does, empowering patients and staff to secure the effective and personalised care that we all expect. It sets out a vision for a 21st Century NHS that:

- helps people to stay healthy;
- gives patients more rights and control over their own health and care;
- gives patients even greater influence over the services they use;
- places quality at the heart of everything it does;
- is pioneering, embracing the best new ideas and treatments;
- values its staff and empowers them to lead local change.

**A High Quality Workforce**

The NSR document ‘*A High Quality Workforce*’, published alongside ‘*High Quality Care for All*’, outlines changes to workforce planning, education and training. This is underpinned by the following principles:
• **a focus on quality** – high quality care requires the provision of high quality education and training. We must ensure that public resources secure the best possible quality and value for money.

• **patient centred** – our workforce should reflect the needs of patients. Therefore, workforce planning should be based on service planning and should reflect how health and social care will jointly meet the needs of the local population.

• **clinically driven** – workforce plans that reflect service plans and professionals meaningfully engaged and involved in the development of plans and the assurance of quality.

• **flexible** – provision of education and training must be sufficiently flexible to give professionals both the breadth and depth of expertise that they need to deliver the high quality care to which they aspire.

• **locally-led** – we recognise that different populations have different needs. In a devolved NHS, to be successful, workforce planning must be devolved locally and assured nationally.

• **clarity about roles** – clearly defined system roles, ensuring a distinction between the responsibilities of those who commission education and training and those who provide it.

1.11 The new devolved workforce planning system will be based on greater clarity of accountability, roles and responsibilities at all levels. Workforce plans will be built up from local PCT commissioners’ service priorities based on the needs of their patients, and commissioners and providers of services will work together to ensure the right staff are in the right place at the right time.

1.12 New professional advisory boards will be established to give clinicians a voice in workforce planning education and training strategy to ensure that the long-term strategy for more flexible workforce deployment and education and training standards is embedded in workforce development plans.

1.13 A Centre of Excellence for workforce planning across patient pathways will be set up to provide objective analysis, advice and support for the whole system. The Centre will perform horizon scanning and analysis of long-term workforce requirements, and will work with the NHS to ensure this is incorporated into current workforce planning and education and training commissioning. The Centre will also have a capability and capacity building function to ensure local NHS organisations can produce high quality workforce plans.

1.14 The new system will ensure high quality staff are employed in the right areas to deliver the services patients need, and combined with more flexible career structures will reduce shortages of staff in key service areas, and reduce the need to pay premium rates for shortage staff groups.

1.15 Key aspects of workforce planning will be improved at national level by establishing an independent advisory non-departmental body, Medical
Education England (MEE), for doctors and dentists and relevant low volume specialities that need to be planned nationally. It will also give advice on integrating and supporting the workforce planning of the healthcare specialist profession.

1.16 One of the key partnerships in the health sector has been that between the NHS and universities. We intend to enable providers of NHS services in both primary and secondary care to come together with partners in the higher education sector and industry to form Health Innovation and Education Clusters.

1.17 In terms of education funding, we will improve transparency, promote fairness and reward quality in education funding. We will rebase the current historical funding arrangements for the Multi-Professional Education and Training (MPET) budget introducing a tariff-based system where the funding follows the student or trainee.

**Training and career pathway for doctors**

1.18 Over the next three years, in close engagement with the Royal Colleges, the professional regulators, the wider medical profession, universities, commissioners and employers, we want to see the development of a reformed postgraduate training pathway for doctors. MEE will take forward the recommendations from the Tooke Inquiry report. The key elements of the training pathway include:

- development of a more reliable and valid selection method for recruitment to Foundation Programme training. MEE will also be asked to commission a formal evaluation of the two-year Foundation Programme.

- specialty training for doctors after completing their Foundation Programme, including training for general practice. At the end of this period, all doctors in training who have achieved the required curricular and assessment standards will be awarded a Completion of Training, which will allow the holder to apply for consultant posts or to become a general practitioner.

- development of plans to introduce modular credentialing for the medical workforce over the coming decade. This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience.

- making better use of the expertise of senior doctors by encouraging them to take on partner, leadership and educational roles as emphasised by the Tooke Report.

- a clear and integrated pathway through which junior doctors and dentists can combine research and education with a clinical career. This was the subject of the Walport report, whose recommendations have been implemented,

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1 Report of the Academic Careers Sub-Committee of Modernising Medical Careers and the UK Clinical Research Collaboration, March 2005, *Medically and dentally qualified staff: Recommendations for training the researchers and educators of the future.* A copy of the The Walport report can be located at www.ukcrc.org
including training schemes launched for the Academic Clinical Fellowship and Clinical Lectureship phase of the training pathway. The focus will be to continue building on the Walport report, so as to provide clear flexible training to encourage more doctors and dentists to pursue a career in clinical research.

**Conclusion**

1.19 The Next Stage Review sets ambitious visions in all 10 SHAs in England to drive up the quality and responsiveness of care to patients in all areas. Working with clinical leaders and maintaining their engagement will be key to delivering the Next Stage Review.

1.20 The challenging NSR agenda will demand efficient use of the resources made available to the NHS in what was a rigorous Comprehensive Spending Review (CSR). This means balancing the need to ensure sufficient funds for service change and reconfiguration where needed with pay awards that ensure we continue to attract, retain and motivate the right calibre of clinicians who will lead the quality improvements they have rightly demanded through the NSR process. This focus on recruitment, retention and morale of doctors and dentists is central to our evidence to DDRB this year.

1.21 Many of our doctors and dentists have benefitted from new contracts and recruitment, retention and morale remain good. We believe that a 2% pay uplift would be sufficient to maintain the recruitment, retention and motivation of NHS hospital doctors and dentists while ensuring the availability of funding needed for the continued service improvements outlined in the NSR.
CHAPTER 2: MEDICAL WORKFORCE PLANNING CONTEXT

Workforce numbers: headline figures

2.1 The NHS has seen unprecedented expansion in the medical and dental workforce since 1997. We now have more than 128,000 hospital and community health services (HCHS) doctors and GPs - over 38,000 more than in 1997 - as well as record levels of doctors in training in UK medical schools and in specialty training. Figure 2.1 below shows the growth in the medical workforce since 1997.

![Figure 2.1 Numbers of HCHS & Public Health Service Medical & Dental Staff: England at 30 September](image)

2.2 The latest annual census figures for England confirm that whilst there was a small fall in the overall workforce, medical numbers continued to grow during the year to 30 September 2007. In particular:

- the numbers of hospital, public health medicine and community health service medical and dental staff (excluding retainers) increased by 2,033 (headcount) or 1.6% and 1,783 (full time equivalents (FTE)) or 1.5%;
- consultant numbers increased by 880 (headcount) or 2.4% and 811 (FTE) or 2.6%;
- associate specialist numbers increased by 218 (headcount) or 7.7% and 156 (FTE) or 6.2%;
- staff grade numbers increased by 118 (headcount) or 2.0% and 113 (FTE) or 2.1%;
- numbers of doctors in training and equivalents have increased by 551 (headcount) or 1.1% and 629 (FTE) or 1.3%;
• GP numbers – excluding GP retainers and GP registrars – increased by 273 (headcount) or 0.8% and 5 (FTE) or less than 0.1%.
• GP registrars increased by 213 (headcount) or 9.4% and 219 (FTE) or 10.0%.

2.3 Figure 2.2 shows the composition of the HCHS medical workforce based on the latest census figures.

![Figure 2.2](image)

### Medical workforce planning context

2.4 The Department of Health has moved away from setting top-down workforce targets to a more devolved approach to workforce planning enabling greater sensitivity to local needs. The proposals set out in the Next Stage Review reinforce this approach. Oversight of workforce planning, including coordination and professional engagement, will be achieved through regional and national structures.

2.5 Currently the Modernising Medical Careers (England) Programme Board (PB) provides policy advice to Ministers on post-graduate medical education and training and oversees implementation. The work of the PB will continue alongside, from January 2009, Medical Education England (MEE), which was announced in *A High Quality Workforce*. MEE, in respect of medical workforce planning, will provide professional scrutiny of and advice on the education and training commissioning plans developed at SHA level. Additionally, MEE and local professional advisory bodies will be supported, in due course, by another new body, the Centre of Excellence, whose core purpose will be to support the operation of SHAs’ workforce planning, education and training systems.

2.6 In recent years, central coordination of medical training has been performed by the NHS Workforce Review Team and the Department of Health. This involves
taking a long-term planning approach that can be broadly summarised as follows:

- assess the long-term need for trained GPs and other specialty doctors;
- then assess the resulting need for doctors in specialty / GP training in the medium-term;
- then assess the resulting need for Foundation Programme doctors in the shorter-term;
- then assess the current need for medical school entrants.

2.7 Workforce planning for doctors spans many decades. It takes seven years to train a doctor to the point of specialty training and around seven more years (currently three years for GPs) to complete specialty training. Once a doctor is trained, they could have a subsequent career of about 30 years. Over such long periods, workforce planning is uncertain and must be interpreted carefully but forecast outcomes can identify risks which can then be mitigated.

**Expectations of future demand**

2.8 As part of the process described above, long-term demand assessments consider:

- population growth and demographic change;
- changes to morbidity;
- changing technology;
- rising public expectations;
- public health initiatives e.g. smokefree legislation and wider tobacco control;
- other specific policies e.g. NSR, the 18-week from referral to treatment target;
- addressing health inequalities;
- shifts between health care settings and changing ways of working.

2.9 The impact of these demands is difficult to predict entirely accurately, so demand scenarios are considered. For example, the increase in demand caused by population growth and demographic change alone suggests an increase in the required medical workforce of around 1% every year will be needed just to ‘stand still’ with potentially greater increases in the number of GPs due to their role in managing long-term conditions. Consideration of the other factors listed above suggest further increases in demand and, therefore, numbers.

**Determining future medical workforce supply**

2.10 To establish the impact of the long-term need for doctors on current training requirements, demand assessments are coupled with long-term supply assessments considering:

- trends in participation and part-time working;
- retirements;
- attrition;
• medical training structure;
• inflow / outflow of international medical graduates;
• regulation e.g. the European Working Time Directive;
• skill mix and new ways of working.

Implications for the numbers in the training pathway

2.11 Using this process has informed decisions on medical training numbers which are reaching the end of a planned expansion. Peak medical school output has been reached and this expansion is now feeding through subsequent training levels.

2.12 Figure 2.3 below summarises the medical training pathway and the full time equivalent numbers expected at each training stage when the medical training expansion is complete. The numbers are necessarily imprecise as they depend on future trends in factors such as participation and attrition. It should also be noted that there may be modifications of the training structure following the Next Stage Review and Tooke Inquiry into Modernising Medical Careers.

Figure 2.3 Current Medical Training Pathway and Estimated FTE Numbers at Each Stage After the Current Medical Training Expansion is Complete

Implications for the long-term demand and supply balance for trained doctors

2.13 The outcomes from the most recent medical workforce modelling can be summarised as follows:

- the balance of demand and supply for doctors as a whole suggests that the number of doctors coming through medical school and foundation programmes is at about the right level;
• in light of the increasing demand for primary and community care services, GP training needs to expand so that in future at least half of doctors going into specialty training will be training as GPs;
• there is also a risk of an oversupply of other trained specialists in the long-term, particularly in surgery, where training numbers are planned to reduce;
• the situation differs across specialties and locations. Investment in specialty training needs to be aligned with service demand. For example, the number of trained doctors in paediatrics and obstetrics & gynaecology may need to grow significantly, depending upon local service configurations.

2.14 These shifts in training investment reflect anticipated shifts in the delivery of care towards primary and community care settings. Local decisions about investment in training also need to consider the impact of developing new ways of working across settings to smooth out potential imbalances or using international recruitment to fill short-term gaps.

2.15 The Department of Health will continue to work with the NHS and the new workforce planning machinery outlined in the NSR to ensure that workforce risks are monitored and addressed. The Workforce Review Team’s ‘Assessment of Workforce Priorities for 2009’ provides a detailed assessment of individual specialties.

Current workforce pressure and the implications for the proposed pay award

2.16 The NHS Vacancy Survey, published by the NHS Information Centre, collects information on vacancies that have been open and actively recruited to for three months or more at the end of March each year. This gives a measure of the vacancies which employers are finding hard to fill rather than normal staff turnover. The 2008 survey shows that long-term vacancy rates continue to fall. The long-term vacancy rate for hospital doctors and dentists was down to 0.9% in 2008 compared with 1.1% in 2007. Long-term vacancy rates were lowest among GPs at an estimated 0.3%.

2.17 Statistical Table 6 shows the latest three-month vacancy rates for HCHS doctors (excluding doctors in training) by SHA area and specialty group. Table 7 summarises the available vacancy data by specialty over the period 2002 to 2008. The three-month vacancy rates for consultants range from 1.3% in North West and London SHAs to 0.3% in South West and South East Coast SHAs. The vacancy rates vary between specialties and, 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.

Conclusion

2.18 All the indications are that the measures put in train to increase supply of doctors have been highly successful. The supply side looks very buoyant in both the short and mid term. Chapter 9 looks at short run supply and demand over the last two years of the Spending Review (2009/10 and 2010/11).
CHAPTER 3: ENTRY TO TRAINING (UNDERGRADUATE)

3.1 There is evidence of good recruitment into medicine. Data on entry to medical and dental schools is at Statistical Tables 1-4. Medical school intake has increased by about 53% since 1997 and dental school intake by about 46% with no shortage of good applicants to fill the available places. 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 2007 entry, the average UCAS tariff points of accepted applicants to medicine and dentistry were 417 and 391 respectively, similar to 2006 with scores of 421 and 388.

3.2 Figure 3.1 shows the trend in numbers of UK applicants to medical schools and medical school places (accepted applicants) since 1994. In 2007, the ratio of applicants to accepted applicants has remained steady with an average of 2.3 applicants for every medical school place. In 2007, 56% of UK accepted applicants were female compared with 59% in 2006, 58% in 2005 and 60% in 2004.

Graduate starting salary comparisons with other professions

3.3 For medical graduates entering their first post, total pay remains very competitive, particularly once account is taken of the availability of posts. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in their ability to enter their chosen career. Indeed, in the 2008 recruitment round all graduates of UK medical schools were successful in securing a place on the Foundation Programme, with 92.4% obtaining a placement within their first choice Foundation School. The legal profession, with which medicine is often compared, attracted 26 applicants for each graduate vacancy.
3.4 A recent survey by the Association of Graduate Recruiters\(^1\) (AGR) reported that in 2008 the rate of increase in median starting salaries paid to graduates by AGR employers was 1.8% - the lowest annual increase since the survey began in 2000.

3.5 Doctors in their first post are employed under the New Deal contract which uses a pay banding system to reward doctors in training grades for the frequency and duration of their out-of-hours work. They receive banding supplements, paid in addition to basic salary, the bandings reflecting: whether the post is New Deal compliant; whether the doctor works up to 40, 48 or 56 hours per week; the type of working pattern; the intensity of work and whether the doctor receives appropriate rest; and the unsocial nature of the working arrangements. Most medical graduates entering their first post earn in excess of their basic salary.

3.6 Using the latest banding figures available from April 2008 and data taken from the AGR survey, Figure 3.2 shows a comparison between the pay of junior doctors in their first post and the pay of graduates entering other professions. The columns in red show the range of actual starting pay for first year Foundation (F1) trainees. The average F1 salary (£31,453) is shown in green. The chart also shows the percentage of F1 doctors on each of the main pay bands with 57% earning £32,793 or more. This continues to stand up well against the starting salaries of other professions including investment banking and legal work, where there were respectively 57 and 26 applications for each graduate vacancy.

![Comparison of Graduate Starting Pay (2008)](image)

3.7 Most medical graduates achieve full registration after one year. At this point their basic pay rises to £27,116. With banding supplements, the average salary for F2 (second year) trainees is £39,047 and for those on the first point of the

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\(^1\) Recruitment Survey 2008, Association of Graduate Recruiters
Specialty Registrar scale (third year trainees) the average salary is £43,464 (based on monitoring returns for April 2008).

Conclusion

3.8 Good quality candidates continue to be attracted to medicine as a career offering good pay and prospects for advancement. However, we should not remain complacent as the slight drop in applications per place could suggest that other professional career options are increasingly competitive. Potential candidates for a medical career will be looking for a good starting remuneration package, as good as or better than competing options. And in the current climate the relative security of the profession, for example against high comparators such as investment banking in Figure 3.2, is likely to increase the attractiveness of a career in medicine or dentistry. A 2% rise for 2009/10 should secure medicine’s place in the market.
CHAPTER 4: HOSPITAL DOCTORS AND DENTISTS IN TRAINING

Modernising Medical Careers

4.1 The postgraduate education and training of doctors is governed by the Modernising Medical Careers (MMC) reforms, beginning with the introduction of the Foundation Programme from August 2005 and new specialty training programmes in August 2007. This meant that:

- the Foundation House Officer (FHO) Year 1 replaced the old Pre-Registration House Officer (PRHO) grade;
- the FHO Year 2 replaced the first year of the Senior House Officer (SHO) grade; and
- a new Specialty Registrar (StR) grade was introduced to replace the training grades that followed on - ie remainder of SHO grade plus the Specialist Registrar (SpR) grades.

4.2 Implementation of MMC in 2007 led to several problems resulting in the ‘Douglas Review’, which remedied the immediate recruitment problems, the Tooke independent inquiry, which reported finally in early 2008 on MMC as a whole, and a Health Select Committee report, which was published in July 2008.

4.3 Since then, many of the issues reported by Tooke and the Health Select Committee have been taken into account in the Next Stage Review report ‘A High Quality Workforce’. The establishment of Medical Education England supported by the Centre of Excellence are expected to determine or influence the future shape of education and training as well as informing and scrutinising workforce planning.

Workforce numbers

4.4 Over the last ten years, the number of doctors in training and equivalents (which includes the registrar group, senior house officer, foundation year 2 and house officer & foundation programme year 1) has increased by 54% from 30,313 in 1997 to 46,783 in 2007. This was part of the first stage of the transformation journey, to increase capacity – the additional staff announced in the NHS Plan.

4.5 Although the number of training opportunities in England increased in 2007, the demand for posts at all levels of specialty training was extremely high particularly in popular specialties and popular locations. For example, in the most popular location – London, Kent, Surrey and Sussex – there were 4.2 applicants for every post. For the two most popular specialties – cardiothoracic surgery and trauma and orthopaedic surgery – there were 14.8 and 5.6 applicants to posts respectively across the UK.

4.6 Indicative statistics for the close of the national recruitment timetable for specialty training recruitment in 2008 suggest that competition was about the same as 2007. In 2007 there were around 28,000 applicants for roughly 15,600 training posts; a ratio of nearly 2:1. So far this year roughly 20,000 trainees have applied for just under 10,000 training posts; a slightly increased ratio
Following the choice of a locally-led recruitment process for 2008, one of the biggest changes for applicants has been that they can make as many applications as they like. However, this did not result in unmanageable increases in the number of applications received. In 2007, the ratio of applications to applicants was around 3.7:1. In 2008, this rose to 5.2:1.

Fill-rates (ie the proportion of training posts filled following recruitment) are comparable to 2007. At the close of Round One last year, the overall fill-rate for England was 85%. Deanery statistics for 29 May 2008 implied a fill-rate of around 84%. However, this almost certainly understates the position, as some of the Deanery data was incomplete.

The popularity of locations shifted significantly in 2008 compared to 2007 - almost certainly caused by applicants' use of competition ratio statistics, which were published for the first time in 2007 to support 2008 applicants. For example, in 2008, the ratio of applicants to posts in London fell significantly, while it rose in those Deaneries where competition in 2007 was comparatively less intense - such as East Midlands.

European Working Time Directive

The European Working Time Directive (EWTD) has applied to the majority of staff since 1998 but its implementation for junior doctors continues to be phased in over a number of years. The NHS is planning to fully implement the 48-hour week by August 2009.

Half of doctors in training already work 48 hours or fewer per week. (This figure is based on "New Deal" contract monitoring junior doctors working hours and a BMA survey also found that about half of doctors in training were working a 48-hour week.) A small number of Trusts including the Homerton, East Sussex and Wigan have implemented the 48-hour week across their hospitals and 95% of doctors in training in NHS North West were already compliant by August 2008.

Parts of the NHS have been supported with EWTD 2009 readiness with a large programme of pilots and supporting tools. Initiatives include extending the Hospital @ Night Programme and more systematic hand-over arrangements to the 24 hour x 7 day week to support the quality of patient care, medical training and the work/life balance of staff. However, some smaller specialties and isolated services do not lend themselves easily to such solutions and the DH continues to work with the medical profession to support the NHS in seeking out other options.

The University of Sheffield has completed its independent research project to assess the impact of changing working patterns and reduced working hours on medical training. The findings will be published on the healthcare workforce portal this Autumn that can be found on: www.healthcareworkforce.nhs.uk
4.14 The early phases of the research revealed that whilst EWTD had challenged the traditional apprenticeship model of training, it also provided opportunities to enhance medical training in a modern healthcare system. The report also identified that organisational culture was crucial to the effectiveness of clinical training. The research developed practical tools and questionnaires to support medical training, focusing on:

- organisational climate (work environment) to support both training transfer and 'on the job' training opportunities;
- empowering trainees to take greater control in maximising their use of 'on the job' training opportunities;
- the need for appropriate evaluation of emerging 'off the job' training methods, such as wet labs and e-learning.

4.15 The Council of European Employment Ministers agreed that changes are required to EWTD to address the SiMAP and Jaeger Judgments that ruled all time spent in a hospital counts as work and made compensatory rest breaks (for missed rest) inflexible. Any changes to the Directive will require the support of the European Parliament under the lengthy co-decision process and the EWTD will not be amended in time to affect planning for August 2009.

The New Deal Contract

4.16 The introduction of the New Deal contract for junior doctors in 2000 provided a mechanism for rewarding these doctors appropriately for the hours they work over and above their basic 40 hours per week, along with a financial incentive to NHS Trusts to reduce the working hours of junior doctors. As stated in paragraph 3.5 above, the contract uses a pay banding system to reward junior doctors for the frequency and duration of their out-of-hours work. The banding supplements are paid in addition to basic salary. 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%.

4.17 Compliance with the New Deal is monitored by NHS Employers. Since March 2005, at least 98% of doctors have been fully compliant with the New Deal (99% in April 2008) compared with 88% in March 2004 and 71% in March 2001. Most junior doctors, in all grades, earn in excess of basic salary through the banding multipliers. The average banding supplement in April 2008 for junior doctors in compliant posts is 48%. Figure 4.1 below shows the proportions of doctors in each pay band by grade as at April 2008. Once all junior doctor posts become compliant with the EWTD, they will attract a maximum supplement of 50% of basic salary.
4.18 We are pleased that the New Deal contract is working as intended and that doctors in the training grades are now seeing the benefits of reduced hours and a more family-friendly working environment. As we reported last year, we expected that as the disincentive to higher hours in the form of the high multipliers took effect, doctors’ earnings would fall.

4.19 The table below shows the movement of PRHO/F1 pay since the implementation of the new contract. Over that period, basic salaries have risen by 23.9% and typical overall pay by 14.3% against inflation of 20.6% (using HM Treasury GDP deflator figures).

**PRHO/F1 Pay – 2001 to 2008**

<table>
<thead>
<tr>
<th>Date</th>
<th>Basic salary</th>
<th>Average multiplier</th>
<th>Typical Pay</th>
<th>Increase on 2001 (basic pay)</th>
<th>Increase on 2001 (total pay)</th>
<th>Inflation (GDP deflator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2001</td>
<td>£17,260</td>
<td>1.56</td>
<td>£26,926</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>March 2002</td>
<td>£17,935</td>
<td>1.57</td>
<td>£28,158</td>
<td>3.9%</td>
<td>4.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>March 2003</td>
<td>£18,585</td>
<td>1.74</td>
<td>£32,338</td>
<td>7.7%</td>
<td>20.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>March 2004</td>
<td>£19,185</td>
<td>1.71</td>
<td>£32,806</td>
<td>11.2%</td>
<td>21.8%</td>
<td>8.7%</td>
</tr>
<tr>
<td>March 2005</td>
<td>£19,703</td>
<td>1.60</td>
<td>£31,525</td>
<td>14.2%</td>
<td>17.1%</td>
<td>11.7%</td>
</tr>
<tr>
<td>March 2006</td>
<td>£20,295</td>
<td>1.57</td>
<td>£31,863</td>
<td>17.6%</td>
<td>18.3%</td>
<td>14.1%</td>
</tr>
<tr>
<td>March 2007</td>
<td>£20,741</td>
<td>1.45*</td>
<td>£30,074*</td>
<td>20.2%</td>
<td>11.6%</td>
<td>17.2%</td>
</tr>
<tr>
<td>March 2008</td>
<td>£21,391</td>
<td>1.44</td>
<td>£30,803</td>
<td>23.9%</td>
<td>14.3%</td>
<td>20.6%</td>
</tr>
</tbody>
</table>

The multiplier is the average of that for all full-time first year trainees in post, except:

* The multiplier is based on an average of the position at September 2006 and October 2007.

4.20 Figure 4.2 below shows how the proportions of doctors in each pay band has changed since September 2006.
4.21 Although providing this necessary incentive, the contract is complex and places additional demands on employers in reviewing the banding of posts and dealing with appeals. As we said in our evidence last year, any changes to the contract need to take into account the direction of travel resulting from the Tooke Inquiry into Modernising Medical Careers and the Next Stage Review, ensuring that any new arrangements support education and service needs. As a first step, we are commissioning NHS Employers to conduct work to look at the effectiveness of the current arrangements. The Review Body has suggested that the balance of pay needs to shift away from banding multipliers towards base pay. It is important to note, however, that this would have superannuation consequences. For every £1 moved into base pay, there is a 14% cost to the employer and a 6% cost to the doctor with no material benefit to either patient care or the employee.

**Banding multipliers**

4.22 In its last report, the Review Body acknowledged that the current levels of the banding multipliers are those that were negotiated between the parties to fully recognise work intensity and out-of-hours.

4.23 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.

**Pay Progression**

4.24 The Review Body is reminded that, in addition to the headline pay uplift, the majority of doctors in the training grades will see their pay increase through progression up the pay scale or to the next grade. Average earnings increase from £31,453 at the start of Foundation Year 1 to £39,047 at the start of Foundation Year 2 and a minimum of £43,464 on commencing Specialty Registrar training. Two years after graduating, most doctors in training will have progressed to the Specialty Registrar scale – a 10-point pay scale.
Excluding the annual pay award, the pay of a specialty registrar who is not yet at the top of the scale increases by between 4.1% and 8.1% per annum (depending on the point they are on in the pay scale). The table at Annex B illustrates the combined effect of incremental rises and Review Body awards on individual doctors’ pay by taking some illustrative examples over a five-year period. For example, a specialist registrar who was on point 2 of the pay scale on 1 April 2003 and who progressed to point 7 by April 2008 has seen their basic salary increase by 42.3% over 5 years compared with the cumulative headline pay awards of 12.4%.

NHS Staff Survey

4.25 Results of the 2007 NHS Staff Survey reveal some positive progress in the attitudes of NHS staff. Over 240,000 staff were sent a survey and with close to 156,000 returns, the response rate was 54%, which is considered a good response, giving a representative view of all staff.

4.26 Job satisfaction is regarded as one of the key indicators of staff motivation and morale. The score is derived from seven questions from the NHS Staff Survey i.e. staff’s satisfaction with the following aspects of their job:

- recognition they get for good work;
- support they get from their immediate manager;
- support they get from colleagues;
- freedom they have to choose their own method of working;
- the amount of responsibility they are given;
- the opportunities they have to use their skills; and
- extent to which the trust values their work.

4.27 To recognise the importance placed on the satisfaction levels of staff, this key score has been included as one of the ‘vital signs’ measured in the 2008/09 NHS Operating Framework; trusts will be expected to improve this score over time (although there is not a target for survey scores, trusts are asked to forecast improvement over time). It has also been included this year as one of the key indicators in the Healthcare Commission’s Annual Health Check.

4.28 The score for job satisfaction in the 2007 NHS Staff Survey for all NHS staff has remained consistently strong and has improved slightly since 2006 from 3.43 to 3.44 (out of a range of 1-5). The job satisfaction score for doctors and dentists in training identifies them as one of the most satisfied staff groups. Their score is higher than average at 3.53, though slightly lower than the previous year. This score is also higher than the score for all doctor and dentist groups, which is 3.49.

4.29 Looking specifically at satisfaction levels related to their level of pay, doctors and dentists in training are significantly more satisfied with their level of pay than NHS staff as a whole. 42% of doctors and dentists in training said that they were either satisfied or very satisfied with their level of pay, compared to 30% of NHS staff as a whole. Doctor and dentist groups as a whole were one of the most satisfied occupational groups with a figure of 48%. The 2004
Workplace Employment Relations Study\(^1\) revealed that only 35% of UK employees were either satisfied or very satisfied with their pay.

4.30 There has been a reduction in the number of doctors and dentists in training working extra hours in the last year (from 80% to 78%), though this figure has remained higher than the NHS average (66%) and doctor and dentist groups as a whole (73%). Figures suggest however, that this has not had an adverse effect on this occupational group, as doctors and dentists in training have reported reduced levels of work pressure and cases of work related stress.

4.31 Cases of work related stress for doctors and dentists in training have fallen consistently over the last three years from 29% to 24%; the national average for all NHS staff stands at 33%. Work pressure felt by doctors and dentists in training has also fallen over the last three years from a score of 2.91 (out of a range of 1-5) to 2.89; the NHS average over the same period has risen from 3.09 to 3.17.

4.32 Over the last three years, all staff groups have reported significant improvements in the support they receive from immediate managers. For doctors and dentists in training this score is again higher than average for NHS staff, having improved from 3.64 (out of a range of 1-5) to 3.72 compared to the national average which saw an increase from 3.55 to 3.63 in the same period.

4.33 Figures for doctors and dentists in training show that the percentage receiving job-relevant training in the last 12 months is consistently high, having sat at 85% for the last two years compared with 78% in the last year for all NHS staff.

4.34 The percentage of trainee doctors and dentists receiving an appraisal (82%) also remains higher than average for NHS staff (62%). However, the lower scores from all staff groups for the quality of the structure of appraisals highlight this as an area for improvement.

Conclusion

4.35 There continues to be high demand for training posts. Doctors in training grades are seeing the benefits of reduced hours and an improved work/life balance with half now working 48 hours or fewer per week. This is one of the most satisfied NHS staff groups, particularly with respect to pay levels. In the circumstances, we ask the Review Body to recommend an award of 2% for this group.

\(^1\) http://www.berr.gov.uk/whatwedo/employment/research-evaluation/wers-2004/index.html
CHAPTER 5: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

5.1 There continues to be evidence of healthy recruitment and retention in these grades with further increases in the numbers of associate specialists and staff grades in the year to September 2007. As Statistical Table 7 illustrates, the three-month vacancy rates for these grades was 1% in 2008, slightly higher than 0.7% in 2007, but very favourable when compared with more than 4% in 2002 to 2004. Between 2006 and 2007 associate specialist numbers employed by the NHS increased by 218 (headcount) or 7.7% and 156 (FTE) or 6.2%. Over the same period, staff grade numbers employed by the NHS increased by 118 (headcount) or 1.9% and 113 (FTE) or 2.1%.

5.2 The introduction of MMC now offers these doctors more opportunities to undertake further training and progress their careers.

5.3 In December 2007, we wrote to the Review Body regarding the new contractual arrangements for these doctors. The Government had given careful consideration to the proposals submitted by the BMA and NHS Employers, bearing in mind the need for pay modernisation for this group of doctors, lessons from previous pay reforms and the need to conform to wider public sector pay policy.

5.4 In England, the Department of Health agreed to release the proposed contracts (for associate specialists and for the new specialty doctor grade) for ballot, subject to a transitional implementation which would give both groups of doctors half their expected pay increase on the introduction of the contract and the other half one year later. The BMA balloted its members on the proposed arrangements, and the contracts were accepted.

5.5 We believe that these transitional arrangements provide a more equitable phasing of the pay benefits of the new contract and are more consistent with current public sector pay restraint. It should be noted that the transitional arrangements relate only to the pay increase of one extra increment that the contracts will award to doctors, and do not apply to other elements of the proposals. For example, where associate specialists increase their 38.5 hours per week to 40, they will receive the associated pay increase in full on signing up to the new contract and completing a prospective job plan (in line with the proposed terms and conditions).

5.6 The new contracts offer staff grade doctors (now specialty doctors) and associate specialists substantial pay increases in return for reform. The new contract offers the opportunity to strengthen job planning, improve incentives for working evenings and weekends, and provide the opportunity for doctors to enhance earnings through additional reward for flexible service delivery.

5.7 The average pay increases for staff grades will be 5.2% from 1 April 2008 and 5% on 1 April 2009; for associate specialists these will be 1.8% on each of these two dates. The transitional pay scales were included in the documentation that NHS Employers submitted to the Review Body on 18 December 2007.
5.8 The terms and conditions for the proposed contract provide for these increases to be payable from 1 April 2008, contingent on doctors expressing an interest and signing job plans within specified periods. Sufficient additional funding was included in 2008/09 to support transitional implementation from April 2008.

5.9 We made no provision for back payment to a date prior to introduction of the contract. As with other pay reforms, this offer is a “something for something deal”. Investment in return for reform means that reward must be linked to the delivery of benefits. This point was reinforced in the findings of the Public Accounts Committee on the implementation of the consultant contract, which noted that backdating is not a justifiable use of public money when it is in respect of a period prior to the introduction of new working arrangements and delivery of benefits.

5.10 Informed by the Public Accounts Committee’s report on the consultant contract, the Department’s offer of the new SAS contracts (in England) was conditional on a joint agreement - between the Department, the BMA’s Staff and Associate Specialists Committee (SASC) (UK) and NHS Employers - that the costs of implementing the new arrangements be reported to the Pay Review Body annually to be taken into account when setting future pay awards. All parties agreed to this condition.

5.11 The intention is to monitor the actual costs against the projected costs in the proposals submitted by the BMA and NHS Employers (taking account of the transitioned implementation of those costs). We propose to monitor this using the Electronic Staff Record (ESR) system. Monitoring will look only at those cost elements associated with the new arrangements that arise directly as a result of the implementation. It will not include costs that are not a direct result of implementing the new contracts – so it will exclude, for example, costs associated with workforce growth and future pay awards.

5.12 NHS Employers have been undertaking some detailed work with the ESR Team to devise a methodology for identifying and monitoring the costs of the new arrangements. The earliest we can expect any information is early 2009. This is because of the time needed for: employers to offer the new contract to eligible doctors (who have 12 weeks to express an interest); doctors and employers to then agree job plans; and information to be entered onto and available from ESR.

5.13 Full documentation on the new arrangements was available on NHS Employers’ website prior to the ballot, together with guidance for employers (listed at Annex C) and frequently asked questions. Following the ballot, NHS Employers ran a series of events for employers.

Enhancing opportunities for SAS doctors

5.14 There are recommendations in the document *Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors* that have been Government policy since 2004. These are designed to enhance the opportunities for SAS doctors. Many of these were taken forward as part of the
successful SAS doctor contract negotiations, with the others being taken forward as set out below.

**Funding for SAS doctors’ Continuing Professional Development (CPD)**

5.15 Recurrent funding of £12 million is being provided for SAS doctor career support, training and CPD. The BMA SASC welcomed this announcement - although they argued it should be ring-fenced and monitored to ensure it is used specifically for this purpose. However, we believe that ring-fencing of the Multi Professional Education and Training (MPET) budget or particular aspects of it is not an effective or efficient way of ensuring that a properly trained workforce with the right skills and competences is available to deliver services to patients. The role of the Department of Health should be to focus on outputs and accountability rather than on ensuring a fixed amount of money is spent for a particular purpose regardless of local priorities.

5.16 Furthermore, the MPET budget service level agreement (SLA) and accountability framework has been issued to ensure that SHAs are held to account for the training they support. The SLA also sets out that there should be a Learning and Development Agreement in place with NHS service providers to underpin the education and training funds passed to NHS trusts. These specify in some detail the outputs that should be delivered for the MPET investment being passed to them. One of the key performance indicators included in the SLA is that "Funding for NCCG (non-consultant career grade) Career Support, and Training and CPD for SAS Grades funding should be used to support SAS doctors wishing to progress their careers".

**Top-up training**

5.17 BMA SASC has also argued that funding should be committed to “top-up” training for SAS doctors. This refers to the training required for well qualified SAS doctors to reach the level at which they can apply for a Certificate of Eligibility for Specialist Recognition (CESR), successful acquisition of which would then provide eligibility to apply for consultant posts.

5.18 Funding can be used for this purpose but, as above, such decisions are for local determination. There also needs to be recognition that such opportunities might be available but should be based on local workforce need - ie:

- if there was a shortage of consultants in a specialty, it would make sense for the SHA to provide the, say, one year of top-up training required by a doctor to help meet this need;

- if there was already an over-supply of doctors in a specialty there can be little justification for using scarce SHA resources on providing top-up training in that specialty.

**Guidance on supporting SAS doctors**

5.19 The Department of Health and NHS Employers jointly published *Employing and supporting specialty doctors: A guide to good practice* in April 2008. BMA
SASC have welcomed this document and also submitted comments and suggestions for its further development.

5.20 This best practice guide for employers of specialty doctors was written to steer employers to get the most out of their specialty doctor workforce through a more structured approach to their employment and professional development. It highlights best practice for employers of specialty doctors so that the valuable contribution to patient care made by them is both maximised and recognised, resulting in the full development of this workforce. Consequently, it makes recommendations for the development of systems that support professional development and highlight the benefits for employers. Where possible, references have been provided to key resources that can support the implementation of these practices.

5.21 We have agreed to a meeting to discuss BMA SASC suggestions for the document along with NHS Employers as co-owners of the document, plus representatives of the SHAs and/or deaneries given their key role in the development of SAS grade doctors.

Credentialing

5.22 Recommendation 3 of *Choice and Opportunity* states:

“A system of limited accreditation of competences is required through which NCCGs with formally recognised skills can work independently at the appropriate level.”

5.23 The *Next Stage Review* included a commitment to develop the concept of modular credentialing that will help take this forward:

“In partnership with the medical profession, in particular the Royal Colleges and the professional regulators, we will develop plans to introduce modular credentialing for the medical workforce over the coming decade”.

5.24 We will, of course, engage with the BMA in the development of these plans.

Conclusion

5.25 There is evidence of healthy recruitment and retention in these grades and the new contracts offer this group of doctors substantial pay increases. We believe a pay award of 2% for this group would be appropriate.
CHAPTER 6: CONSULTANTS

6.1 Since 1997 the number of consultants (including directors of public health) working in the NHS in England has increased by 12,200 (56.8%) to 33,674 (31,430 FTE) in 2007. Forecasts show increasing demand for consultants, with around 2,000 more consultants employed by 2010/11. This reaffirms the Government’s commitment to having more specialist doctors overall.

6.2 The March 2008 three-month vacancy rate for medical and dental consultants was 0.9%. The three-month vacancy rates for consultants since 2002 are shown below indicating there are no issues in recruiting.

<table>
<thead>
<tr>
<th>Year</th>
<th>Three-month vacancy rate for HCHS consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>3.8%</td>
</tr>
<tr>
<td>2003</td>
<td>4.7%</td>
</tr>
<tr>
<td>2004</td>
<td>4.4%</td>
</tr>
<tr>
<td>2005</td>
<td>3.3%</td>
</tr>
<tr>
<td>2006</td>
<td>1.9%</td>
</tr>
<tr>
<td>2007</td>
<td>1.2%</td>
</tr>
<tr>
<td>2008</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

6.3 Of the 33,674 consultants (including directors of public health) working in the NHS in England, 12,641 (or 37.5%) are aged 50 or over, of which, 2,581 are aged 60 or over. An analysis of the latest information on retention and retirements is at Annex D.

6.4 Fewer than 10% of consultants remain on the old pre-reform contract (a five point incremental scale rising to £79,001). The 2003 consultant contract, which applies to all new consultants, has eight pay thresholds ranging from £73,403 to £98,962.

6.5 The 2003 contract was designed to provide, over time, a 15% increase in career earnings and a 24% increase in the maximum basic salary, and was accompanied by a three-year pay deal of 10% (2003/4 to 2005/06). Average earnings per head for consultants have increased significantly since the introduction of the new contract. As can be seen from the pay metrics at Annex A, in the first four years of the contract, consultants average earnings increased by 30% and we estimate that in the first six years (to 2008/09) the increase was 38%. We would expect to see continued growth in average earnings per head, at a rate of about 1% above the headline pay settlement, as consultants progress through their thresholds towards the new maximum.

6.6 An analysis of the percentiles of annual earnings for full-time employees in the UK over the period 2002/03 to 2006/07 suggests that the average earnings of consultants in England over the same period were in the 99th percentile of earnings for all employees, ie that only 1 to 2% of full-time employees in the UK earn as much as, or more than, the average consultant. (The percentiles for full-time employees in the UK were provided on request by ONS, from a breakdown of Table 1.7 of the Annual Survey of Hours and Earnings (ASHE)
2003 to 2007. The quality of this data is considered to be less reliable at the 98th and 99th percentile, due to the small number of employees earning at this level in the survey.) The average earnings of consultants in England are taken from DH estimates of historic earnings, as set out in the pay metrics in Annex A.

6.7 The job planning process is key to the new contract. It provides a stronger, unambiguous framework of contractual obligations. There is a more transparent framework for ensuring that consultants have the facilities and other support needed to carry out their responsibilities and duties and meet agreed objectives. The contract also makes clear the link between job planning and appraisal to reflect the need for consultants to maintain, through continuing professional development, the skills and knowledge needed for their work.

6.8 The Public Accounts Committee’s Report on the consultant contract, and the Government’s response were published in 2007. The Government response to the Committee’s recommendations is at Annex E. A key recommendation was that the contract has the capacity to provide further benefits through effective, prospective job planning linked to service and patient needs, but has yet to be fully used to achieve these. The Department has commissioned NHS Employers to deliver a Large Scale Workforce Change Programme over ten months from October 2007. This is a fast-paced programme based around the consultant contract, and focused on sharing good practice to deliver benefits to patients, staff and employers. The specific overall aim is to help trusts and consultants to identify, articulate and share benefits and learning that have been secured through effective implementation of the contract. This includes consideration of how the NHS is using IT applications to manage and update consultant job plans. The programme is running at full capacity, with 46 trusts participating. NHS Employers will communicate the learning to the wider NHS in autumn 2008.

6.9 We, NHS Employers and the BMA are keen to use the learning from NHS organisations to ensure that the contract is used to best effect to maximise benefits to patients, the profession and the service.

Clinical Excellence Awards

6.10 The Clinical Excellence Award (CEA) scheme, introduced in 2003, replaced the previous consultant reward schemes – discretionary points (DPs) and distinction awards (DAs). Consultants on either contract with at least one-year’s service are eligible to apply for CEAs which can increase their basic salary by between £2,913 (CEA level 1) and £74,676 (CEA level 12). All levels of CEA, DA and DP are pensionable. The Advisory Committee on Clinical Excellence Awards (ACCEA) have reported¹ that 68% of eligible consultants held an award (CEA, DP or DA) and 13% of consultants held a CEA at or above level 9 or a distinction award (representing between £34,956 and £74,676 each).

6.11 The NHS Next Stage Review Final Report “High Quality Care for All” stated that the current CEA scheme will be strengthened, to reinforce quality improvement. In Chapter 5 – Freedom to focus on quality: putting frontline staff in control – it stated:

¹ Advisory Committee on Clinical Excellence Awards Annual Report, January 2008
“The NHS Medical Director and National Clinical Directors will also work with senior clinicians to ensure that clinical leadership becomes a stronger force within the NHS. Compared to healthcare organisations in the US, such as Kaiser Permanente, the NHS has very few clinicians in formal leadership roles.

For senior doctors, the operation of the current Clinical Excellence Awards Scheme will be strengthened – to reinforce proposals in this chapter to drive quality improvement.

New awards, and the renewal of existing awards, will become more conditional on clinical activity and quality indicators; and the Scheme will encourage and support clinical leadership.

The scheme will also become more transparent, with applications being publicly available.

The profession will be involved in developing and introducing these amendments.

In making national awards, the independent Advisory Committee on Clinical Excellence Awards (ACCEA) will have regard to advice from the National Quality Board and the NHS Leadership Council.”

6.12 We will keep the Review Body informed as the detail is developed with the profession and the service.

6.13 For 2009/10, we believe that the numbers of new bronze, silver, gold and platinum awards should again be determined by the ACCEA having regard to the available funding and the number of awards released at each level through retirements, resignations, withdrawals and progression through the scheme. We propose that the value of clinical excellence awards, distinction awards and discretionary points should be increased in line with the award we propose for all salaried medical grades.

Conclusion

6.14 Consultants have seen their earnings increase significantly since the introduction of the new contract. We now have record numbers of consultants and vacancies are at an all–time low. We believe that an award of 2% would be appropriate for this group.
CHAPTER 7: DENTISTS

Introduction:

7.1 The new arrangements for commissioning primary dental services in the NHS have now been in place for two-and-a-half years. The transition to a system of locally commissioned services has been completed. We are now focussing on ensuring that the NHS is using the opportunities of local commissioning to their full advantage to meet local needs and to reflect the wider objectives for primary and community care identified as part of the NHS Next Stage Review. This includes ensuring that services are not just easily accessible but are much more responsive to individual patient needs; putting a stronger emphasis on promoting health at a practice based level, for instance by ensuring the use of the evidence-based guidance contained in Delivering Better Oral Health – the preventive toolkit; and promoting continuous improvements in quality working with the profession, patient groups and clinical advisors.

7.2 This approach needs to be underpinned by more effective PCT commissioning and clinical engagement, areas where there is room for improvement. We need to ensure that the NHS is using the opportunities of local commissioning to their full advantage to meet local needs. Nonetheless, we have already seen:
• new dental services commissioned with a local focus on the needs of patients;
• better working arrangements for dentists;
• the NHS beginning to build on the secure funding now in place to improve patient access, and undertaking procurement exercises across the country to further expand dental provision;
• excellent examples of PCTs using the new commissioning arrangements to improve patient access through local dental help lines and improved access to out of hours and emergency services.

7.3 It is notable that, in 2007/08:
• units of dental activity (UDA) increased by 4.5% to a level higher than was delivered in the last year of the old system. Courses of treatment increased by 2.7%. However these increases are not yet reflected in the dental access indicator recording patients seen in the preceding 24 months, which has fallen by 1.1 million since March 2006. This statistic still reflects the temporary loss of some services in the immediate wake of the April 2006 changeover.
• PCTs continue to commission new services to improve patient access with no significant reported shortage of dentists offering to expand their services or establish new practices in tendering exercises for new services.
• the number of dentists providing NHS services increased by 655 or 3.2%.
• the Government’s investment in expansion of undergraduate dental education will help to sustain this more healthy workforce position.
• there were more Vocational Trainee (VT) places for dentists wishing to enter general practice and an increase in dentists wishing to participate in the scheme as trainers.
7.4 We believe that the award for dentists in 2009/10 should reflect the notable increase in net earnings for all groups of dentists – at least 10% for those holding contracts. It is possible to make the case from these earnings data that there should be no increase in gross contract values this year. However, we recognise the need to consider implications for motivation and morale, and we therefore recommend that there should instead be a simple increase in gross contract values for 2009/10 of 1.0%. This would start to take account of the effects of the large reduction in expenses caused by the move towards more preventative and simpler courses of treatment with a lower expenses element.

7.5 An award of around this level would also allow a greater proportion of growth funding to be used to improve access for patients. The large national increase in the dental budget was designed to provide additional access for patients and to improve services, not simply to increase the net incomes of dental providers. The new funding presents significant opportunities for contractors to bid for new work and increase their income through providing additional services.

7.6 Many PCTs are making good progress through strong commissioning plans, improved partnership with local dentists, good use of data, competitive procurements and a new focus on patient needs. Some recent examples can be found at Annex F, varying from major procurement exercises to expanding existing practices. Our challenge is to spread this good commissioning practice but this depends on having the resources to spend on new services, which has been reduced by high automatic increases in contract values through the pay awards. We should now be working to increase incentives for dental providers to work with PCTs to increase patient access not reducing flexibility through high “automatic” awards.

Significant Issues

7.7 There are two main issues for this year’s Review:

- the current balance between net income and expenses, the effect on dentists’ net remuneration and the implications for the Review Body’s dental formula – which in our view needs to take specific account of the evidence on movements in dental expenses;

- the trade-off between increasing dentists’ income and improving access for patients.

7.8 The evidence submitted by the NHS Information Centre (IC) (as agreed by both the Department of Health and the BDA) shows that net dental income continues to rise at a rate well above the recommendations of the Review Body. Although this year’s data is clouded by the effects of changes in the contractual system and the population of dentists surveyed, it still gives a clear picture of increased net earnings and reduced expenses. We calculate that total income for all dentists has increased from about £80,000 in 2004/05 to around £96,000 in 2006/07. Figures for all NHS dentists derived from the IC figures are shown in table 7.1.
Table 7.1

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Average Gross Income</th>
<th>Expenses</th>
<th>Net Profit</th>
<th>Expenses/Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05 GDS Only</td>
<td>13,309</td>
<td>£193,215</td>
<td>£113,187</td>
<td>£80,032</td>
<td>58.6</td>
</tr>
<tr>
<td>2005/06</td>
<td>18,796</td>
<td>£205,368</td>
<td>£89,919</td>
<td>£89,919</td>
<td>56.2</td>
</tr>
<tr>
<td>2006/07</td>
<td>19,547</td>
<td>£206,255</td>
<td>£96,135</td>
<td>£96,135</td>
<td>53.4</td>
</tr>
</tbody>
</table>

7.9 The main reasons for the changes appear to be an overestimation of the increase in practice expenses in the past (fuelled by the use of RPI as an indicator rather than GDP as is used, for example, in the pharmacists’ expense formula), the lack of an efficiency requirement in the uplift, and the recent reduction in expenses resulting from changes in treatment patterns (as demonstrated in this year’s NHS IC evidence on treatment complexity and, we understand, information from the Dental Laboratories Association).

7.10 This has a direct effect on PCTs’ ability to improve patient access to NHS dentistry: each 1% increase in gross contract values represents about £27.5 million of resources that could otherwise commission services for an additional 400,000 NHS patients.

Overall context: progress through reform

7.11 The Department launched reforms to NHS dental services in April 2006 against a background of widespread discontent with the previous arrangements. There had previously been no fundamental change to the system originally set up in 1948 and no significant change to the contractual arrangements established in 1990. Dentistry had fallen significantly out of step with the mainstream NHS. The key problems included:

- **access to services**: the location and volume of services were previously decided by dentists, not by the NHS. When some dentists began to drift away from the NHS in the 1990s, significant access problems emerged in some areas.

- **remuneration system**: dentists were paid on a fee-per-item system which created incentives for more invasive and complex treatment and increased costs – this was not consistent with reducing disease incidence, or with a population with an increasing number of citizens with good oral health.

- **patient charges**: there were over 400 patient charges for different treatments, which caused confusion for patients and made it hard to distinguish between NHS and private treatment.

7.12 The new system was designed to:

- support access improvements by putting the local NHS in charge of commissioning local services and deciding where to locate new services;
• provide dentists with the stability of an agreed annual income in return for an agreed level of patient care, measured through overall courses of treatment (rather than individual items); and

• simplify the charging system by introducing just three charges, linked to overall courses of treatment (rather than individual items).

Table 7.2: Old and new dental contracts

<table>
<thead>
<tr>
<th>Old national contract</th>
<th>New local contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate fees for each individual item of treatment (fee-per-item) created a ‘treadmill’ effect.</td>
<td>Provide security and predictability of agreed annual NHS income, in return for carrying out an agreed number of courses of treatment each year (with a simple weighting to reflect relative complexity).</td>
</tr>
<tr>
<td>Dentists wishing to provide simpler courses of treatment, e.g. with greater emphasis on prevention, were financially penalised.</td>
<td>Dentists can carry out less complex and invasive courses of treatment without financial penalty. This allows dentists to spend more time on prevention and is likely to reduce average workload and expenses.</td>
</tr>
</tbody>
</table>

7.13 Despite the predictions of the British Dental Association (BDA) of a mass exodus of dentists, the vast majority of practices signed up to the new system and PCTs have commissioned new services to replace those lost, though some did so more quickly than others. The time-lags involved in commissioning new services and having these services build up to full capacity is reflected in comparative activity figures for the first two years of the new arrangements. Overall activity reduced by about 4% in 2006/07 but was reversed in 2007/08 by a rise of 4.5% and further increases are expected this year.

7.14 There were also initial concerns, repeatedly emphasised by the BDA, that a high proportion of those contracts which were initially signed “in dispute” between the dental provider and the PCT would result in further dentists leaving the NHS. In fact, in over 99 per cent of cases, the disputes process has ended with dentists deciding to stay with the NHS. By the end of 2007/08, in only 14 cases had dentists given up their NHS contracts after these disputes.

7.15 Following this transitional period, the Department is now supporting PCTs to focus on using commissioning to drive up access, support and improve quality, and enhance oral health. Overall, two and a half years into the new system, we now have a secure basis for developing dental services over the coming years. The local NHS now has a statutory duty to provide dental services and the flexibilities needed to develop services to reflect local needs. In many areas, patients are already experiencing the positive results of this in terms of new or developed services, as illustrated by the examples at Annex F.

7.16 This is supported by the inclusion of NHS dentistry in the NHS Operating Framework which requires PCTs to develop commissioning plans that will deliver year-on-year increases in dental access.
Factors in the Review Body’s Remit

7.17 The remit for the Review Body has remained constant for a number of years, and our comments on specific aspects of this are set out below. It may also, however, be timely to consider if there are aspects of the new contractual arrangements that require recommendations outside the traditional remit. In particular, the uplift recommended by the DDRB now only directly affects the income of those dentists who hold provider contracts, and increasingly limited companies rather than individual dentists hold these contracts: the pay and conditions of individual dentist performers are now entirely set by the local dental market. There is considerable anecdotal evidence, backed by PCT intelligence, that many practice owners did not pass on last year’s 3.4% award to their performers, increasing their own profit margins instead. NASDA, the association of dentists’ accountants, reports that gross payments to performers fell from £84,308 in 2005/06 to £82,864 in 2006/07 and although their costs fell, their average net profit reduced from £70,695 to £70,306.

Recruitment and retention

7.18 The most important aspect of the pay review system is to ensure that there is a sufficient incentive for dentists to provide NHS services for a reasonable, but not excessive reward. The numbers of dentists providing NHS services continues to increase.

Table 7.3

<table>
<thead>
<tr>
<th>Dentists on PCT lists and their assistants</th>
<th>Dentists</th>
<th>Increase since 2002/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2004</td>
<td>19,026</td>
<td>1%</td>
</tr>
<tr>
<td>March 2005</td>
<td>19,797</td>
<td>5%</td>
</tr>
<tr>
<td>March 2006</td>
<td>21,111</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dentists doing NHS work in the year</th>
<th>Dentists</th>
<th>Increase since 2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>20,160</td>
<td>n/a</td>
</tr>
<tr>
<td>2007/08</td>
<td>20,815</td>
<td>3.2% on 2006/07</td>
</tr>
</tbody>
</table>

7.19 The best indicator of dentists’ willingness to provide NHS services under the new contracts is the continued success of the tendering exercises undertaken by PCTs. PCTs who have put services out to tender have reported no shortage of potential applicants. The commissioning requests from PCTs have brought a response from a variety of providers including corporate bodies, partnerships and existing practices seeking to expand. For example, Devon PCT recently received 28 expressions of interest in response to an invitation to establish a large general dental practice, and the PCT was able to select a contractor after interviewing a final shortlist of 6 tenderers. This suggests that NHS dentistry is now seen as a valuable commodity and, to dentists, is no longer seen as poorly remunerated when compared with private work. The NHS Information Centre statistics for dentists who hold contracts and also perform NHS
dentistry shows that highly committed NHS dentists had the highest net profit in 2006/07 – an average of £146,600 compared to an average of £122,000 for dentists with NHS commitment below 75%. Some of the difference is due to additional payments in 2006/07 from the ending of the old arrangements.

Table 7.4: 2006/07 Average earnings and expenses by NHS commitment for providing-performer dentists, England and Wales

<table>
<thead>
<tr>
<th>NHS commitment</th>
<th>Population</th>
<th>Average (£)</th>
<th>EER (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Gross earnings</td>
<td>Expenses</td>
</tr>
<tr>
<td>&lt;=25% (mainly private)</td>
<td>1,160</td>
<td>£331,902</td>
<td>£214,296</td>
</tr>
<tr>
<td>&gt;25 &lt;75% (mixed)</td>
<td>834</td>
<td>£357,080</td>
<td>£228,832</td>
</tr>
<tr>
<td>75%+ (mainly NHS)</td>
<td>2,614</td>
<td>£353,631</td>
<td>£207,033</td>
</tr>
<tr>
<td>All responders</td>
<td>4,607</td>
<td>£348,784</td>
<td>£212,806</td>
</tr>
<tr>
<td>No survey</td>
<td>3,373</td>
<td>£360,816</td>
<td>£227,561</td>
</tr>
<tr>
<td>All Dentists</td>
<td>7,980</td>
<td>£353,869</td>
<td>£219,042</td>
</tr>
</tbody>
</table>

7.20 As Table 7.5 shows, this assessment is backed up by NASDA figures.

Table 7.5

<table>
<thead>
<tr>
<th>Year</th>
<th>2001/02</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS net profit for the practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS</td>
<td>£86,500</td>
<td>£90,400</td>
<td>£104,000</td>
<td>£118,000</td>
<td>£142,400</td>
<td>£149,500</td>
</tr>
<tr>
<td>Mixed</td>
<td>£79,800</td>
<td>£87,200</td>
<td>£98,800</td>
<td>£100,400</td>
<td>£129,600</td>
<td>£147,100</td>
</tr>
<tr>
<td>Private</td>
<td>£94,300</td>
<td>£100,100</td>
<td>£113,000</td>
<td>£124,700</td>
<td>£131,400</td>
<td>£130,900</td>
</tr>
</tbody>
</table>

NHS practices are those where NHS earnings are 80% or more. Private practices are those where private earnings are 80% or more.

7.21 Practice profits for practices with high NHS commitment have been rising strongly and now exceed the profits in mainly private practices; the IC statistics show NHS practices 20% higher with some temporary effect from the ending of the old pay arrangements, whilst NASDA report NHS practices 14% higher.

7.22 The willingness of dentists to bid for and undertake NHS contracts, including in areas where dentists had previously chosen not to set up or provide NHS services, clearly demonstrates that recruitment and retention issues are not acting as a bar to improving access. The rate-limiting factor in the first two years of the new contract was the strategic capacity and capability of PCTs to commission services at a rate to reflect levels of local need, not the availability of dentists to provide services. That is why we have used the Operating Framework to ensure that PCTs rapidly enhance their commissioning capacity and why we have increased dental budgets to support increased levels of commissioning.

Recruitment: The future workforce supply

7.23 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.
following the 2003 workforce review. It is clear that there are more dental vocational trainees (DVTs) and an increase in interest by dentists to provide the training (976 applications from prospective VT trainers for 834 posts).

7.24 It is difficult at this stage to update the conclusions of the 2003 workforce review to assess the optimum level of future workforce supply. 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 long term workforce strategy. 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. It is still too early to assess these factors, but the reduction in the complexity of treatment and gradual implementation of National Institute for Clinical Excellence (NICE) guidelines for longer recall intervals should mean that more patients can be seen by the current dental workforce.

Motivation

7.25 The motivation of NHS dentists and the quality of their working lives was another critical factor in the introduction of the new contracts. The new arrangements have led to a reduction in elements which might have caused stress and have reduced the workload required of dentists. In particular:

- the implementation of 5% fewer courses of treatment for the same contract value on transfer to the new contracts (for GDS dentists) gave them more time to spend with patients for the same levels of remuneration. This also gives dentists more time to spend on essential professional issues such as clinical governance and training.

- the regular payments made to providers under the contracts gives a guaranteed monthly income for pre-agreed levels of work across the whole year.

- dentists are working shorter hours and have more holiday. Working hours have fallen since 2000 from an average of 39.4 hours to 37.0 hours a week in 2007/08. Holidays have increased from 4.4 weeks to 4.9 weeks – excluding Bank Holidays.

- the proportion of dentists’ time spent on administration work has remained at 15% since the year 2000.

7.26 We recognise that any transitional period creates stress and challenges but believe that this has now passed as the system has bedded down. We also acknowledge that some dentists criticise the three-banded system for weighted courses of treatment because it does not recognise variations in the levels of work done within each course of treatment. PCTs have also asked for a better indicator of clinical workload. We have taken account of these issues and have enhanced the data on courses of treatment provided by dentists to give a better indication of the clinical workload: although it remains a simple system
to use and administer. This enhanced data return was launched in April 2008 and should provide the data to allow for fair comparisons between practice workloads, thus addressing a major concern of the profession’s representatives.

**Regional/local variations and their effects on the recruitment and retention**

7.27 As noted above, all English health regions are now able to recruit and retain dentists: this is a major improvement over the previous system. It is important to remember that, under the new contracts, PCTs can also vary contract values according to local costs, demand etc. This includes making allowances for any particular local expenses or workforce issues or areas of high patient needs. At PCT level, this action can include:

- taking account of dentists who specialise in difficult patients or complex procedures;
- assisting practices with decontamination issues;
- helping practices improve their buildings: such as disabled assess and better patient facilities;
- taking account of regional differences in staff costs;
- measures attracting dentists to tender for, or provide services in, areas that have previously struggled to attract the workforce;
- designing variations to the contract to allow for high patient needs.

7.28 This allows PCTs to take full account of local expense and workforce issues (for example high rents or shortages of dental nurses) when setting contract values. Contract remuneration (which is based on Pay Review Body recommendations) covers both the expenses involved in running a practice (including premises and equipment) and net income for the dentists who provide services. The new system also gives more explicit powers to PCTs to give additional targeted support to practices where appropriate. To support this, the Department made available £100 million capital funding in 2006/07 and 2007/08 to help improve the quality of premises and equipment and support the costs involved in opening new practices. Continued support is available through normal NHS capital allocations.

7.29 The new and increasingly mature relationship between PCTs and their local practices should also help allay some of the concerns currently expressed about ‘goodwill’ value. When a dental practice is sold, the practice owner may derive goodwill value from the sale if patients are likely to go on receiving services from the new practice. Under the new arrangements, a practice has to have a contract with the local PCT to provide services, and NHS contracts cannot be legally assigned to a second party. The PCT is therefore responsible for deciding whether, and on what terms, to offer a contract to a new practice owner. However, this does not prevent practices
having a goodwill value, so long as the practice is providing services that are valued by the PCT and local patients and so long as the practice discusses any proposed sale or transfer with the PCT early in the process. This enables the PCT to consider whether there are any changes it would like to see in the services being provided. These arrangements are likely to support and even increase the goodwill value of practices that are providing a valued service for NHS patients.

The requirement for NHS Dentistry: Meeting demand for services

7.30 Since 2006, PCTs have had a new statutory requirement to provide or commission primary dental services to reflect local requirements. It is for PCTs to assess the local demand for NHS dentistry and commission services that best meet these needs. This includes:

- carrying out local needs assessments, consulting the local public, and developing strategic commissioning plans to match the services commissioned – and their location – to local needs and priorities.

- ensuring that, where services are commissioned but not fully delivered, the practices involved put in place measures to make good the shortfall in delivery, or the relevant resources are re-invested in other practices that have the capacity to deliver the required service.

- working with practices to ensure appropriate patterns of patient attendance (in line with NICE guidelines on recall intervals) and treatment (i.e. providing all appropriate care within a single course of treatment), in order to ensure effective use of resources. For instance, some patients with good oral health, who may traditionally have been recalled at intervals of six months or so, may need to attend less frequently under the NICE guidelines, which could free up appointment slots for other patients.

- monitoring and benchmarking numbers of patients seen to help understand reasons for variations and create sustained focus on improvement.

7.31 Access has been the single most difficult and high-profile issue for NHS dental services for the last 15 years. The key test of the reforms over the long term will therefore be their ability to support improved patient access to services.

7.32 There is, however, no simple measure to gauge how effectively PCTs are meeting local needs. The main measure used to track access to NHS services is the number of people who receive care or treatment from an NHS dentist at least once over a two year period. (The National Institute for Health and Clinical Excellence recommends that adults attend the dentist at least once every two years.) On its own, however, this does not capture total levels of access to services, given that some people will choose to visit the dentist less regularly than every two years and some will choose to have private services. Historical data suggests that in a system where there are no problems of access to services around 60% or so of people will choose to use NHS services within a two-year period, but with variation between PCTs.
PCTs and dentists have been adjusting to the new contract arrangements introduced in April 2006. As table 7.6 shows, there was some initial loss of dental activity, but since then there have been steady increases in PCT commissioning and in activity delivered. Commissioned annual activity continues to grow.

| Table 7.6 |
|---|---|
| Annual services commissioned* (units of dental activity) |
| UDAs offered to dentists for April 2006 | 77.9 million |
| as of May 2006 | 76.9 million |
| as of September 2006 | 78.3 million |
| as of March 2007 | 78.4 million |
| as of June 2007 | 78.6 million |
| as of September 2007 | 78.7 million |
| as of December 2007 | 79.4 million |
| as of March 2008 | 79.6 million |
| as of June 2008 | 80.1 million |

Patient access is expected to improve as the full effect of the re-commissioned and additional services come fully into effect this year and PCTs start to invest the major (11%) increase in funding provided in 2008/09.

Under the old dental remuneration system where a DDRB uplift was applied to each item of service fee thus potentially encouraging a dentist to undertake more NHS courses of treatment on more patients, it was arguable that a higher increase could lead to improved patient access. This is now not the case. Increasing the value to dentists of the base contracts reduces the ability of PCTs to commission additional services and can actually reduce patient access. Each 0.1% uplift on DDRB costs £2.75 million a year. This would provide access to NHS dentistry for about 40,000 patients.

The availability of funding and the impact of pay awards on access

As set out earlier, the evidence shows that there is no longer a need to provide dentists with additional national incentives to work for the NHS (ie. higher pay) but to allow PCTs to use the available dental funding stream and any additional funding they wish to bring to bear from their main allocations to buy additional access.

The resources allocated to PCTs by the Department of Health for commissioning primary dental care services totalled some £2.1 billion in 2008/09. The Department estimated that with patient charge revenue this might generate total gross resources of some £2.7 billion, based on central assumptions about the volume of services that might be commissioned and the mix between charge paying and exempt patients. The Department provided
PCTs with the relevant details of indicative local gross and charge income budgets as a guide to help satisfy themselves that the contracts agreed for their area provide value for money and adequately underpin patient charge revenue expectations.

7.38 The net level of provision for 2008/09 is £750 million more than levels of net expenditure in 2003/04, an increase of 56%.

7.39 NHS accounts data for 2007/08 shows that net expenditure for the year (i.e. after deducting income raised from patient charges) was close to the £1.9 billion allocated to PCTs. Although some PCTs received lower than expected levels of patient charge income during the year this does not affect the annual service levels agreed at the start of the year with individual dental practices. A practice’s NHS income and the annual services it agrees to provide in return are not affected by how much money is raised from charges.

7.40 There are a number of factors behind the reduction in the proportion of charge income, including changes in the mix of patients (charge-payers and charge-exempt patients) receiving NHS care and the number of charge-free treatments given to patients who would normally pay charges. In some cases, a reduction in charge income may reflect a conscious decision to target new services at particular population groups, e.g. children’s orthodontic services or services for more deprived areas. In other cases, income was initially depressed by reporting errors, which should now become much less frequent as a result of additional validation checks and monitoring reports introduced by the NHS BSA. As the new arrangements settle down further, we anticipate that there will be much greater stability of patient charge income.

**Expenses and pay elements**

7.41 The settlement for pay and expenses this year has to be seen in the context of the Government’s targets on inflation and pay.

7.42 The NHS has an excellent reward package for dentists which we believe has 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;

- a 5% reduction in overall activity in the old system (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

- access at PCTs’ discretion to NHS capital.
The new dental contracts provide 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.

Although the transition period for the new contracts and the associated guarantees for dentists and ring-fencing arrangements for PCT dental budgets were set at three years from April 2006, we do not expect any major changes to take place at the end of this period. The ring-fence has now been extended to 2010/11. PCTs should be building up long term, mutually beneficial working relationships with their dental providers and 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 five-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.

We will also be continuing to supply dentists with details of how many regular patients they have, i.e. those seen by them in the previous 24 months and not subsequently seen by another practice. This “practice list” (a complete version is available to dentists on request) enables 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.

NHS Pensions

Dentists’ pension benefits are calculated as 1.4% of their total pensionable pay, which is uprated every year. As an example, a committed NHS dentist whose total pensionable earnings averaged £96,000 per year over a working life of 40 years could expect to receive a pension of £53,760 a year, payable on an unreduced basis from age 60 and uprated in line with RPI on an annual basis. For new entrants, from April 2008 pension is calculated as 1.8% of total pensionable pay, payable on an unreduced basis from age 65. The value of the NHS pension scheme is set out and discussed in Chapter 10. The table in Annex G sets out the benefits for current GDPs.

Expenses

Table 7.1 shows a continuation of the trend for markedly reduced practice expenses first seen in the 2006/07 data on the Personal Dental Services pilots. This, together with the data on treatment complexity in 2007/08 from the NHS Information Centre (NHS IC), provides clear evidence about the broad effects
of the new contracts on the key drivers of practice expenses which should be taken into account in this pay round.

7.48  The calculated expenses ratio has fallen from 58.6% in 2004/05, for General Dental Service (GDS) dentists only, to 53.4% in 2006/07 for all dentists. This is a 9% reduction in the two year period.

7.49  NASDA have highlighted the drop in expenses. Total expenses as a percentage of total fee income fell by two percentage points in 2006/07 from 63.1 to 61.1. The average spend on dental laboratory bills is down from 7.5% to 6.9%, reflecting a reduction in both NHS and private practice. NASDA report that for NHS practices, laboratory fees have fallen from 8% of gross income in 2005/06 before the new contract arrangements to 5.6% in 2006/07.

7.50  The study published by the NHS IC compared the reported incidences of the most common dental treatments in 2007/08 with incidences in 2003/04. 2003/04 was the last year before the switch to Personal Dental Service (PDS). This study updated a provisional study which we mentioned in our evidence last year. The new study confirms a marked reduction in clinical complexity and, in particular, in the items of treatment which bear the highest expenses such as restorative treatment including crowns and bridges. Overall complexity has fallen with major changes in the patterns of some treatment areas as set out in table 7.7 below.

7.51  The overall reduction in advanced treatments (crowns, bridgework and dentures) is about 29%. In table 7.8, the changes in individual treatment items are weighted together using 2003/04 expenditure.

7.52  As shown in table 7.9, the reduction in the weighted average for other treatments is 17%.

7.53  Dentists are carrying out 33% fewer advanced treatments and about 20% fewer other treatments after taking into account the reduction of 5% in weighted courses of treatment under the new contract.
### Table 7.7: Number of treatment items per 100 courses of treatment and incidences as percentage of courses 2003/04 and 2007/08

<table>
<thead>
<tr>
<th>Number of items per 100 CoT</th>
<th>2003/04 Items</th>
<th>2007/08 Items</th>
<th>Difference Items</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs</td>
<td>52.4</td>
<td>29.5</td>
<td>-23.0</td>
<td>-44%</td>
</tr>
<tr>
<td>Extractions</td>
<td>10.0</td>
<td>11.2</td>
<td>1.2</td>
<td>+12%</td>
</tr>
<tr>
<td>Fillings</td>
<td>49.8</td>
<td>37.1</td>
<td>-12.6</td>
<td>-25%</td>
</tr>
<tr>
<td>Root-fillings</td>
<td>3.9</td>
<td>1.8</td>
<td>-2.0</td>
<td>-51%</td>
</tr>
<tr>
<td>Veneers</td>
<td>0.3</td>
<td>0.2</td>
<td>-0.1</td>
<td>-33%</td>
</tr>
<tr>
<td>Crowns</td>
<td>4.6</td>
<td>2.5</td>
<td>-2.1</td>
<td>-46%</td>
</tr>
<tr>
<td>Inlays</td>
<td>0.7</td>
<td>0.3</td>
<td>-0.3</td>
<td>-43%</td>
</tr>
<tr>
<td>Bridgework</td>
<td>1.8</td>
<td>0.8</td>
<td>-1.0</td>
<td>-56%</td>
</tr>
</tbody>
</table>

**Percentage of CoT with**

| Examination                  | 78.4          | 78.1          | -0.3             | n/c     |
| Periodontal treatment        | 54.6          | 46.2          | -8.4             | -15%    |
| Dentures                    | 2.7           | 3.1           | 0.4              | 15%     |
| Full upper and lower dentures| 0.5           | 0.5           | 0.0              | n/c     |
| Partial dentures             | 1.9           | 2.2           | 0.3              | +16%    |

Note: The difference may not equal the 2003/04 figure subtracted from the 2007 figure due to rounding.

### Table 7.8: Advanced treatments: expenditure and change in incidences

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>2003/04 SPEND</th>
<th>% REDUCTION IN 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veneers</td>
<td>£6 million</td>
<td>33%</td>
</tr>
<tr>
<td>Inlays</td>
<td>£17 million</td>
<td>43%</td>
</tr>
<tr>
<td>Crowns</td>
<td>£143 million</td>
<td>46%</td>
</tr>
<tr>
<td>Bridgework</td>
<td>£44 million</td>
<td>56%</td>
</tr>
<tr>
<td>Dentures</td>
<td>£91 million</td>
<td>increase of 15% which occurs in partials - no change in full dentures</td>
</tr>
<tr>
<td>Total</td>
<td>£301 million</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Table 7.9: Other treatment: expenditure and change in incidences

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>2003/04 SPEND</th>
<th>% REDUCTION IN 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>£151 million</td>
<td>n/c</td>
</tr>
<tr>
<td>Radiographs</td>
<td>£43 million</td>
<td>44%</td>
</tr>
<tr>
<td>Periodontal treatment</td>
<td>£174 million</td>
<td>15%</td>
</tr>
<tr>
<td>Fillings</td>
<td>£181 million</td>
<td>25%</td>
</tr>
<tr>
<td>Root fillings</td>
<td>£49 million</td>
<td>51%</td>
</tr>
<tr>
<td>Extractions incl. sedations</td>
<td>£42 million</td>
<td>-12%</td>
</tr>
<tr>
<td>Total</td>
<td>£640 million</td>
<td>17%</td>
</tr>
</tbody>
</table>

The effect of the significant reductions in dental activity within courses of treatment is to decrease total expenses by about 8% with a corresponding increase in net income of about 10%. This is obtained by applying the recorded changes in activity to the DDRB formula for calculating the dental uplift, as follows:

The DDRB formula for the uplift in 2008/09:
Uplift \(_{2008-09}\) = \(0.45 \times x + 0.165 \times y + 0.385 \times z\)

Where:

- \(x\) = increase in GDP remuneration
- \(y\) = increase in staff costs
- \(z\) = increase in other costs

7.55 Other costs includes consumables costs and laboratory costs. Each of these is about 15% of dental expenses as reported in early income and expenses surveys and in BDA surveys. 15% of dental expenses represents 15% times 55% of total payments (income and expenses) ie 8.25% of total payments.

7.56 Incorporating consumables and laboratory costs into the formula equation gives:

\[ \text{Uplift }_{2008-09} = 0.45 \times x + 0.165 \times y + 0.0825 \times c + 0.0825 \times l + 0.22 \times z_0 \]

Where:

- \(c\) = increase in consumables costs
- \(l\) = increase in laboratory costs
- \(z_0\) = increase in the remainder of costs

7.57 Under the new contract the volume of consumables has fallen by about 21%: UDA requirement is 5% less and activity within courses of treatment is down by about 17%. The volume of advanced treatments has fallen by about 33%; UDA requirement is 5% less and activity within courses of treatment is down by about 29%.

7.58 The reductions in these volumes leads to lower costs and an increase in net income. Consumables share falls by 21% from 8.25% to 6.5%; laboratory costs share falls from 8.25% to 5.5%. There is a corresponding increase in the share of net income from 45% to 49.5%.

7.59 Taking these changes into account the new equation is:

\[ \text{Uplift }_{2008-09} = 0.495 \times x + 0.165 \times y + 0.065 \times c + 0.055 \times l + 0.22 \times z_0. \]

7.60 Net income has increased from a share of 0.45 to a share of 0.495 ie an increase of 10%. Net income is now 10% higher because of the reduction in costs. Expenses have fallen from a share of 0.55 to a share of 0.505 ie a decrease of 8%.
Dentists’ concerns

7.61 The main concerns raised by dentists relate to the use of banded courses of treatment as the basis for defining the levels of patient care they provide over the course of the year in return for an agreed annual contract value.

7.62 Dentists are concerned that these allowances are not sufficiently sensitive to differences in the health needs of patients (e.g. a Band 2 course of treatment counts the same towards a dentist’s annual service requirements, whether that course of treatment includes a single filling or several fillings) and that there is no explicit financial reward for more time spent on preventative activity. These concerns overlook the fact that the new contracts pay dentists the same overall income as before, in return for carrying out 5 per cent fewer courses of treatment than under the old GDS system – and that the removal of the fee-per-item system supports dentists in carrying out simpler courses of treatment. Some courses of treatment will cost more than the average for that band, others will cost less than average. This averaging effect is the inevitable consequence of abolishing the unpopular fee-per-item system. But, if courses of treatment are generally simpler than before, there would have to be a significant change in the oral health needs of a dentist’s patient base to cause an increase in overall costs. The data from the recent sample survey of complexity within banded courses of treatment published by the NHS Information Centre on 21 August 2008 clearly shows that dentists are providing simpler courses of treatment and, therefore, dentists’ net earnings are growing.

7.63 It is clear, however, that more needs to be done to ensure that dentists and commissioners have enough information to judge if case mix or treatment patterns have significantly changed and adjust the remuneration appropriately in these circumstances. Some PCTs have addressed this issue by providing for additional remuneration (or lower initial annual service requirements) in cases where dentists take on more patients from areas with traditionally poor access to services and higher oral health needs. The Department recognised, however, that there was a strong case for having more easily accessible data on the treatments carried out within each band so informed judgements can be made. In consultation with the NHS and the profession we developed an improved clinical data set that now allows PCTs and practices to look more clearly at the relationship between treatment patterns and local health needs. This commenced in April 2008. The Department has also been supporting PCTs in developing a range of indicators that can be used to measure quality, patient experience, access to services and other measures. These are now available to PCTs and will be shared with providers by the end of the year.

7.64 Providers have objected to PCTs recovering money when contracts have not been achieved, and asserted that this so called “clawback” means they do not, in fact, have a predictable income as promised. However, it is unreasonable for these providers to expect to retain contract payments for services which they have not delivered. An allowance of up to four per cent underperformance is already built into the contracts: a provider must exceed this before any recovery can take place. Conversely, allowing further underdelivery without
the option of recovering payments would penalise providers who have delivered their contracted levels of service.

**Decontamination**

7.65 The Department will shortly be publishing Health Technical Memorandum 01-05: Decontamination in primary care dental practices. The aim of this guidance is to initiate a process of continuous improvement in the standards of decontamination. Compliance with this guidance however, should not place any significant financial burden on dental practices, as it does not impose any significant capital costs on practices. In terms of equipment used in decontamination, practices should already be adhering to guidance issued by BDA, developed with the Department of Health in 2003 (Advice sheet A12 Infection Control in Dentistry).

7.66 For some practices, which routinely use manual washing before sterilization, an extra sink may be required for the final rinsing of instruments but the cost of installation would normally be minimal in relation to a practice’s overall expenses. Further, practices may wish to purchase Reverse Osmosis (RO) machines, to provide water of sufficient quality. Previously, these practices will have been purchasing distilled water for this purpose. In these practices, the financial saving on distilled water will offset the cost of the machine over a period of time.

7.67 There will inevitably be indirect costs associated with cascading the guidance through the practice, development of plans to improve standards and auditing the level of compliance. This, however, should be part of on going practice development. Auditing within practice is part of clinical governance, and as such is part of the overall contract value.

**Local issues**

7.68 As noted above, 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 such “hot spot” areas and would reduce flexibility to increase access in areas of highest needs.

**Conclusion**

7.69 As stated in our introduction, we believe that the pay award for dentists in 2009/10 should reflect the notable increase in net earnings for all groups of dentists – at least 10% for those holding contracts. We are not, however, asking for a proportionate reduction in gross contract values to compensate for lower costs, given the implications for motivation and morale. Instead, we ask
that there should be a simple recommendation for a nominal increase in gross contract values for 2009/10 of 1.0%. This would start to take account of the effects of the large reduction in expenses caused by the move towards more preventive and simpler courses of treatment with a lower expenses element. This would also allow PCTs to commission more dental services and increase patient access. This would in turn enable dentists who provide these additional services to increase their NHS income, rather than deploying resources in ways that bring no benefits to the public and no efficiency gains.

**SALARIED PRIMARY DENTAL CARE DENTISTS**

7.70 We reported last year on progress with negotiating completely new terms and conditions of service for this relatively small but important staff group within dentistry, who are mainly directly employed by PCTs and who provide a range of clinical and public health services especially for priority and at-risk patient groups. The purpose of the new contractual arrangements was to give staff a clear career framework and progression based upon a competency framework and annual appraisal process, and to reward competence and commitment. The Department made available additional funding equivalent to 10% of the existing pay bill for this staff group. The new contract rewards clinical as well as managerial competence and responsibility and gave all staff a salary uplift upon assimilation. The specific scale of uplift for individuals depended on their existing job and how they assimilated into the new competency-based career structure. Following assimilation onto the new pay spine, all salaried primary care dentists received back-dated pay from 1 June 2007. They received a further uplift of 2.2% on the new pay spine from 1 April 2008 consequential upon implementation of the DDRB recommendation last year.

7.71 The negotiations were conducted on behalf of the NHS by NHS Employers, who were commissioned by the Department to undertake that role in recognition of their increasing responsibility for pay and terms of service issues for most groups of NHS staff. The negotiations with the BDA were completed in late autumn 2007 and received overwhelming support in a ballot of salaried dentists. One important feature of the new contract is that it has eliminated almost all of the salary supplements which had, over time, become a feature of the previous contract. Those characteristics of jobs which had previously attracted supplements are now reflected in the grade bandings. The sole remaining supplement is one for those Band A dentists who supervise a dental vocational practitioner or undergraduate dental students.

7.72 Implementation followed in the spring of 2008 with all new entrants to the service being appointed in the new pay and career structure from 4 February 2008 with an expectation that all existing members of staff would be assimilated to the new structure by May 2008. The implementation process was supported by NHS Primary Care Contracting who, at the request of the Department, ran a number of events for those responsible for contract implementation and who developed an implementation toolkit to assist PCTs. We understand that the implementation process has gone smoothly.

7.73 From 1 April 2008, pay rates for these staff are now promulgated by NHS Employers, who have included this staff group within their medical and dental
Pay Circulars. The currently applicable circular is (M&D)3/2008 issued on 25 April 2008; pay scales for salaried primary care dentists are shown in Annex A, Section 9 of that document.

7.74 Having regard for the new contract introduced this year and all the general circumstances, we believe that it would be appropriate to uplift salaries and the one remaining supplement across this staff group by the same percentage uplift as for all other NHS-employed doctors and dentists to maintain parity. We also propose that the full-time salary for vocational dental practitioners in the salaried primary dental care service is uplifted by the same percentage.

**DENTAL PUBLIC HEALTH STAFF**

7.75 We reported last year that we had published an Oral Health Plan for England. “Choosing Better Oral Health” was published in November 2005. 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 stated 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”. More recently, as part of a drive to secure oral health improvement, we have produced a toolkit for dentists “Delivering Better Oral Health” launched in September 2007 to assist individual practitioners in developing a health improvement component to their clinical practise, and to assist PCTs in commissioning for oral health improvement.

7.76 The clinical quality, patient safety and health improvement components of dentistry are all ones in which dental public health specialists play a key role, as their formal training and competencies specifically equip them to provide specialist expertise and undertake an advocacy and leadership role in relation to this agenda. They therefore represent an important element of NHS management capability in both SHAs and PCTs and their expertise needs to be suitably utilised and deployed. The recent House of Commons Health Select Committee inquiry into NHS dentistry has commented on the need for PCTs to utilise specialist in dental public health to enable them to commission effectively in accordance with local oral health needs, and we agree with that view. There are, however, significant workforce issues arising from the relatively low numbers of these staff. This has manifest as significant gaps in some parts of England, and in other areas of single-handed consultants having to work across large geographical areas spanning a number of NHS organisations.

7.77 We reported last year that the Department had established a wide-ranging review of capacity and capability in dental public health in the NHS, which is being undertaken as part of the Department’s work to strengthen the wider public health workforce as well as our work to develop commissioning capacity in dentistry. The review, led by the Department, is working with an external stakeholder group drawn from the wider public health community, NHS management, and dentistry, the latter including the BDA. It will report at the end of the year.
7.78 Dental public health 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. However, for historical reasons their terms of service and negotiating arrangements were separate, which had a number of disadvantages for both staff and employers. Following discussions with the BDA and with NHS Employers during 2007/08, it has been agreed that these staff will be fully incorporated 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. This assimilation has been completed with effect from 1 April 2008 and the Department no longer publishes separate pay circulars for this staff group.

7.79 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 8: OPHTHALMIC MEDICAL PRACTITIONERS

Summary

8.1 The Department of Health is currently negotiating the 2008/09 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. We will report back on these discussions in due course.

Background

8.2 Between 31 December 2005 and 31 December 2006, 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 479 to 406, and the number of optometrists increased from 8,692 to 9,102. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

8.3 In 2006/07, 11.2 million sight tests were paid for by PCTs in England and LHBs in Wales. This was 1.2% more than in 2005/06. Within these figures, the proportion of sight tests carried out by OMPs was 1.7% in 2006/07.

8.4 The surveys, which we have conducted into the working patterns of optometrists and OMPs, show that the majority of OMPs practise part-time. Half of the sight tests carried out by OMPs are part of a hospital appointment. (Source: Sight tests volume and workforce survey 2006/07).

8.5 In January 2007, the Department published the findings of a review of General Ophthalmic Services. The main focus of the review was to assess how to support the NHS in making greater use of community-based services to improve patient experience and patient choice. The main output of the review was a toolkit to help PCTs and practice based commissioners assess local needs and design and commission services to meet these needs.

8.6 To further support the NHS in planning and delivering primary eye care services, NHS Primary Care Commissioning issued a ‘Step by Step’ guide to commissioning in autumn 2007.

8.7 From 1 August 2008, regulations changed in respect of General Ophthalmic Services to move from maintaining local ophthalmic lists of providers to having contracts with businesses who provide the NHS sight testing service. This change allows PCTs to contract with any suitable provider and not only with the limited categories of provider that previous regulations allowed to be on the ophthalmic list. Individual clinicians who carry out NHS funded sight tests (optometrists and ophthalmic medical practitioners) must be included on a local performers list and are able to work anywhere in the country on the basis of this listing. These changes have no effect on fees paid for NHS funded sight tests.
Conclusion

8.8 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 98% 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.
CHAPTER 9: NHS FINANCES

Introduction

9.1 This chapter sets out the financial context for our recommendations, including the Department of Health’s Departmental Expenditure Limits (DELs) for 2008/09 to 2010/11 as announced as part of the 2007 Comprehensive Spending Review. It also highlights the challenges the Department faces in a world of reduced funding growth whilst demand for services continues to increase alongside higher expectations of service quality.

9.2 Pay (directly and not directly employed staff) accounts for around 46% of NHS revenue expenditure (and around 62% of HCHS expenditure). The paybill increases as staff numbers increase but is also affected by the annual pay uplift and pay drift.

9.3 The NHS has the difficult task to balance pay and non-pay pressures, given the workforce has to be of sufficient size, expertise and motivation to deliver service improvements and meet underlying demand. If we set the pay award too low we might not secure the workforce required to deliver service priorities. If we set the pay award above the required level, this will be at the cost of service developments and improvements; and reduce demand for doctors and other staff.

Funding available

9.4 As part of the 2007 Comprehensive Spending Review (CSR07), the Department of Health received funding settlement for 2008/09 to 2010/11. The DELs set by HM Treasury represent absolute limits on NHS expenditure. There is no flexibility to bring forward expenditure – i.e. to spend more in an earlier year, with lower expenditure in future years. There is flexibility to delay expenditure – i.e. to defer resources and expenditure into future years – but this is subject to approval by HM Treasury, and limited by affordability constraints on public finances in future years.

9.5 Across the past two spending reviews (covering 2003/04 to 2007/08) the NHS received average annual real terms growth in funding of 5.9% compared to 3.7% across all government spending departments. Moving forward to CSR07 (2008/09 to 2010/11), as expected, the funding settlement for the NHS is significantly lower than prior years but remains high compared to other government departments: an average of 3.7% compared to 1.9%. The comparatively higher funding is in recognition of the challenging forward programme of service development for the NHS. It is not a signal that NHS staff need higher than average pay awards or that the NHS labour markets are tight.

9.6 The settlement requires the NHS to deliver 3% cash-releasing efficiency savings over the CSR07 period. Table 9.1 shows the NHS revenue figures from 2005/06 to 2010/11.
### Table 9.1 Departmental Revenue Expenditure Limits to 2010/11

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue Net NHS Expenditure £m</th>
<th>Cash growth £m</th>
<th>Cash growth %</th>
<th>Real terms increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>Outturn 74,168</td>
<td>7,295</td>
<td>10.9</td>
<td>8.6</td>
</tr>
<tr>
<td>2006/07</td>
<td>Outturn 78,468</td>
<td>4,300</td>
<td>5.8</td>
<td>3.0</td>
</tr>
<tr>
<td>2007/08</td>
<td>Estimated Outturn 86,291</td>
<td>7,824</td>
<td>10.0</td>
<td>6.9</td>
</tr>
<tr>
<td>2008/09</td>
<td>Plan 92,475</td>
<td>6,184</td>
<td>7.2</td>
<td>4.0</td>
</tr>
<tr>
<td>2009/10</td>
<td>Plan 98,263</td>
<td>5,787</td>
<td>6.3</td>
<td>3.4</td>
</tr>
<tr>
<td>2010/11</td>
<td>Plan 104,603</td>
<td>6,340</td>
<td>6.5</td>
<td>3.6</td>
</tr>
</tbody>
</table>

1. Figures may not sum due to rounding.

### Expenditure plans

9.7 The core purpose of the Department of Health is to develop strategies and policies aimed at improving the health and wellbeing of the population. Competing priorities call upon the available limited funding. Funding requirement is analysed across three broad areas:

- baseline pressures;
- underlying demand; and
- service development

9.8 Pay is considered as a baseline pressure, one of the unavoidable must dos that represents the first call on resources. However, a balance needs to be made between pay remuneration and non-pay priorities even within the baseline. There is an obvious trade-off between the level of pay uplift and the opportunity to implement policies designed to improve health and develop the quality of NHS services.

9.9 **Baseline pressures** cover the cost of meeting existing commitments and does not include additional activity. This is the first call on NHS resources. The Department of Health estimates the HCHS paybill by combining estimates of pay settlement, pay drift and workforce growth. The HCHS paybill forms a significant part of baseline pressures along with prescribing (primary care and hospital) and primary care services. Overall, these three areas consume around £60 billion worth of resources. Additionally, there will be cost pressures arising from the general increase in cost of goods and services, the revenue cost of capital and programmes such as the NHS Litigation Authority. Pay pressures are assessed on the basis of short-run demand and supply position, evidence on staff morale, motivation and applications to training places.

9.10 **Underlying demand** is pressure due to general growth in activity levels. Whilst the level of funding growth available to the NHS has lowered, the expectation on NHS services has not diminished, if anything, they have increased, as demand for services continues to grow. Factors such as changes to population,
demographics, morbidity, rising public expectations can all contribute to driving up demand. Table 9.2 below shows the upward trend in hospital activity.

Table 9.2

<table>
<thead>
<tr>
<th>Year</th>
<th>Elective Admissions</th>
<th>Emergency Admissions</th>
<th>Attendance (A&amp;E and Minor Injuries Unit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Growth</td>
<td>Number</td>
</tr>
<tr>
<td>2002/03</td>
<td>5,366,830</td>
<td>-</td>
<td>4,041,290</td>
</tr>
<tr>
<td>2003/04</td>
<td>5,553,037</td>
<td>3.5%</td>
<td>4,310,995</td>
</tr>
<tr>
<td>2004/05</td>
<td>5,668,810</td>
<td>2.1%</td>
<td>4,535,287</td>
</tr>
<tr>
<td>2005/06</td>
<td>5,795,478</td>
<td>2.2%</td>
<td>4,732,166</td>
</tr>
<tr>
<td>2006/07</td>
<td>5,846,872</td>
<td>0.9%</td>
<td>4,738,978</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.11 Service development covers policy and manifesto commitments; some of these can be legislative requirements and some of these can be contractual obligations. These are new measures and are agreed with HM Treasury as part of the spending review settlement. Examples include:

- providing high quality care for adults approaching end of life;
- tackling childhood obesity;
- improving mental health services;
- more personalisation of service and improved outcome for people with long term conditions.

9.12 Responsibility for determining services to meet local needs resides with PCTs so there will be local variations on spending in specific services. However, through the NHS Operating Framework, the Department ensures patients are at the heart of service development by clarifying key service priorities for the NHS, financial rules and accounting framework.

Short run supply and demand position for medical workforce

9.13 Increases in underlying activity and service developments will increase demand for doctors and other professional staff. This derived demand for doctors is compared to workforce supply in order to assess the tightness, or otherwise, of doctor labour markets. The increase in the supply of doctors is taken from the Workforce Review Team and includes changes to participation rates from, for example, the changing gender mix of the workforce and changes to doctors’ work-life balance.

9.14 Table 9.3 below compares the projected supply of consultants, junior doctors and other medical staff.
Table 9.3 Short Run Workforce Demand & Supply

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>32,647</td>
<td>34,113</td>
<td>-0.4%</td>
<td>35,596</td>
<td>35,784</td>
<td>-0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Grades</td>
<td>48,755</td>
<td>50,865</td>
<td>0.0%</td>
<td>51,417</td>
<td>51,417</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Medical</td>
<td>10,756</td>
<td>11,166</td>
<td>1.9%</td>
<td>11,577</td>
<td>11,445</td>
<td>1.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>92,158</td>
<td>96,144</td>
<td>0.1%</td>
<td>98,589</td>
<td>98,646</td>
<td>-0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1) The convention for training grades is that we assume demand = supply. The main driver for Junior Doctor demand relates to their future service contribution once trained. Our training numbers (or supply of Junior Doctors) are in-line with our anticipated future needs for their contribution once trained and as such the immediate demand for Junior Doctors broadly matches supply.
2) The “Other medical” category includes those doctors who are not in training and are not consultants. The majority of doctors in this category are Staff Grades and Associate Specialists.

9.15 For Consultants and Other Medical our current forecasts are for demand to increase by 8.8% over the next two years (i.e. between 2008/09 and 2010/11). Supply is forecast to increase by 8.7% over the same period. Longer term, on current projections, we expect a small surplus of consultants to materialise in 2011/12. However, if we do not address this position, then we are likely to be faced with a 10% excess supply by 2014/15.

9.16 We therefore need a level of pay award that will not damage supply or the morale and motivation of the medical workforce in the short run but also one that will avoid storing up pressures for the mid-term. Given the likely trends in the wider economy on employment and earnings growth described in Chapter 11, we believe a 2% uplift is appropriate.

9.17 We believe moving above the 2% assumption will generate excess supply of staff and reduce scope for service developments.

Balancing pay and service development

9.18 As outlined in the previous chapters, the medical workforce has experienced significant growth in recent years across all workforce groups and there is a very healthy recruitment and retention position demonstrated by falling vacancy rate. Workforce and associated reforms (e.g. pensions) in recent years have also ensured that staff receive benefits that extend to the longer term.

9.19 We believe a 2% pay settlement will continue to support this positive trend whilst at the same time providing the right balance of funds for the NHS to sustain service development and to take up the challenges of the Next Stage Review proposals. The funding envelope for the NHS is fixed and there are no additional resources to fund excess costs.

9.20 Table 9.4 below shows a breakdown of the deployment of growth in expenditure over the previous two spending review periods and plans for CSR07.
9.21 This table shows that in the years of high pay growth in 2003/04 and 2004/05, a smaller proportion of growth in resource was deployed to service developments and underlying activity than in 2005/06 to 2007/08. The position for the CSR07 period is constrained by the relatively modest settlement. The Department of Health recognises that around 29% of the growth needs to go into HCHS pay increases, but going above that proportion will be at the direct cost of spend on service developments as pay consumes a higher proportion of additional funds than previous spending reviews.

Table 9.4: DISPOSITION OF ADDITIONAL REVENUE RESOURCES IN SR2002, SR2004 AND CSR2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Growth and Service Developments</td>
<td>39%</td>
<td>60%</td>
<td>47%</td>
</tr>
<tr>
<td>HCHS Pay (Price Only Component)</td>
<td>27%</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td>Secondary Care Drugs</td>
<td>4%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>EEA Medical Costs, Welfare</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Food and NHS Litigation</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Primary Care Drugs</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>General Dentistry, Ophthalmic and Pharmaceutical Services</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Prices</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>General Medical Services</td>
<td>16%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Pay for Not Directly Employed Staff</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Notes
2. Funding for change in pensions indexation in 2003/04 has been stripped from the calculation as it does not represent additional purchasing power to NHS.

9.22 Each 0.5% increase in settlement for doctors will add around £50 million to the NHS paybill. In addition there will be the additional and significant pay cost from pay reform and pay drift.

9.23 Some examples of programmes that could be detrimentally affected as a result of a high pay agreement are:

- a commitment of £88 million in 2009/10 and £198 million in 2010/11 has been made for the national End of Life Strategy – one of the key pathways of the Next Stage Review and a 2005 manifesto commitment;
- a funding of £75 million has been pledged towards the ‘Healthy Weight, Healthy Lives’ strategy to tackle obesity;
- a total of £103 million in 2009/10 and further £70 million in 2010/11 towards the programme to improve access to Psychological Therapies;
• £34 million has been committed to fund programmes to support local communities as part of the national health inequalities Public Service Agreement target.

9.24 We recognise the need to provide a fair reward for staff but at the same time need to balance this with the NHS’s longer-term aspirations for high quality care for patients, more personal services and greater choice for all.

Conclusion

9.25 The funding available to the NHS is fixed and is deployed to cover baseline pressures, underlying demand and service developments. Increases in expenditure in one area are at the cost of developments in other areas. Higher levels of pay would not only reduce funds available for service developments, it would also reduce the derived demand for workforce. Thus we might see doctors unable to find posts combined with some of the priorities in paragraph 9.23 being delayed or only partially implemented.

9.26 The medical workforce is facing good recruitment and retention and looking to the medium term, there may be a need to guard against over supply. As a result of the workforce reforms over recent years, staff are benefiting from a good overall remuneration package. We therefore support a 2% pay uplift and believe this is a prudent balance between the public’s aspirations for continuing NHS service improvements and the supply, motivation and morale of the medical workforce.
CHAPTER 10: NHS PENSIONS AND TOTAL REWARD

NHS PENSION SCHEME

10.1 NHS staff reward is not limited to current pay. The NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary (final salary for most staff but career averaged salary for GPs). This sort of pension is a very valuable part of the reward package for staff. The changes that have taken place in pension arrangements from 2008 represent an improvement in the short term in the value of NHS pensions, once longevity is taken into account, which is why staff contributions have increased in part to help pay for these improvements. In the medium to longer term changes to the benefit structure in the 2008 section of the scheme will reduce costs to taxpayers through holding down the cost of employers’ contributions below the level these would otherwise have reached. In addition, other cost sharing measures will mean that any further improvement in the benefit to employees will need to be paid for in higher staff contributions or otherwise be foregone.

10.2 The higher employee pension contributions represent a transfer of reward from current to deferred pay, rather than a reduction in net remuneration. The total level of employer contributions has remained unchanged at 14.0% following the publication of the report of the Government Actuary on the valuation of the Scheme as at 31 March 2004. There is provision for a possible increase to 14.2% up to 2016 if scheme experience is unfavourable. The report showed that as a result of the changes to the NHS Pension Scheme being implemented from 1 April 2008, the recommended employer contribution rate has reduced from 15.3% of pensionable pay (that would have been required had the benefit structure and employee contributions continued unchanged) to 14% of pensionable pay (the current contribution rate).

10.3 On any measure, an NHS pension is and will continue to be a very valuable benefit. Its value is increasing in relation to private sector provision in particular, where there is increasing abandonment of defined benefit schemes in favour either of defined contribution provision or of no occupational scheme (with an employer contribution) at all. Doctors enjoy high career pay progression and in the context of a final salary scheme tend to enjoy higher benefits in relation to the contributions made. Staff with high career pay progression benefit the most from a final salary pension. The Government Actuary’s Department (GAD) calculated the value of the employer contribution needed to provide pension benefits for a typical consultant in the NPA60 scheme with a 35 year career. They found that this was worth 22.5% of salary (compared with the 14% employer contribution required to fund benefits for all scheme members).

10.4 Following the conclusion of the NHS Pension Scheme Review in September 2007, regulations introducing various changes and improvements for existing members to the 1995 section of the Scheme came into effect from 1 April 2008. For new entrants to the Scheme from 1 April 2008, regulations were made and came into effect from 1 April 2008 granting access to a new section of the Scheme, the 2008 section. Amongst the changes introduced were:
• **Existing members have:**

  • retained their 1/80ths, index-linked defined benefit pension and its additional 3 x pension lump sum;
  • retained their normal pension age (NPA) of 60 (55 for health professionals and mental health officers in post before 1995);
  • retained their current minimum pension age (MPA) of 50;
  • gained the facility to commute further pension (up to a total of 25%) at the rate of £12 lump sum for each £1 foregone;
  • gained 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.

• **New entrants:**

  • receive an index-linked, final salary pension, but with improved, 1/60ths accrual in exchange for dropping the additional lump sum payable under the 1995 section;
  • 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;
  • have retirement benefits calculated on the average of the best 3 consecutive years in the member’s last 10 before retirement, re-valued by RPI. This will ensure that they can ‘step-down’ to a lower paid post without affecting the pension they have accrued;
  • gain the ability to draw-down part of their pension whilst continuing to work and build-up further pension;
  • have a NPA of 65 and a MPA of 55;
  • gain lifetime survivor pensions for nominated partners;
  • receive extra pension for service earned up to NPA65 if they continue to work beyond NPA65.

10.5 The new arrangements for both sections of the scheme have maintained a high quality, defined benefit, scheme as an integral part of the NHS reward package. Following the publication of the Scheme valuation in December 2007, the employer contribution has remained at 14%, due to the changes to the Scheme being implemented from 1 April 2008. From 1 April both existing and new entrant employees 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. This means that the majority of junior hospital doctors now contribute 6.5% of their pensionable pay. Consultants will fall into the higher 7.5% and 8.5% bands.

10.6 There has also been agreement to lift the cap on earnings that count as pensionable which was in place as a statutory requirement from 1989 – 2006 for future service. This will mean a significant boost to the pensions of many doctors with a start date for pensionable service after 1989.
10.7 Uniquely among self-employed people, general medical and dental practitioners have access to a high quality defined benefit pension scheme effectively guaranteed by the Exchequer and increased in value before payment in line with increases in earnings. The Career Average Revalued Earnings model has also applied to new entrants to the civil service since mid-2007. The Government Actuary assessed the cost of the pension scheme for practitioners as over 26% of pensionable pay from April 2008 compared with maximum contributions of 22.5% for the highest paid GPs. This cost will increase following the outcome of the judicial review on GP dynamisation as this will increase past service costs that need to be recovered.

Comparability of the NHS Pension Scheme

Public Sector:

10.8 On a “net of member contributions” basis, the NHSPS is relatively less valuable than the civil service arrangements but broadly equivalent to the Teachers’ Pension Scheme. It is slightly more valuable than the Local Government Pension Scheme, except for LGPS members who enjoy transitional protection of a facility to take an unreduced pension before that scheme’s normal pension age 65. In terms of retention, it is unlikely that many doctors would consider an alternative public sector career. Nor is there evidence that the relative value of public service pension schemes likely to be a factor in decisions about entering medical school.

Private Sector:

10.9 In assessing the impact of pensions in the retention of doctors, the most pertinent comparison is with the private sector. Statistics taken from the first release of the ONS Occupational Pension Scheme Survey, 2007 (released July 2008) indicate that in 2007 employer contributions to UK private sector defined contribution (DC) occupational pension schemes averaged at 6.4% of pay with employer contributions to open, defined benefit (DB) schemes similar to the NHSPS averaging at 15.0% of pay.

10.10 Many private sector employers do not offer any sort of employer-sponsored occupational pension provision. The ONS survey indicates that 3.6 million private sector employees were members of their employers’ occupational DB or DC pension schemes in 2007. That is a relatively small proportion of the 23 million or so employees in the private sector. Where private sector employers now offer a pension scheme to new staff, many offer only a DC arrangement with a typically much lower level of employer’s contributions and under which members face all investment and other risks, such as longevity, that are associated with pension provision. According to the Occupational Pension Schemes Survey (OPSS) 2007, only 6% of private sector workers participate in an open defined benefit scheme, with a total of 12% in open and closed defined benefit schemes.

10.11 Even where a DB scheme is available in the private sector the employer contributions will often include significant additional contributions being paid
to address accumulated deficits. It is therefore possible that the underlying contributions towards the cost benefits accruing in DB schemes in the private sector is materially less than 15.0%. Care should also be taken when comparing contribution rates in that the rates will vary according to the funding methodology and actuarial assumptions adopted.

10.12 Therefore, rather than comparing employers’ contributions to the schemes, it may be more appropriate to consider the scale of pension benefits offered. For example, the ONS’s 2007 Occupational Pension Scheme Survey found that 62 per cent of active members of private sector DB schemes had a normal pension age of 65. The normal pension age applicable to members of the NHS pension scheme is 60, for members joining before April 2008.

TOTAL REWARD

10.13 The general NHS reward package for hospital doctors is very competitive at postgraduate training, career grade and consultant levels. A medical career in the NHS remains highly attractive in terms of financial reward, the wider reward package and job satisfaction.

10.14 This benefit package includes the following:

- retention of a high quality defined benefit pension with protection of the normal pension age of 60 for existing staff;
- high annual leave allowances: 35 days rising to 40 compared with 28 days statutory entitlement;
- excellent sick pay entitlement: six months full pay and six months half pay after 5 years;
- doctors in training receive 30 days study leave;
- 39 weeks paid maternity leave; eight weeks at full pay, 18 weeks at half pay and 13 weeks at statutory levels;
- flexible working;
- security of employment is extremely high for doctors in the NHS and there have been very few redundancies. Doctors, along with other NHS staff also have the protection of redundancy arrangements that compare with the best private sector arrangements; generally up to two times annual salary with transitional protection of the right to retire early with an enhanced pension.

10.15 The survey of benefits and perquisites submitted to the DDRB by the BMA for the 2008 review found that the NHS was in line or ahead of private sector market practice in the areas of:

- pensions;
- sickness leave, (NHS 26 weeks full pay plus 26 weeks half pay after 5 years service vs 100% of base salary for 2 to 4 weeks reducing to 50% of base salary);
- annual leave, (NHS 32 days after 7 years service as a consultant plus 10 public and statutory holidays vs 25 days plus 8 public holidays);
• maternity/paternity leave; and
• flexible working, career breaks and sabbaticals (the NHS is more accommodating).

It is important to emphasise that this comparison is with the benefits available to senior staff and executives in private sector comparators.

10.16 The survey suggested the NHS was behind private sector market practice in the provision of private medical insurance, life assurance, car allowance and season ticket loans. The NHS does not provide season ticket loans, PMI or status related car allowance. Best private sector practice is 4 x salary life cover, compared to 2 x salary life cover in the NHS.

10.17 Access to training and development is an important part of the overall package for doctors. A Survey of 1000 plus new graduates by Ernst and Young (August 2007) indicated that 44% felt that training and development provision was the most important factor in choosing an employer with 18% identifying salaries and benefits as the most important. Doctors in training enter a structured postgraduate training programme with provision for 30 days a year paid study leave.

The chart above monetarises the value of the total employment package. As well as base pay, it includes a representative value of other pay allowances and employer pension contributions at the actual rate paid. It includes the value of the additional holiday allowances over statutory provision and the value of sick pay provision above the statutory requirements based on average sickness absence levels. This understates the overall value of the package as it does not attempt to monetarise other important elements such as flexible working, child
care and maternity leave that do not apply to all doctors. It also understates the true value of pension contributions for most hospital doctors as they have higher than average benefits from the final salary scheme.

10.19 The chart shows that for doctors in training the value of employers pension contributions and annual, study and sick leave provisions above statutory requirements add over 20% to the value of the reward package and are worth £11,000 to a doctor in the second year of training and £14,000 to a doctor five years into training.

10.20 For consultants the value of these benefits over statutory provision along with employer pensions contributions is over £25,000 and represent nearly 20% of the value of the reward package.

10.21 This work shows base pay as a proportion of total reward to be just over 60% for a consultant with 14 years seniority and just over 50% for the doctors in training.
CHAPTER 11: GENERAL ECONOMIC CONTEXT

SUMMARY
Macro Economy

11.1 The macroeconomic context for this year’s pay decisions is substantially changed from last year amidst what the IMF has described as “the biggest global financial shock since the Great Depression”\(^5\). The unprecedented twin global effects of the credit crunch and the rapid rise in food and energy prices have hit all the world’s major economies, including the UK. In the 2008 Budget, growth was forecast to slow below trend in both 2008 and 2009.

11.2 These challenging times should be seen in the context of strong GDP and employment growth over the past decade. This, and a policy framework to promote an open and flexible economy, has according to the IMF provided the UK with, “a strong foundation”\(^6\) from which to handle these global challenges.

11.3 Nevertheless, decisions taken in the next year or so by individuals, businesses, unions, the Government, and the Bank of England will be critical in determining how, and how well, the UK responds to these adverse conditions. With GDP growth slowing, responses across the economy will determine both how quickly the UK economy recovers, and who bears the inevitable cost of the adjustment.

11.4 In terms of what this means for the Government’s pay policy, the fundamental objectives remain unchanged, to recruit and retain high quality workforces; affordability and value for money for the tax payer; and consistency with achievement of the inflation target; but two of these have particular importance for responding to the current macroeconomic environment. Firstly, supporting the Bank of England in ensuring that inflation returns to target as quickly as possible; and secondly, ensuring overall affordability of workforce spending (and the value of spending on pay relative to other aspects of public services). Each of these is discussed in the sections below.

11.5 The other key impact of current macroeconomic conditions is on the final key objective - to recruit and retain a high quality public sector workforce. Levels of investment in recent years have resulted in the broadly very healthy recruitment and retention position in the public sector; looking forwards, as the economy weakens we should expect an increase in the relative attractiveness of the public sector as an employer. But clearly the situation for any specific workforce will be shaped by the labour markets in which it competes. The final section looks at the latest high-level labour market impact and the latest data across the economy.

Inflation

11.6 The recent rise in inflation has largely been driven by unforeseen shocks, stemming from developments in global food and energy markets. The latest

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\(^5\) IMF World Economic Outlook: Housing and Business Cycle, April 2008, p.4
\(^6\) IMF Article IV Consultation, Concluding Statement of the Commission, May 2008, p.1
Bank of England estimate is for inflation to return to target in early 2010. As low inflation provides the platform for higher employment, productivity and economic growth, it is critical that the current increases in inflation remain temporary.

11.7 The Government’s aim is to do everything it can to support the Bank of England in ensuring that inflation returns to target as quickly as possible. The Bank of England considers pay restraint across the whole economy to be key to maintaining low and stable inflation. The mechanism by which pay decisions can helpfully influence the future path of inflation is through managing inflation expectations and guarding against second round effects such as a wage-price spiral (i.e. current levels of inflation feeding into higher wage settlements and hence higher future inflation). Pay setting in the public sector has an important role to play. The public sector is a significant part of the overall labour market, employing one in five workers, and so through competition in the labour market and through signalling, it can have an impact on wage setting decisions in the private sector. As the Governor of the Bank of England has said “clearly they [public sector pay settlements] affect the tone of the labour market as a whole and will have an effect on the likely path of private sector settlements.”

11.8 While the Government is clear that pay should be based on labour market fundamentals for that specific workforce, it understands that many individuals perceive the fairness of their pay awards to be determined by how well they keep pace with rising prices, and by how their award compares with others in the economy. This is particularly pressing at the current time with rising food and fuel prices putting pressure on household budgets. But in order that the UK can return as quickly as possible to previous low levels of inflation, which benefit the whole of the economy, it is critical that both the public and private sector, at senior levels as well as the wider workforce, exercise restraint to guard against second round effects which risk entrenching higher inflation and would limit the Bank of England’s ability to cut interest rates more swiftly.

Labour Market Indicators

11.9 Despite recent events employment across the economy is still at record levels, with over 400,000 jobs created over the past year. However, there are some indications of a recent moderate loosening in the labour market, with unemployment rising over the three months to June 2008. The labour market is expected to weaken further as the economy slows, placing downward pressure on wages in the coming months.

11.10 The broadly very healthy recruitment and retention statistics in the public sector suggest that the total reward package (including pensions benefits, leave and training entitlements) in the public sector has proved competitive even through a period of sustained economic growth. Within this, public sector average earnings have increased by 3.0% more in nominal terms than the private sector since 2000.

7 MPC interest rate decision press conference 7 February.
8 ILO claimant count increased by 60,000 (3.7%) in the year to June. Labour Force Survey.
11.11 And in the current labour market environment we should therefore expect certain generic features of public sector employment, such as job security to increase the relative attractiveness of the public sector as an employer.

**Affordability and Value for Money**

11.12 Budget 2008 confirmed the nominal current spending envelopes for the CSR07 period (2008/9 to 2010/11) setting out that current spending will grow by 1.87% in 2009/10. This represents a significant tightening of spending in the CSR compared to previous spending reviews and as the slowing of the economy impacts on Government receipts and hence the public finances, such tightening is likely to be sustained (the Chancellor will provide a full assessment of the public finances and the outlook for the economy in the Pre-Budget Report in the autumn). Therefore, it is crucial that current and future pay settlements take account of affordability and value for money.

11.13 Departments’ planning assumptions on paybill reflect affordability constraints and the need to weigh the value of spending on pay relative to other aspects of public services. The circumstances of individual departments are discussed in the Government’s workforce-specific evidence.

**EVIDENCE ON THE GENERAL CONTEXT**

**Introduction**

11.14 Public servants are vital to the delivery of good public services and form a large part of the UK’s workforce. The key principles guiding the Government’s pay policy are; ensuring that total pay settlements represent value for money and are affordable within departments’ overall expenditure plans; reflect the recruitment and retention position of workforces and are consistent with the achievement of the inflation target of 2 per cent.

11.15 Public sector pay makes up about a quarter of Government expenditure, with an annual cost of around £145 billion. This means that public sector pay is integral to sound public finances alongside the Government’s priority to deliver value for money for taxpayers. With pay review body workforces making up about 40% of the public sector workforce, pay review body recommendations clearly play an important role in setting an overall direction of travel on public sector pay.

**Economic Context**

11.16 Over the past decade, the government’s macroeconomic framework has delivered a period of stability and continued economic growth. The UK economy has grown at a rate of almost 3 per cent a year, with real incomes per head up more than 25 per cent. It has also benefited from its longest period of sustained low and stable inflation since the 1960s and shown greater stability and stronger GDP growth than most of its major competitors. Historically low inflation, in turn, has provided the platform for record employment levels, higher investment, productivity and economic growth. Labour market
conditions continue to be favourable and despite record employment levels and high oil prices we have yet to see any evidence of upward pressure on earnings across the economy.

11.17 However, the ongoing disruption in global financial markets, together with the global commodity price shock means there is significant uncertainty surrounding the UK’s economic prospects. Therefore, it is all the more important that the Government maintains its commitment to macroeconomic stability and sound public finances in order to set the conditions for continued long run economic prosperity.

Inflation

11.18 This section sets out the current issues in respect of inflation trends, the historical context, the current position of the UK labour market and public sector pay awards.

11.19 Whilst setting pay awards at the right level is key to the delivery of good public services the level of pay awards are also important in keeping inflationary pressures under control. The Bank of England considers pay restraint across the economy to be key to maintaining low and stable inflation. Public sector pay is an important part of this because public sector employment constitutes a fifth of UK employment, competing with the private sector for workers, and because the public sector can provide powerful signals to the rest of the economy. Given this significance, it is critical that individual public sector wage settlements, as well as being appropriate to that workforce, help to anchor wage expectations in other parts of the public sector as well as the rest of the economy. In this respect, the Governor of the Bank of England said in a press conference in February this year, “...Clearly they [public sector pay settlements] affect the tone of the labour market as a whole and will have an effect on the likely path of private sector settlements in due course.”

11.20 Over the recent past, inflation has been boosted by unforeseen shocks: increases in energy prices, driven by developments in the oil and wholesale gas markets and higher food prices, which have been affected by a number of temporary global factors. These components alone account for about 2.1 percentage points of the 2.6 percentage point rise in the CPI annual rate since December, see Chart 11.2 below.

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11.21 CPI inflation reached 4.7% in August and is expected to peak around 5% in the coming months before falling back. The Budget forecast was for inflation to return towards target in early 2010 as the effect of the temporary factors recede. This is consistent with the Bank of England August inflation forecast and the view of independent forecasters. The latest average of independent forecasts is for CPI inflation at 4.5% in 2008Q4 and 2.1% in 2009Q4.

11.22 In contrast to periods of higher inflation in previous decades, the credibility of the UK’s monetary policy framework has so far kept long-term inflation expectations anchored and earnings growth has remained stable and subdued. Nevertheless, evidence from the Bank of England of higher temporary inflation
feeding into near-term inflation expectations exists\textsuperscript{11}. The risk then is that these higher inflation expectations feed through into higher wages and so higher prices as firms struggle to maintain their profits. The result is a self-defeating cycle of rising wages and prices, the worst of which we have seen in the 1970s when inflation rose to a high of over 20\% in 1975.

<table>
<thead>
<tr>
<th>CPI (Publication date)</th>
<th>2008 Q4</th>
<th>2009 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMF\textsuperscript{12} (Apr 08)</td>
<td>2.5</td>
<td>2.1</td>
</tr>
<tr>
<td>NIESR (Aug 08)</td>
<td>4.1</td>
<td>2.7</td>
</tr>
<tr>
<td>HSBC (Aug 08)</td>
<td>4.7</td>
<td>1.4</td>
</tr>
<tr>
<td>ITEM Club (Aug 08)</td>
<td>4.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Bank of England (Aug 08)</td>
<td>4.8</td>
<td>2.66</td>
</tr>
</tbody>
</table>

It is therefore important that wage setting be based on realistic inflation expectations that the inflation target will be met, rather than based on temporarily high inflation. If high pay settlements in the public sector encourage the same in the private sector, this could lead to inflationary wage pressure and consequently higher interest rates and threaten growth and job prospects when the economy is already weakening. The Governor of the Bank of England said "...the belief that we could avoid the adjustment by pushing up our pay would lead to a self-defeating process of higher wages offset by higher prices. It is the task of the MPC to ensure that the process of adjustment does not lead to a persistent rise in inflation."\textsuperscript{13} Therefore, it is vital that we remain vigilant over inflation with awards consistent with the CPI target of 2\%.

**Fiscal Context and Affordability**

The key issue with respect to the fiscal context is the amount of money available for current spending over the CSR period – fixed by our commitment to meet the golden rule (one of the Government’s two fiscal rules that underpin fiscal policy, as set out in the Code for Fiscal Stability, HM Treasury 1998). The golden rule requires that “over the economic cycle the Government will borrow only to invest” so that current spending is not financed by borrowing. This means that the ‘current budget’ (the difference between current receipts and current expenditure, including depreciation) must be in balance or surplus over the cycle (the present cycle began in 1997/98).

Budget 2008 set out how fiscal policy accommodates the impact on the public finances of continued disruption in global financial markets, reducing the surplus on the current budget in the early years of the forecasts. The current balance is forecast to reach surplus in 2010/11 ensuring that the Government is on track to meet the golden rule in the next cycle, see Chart 11.3. Budget 2008 also confirmed the nominal current spending envelopes for the CSR07 period (2008/09 to 2010/11) so that current

\textsuperscript{11} http://www.bankofengland.co.uk/publications/quarterlybulletin/qb070402.pdf
\textsuperscript{12} IMF data relates to full calendar year and not specific quarter.
\textsuperscript{13} Mervyn King, speech to Birmingham Chamber of Commerce, 23 January 2007.
spending grows by 1.67% and 1.87% in real terms in 2008/09 and 2009/10 respectively.

Chart 11.3: Surplus on the current budget

In other words, based on forecast economic growth and tax receipts, and ensuring sound public finances consistent with the fiscal rules, current spending can grow by up to 1.9% per annum in real terms over the CSR years (2008/09 to 2010/11). This sets the spending envelope for the CSR, and as shown in Chart 11.4 represents a marked slowdown in spending growth compared to the significant increases in investment in recent spending review periods.

Chart 11.4: Spending growth over recent spending review periods

This is the tightest spending review in nearly a decade. From 1998 to 2004, spending envelopes have averaged 3.8% per annum (real). Thus, the fiscal context in which Review Bodies now operate contrasts sharply with previous years.
11.28 Expenditure on pay is a significant component of public sector spending. Excluding demand-led items like social security benefits, pay on average accounts for around a half of remaining Departmental resource spending, though for some Departments this will be significantly higher. A high pay/RDEL ratio implies limited substitutability between pay and non-pay spending, so given tight RDEL budgets in the CSR, the importance of pay restraint is even greater.

11.29 Whilst the overall CSR spending envelope will grow by 1.9% p.a., this must fund a range of competing pressures. Pay costs must be met from within specific Departmental allocations, which will also need to fund a range of public service commitments. Additionally spending needs to be allocated between a range of non-pay and pay pressures.

11.30 To help ensure that the taxpayer gets the best deal possible from the public services they fund, the Government has launched several programs aimed at achieving value for money in areas other than public sector pay. For example, the Operational Efficiency Programme\(^{14}\), which draws on expertise from across the public and private sectors. This programme of work is far reaching across the public sector, focusing on back office/IT; collaborative procurement; asset management/sales; property local incentives and empowerment. Alongside other efficiency measures and affordable pay awards, this will help ensure the Government continues to pursue value for money for taxpayers, at a time of constrained resources.

**Labour Market Context**

11.31 Looking ahead, the overall labour market situation is expected to deteriorate (according to the Bank of England’s latest inflation report). A slowdown in demand, together with increased non-wage costs associated with higher oil, gas and import prices, is likely to put downward pressure on employment growth. The unemployment rate has started to rise and may increase further due to the cyclical slowdown in output, reducing pressure on wages in the private sector. At the same time, the relative attractiveness of the public sector as an employer should strengthen if worker uncertainty increases due to a worsening labour market position. Taken together, this augurs for pay restraint in the public sector.

11.32 Significant investment in public services and the increasing attractiveness of the total reward package for public sector workers, has helped deliver major growth in the numbers of key frontline workers since 1997 with 80,000 more nurses, 38,000 more doctors, 36,000 more teachers, 102,000 more teaching assistants and 14,000 more police officers.

11.33 Furthermore, over the past two Spending Review periods, average public sector pay increased more rapidly than in the private sector. Public sector average earnings have increased by 3.0% more in nominal terms than the private sector

\(^{14}\) Fuller information can be found at [http://www.hm-treasury.gov.uk/media/8/5/oep_prospectus030707.pdf](http://www.hm-treasury.gov.uk/media/8/5/oep_prospectus030707.pdf).
over the period since 2000\textsuperscript{15}, see Chart 11.5 below. During the period from mid 2006 public sector average earnings was lower than the private sector. In recent months, public sector and private sector pay growth have broadly converged and are currently both below trend.

Chart 11.5: Pay growth in the public and private sectors

<table>
<thead>
<tr>
<th>Earnings growth (3-month average, incl bonuses)</th>
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<tbody>
<tr>
<td>%</td>
</tr>
<tr>
<td>Jun-00</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Private sector</td>
</tr>
</tbody>
</table>

Source: ONE Average Earnings Index

**Paybill Growth.**

11.34 Basic increases are of course only one component changes in total reward and for reasons of affordability, settlements need to be set alongside overall paybill growth. When determining settlements, it is critical that all factors that will increase earnings are taken into account, some of which result in pay drift, such as:

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

11.35 Therefore we are keen that Pay Review Bodies 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, which includes workforce growth, changes in pensions contributions etc.

11.36 For example, it is important to avoid comparing basic pay increases with inflation. Whilst it is true that workers at the top of pay scales will, only receive the basic award, many others will receive a further increase from progression worth an additional 2% – 9% depending on workforce and individual circumstances.

11.37 For the HCHS medical workforce, an illustration of the combined effects of growth in average pay and in workforce numbers is at Annex A.

11.38 Whilst pay growth is an important element of remuneration it is the relative \textit{level} of public sector pay that determines whether it is set at the right level in the market to be a positive influence on workers, without being set so high so as to offer poor value for money. However, while it is not straightforward to calculate the correct “market rate” for a public sector worker, we can consider the indirect influence of pay levels through their impact on recruitment and retention. However, there is a wide range of evidence that shows that workers are concerned about both pay and non-pay elements of the employment offer. Therefore a change to pay is not always the answer to addressing specific workforce recruitment and retention challenges.

\textbf{Total Reward.}

11.39 Healthy levels of recruitment and retention depend on a range of factors in addition to base pay awards. A "total reward" approach draws together all the financial and non-financial investment an employer makes in its workforce. It emphasises all aspects of reward as an integrated and coherent whole, from pay, pension and benefits through flexible working to learning and development and the quality and challenge of the work itself. Important as these elements are, there is no systematic and comparable information on most of these elements across the public sector. However, one important and valuable element of total reward where information is available is public sector occupational pensions.

\textbf{Public Sector Pensions.}

11.40 Occupational pensions are a form of deferred pay, paid to employees upon their retirement rather than when it is earned. They are a more important part of the total reward package in the public sector than in the private sector, for two main reasons:

- coverage: the public sector workforce has far greater access to these schemes than private sector workers (90% participation by serving employees versus 15% as at 2007\textsuperscript{16}); and

- the value of employers’ contributions: in the public sector on average these are set at higher percentages of pay than in the private sector.

11.41 Almost all public sector occupational pensions are defined benefit (DB)\textsuperscript{17} schemes, with negligible membership of Defined Contribution (DC) schemes. Pensions cost public sector employers around 16\% of pensionable paybill in addition to salary costs, whereas schemes in the private sector are a mixture of

\textsuperscript{16} Calculated from \textit{Occupational Pension Schemes Survey (OPSS) 2007, First Release} and \textit{ONS Labour Market Statistics (August 2008)}.

\textsuperscript{17} Defined Benefit schemes are where the pension is related to the member’s salary or some other value fixed in advance. In Defined Contribution schemes the pension is based on the contributions made and the investment return they have produced.
DB and increasingly DC, costing employers around 13%\(^{18}\) of pensionable paybill in addition to salary costs. The difference of around 3% on average in the level of employer contribution represents the higher value of deferred pay in the public sector. However, it is important to note that the 16% average figure is calculated with reference to the biggest unfunded public sector schemes only and across the public services there is significant variation. It therefore would be more appropriate to compare within similar sectors (see table 11.3 below). Also note that this comparison only applies to the 15% of private sector employees who are active members of occupational\(^{19}\) pension schemes.

Table 11.3 – Employer Contribution rates for selected Public Service pension Schemes 2008/09

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Employer Contribution rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Government(^a)</td>
<td>14-15%</td>
</tr>
<tr>
<td>NHS staff(^b)</td>
<td>14.0%</td>
</tr>
<tr>
<td>Teachers(^c)</td>
<td>14.1%</td>
</tr>
<tr>
<td>Civil Service</td>
<td>19.4%</td>
</tr>
<tr>
<td>Armed Forces(^d)</td>
<td>25.6%</td>
</tr>
<tr>
<td>Police(^e)</td>
<td>24.2%</td>
</tr>
<tr>
<td>Judiciary</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

\(^{a,b,c,e}\) For England and Wales only
\(^{d}\) Resource accounts quote officer and other ranks rates separately this is actual weighted rate

Source: From Schemes

Chart 11.6: Active members\(^{20}\) in public and private sector, 1991-2007

Source: GAD/ONS

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\(^{18}\) Occupational Pension Schemes Survey (OPSS) 2007, First Release.
\(^{19}\) i.e. DB and DC: some employers make some contributions to other schemes such as stakeholder but there is currently not robust enough data available.
\(^{20}\) Active members are current employees who are building up rights to an occupational pension scheme.
Chart 11.6 shows that the private sector has been steadily exiting from pension provision since the last peak in 1991. This is due to rising costs, driven by factors such as increased regulation, increased longevity expectations and a reduction in optimism over investment returns. In comparison, over the same period, public sector pension provision has been broadly increasing (except after a fall in the 80s early 90s, driven by privatisation) and there are now many more active members in the public than in the private sector, despite the public sector representing only around 20% of the UK workforce. In short, as the more generous DB pension schemes have become more costly, the private sector has increasingly chosen to close these schemes and either move to DC or not contribute to an occupational scheme, whereas the public sector has retained DB but introduced reforms intended to contain cost pressures, see Table 11.4 and Chart 11.7.

Table 11.4 – Breakdown of Private Sector pension, active members 2007

<table>
<thead>
<tr>
<th>Total Active members in private sector in 2007</th>
<th>3.6m</th>
</tr>
</thead>
<tbody>
<tr>
<td>In DC schemes</td>
<td>0.9m</td>
</tr>
<tr>
<td>In DB schemes</td>
<td>2.7m</td>
</tr>
<tr>
<td>Of which are in open21 DB schemes</td>
<td>1.3m</td>
</tr>
<tr>
<td>For comparison - Total Active members in public sector in 2007 (almost all DB)</td>
<td>5.2m</td>
</tr>
</tbody>
</table>

Source: ONS Occupational Pension Schemes Survey (OPSS) 2007, First Release

Chart 11.7: Proportion of private sector employees participating in an occupational pension scheme, 1991-2004

Source: Pensions Commission analysis based on GAD pensions and ONS employment data

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21 Open Schemes – open to new members to enter into the scheme as opposed to closed schemes where active members continue to accrue pension but no new members can join.
11.43 The Pensions Commission noted that active membership of open DB schemes was estimated to have fallen by 60% between 1995 and 2004 and estimated it would fall by a further 10-20% in the future\(^{22}\). OPSS data for 2007 shows the lowest level of private sector active membership of these schemes since the mid 1950’s and there is no reason to think, given increasing longevity and thus increasing cost expectations, as well as the proportion of members in closed schemes, that this trend will reverse in the near future.

**Summary**

11.44 Public servants are vital to the delivery of good public services and the Government remains committed to the support of those professionals in their efforts to deliver the best possible services. The key principles guiding the Government’s pay policy are: ensuring that total pay settlements represent value for money and are affordable within departments’ overall expenditure plans; reflect the recruitment and retention position of workforces and are consistent with the achievement of the inflation target of 2 per cent.

11.45 Strong fiscal management and low inflation has provided the platform for record employment levels, productivity and economic growth and higher investment in public services has led to more and better paid public servants. The level of public sector pay is an important part of our keeping within tight fiscal constraints and in helping to lower inflationary pressures.

11.46 During this period of weak global economic growth and increased cost pressures, it is vital that public sector pay settlements remain affordable and provide value for money. And in helping to anchor inflation expectations, maintaining restraint in public sector pay settlements will help prevent this temporary rise in inflation turning into a more persistent one, contributing to the Government’s aim to protect living standards in the face of global price increases.

11.47 Public and private sector average earnings are both subdued and broadly convergent. Following recent pay growth, the improving relative attractiveness of the wider public sector total reward package, and the current economic uncertainties, the overall picture on recruitment and retention is healthy and which means a continued period of pay restraint is merited.

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Chapter 12: Evidence from the Welsh Assembly Government

12.1 This Chapter has been prepared by the Health and Social Services Department (NHS Wales) to complement the evidence from the other Health Departments and highlights those policies distinctive to Wales.

Proposals to Change the Structure of the NHS in Wales

12.2 The Health Minister announced on 16 July plans to simplify the NHS structure in Wales and meet the Welsh Assembly Government’s ‘One Wales’ commitment to end the internal market by creating single local health organisations that would be responsible for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system currently operating.

12.3 The Assembly will therefore be consulting in the Autumn on creating 7 new organisations to take on the functions currently carried out by both NHS Trusts and the 22 Local Health Boards in relation to both primary and secondary care.

12.4 The Minister will also be considering a proposal for a new National Board which would be responsible for planning and possibly funding NHS services on an all-Wales basis.

12.5 There have already been a series of Trust mergers with effect from 1 April and 1 July 2008 resulting in a reduction of Trusts from 14 to 9.

Workforce Strategy

12.6 Designed to Work, the workforce and people management strategy for NHS Wales, was launched in June 2006. Organisations’ progress on the delivery of the strategic aims of the strategy has been monitored on an on-going basis. The most recent review of progress was undertaken in the spring of 2008 and is summarised in paragraphs 12.7 – 12.12 below.

Theme 1 – Develop a new approach to role redesign and innovative work systems to meet patient needs.

12.7 There is evidence that local organisations are developing and implementing new and extended roles and innovative working practises to meet the needs of patients. The evidence suggests that in the main this is being driven from the bottom up in response to local need rather that from an over arching strategic workforce development plan.

12.8 Whilst the freedoms of Agenda for Change are facilitating these developments there is, in the main, limited evidence that organisations have developed a comprehensive pay modernisation benefits realisation strategy.

Theme 2 - Create an organisational and workforce development planning system to deliver service change
A revised workforce planning process has been developed and has been implemented across NHS Wales. The new system will ensure that workforce planning is undertaken on a health economy basis and will focus on whole workforce planning fully integrated with financial and service plans at a local and health economy level. Most organisations have strengthened their workforce planning functions to ensure they are able to meet the demands and challenges of the new system.

**Theme 3 – Develop a modern people management, human resources and organisational development service for the delivery of innovation**

Significant progress has been made in relation to the utilisation of ESR and all organisations have developed benefits realisation strategies. This work is enhancing the management of sickness absence and is providing more robust information reporting processes.

Most organisations have reviewed their organisational structures and operating arrangements to ensure that clinicians are fully engaged and clinical leadership is enhanced. Similarly most organisations have restructured their HR functions to enable focus on key strategic HR initiatives. To support the development of HR skills for managers remains a key priority for most organisations and there is generally more that needs to be achieved in relation to this objective.

Good progress has been made on the equalities agenda and the key actions outlined with Designed to Work. There is clear evidence that the equalities agenda is beginning to become mainstream business. The monitoring data confirms that generally recruitment and retention remain strong throughput Wales but work is still needed in some organisations to reduce the reliance on bank, agency and locum staff.

**Workforce Numbers: Headline Figures**

Between September 2006 and September 2007 the number of WTE directly employed NHS staff increased by 0.4% (287) to 70,907. Hospital medical and dental staff increased by 196 (4%) to 5,332 of which the number of hospital medical consultants increased by 126 (7%) to 1,820 wte. There were increases in the other hospital grades as follows:

- Associate Specialist 187 to 204 (9%).
- Specialist Registrars 871 to 1,326 (52%)
- House Officers 391 to 565 (45%).

There were decreases in other hospital grades as follows:

- Senior House Officers 1,411 to 846 (40%)

There has been an 89% increase in medical student intake (190 in 1999 to 360 in 2007). There are 2,819 training posts in Wales of which 1,299 are in specialist training. The fill rate in 2008 recruitment round was 86% in Wales. Vacancies were later filled locally.
Workforce Planning

12.15 A new Integrated Workforce Planning System is being implemented which brings together service and service modernisation, workforce and financial plans. All NHS organisations are receiving training to support implementation.

12.16 The Workforce Development Unit will gather information about NHS Wales workforce, population and labour market, UK, EU and global issues affecting medical and dental workforce. They will also carry out modelling work as to what the future NHS workforce may look like.

12.17 All this information will be used to provide advice to the Advisory Group for Medical and Dental Workforce Development made up of representatives from the service, education and professional bodies who will in turn advise the Assembly’s Education and Commissioning Board. The Assembly Government holds the budget for education funding and continuously looks to best ways to ensure value for money.

DOCTORS

Consultant Vacancies

12.18 The following tables show how the three-month vacancy rate for medical and dental consultants has changed over the last 12 months. Consultant vacancies have fallen from 59.5 (3.0%) in March 2007 to 37.0 (1.7%) in March 2008.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>4.4</td>
<td>4.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>1.0</td>
<td>4.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>-</td>
<td>-</td>
<td>3.0</td>
</tr>
<tr>
<td>Dental Group</td>
<td>1.0</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>ENT</td>
<td>2.0</td>
<td>1.0</td>
<td>-</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>1.0</td>
<td>2.0</td>
<td>-</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-</td>
<td>1.0</td>
<td>-</td>
</tr>
<tr>
<td>Urology</td>
<td>2.0</td>
<td>3.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Cardio-Thoracic Surgery</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Pathology</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haematology</td>
<td>3.0</td>
<td>3.0</td>
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</tr>
<tr>
<td>Histopathology</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Medical microbiology</td>
<td>1.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.0</td>
<td>3.0</td>
<td>1.0</td>
</tr>
<tr>
<td>General Medicine group</td>
<td>14.0</td>
<td>12.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>1.5</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Community Health</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>15.6</td>
<td>13.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Radiology</td>
<td>6.0</td>
<td>5.0</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59.5</strong></td>
<td><strong>57.0</strong></td>
<td><strong>37.0</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bro Morgannwg</td>
<td>4.0</td>
<td>-</td>
<td>1.0</td>
</tr>
</tbody>
</table>
12.19 The vacancy rate for other doctors and dentists (excluding training grades) has risen in the last six months from 1.1% to 1.7%.

EWTD and Hospital at Night

12.20 Compliance towards the August 2009 48-hours target has increased and in July stood at 49% as shown in the Table below. Specialty compliance is consistent with other UK health departments with indications that there are potential difficulties in achieving compliance within anaesthetics, surgery, obstetrics and gynaecology and paediatrics. These four specialties are only 28% compliant.

12.21 Solutions must support patients safety, clinical training and the well-being of doctors in training. The re-design of patient services, the introduction of the Hospital at Night model and new ways of working are amongst some of the solutions.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Number of Doctors in Training</th>
<th>Number of Doctors Compliant with 2009 48 hours</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe</td>
<td>618</td>
<td>453</td>
<td>73</td>
</tr>
<tr>
<td>Cardiff</td>
<td>621</td>
<td>203</td>
<td>33</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>296</td>
<td>130</td>
<td>44</td>
</tr>
<tr>
<td>Gwent</td>
<td>426</td>
<td>133</td>
<td>31</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>247</td>
<td>157</td>
<td>63.5</td>
</tr>
<tr>
<td>North Wales</td>
<td>351</td>
<td>165</td>
<td>47</td>
</tr>
<tr>
<td>North West Wales</td>
<td>146</td>
<td>45</td>
<td>31</td>
</tr>
<tr>
<td>Powys</td>
<td>4</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Velindre</td>
<td>66</td>
<td>66</td>
<td>100</td>
</tr>
<tr>
<td>Wales</td>
<td>2775</td>
<td>1356</td>
<td>49</td>
</tr>
</tbody>
</table>

Consultant Contract

12.22 The aims of the amended Consultant Contract introduced in Wales in December 2003 were to reduce Consultant working hours, improve consultant recruitment, and engage consultants in service modernisation. Annual Reports from Trusts are the second stage in the Assembly’s 3-stage approach to benefits realisation pending Consultant Outcome Indicators (COIs) being able to deliver useful and usable information.
12.23 The key findings from the third round of Reports are as follows:

- Average consultant weekly working hours were 41.0 hours at March 2008, a reduction of 0.5 hours over March 2007, and down from 45.6 hours in December 2003.

- The total number of consultants employed across Wales was 2,138 at March 2008, an increase of 115 on March 2007, and a rise of 34% since September 2003.

- Consultant vacancies were running at 1.7% at March 2008, compared with 3.0% in March 2007 and 9.5% in September 2003. The majority of Trusts report being able to fill most posts with a good field of candidates; some consider recruitment to have improved in the past year and none report that recruitment has been more difficult.

- Just over 2,250 additional sessions were being paid to consultants in March 2008, 250 less than in March 2007. Consultants were receiving an average payment of just under 0.9 additional sessions for Direct Clinical Care (DCC) and Supporting Professional Activities (SPA), a reduction of 13% on the previous year.

- The average split between DCC sessions and SPA was 8.1 to 2.5 in March 2008, a decrease of 0.1 DCCs, and an increase of 0.1 SPAs over the year. The net service delivery effects across Wales, taking account of the increased number of consultants, was an extra 3% in capacity to undertake DCC activity, and an extra 10% in SPA activity, which in effect is an additional investment in service quality, over March 2007. Trusts are increasingly looking to assess the specific benefits from SPA activity.

- COIs were launched in September 2005, with the first set of reports shared with Consultants in July 2006. Considerable work was undertaken to take on board consultant comments about the appropriateness of indicators in many specialties in time for the July 2007 reports, and on data quality in time for the July 2008 reports. This work has been enhanced by the engagement of national Specialty Advisory Groups.

- 65% of consultants participated in the 2008 Consultant On-line Survey, adding considerably to the information contained in reports. The emphasis will now be on beginning to use reports in all consultant job planning or appraisal meetings, as well as on addressing the appropriateness of indicators and the sources and quality of data.

**SAS Doctors**

12.24 Wales is currently implementing the new SAS Doctors contracts for specialty doctors and the closed revised associate specialist grade agreed at a UK level. This agreement came into effect from 1 April 2008, and is the same as for the rest of the UK except for the Job Plan Outcomes categories, arrangements for
private practice, and some terminology all of which reflect the different consultant contract in Wales.

12.25 All new appointments in Wales are now to the specialty doctor grade, and we have agreed with the BMA and the Service a common timescale and approach to the assimilation process for existing SAS Doctors in post at April 2008. All 851 eligible doctors have been invited to express interest, and the vast majority (information as at July 2008) have replied with 716 expressing an interest and 35 confirming they do not wish to express an interest. Job planning training has been conducted in all Trusts in Wales, and employers are aiming to complete this by the end of October so that a formal offer of a new contract can then be made to those doctors who have expressed an interest. The overall take-up of the new contract amongst existing doctors is likely to be known in early 2009.

12.26 The Window of Opportunity - effectively the last chance for current eligible doctors to seek personal regrading to the revised associate specialist grade - has also commenced and will continue to be available until 31 March 2009.

12.27 There are several hundred SAS Doctors who are not eligible for the new contract. These are mainly practising GPs working in the old clinical assistant and hospital practitioner grades, but while their numbers are considerable their overall contribution is relatively limited as most work only one or a small number of sessions per week. Those doctors not employed on national terms and conditions whose role does not mirror that of SAS Doctors have also not been included - generally those Trust Doctors whose service roles mirror those of training grade posts.

12.28 There does not appear to be a significant recruitment problem for SAS Doctors in Wales - the latest available published information as at March 2008 shows a 1.7% vacancy rate amongst SAS Doctors. It is too early to say whether the position has changed as a result of the introduction of the new specialty doctor grade.

Accommodation Review Group

12.29 Following a meeting with BMA Wales and the Post Graduate Deanery to discuss accommodation for F1 doctors, the Minister agreed to create a Working Group to look at accommodation throughout the NHS in Wales in terms of recruitment, priorities, take-up and standards.

12.30 The Minister considered that the whole issue of availability and standards of accommodation for all staff groups needed to be assessed in relation to their effect on the recruitment and retention of all staff. The Group have been asked to report by the end of November 2008. In the meantime, F1 accommodation will continue to be provided free until 31 July 2009 but Trusts are aware of the tax implications.

DENTISTS

Recruitment and retention

12.31 There are more General Dental Practitioners in the NHS in Wales than at any time in the past. The latest workforce data for the year ending 31 March 2008
showed there were 1,247 dentists with NHS activity recorded against them. This is an increase of 106 (9%) over the previous year. There were 4.2 dentists per 10,000 population in the year ending 31 March 2008, an increase from 3.8 the previous year. In 2004 the figure was 3.5 per 10,000.

12.32 In 2007/08, the numbers of male and female dentists aged under 35 were similar but over 35 there were more than twice as many male dentists as female dentists. In 2007/08 12 per cent of all dentists were 55 years old or over and 39 per cent were female.

12.33 Access to general dental services in Wales has improved following the significant investment supporting the introduction of the new dental contract in 2006. The flexibility in the Regulations supporting the contract allows Local Health Boards (LHBs) to shape and plan services to meet the local need and the wider oral health agenda. During the summer of 2008, 19 out of a total of 22 LHBs reported no access issues and had dental practices in their areas accepting new NHS patients.

12.34 The total spend on NHS dentistry in Wales continues to grow significantly. In 2007/08 it was £123.9 million compared to £121.7 million in 2006/07, £104.4 million in 2005/06, £81 million in 2004/05 and £75.8 million in 2003/04.

12.35 The Dental Earnings and Expenses report produced by the NHS Information Centre for Health and Social Care shows that the average net profit after expenses (before income tax) for all dentists in England and Wales in 2006/07 was £96,135. For dentists in Wales this figure was £98,945.

12.36 There is evidence to support the view that the NHS remains an attractive option for dentists with many wishing to contract with Local Health Boards (LHBs) to provide general dental services. There was no shortage of applicants when additional contract activity became available during the year.

Effect of the new system

12.37 We are however conscious of the concerns expressed by dentists and some LHBs about certain operational aspects of the contract. In November 2007, the Minister for Health and Social Services asked for a review of the dental contract.

12.38 This work was taken forward by the Dental Contract Review Task and Finish Group established to explore possible solutions, the implications and cost of any changes to the contract. The Group included representatives of the dental profession, the BDA, LHBs and patient groups. The review was conducted in five phases and the key issues were identified as:

- financial issues (national benchmarking, understanding and deciding on contract currency);
- contract management and overall contract performance to meet oral health aims;
- information (measuring oral health and information on population needs/defining valid outcome measures, patient information needs); and
• workforce issues.

12.39 The final Report was agreed by the whole Group and accepted that the dental contract is broadly a workable system, and that with amendment can be improved with also the potential to enhance oral health. It makes a number of wide-ranging recommendations, some with further work to follow, to increase the effectiveness of the contract and deliver improvements in oral health.

12.40 Sub-groups to the main Group have been established to develop ongoing work streams to review vocational training in Wales addressing the issue of VT+1 and General Professional Training (GPT). In addition work continues on reviewing Units of Dental Activity (UDAs) as the sole contract currency and the development of a basket of indicators to improve the performance management of the contract including the issue of quality.

12.41 We have always maintained that the new arrangements would require a period of bedding down to allow the very significant changes to the contract to iron out a number of transitional issues. In 2007/08 there was a welcome improvement in the delivery of services dentists needed to achieve to meet their contractual commitment. In terms of UDAs, 94.2% of total contracted activity in 2007/08 was delivered. The pattern of contract performance breaks down as:

- 38% of contracts delivered 100% or more of contracted activity (35% in 2006/07);
- 60.3% delivered 95% or above (55.5% in 2006/07); and
- 39.7% delivered less than 95% of contracted activity (44.5% in 2006/07).

12.42 Regional variations remain and there are pockets in a few rural areas where improving access still represents a challenge for service planners. Some LHBs have found it difficult to attract dentists to their locality while others have historically had low levels of provision and investment and are now having to grow services from a relatively low base.

Vocational training

12.43 In 2004 the number of dental students in Wales increased from 55 to 64. The first intake of the increased number of students will graduate in 2009 and will commence their Vocational Training in one of the six Welsh VT Schemes. In 2010 these numbers will increase by a further 12 bringing the total up to 76.

The salaried service

12.44 The Contract Review Group were also asked to lay the ground for fulfilling the Assembly Government’s published goal of consolidating and developing the Community Dental Service (CDS) in Wales. The Group’s recommendations are currently with the Minister and will be viewed within the context of the current consultation on the wider reorganisation of the NHS in Wales.

12.45 The CDS is also playing an integral part in the delivery of a National Oral Health Action Plan which will provide a long-term plan of action designed to improve oral health. Two super pilot areas covering approximately half the
population of Wales are due to commence in October. The new salaried dental care contract was introduced with effect from 4 February 2008 for all new appointments while existing staff following assimilation onto the new pay spine received backdated pay from 1 June 2007.

12.46 As in previous years the Assembly Government view is that the pay award for dentists in 2009/10 should be a simple recommendation for an increase in net pay and expenses which reflects the changes in the supply of dentists, the change in the type of work provided, particularly the move to simpler courses of treatment with a lower expenses element.

EMPLOYERS VIEWS

12.47 A questionnaire was sent to employees in Wales seeking their views on the key areas covered by the Review Body and the main findings were as follows:

- In response to the three most significant priorities in assessing pay levels for 2009/10, the majority of Trusts cited recruitment, retention and the financial position of the organisation.

- On the question of what are the three most likely consequences of a higher pay award than is affordable, Trusts quoted a reduction in service capacity, a failure to meet the targets set by government and a failure to meet the business objectives set by their Board.

- The majority of Trusts favoured the same percentage increase for all grades.

- The main difficulties in recruitment or retaining doctors was confined to the rural parts of Wales and the particular shortage of recruits in A&E and paediatrics. In order to resolve these, Trusts have made use of locums from other agencies, internal locum cover and introduced skill mix changes.

- The following non-pay measures have been utilised in relation to doctors and dentists:
  - career breaks, childcare support, flexible hours, flexible retirement arrangements and term time only working

- In terms of benefits experienced from consultant pay reform Trusts quoted:
  - improved working practices and service quality
  - reductions in waiting times for treatment
  - introduction of new working roles
  - improved team working
  - improved recruitment and retention.

- In respect of doctors in training, the main issue was not pay but the “fall out” from MMC last year and the shortage of doctors for certain posts on training schemes. It was recognised that the proposed relaxation of some of the rules around overseas recruitment should help the locum situation.
NHS WALES STAFF SURVEY

12.48 All 86,875 employees were invited to complete the NHS Wales 2007 Staff Opinion Survey. Overall 26,565 employees returned a questionnaire, which represents a response rate of 31%.

Key Strengths

- high level of intention to stay working for NHS Wales in 12 months time;
- respondents felt their job made good use of their skills and abilities;
- most respondents were clear about what they were expected to achieve in their job;
- respondents were very positive about the support they got from colleagues;
- 74% of consultants did feel their pay was reasonable and 77% were satisfied with the total benefits package. The figures for other medical staff were 53% and 64% respectively;
- performance reviews accurately reflected performance and helped respondents to focus on improving their performance.

Key Opportunities for Improvement

12.49 There was dissatisfaction amongst respondents with communication between management and respondents and staff were quite negative about how effectively change was managed. Other issues impacting on this were:

- involving respondents in decisions
- perception of how open and honest communication was from senior management
- perception of the extent to which senior managers were focused on meeting patients/clients needs

12.50 Perception of job security was quite low, possibly due to large levels of change, and this had quite a high impact on satisfaction and engagement levels amongst respondents. There appeared to be issues with how respondents felt they were treated, with low levels of satisfaction with:

- being treated with fairness and respect and general respect of individual differences
- level of bullying, harassment and discrimination and violent/aggressive incidents being experienced by respondents
- low levels of reporting bullying and harassment and discrimination and low satisfaction with the outcome.
**Next steps**

12.51 An all Wales Improvement Plan has been drafted to address the following priority issues and will determine what needs to be improved, how it is going to be improved, who is responsible for making it happen and how the success of the improvement will be measured:

- communication and senior management;
- treated fairly and consistently;
- work environment and facilities;
- work life balance and conditions

**FINANCE**

12.52 The funding for NHS pay awards is met from the Health and Social Services Main Expenditure Group (MEG) of the Assembly Government budget. There are currently 11 MEGs, each representing the main areas of devolved responsibility for the Assembly Government. As well as Health and Social Services, other MEGs include Social Justice and Local Government, Economy and Transport, Children, Education, Lifelong Learning and Skills and others.

12.53 The allocation of the Assembly Government budget to MEGs is determined by Welsh Ministers, and approved by the National Assembly for Wales. Welsh Ministers are not constrained by how funding is allocated between UK Government departments in allocating funding to MEGs.

**2008/09 to 2010/11 Health and Social Services MEG Allocation**

12.54 The table below demonstrates the changes in the Health and Social Services budget going forward to the remainder of the current Spending Review Period.

<table>
<thead>
<tr>
<th>Year</th>
<th>HSS DEL £m</th>
<th>Cash growth £m</th>
<th>Cash growth %</th>
<th>GDP deflator</th>
<th>Real Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05</td>
<td>4,469</td>
<td>403</td>
<td>9.9%</td>
<td>2.76</td>
<td>7.0</td>
</tr>
<tr>
<td>2005/06</td>
<td>4,671</td>
<td>202</td>
<td>4.5%</td>
<td>2.11</td>
<td>2.4</td>
</tr>
<tr>
<td>2006/07</td>
<td>4,888</td>
<td>217</td>
<td>4.6%</td>
<td>2.87</td>
<td>1.7</td>
</tr>
<tr>
<td>2007/08</td>
<td>5,141</td>
<td>253</td>
<td>5.2%</td>
<td>3.25</td>
<td>1.9</td>
</tr>
<tr>
<td>2008/09</td>
<td>5,353</td>
<td>212</td>
<td>4.1%</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>2009/10</td>
<td>5,527</td>
<td>174</td>
<td>3.3%</td>
<td>2.75</td>
<td>0.5</td>
</tr>
<tr>
<td>2010/11</td>
<td>5,723</td>
<td>196</td>
<td>3.5%</td>
<td>2.75</td>
<td>0.8</td>
</tr>
</tbody>
</table>

GDP deflators from 2008/09 onwards as at June 2008
Source of HSS DEL: 2007 Final Budget less transfers in for Youth Justice and CAFCASS

12.55 It can be seen that real growth funding over the next two financial years is significantly lower than any previous years. This will significantly constrain the affordability of pay awards over the Chancellors 2% planning target.
Pay increase funding

12.56 Within the annual cash increases outlined above, additional funding is included for pay cost increases as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Funding (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>£91m</td>
</tr>
<tr>
<td>2009/10</td>
<td>£80m</td>
</tr>
<tr>
<td>2010/11</td>
<td>£75m</td>
</tr>
</tbody>
</table>

This funding has to cover:

- cost of pay awards at current staffing levels;
- the additional cost of incremental drift following introduction of Agenda for Change; and
- the introduction of the unsocial hours element of Agenda for Change.

12.57 The reducing amount of the increases reflected a planning assumption when budgets were set that incremental drift on Agenda for Change would reduce over the period as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007 – 08</td>
<td>1.6%</td>
</tr>
<tr>
<td>2008 – 09</td>
<td>1.2%</td>
</tr>
<tr>
<td>2009 – 10</td>
<td>0.8%</td>
</tr>
<tr>
<td>2010 – 11</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Evidence now is that incremental drift will be at historic rates - 1.6%. This shortfall in funding will need to be met within the additional funding for pay cost increases.

12.58 Funding is already included in baselines for the current estimated costs of the SAS doctors contract. However, if costs exceed current estimates, then the difference in cost will also need to be met from the pay increase funding.

Other pressures against the Health and Social Services MEG

12.59 The Health and Social Services MEG is also facing a range of other pressures that will need to be funded within the cash settlement above:

- non-pay inflation – this is currently estimated to be at least 5% going forward to 2009-10. Some initial estimates by NHS trusts place this cost increase at nearly 10%.

- continuing care – Health services are experiencing a significant growth in individual packages of care. Estimates are that this is increasing at the rate of approximately £50 million per annum, which is equivalent to 1.5% of the Hospital and Community Health Services (HCHS) allocation.

- commitments from the One Wales Coalition Government programme, including:
  - minimum of one family nurse per secondary school;
  - extra funding for palliative care;
  - new priority for mental health;
- improved provision for long term conditions, such as stroke and diabetes;
- improved access to services, including well-being centres.

Summary

12.60 The 2007 CSR settlement has resulted in significant reduction in real growth funding available over the next two years. The real growth funding available to the Health and Social Services budget in 2009/10 and 2010/11 is particularly low, compared to England. At the same time, pay awards will have a similar impact in Wales to England. This places the Health and Social Services Budget in Wales under even greater pressure, and constrains the ability to afford pay awards above a 2% planning level.

CONCLUSION

12.61 In view of the continuing healthy position in recruitment and retention and the morale of the medical and dental workforce, the Assembly supports the rationale for a headline pay award of 2%.
CHAPTER 13: EVIDENCE FROM THE SCOTTISH GOVERNMENT HEALTH DIRECTORATES (SGHD)

SUMMARY

13.1 This chapter has been prepared by the Scottish Government Health Directorates (SGHD) to complement evidence from the Department of Health in England, the Welsh Assembly Government and the Northern Ireland Assembly. It sets out where circumstances, initiatives and policies within NHS Scotland (NHSS) are distinct from elsewhere in the UK and confirms SGHD’s endorsement of evidence given elsewhere that represents a UK position.

The evidence sets out:

- The Scottish Context
- Specific information about individual medical staffing groups
- Dental Services in Scotland
- Workforce and Pay Strategy
- Working Time Regulations
- Efficient Government
- Regional Pay
- NHS Finance in Scotland
- Conclusion and Pay Proposals for 2009-10

THE SCOTTISH CONTEXT

Background

13.2 In December 2007, the Scottish Government set out its strategy for health and wellbeing in Better Health Better Care. This set out the challenges arising from an ageing population, persistent health inequalities and a growth in long term conditions and described a range of actions to meet the Scottish Government’s strategic objective of helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.

13.3 Better Health Better Care described the concept of a more mutual NHS which sees the Scottish people and the staff who work for the health service as partners, or co-owners, of the NHS. Based on the values of cooperation and collaboration, the plan set out a range of actions to strengthen patient and public involvement in both the management of the service and the way in which individual packages of care are designed and delivered. These include action to strengthen and embed patient experience information in the performance management of the NHS, introduce elections to NHS Boards, provide greater support for self management and encouragement for networking across professional groups within the service.

13.4 Better Health Better Care placed significant emphasis on partnership working, particularly with local authorities across Scotland, around a shared agenda to
improve health and tackle health inequalities. It describes the NHS as an enabling service, supporting people to make and sustain healthy lifestyle choices on issues such as smoking, alcohol consumption, diet and physical exercise.

13.5 In 2008, the Scottish Government published Equally Well, the report of the Ministerial Taskforce on Tackling Health Inequalities. This prioritised action on the earliest years of a child’s life, the high economic, social and health burden imposed by mental illness, the "big killer" diseases of cardiovascular disease and cancer and drug and alcohol problems and their links to violence. It set out a number of key principles for future action, including:

- improving the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health.
- addressing the inter-generational factors that risk perpetuating Scotland's health inequalities from parent to child, particularly by supporting the best possible start in life for all children in Scotland.
- engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health.
- delivering health and other public services that are universal, but also targeted and tailored to meet the needs of those most at risk of poor health. We need to prevent problems arising in the future, as well as addressing them if they do.

13.6 Better Health Better Care set out a comprehensive approach to quality improvement for the NHS in Scotland based on the six dimensions of patient centeredness, patient safety, effectiveness, efficiency, equity and timeliness. In so doing, it committed to a range of key actions including:

- the introduction of a patient experience programme, Better Together
- the development of a new self management strategy for Scotland
- further support for the Patient Safety Alliance and investment in tackling Healthcare Acquired Infection
- a national efficiency and productivity programme
- a new eHealth strategy
- the implementation of a new, sustainable model of remote and rural healthcare
- the introduction of an 18 weeks whole journey standard by December 2001.

Last Year’s DDRB Recommendation

13.7 On 7 April 2009, following the publication of the DDRB’s Thirty-Seventh Report, the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon announced that the Scottish Government had accepted the DDRB’s recommendations on pay levels for 2008-09 for doctors and dentists and would implement these pay awards to all doctors and dentists in full and without staging from 1 April 2008.
Whilst SGHD accepted the pay recommendations, Scottish Ministers again rejected the DDRB recommendation on additional funding for distinction awards in Scotland to cover the newly eligible senior academic GPs. As previously stated in our evidence, SGHD does not consider it appropriate to increase the funding on the grounds that the level of dilution of the awards to the pre-existing consultant body is not considered sufficient to justify any extra resources and also in view of the current on-going review of the distinction awards scheme.

SPECIFIC INFORMATION ABOUT MEDICAL STAFFING GROUPS

Hospital Consultants

The proportion of consultants on the new contract in NHS Scotland as at September 2007 is 98.1% compared to 98.5% in 2006. The anomaly in the figures between 2006 and 2007 is due to consultant recruitment mainly in NHS Greater Glasgow and Clyde whose job plans had not been signed off when the figures were collated. It is expected that this will be corrected when the figures are received for 2008 for this NHS Board. The average number of programmed activities agreed in NHS Scotland as at September 2008 has risen very slightly to 11.6 from the previous level of 11.5.

Work continues on embedding the annual consultant job planning process into the service planning process and in realising the benefits to be gained from this contract. SGHD continues to collect examples from NHS Boards on how the contract is supporting service redesign and performance targets. Indeed NHS Boards are describing, through their benefits realisation plans, how the contract is supporting enhanced flexibility in working practices, alignment of activity to the delivery of national waiting time commitments and robust discussion to determine work priorities facilitated by the job planning process.

In line with guidance issued, the 2007 iteration of plans showed that Boards were keen to develop their planning and wherever possible to incorporate this work into their wider existing planning mechanisms. Whilst it was encouraging to see that NHS boards were keen to integrate planning, there is more to be done, in discussion with the service, to further streamline and integrate pay modernisation requirements with other planning requirements. SGHD are therefore currently reviewing the future pay modernisation planning arrangements, with specific reference to service redesign plans, the local delivery planning process and workforce plans, to explore options for achieving a more integrated approach. Therefore 2008-09 has been identified as a transitional period in which to develop further the pay modernisation benefits realisation planning process and to continue to support boards in identifying benefits facilitated by the levers provided through pay modernisation.

Review of Distinction Awards and Discretionary Points

The Review Group has continued to meet and although this work has taken longer than anticipated a new framework for Distinction Awards and
Discretionary Points has been developed. Financial modelling work around the new framework is now being carried out and it is expected that this will be completed in the near future. The Group will meet again later in the year to consider those results and agree any revisions to the framework before submission to the Cabinet Secretary for her approval.

**Staff and Associate Specialist (SAS) Doctors**

13.13 Following the ratification of the UK agreement on the new contract for Staff and Associate Specialist (SAS) Doctors in early 2008, SGHD was approached by the BMA in Scotland and asked to discuss a Scottish specific implementation of the contract. Discussions subsequently took place with officials from the Scottish Government Health Directorates, NHS Scotland Employers and the BMA and an agreement was reached on 14 February 2008 on the implementation of a new contract for non-consultant career grades in Scotland. The BMA subsequently balloted their members on this agreement and 79% of doctors voted in favour of the contract as offered by Scottish Ministers.

13.14 The main points of the Scottish agreement are:

- the new contract will follow the agreed UK terms and conditions but with better assimilation arrangements for Scottish non-consultant career grade doctor;

- specifically, eligible doctors in Scotland who transfer to the new contract on 1 April 2008 will be moved on to the pay point that they would have been on had the contract been implemented from April 2007;

- back pay will not apply to the period from 1 April 2007 – 31 March 2008;

- the new contract will be implemented on an optional, not mandatory basis.

13.15 The cost of the new contract across NHS Scotland is estimated at £10.2m for 2008-09 based on 100% take up.

13.16 The Specialty Doctor and Associate Specialist Contract Scottish Implementation Group (SDASCSIG) comprising a partnership of SGHD, NHS Employers in Scotland and BMA Scotland representatives, has been set up to agree and make appropriate decisions to ensure the smooth implementation of the new contracts for the Specialty Doctor and Associate Specialist grades and to deal with issues as they arise during the implementation process.

**Doctors in Training**

13.17 Following two periods when New Deal monitoring was not reported/ suspended during the initial implementation of MMC Specialty Training, New Deal compliance was monitored for the period from August 2007 to January 2008. Figures published by Information Statistics Division (ISD) show that 98.4% of junior doctors were fully compliant with the New Deal. All
Foundation Year 1 doctors are compliant and, of the 81 doctors who remain non-compliant, 10 are Foundation Year 2 and the rest are Specialty Training grades. These posts are mostly in smaller specialties or remote and rural areas where reaching compliance is difficult and where the smallest reduction in staffing numbers can have a great impact on compliance levels.

13.18 Arrangements to support New Deal implementation continue as agreed last year. These arrangements will be reviewed next year so that a decision can be taken as to whether this work can be merged into health boards from August 2009.

**Average Pay Supplement by Grade and Rota**

13.19 Service modernisation continues across NHS Scotland which has resulted in further reductions in the average banding supplements paid to junior doctors. The table below shows that this has now reduced to 55.9% in Scotland.

### Average Pay Supplement by Grade and Rota

<table>
<thead>
<tr>
<th></th>
<th>All Grades</th>
<th>Specialty Training / Registrar</th>
<th>Foundation Year 2</th>
<th>Foundation Year 1</th>
<th>Fixed Term Specialty Training</th>
<th>General Practice Specialty Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2007 - January 2008</td>
<td>55.9%</td>
<td>56.0%</td>
<td>52.8%</td>
<td>57.6%</td>
<td>60.2%</td>
<td>54.5%</td>
</tr>
<tr>
<td>August 2005 - January 2006</td>
<td>63.0%</td>
<td>60.4%</td>
<td>63.2%</td>
<td>65.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2005 - July 2005</td>
<td>66.2%</td>
<td>64.0%</td>
<td>65.7%</td>
<td>70.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2004 - January 2005</td>
<td>68.8%</td>
<td>67.4%</td>
<td>68.6%</td>
<td>72.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2004 - July 2004</td>
<td>75.8%</td>
<td>73.2%</td>
<td>76.0%</td>
<td>79.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2003 - January 2004</td>
<td>76.3%</td>
<td>72.9%</td>
<td>77.3%</td>
<td>78.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2003 - July 2003</td>
<td>81.7%</td>
<td>76.1%</td>
<td>84.6%</td>
<td>81.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.20 This reduction in banding shows that the contract is having its intended effect in terms of reducing doctors working hours and so improving their work/life balance. It is acknowledged that this has consequences for their overall pay and in light of that we note that the Department of Health has commissioned NHS Employers to conduct work, including consultation with stakeholders, to scope options for reforming the junior doctors’ contract. SGHD will both participate in this process at UK level and conduct Scottish specific scoping work with stakeholders in relation to this contract.

13.21 While accepting that it is in the interests of all parties that there be future discussion in relation to the juniors doctors pay and contractual arrangements, our position remains that salary levels remain sufficiently high to continue to attract good quality applicants to medical schools in Scotland and to be competitive with those of other professions. The great advantage of ready access to NHS training posts also remains a significant benefit for junior doctors.
Travel and Relocation for Specialty Trainees

13.22 Since April 2008 SGHD have been facilitating discussions between the Scottish Junior Doctors Committee and NHSScotland employers on arrangements for recompensing trainees who move between different locations in the course of their training programme. These discussions have now concluded successfully, with agreement reached on interim arrangements pending the outcome of an overall review of the future shape of the medical workforce in Scotland.

GP Specialty Registrars

13.23 All 290 ST1 posts providing an additional six months work in a GP practice have been filled. In addition, we created a further 54 four year GP training programmes that have been popular and have been filled. In addition to filling these extra posts, Scotland also passed around 40 candidates deemed suitable into the UK clearing system for GP appointments. Considering the vacancy levels elsewhere, this emphasises again the current attractiveness of a career in general practice. In line with the position in relation to junior doctors working in hospitals a 50% supplement is paid at present to trainees in the course of their placements in General Practice. We feel that some of the justification for this payment, in particular that which relates to recruitment and retention has less force than was previously the case and would recommend that the level of GP supplement be reduced to 45% for next year.

13.24 We have been working with the BMA and NHS Education for Scotland (NES) on the model contract which is offered to GP practices for use with their GP Specialty Registrars. The agreed version has now been placed on the BMA website and is available for those trainees who started in practice in August. However, in the longer term, we think consideration should be given to who should hold the contract for these staff as the GP trainers are not happy with being their putative employer while NES pay the salaries and allowances direct to the trainees. This is another issue we will re-visit during the next year.

Free Accommodation for Doctors in Training

13.25 In 2006, amendments to the Medical Act removed the requirement for doctors in training to be contractually resident during their first year of hospital training. This was enacted in August 2007.

13.26 The Scottish Government view, in conjunction with the other UK Health Departments, was that the removal of the resident requirement was an improvement in doctors’ conditions of service in the sense that it reflected the improvements in their working hours and conditions. NHS Scotland Employers view was that where accommodation was necessary to meet a statutory or contractual requirement, it was provided at no charge, but where it was not necessary, it was not provided. This is in line with the provisions for all other NHS staff groups.
Following the decision taken in Wales that Junior Doctors’ should continue to receive free hospital accommodation, pending an overall study of accommodation issues for all NHS staff in that country, Scottish Ministers asked officials to review the current position in Scotland. This review has revealed that the circumstances in Scotland in relation to accommodation issues do not support the assertion that Health Boards should be required to continue provision of free accommodation. Scottish Ministers have therefore decided that no further action needs to be taken on this issue at this time. It is however worth noting that, as in other UK countries it is open to individual Health Boards to make decisions in relation to the provision of free accommodation in the best interests of the service.

EDUCATION AND TRAINING
Postgraduate Medical Training – Modernising Medical Careers

Selection and recruitment in Scotland has gone well during 2008, with negligible controversy compared to 2007 when we were more enmeshed with UK wide governance and process. Around 7,000 applications were received as part of the 2008 national recruitment round for approximately 1,300 posts at various Speciality Training and GP Training levels. Because candidates were able to make multiple applications, the national applicant pool was around 6,000 junior doctors, with the overall ratio of applications to vacancies in line with both expectations and with the rest of the UK.

As with last year, we have maintained a flexible and pragmatic approach to the recruitment of our junior doctors and have worked in partnership with all key Scottish stakeholders to ensure the selection and recruitment processes remained fit for purpose. The recruitment process itself involved three waves of offers being made to allow candidates who did not secure their first preference in the first wave continued opportunities to secure posts. Implementation of this approach would not have been possible without the full support of NHS Education for Scotland (NES) and NHSScotland; and we would wish to once again formally acknowledge the substantial support given by the Service in ensuring successful implementation of the recruitment process in 2008.

There remain current issues in Scotland with unfilled fixed term posts and we are looking at options for how these are dealt with differently in future years to ensure they remain attractive career options to doctors wanting to train in Scotland.

The Scottish Government is grateful to Professor Sir John Tooke for his report “Aspiring to Excellence;” and we fully support the points made about the need for clear governance structures and evidence based policy development. Through consultation with our stakeholders there remains broad agreement that our Modernising Medical Careers governance arrangements are robust and inclusive; and we are committed to improving these as we continue to develop the MMC model in Scotland.
13.32 We are aware there remains much to be done to arrive at a consensus about how medical training can be reshaped to deliver a medical workforce that is trained primarily to deliver excellent patient care but which can also deliver requirements in research, leadership, teaching and more. Some of the work we are doing in Scotland will be useful in this context and we will continue to feed into the various wider UK discussions on this over the coming months.

13.33 Finally, agreement has been reached within NHSScotland that solutions are needed to deal with managing the bulge of trained doctors; controlling training numbers at a more realistic level; and to develop the concept of the trained doctor further. We remain confident that a future solution that incorporates greater flexibility in the early stages of training leading to increased specialisation as careers progress is both desirable and achievable; and is an outcome that can be realised through further development of the MMC training model.

DENTAL SERVICES IN SCOTLAND

Dental Services

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

13.34 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 for Improving Oral health and Modernising NHS Dental Services in Scotland 2005. The measures outlined in the Action Plan are designed to address Scotland’s poor oral health record, provide better access to NHS dental services for patients and provide an attractive package for professional staff that 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

13.35 The three years of the Action Plans are now complete and most targets have been met although work continues to develop NHS dental services in Scotland. The Scottish Government committed to investing an additional sum of £150 million over the three years in order to achieve the goals. This amounted to £45 million in 2005/06, £100 million in 2006/07 and £150 million in 2007/08. Cumulatively, this amounted to £295 million over the three years. Of this, £237 million went to primary care dental services. A breakdown of the funding for NHS dentistry for 2007/08 is provided below:

FUNDING – 2007/08

Forecast spend of £321.254 m on general dental services
£6.63m Rent reimbursement payment
£2.5m Practice Improvement Funding
£2.78m Emergency Dental Services
£14m Oral Health
£13.7m Education & Training
£1.3m Scottish Dental Access Initiative
£0.54m Vocation training golden hellos
£22.8m General Dental Practice Allowance
£0.66m Remote Areas Allowance
£2.9m Deprived Areas Allowance

Fees

13.36 The Scottish Government would welcome DDRB reporting on an uplift to fees as in previous years.

Total Number of NHS Dentists in Scotland

13.37 The table at Annex H shows the headcount of dentists in Scotland by service sector as at 30 September for the years 1997 to 2007. This information can also be viewed on the NHS NSS ISD website. http://www.isdscotland.org/isd/Dental-workforce.jsp?pContentID=4670&p_applic=CCC&p_service=Content.show&

13.38 The total number of dentists registered to provide NHS general dental services has consistently risen and rose again at 31 March 2008 to 2,576.

13.39 It should be noted that the Scottish Executive’s target for an annual increase of at least 50 dentists was met in 2005, and this trend has continued as a result of the increased incentives that are contained in the Action Plan. The target to increase the number of dentists by at least 200 over the March 2004 number has already been met although work continues to further expand the dental workforce.

Allowances for Independent General Practitioners

Vocational Trainee (VT) Golden Hellos

13.40 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 £3,000, which is available to all VTs with an additional payment of £3,000 to VTs who take up a post in a designated area.¹

13.41 There have been 135 claims from VTs in 2007/08, of which 31 claims were from designated areas and 104 from non-designated areas. This is a slight decrease from 139 last year. The total VT allowance paid was £549,170, a decrease from last year’s figure of £596,797.

¹ designated areas are classified as Arran within Ayrshire and Arran, Bordes, Dumfries and Galloway, Fife, Grampian, Highland, Orkney, Shetland and the Western Isles NHS Boards.
SUMMARY 2006/07

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF VDP'S</th>
<th>TOTAL OF VDP'S PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>9</td>
<td>£57,387.42</td>
</tr>
<tr>
<td>East</td>
<td>25</td>
<td>£97,745.50</td>
</tr>
<tr>
<td>North</td>
<td>9</td>
<td>£60,771.42</td>
</tr>
<tr>
<td>South East</td>
<td>34</td>
<td>£141,596.92</td>
</tr>
<tr>
<td>West</td>
<td>62</td>
<td>£239,295.56</td>
</tr>
<tr>
<td>TOTAL</td>
<td>139</td>
<td>£596,796.82</td>
</tr>
</tbody>
</table>

SUMMARY 2007/08

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF VDP'S</th>
<th>TOTAL OF VDP'S PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>4</td>
<td>£27,000.24</td>
</tr>
<tr>
<td>East</td>
<td>23</td>
<td>£87,571.38</td>
</tr>
<tr>
<td>North</td>
<td>8</td>
<td>£54,000.48</td>
</tr>
<tr>
<td>South East</td>
<td>35</td>
<td>£141,500.10</td>
</tr>
<tr>
<td>West</td>
<td>65</td>
<td>£239,097.90</td>
</tr>
<tr>
<td>TOTAL</td>
<td>135</td>
<td>£549,170.10</td>
</tr>
</tbody>
</table>

13.42 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. In 2007 this increased again to 97.6% registering an interest for VT in Scotland and 93.5% actively pursued this interest. In 2008 again 97% of Scottish graduates registered an interest in VT in Scotland, with 96% of graduates pursuing a place. 83% of the 2008 graduates secured a place, and 8% of graduates obtained a Year 1 HDS/SDS post.

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

<table>
<thead>
<tr>
<th>Expected Graduation Date</th>
<th>Total Number Expected Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2008</td>
<td>135</td>
</tr>
<tr>
<td>July 2009</td>
<td>150</td>
</tr>
<tr>
<td>July 2010</td>
<td>174</td>
</tr>
<tr>
<td>July 2011</td>
<td>156</td>
</tr>
<tr>
<td>July 2012</td>
<td>174*</td>
</tr>
</tbody>
</table>

Note: There will be additional graduations for July 2012 as the Scottish Government have committed to opening a third Scottish dental school, located in Aberdeen. The first student intake will be October 2008.

13.44 Student 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 past decade.

13.45 The number of dental VT places in Scotland continues to increase. The total cohort size and breakdown into country of qualification between 2000 and 2008 is shown in the table below:
The number of VT numbers issued has greatly increased in the last year, demonstrating the positive effects of the recent initiatives on recruitment. The figures are provided in the table below:

<table>
<thead>
<tr>
<th>VT Cohort Year</th>
<th>Number in Cohort</th>
<th>Scotland</th>
<th>Other UK</th>
<th>Abroad</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>100</td>
<td>77</td>
<td>11</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>2001</td>
<td>94</td>
<td>78</td>
<td>14</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>2002</td>
<td>101</td>
<td>89</td>
<td>7</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>2003</td>
<td>101</td>
<td>90</td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2004</td>
<td>113</td>
<td>88</td>
<td>15</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>2005</td>
<td>126</td>
<td>95</td>
<td>15</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>2006</td>
<td>138</td>
<td>111</td>
<td>22</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>2007</td>
<td>153</td>
<td>115</td>
<td>28</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>2008</td>
<td>154</td>
<td>117</td>
<td>22</td>
<td>15</td>
<td>-</td>
</tr>
</tbody>
</table>

General Dental Practice Allowance

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

13.48 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.

13.49 The total practice allowance paid in 2007/08 was £22,832,491 rising from £4,068,375 in 2004/05, £15,422,380 in 2005/06 and £21,643,706 in 2006/07. It should be noted that the amount payable per practice was increased in 2005/06 to 6% of accumulative gross practice earnings. Those practices who meet the 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 2007/08, 70.5% of dental practices qualified for the additional 6% of this allowance.

Remote Area Allowance

13.50 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 of claims from salaried
dentists. Allowances to salaried dentists are paid locally 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.

13.51 £662,400 was paid in 2007/08 a further increase in the total amount of allowance paid from £323,700 in 2004/05, £448,500 in 2005/06 and £595,200 in 2006/07. However, it should be noted that this allowance has been increased from a maximum of £6,000 in 2004/05 to a maximum of £9,000 in 2005/06.

13.52 The total number of claims has risen to 87 in 2007/08 from 84 in 2006/07. This figure does not take into account the number and as such the information on uptake is not held centrally.

Sedation Allowance

13.53 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.

13.54 The total allowance paid in 2004/05 was £77,000 which decreased to £63,000 in 2005/06. This was the second consecutive year that the total sedation allowance paid had decreased. To address the decrease in claimants a review of the terms of the allowance was 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 in 2006/07 the amount that was paid increased to £101,000 with a further increase to £127,000 in 2007/08.

Rent Reimbursement

13.55 In 2007/08 £6,636,639 notional rent reimbursement was paid to dental practices in Scotland who met the NHS commitment criteria.

Recruitment and Retention Allowance

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

13.56 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. Payment of £10,000 is paid over a two year period. There is an additional £10,000 available over a two year period if the dentist is
in a designated area. Recipients must provide NHS general dental services at a rate of 80% of total earnings for three years in exchange for the allowance.

13.57 A total of 91 new claims were received in 2007/08, as compared to 99 in 2006/07. The total amount paid was £970,000. Allowances to salaried dentists are paid locally and as such the information on uptake is not held centrally, although it should be noted that there has been a substantial increase in the numbers of salaried dentists in the period from 2005 to 2007.

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

13.58 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 in Scotland after a minimum 5-year break. 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 general dental services at a rate of 80% of total earnings for three years in exchange for the allowance.

13.59 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 had fallen to 10, and the total amount paid was £27,500. In 2006/07 the number of claims increased to 58 and £195,000 was paid. In 2007/08 the number of claims increased to 71 and £217,000 was paid. However, this figure does not take into account the number of claims from salaried dentists. Allowances to salaried dentists are paid locally and as such the information on uptake is not held centrally.

Scottish Dental Access Initiatives (SDAI)

13.60 The Scottish Government has paid over £1.28 million to NHS Boards under the Scottish Dental Access Initiative Scheme in respect of 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. Until 1 April 2007 up to £100,000 was paid by the Scottish Government to assist in setting up new dental practices and up to £50,000 to expand existing practices. From 1 April 2007 this scheme has been devolved to NHS Boards and the funding has been increased to a grant of, for example, £100,000 towards the set up costs of a new or purchase of an existing NHS practice with £25,000 per additional surgery over and above the first and up to £50,000 towards the cost of extending an existing NHS practice for each of the first two surgeries and £25,000 per additional surgery over and above the first 2. Funding under this scheme is also available for the relocation of NHS practices.

13.61 In the past year, over £7,135 has also been paid under the SDAI return to work scheme to dentists returning to work after a break of 5 years or more.

Deprived Areas Allowance

13.62 On 1 April 2006 a Deprived Areas Allowance of £9,000 was introduced. As an interim arrangement this allowance could be claimed by those dentists who
serve disadvantaged urban areas, ie whose practices were situated in such areas, and for 2006/07 £4.1 million was paid to those dentists who provided general dental services in a SIMD (Scottish Index of Multiple Deprivation) area 5, or DEPCAT 7 i.e. the most deprived areas. The method of paying this allowance was changed from 1 April 2007. This payment is now made to the dentist as an enhancement to the item of service fee and continuing care and capitation fee for those patients who reside in a SIMD 5 area. In 2007/08 £2,900,000 was paid to dentists in respect of patients who reside in a SIMD 5 area.

Management and Funding of Dental Clinical and Special Wastes

13.63 With effect from 1 April 2006 arrangements are now in place for the management of waste under the NHS Boards Clinical Waste Consortia. For 2006/07 just under £1m was transferred to NHS Boards to meet the costs for clinical and special uplift for dentists who fulfil the requirements for NHS committed practices this rose to £1.038 million in 2007/08.

Review of Salaried Services

13.64 DDRB has requested evidence on the outcomes of negotiations for the review of salaried services. Annex I outlines the operation of the current salaried services. A review of the salaried services was undertaken by the Scottish Executive. A copy of the report containing the review can be viewed at: http://www.scotland.gov.uk/Publications/2007/01/10103940/19.

13.65 A Project Implementation Board was established to consider how the recommendations contained in the Review of Primary Care Salaried Dental Services in Scotland could be taken forward as quickly as possible. The Board produced a report and recommendations in December 2007. Work is ongoing on implementing the recommendations contain in that report with a view to the combination of the CDS and salaried GDS into a new Scottish public dental service beginning in April 2009.

Dentists from Overseas

13.66 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.

13.67 Forty dentists from Poland have been recruited to work within the NHS in Scotland. This is one way of increasing the salaried service. They are working 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.
One of the actions from the last DDRB report was around the relationship between the fee and the underlying ‘cost’ of treatment, which DDRB said was unclear, and it was therefore very hard to know how appropriate the fee/cost relationship implied by the fee is. Annex J explains the system that was in place until 1 April 2004 when DDRB stopped recommending changes to the target average net income (TANI) for dentists and began recommending a percentage increase in the fee scale.

WORKFORCE AND PAY STRATEGY

The Scottish Government Health Directorates’ 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. SGHD continues to work 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 workforce planning to ensure that the right workforce is in the right place delivering the right care

National Workforce Planning

At 30 September 2007 there were 162,139 staff in NHSScotland. The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland increased by 7.5% (WTE). This represents changes across the medical and dental grades as follows:

- consultant headcount numbers increased by 197 (4.8%) between September 2006 to September 2007 with a corresponding 186.8 (4.8%) rise in WTE;
- staff and associate specialist grade numbers increased by 88.5 (13.6%) (WTE) between September 2006 and September 2007;
- SHO (figures include FY2) numbers decreased by 62.3% (WTE);
- House Officer/FY1 numbers decreased by 2.0% (WTE);
• GP numbers (excluding Registrars) increased by 95 (2%) (headcount);
• GP Registrar numbers increased by 6 (1.9%) (headcount).

13.71 More detailed workforce data are presented in Annex H. GP numbers are not available by WTE. Specialist Registrar numbers are not available. From September 2007 run-through speciality training posts were introduced and presented under the grouping “Speciality training” which also includes grades previously included under the Registrar group. From September 2007 the majority of posts under the foundation programme moved to speciality training posts. For these reasons, figures are not directly comparable to previous years.

**Workforce Planning in Scotland**

13.72 The National Workforce Planning Framework sets out the workforce planning cycle for NHSScotland. NHS Boards work to an annual planning cycle, publishing new plans in April of each year. Regional Workforce Plans are published each September. NHS Board and Regional plans inform the National Workforce Strategy published each December.

13.73 In developing their plans NHS Boards project their workforce demand for the short, medium and long term taking account of drivers for change. Some examples of these drivers include: service redesign, demography and role enhancements.

13.74 The Scottish Government have and will continue to use NHS Board and Regional assessments of future staffing requirements to inform decisions about the number of medical and dental training places in Scotland annually in August. The numbers are published in the National Workforce Strategy “Planning Tomorrows Workforce Today” and the 2007 document is available at http://www.scotland.gov.uk/Publications/2007/12/13102832/0


13.76 An evaluation of the effectiveness of the National Workforce Strategy documents has been completed and the results are currently being analysed. The outcomes from the evaluation will be used to inform this year’s publication in December.

**Medical Workforce Supply**

13.77 Scottish Ministers are responsible for determining target supply training numbers for controlled NHS staff groups (including doctors and nurses). The overarching principle is to ensure sufficient output in order to supply NHSScotland’s future demand thereby supporting the delivery of services, in a way that is both affordable and sustainable.
Future demand for consultants is estimated by the NHS Boards in their workforce plans and takes into account factors such as changing models of care and patient demography. A national supply model projects consultant stock into the future taking account of retirements and trainees expected to obtain their Certificate of Completion of Training (CCT) and enter the consultant workforce. Supply and demand are compared and current training numbers can be increased or decreased depending on whether the model is showing future under or oversupply. Findings from the model act as a starting point from which discussions with Specialty Training Boards and NHSS service representatives can take place to decide final training numbers.

For most specialties in Scotland, the national model is forecasting there will be an oversupply of consultants in the future. One of the main objectives of Modernising Medical Careers (MMC) is to move service delivery from the trainees to the trained doctor. With NHS Board planning not currently advanced enough to take account of this factor, it is expected that more consultants will be needed in the future than the estimated demand indicates. The future workforce is considered to be made up of a combination of increased medical establishment and new and enhanced roles to maximise efficient use of available medical expertise and skill.

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

**Specialty Training for 2008-09**

Due to still being in an MMC transitional period and taking account that NHS Board demand projections may not yet reflect services delivered by trained doctors, we planned not to reduce places in any specialties (ST) places rose by 226. The increases in ST places coincided with a parallel reduction in FTSTA numbers for most specialties.

**Vacancies** in 2008. Where an undersupply was highlighted we adopted a phased approach to matching demand, starting with modest increases in 2008. This is intended to smooth out the supply of CCT gainers from year to year, settling at an optimum level. The views of NHSS service representatives and Specialty Training Boards were an important input to this process.

For the majority of specialties, potential future undersupply was catered for through the conversion of FTSTA (Fixed Term Specialty Training) posts, which also enabled the reduction of these posts in the system.
Overall, run-through Specialty Training

13.83 The WTE medical and dental consultant vacancy rate increased from 272.3 as at 30 September 2006 to 282.0 as at 30 September 2007. The 6 month vacancy rate decreased from 165.0 to 163.2 over the same period. Currently, no information is available on Associate Specialist, Staff Grade or GP vacancies.

Medical Review

13.84 The Scottish Government are taking forward a review to establish consensus within the Scottish medical profession and NHSScotland on what a “trained doctor” delivered service means by addressing the recommendation made by Professor Sir John Tooke in his report “Aspiring to Excellence” about developing the understanding of the roles of the doctor in the contemporary healthcare team.

13.85 Two national events have been held aimed at the planning the reshaping of the medical workforce. These events were aimed at the wider audience in NHSScotland in recognition that changes in the medical workforce will impact on the wider healthcare system. Agreement has also been reached within NHSS that we have to find solutions to deal with: managing the future projected bulge of trained doctors; controlling training numbers at a more realistic level; and to develop the concept of the trained doctor further.

13.86 Further work is being undertaken with NHS Boards and Regional Workforce Directors to further develop workforce planning capacity and to develop a framework for improving medical workforce projections.

Stepping up recruitment and improving NHSScotland’s reputation so that we can attract the best workforce in an increasingly competitive world

NHS Scotland Careers Campaign

13.87 The NHS Scotland National Campaign was launched in 2006. Two periods of media activity, including a national TV advert, ran from March 2006 – May 2006 and January 2007 – March 2007. The campaign has a dedicated careers website and 0845 helpline number.

13.88 Figures collated from March 2006 – April 2007 show that there have been over 140,000 visits to the campaign website. The campaign website dedicated 0845 number has received over 7800 calls between March 2006 and March 2007. These enquiries included requests for general NHS Scotland careers info and our careers brochure and also more specific career / training advice e.g. return to nursing. Since the end of media activity in April 2007 there have been approx 100 calls a month to the careers helpline number.

13.89 The campaign was not a recruitment drive and therefore impact was not measured at Board level in terms of vacancies filled. The aim of the 2006 campaign was to raise awareness of career opportunities within NHS Scotland
and encourage the public to consider a career within the organisation. This focus was shifted slightly to give more weight to the NHS being a place where all roles play a part in the overall success of the NHS.

13.90 Overall the campaign was successful in meeting its core aim of delivering key campaign messages to the target audience.

13.91 Positive increases were seen in the following attitudes included:

- I feel proud of NHS Scotland;
- NHS Scotland is modern and forward-looking in its approach to patient care;
- NHS Scotland has opportunities for people with lots of different backgrounds;
- I would encourage someone I know to work for NHS Scotland.

13.92 There are no immediate plans to undertake another national campaign and discussions are currently taking place between Scottish Government and NHS Scotland on how best to handle careers promotion.

Vacancies

13.93 Latest available consultant vacancy figures confirm that as at 30 September 2007 there were 282.0 WTE medical and consultant vacancies, a small increase from the previous year’s figure of 271 as at 30 September 2006.

13.94 SGHD is continuing to work with Health Boards in Scotland to reduce the number of vacancies and thereby increase the number of consultants in post. Measures to reduce consultant vacancies include:

- An Advance Appointment Scheme established in July 2006 to improve retention of CCT holders by facilitating their transition to consultant grade. It provides funding for induction into their first consultant post, enabling them to work in tandem for a short period with the outgoing consultant, who is about to retire or to leave their post. In 2007/08 funding was awarded to three NHS Boards to provide an induction for 6 newly appointed consultants over periods ranging from 4-6 months, providing funding totalling £198,370.

- Working with Boards to improve the procedures around the advertising of consultant vacancies, making it easier and less costly for Boards. This includes amending the General Guidance on Medical and Dental Appointments, which now advises NHS Boards that the Scotlands’s Health on the Web (SHoW) vacancy database is now counted as one of the two UK publications where NHS Boards in Scotland can advertise vacancies. This potentially offers a significant cost saving to NHS Boards when advertising consultant posts as use of this site is free and available to all Boards in NHSScotland.

13.95 As part of the review of Appointment Advisory Committees, we undertook a review of the recruitment process for consultants. SGHD commissioned
independent research into best practice in senior medical recruitment, and held a public consultation on the resulting options. Following this, a short life working group has been convened to develop the consultant recruitment process. The revised process will incorporate best practice identified in the review.

13.96 In addition, in 2007/08 SGHD provided £600k funding through the Remote and Rural Pathways group to fund projects which supported the recruitment and development of staff to remote and rural areas. The funding went to two projects in NHS Highland and a project in NHS Orkney.

Staff Retention

13.97 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 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. NHS Scotland has 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.

13.98 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 staff are treated 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 to manage, but this has to be done fairly and consistently.

13.99 SGHD has made clear to NHS Boards that they should fulfil their statutory obligation to 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.

Implementing better practice so that NHSScotland can retain a workforce that is keen and proud to work for the organisation

Partnership working

13.100 The open and transparent way NHSScotland works with staff 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. This is carried out through a range of means, including national partnership bodies that consider strategic service and workforce issues; and through local partnership structures and an Employee Director (chair of the local trade unions and professional organisations) sitting on each
organisational Board as a non-executive director. The Staff Governance Standard, which is enshrined in legislation, has also been reviewed to take account of changed national partnership structures, although the basic principles remain the same. This is essentially a system of corporate accountability for the fair and effective management of staff, and under this Standard, 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.

13.101 The Staff Governance Standard is about how NHSScotland staff are managed, and how they feel they are managed. It is underpinned by the 12 policy guidelines which aim to provide consistency of treatment for staff across Scotland. These documents cover topics such as Managing Health at Work to Dignity at Work. 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

13.102 The most recent staff survey (a census rather than a sample survey) took place in 2006 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.

13.103 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.

13.104 The Scottish Workforce and Staff Governance Committee (SWAG), which is a partnership committee comprising trades unions, professions, NHS Employers and SGHD, have considered the outcomes from the staff survey, and work is ongoing to address the issues at both local and national level.
**Occupational Health and Safety Services (OHSS) and Healthy Working Lives**

**Healthy Working Lives**

13.105 Healthy Working Lives is concerned with anything that can impact on the health, wellbeing and safety of NHSScotland staff. It is about creating a climate in which staff are nurtured and can flourish, where they feel safe and protected and where staff are keen to do well, proud to work for the NHS and are prepared to go the extra mile to achieve personal and corporate goals.

**OHSxtra**

13.106 OHSxtra is a fast track rehabilitation scheme for NHSScotland staff. Following two successful pilot schemes in 2005 the Scottish Government has invested £2 million of funding to establish the OHSxtra model in 16 NHS Boards across Scotland. The first eight Boards to receive funding have been operational for around one year and the Scottish Government will soon be carrying out an evaluation exercise in these Boards to establish whether the success of the pilot schemes has been replicated.

13.107 The OHSxtra model is a fast track case managed approach to Physiotherapy, Occupational Therapy and Mental Health services including counselling and CBT. The analysis of the pilot schemes revealed that the model is particularly successful at preventing absence and returns at least £1.69 cost avoidance for every £1 invested.

**OHSS Review and OHSS Policy Advisory Group**

13.108 The OHSS Review Implementation Group (OHSSRIG) was set up in 2007 on behalf of the Management Steering Group (MSG) to take forward the recommendations from the 2005 Occupational Health and Safety Services Review. OHSSRIG is a short life group and is expected to submit its final report to the MSG in autumn 2008.

13.109 The OHSS Policy Advisory Group (OHSSPAG) was set up by OHSSRIG in 2007 to be the technical working group on OHSS for NHSScotland. The initial remit of the group is to review and develop OHSS standards, promote consistent OHSS delivery across NHSScotland, and take forward a work programme of practical OHS measures to the benefit of the NHSScotland workforce.

13.110 Work being taken forward by the group’s current action plan includes:

- the development of a Manual Handling Training Passport
- the development of a Violence and Aggression Training Passport
- carrying out a review of the Managing Health at Work Partnership Information Network Policy Guidelines
- a review of the OHSS Minimum Dataset
- a review of the OHSS Minimum Standard Guidelines
- production of Pre-employment Health Assessment Guidelines
• an investigation into the options for electronic Transferable OH Records that will be compatible across all NHSScotland Boards
• a review of Mental Health Policies.

Protecting Staff from Violence and Aggression

13.111 In 2008 the Emergency Workers (Scotland) Act 2005 was extended to provide legal protection to doctors, nurses and midwives whenever they are on duty.

13.112 In 2007/08 there have been violence and aggression awareness campaign posters and leaflets produced for GP Practices, Dental Practices and Pharmacies.

13.113 Further work in 2008 will include investigating the scope for developing agreements with the police and Procurator Fiscals office to increase protection for NHS staff.

Enhancing rewards and developing capability to demonstrate NHS Scotland commitment to a workforce that is flexible, motivated and driving change.

13.114 At a strategic level, Better Health, Better Care identifies NHS staff as the agents of change and asserts that it will not be possible to bring about the improvements that are envisaged unless the people who will deliver these improvements are protected in their place of work, recognised and rewarded for their contribution to success and given the opportunities to develop the skills and experiences they require. All of this places pay and reward issues in a central position in delivering on BHBC objectives.

13.115 The level of pay award that doctors and dentists receive needs to maintain supply into the medical workforce as well as morale and motivation and morale in this staff group, while not building up cost pressures for the short and medium term. There is a need to balance the legitimate aspirations of medical staff to be appropriately rewarded for the valuable work they do with the other potential cost pressures that NHSScotland faces, such as increasing demand related to demographics, service development, and increasing costs in other areas of the health budget, such as drugs costs. Further information in relation to the affordability of this level of increase in the specific situation in Scotland is at paragraphs 13.132-13.156.

13.116 We would also assert, as in previous years, that the level of pay increases that are provided to doctors need to be considered in the context of the overall reward package that doctors, along with other NHS staff enjoy. We believe that a medical career in the NHS continues to provide very attractive financial rewards, excellent training and job opportunities, as well as a high level of job satisfaction. It is also the case that the recruitment and retention position in relation to medical staff remains healthy and security of employment for doctors remains high.

13.117 Other aspects of the reward package such as the pension arrangements for NHS staff continue to compare favourably with other public sector schemes and are extremely advantageous in comparison with many of the current arrangements in the private sector.
Taking all of this into account, we would recommend a 2.0% increase for medical staff in for 2009/10.

WORKING TIME REGULATIONS (WTR)

Junior Doctors

NHS Boards in Scotland continue to implement the Hospital at Night across more services and hospitals. They participated in the National Survey conducted earlier this year by National Workforce Projects. Over 99% of junior doctors are compliant with the current limit of an average of no more than 56 hours a week and 51% are already compliant with the 2009 target of 48 hours. The current vacancies make designing rotas down to 48 hours more difficult.

SGHD has asked boards to submit Action Plans showing their current state of readiness and how they plan to reach the 2009 target. Our WTR Adviser has visited all boards to discuss these plans with them and to help implementation. SGHD is preparing a state of readiness report identifying the problem areas. We will also be examining possible solutions to these.

Another WTR Forum was being hosted in September with the theme of difficult specialties. Speakers from the service shared their experience in resolving problems in certain specialties and WTR and Hospital at Night Co-ordinators from across the country had the opportunity to network. The Forum was well received and many participants judged it to be well worth attending.

Consultants

Job planning proposals for the 98.1% of consultants who are on the new contract in Scotland are published by ISD. These show that 5 Boards reported an average of over 12 PAs, that is more than 48 hours, in certain specialties. All Boards were reminded last year that any consultant working more than an average of 48 hours a week over the 26 week reference period must sign a WTR opt out.

EFFICIENT GOVERNMENT

In relation to Efficient Government targets the position is as follows:

Increasing Consultant Related Productivity

The consultant productivity target is based on four measures, review to new consultant led cases, average length of stay for both routine and non-routine patients and supporting day surgery as the norm. Significant time release (productivity) savings have already been made against this target. The target in the first two years has been comfortably met, the £32.8m actual savings in 2006/07 is derived by adding the £32.8m achieved in the first year to the
£39.2m achieved in 2006/07. It will be December 2008 before savings for 2007/08 can be confirmed.

**Sickness Absence Target**

13.125 This is a HEAT target, the original date has been revised and extended for another year, therefore there is a high priority and focus on meeting the 4% target by March 2009. (The HEAT targets are a set of agreed core performance targets and measures for the NHS in Scotland – HEAT stands for Health Improvement, Efficiency, Access and treatment.)

13.126 Currently the YTD rate across NHS Scotland is 5.29% to June 2008. Latest monthly figure for June 2008 is 4.86%.

13.127 A national forum has now been established chaired by Iain Crozier and with membership from the HRD community, staff side and nursing. Currently the group is looking at:

- a contact centre approach to managing sickness absence
- dissemination of non recurring funding for agreed bids for work which promotes attendance and manages sickness absence
- agreement of a group Workplan
- support for the creation of an attendance management Leads network, boards have identified sickness absence leads for their area and it is planned to have the first networking event in the Autumn. The outline plan for the network is to share good practice, offer support and to discuss/explore issues and developments in their areas in relation to managing sickness absence.

**Benefits realisation from pay modernisation**

13.128 As mentioned previously, work continues on embedding the annual consultant job planning process into the service planning process and in realising the benefits to be gained from this contract. We continue to collect examples from boards on how the contract is supporting service redesign and performance targets. Indeed boards are describing through their benefits realisations plans how the contract is supporting, enhanced flexibility in working practices, alignment of activity to the delivery of national waiting time commitments and robust discussion to determine work priorities facilitated by the job planning process.

13.129 The new contract for Specialty Doctors and Associate Specialists has now been implemented and we will be working with NHS Scotland to ensure that patients, doctors and the NHS in general gain benefits from this contract.

13.130 More generally, the 2007 iteration of benefits realisation plans showed that Boards were keen to develop their planning and wherever possible to incorporate this work into their wider existing planning mechanisms. Whilst it was encouraging to see that NHS Boards were keen to integrate planning, there is more to be done, in discussion with the service, to further streamline
and integrate pay modernisation requirements with other planning requirements. We are therefore currently reviewing our future pay modernisation planning arrangements, with specific reference to service redesign plans, the local delivery planning process and workforce plans, to explore options for achieving a more integrated approach. Therefore 2008/09 has been identified as a transitional period in which to further develop the pay modernisation benefits realisation planning process and to continue to support boards in identifying benefits facilitated by the levers provided through pay modernisation.

REGIONAL PAY

13.131 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.

NHS FINANCE IN SCOTLAND

RESOURCES AND AFFORDABILITY

Introduction

13.132 This section sets out the financial context for our recommendations, including the Scottish Government Health Directorates’ Departmental Expenditure Limits (DELs) for 2008-09 to 2010-11, as announced as part of the 2007 Spending Review. It also highlights the challenges facing NHSScotland in meeting increasing demand and higher expectations of service quality in a period of reduced funding growth.


13.134 Around 50% of expenditure within the health budget is pay, so even very small changes in pay have a substantial effect on the affordability constraints of NHSScotland. Pay settlements above the planned level mean that plans would have to be revised to stay within the level of available resources.

13.135 The pay increases for 2009-10 become a recurrent pressure on NHSScotland.

FUNDING AVAILABLE

NHS expenditure limits between 2008-09 and 2010-11

13.136 The funding envelope for the NHS in Scotland was set as part of the 2007 Spending Review outcome. The Departmental Expenditure Limits (DELs) set represent absolute limits on NHS expenditure in Scotland.

13.137 The Departmental Revenue Expenditure Limits to 2010-11 as published in September 2008 in the Scottish Budget Draft Budget 2009-10 are as follows:
### EXPENDITURE PLANS

13.143 Baseline pressures, underlying demand and service developments all have competing calls on the resources available for the NHS in Scotland. Pay is one of the baseline pressures. However, a balance needs to be struck between pay and non-pay priorities. There is an obvious trade-off between the level of pay uplift and the opportunity to further develop NHS services in Scotland.
Baseline pressures

13.144 Baseline pressures cover the cost of meeting existing commitments.

13.145 Baseline pressures are expected to consume around 70% of the additional resources available and a significant proportion of this will be taken up by pay. The paybill is a combination of pay settlements and incremental drift. The NHS paybill in 2007-08 was £4.9 billion (including agency staff).

13.146 Recruitment and retention of the medical workforce is good and workforce reforms over recent years means staff are benefitting from a good overall remuneration package. Over the next year we believe that a 2.0% increase in pay for the DDRB remit group is a prudent level balancing NHS aspirations for service improvements, staff morale and wider economic conditions.

13.147 The other main areas of baseline pressure - many of which are demand led - that need to be funded from overall NHS growth, and where delivery could be put at risk if a higher pay award was agreed, include the following:

- Drugs prescribed by GPs and those used in the hospital setting, which have an underlying growth rate of around 7% each year will form 20% of the baseline pressures. Expenditure in 2007-08 total £1.2 billion. In addition, we anticipate this proportion could increase as new treatments become available.

- The underlying cost of goods and services which, in Spending Review 2007, were estimated to rise by 2.75% each year and are expected to consume around 16% of baseline pressures.

- Other additional investment making up baseline pressures include: investment in family health services such as dental and pharmaceutical services; the revenue consequences of capital investment, etc

UNDERLYING DEMAND

13.148 Underlying demand is pressure due to general growth in activity levels arising from factors such as changes to population, demographics, morbidity and rising public expectations.

SERVICE DEVELOPMENT

13.149 The commitment to improvement continues through our ambitious programme of work over the next two years. Such achievements can only be made if resources are not diverted into unnecessarily large increases in pay award.

Key service developments include:

- Ensuring that by the end of 2011 nobody will wait longer than 18 weeks from GP referral to treatment for routine conditions
• eHealth
• phasing out prescriptions charges for those who still pay them
• Hepatitis C Action Plan Implementation
• reducing the harm done by misuse of alcohol
• a screening programme to detect MRSA colonisation of hospital patients at admission, and thereby prevent the spread of infection, reduce serious illness, and release hospital resources for use by other patients
• investment in specialist children’s services including cancer care and high dependency facilities.

Balancing Pay and Service Development

13.150 The increase in NHS resources afforded from Spending Review 2007 provides a fixed funding envelope for the NHS in Scotland. There will be no resources over and above this to fund any excess costs, including those arising from pay settlements. If pay increases are higher than we have planned for, other costs will need to be lower. Many of the non-staff costs are not easily controlled, and represent a smaller proportion of expenditure than the staff element, so higher pay will lead to lower levels of employment.

13.151 Many of the service improvements described above are dependent on staff. This suggests that if a higher proportion of the extra resources are diverted into unnecessarily large pay increases, the service improvements necessary to meet output targets cannot be delivered. However we do not believe it is possible to quantify in any precise way the impact that the Review Body’s recommendations on pay in one year will have had on the achievement of output targets in the next.

13.152 It is not possible to say exactly what areas would be at risk from a large pay deal because decisions would be made locally, but it is very likely that higher pay settlements would lead to fewer staff than would otherwise be the case. For example, any additional increase in the paybill for the DDRB’s remit group would need to be met from allocations and locally this would translate as a major cost pressure. We know that £1 million would fund 28 qualified nurses, or 10 doctors or 426 elective procedures.

Conclusion

13.153 The NHS in Scotland will continue its challenging programme of work over the next two years. Although funding for health will continue to increase, the overall increase in health funding over the next two years is significantly lower than the growth enjoyed since 1997-98 to 2007-08.

13.154 Public expectations of the NHS in Scotland continue to increase and NHSScotland has a responsibility to continue to make progress on improving services and to contribute to wider government objectives.

13.155 High pay awards could lead to a reduction in staff employed and put at risk the delivery of key services within the NHS in Scotland.
13.156 NHSScotland staff form a crucial part in meeting these challenges. However, the Scottish Government’s significant investment in increased staff numbers over recent years and pay reform have provided the increased capacity and stable recruitment and retention situation necessary to meet these challenges. We therefore support a 2.0% pay uplift and believe this is a prudent level balancing NHS aspirations for service improvements, staff morale and wider economic conditions.

CONCLUSION AND PAY PROPOSALS FOR 2009/10

13.157 SGHD’s over-arching workforce 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 in Scotland. In seeking to achieve this objective, in a complex and often challenging environment, we need to balance the measures that are employed to support recruitment and retention and to maintain and improve morale and motivation amongst NHS staff, with a number of other considerations, such as achieving value for money, affordability and consistency with overall public sector pay policy.

13.158 It is our view that an increase of 2.0% would represent a level of pay increase for medical staff which is fair, affordable, and takes account of the above factors. We would therefore recommend a 2.0% pay increase for medical staff in 2009/10.
CHAPTER 14: EVIDENCE FROM THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES & PUBLIC SAFETY IN NORTHERN IRELAND

SUMMARY

14. This chapter has been prepared by the Department of Health and Social Services and Public Safety in Northern Ireland. It sets out where circumstances, initiatives and policies within the Health and Social Care (HSC) in Northern Ireland are different from other parts of the UK NHS.

The evidence sets out:

- The Northern Ireland Context;
- Northern Ireland Executive Pay Policy;
- The Northern Ireland Health Sector;
- The Policy Context;
- The Medical and Dental Workforce;
- Pay and Workforce issues;
- Affordability; and
- Pay Conclusions.

The Northern Ireland Context

Demographics

14.1 Changes in the size and composition of NI’s population will have a major bearing on the levels of public services needed in the future. While NI currently has a relatively young population, indications are that this will change over the next ten years. NI is expected to follow the trend of most industrialised countries with the proportion of those aged 18 and under falling while the proportion of those aged 65 and over will rise.

14.2 These population projections, in conjunction with levels of deprivation in NI, have clear implications for the provision of public services and workforce needs in the local health sector. It is expected that the ageing population will increase demand for health professionals.

The Labour Market

14.3 Employment has grown rapidly over the past decade in NI. The local unemployment rate, at 4.4%¹ is currently the third lowest of the UK regions. However, there are hidden structural problems in the local labour market. Economic inactivity is the highest of any UK region at 27.0% and this can only partly be explained by NI’s high full-time education participation. In a context of a historically low claimant count the level of long-term unemployment and incapacity claims are significant obstacles to maximising the pool of actively available labour.

The Cost of Living

14.4 Figures produced by the Office for National Statistics (ONS) suggested that in 2004 the cost of living in NI was 4.7% lower than the UK average. However, NI’s cost of living was above that of the North East of England, Scotland and Wales. It should be noted that ONS do not produce regional cost of living figures regularly and that the above estimate is now very dated. More recent survey evidence published by Croner Reward\(^1\) indicates that consumer prices have since increased more in the UK (5.8% p.a.) than in Northern Ireland (5.1% p.a.). This suggests that Northern Ireland’s cost of living has reduced further relative to the UK as a whole since 2004.

The Public Sector Workforce

14.5 The Public sector in NI employs just 220,871 people or 28.1% of all in employment (24.8% when Reserved functions\(^2\) are excluded). On either measurement this is a significantly higher share compared to 19.5% for the UK. This is in part due to the lower employment rate in NI\(^3\) and the greater need for public services due to the demographic structure of the population and its socio-economic status. While the relative size of the public sector in NI has been declining this has been due to growth in private sector employment as opposed to downsizing in the public sector.

14.6 Pay Review Bodies (PRB) health staff groups account for 60,500 (27.2%) of public sector employee jobs in Northern Ireland. DDRB account for some 3,800 staff (1.7% of public sector employee jobs).

14.7 Monitoring returns to the Equality Commission provide insight into recruitment difficulties experienced by both the public and private sectors. The most recent number of applicants per post filled recorded for the public sector as a whole in 2006 was 8.2 – compared to a ratio of 6.0 for the private sector. There are, however, significant variations within the public sector with the number of applicants per post consistently higher for District Councils (12.7) and consistently lower in the Health sector (5.4).

Public Sector Pay

14.8 Public sector pay in Northern Ireland accounts for an increasing share of the Departmental Expenditure Limit (DEL) budget. Estimates for the 2008-09 financial year indicate that pay costs will account for 51 per cent of Resource DEL. This means that each one per cent increase in the total paybill would equate to additional annual costs of £42 million.

14.9 Overall public sector earnings in NI, at £531.90 per week, are below the UK average (£555.50) but are higher than three other regions – Scotland, Wales, and the North East. This reflects a relatively larger proportion in higher

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2 Reserved functions include the NI Office, Police Service of NI, NI Prison Service, UK Central Government and UK Public Corporations.
3 If NI’s employment rate equalled the UK average the current level of public sector employment would account for 26.8% of all in employment.
occupations in NI – at the level of individual occupational groups Northern Ireland is generally among the regions with relatively low earnings. However, average earnings are influenced by the protective services whose higher earnings levels are a legacy of the security situation. Excluding Protective Services, the average public sector wage in NI is £514.27, compared to £544.54 for the UK as whole.

14.10 Public sector earnings in NI outstrip those of the private sector - the differential for public sector employees not working in protective services is 19.2%. Private sector earnings, at £431.58 per week in NI, are 21% below the UK average of £549.10. In addition they are also significantly lower than any other UK region. For each major occupational group, with the exception of associate professionals and technical occupations, private sector earnings in NI are the lowest of all the UK regions.

14.11 Although most regions (with the exception of London, the South East, and the East of England), exhibit a pay differential in favour of the public sector, the differential is not as pronounced as that found in NI.

14.12 While the headline public-private sector earnings differential is 23.2% in NI, this reduces to 19.2% when the UK occupational structure is imposed. Moreover, taking an equivalent job in the NI private sector the expected earnings in the public sector are 12.2% higher (i.e. adjusting for occupational mix), compared to 2.2% lower for the UK as a whole. In addition such comparisons do not factor in differences in non-pay benefits (such as the value of public sector pensions).

**Northern Ireland Executive Pay Policy**

14.13 On the 24th May 2007, the Executive endorsed the principle of adherence to the UK Government’s public sector pay policies. Enforcement of pay growth limits is devolved to the NI Executive within the overarching parameters set by HM Treasury. In addition the Chancellor has deemed public sector pay to be a key macroeconomic variable and therefore HM Treasury retains a sanction role over pay policy in the devolved administrations. This means that the Department of Finance and Personnel (DFP) Minister has the scope, within the parameters of the UK Government’s pay sector policy, to approve pay remits for most of the staff groups in bodies within the wider public sector in Northern Ireland.

14.14 The pay remit approval process applies to the staff costs of virtually all public bodies and staff groups that are either partly or wholly funded by the Northern Ireland Departmental Expenditure Limit (DEL).

14.15 The Executive’s control of public sector pay will be based on the principle that the public sector should offer a pay and reward package that allows it to recruit, retain and motivate suitable staff. Public sector pay should also reflect the circumstances specific to the local labour market.

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1 Source: Annual Survey of Hours and Earnings (ASHE) 2007
14.16 The latest HM Treasury Pay Guidance for 2008/09 now has a consolidated pay range of 1.5 – 4.5 per cent for Increase for Staff in Post (ISP). It also states that ‘the expectation is that for this year Civil Service pay awards will average in the region of 3.75 %’.

14.17 The HM Treasury guidance includes a section on local pay which explicitly calls for public sector pay remits to reflect ‘the relevant local labour markets in which they operate’. The HM Treasury guidance also states that departments will be challenged on the degree to which their pay proposals are consistent with local pay policy. The primary evidence base that the HM Treasury uses in considering the local labour market characteristics is the Northern Ireland Pay and Workforce Plan 2007-08 (and now updated 2008-09 Technical Annex).

14.18 Under devolution, HM Treasury does appear to have a limited role in terms of public sector approvals and control. The Statement of Funding Policy between HM Treasury and the Devolved Administrations (DAs) requires the DAs to ‘consult’ with HM Treasury on pay issues. However, the previous Chancellor, Gordon Brown, has deemed public sector pay a ‘key macro-economic variable’ which therefore is determined by the HM Treasury alone. This view was restated by the then Chancellor in his 2007 budget statement which stated that ‘over the 2007 CSR period controlling pay spending will be essential in delivering value for money from public spending and keeping inflationary pressures in check. The Government has made clear that pay settlements must be consistent with the achievement of the CPI inflation target of 2 per cent’.

14.19 The primary concern that HM Treasury has on pay determination within the DAs is that precedents might be set for public sector staff groupings in the devolved administrations that could be repercussive within England. The danger that the devolved administrations face in setting such a repercussive precedent is that HM Treasury could levy a financial penalty on the Block DEL. The HM Treasury Statement of Funding Policy states:

- ‘the DEL of the devolved administration will be adjusted downwards to compensate for costs incurred by the United Kingdom Government as a result of the actions of a devolved administration’

and

- ‘where decisions taken by any of the devolved administrations or bodies under their jurisdiction have financial implications for departments or agencies of the United Kingdom Government ...... the body whose decision leads to the additional cost will meet that cost.’
The Northern Ireland Health Sector

14.20 Given Northern Ireland’s unique geographical circumstances within the UK it is to be expected that the health services in Northern Ireland have distinct characteristics – most notably that health and social care are integrated within the Health Boards and Health and Social Care Trusts structure.

14.21 The Northern Ireland Executive forms the Government of Northern Ireland and comprises ten departments plus the Office of the First Minister and deputy First Minister. Each Department is headed by a Minister who sits on the Assembly’s Executive Committee. The Department of Health, Social Services and Public Safety (DHSS&PS), under the Health Minister is responsible for supporting the Assembly’s Executive Committee in taking forward measures to improve public health and wellbeing. The key objectives for health and social care are:

- to develop and promote policies and strategies that will lead to good health and well-being, a reduction in preventable disease and ill-health, and greater social justice; and
- to ensure the delivery of effective, high quality health and social care.

14.22 A twenty-year regional strategy for health and wellbeing, A Healthier Future, published in 2004 constitutes a vision for health and social care and contains a series of commitments for improving health and wellbeing. These objectives are supported by Programme for Government 2008 – 11 and associated Public Service Agreements. DHSSPS has responsibility for PSAs and is contributing to another 5 PSAs. These PSA commitments are in turn supported by the annual Priorities for Action (PFA), which outline 10 key Ministerial priorities as set out below:

- improving health and well-being
- ensuring safer, better quality services
- improving acute services
- ensuring fully integrated care and support in the community
- improving children’s services
- improving mental health services
- improving services for people with a disability
- ensuring effective financial control and improved efficiency
- improving productivity
- modernising the infrastructure.

14.23 A major programme of reform in primary, community and secondary care is underway. This includes: the most significant reform to hospital services in a generation to transform access to elective and emergency care; the implementation of the new configuration of hospital services and other changes set out in “Developing Better Services”, the implementation of the recommendations of the “Community Care Review”, improving quality and
governance of services under “Best Practice- Best Care”, promoting the health status of the population under “Investing for Health” and harnessing new technology under the “Information and Communication Technologies Strategy”.

The Policy Context

14.24 The Executive is committed to building capacity to support reform and modernisation in health and social care. It plans to extend and increase the quality of the range of services in the primary care sector – including improving access to doctors, nurses, allied health and other health professionals. These services will be improved by developing team working across professions and by networking specific services such as cancer and renal services.

Improving Services

Developing Better Services

14.25 The implementation of the Ministerial decisions on Developing Better Services, announced in February 2003, means that acute services would be delivered from a smaller number of facilities. These will be more strongly patient-focused and organised around population groupings rather than facilities. In addition, a number of new local facilities will deliver a wider range of services on a local basis – including day case surgery, high quality diagnostic services, out-patient clinics and rehabilitation and step-down beds.

Improving Performance

Programme for Government 2008-11 targets

14.26 Under the current Programme for Government, a wide range of PSA commitments have been set to promote health and address health inequalities and deliver high quality health and social services, for example:

- reducing the number of suicides
- establishing a comprehensive bowel screening programme
- reducing healthcare associated infections
- further reducing waiting times for outpatient assessment, diagnosis and inpatient/ day-case treatment
- further reducing waiting times for cancer diagnosis and treatment
- improving ambulance response times to emergency calls
- reducing unplanned hospital admissions
- reducing the number of children in care
- reducing waiting times for a range of mental health services
- continuing the resettlement programme for long-stay patients in mental health and learning disability hospitals
Delivery of these commitments is planned on an annual basis through Priorities for Action (PfA), which specifies – in addition to the relevant three-year PSA targets – a number of “Ministerial” standards, targets and actions for each year. These additional standards, targets and actions are necessary both to help ensure that satisfactory progress is to be made towards the three-year PSA targets, and to ensure that performance is improved in areas which are a priority, but for which there is no equivalent PSA target (e.g. A&E waiting times). These targets – taken together with the detailed resource allocations – provide the framework within which Boards and Trusts prepare their commissioning and delivery plans.

Improving productivity remains a key priority for the Department and the HSC and targets set in this area include:

- achieving a 3% improvement in hospital productivity year-on-year;
- reducing staff absenteeism to 10% below average 2007-08 levels;
- ensuring no more than 2% of operations are cancelled;
- achieving a reduction in the ratio of qualified to unqualified nurses and AHPs;
- reducing staff turnover by 5% compared to 2007-08.

Review of Public Administration

The Review of Public Administration was launched by the Northern Ireland Executive in June 2002 to deliver wide-ranging and comprehensive modernisation and reform across the public sector.

There were two major phases for implementation of the RPA within health and social care. The first phase involved the establishment of the 5 new integrated Health and Social Care Trusts and the retention of the Northern Ireland Ambulance Trust with effect from 1 April 2007. The second phase is now underway and is scheduled for completion by April 2009. It includes establishing new organisational arrangements to replace the present four Health and Social Services Boards, four Health and Social Services Councils and a number of Agencies. Work is continuing to establish the following structures:

- a new Regional Health and Social Care Board that will focus on financial management, performance management and commissioning;
- a new Regional Agency for Public Health and Social Well-being to create better inter-sectoral working to tackle health promotion and inequalities and help realise the shared goal of a better and healthier future for all;
- the establishment of five Local Commissioning Groups to cover the same geographical areas as the five Health and Social Care Trusts;
• a smaller, more sharply focused Department;
• a regional support services organisation that will provide a range of support function for the health and social care service;
• a new Patient and Client Council;
• increased democratisation through local government representation on key bodies and improved partnership working.

14.31 The Review of Public Administration is expected to deliver a reduction of nearly 1,700 staff and savings of more than £53 million by April 2011. It is envisaged that the proposals for organisational change together with the rationalisation of Health and Social Care Trusts would help to deliver the efficiencies required under the Comprehensive Spending Review. It is acknowledged that decisions on future structures however, would need to be supported by human resource policies to address the concerns of staff and implemented in close partnership with staff side organisations.

HR Strategy “The Employer of Choice”

14.32 The current strategy for managing people in the HSC, “The Employer of Choice”, states that the delivery of modern, high quality services requires effective leadership of, and investment in, the staff who deliver them. The range of services available and the quality of care received by service users depends upon the people who work in the service. Staff are the major asset of the HSC and the strategy maps out the HR agenda for the HSC in six key strategic areas:

• workforce planning;
• retention, return, recruitment and reward;
• improving working lives;
• equality and fairness;
• education and training; and
• employee relations.

14.33 A new strategy has been developed in partnership with employers and trade unions representatives which builds on the themes set out in the Employer of Choice. It develops a focus on the need for modernisation and reform in the workplace with particular emphasis on improving productivity by building on recent pay reforms.

Workforce Learning Strategy

14.34 A Workforce Learning Strategy for the HSC has been developed on a partnership basis and will address and recommend the way forward in all aspects of learning throughout the HSC organisations. The strategy recognises a need for “the continuous development of skills, knowledge and understanding that are essential for employability and fulfilment”. To achieve this staff should develop the habit of learning throughout their health and social care career, as well as providing the right range of learning opportunities in a timely and accessible manner. The strategy provides a development framework for individuals, teams and organisations and aims to:
• equip staff with the skills and knowledge to work effectively and flexibly in caring for patients and clients;
• support staff to grow, develop and realise their potential;
• support changes and improvements in patient and client care;
• enable staff to take advantage of available career opportunities;
• maximise the return on investment in training and education; and
• link and empower existing workforce learning/training strategies.

14.35 The strategy recognises that effective learning and development underpins successful organisation performance. It supports the further development of a learning culture across the HSC, enabling individuals to progress in their careers, as well as supporting those staff whose career commitment is to their current posts. Consequently, learning and development goals should be an integral part of HSC organisation strategies.

Information and Communication Technology

14.36 The HSC ICT Strategy provides a long-term vision for the effective use of IT systems to improve the quality of service delivered to the patient. The full implementation of the strategy will improve the discharge of back of office functions by allowing for the speedy retrieval of patient records and details and the easy transfer of information from one site to another. This will mean that professional staff can access information systems from their clinical work areas and so reduce the time they spend in the manual processing of data.

The Medical and Dental Workforce

General Employment Figures

14.37 There are almost 78,000 employed in the Health and Social Care delivering essential services to the community. The effective delivery of good quality care to service users is dependent on the skills, ability and organisation of the health and social care workforce.

14.38 The largest grouping in the HSC workforce is Qualified Nursing & Midwifery staff (27.0% of Headcount), followed by Administrative & Clerical staff (21.1%), Professional & Technical (11.7%), Social Services and Ancillary & General (both 11.5%). Compared to 1997, the number of Qualified Nursing & Midwifery staff has risen by 21.5%. Administrative & Clerical staff Headcount has increased by 34.0% over the same time period, although the growth rate slowed in 2005 and the overall Headcount figure is now in decline (dropping by 4.5% between March 2007 and March 2008) due to the Review of Public Administration.

Table 1: HSC Workforce Numbers (Whole Time Equivalent) for 1997-2008

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1Total Staff in post. Excluding (approx 17,500) Bank Staff, home help and student nurses reduces the total to 60,500 or 51,927.5 Whole Time Equivalent (Figures as at 31st March 2008, Source: Human Resources Management System).
The HSC workforce was in decline in the 1990’s reaching a low of 45,658 staff (Headcount) in March 1998. After that the workforce rose by an average of 900 (Headcount) per annum up until 2002. The year 2002/03 saw the biggest increase in staff numbers with an extra 3,159 staff joining the HSC making a total headcount of 52,489. From 2002/03 to 2006/07 the workforce continued to increase by an average of 2,000 staff per annum. However 2007/08 saw a small decrease in total staff numbers from 60,578 to 60,500 staff. This decrease was due to the number of Administration staff being reduced by 607 due to the Review of Public Administration (all other Terms & Conditions Groups showed slight increases in the number of staff). In terms of headcount, as at March 2008, females accounted for 79.5% of the HSC workforce whilst part-time workers accounted for 39.5% of the workforce.
14.40 Staff costs for the HSC workforce have increased by an average of £116m over the last five financial years to reach over £1.7bn in the 2007/08 financial year. The year on year increase in staff costs has dropped over the last two financial years, with the increase from 2006/07 to 2007/08 being down to just £94m. Table 3 below sets out the increase in pay costs over the past 10 years.

Table 3: Total Staff Costs 1997/98 – 2007/08

<table>
<thead>
<tr>
<th>Year</th>
<th>Staff Costs (£ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997/98</td>
<td>800</td>
</tr>
<tr>
<td>1998/99</td>
<td>800</td>
</tr>
<tr>
<td>1999/00</td>
<td>800</td>
</tr>
<tr>
<td>2000/01</td>
<td>800</td>
</tr>
<tr>
<td>2001/02</td>
<td>800</td>
</tr>
<tr>
<td>2002/03</td>
<td>800</td>
</tr>
<tr>
<td>2003/04</td>
<td>800</td>
</tr>
<tr>
<td>2004/05</td>
<td>1,000</td>
</tr>
<tr>
<td>2005/06</td>
<td>1,200</td>
</tr>
<tr>
<td>2006/07</td>
<td>1,400</td>
</tr>
<tr>
<td>2007/08</td>
<td>1,600</td>
</tr>
</tbody>
</table>

Recruitment and Retention

*Graduate Recruitment*

14.41 The Independent Review of Health reported that the picture in terms of recruitment can sometimes be confusing since the recruitment procedure begins with student choices on degree courses. The Department has invested in an increase in the local medical school which began in 2005. By 2010 local output from the medical school, will have increased by 25% upon the 2005 numbers.

Table 4: Accepted applicants by subject group and country of accepting institution 2006 and 2007

<table>
<thead>
<tr>
<th>Subject Group</th>
<th>Year</th>
<th>England</th>
<th>Wales</th>
<th>Scotland</th>
<th>N. Ireland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine and Dentistry</td>
<td>2007</td>
<td>7,176</td>
<td>452</td>
<td>1,120</td>
<td>309</td>
<td>9,057</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>7,294</td>
<td>451</td>
<td>1,098</td>
<td>303</td>
<td>9,146</td>
</tr>
<tr>
<td>% change</td>
<td></td>
<td>-1.6%</td>
<td>0.2%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

Source: UCAS

14.42 While the wider trend indicates a slight downturn in the number of applications to medicine and dentistry, the percentage of applicants in Northern Ireland is equivalent to Scotland, and higher than England and Wales who have invested heavily in an increase in medical students in previous years.

14.43 Following graduation in 2008, 100% of local students who applied to the NI Deanery were successful in securing a place on the Foundation Year Programme.
Vacancies – Comparison to GB

14.44 Comparison of staff vacancy rates across UK Health Departments is extremely difficult due to the different methods of calculating vacancies and classifying staff. The table below sets out a broad comparison of long-term vacancy rates. The trend for Long-term vacancy rates is that the long-term vacancy rates are generally falling across all Terms and Conditions groups in both Northern Ireland and England, with a marked decrease in Northern Ireland from 2.6 in March 2005 to 0.9 by March 2008.

Table 5: Long-Term Vacancy rates in Health Service for England and NI

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin &amp; Clerical</td>
<td>0.8</td>
<td>N/A</td>
<td>0.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Ancillary &amp; General</td>
<td>1.8</td>
<td>1.3</td>
<td>1.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing, Midwifery &amp; Health Visiting</td>
<td>1.7</td>
<td>1.9</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Social Services</td>
<td>0.9</td>
<td>N/A</td>
<td>0.8</td>
<td>N/A</td>
</tr>
<tr>
<td>Professional &amp; Technical</td>
<td>2.3</td>
<td>2.4</td>
<td>1.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Medical &amp; Dental</td>
<td>2.6</td>
<td>3.1</td>
<td>1.2</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Source: NI HSC Trusts and Organisations & NHS Information Centre.

Notes:

a. A long-term vacancy is defined as an unoccupied post which had been vacant for three months or more and which the organisation was actively trying to fill on the survey date.

b. The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

Current Vacancies: Changes over Time

14.45 The current vacancy rate for HSC staff has fallen over the last few years. The table below indicates that over the period 2005 to 2008 there was a downward trend in vacancy rates across all Terms & Conditions groups in the NI HSC.

Table 6: NI HSC Current Vacancies Rate %

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin &amp; Clerical</td>
<td>3.3</td>
<td>2.7</td>
<td>2.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Ancillary &amp; General</td>
<td>5.1</td>
<td>3.5</td>
<td>3.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Nursing, Midwifery &amp; Health Visiting</td>
<td>3.9</td>
<td>3.0</td>
<td>3.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Social Services</td>
<td>3.9</td>
<td>3.7</td>
<td>2.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Professional &amp; Technical</td>
<td>5.1</td>
<td>4.9</td>
<td>4.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Medical &amp; Dental</td>
<td>6.4</td>
<td>3.0</td>
<td>2.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: NI HSC Trusts and Organisations
Notes:

a. A current vacancy is an unoccupied post, which on the survey date was vacant and which the organisation was actively trying to fill.
b. The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).
c. It is not possible to compare current vacancy rates with England, as England only collect information on Long-term vacancy rates.

14.46 The Independent Review of Health noted a fall in the vacancy rates in some staff categories in the past year and suggested that this might be attributable to improved retention strategies at employer level, and to an increase in the number of newly qualified staff entering the employment market.

14.47 In relation to medical staff, increased numbers of medical students since 2000 have had some effect in the training grades. Also, since 2005 there has been reasonable success in inwardly recruiting to Foundation programmes, where the number available exceed the output of the local medical school. At the more experienced end, i.e. consultant level, the investments in specialist training numbers in the late 90s and early years of this decade are impacting on consultant vacancies in recent years.

Workforce Planning

14.48 Approximately 50% of HSC staff are in regulated professions. They must hold approved qualifications and be on the register of an appropriate professional body. DHSSPS is responsible for commissioning the training of regulated staff, largely through the local Universities. The DHSSPS has to ensure that it is commissioning the appropriate numbers of student places (referred to as pre-registration places) to maintain an adequate supply of qualified staff. It takes 5 years to train a medical students and the DHSSPS currently commissions an annual intake of approximately 250 medical students.

Workforce Plans

14.49 In September 2001, DHSSPS commenced a series of uni-professional workforce reviews (i.e. a review of each profession separately – such as Medical, Nursing, Dietetics, Dental, Social Services, etc.) covering the main groups employed within the HSC. The workforce planning cycle comprises a major review approximately every three years, with interim update reviews. In this way the reviews are intended to enable the DHSSPS to gain workforce intelligence on the trends in employment for each professional group and this in turn will inform planning of needs over subsequent years.

14.50 The data collected also covers qualitative information and, together with the data on recruitment and retention, enables the DHSSPS to work with the HSC in developing strategies to both attract people to working in the health service professions and build their career in that field.

14.51 The purpose of the up-date reviews is to identify any developments which are likely to have an impact on the workforce, and to check back as to whether the workforce is showing the trends predicted in the main review. This is
intended to act as an early warning system whereby the DHSSPS can take action as necessary and in this way aim to address potential workforce problems at an early stage.

14.52 The last workforce review of the medical profession was carried out in 2006, at which time the impact of Modernising Medical Careers was not as yet clear. The Department has just commenced work on a further review of the Medical profession, which will assess particularly the impact on Modernising Medical Careers.

14.53 A review of Hospital Dentistry will also be taken forward this autumn.

Productivity and Workforce Planning

14.54 Following a review of workforce productivity carried out by Professor Appleby of the King’s Fund, London, DHSSPS, in December 2005, began work to explore the findings of the Appleby Report that productivity levels in the HSC are lower than those in the NHS, England. This work on productivity has involved analysis of comparative data with England, identification of where significant differences in performance levels exist, identification of the gains to be delivered through the recent pay reforms, and provision of recommendations as to how productivity in N. Ireland can be improved and maintained. This work relates to all professional groups in the HSC.

14.55 DHSSPS has now developed a range of productivity indicators and these are monitored for all Trusts. These indicators cover for example ratios of fully trained professional staff to supporting staff, staff turnover, sickness absence, and hospital activity measures. A number of targets have also been put in place for some of those indicators.

14.56 Productivity issues are also addressed in the workforce planning reviews, which explore potential opportunities for greater skill-mix and different and more efficient ways of working in the delivery of service.

14.57 The following PSA and Ministerial targets will be subject to intensive monitoring by the Department during 2008-09 to ensure satisfactory progress is made:

- **hospital productivity (PSA 9.1):** each Trust will be expected to achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

- **cancelled operations (PSA 9.1):** each Trust should ensure that, by March 2009, no more than 2% of operations are cancelled for non-clinical reasons on the day of admission or later.

14.58 All of the remaining elements of the PSA target – translated into Ministerial targets for March 2009 as detailed below – will be subject to quarterly or six-monthly monitoring by the Department during 2008-09:
• (PSA 9.1) each Trust should ensure that, during 2008-09, levels of absenteeism are reduced to 10% below average 2007-08 levels, working towards a regional target of 5.2% in 2010-11.

• (PSA 9.1) each Trust should ensure that, by March 2009, they meet their individual target set by the Department to achieve an overall reduction in the number of admin and clerical staff, as a proportion of all Trust staff, to 19.5%.

• (PSA 9.1) each Trust should ensure that, by March 2009, they achieve a reduction of one point in the ratio of qualified to unqualified nurses.

• (PSA 9.1) each Trust should ensure that, by March 2009, they achieve a reduction of one point in the ratio of qualified to unqualified AHPs.

• (PSA 9.1) each Trust should ensure that, during 2008-09, staff turnover (excluding admin and clerical staff) is reduced by 5% compared to the position in 2007-08.

**Pay and Workforce Issues**

14.59 Northern Ireland has traditionally applied the Pay Review Body recommendations to its workforce. There is recognition that the Pay Review Body will take into account the local labour market context.

**General Dental**

14.60 DHSSPSNI is currently involved in negotiations with the Dental Practice Committee (DPC) of the British Dental Association (BDA), with the aim of agreeing a new dental contract for practitioners in Northern Ireland. While progress has been slower than we might have hoped, we intend to pilot a new contract in 2009.

14.61 As in England, there has been a steady drift of dentists moving from the health service to the private sector. This has resulted in increasing access issues in various parts of Northern Ireland. Following representations from the BDA that additional funding was required to encourage dental practitioners to remain in the Health Service, the Health Minister agreed to provide an additional £2m recurrently in the practice allowance with effect from April 2007. It was hoped that this significant investment in the 361 dental practices in the province would slow the drift into private practice. It is difficult to produce detail on dentists who have left, or are carrying out less work in, the health service. The new contract in England, and the use there of corporate dentists in areas where less health service work is being carried out, also make it difficult to compare NI and the rest of the UK. However, the latest figures for health service dentistry expenditure for 2008-09 show projections of a reduction in expenditure of 5%, compared with last year, equating to over £3m less spend. This is the hardest available evidence of continuing drift.

14.62 Over the course of 2007, it has become apparent that dentists were continuing to opt for private practice in many areas. In September 2007 the Minister agreed to a further substantial package of financial measures, back-dated to April 2007, to a total estimated cost of £4.4m. This included a further
recurrent £2m towards the practice allowance, specifically to address the profession’s main concern with the dental contract, increasing overhead costs. The effect of this will be to increase the percentage of practice allowance paid to Health Service committed practices from 8% to 11%. On average, Health service committed practices will now receive an annual practice allowance of £29,600 compared with £21,500 previously. Based on 2006-07 payments, this means that an average practice relies on approximately 67% of its income from item of service payments, 23% capitation and continuing care, and the remaining 10% coming from block payments such as the practice allowance. This ratio will alter for 2007-08 due to the increased weighting given to non-item of service payments.

14.63 The remainder of the £4.4m was made up of £1.5 non-recurrent to assist Health Service dentists to improve sterilisation and infection-control procedures, £500k recurrently in additional vocational training allowances paid to dental practitioners, and £400k to resource new salaried dental service posts in those parts of the country most affected by access issues.

14.64 In total therefore, the Department has invested a total of £6.4m additional funding in health service dentistry in 2007-8, of which £4.5m is recurrent.

14.65 In an effort to resolve the access issue, the Minister has approved a tender exercise for additional dental services. The likelihood is that this will attract dental service providers from outside the province. We intend to advertise in Autumn 2008, following a consultation exercise.

General Medical

14.66 There has been a joint communication from the Department of Health, NHS Employers and the GPs committee to DDRB raising a number of issues concerning DDRB’s consideration of GMP pay for 2009/10, and seeking an extension to the deadline for submitting initial evidence. The GMS contract is UK wide and any evidence Northern Ireland would submit would be dependent on what is happening at the national level.

Doctors in Training

MMC

14.67 Reform of postgraduate medical training began with changes in Higher Specialist Training introduced by the then Chief Medical Officer (England), Sir Kenneth Calman in 1993. His successor, Sir Liam Donaldson, continued the process with the publication of a consultation paper, Unfinished Business in 2002. The response to this paper was a series of far reaching reforms termed ‘Modernising Medical Careers’ (MMC).

14.68 In March 2002 in recognition of the growing dissatisfaction with the recruitment process, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned a review of the recruitment processes in Northern Ireland with a view to rationalisation. The review recommended the introduction of a centralised selection and recruitment system for all grades of
junior doctors. This was then taken forward at a national level under the Modernising Medical Career reforms. Recruitment to Foundation Posts in 2005 in Northern Ireland and in seven other Deaneries involved a centralised application process (MDAP). This centralised selection and recruitment system at foundation level was successful and was adopted nationally in 2006. Given the success of the MDAP system it was expected that a similar centralised application and selection system could be used to recruit all grades of junior doctors. Subsequently Northern Ireland became part of the Medical Training Application Service (MTAS), a UK co-ordinated on-line electronic application process.

14.69 Following the well publicised problems with recruitment using the MTAS system in 2007, the local Health Minister commissioned a review of the process used and primarily its impact on:

- services for patients
- doctors-in-training
- employers
- the local deanery, the Northern Ireland Medical and Dental Training Agency.

14.70 A number of recommendations were put forward on a local way forward for the 2008 recruitment exercise. There was also the overwhelming view that Northern Ireland should remain part of the national recruitment system, although it would be managed through a local on-line service.

14.71 The number of doctors in training has increased from approximately 1100 in 1997 to 1700 in 2007, this represents an increase of 54% over the last ten years.

2008 Recruitment process

14.72 The recruitment process in 2008 was carried out by the local deanery, the Northern Ireland Medical Training Agency. There was adherence to the national timetable at each stage of the recruitment process. At the opening of Round 1, there were a total of 425 posts to be filled (340 Core and Run Through, and 85 FTSTA). At the end of Rounds 1 and 2, the number of core and run through posts which were actually available and filled was 325, and the FTSTA posts available increased to 132, however 10 were unfilled. Following the clearing process, and subsequent reduction in the fill rate, there were 68 unfilled posts in total (all FTSTA) at 31 July 2008. The proportion of posts filled at 31 July 2008 was 389, ie 85.1% of posts available.

14.73 The vacancies impacted upon a number of specialities, notably Paediatrics, General Medicine Accident and Emergency medicine, Obstetrics and Gynaecology and Surgery. Follow up work is being carried out with Trusts to identify how the vacancies have been filled.
In Northern Ireland, the Improving Junior Doctors Working Lives Implementation Support Group (ISG) was established in 2001 to assist trusts in implementing the New Deal for junior doctors. More recently the role of ISG has evolved to include the implications of the European Working Time Directive (EWTD) which has applied to junior doctors since August 2004. ISG oversees the implementation of New Deal and EWTD and works in an advisory capacity with trusts, Boards and the Department to help develop solutions on New Deal and EWTD compliance. Since August 2004 ISG has collected data from trusts on EWTD compliance along with data on New Deal compliance. Data is submitted to ISG on a twice yearly basis.

The latest monitoring data on New Deal and EWTD compliance is at Spring 2008. The New Deal monitoring at Spring 2008 showed that 92% of doctors in Northern Ireland were fully compliant with the New deal contract, compared to 87% at Autumn 2007. The non compliant posts are mainly in specialties such as obstetrics and gynaecology, and also surgery where solutions remain difficult. These specialties, in particular, the surgical sub specialties represent the greatest challenge where projected future consultant needs no longer justify current numbers of training grade doctors, let alone an increase to meet the requirements of the EWTD in 2009.

While there has been a decrease in overall bandings over the past few years, it should be noted that most junior doctors (around 80%) are still being paid at Band 1a or higher ie at least a 50% uplift in salary. This includes doctors in non compliant New Deal posts who are paid a Band 3 supplement (100% of basic salary); doctors in New Deal compliant posts who are paid a Band 2A supplement (80% of basic salary); doctors in New deal compliant posts who are paid a Band 2B supplement (50% of basic salary); and doctors in New Deal compliant posts who are paid a Band 1A supplement (50% of basic salary). Even if the EWTD deadline of August 2009 is met when doctors in training should work no more than 48 hours, they could still be paid a banding supplement of up to 50% of basic salary (Band1A or lower).

The EWTD monitoring at Spring 2008 showed that 40% of doctors were fully compliant with the EWTD 2009 requirements. At Autumn 2007 72% of doctors were fully compliant with the EWTD requirements, although it should be noted that those figures relate to EWTD 2007 requirements. Clearly considerable progress needs to be made if the EWTD 2009 requirements are to be achieved.

ISG continues to make significant investment in projects which will help improve compliance rates. Hospital at Night is seen as a vital tool in the drive to achieve EWTD compliance by 2009. To date ISG has funded hospital at night projects in each trust although these are at different stages of development.
Specialty Doctors and Associate Specialists

14.79 In March 2008, following approval by the Minister, the Department of Finance and Personnel gave formal approval for the introduction of new contracts for the new specialty doctor grade and for associate specialist doctors. The new contracts were the outcome of UK wide negotiations involving NHS Employers, the BMA and the four UK health departments. The negotiations began in April 2005 although Northern Ireland did not formally join the negotiation process until March 2006.

14.80 In Northern Ireland introduction of the contracts have been approved on the basis that they are subject to transitional implementation arrangements over a two year period to ensure increases are in line with public sector pay policy.

14.81 The transitional arrangements will give both groups of doctors half their pay increase in year 1 and the other half in year 2. Under the original proposals specialty doctors were to receive a full assimilation increment in year 1, while associate specialists were not due to receive their full increase until year 2. Specialty doctors will receive on average an assimilation increase of 5.2% in year 1 (1 April 2008) and 5% in year 2 (1 April 2009), and associate specialists an assimilation increase of 1.8% in year 1 and 1.8% in year 2. These increases do not include any increase for the other elements of the contract such as on call and out of hours. Also, associate specialists who accept the new contract and increase their hours from 38.5 to 40 will receive the appropriate increase for the extra hours.

14.82 There are around 450 doctors in Northern Ireland eligible for the new contracts. The new contracts offer these doctors substantial increases in pay in return for reform. The proposals include improved job planning, improved incentives for working evenings and weekends and recognition for on call. The new contracts should significantly improve the recruitment, retention and morale of this group of doctors.

14.83 The increases in pay will be effective from 1 April 2008 subject to doctors expressing an interest and agreeing job plans within specific periods. The contract documentation was issued to all employers in Northern Ireland in April 2008. The Department ran a number of workshops for employers in June on the detail of the contracts. Trusts are currently collecting information on the numbers of doctors that may be interested in moving to the new contract.

14.84 The Department will be monitoring implementation of the new contracts in Northern Ireland, in particular how actual costs and benefits of the contracts compare against the expected costs and benefits.

Community Dentists

14.85 We are aware that a new contract has been agreed for salaried primary dental care dentists in England. The Department is currently considering whether a similar contract should be introduced for community dentists in Northern Ireland. The Department met the BDA in June 2008 to discuss the matter, in
particular the potential benefits to patients of introducing such a contract. The Department also recently commenced a survey of all trusts in Northern Ireland in order to help establish the costs of a new contract. The question of a new contract for community dentists is therefore at a very early stage. It should also be stressed that implementation of such a contract in Northern Ireland would require the approval of both the Minister for Health, Social Services and Public Safety, and the Department of Finance and Personnel.

Consultants

14.86 The new consultant contract was implemented in Northern Ireland with effect from 1 April 2004.

14.87 The last monitoring exercise on the contract took place in September 2007. At September 2007 98% of consultants in Northern Ireland were employed under the terms of the new contract – a total of 1194 consultants out of a population of 1220. The average number of programmed activities was 10.95 (compared to 11.32 at September 2006).

14.88 Over the past year the Department has been addressing the issue of job planning within the contract. The job planning process is a key element of the new contract. Effective job planning should help to improve productivity, efficiency and the quality of care for patients. This process has proved to be a difficult and challenging element of the contract in Northern Ireland. A group was set up including representatives from the Department, the BMA, and employers to address the issue, and new regional job planning guidance was agreed in May 2008. This guidance has been commended to all employers and consultants. It is hoped that the guidance will significantly improve the job planning process and will go some way to ensuring a fair and transparent approach for both employers and consultants.

14.89 The Department, over the past year, has been attempting to agree a benefits realization framework document with the BMA, in order to help establish exactly what benefits the contract has delivered for patients, employers and consultants. It is hoped that agreement can soon be reached and that the document can be issued to employers for completion.

Clinical Excellence Awards

14.90 In our evidence last year we advised that the new Northern Ireland Clinical Excellence Awards scheme, introduced in 2005, was subject to review after three years. We also mentioned that some disappointment had been expressed about the number of lower awards allocated to consultants by trusts in the first two years of the new scheme. We have no data at this stage on the number of lower awards allocated by trusts in the 2007-2008 year. However, the Department allocated an additional £100k to trusts in 2007-2008, as an interim measure pending the outcome of the review, to help alleviate some of the difficulties faced by trusts. The additional funding recognized the fact that in the first two years of the new scheme all higher awards were allocated to existing B distinction award holders, which meant that no awards were freed up locally through that mechanism.
14.91 The review of the scheme commenced in October 2007 when a review group was established. The review group included the Northern Ireland Clinical Excellence Awards Committee Chairman and Medical Director. The review covered a number of areas including the funding mechanism for lower awards. A consultation paper was issued in January 2008 and a total of 44 responses were received. The review group also met with the BMA on two occasions as part of the consultation process. The review group finalized its work in May 2008 when it made a number of recommendations to the Department.

14.92 The Minister, after very careful consideration, accepted all of the recommendations of the review group in July 2008. Annex K sets out in detail the review outcome. The Department has agreed to introduce a formula based approach to determine the number of lower awards, and to allocate additional resources to trusts to help meet these costs. A formula based system will be more transparent and will provide a greater degree of consistency across trusts. It will also guarantee and maintain an increase in the number of local awards. The level of formula set (0.25 awards per eligible consultant) takes into account affordability considerations and changes in the handling of step 9 awards. The Department has agreed that the committee should take over step 9 awards. This will have the effect of taking some financial pressure off trusts and freeing up more awards locally when step 9 higher awards are made to lower award holders. The Department accepts that the proposal on step 9 awards should be reviewed after three years to see if it remains necessary in light of the development of local awards.

14.93 It is also worth mentioning that, although the formula set for lower awards is lower than the England formula, Northern Ireland has a different awards scheme. The scheme in Northern Ireland has developed from previous consultation exercises. For example there are different rules on eligibility and with regard to the application process. In Northern Ireland self nomination by a consultant is the only method of applying for an award. A higher formula for lower awards could result in more awards being available than applications made. It is important to ensure that the awards allocated reflect “excellence” in the medical workforce. It may not always be appropriate therefore to simply replicate elements of the England scheme in Northern Ireland.

14.94 The Department intends to implement the recommendations of the review group for the 2008-2009 awards round, although this will mean a delay to the start of the awards round.

Affordability

DHSSPS 2009-10 Health and Social Services Budget

14.95 The 2009-10 DHSSPS budget is £4,356m, representing an increase of 3.38% from 2008-09. In addition to the resources allocated by the NI Executive, through the delivery of efficiency savings, entitlement to additional in-year resources, reductions to existing spending programmes and over committing existing budgets, DHSSPS has a total of £251.8m additional resources available in 2009-10.
The £251.8 million is required to meet the following:

- £216.7m to meet inescapable cost pressures including £94m to meet increases in costs of the Health and Social Care pay bill
- £35.3m for the development and improvement of patient services

The NI Health and Social Services budget will have to meet a range of expected pressures in 2009-10 from this settlement. Each Health and Social Care (HSC) organisation has been told to plan on making cash-releasing efficiency savings of 3% next year. In addition to pay awards and general non-pay inflation, HSC organisations face significant inescapable cost pressures arising from existing Ministerial commitments, demographic change and organisational restructuring.

These pressures mean that there is no flexibility within the Health and Social Services budget to afford pay cost increases in excess of the £94 million identified without impacting directly on patient care by way of reducing resources available for service improvement. DHSSPS has already taken the decision to commit more resources than are available to bring forward much needed service improvements in an effort to ensure Northern Ireland’s expenditure addresses the recommendations of the Appleby Review of the HPSS (broadly equivalent to Wanless in England).

Table 1 - DHSSPS budget position for 2009-10

<table>
<thead>
<tr>
<th></th>
<th>2009-10 £m</th>
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<tbody>
<tr>
<td><strong>Additional Resources Available:</strong></td>
<td></td>
</tr>
<tr>
<td>Additional funds allocated by NI Executive</td>
<td>136.8</td>
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<tr>
<td>Resources recycled through efficiency savings</td>
<td>115</td>
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<tr>
<td><strong>Total Funding available</strong></td>
<td>251.8</td>
</tr>
<tr>
<td><strong>Additional Resources Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>Inescapable costs</td>
<td>216.7</td>
</tr>
<tr>
<td>Service Developments</td>
<td>35.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>252.1</td>
</tr>
<tr>
<td><strong>Over Commitment</strong></td>
<td>-0.3</td>
</tr>
</tbody>
</table>

Pay Increase Funding

The £94m available is expected to meet the costs of the following:

- costs of pay awards arising during the year;
- the additional costs of incremental drift following the introduction of Agenda for Change and the Consultants Contract;
- the introduction of the unsocial hours element of Agenda for Change;
- the introduction of the new SAS Doctors contract;
- changes to grade and skill mix.

14.100 Pay reform consequentials are expected to cost £15m leaving £79m to meet the costs of pay awards – sufficient to meet an overall 2% award in 2009-10.

Detailed breakdown of the 2009-10 resource requirements

Table 2 – Breakdown of Inescapable Costs

<table>
<thead>
<tr>
<th></th>
<th>2009-10 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pay and Pay Reform consequentials</td>
<td>94,000</td>
</tr>
<tr>
<td>2 Non Pay at 2.7%</td>
<td>20,000</td>
</tr>
<tr>
<td>3 Pharmaceutical Services - Hospital and FHS Drug costs</td>
<td>48,000</td>
</tr>
<tr>
<td>4 Amended NHS Pension (Superannuation) Scheme</td>
<td>1,000</td>
</tr>
<tr>
<td>5 Pandemic Flu Emergency Provision</td>
<td>-1,000</td>
</tr>
<tr>
<td>6 Medical Workforce Training and Tuition Fees</td>
<td>6,000</td>
</tr>
<tr>
<td>7 Renal Services</td>
<td>1,000</td>
</tr>
<tr>
<td>8 Child Protection</td>
<td>1,000</td>
</tr>
<tr>
<td>9 Children with Complex Needs</td>
<td>1,000</td>
</tr>
<tr>
<td>10 Blood Safety</td>
<td>2,000</td>
</tr>
<tr>
<td>11 Revenue Consequences of capital investment</td>
<td>22,720</td>
</tr>
<tr>
<td>12 GP Contract</td>
<td>3,000</td>
</tr>
<tr>
<td>13 Additional acute costs</td>
<td>0</td>
</tr>
<tr>
<td>14 Mainstreaming Children and Young People's Package</td>
<td>-1,000</td>
</tr>
<tr>
<td>15 Demographic Pressures in Primary and Community Services</td>
<td>11,000</td>
</tr>
<tr>
<td>16 Capitation</td>
<td>7,000</td>
</tr>
<tr>
<td>17 Nursing mentoring</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Total Inescapable Costs</strong></td>
<td><strong>216,720</strong></td>
</tr>
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</table>

Table 3 – Breakdown of agreed Service Development Proposals

<table>
<thead>
<tr>
<th></th>
<th>2009-10 £’000</th>
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</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>1,350</td>
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<tr>
<td>Mental Health Welfare Reform</td>
<td>500</td>
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<tr>
<td>Primary Care Welfare Reform</td>
<td>-465</td>
</tr>
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<td>Mental Health NICITI</td>
<td>0</td>
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<tr>
<td>Learning Dis.</td>
<td>2,000</td>
</tr>
<tr>
<td>Long Term Conditions: Chronic disease</td>
<td>3,650</td>
</tr>
<tr>
<td>ECCH</td>
<td>0</td>
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<tr>
<td>Long Term Conditions: Remote monitoring</td>
<td>2,000</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1,000</td>
</tr>
<tr>
<td>Service</td>
<td>Amount</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Stroke</td>
<td>1,000</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>1,000</td>
</tr>
<tr>
<td>Cancer Control - Bowel Screening</td>
<td>1,000</td>
</tr>
<tr>
<td>Cancer Control HPV vaccination</td>
<td>6,000</td>
</tr>
<tr>
<td>Public Health</td>
<td>1,850</td>
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<tr>
<td>Public Health Suicide</td>
<td>0</td>
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<tr>
<td>Public Health Flu vaccination</td>
<td>150</td>
</tr>
<tr>
<td>Specialist Drugs</td>
<td>2,000</td>
</tr>
<tr>
<td>Quality &amp; Safety</td>
<td>0</td>
</tr>
<tr>
<td>Disability</td>
<td>1,000</td>
</tr>
<tr>
<td>Children</td>
<td>2,000</td>
</tr>
<tr>
<td>Acute Services</td>
<td>1,000</td>
</tr>
<tr>
<td>Elective Care Access</td>
<td>1,000</td>
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<tr>
<td>NI Fire and Rescue Service</td>
<td>0</td>
</tr>
<tr>
<td>Research and development</td>
<td>0</td>
</tr>
<tr>
<td>Fertility and Paediatric Cardiac Services</td>
<td>1,300</td>
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<tr>
<td>Free Prescriptions</td>
<td>6,000</td>
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<tr>
<td><strong>Total Service Developments</strong></td>
<td><strong>35,335</strong></td>
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</table>

**Pay Conclusion**

14.101 The Executive is committed to implementing UK national pay policy as defined by UK guidance. The presumption is that the Department of Health rationale for a pay settlement in the region of 2.0% should apply to Northern Ireland but the Executive reserves its position as the Pay Review Body considers the Northern Ireland evidence.
ANNEXES
PAY METRICS (ENGLAND)

Historical figures
The historical pay metrics (up to and including 2006/07) have been estimated using pay bill data from NHS financial returns, NHS accounts, and Foundation Trust annual reports, together with workforce statistics from the annual NHS workforce census.

Figures for 2007/08, 2008/09 and 2009/10 are projections (see below).

The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors’ employees, GPs, other GP practice staff or family dentists and their staff.

The pay bill figures come from the NHS financial returns and Foundation Trust annual reports. The latter do not include a breakdown by staff group, so this has been estimated using the NHS financial returns. Pay bill per full-time equivalent (FTE) employee has been calculated by dividing pay bill by the FTE number of staff.

Earnings and earnings per FTE figures have been estimated from the pay bill and pay bill per FTE figures using NHS accounts data together with the NHS Pension Scheme and National Insurance rates and thresholds which apply to NHS employers.

Some minor changes have also been made to 2006/07 figures. This takes account of some small errors identified in the Financial Returns.

Note that, in years when the number of staff in higher paid staff groups has grown by more than the number in lower-paid groups, the average earnings figure for all staff has increased as a result.

Pay bill and pay bill per FTE figures had a step increase in 2004/05 when responsibility for the cost of pensions indexation was transferred from the Treasury to NHS employers.
Projected figures

Figures for 2007/08, 2008/09 and 2009/10 have been projected from the 2006/07 estimates.

The workforce FTE figures for each staff group are taken from the September 2007 NHS census (published March 2008) for 2007/08 and, for 2008/09 and 2009/10 are supply projections produced by the NHS Workforce Review Team for DDRB staff, and demand projections produced by DH for NHSPRB staff. These have been selected as the best available forecasts. Projections for medical and dental groups have been modelled individually, taking into account information on current numbers employed by the NHS, age profiles, historical retirement trends, training numbers, international recruitment, wastage, historical career trends and participation rates as appropriate.

Projections for 2007/08 have been calculated for each staff group by applying the general pay uplift, workforce growth, estimated earnings drift and estimated on-costs drift to the 2006/07 estimates. Projections for 2008/09 and 2009/10 have been calculated in a similar way, based on the 2007/08 projections, but with a range of general pay uplift figures for 2009/10.

Earnings drift for each staff group has been estimated using a combination of analysis of historical earnings growth together with estimates of the cost of specific drivers. These drivers include recent and planned NHS pay reform and the forthcoming national increase in minimum holiday entitlement. Other drift will arise from previous changes to national pay arrangements; occupation and grade drift (skill mix change); local pay decisions; and use of other earnings, eg use of overtime, use of recruitment & retention premia and bonuses.

On-costs drift has been estimated using the projected earnings per FTE figures together with expected increase in employers’ pension contribution rate and the published and expected national insurance rates and thresholds relevant to NHS employers.
Pay metrics for DDRB remit (England)

### HCHS Medical Paybill (£million)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultants</strong></td>
<td>1,773m</td>
<td>2,024m</td>
<td>2,278m</td>
<td>2,538m</td>
<td>3,114m</td>
<td>3,681m</td>
<td>3,983m</td>
<td>4,310m</td>
<td>4,554m</td>
<td>4,877m</td>
<td>5,145m</td>
</tr>
<tr>
<td><strong>Training grades</strong></td>
<td>1,302m</td>
<td>1,432m</td>
<td>1,699m</td>
<td>1,938m</td>
<td>2,266m</td>
<td>2,532m</td>
<td>2,668m</td>
<td>2,804m</td>
<td>2,843m</td>
<td>3,045m</td>
<td>3,156m</td>
</tr>
<tr>
<td><strong>Other medical</strong></td>
<td>483m</td>
<td>541m</td>
<td>611m</td>
<td>685m</td>
<td>763m</td>
<td>864m</td>
<td>920m</td>
<td>967m</td>
<td>992m</td>
<td>1,150m</td>
<td>1,210m</td>
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<tr>
<td><strong>Total HCHS med</strong></td>
<td>3,558m</td>
<td>3,997m</td>
<td>4,589m</td>
<td>5,161m</td>
<td>5,642m</td>
<td>6,142m</td>
<td>6,777m</td>
<td>7,571m</td>
<td>8,081m</td>
<td>8,388m</td>
<td>9,072m</td>
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### Growth in HCHS Medical Paybill

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<tr>
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<td>12.1%</td>
<td>14.2%</td>
<td>12.6%</td>
<td>11.4%</td>
<td>22.7%</td>
<td>18.2%</td>
<td>8.2%</td>
<td>8.2%</td>
<td>5.6%</td>
<td>7.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Training grades</strong></td>
<td>9.1%</td>
<td>10.0%</td>
<td>18.7%</td>
<td>14.1%</td>
<td>16.9%</td>
<td>11.7%</td>
<td>5.4%</td>
<td>5.1%</td>
<td>1.4%</td>
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<tr>
<td><strong>Other medical</strong></td>
<td>11.8%</td>
<td>12.0%</td>
<td>13.0%</td>
<td>12.1%</td>
<td>11.4%</td>
<td>13.3%</td>
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<td>2.6%</td>
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<tr>
<td><strong>Total HCHS med</strong></td>
<td>11.0%</td>
<td>12.3%</td>
<td>14.8%</td>
<td>12.5%</td>
<td>19.0%</td>
<td>15.2%</td>
<td>7.0%</td>
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### HCHS Medical Paybill per FTE (£)

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### Growth in HCHS Medical Paybill per FTE

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<tr>
<td><strong>Training grades</strong></td>
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<td>7.5%</td>
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<tr>
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### HCHS Medical Earnings per FTE (£)$

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<td>117,728</td>
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<td>50,950</td>
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### Growth in HCHS Medical Earnings per FTE$

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<td>14.9%</td>
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<td>3.2%</td>
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<tr>
<td>Training grades 6</td>
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<td>6.4%</td>
<td>14.3%</td>
<td>7.5%</td>
<td>8.5%</td>
<td>-4.6%</td>
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<td>0.1%</td>
<td>0.2%</td>
<td>1.5%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Other medical 7</td>
<td>10.7%</td>
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<td>8.1%</td>
<td>5.0%</td>
<td>11.4%</td>
<td>6.0%</td>
<td>6.0%</td>
<td>2.0%</td>
<td>1.5%</td>
<td>8.4%</td>
<td>1.5%</td>
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<tr>
<td>Total HCHS med</td>
<td>8.2%</td>
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<td>2.1%</td>
<td>2.9%</td>
<td>0.6%</td>
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### HCHS Medical workforce$

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<td>46,051</td>
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<td>8,987</td>
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<td>9,517</td>
<td>9,666</td>
<td>9,661</td>
<td>9,934</td>
<td>10,053</td>
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<td>11,166</td>
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<td>72,260</td>
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<td>85,975</td>
<td>87,533</td>
<td>92,158</td>
<td>96,144</td>
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</table>

### Growth in HCHS Medical workforce$

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<td>4.0%</td>
<td>7.3%</td>
<td>6.4%</td>
<td>6.8%</td>
<td>5.2%</td>
<td>3.4%</td>
<td>2.6%</td>
<td>3.9%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Training grades 6</td>
<td>1.4%</td>
<td>2.3%</td>
<td>2.6%</td>
<td>6.0%</td>
<td>7.3%</td>
<td>11.7%</td>
<td>6.5%</td>
<td>4.9%</td>
<td>1.4%</td>
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</tr>
<tr>
<td>Other medical 7</td>
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<td>-0.6%</td>
<td>1.6%</td>
<td>-0.1%</td>
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<td>1.2%</td>
<td>7.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Total HCHS med</td>
<td>2.7%</td>
<td>2.9%</td>
<td>3.2%</td>
<td>6.6%</td>
<td>5.9%</td>
<td>8.6%</td>
<td>5.2%</td>
<td>4.1%</td>
<td>1.8%</td>
<td>5.3%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Notes:
1. Figures for NHS Staff in England only & exclude agency
2. Includes estimates for Foundation Trusts
3. Pay bill figures taken from final NHS financial returns for 2006/07.
4. Figures in grey are projections and subject to change. Growth includes hangover from staging of settlement in the previous year. This gives an additional 0.3% increase in earnings for the year for training grades above
5. In 2004/05 responsibility for the cost of pensions indexation shifted from HMT to NHS employers.
6. All medical training grades, includes Foundation years 1&2, house officer, senior house officer and all registrar groups. Breakdown of training grades into previous registrar and HO/SHO groups is not possible because of MMC.
7. All non-consultant medical & dental staff not in training posts. Includes associate specialists, staff grade and dental officers.
8. Workforce figures for 2008/09 and beyond are projections and subject to change.
9. In 2006/07, consultants pay settlement was staged (1% in April, 2.2% in November) giving an overall settlement uplift of 1.5% in the year.
ANNEX B

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 for the years from 1 April 2003. 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 2003.

For example, a new staff grade starting on 1 April 2003 on the minimum of the scale would have received basic pay of £29,060. By April 2008, the doctor would have progressed to point 5 of the pay scale and the doctor’s basic salary would have increased to £46,935 - an increase of 61.5% over 5 years. The basic salary of a consultant with thirty years seniority who transferred to the new contract has increased from £78,195 in April 2003 to £98,962 in April 2008 – an increase of 26.5%. A consultant who was on the maximum of the scale on 1 April 2003 and who chose to remain on the pre-2003 contract has had a salary increase of 11.7% over 5 years.

<table>
<thead>
<tr>
<th>GRADE</th>
<th>YEAR</th>
<th>(a) ACTUAL BASIC SALARY £</th>
<th>(b) ANNUAL % INCREASE (of which DDRB headline award)</th>
<th>(c) CUMULATIVE % INCREASE (of which DDRB headline award)</th>
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<td>SHO</td>
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<td>23,940</td>
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<td>33,472</td>
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<td>SpR</td>
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<td>(a) ACTUAL BASIC SALARY £</td>
<td>(b) ANNUAL % INCREASE (of which DDRB headline award)</td>
<td>(c) CUMULATIVE % INCREASE (of which DDRB headline award)</td>
</tr>
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<td>Consultant (30+ years seniority on transfer to new contract)</td>
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<td></td>
<td>1 April 2005 (threshold 5)</td>
<td>78,094</td>
<td>9.0 (2.2)</td>
<td>16.2 (8.9)</td>
</tr>
<tr>
<td></td>
<td>1 Nov 2006 (threshold 6)</td>
<td>85,153</td>
<td>7.4 (1.1)</td>
<td>24.8 (10.1)</td>
</tr>
<tr>
<td></td>
<td>1 Nov 2007 (threshold 7)</td>
<td>91,495</td>
<td>2.2 (2.2)</td>
<td>27.6 (12.5)</td>
</tr>
<tr>
<td></td>
<td>1 April 2008 (threshold 7)</td>
<td>93,508</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant (remaining on pre-2003 contract)</td>
<td>1 April 2003 (maximum)</td>
<td>70,715</td>
<td>2.5 (2.5)</td>
<td>2.5 (2.5)</td>
</tr>
<tr>
<td></td>
<td>1 April 2004 (maximum)</td>
<td>72,483</td>
<td>3.0 (3.0)</td>
<td>5.6 (5.6)</td>
</tr>
<tr>
<td></td>
<td>1 April 2005 (maximum)</td>
<td>74,658</td>
<td>2.2 (2.2)</td>
<td>7.9 (7.9)</td>
</tr>
<tr>
<td></td>
<td>1 Nov 2006 (maximum)</td>
<td>76,300</td>
<td>1.3 (1.3)</td>
<td>9.3 (9.3)</td>
</tr>
<tr>
<td></td>
<td>1 Nov 2007 (maximum)</td>
<td>77,300</td>
<td>2.2 (2.2)</td>
<td>11.7 (11.7)</td>
</tr>
<tr>
<td></td>
<td>1 April 2008 (maximum)</td>
<td>79,001</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IMPLEMENTATION OF SAS CONTRACT: LIST OF NHS EMPLOYERS
GUIDANCE FOR EMPLOYERS

The following documents are available on NHS Employers website:
http://www.nhsemployers.org/pay-conditions/pay-conditions-1206.cfm

- **SAS Contract** The new model contract for SAS doctors.

- **Terms and conditions of service for associate specialists – England (April 2008)** Terms and conditions of service for associate specialists for the new contractual arrangements.

- **Terms and conditions of service for specialty doctors – England (April 2008)** Terms and conditions of service for specialty doctors for the new contractual arrangements.

- **Applications for re-grading to associate specialist through a Window of Opportunity** Collective agreement between NHS Employers and the BMA setting out the arrangements that shall apply to applications for re-grading to associate specialist through the window of opportunity.

- **Employing and supporting specialty doctors: a guide to good practice (April 2008)** NHS Employers has produced this good practice guide, in association with the DH Modernising Medical Careers (MMC) team, for employers of specialty doctors to help them work towards the common goals of improved standards.


- **Standard person specification** Standard person specification for a specialty doctor post.

- **Guide to contracting for additional programmed activities for associate specialists and specialty doctors (December 2007)** Guide to best practice for contractual arrangements for planned programmed activities.

- **Contract for APA Current Workload FT** Model contract for one or more Additional PA(s) for a full-time specialty doctor or associate specialist to recognise current workload.

- **Contract for APA Current Workload PT** Model contract for one or more Additional PA(s) for a part-time specialty doctor or associate specialist to recognise current workload.
• **Contract for APA Spare Pro Cap FT** Model contract for one or more Additional PA(s) for a full-time specialty doctor or associate specialist to recognise spare professional capacity.

• **Contract for APA Spare Pro Cap PT** Model contract for one or more Additional PA(s) for a part-time specialty doctor or associate specialist to recognise spare professional capacity.

• **Transitional pay and incremental arrangements for associate specialists and specialty doctors version 2** Updated version of the transitional pay and incremental arrangements for associate specialists and specialty doctors.

• **Contract proposals for specialty doctors and associate specialists: introduction for employers** (March 2008) This briefing provides an overview of the proposed arrangements for new contracts for staff and associate specialist doctors and the implications for employers.

• **Model expression of interest letter** Model letter to SAS doctors asking whether they wish to express an interest in moving to the new specialty doctor or associate specialist (2008) contracts.

• **Model offer letter** Model offer letter for new SAS contractual arrangements 2008.

• **Clinical manager checklist** A checklist to help clinical managers with the job planning process.

• **Doctor checklist** A checklist to help doctors with the job planning process.

• **Doctor Job planning Diary** A diary to help doctors with the job planning process.

• **Guide to Job planning: Specialty doctors and associate specialist (April 2008)** Job planning checklist and diary.

• **Pay circular (M&D) 1/2008** - introduces the new arrangements and sets out pay scales (2007/08 rates).
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; 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 and training numbers have increased to reflect an expected decline in participation rates.

**How are retirement rates modelled?**

4. Workforce modelling for the Department of Health is performed by the NHS Workforce Review Team (WRT), 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 and the NHS 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.

**Data on early retirement intentions**

9. The Medical Careers Research Group (MCRG) provided 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 (latest data available). 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.

10. This 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 between 1997 to 2008 by category of retirement. The figures include all retirements on grounds of age, ill health, premature retirements following redundancy or interests of efficiency and voluntary early retirement before age 60 (introduced from 6 March 1995). Where possible data is shown separately for each category.

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 30.

16. 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

17. It should be noted that the current extract may not be consistent with previous DDRB extracts due to a number of factors e.g. on-going program to cleanse member records.

18. As with previous years’ evidence, the figures relate to England and Wales. It has not been possible to dis-aggregate Welsh data for this exercise.

19. The NHS Pensions data recording system manages over 1.3 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.

20. In addition to the above consideration, the BSA introduced a pension processing system in October 2005. The retirement data provided since September 2006, to assist in supporting evidence/guidance for DDRB, represented the extract from this new pension processing system. This new system is designed to assist in the daily processing of pension calculations and will in the future support scheme valuation, however development to utilise the system for valuation has yet to be fully defined and validated. The latest information has been amended to reflect the latest extract over retrospective years, but comparisons across the yearly reports is not possible.

### Table 1: Consultant Retirements and Reasons for Retirement

<table>
<thead>
<tr>
<th>Year end 31 March</th>
<th>Age</th>
<th>Ill-health</th>
<th>Deferred Pension Benefits</th>
<th>Redundancy</th>
<th>Agreed Voluntary Early Retirement (AVER)</th>
<th>Voluntary Early Retirement (VER)</th>
<th>Unknown</th>
<th>Total Pension Awards</th>
<th>Retirement Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>258</td>
<td>57</td>
<td>37</td>
<td>27</td>
<td>*</td>
<td>*</td>
<td>33</td>
<td>412</td>
<td>1.91</td>
</tr>
<tr>
<td>1998</td>
<td>296</td>
<td>52</td>
<td>38</td>
<td>19</td>
<td>*</td>
<td>*</td>
<td>35</td>
<td>440</td>
<td>1.97</td>
</tr>
<tr>
<td>1999</td>
<td>274</td>
<td>57</td>
<td>26</td>
<td>18</td>
<td>*</td>
<td>*</td>
<td>37</td>
<td>412</td>
<td>1.76</td>
</tr>
<tr>
<td>2000</td>
<td>294</td>
<td>55</td>
<td>27</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>25</td>
<td>412</td>
<td>1.68</td>
</tr>
<tr>
<td>2001</td>
<td>338</td>
<td>66</td>
<td>40</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>29</td>
<td>484</td>
<td>1.87</td>
</tr>
<tr>
<td>2002</td>
<td>355</td>
<td>65</td>
<td>30</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>26</td>
<td>483</td>
<td>1.78</td>
</tr>
<tr>
<td>2003</td>
<td>325</td>
<td>59</td>
<td>25</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>31</td>
<td>447</td>
<td>1.55</td>
</tr>
<tr>
<td>2004</td>
<td>360</td>
<td>56</td>
<td>33</td>
<td>16</td>
<td>*</td>
<td>*</td>
<td>36</td>
<td>501</td>
<td>1.53</td>
</tr>
<tr>
<td>2005</td>
<td>358</td>
<td>46</td>
<td>33</td>
<td>9</td>
<td>*</td>
<td>*</td>
<td>40</td>
<td>486</td>
<td>1.51</td>
</tr>
<tr>
<td>2006</td>
<td>476</td>
<td>52</td>
<td>29</td>
<td>6</td>
<td>4</td>
<td>42</td>
<td>47</td>
<td>656</td>
<td>1.99</td>
</tr>
<tr>
<td>2007</td>
<td>592</td>
<td>58</td>
<td>14</td>
<td>6</td>
<td>3</td>
<td>76</td>
<td>34</td>
<td>783</td>
<td>2.32</td>
</tr>
<tr>
<td>2008</td>
<td>624</td>
<td>58</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>86</td>
<td>32</td>
<td>821</td>
<td>2.43 (ii)</td>
</tr>
</tbody>
</table>

* AVER and VER Data for 1997 – 2005 is not separately captured in this extract.

(i) total pension awards as a percentage of consultant workforce (headcount) as at 30 September

(ii) based on 2007 workforce numbers as 2008 numbers are not available until 2009

**MCRG Analysis of Wastage Rates**

21. The MCRG figures on wastage rates provided to DDRB in previous years were based solely on respondents from their surveys. They were therefore vulnerable to non-responder bias. Non-responders are more likely to be abroad, or working outside the NHS or outside medicine, and consequently are less likely to have been easy to contact and to have replied to their surveys. This results in an under-estimate of the numbers not in UK medicine.

22. MCRG worked with DH, and used data from the DH employment record to augment the data from their surveys. By the use of a statistical method known as capture-recapture
analysis, they have calculated the number and percentage of doctors in each year of qualification which they have studied, who were not working in the NHS five years after qualification. The result is a more reliable measure of non-participation. It is also specifically related to **non-participation in the NHS** rather than non-participation in UK medicine, or in medicine as a whole. This is a measure more applicable to DDRB’s purposes than the previous measure related to UK medicine as a whole.

### Results and commentary

23. The MCRG have calculated figures for five years after qualification (i.e. graduation from medical school in the UK) for five cohorts of doctors who qualified between 1999 and 1983. The most recent data therefore correspond to the qualifiers of the year 1999 and represent their working situation in September 2004. Data for the 2002 cohort in 2007 will be calculated in the coming months, when data for September 2007 will become available.

24. The numbers and percentages of doctors not in the NHS **five years** after qualification are shown in Table 2 below. Figures are provided separately for all doctors, for doctors whose family home prior to entering medical school was known to be in Great Britain, and for those who were known to have come from outside Great Britain to study medicine.

25. The first part of the table (section (a)) shows a steady fall from 19.9% non-participation in the NHS among the qualifiers of 1988 in 1993, to 14.6% of the 1999 qualifiers in 2004.

26. Among doctors from family homes in Great Britain (section (b) of the table), the pattern is similar with the percentage falling from 16.0% of 1988 qualifiers to 13.1% of 1999 qualifiers.

27. The small number of doctors from family homes outside Great Britain (section (c) of the table) showed approximately 30% wastage from UK medicine after five years, in each cohort surveyed.

28. It should be noted that the percentages not practising in the NHS shown in this table are higher than the percentages quoted on previous occasions for those not practising in UK medicine. This is partly because of responder bias as described above; and partly because the percentage not in UK medicine will always be lower than the percentage not in the NHS (because the latter includes those working in areas of UK medicine outside the NHS).
Table 2: Percentages of all medical qualifiers from medical schools in Great Britain, who were working in the NHS in Great Britain five years after qualification (excludes graduates from Northern Ireland)

(a) All doctors regardless of place of family home

<table>
<thead>
<tr>
<th>Year of qualification</th>
<th>Number in cohort</th>
<th>Percent (number) not working in the NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Not yet available</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>4003</td>
<td>14.6% (583)</td>
</tr>
<tr>
<td>1996</td>
<td>3678</td>
<td>16.1% (592)</td>
</tr>
<tr>
<td>1993</td>
<td>3482</td>
<td>16.6% (580)</td>
</tr>
<tr>
<td>1988</td>
<td>3536</td>
<td>19.9% (705)</td>
</tr>
<tr>
<td>1983</td>
<td>3631</td>
<td>16.7% (608)</td>
</tr>
</tbody>
</table>

(b) Doctors from family homes in Great Britain

<table>
<thead>
<tr>
<th>Year of qualification</th>
<th>Number in cohort</th>
<th>Percent (number) not working in the NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Not yet available</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>2783</td>
<td>13.1% (364)</td>
</tr>
<tr>
<td>1996</td>
<td>3103</td>
<td>14.8% (459)</td>
</tr>
<tr>
<td>1993</td>
<td>2921</td>
<td>14.6% (426)</td>
</tr>
<tr>
<td>1988</td>
<td>2529</td>
<td>16.0% (405)</td>
</tr>
<tr>
<td>1983</td>
<td>3138</td>
<td>15.2% (477)</td>
</tr>
</tbody>
</table>

(c) Doctors from family homes outside Great Britain

<table>
<thead>
<tr>
<th>Year of qualification</th>
<th>Number in cohort</th>
<th>Percent (number) not working in the NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Not yet available</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>128</td>
<td>28.0% (36)</td>
</tr>
<tr>
<td>1996</td>
<td>106</td>
<td>29.2% (31)</td>
</tr>
<tr>
<td>1993</td>
<td>170</td>
<td>27.1% (46)</td>
</tr>
<tr>
<td>1988</td>
<td>103</td>
<td>31.1% (32)</td>
</tr>
<tr>
<td>1983</td>
<td>204</td>
<td>27.1% (55)</td>
</tr>
</tbody>
</table>

Note: Family home is not known for different numbers of doctors in each cohort; hence the numbers in sections (b) and (c) above do not add to those in (a).

Source: MRCG, Oxford University
Update on the Treasury Minutes to the Thirty Fifth Report, together with the Fifty Seventh to the Sixty Fifth Reports from the Committee of Public Accounts 2006-2007

35th Report  BBC Outsourcing: The BBC’s contract with Sloman Business Services - Update
57th Report  DEFRA: Reducing the reliance on landfill in England
58th Report  Estimating and monitoring the costs of building roads in England
60th Report  Big Science: Public Investment in large science facilities
61st Report  Managing the Defence Estate
62nd Report  The Thames Gateway: Laying the foundations
63rd Report  HM Treasury: Tendering and benchmarking in PFI
64th Report  The management of staff sickness absence in the Department for Transport and its Agencies
65th Report  Filing of VAT and Company Tax Returns

Presented to Parliament by the Exchequer Secretary to the Treasury by Command of Her Majesty
February 2007
Fifty Ninth Report

Department of Health

Pay Modernisation: a new contract for NHS Consultants in England

1. The Department of Health (the Department) welcomes the Committee’s report and recommendations on the first major revision of the consultant contract for over 50 years. The report examined the contract negotiation; the cost implications; the effectiveness of the implementation process; and the extent to which the expected benefits for patients and the NHS had been realised.

2. The consultant contract is a fundamental reform to the way the NHS contracts with its most senior doctors. The contract introduces improved transparency and accountability. It provides a strong platform on which to build; however, it represents a major cultural change. The costs and benefits of the contract therefore need to be judged over a reasonable time frame.

PAC Conclusion (1): The Department underestimated the cost of the new contract by at least £150 million. It did not model its financial assumptions in a rigorous way and did not draw, for example, on all available workload data. The Department should use sufficient, relevant and reliable data to cost new policies more accurately.

PAC Conclusion (2): The Department did not pilot the new contract before implementation, and it underestimated the scale of change in introducing the new contract. The implementation of the new contract was rushed and hospital trusts concentrated on getting new consultants on to the new contract, rather than planning how to use the contract to improve the delivery of services. Major new Human Resource policies should be fully piloted within the NHS before implementation to test any assumptions and effects.

3. The Department accepts that the contract cost more than was first estimated and allocated. The Department’s Workforce Directorate, supported by its Finance and Economic & Operational Research Directorates, conducted extensive and thorough financial modelling using all the available data. A key problem at the time was the lack of robust information from NHS organisations about actual consultant activity. A potential cost pressure was identified during implementation; based on estimates of this pressure an additional £150 million funding was invested, although subsequent analysis suggested that the actual cost pressure was nearer to £90 million. The National Audit Office report stated that measuring the actual cost of the contract is complex, but estimated the actual cost as between £649 million and £765 million, compared to total Departmental funding of £715 million.
4. The Department agrees that relevant and reliable data should be used to cost new policies. For workforce and pay policies, the introduction of the Electronic Staff Record (ESR) system will provide much more extensive data to inform the modelling and costing of new workforce policies. ESR now covers over one million NHS staff and its implementation is due to be completed by April 2008. The importance of reliable data has been reinforced in the NHS Operating Framework, published by the Department on 13 December 2007, which states: "From April 2008, the data warehouse fed from the Electronic Staff Record will increasingly be used for strategic workforce planning and monitoring purposes. Trusts should focus on workforce data quality."

5. The Department has also introduced new procedures for ensuring that policy costing is subject to rigorous testing. In May 2006, the Department established the Revenue Investment Branch (RIB) to help improve the quality of forecasting the financial impact of its policies on the NHS, central budgets and arm's length bodies.

6. In July 2007 the RIB issued guidance in a costing handbook, which will assist policy makers (and their analytical staff) to cost policy proposals and ensure transparent accountability for risk and uncertainty. The RIB has also provided a series of workshops for policy staff to assist them to apply the methodology set out in the handbook.

7. The RIB has already reviewed the costs associated with a range of significant policies to ensure that proposals have been adequately tested and that the quality of the financial advice provided is sound.

8. The Department agrees it should consider whether to pilot new HR policies before implementing them across the NHS, and to do so where this is practical and beneficial. This approach has already been applied in the reform of non-medical pay where extensive and thorough cost modelling for Agenda for Change was supplemented by one year's information from 12 early implementer (pilot) sites. The Department did wish to pilot the consultant contract but in negotiations the British Medical Association (BMA) was not prepared to accept any pilot exercise.

PAC Conclusion (3): Many hospital managers negotiated more hours with consultants than their NHS trust could afford. NHS trusts failed to set a cost envelope and clinical managers agreed hours of work based on historical patterns of working, which they could not afford. In taking the contract forward, NHS trusts should set boundaries within which managers should negotiate individual contracts based on a clear understanding of what work the trust needs and can afford.

9. The Department agrees that some trusts had cost over runs, others managed to work within the financial envelope. However, trusts have improved their job planning processes and as mentioned in paragraph 17 of the Committee's report, "since 2005-06 the average number of programmed activities (PAs) that NHS trusts have agreed with consultants has decreased and therefore the cost pressure has reduced."

10. The Department agrees that job planning between employers and consultants should be based on a prospective assessment of the contribution required from consultants to meet patient and service needs. This should be informed by local delivery plans, trust business plans and sound financial planning.
 PAC Conclusion (4): Productivity of consultants has decreased, consultants are now working fewer hours than they did under the old contract, and activity per consultant has reduced. The Department expected that the new contract would deliver productivity gains of 1.5 per cent per year through efficiency gains and quality improvements. The Department's original method for evaluating productivity suggests it has decreased by 0.5 per cent in the first year of the contract. The Office of National Statistics has now developed more sophisticated measures of productivity but figures are not yet available for 2005 and 2006. NHS Employers should help NHS trusts identify appropriate ways of measuring and comparing productivity of consultants locally.

11. The Committee’s report clearly states in paragraph 21 that it is too early to tell the effect of the contract on consultant productivity. This does not support the conclusion that consultant productivity has decreased.

12. The introduction of the new contract reflected the Government’s clear intention to reduce individual consultant hours to improve consultants’ working lives, quality of patient care and patient safety, and comply with European Working Time Regulations. Activity per consultant was expected to fall in line with this reduction in hours worked but this is not the same as a reduction in consultant productivity.

13. An ONS publication on health productivity in January 2008 included new estimates of NHS productivity. Measurement of health productivity is very difficult, and caution should be taken when interpreting the figures that are sensitive to the method of measurement. However, they do show that the trend of declining productivity since 2000 levelled off in 2004, 2005 and particularly 2006. This improvement is due to renewed focus on efficiency across the NHS, and in particular to improvements in front line service design and care pathways. The new contract provided the flexibility and incentives by which consultants could be engaged to lead and deliver these important changes that are continuing. The ONS figures currently include only partial recognition of improved quality of healthcare and health outcomes.

14. The NHS Employers organisation is working with a range of stakeholders to develop productivity measures across the NHS. In the meantime, the Department remains keen that trusts are able to benchmark the clinical activity of consultants. The Department has therefore produced Delivering Quality and Value: Consultant Clinical Activity 2005-06, (which measures inpatient activity but excludes other duties such as management, teaching and research etc) and enables clinicians and managers to:

- compare the activity rates of consultants within their trust to national activity rates;
- compare activity rates across specialty areas;
- identify the highest performing consultants to spread the working practices and techniques that are enabling high performance;
- inform job planning and appraisal;
- help consultants consider where their efforts might best be applied to achieve greatest productivity and patient care improvements.
15. The Department plans to repeat this exercise using data for 2006-07 and 2007-08.

16. The information presented in the Delivering Quality and Value publication is consistent with that used in the Better Care Better Value Benchmarking tool launched by the DH and NHS Institute in September 2006. This tool allows trusts and primary care trusts (PCTs) to compare their performance in key areas with other organisations, to identify the areas that provide the greatest opportunity for delivering efficiency and productivity gains through service improvements.

PAC Conclusion (5): NHS trusts with their clinical managers did not have the time or expertise to negotiate or carry out effective job planning. The Department and NHS Employers should develop training aids and tools, such as electronic job plan software, to help managers improve their capability and capacity to carry out effective job planning, and NHS trusts should allocate enough time to medical managers for job planning.

PAC Conclusion (6): In the first two years of the contract, job planning tended to follow historical patterns of service provision, with insufficient links to organisational objectives and little consideration of redesigning services, such as introducing evening clinics, to meet patient needs. NHS trusts should agree job plans, in partnership with consultants or teams of consultants, which are consistent with organisational objectives and reflect feedback from patients. Whilst job plans should be renegotiated annually, managers and consultants should assess individual job plans more frequently and agree to modifications, where appropriate, if they fail to meet patient needs.

17. The Department agrees that trusts did not all have the time or expertise to carry out effective job planning during the early stages of implementation: this worked best where it was done in partnership between clinicians, financial managers and HR managers. The Department agrees that appropriate tools should be used by NHS trusts to support effective prospective job planning including annual and ongoing review.

18. However, the Department issued a number of guidance documents at the time the consultant contract was being implemented. One of these was the Job Planning Toolkit, developed by the former NHS Modernisation Agency and launched jointly with the BMA in January 2005. This is still available online at NHS Employers website for NHS trusts and employers to use. It includes a job planning handbook, a training package, a reference manual and an evaluation framework.

19. More recently, the Department of Health has commissioned NHS Employers to deliver a Large Scale Workforce Change Programme over ten months from October 2007. This is a fast-paced programme based around the consultant contract, and focused on sharing good practice to deliver benefits to patients, staff and employers. The specific overall aim is to help trusts and consultants to identify, articulate and share benefits and learning that have been secured through effective implementation of the contract. This includes consideration of how the NHS is using IT applications to manage and update consultant job plans. The programme is running at full capacity, with 46 trusts participating. NHS Employers will communicate the learning to the wider NHS in autumn 2008.
PAC Conclusion (7): The proportion of time consultants spend on direct clinical care has not reached the expected 75 per cent level, and NHS trusts have not used the contract to extend patient services, such as providing out-patient clinics at the weekend. NHS trusts should negotiate job plans for consultants based on the Department’s objective that at least 75 per cent of their time should be spent on direct clinical care. They should use the job planning process, in partnership with consultants, to redesign services and improve the patient experience. NHS Employers should identify and share good practice in using job planning to extend patient services and tailor them to patient need.

20. The Department does not support the recommendation that all consultants’ job plans should assign 75 per cent of their time to direct clinical care. This would remove one of the key flexibilities in the contract that allows employers to tailor consultants’ duties according to patient and service need.

21. It was not the Department’s objective to set such a target. The Heads of Agreement between the Government, NHS Employers and the BMA in July 2003 stated that full time consultants would “normally devote on average 7.5 programmed activities per week to direct clinical care except where their agreed level of duties in relation to supporting professional activities, additional responsibilities and other duties is significantly greater or lower than 2.5 programmed activities. In this case, there will be local agreement as to the appropriate balance between direct clinical care and other activities”. The model contract leaves the balance to be agreed locally.

22. The amount of time spent on direct clinical care has increased as a proportion of time worked since the implementation of the contract. Whilst individual consultant hours have reduced there has been an increase in the number of consultants, resulting in the number of consultant hours devoted to direct clinical care increasing from around 695,000 in 1998 to around 920,000 in 2005. The Department therefore sees no need to constrain the local flexibility that allows employers to secure and adjust the consultant contribution according to changing patient and service needs, and to ensure that appropriate consultant time is allocated to other important duties such as teaching, management, audit and research.

23. The Department agrees that employers should use the job planning process to improve the patient experience. The Large Scale Workforce Change Programme, mentioned above, will speed the spread of best practice.

PAC Conclusion (8): Consultants’ pay has, on average, risen by 27 per cent in the first three years of the contract compared to the Department’s prediction of a 15 per cent increase. Higher pay has helped improve recruitment and retention and has halted a rising trend in the amount of private practice carried out by NHS consultants. The increased pay will only be justified, however, if the expected improvements to productivity are achieved. In return for their increased pay, consultants should increase their support for service redesign with the aim that productivity gains will be achieved by working differently.
24. Consultant pay has increased broadly in line with the Government's intention which was to deliver, over time, a 15 per cent real terms increase in career earnings and a 24 per cent increase in the maximum basic salary. These increases were accompanied by a multi-year pay deal providing headline awards of 10 per cent over three years.

25. Pay for consultants in NHS trusts did increase by an average of 27 per cent over the first three years of the contract. However, the total average increase (for all NHS consultants) was 24 per cent. Figures from the DH historical pay bill model show average consultant pay in 2002-03 was £88,222 and in 2005-06 £109,338 – showing an increase of 24 per cent over the first three years of the contract (2003-04 to 2005-06). These figures include all NHS organisations, including PCTs and Strategic Health Authorities. The NAO modelling used data from a sample of NHS organisation (NHS trusts).

26. The Department agrees with the recommendation that the contract was a "something for something deal" with investment in return for reform. The Department remains committed to ensuring continuous improvement in realising the benefits of this important change.
DEVELOPMENTS IN DENTISTRY: PCT CASE STUDIES

Bristol Teaching PCT

1. Bristol PCT is one of the top 20 performing PCTs against the 24 month access figures. They attribute their access position to various factors, in particular:

- Dental hospital in the patch, which means that dentists tend to stay in the area once trained. They have no shortage of dentists, and no dentists are leaving
- Adequate dental management capacity – prior to reorganisation, the Avon PCTs worked jointly to commission dentistry, so have a strong team which has built good relations with local practices
- Procurement exercises for additional capacity have already happened, and are continuing to happen

Commissioning & Procurement

2. The PCT is continuing to invest in dentistry – they conducted a procurement exercise last year for urgent access slots (to replace their DACs), 2 new practices and expanding capacity at 2 existing practices. For next year, they are looking to open a new dental suite in a new LIFT premises. Further ahead, they are looking to recruit a dental public health consultant and review their CDS.

- 45% of practices (about 24) are currently accepting new NHS patients.
- The PCT has a policy of not investing at all in practices with restricted lists.

Managing Access

3. The PCT has a dental Helpline in place, and urgent access slots are publicised.

Performance Management

4. The PCT has a consistent performance management policy:

- Underperformance is clawed back to 96% (not 100%)
- In the case of persistent underperformance, the PCT tries to negotiate re-basing the contract
- Practice reviews are done on basis of the information practices submit using the PCC Toolkit – this ensures a consistent approach
- There is a SLA with the Dental Reference Service to undertake practice inspections

Communications

5. The PCT’s view is that local people are still affected by the unjustified negative stories in the press about access. No specific campaigns undertaken, although PCT publicises its Helpline and access slots.
Devon PCT

6. Devon PCT is one of the top 20 performing PCTs against the 24 month access figures. Their approach to NHS dentistry is based on good commissioning, active access management and robust performance management.

- 31 (25%) of Devon practices are currently accepting new patients.

7. There is still a waiting list to access NHS dentistry but this is being progressively reduced. Waiting times to be allocated have dropped from well in excess of 12 months in many areas to an average of 4 to 5 months and in some areas allocation is the same day or week.

Commissioning

8. The PCT has moved quickly to commission new services and replace those that have been lost. They have commissioned services in areas with historic poor access including:

- Exeter
- Exmouth
- Okehampton
- Ilfracombe
- Newton Abbott
- Totnes
- Cholmondeley

9. The PCT has taken a three stage approach to investing new money:

- In areas where a relatively small increase in capacity is needed but a major tender exercise is not justified they have held service development and expansion negotiations with practices that are performing well and delivering a high quality service.

- Where the PCT has identified the need for a new practice they have conducted a formal tender exercise, eg Totnes. In total they have commissioned an additional 63,000 UDAs recurrently – there will be slippage against some of these due to lead in time, with schemes starting between April 08 and end of 08.

- Any slippage has been invested on a non-recurrent basis to provide short-term capacity increases whilst the new services come on stream. 40,000 Units of Dental Activity (UDAs) have been commissioned in this way for 2008/09. This approach will provide short term improvements to access in those areas where patients have been waiting longest for a service, eg Axminster, Seaton, Honiton and Exmouth, whilst the permanent capacity comes on stream.

10. In addition the PCT has also worked with practices to look at encouraging vocational training in areas where there are access problems. They have used capital to assist
expansion which has resulted in new training practices in Dawlish and Salcombe – thus improving access as patients see the Vocational Dental Trainees (VDT).

**Managing Access**

11. For new contracts the PCT has included both a UDA requirement in the contracts and a minimum expectation for the numbers of new patients the practice is expected to see. This has been calculated on the basis of the county-wide UDA to patients seen ratio (just below 3 UDAs per patient).

12. The PCT holds the waiting list for people seeking access to NHS dentistry. The number to contact is advertised via NHS Choices. As new services come on stream practices are required to take patients from this list.

13. As access eases in areas where there have been historic problems, ie there is no waiting list, the entries for individual practices are changed to indicate that they are accepting new patients directly.

14. In addition they are beginning to run newspaper advertisements in areas where practices indicate that they have spare capacity.

**Performance Management**

15. Whilst the PCT is not unsympathetic to genuine reasons, they have taken a robust approach to underperformance and recovered the full amount where practices exceed the 4% tolerance. The funds have been re-invested non-recurrently.

16. In addition the PCT has reduced a number of contract values where there has been consistent under-performance. These funds have been re-invested in dentistry.

**Medway PCT**

17. Medway is one of the top 20 performing PCTs against the 24 month access figures. Of their 39 practices, 25 are currently taking new NHS patients, 22 accept all categories of patient and 22 offer same day urgent access slots. Their approach is based on:

- Constructive working relationships with their practices
- A clear, but sympathetic performance management framework
- A clear investment policy
- Good oral health promotion linked to publicity campaign
- Close links with KSS Deanery

**Performance Management**

18. The PCT takes a sympathetic approach and will always consider the reasons put forward by the practice in cases of underperformance. Their policy is to allow up to 15% underperformance to be carried forward for singlehanded practices and 25% for multihanded practices, provided (a) there is a valid reason – the PCT expects to see hard evidence of this – and (b) the practice can demonstrate to the PCT’s satisfaction
that they have a realistic plan to deliver the extra activity in the following year. Where there is underperformance in 2 successive years, the PCT claws back the money.

19. The PCT maintains detailed practice profiles for all practices, which are used at practice visits to highlight any exceptions/outliers (eg high % of re-cycling of current patients).

**Investment Policy (capital & revenue)**

20. The policy is simple – good performance is rewarded with PCT investment.

21. Where practices perform in line with the PCT’s expectations, then the PCT will consider making capital grants to enhance the practice’s infrastructure. The PCT will not invest in practices with restricted lists unless they agree to take all patients. When the PCT ended up with more Patient Charge Revenue (PCR) than expected, the extra money was used to invest in practice infrastructure.

22. The PCT applies a similar policy when commissioning extra activity.

**Oral health promotion & communications**

23. The PCT has invested in oral health promotion (they have 45 hours/week currently focussed on children – schools and nurseries – and are about to expand the team to enable them to focus on elderly people as well)

24. They are running a postcard and business card campaign (see below) to raise public awareness of oral health issues and how to find a NHS dentist. Supplies of postcards are distributed via libraries, GP surgeries, pharmacies, schools, CAB, local barracks etc.

**Oral Health Awareness**

![Image of postcards promoting oral health awareness]
25. The PCT is also working with the Local Authority to run a success story about local dentistry entitled “Medway bucks the trend” (in other words, you can get a NHS dentist in Medway). Unfortunately, they are having difficulty interesting the local press in it as they seem to be more interested in a bad news story.

**PCT Helpline**

26. The PCT’s helpline is run by the PCT’s own dental team, thus ensuring that patients get up-to-date, accurate advice.

**VT training programme**

27. The PCT has funded an extra 2 VT places in Medway. If a practice had a VDP in 2007/8, then the PCT would – subject to the practice demonstrating they could sustain the extra activity – provide funding so the practice could retain the VT in 2008/9. This funding has been allocated on a temporary basis, and will be kept under review.

**Oldham PCT**

28. The PCT has a clear strategy for improving access to NHS dentistry (see their 10 strategic steps below).

29. This includes a range of innovative initiatives including:
Salaried dental service

30. The PCT’s salaried dental service provides an outreach screening and treatment service to older people in residential care and a domiciliary service to housebound older people. Final year dental undergraduates from Manchester dental school are offered supervised block placements with the service in an outreach teaching programme. The PCT DS also has a wider training remit and hosts a joint trainee post with Manchester Dental Hospital.

Dental nurse cadet scheme

31. The PCT DS is also involved in the PCT’s award-winning dental nurse cadet scheme. The initiative is now seeing its second cohort of students and continues to help to improve access. This scheme, set up in 2004, aims to bring more dental nurses into the NHS and to enable dental teams to deliver aspects of dentistry traditionally carried out by dentists. It also enables better communication with patients who do not speak English as many of the students are bilingual. The project is run in collaboration with Oldham College and local dentists.

New capacity

32. Since 2006, the PCT has opened 2 new practices in Moorside, and Springhead.

33. In April 2007 the PCT committed c. £1m (from its general NHS budget) to expand capacity, including
   • a new practice in Glodwick
   • expansion of some existing practices

34. When the Glodwick dental practice opens, these 3 practices will have the collective capacity to see around an additional 10,000 people a year, depending on patient needs.

Redesigning services

35. A significant and pioneering change to dental services in Oldham will be created by the service redesign project in general dental practice.

36. This project is unique in England and is being carried out in partnership with Salford PCT and the North West Deanery. It will focus on using the whole dental team including therapists and dental nurses to encourage prevention of dental decay particularly in areas where there are fewer dentists per head of population. One of the main ways of ensuring prevention is seen as a priority will be to build measurement of working towards prevention guidelines into dentists’ contracts.

37. As part of this scheme, an innovative dental service will soon be starting in a part of Oldham which has high levels of dental disease. The newly established dental team will carry out disease risk assessments with all patients. The patients will then follow one of three care pathways according to clinical guidelines.
## 10 Strategic Steps

### Oldham PCT – Oral Health Improvement Plan - Access, Quality and Outcomes

### Improvement Plan 2007 - 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009/10</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievements to Date</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital funding used to support improvements in infection control, meet GDA and VT training opportunities</td>
<td></td>
<td></td>
<td>Detailed needs assessment completed for Glodwick</td>
<td>Implement DwSPI dental specialties under consultant/specialist supervision</td>
<td>Undertake qualitative research impact of service re-design</td>
<td>Evaluate new system and report on impact on oral health outcomes</td>
</tr>
<tr>
<td>Established dental help line to manage access</td>
<td></td>
<td></td>
<td>Service re-design and innovative service specification produced</td>
<td>Transfer of PCT DS to ICC plus establish other innovative practice models</td>
<td>Evaluate skill mix of practitioners involved in DwSPI scheme</td>
<td>Integration of dentistry to NHS IM&amp;T</td>
</tr>
<tr>
<td>Implemented new working arrangements, 36 practices</td>
<td></td>
<td></td>
<td>Engaged in full tender process to procedure new service</td>
<td>Roll out service re-design to practices and PCT DS if improvements in oral health demonstrate it</td>
<td>Practices compliant with new infection control requirements</td>
<td>Practices compliant with new infection control requirements</td>
</tr>
<tr>
<td>Opened new practice in Moorside LIFT development</td>
<td></td>
<td></td>
<td>Public involvement in evaluation panel</td>
<td>Establish a tendering and procurement process</td>
<td>Larger more specialist multi-surgery facilities in primary care</td>
<td>Larger more specialist multi-surgery facilities in primary care</td>
</tr>
<tr>
<td>Census epidemiological survey of 5-year old children and questionnaire to parents</td>
<td></td>
<td></td>
<td>Additional practice awarded VT training practice. Existing VT trainer receives 3 year contract, one of only 2</td>
<td>Procurement of out-of-hours service for Oldham</td>
<td>Improved oral health</td>
<td>Improved oral health</td>
</tr>
<tr>
<td>Six month review event held</td>
<td></td>
<td></td>
<td>Public involvement in evaluation panel</td>
<td>&quot;Brush Together Smile Forever&quot; programme delivered to 3,000 parents of under-5s</td>
<td>Routine access to NHS dental service</td>
<td>Routine access to NHS dental service</td>
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<tr>
<td>Transition of CDS to PCT DS</td>
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<td>Contributed to NHS Dental Workforce Resource Pack</td>
<td>Pilot &quot;Smile with Prophet&quot; programme in 4 Mosques</td>
<td>Increased numbers of children attending school decay free</td>
<td>Increased numbers of children attending school decay free</td>
</tr>
<tr>
<td>Establish a tendering and procurement process</td>
<td></td>
<td></td>
<td>&quot;Brush Together Smile Forever&quot; programme delivered to 3,000 parents of under-5s</td>
<td>General Dental Council submission to be an accredited trainer of extended duty dental nurses</td>
<td>Evaluate and report on specialist model and monitor performance impact on referrals to specialist care</td>
<td>Evaluate and report on specialist model and monitor performance impact on referrals to specialist care</td>
</tr>
<tr>
<td>Procurement of out-of-hours service for Oldham</td>
<td></td>
<td></td>
<td>Pilot &quot;Smile with Prophet&quot; programme in 4 Mosques</td>
<td>Develop preferred provider process and engagement</td>
<td>Practice visits scheme includes lay assessors</td>
<td>Practice visits scheme includes lay assessors</td>
</tr>
<tr>
<td>Clinical Governance Framework and Work Plan developed and distributed to primary dental care teams</td>
<td></td>
<td></td>
<td>General Dental Council submission to be an accredited trainer of extended duty dental nurses</td>
<td>New practice opened in Glodwick</td>
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</tr>
<tr>
<td>Infection Control training event and resources &amp; training provided in practice</td>
<td></td>
<td></td>
<td>Develop preferred provider process and engagement</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Brushing Together Smile Forever&quot; programme</td>
<td></td>
<td></td>
<td>New practice opened in Glodwick</td>
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</tbody>
</table>

### Future Plans

- Evaluate new system and report on impact on oral health outcomes
- Implement DwSPI dental specialties under consultant/specialist supervision
- Undertake qualitative research impact of service re-design
- Transfer of PCT DS to ICC plus establish other innovative practice models
- Evaluate skill mix of practitioners involved in DwSPI scheme
- Integration of dentistry to NHS IM&T
- Practices compliant with new infection control requirements
- Larger more specialist multi-surgery facilities in primary care
- Improved oral health
- Routine access to NHS dental service
- Increased numbers of children attending school decay free
Other recent local developments in dentistry

- Bolton PCT has been given an extra £852,000 by NW SHA for dental services in the area. £400,000 of this sum will fund a new surgery in Horwich with capacity for 10,000 patients
- £1 million will be invested in Leicester’s dental services to improve access for nearly 30,000 patients
- North Yorkshire PCT is to increase spending on NHS dentistry over the next two years by more than £6m and to make about 75,000 extra places available
- A nine-surgery dental practice in Shelton, Norfolk is due to see its first patients next month
- All patients living within a 20-mile radius of Lincoln can now be seen by an NHS dentist, according to the county's dental service
- Somerset PCT will spend about an extra £2.6 million on dentistry this year, split between four priority towns
- Devon PCT has increased its dental provision for people living in the Teignbridge area of South Devon by about 4,300 extra patients
- A new NHS practice in Biddulph, Staffordshire has capacity for thousands of extra patients. Five hundred people are already on the books after its first day and dentist Julian Keen assured patients that the surgery could cope with demand
- A dentists’ surgery in Leigh has applied to the council for permission to expand its NHS practice with at least one new dentist and one hygienist
- NHS Suffolk has invested an extra £1.8 million in NHS dentistry and completed a tendering process to provide a further two-dentist NHS practice in Bury St. Edmunds. A new practice will also be set up in Hadleigh
- Gloucester PCT has recruited dentists for three new practices in Tewkesbury, Cirencester and Lydney. The Lydney practice will take on 11,000 patients
- A new NHS doctor and dentist surgery has opened in Plymouth. The dental practice will provide routine and emergency treatment for about 4,000 patients. Plymouth PCT has found NHS dentists for 23,500 people since April 2006
- The amount of dental work commissioned and provided by Wiltshire PCT has risen by nearly 10 per cent over the past year
- A new NHS dentist is opening its doors for 6,000 patients in Romsey. Thousands more people will access an NHS dentist with four new surgeries elsewhere in Hampshire
- A new dental surgery is opening in Sheffield city centre offering emergency and out-of-hours treatment
## BENEFIT STRUCTURE OF THE NHS PENSION SCHEME – PRACTITIONERS

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Pension Age (NPA)</td>
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<tr>
<td>Pensionable Pay (PP)</td>
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<tr>
<td>Total Uprated Pensionable Pay (TUPP)</td>
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<tr>
<td>Yearly Average of Uprated Pensionable Pay (YAUPP)</td>
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<tr>
<td>Relationship to Second State Pension (S2P)</td>
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<td>Members’ Contributions</td>
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<tr>
<td>Benefits Payable on Retirement</td>
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<tr>
<td>On Normal Retirement</td>
</tr>
<tr>
<td>(1) Pension</td>
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<tr>
<td>(2) Lump sum</td>
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<tr>
<td>On Ill-Health Retirement (after completing 2 years service)</td>
</tr>
<tr>
<td>Benefits Payable on Death-in-Service</td>
</tr>
<tr>
<td>(1) Lump sum</td>
</tr>
<tr>
<td>(2) Widow’s, widower’s or surviving Civil Partner’s pension</td>
</tr>
<tr>
<td>Benefits Payable on Death-in Retirement</td>
</tr>
<tr>
<td>(1) Lump sum</td>
</tr>
<tr>
<td>(2) Widow’s, widower’s or surviving Civil Partner’s pension</td>
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<tr>
<td>Benefits on Withdrawal</td>
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<tr>
<td>(1) Less than 2 years’ service</td>
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<tr>
<td>(2) 2 or more years’ service</td>
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<tr>
<td>Increases to Pensions</td>
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<tr>
<td>(1) In payment</td>
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<tr>
<td>(2) In deferment</td>
</tr>
<tr>
<td>Service Enhancement on Ill-Health Retirement or Death-in-Service</td>
</tr>
</tbody>
</table>

Notes:
- (a) Only service from April 1988 accrues for widowers’ and surviving civil partners’ benefits. Additional contributions may have been paid to improve these contingent survivors’ pensions. Certain short term (up to 6 months) survivors’ pensions may be paid in addition.
- (b) Subject to a maximum enhancement of the potential service to age 65.
- (c) Subject to a maximum enhancement of the pensionable service to age 60.

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* All benefits are subject to a maximum of £39,000 per year.
## ANNEX H

### NHS SCOTLAND DENTAL WORKFORCE STATISTICS

#### HEADCOUNT AS AT 30 SEPTEMBER

<table>
<thead>
<tr>
<th></th>
<th>Sep-97</th>
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<th>Sep-99</th>
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<th>Sep-05</th>
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<tr>
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<tr>
<td><strong>Annual percentage change</strong></td>
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<td>0.9%</td>
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<td>2.0%</td>
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<td><strong>Non-salaried dentists</strong></td>
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<td>Principals</td>
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</table>

**Source:** ISD Scotland

**Notes**

1 Data for previous years have been revised. Double counting between the three different services and within the General Dental Service (GDS) has now been eliminated.

2 Due to improvements in the collection of information on GDS salaried dentists, figures from 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.

3 Salaried dentists and community dentists both work in the salaried primary care dental sector and are employed by NHS boards. Reporting arrangements vary between boards in the way these dentists are classified. Gradually from 2008, the salaried primary care dental Practitioner classification will be introduced to cover the activities of both types of dentist.

4 Specialists in oral and maxillofacial surgery are no longer present in tables showing hospital dentists. They now appear in tables showing specialists in hospital medical surgery. Historical data, from 1996 to 2006, have also been amended.

5 Improvements continue to be made both in the historical classification of hospital and community dentists and in the monitoring of these dentists leaving and joining the service. North Region includes Grampian, Highland (including part of NHS Argyll & Clyde from 2006), Orkney, Shetland, Tayside and Western Isles. East Region includes Borders, Fife and Lothian. West Region includes Ayrshire & Arran, Argyll & Clyde (up to 2005), Forth Valley, Greater Glasgow (up to 2005), Greater Glasgow & Clyde (from 2006), Lanarkshire and Dumfries & Galloway.

The dissolution of NHS Argyll & Clyde took effect from 1st April 2006. From 2006, staff from NHS Argyll & Clyde transferred to NHS Highland and NHS Greater Glasgow & Clyde.
1. 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.

2. 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

3. The remit of the Salaried General Dental Services (GDS) is the same as that of overall GDS (i.e. 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 339 salaried GDPs in Scotland. 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.
ANNEX J

GDP REMUNERATION : Text of a 1992 article

GDP REMUNERATION
A LAYMAN’S VIEW OF THE PRESENT SYSTEM

This article aims to provide dentists with a short, factual account of how their remuneration system works. The system is extremely complex. So, especially at a time when there are such problems attached to remuneration it is essential that those whom it most affects - dentists themselves - should have basic knowledge of how the system works and how their NHS Income is derived.

A FEW BASICS

To avoid any misunderstanding, it should be understood at the outset that this article describes how general dental practitioners ("dentists") are paid for the services they provide under the NHS. It says nothing about their private income, nor about the way in which other dentists (eg. those in the CDS or hospital sector) are remunerated. In other words, it describes the process which leads to the setting of ‘the new fee scale’ and the publication of a revised Statement of Dental Remuneration (SDR).

In 1990, the new contract introduced several far-reaching changes to the structure of payments to dentists. However, the basic principle remains that the average dentist should earn a pre-determined income from the NHS, before tax and after meeting the expenses associated with running his or her NHS practice. The amount individual dentists earn will depend on the amount of work they do and the expenses they incur.

A TWO-STEP PROCESS

Essentially, the entire process can be represented in just two steps:

- the determination, in gross terms, of the Amount Due to the average dentist in the financial year under consideration (1 April to 31 March); and
- the setting of a fee scale which, together with other allowances and direct reimbursements payable, will deliver this Amount Due.

THREE KEY PLAYERS

There are three key players involved in the process. In order to understand the system, the roles of these players and the relationship between them must be understood as well:

i. The Doctors' and Dentists' Review Body (DDRB) - The DDRB was set up to be independent of both the Government and the professions, although it takes evidence from both about pay-related issues. There is no restriction on what evidence might cover, this is left to the discretion of those submitting it. For example, in the case of dentists, both the Health Departments and the BDA submitted evidence to the last Review Body on the new contract, manpower, and dentists' workload. DDRB considers the evidence and reaches its own conclusions. It then submits a report on its findings to the Prime Minister, which includes recommendations for pay levels in the next year. In the case of dentists, this means a recommendation for a target average net income or TANI. The Government then decide whether to accept the Review Body's recommendations.

ii. The Dental Rates Study Group (DRSG) - this Group is led by an independent Chairman, with membership drawn from the Health Departments and the BDA. It has three central functions:

- to forecast an amount for dentists' practice expenses;
- to add TANI to the agreed practice expenses to produce the gross Amount Due or target average gross income (TAGI)
- to use TAGI to set a fee scale Intended to deliver that Amount Due.

iii. The average GDP - The whole system turns on this. However, the average in question is not referenced to the entire population of dentists, but to that part which provides the DRSG with its
database. It excludes ‘leavers and joiners’, i.e. dentists who were not in practice for all of the immediately preceding 12 months, and dentists who operate through bodies corporate. It amounts to some 90 per cent of the total dentist population although, not least because of the huge variation in hours worked by individual dentists, the average dentist may bear little relationship to any actual dentist.

**DETERMINING THE AMOUNT DUE**

Essentially, the Amount Due comprises TANI, as set by Government in the light of the Review Body's recommendation, and the DRSG forecast of practice expenses likely to be incurred in the year under consideration. The latter is based upon data obtained from an annual confidential enquiry, conducted by the Inland Revenue on the DRSG's behalf, to establish dentists' actual practice expenses and take into account trends in practice expenses and other relevant factors.

**THE BALANCING MECHANISM**

Since the DRSG can only forecast what dentists' expenses are likely to be and the volume of treatments which dentists are likely to deliver in the year it is considering, a balancing mechanism corrects for any over-or under-estimation in forecasts which led to an over- or under-payment in average net income. The method is simply to compare what dentists actually received in net income in any one year with what they were intended to earn in that year. Any under- or over-payment is used to adjust the net income element of the Amount Due for the forthcoming year. Because of the time lags before audited practice accounts become available and can be analysed by the Inland Revenue, the balancing mechanism is operated three years in arrears. To avoid unduly large adjustments, there is a ceiling on the amount that can be balanced in any one year, with the outstanding balance being carried forward for consideration in the next DRSG round.

**SETTING THE FEE SCALE**

The fee scale is the vehicle which delivers the Amount Due into the pockets of dentists. After the Amount Due has been determined, however, and before any fees can be set, the DRSG ‘top-slices’ from the available money whatever is necessary to cover maternity payments, sickness payments, post-graduate education allowances and the like. It is what remains (about 95%) which is used to set fees for the items of treatment listed in the fee scale. In setting each fee, the DRSG has to consider three separate factors: (I) the laboratory and materials costs associated with different treatments; (II) a time element (or relativity) which recognises that different treatments take different lengths of time to administer; and (III) the likely incidence of each item of treatment in the coming year. This last component, the likely incidence of treatments in the coming year and the overall volume of work to be performed, is a particularly difficult area for the DRSG to forecast.

**SUMMARY**

The DDRB takes account of factors such as the new contract, manpower, workload etc, in making its recommendation to the Government on the appropriate level of TANI.

The DRSG forecasts average practice expenses, so that, when this is added to the TANI as decided by Government, it produces TAGI.

The DRSG produces a fee scale to deliver gross income to dentists, and the ultimate objective of providing the average dentist (after expenses) with the TANI decided by Government.

The balancing mechanism enables the ORSG to correct for any under- or over-estimation of its forecasts which have resulted in an under- or over-payment in net income. There is a ceiling which limits the amount which can be balanced in any one year.

Department of Health

April 1992
ANNEX K

NORTHERN IRELAND CLINICAL EXCELLENCE AWARDS SCHEME – OUTCOME OF REVIEW

1. This note summarises the outcome of the review of the Northern Ireland Clinical Excellence Awards scheme. The review commenced in October 2007 when a review group was set up tasked with taking forward the review. The review group included the NICEAC Chairman and Medical Director. A paper was issued for consultation in January 2008 and a total of 44 responses were received. The review group met with the BMA on two occasions as part of the consultation process. It made its recommendations to the Department in May 2008 and those recommendations have now been accepted.

Options on Funding for Lower Awards

2. The review group recommended a formula based system for allocating lower clinical excellence awards. It was considered that a formula based system would be more transparent, and would provide a greater degree of consistency across trusts. It would guarantee and maintain an increase in the number of local awards, in parallel with changes in the number of eligible consultants, which was considered fundamental to the proper working of the scheme as a whole.

3. Taking into account affordability considerations, and changes in the handling of step 9 awards as outlined below, the review group recommended a 0.25 formula i.e. a minimum of 0.25 awards per eligible consultant. It was also considered that this formula would strike the right balance between ensuring awards are allocated on the basis of clinical excellence and ensuring consultants are given the opportunity of moving through the awards process in a consistent and continuous manner. There was strong support from employers for a 0.25 formula rather than any higher formula.

4. It is estimated that a 0.25 formula would require additional recurrent costs of around £200k. This takes into account changes to the process for step 9 awards as outlined below. It also takes account of the funds that should already be available to trusts for lower awards including £100k allocated to trusts in 2007-2008, funds freed up through retirements of lower award holders, and funds freed up when higher awards are allocated to lower award holders.

5. NICEAC has a quality assurance and monitoring role over the local process. Trusts will be required to report annually to the Committee on the outcome of the local process. If a trust does not allocate the minimum number of awards under the formula, it will be required to provide an explanation in its report to the committee.
Eligibility for Lower awards

6. A majority of respondents to the consultation paper favoured the current three year eligibility period. The review group therefore considered that the current 3 year eligibility period was reasonable.

7. Having regard to the points made by some consultees about recruitment difficulties, and also having regard to considerations of equity raised by some “in comers”, the review group recommended that consultant level experience outside the UK should be taken into account in determining the eligibility period for awards.

Eligibility for Higher Awards

8. There was a very mixed response from consultees on the threshold level for higher awards. The review group recommended that the current threshold of four lower awards was reasonable and should remain in the meantime. It was noted that the threshold had recently been reduced in response to the difficulties being encountered by consultants because of the lack of local awards. It was agreed that once the new arrangements for local awards had bedded in, it would be appropriate to review the threshold again.

9. The group agreed that trusts should have discretion to make more than one lower award to a consultant in a single year.

Openness and Transparency

10. There was little support from consultees to the proposal that CVs of successful consultants should be made available to other consultants or that anonymised CVs should be posted on the NICEAC website. Concerns were raised about confidentiality issues and the potential for stylised application forms. The review group did not therefore recommend any change in this area.

Step 9 Awards

11. There was very strong support from consultees to the proposal that NICEAC should decide step 9 applications, and the review group agreed that NICEAC should take over step 9 applications. Under the current arrangements a consultant can potentially move from a step 4 to a step 10 award. The review group felt that this was too great a jump (around £34k of an increase). The group also felt that the proposal, given the lack of lower awards recently, would take some financial pressure off trusts and would free up more awards locally when step 9 higher awards are made to lower award holders. It was agreed that this proposal should be subject to review as set out in paragraph 17 below. There may be a case for returning step 9 awards to trusts at a later stage when the local awards situation settles down.

12. Lower award holders (who satisfy the eligibility criteria in paragraph 8) may in future apply for a step 9; B award holders will continue to be able to apply for a step 10.

13. Step 9 awards, as with the other higher awards, should be given to recognise and reward contributions to the HSC which are “over and above” the standard normally expected of a consultant in their post.
14. It was recommended that NICEAC, in deciding on step 9 applications, should give a double weighting to criterion 1 in recognition of the importance attached to “delivering a high quality service” and because this weighting currently exists in step 9.

15. It was recommended that step 9 should only be considered by the regional committee – not at both local and regional level.

16. It was recommended that it would no longer be appropriate to allow consultants to apply for both a lower and a higher award in the same year. The new proposals mean that there will not be the same restriction on the number of local awards, and there will also be a need to develop a more normal distribution of awards.

17. It was recommended that the step 9 proposal should be reviewed after 3 years, to see if it is still necessary in the light of the development of local awards.

18. Table 1 below show the values of awards at 2008-2009 prices. Table 2 shows the awards consultants may apply for now that step 9 is part of the regional process. Consultants are normally expected to move through the awards process one step at a time, but consultants holding 4-7 local awards may apply for either the next highest local award or the first value of the higher awards (step 9).

**Table 1 - Values of awards at 2008-2009 prices**

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Table 2 - Awards that may be applied for

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<td>A Award</td>
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Higher Awards

19. With regard to higher awards, Northern Ireland is now part of the DDRB process. It is noted that the number of new higher awards will be considered through that process. We understand that DDRB make recommendations to the Department on higher awards and normally link any increase in awards to the increase in the consultant population. The review group pointed out that the higher award budget would need to be closely monitored, particularly as the regional committee will now have responsibility for step 9 awards.

Research

20. A number of respondents felt that there was too much emphasis on research in the scheme. The review group felt that the weight given to research had already been reduced in the new scheme (introduced in 2005) given that it is part of one criterion along with teaching and training. The guide to the scheme also advises that criterion 4 (a) is not restricted to pure research. Applicants who have introduced innovation into the delivery or organisation of healthcare may also describe this under criterion 4 (a).

Local Committees

21. Some respondents stated that the composition of local committees should be changed. The review group decided not to recommend any change to the composition of local committees.
STATISTICAL TABLES
LIST OF STATISTICAL TABLES

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Table 6  3 month vacancy rates for all HCHS doctors (excluding training grades) and consultants by specialty Group by SHA at March 2008

Table 7  3 month vacancy rate for all HCHS doctors (excluding training grades) and consultants by specialty group 2002 to 2008