Review Body on Doctors’ and Dentists’ Remuneration

Review for 2010

Written Evidence from the Health Departments for the United Kingdom

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EXECUTIVE SUMMARY

1. As the Doctors’ and Dentists’ Review Body (DDRB) is aware, the general aims in setting pay uplifts are not to maintain existing pay relativities or differentials, or to protect the real values of particular salaries over time. They are to set salaries and incomes at the right levels to recruit, retain, and motivate sufficient numbers of high quality doctors and dentists to deliver Government policy for the benefit of patients, and to do so in a manner which is affordable in both the short and longer terms.

2. In the light of these general criteria, the Government proposes the following 2010/11 uplifts:

- up to 1% for non-consultant salaried doctors – that is, doctors in training, Specialty Doctors, and Staff Grade and Associate Specialists;
- up to 1% for salaried General Medical Practitioners, and salaried primary dental care dentists;
- no salary uplift for consultant doctors, and no uplift in the present levels of Clinical Excellence Awards;
- an uplift of 0.5% in gross GMS contract payments to self-employed General Medical Practitioners, which is intended to produce no increase in net payments; and
- no uplift in gross payments to self-employed General Dental Practitioners, which on current figures would produce a 0.6% increase in net payments after reasonable efficiency savings of 1% on expenses.

3. These proposals are informed by:

- the need for the public sector (and especially its higher-paid groups) to provide leadership in pay restraint;
- the healthy recruitment and retention position across all NHS staff groups – and the expectation that this position will strengthen further through 2010/11. In 2008 there was an average of 2.2 applicants for every medical school place. The long term vacancy rate for hospital doctors and dentists has seen a modest rise since last year from 0.9% to 1.5%. Long term vacancy rates amongst General Medical Practitioners remain unaltered at an estimated 0.3%;
- the effects of the recession on the labour market, particularly in the private sector;
- the excellent job security, career prospects, and total reward packages enjoyed by doctors and dentists, including generous final salary pensions;
- the low levels of inflation, both at present, and as forecast for 2010/11;
- the need for affordable uplifts, in view of the recurrent nature of pay uplift costs and the tighter financial position for the NHS and the wider public sector after 2010/11; and
the need to maintain the morale and clinical engagement of these staff groups during a challenging period for the NHS, as it works to embed the reform programme of the Next Stage Review, against a background of generally increasing demand.

4. Since the Government submitted its evidence last year, the principles which guide its approach to pay uplifts have not altered but the economic outlook has changed markedly. CPI inflation has fallen from its September 2008 peak of 5.2% to 1.6% in August 2009. The Treasury forecasts that CPI inflation will fall to 0.4% by the end of 2009/10, before rising to 1.4% by the end of 2010/11. RPI inflation has been negative since March 2009 (-1.3% in August 2009), and is expected to remain so until the end of 2009/10.

5. The recession has had significant effects on the labour market. Unemployment now stands at 2.47 million, and vacancies have fallen to 434,000 million for the three months to August. According to the latest three-monthly averages, the growth in average earnings including bonuses in the public sector has moved to 3.4% (3.6% excluding bonuses). This compares to 1.2% in the private sector (1.8% excluding bonuses). Average earnings growth excluding bonuses in the private sector is at its lowest rate since the present data series began in 1997, and there are widespread reports of pay freezes.

6. The public sector in general is increasingly seen as an attractive and secure employment option, and there has been a greater recognition of its pension benefits. The NHS is no exception to this trend, especially as its continued final salary pension scheme is widely regarded as a significant staff benefit. Doctors and dentists are seen to be enjoying greater levels of job security, and of certainty of future income levels, than many comparable professional groups.

7. However, pay uplifts must be fully affordable in the short and long term and uplifts must enable the NHS to carry out its functions both now and in future, when it is expected that available resources will be much tighter. The funding envelope for the NHS is fixed. Every 1% in uplifts for salaried doctors would cost £100 million per year, with important implications for delivery of planned NHS service developments including, for example, work to prevent obesity, as set out in Healthy Weight, Healthy Lives, support for improvements in maternity care and implementation of the national End of Life Strategy.

8. The Government sees no reason for the NHS to be exempt from a realistic approach to public sector pay this year despite the significant challenges over 2010/11 and beyond, as it embeds the Next Stage Review; continues to implement World Class Commissioning and focuses on improving productivity and efficiency through the Quality, Innovation, Productivity and Prevention (QiPP) programme.

9. Doctors’ and dentists’ efforts in the past have contributed significantly to the strong position from which the NHS starts in facing these challenges. Over the last few years, doctors and dentists have played a fundamental role in delivering the 18 week waiting-time commitment and improving patient satisfaction - in the 2008 HealthCare Commission survey, 92% of people gave a positive rating for their overall hospital care. The Government relies on doctors and dentists to provide leadership in supporting the reform process which is now building on this base. The Government is also relying on them to show leadership in pay restraint.
10. The medical workforce is broadly in balance, and recruitment and retention, and morale, among all **salaried doctors** are strong:

- vacancy rates are low at 1.5% - compared to 4.7% in 2003 and a long-term average of 4%;

- applications to medical school remain healthy at 2.2 applicants per place in 2008 (slightly down on 2007, but still above the average of 2.1 since 1994);

- graduate earnings continue to compare well with other professions, with average earnings for junior doctors in their first posts being higher, at £31,066, than many professional groups across the public and private sector; and

- there is no evidence of any serious morale issues - either generally or among any particular group of doctors - with job satisfaction scores from the Staff Survey generally up on 2008, and above those for other staff groups in the NHS.

11. In view of this, the Government considers that there are no compelling grounds for any uplifts for hospital doctors of any grade. It is therefore proposed that consultants should not receive an uplift this year, which is consistent with the wider approach to senior public sector salaries. However, the Government is content for the DDRB to consider whether there are grounds for an uplift for other hospital doctors up to a maximum of 1%.

12. As set out above, the maintenance of existing pay relativities or differentials, or the protection of the values of particular salaries, are not among the general aims in setting pay uplifts. However, in making these proposals, the Government is mindful of the possible effects of the following factors on the morale of hospital doctors below the level of consultant:

- in the seven years since the introduction of the 2003 consultant contract, average earnings have increased by 39%. This compares to average rises of 26.7% in the basic salaries for junior doctors in their first posts (and typical rises of 13.7% in overall pay) since the introduction of their 2001 contract;

- average earnings of consultants in England in 2007/08 were in the 98th percentile of earnings for all employees; and

- the real earnings and hours worked of junior doctors have fallen on average, as the implementation of the European Working Time Directive has progressed.

13. The DDRB will also wish to be aware that the Government is also continuing to address issues which are specific to different medical grades:

- the Health Departments have commissioned NHS Employers to carry out scoping and cost-modelling work on the effectiveness and value for money of the current contractual arrangements for **junior doctors**, and a report is expected before the end of 2009; and

- the Department continues to monitor the successful implementation of the new contract for **staff and specialty doctors**, with 4,011 doctors on the new contract
in July 2009 – 43% of the total who are eligible, compared to 274 (4%) in September 2008.

14. There is no evidence to suggest that there are recruitment or retention problems for General Medical Practitioners (GMPs):

- there were a record 34,010 GMPs in September 2008 – up by 1.9% on 2007;
- survey work in February 2009 found that work/life satisfaction was a healthy 63%; and
- average working hours are significantly lower than before the new GP contract.

15. The Government does not wish to reduce the average net earnings of GMPs. However, the new GP contract has resulted in higher than expected increases in contractor pay. The proposed uplift is in accordance with the Government’s aim to direct more of its additional investment into improving services in primary care.

16. Given that the wider NHS is required to deliver 3% cash releasing efficiency savings in 2010/11, it is our belief that, to be fair and equitable, any uplift to GMP contractor payments should also assume efficiency improvements can be made in general practice. We consider a 1% cash releasing efficiency assumption to be realistic in the current climate.

17. We believe this represents a fair deal, particularly as GMPs can increase their net income from other potential NHS earnings outwith the DDRB remit.

18. Likewise, there is strong evidence that there are no recruitment or retention problems for General Dental Practitioners (GDPs), and their working arrangements have improved:

- there were 655 more dentists working in the NHS in 2007/08, compared to 2006/07;
- they worked slightly shorter hours on average in 2008, compared to the previous year;
- their average working hours are significantly lower than before the introduction of the new contracts; and
- there is continued growth in access to NHS dentistry – the number of people seeing an NHS dentist within a 24-month period was 720,000 higher in June 2009, than in the corresponding period to June 2008, and dentists delivered 1.4m (4%) more courses of treatment in 2008/09, than in 2007/08.

19. The cost of NHS primary dental services is approaching £2.9 billion a year. Each 1% uplift to dentists’ incomes will cost about £29 million a year – equivalent to dental access for about 400,000 new patients. PCTs are currently working to add capacity under a major procurement exercise as part of the Dental Access Programme. The aim is to ensure that everyone who wishes to access NHS dentistry can do so by March 2011. The proposed 2010/11 award would allow PCTs to commission more dental services and increase patient access – and in turn to enable dentists to increase their NHS incomes through new services.
# REVIEW BODY ON DOCTORS’ AND DENTISTS’ REMUNERATION
## THIRTY-NINTH REVIEW
### WRITTEN AND STATISTICAL EVIDENCE FROM THE HEALTH DEPARTMENTS

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CHAPTER 1: MEDICAL WORKFORCE PLANNING CONTEXT

Workforce Numbers: Headline Figures

1.1 The NHS has seen unprecedented expansion in the medical and dental workforce since 1997. There are now more than 133,000 hospital and community health services (HCHS) doctors and GPs - over 44,000 more than in 1997 - as well as record levels of doctors in training in UK medical schools and in specialty training. Figure 1.1 below shows the growth in the medical workforce since 1998.

Figure 1.1

The latest annual census figures for England confirm that the NHS workforce has increased in 2008 to the highest ever recorded. Medical numbers continued to grow during the year to 30 September 2008, in particular:

- the numbers of hospital, public health medicine and community health service medical and dental staff (excluding retainers) increased by 5,510 (headcount) or 4.3% and 4,438 (full time equivalents (FTE)) or 3.7%;

- consultant numbers increased by 1,236 (headcount) or 3.7% and 1,249 (FTE) or 4.0%;

- associate specialist numbers increased by 164 (headcount) or 5.4% and 153 (FTE) or 5.8%;

- staff grade and specialty doctor numbers increased by 319 (headcount) and by 215 (FTE);
numbers of doctors in training and equivalents increased by 2,395 (headcount) or 5.1% and 2,247 (FTE) or 4.9%;

- GP numbers – excluding GP retainers and GP registrars – increased by 646 (headcount) or 1.9%, though FTEs fell by 261 (FTE) or -0.8%; and

- GP registrars increased by 712 (headcount) or 28.6% and 646 (FTE) or 26.8%.

1.3 Figure 1.2 shows the composition of the HCHS medical workforce based on the latest census figures.

Figure 1.2

A High Quality Workforce – a New Approach to Workforce Planning

1.4 As the Department reported in its evidence last year, the Next Stage Review document *A High Quality Workforce*, (published alongside *High Quality Care for All*) outlined important changes to workforce planning, education and training. These changes were underpinned by the following principles:

- **A focus on quality** – high quality care requires the provision of high quality education and training. Public resources must be used to secure the best possible quality and value for money.

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

- **Clinically driven** – all workforce plans should reflect local service and financial plans, and clinicians should be meaningfully engaged and involved in the development and quality assurance of those plans.
Flexible – the 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 – the Department recognises that different populations have different needs. If a devolved NHS is to be successful, then workforce planning must be both devolved locally and assured nationally.

Clarity about roles – clearly defined system roles are essential, ensuring a distinction between the responsibilities of those who commission education and training and those who provide it.

1.5 The strengthened workforce planning system will be based on greater clarity of accountability, roles and responsibilities at all levels. Workforce plans will be more scenarios based and built up from local Primary Care Trust (PCT) commissioners’ service priorities, based on the needs of their patients. Commissioners and providers of services will work together to ensure that the right staff are in the right place at the right time.

1.6 New professional advisory boards have been 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.

1.7 Sir Christopher Edwards has been appointed as the Chair of Medical Education England (MEE), an independent body that advises Ministers on education, training and workforce planning for dentists, doctors, healthcare scientists and pharmacists, with the aim of supporting the drive for excellence in patient care. Work is currently being undertaken on setting out the work programme for MEE within a clear overall strategic framework.

1.8 Professional Advisory Boards have also been set up for Nursing, Midwifery & Health Visiting, and Allied Health Professionals. These Boards will provide advice on modernising careers programmes and workforce planning.

1.9 A Centre for Workforce Intelligence (CfWI) for workforce planning across patient pathways will be set up to provide objective analysis, advice and support for the whole system. The supplier of the CfWI will be selected by November 2009, following a full procurement process.

1.10 The CfWI will:

- provide strategic oversight and leadership on the quality of workforce planning across the healthcare system including that which is delivered by social care;

- align the whole system around a shared endeavour to improve and use high quality data, analysis, interpretation and modelling;

- horizon scan for innovation and future service, workforce and labour market issues that are likely to have an impact on new care pathways and the health and social care workforce; and

- provide leadership for capability building, by supporting national, regional and local organisations to build their effective use of workforce information and tools,
promote best practice in workforce planning, challenge the NHS and social care services to improve performance; and set standards for resources and tools.

1.11 The strengthened system will ensure more flexible career structures, will help to reduce shortages of staff in key service areas, and will reduce the need to pay premium rates for where there are shortages in particular staff groups.

1.12 One of the key partnerships in the health sector has been that between the NHS and universities. The Department intends 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 (HIECs). HIECs will play a key role in strengthening education and the adoption/diffusion of innovation on to care pathways.

1.13 In terms of education funding, the Department will improve transparency, promote fairness and reward quality in education funding. The current historical funding arrangements for the Multi Professional Education and Training (MPET) budget will be re-based, and a tariff-based system introduced in which funding follows the student or trainee.

1.14 This will all be underpinned by a new assurance framework that will strengthen the accountability of the Strategic Health Authorities (SHAs), including their accountability for regional workforce planning and development. The Department will hold meetings with SHAs to discuss workforce and education and training plans, which will link into the SHA Assurance Process. This will help to ensure that SHA strategic plans reflect long-term healthcare developments and will deliver the workforce required to provide high quality care for all.

1.15 Planning the medical workforce is a complex and demanding task, and relies on high quality intelligence on the shape of the workforce in years to come. The new arrangements for clinical engagement through MEE and research and analysis from the CfWI will help to ensure the NHS trains the right numbers of doctors in the right specialties.

1.16 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, he or she could have a subsequent career of 30 years or more. Over such long periods, workforce planning is uncertain and must be interpreted carefully. By modelling future scenarios against current assumptions, forecasting outcomes can identify potential risks and help shape mitigation strategies.

**Expectations of Future Demand**

1.17 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, for example the smoking ban;
• other specific policies, for example the NSR, and the 18-week target from referral to treatment;
• work to address health inequalities;
• changing ways of working including shifts between health care settings; and
• changing affordability levels in light of the fiscal position.

1.18 The impact of these demands is difficult to predict with precision, 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 suggests further increases in demand (and, therefore, numbers); however, any analysis of demand is necessarily constrained by affordability implications.

Determining Future Medical Workforce Supply

1.19 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 (ie how the headcount supply of workforce relates to the FTE supply);
• retirements;
• attrition;
• medical training structures;
• the inflow and outflow of international medical graduates;
• the impact of regulation, for example the European Working Time Directive; and
• skill mixes and new ways of working.

Implications for the Numbers in the Training Pathway

1.20 This process has been used to inform decisions on medical school training numbers, which are reaching the end of a planned expansion. Medical school output has increased from 3,261 in 1997/98 to 5,569 in 2007/08, representing growth of 71%. Undergraduate output has now peaked, and there are no immediate plans for further increases - though numbers will be reviewed automatically as part of each Comprehensive Spending Review process. However, the expansion in medical graduates up to 2007/08 is now feeding through into post-graduate medical training programmes.

1.21 Figure 1.3 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 broad-based, 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 the MEE work programme to review aspects of medical training.

Figure 1.3 Current Medical Training Pathway and Estimate 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**

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

- nationally, 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 the light of the increasing demand for primary and community care services, GP training needs to continue to expand so that in the future around half of doctors going into specialty training should be training to become GPs rather than consultants (in 2009 around 2,600 GP training places have been filled.);

- 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; and

- regionally, however, the situation differs across specialties and locations. Investment in specialty training therefore needs to be aligned with local service demand. For example, the number of trained doctors in paediatrics and obstetrics may need to grow significantly, depending upon local service configurations.

1.23 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.

1.24 The Department 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.

**Entry to Training (Undergraduate)**

1.25 There continues to be evidence of good recruitment into medicine. Data on entry to UK medical and dental schools is at Statistical Tables 1-4. Medical school intake has increased by 56% since 1997, and dental school intake by 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 2008 entry, the average UCAS tariff points held by accepted applicants to medicine and dentistry were 422 and 399 respectively, compared to 417 and 391 in 2007.

1.26 Figure 1.4 shows the trend in numbers of UK applicants to medical schools and medical school places (accepted applicants) since 1994. In 2008, there was an average of 2.2 applicants for every successful applicant. In 2008 and 2007, 56% of UK accepted applicants were female compared with 59% in 2006 and 62% in 2003.

**Figure 1.4**

![Graph showing UK applicants and accepted applicants for medicine 1994 to 2008](image)

**Current Workforce Pressures**

1.27 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 2009 Survey shows that long-term vacancy levels are very much the exception in the NHS, and remain at historically low levels for most staff groups.
1.28 The long-term vacancy rate for hospital doctors and dentists has seen a modest rise since last year - from 0.9% to 1.5% (that is, from 382 to 674). This probably reflects a slight delay in filling new posts following the increased investment in medical expansion this year, aided by the additional funding to support implementation of the European Working Time Directive from 1 August 2009. For example, the Royal College of Obstetrics and Gynaecology has reported double the number of consultant appointments in the first half of 2009. Long-term vacancy rates among GPs remain unaltered at an estimated 0.3%, after three successive years of decreasing vacancy rates.

1.29 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 2009.

1.30 The number of hard to fill vacancies amongst consultants has increased from 276 to 349, following three successive years of decreasing vacancies. Nevertheless, the numbers remain small compared to the peak year of 2005, when there were 970 vacancies. The highest vacancy rates among consultants are in London at 1.7%, followed by the North West at 1.5%. London’s consultant vacancy rate was 1.3% in 2008, and accounted for 29% of all three-month consultant vacancies in England. The capital now accounts for 33%.

1.31 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**

1.32 In sum, all the indications confirm that medical recruitment and retention in the NHS is in a very healthy position. Vacancies remain low, despite a substantial expansion in the last 12 months to ensure delivery of the EWTD. Additional investment in undergraduate medical numbers is now working through the training pipeline, and the NHS is becoming increasingly self-sufficient in terms of matching supply with demand in most specialties and locations. International recruitment remains available to address any skills gaps and there is good reason for confidence that this, combined with the flexibility of recruitment and retention *premia* within the consultant contract, now provides employers with the ability to fully staff their services in meeting rising patient expectations.
CHAPTER 2: HOSPITAL DOCTORS AND DENTISTS IN TRAINING

Overview

2.1 There are no specific recruitment and retention problems among doctors in training. In particular, it should be noted that:

- the number of doctors in training in England has increased by 2,395 in the year to September 2008;
- demand for medical school places remains high with 2.2 applications per place, in 2008;
- fill rates for post-graduate medical training programmes are high and increasing year-on-year;
- in terms of average earnings for new graduates, medicine continues to stand up well in comparison with other graduate careers – including law and investment banking; and
- levels of job satisfaction among doctors and dentists in training are broadly the same as last year.

2.2 In view of the general considerations set out above, the Department considers that an uplift of up to 1% for doctors and dentists in training is appropriate. In this, the Department is mindful of the effects of the implementation of the European Working Time Directive on the earnings of doctors in training. The average pay Banding Supplement across all training grades fell from 48% in the year ended March 2008, to 45% in the year to March 2009 (although, as the Review Body noted last year, it is unlikely to fall much further). The Department has therefore commissioned NHS Employers to undertake a review of the effectiveness of the current contractual arrangements. The outcome of this review is expected in November 2009.

General Position

2.3 The introduction of the current junior doctors' contract in 2000 provided a mechanism for rewarding junior 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. The contract 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.

2.4 For posts which comply with the New Deal hours limits and rest requirements, 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%. The current levels of the banding multipliers are those that were negotiated between the parties to fully recognise work intensity and out-of-hours. We remain firmly of the view that these relativities are fair and provide an appropriate financial incentive for Trusts and trainees to manage the workload of doctors in training.
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 March 2009) compared with 88% in March 2004 and 71% in March 2001. The latest monitoring returns show that 95% of junior doctors earn in excess of basic salary through the banding multipliers although there is some variation between grades. Figure 2.1 below shows the proportions of doctors in each pay band by grade as at March 2009. The average banding supplement in March 2009 for compliant posts is 45% and is unlikely to fall significantly beyond this level. Once all junior doctor posts become compliant with the European Working Time Directive (EWTD), they will attract a maximum supplement of 50% of basic salary.

![Figure 2.1 - Summary of proportions in pay bands by grade](image)

**The European Working Time Directive**

The Review Body will recall that the European Working Time Directive (EWTD) has applied to the majority of staff since 1998 but its implementation for doctors in training grades has been phased in over a number of years. We reported last year that the NHS had made considerable progress in achieving compliance with the EWTD and was striving to fully implement the 48-hour week for doctors in training by the August 2009 deadline.

Our overall aim has been to ensure that, consistent with patient safety, the maximum number of services would be supported to achieve compliance by 1 August. The current pay structure for junior doctors has supported this ambition and has enabled us to ensure EWTD compliance in all but a few services with special difficulties. These include services where additional support may be needed to provide 24-hour immediate patient care, some supra-specialist services (services that are centred in one place but which serve several different areas), and some rural units in small and remote parts of the country.

To support these services, the UK Governments notified the European Commission in January 2009 of the UK’s intention to take up the option of a limited derogation under Article 17(5) of the EWTD. (Source – the Derogation Notice, which can be found at...
A list of 200 service rotas were included for derogation in The Working Time (Doctors in Training) (Amendment) Regulations 2009. This amendment to the Working Time Regulations became law on 1 August.

2.10 A SHA Quality Assurance process has been developed with support from the BMA and medical Royal Colleges to ensure close monitoring and identify specialties that may require further support post 1 August. The Department will continue to monitor the situation until December and into the New Year if required. A further derogation can be sought if necessary for services where a potential risk to patient care has been identified after 1 August.

Developments in Postgraduate Medical Education and Training

2.11 We reported last year that the Next Stage Review report ‘A High Quality Workforce’ took account of the Tooke Inquiry and Health Select Committee report into Modernising Medical Careers (MMC) and announced the establishment of Medical Education England (MEE).

2.12 The MEE Board has been established and has developed its vision, strategic priorities and work programme. Three initial priorities have been identified which will help us better understand and improve the future training environment:

- a review of the impact of a fully compliant EWTD environment on the quality of training. This will look to ensure that doctors in training continue to receive the quality of training opportunity within a 48-hour working week;

- a review of training as set out in ‘A High Quality Workforce’. The first stage of this is a review of the Foundation Programme years 1 and 2; and

- shadowing of junior doctors by undergraduates in their final year of medical school.

Workforce Numbers

2.13 At the September 2008 census, the number of doctors in training in England was 49,178 - an increase of 2,395 (5.1%) on the September 2007 position and 18,330 (59.4%) more than ten years ago. The FTE figure increased by 4.9% in the year to 2008 (from 46,051 to 48,298).

2.14 Entry to the Foundation Programme in 2009 has enabled places for all applicants from UK medical schools.

2.15 The competition for specialty training places varies across specialties and locations. The fill rate for specialty training programmes continues to increase despite changes to the immigration rules in 2008 requiring training places to be offered firstly to UK and EEA nationals. This change in immigration policy resulted in a reduced pool of applicants, with 15,000 applicants in 2009 compared to 18,000 in 2008. However, initial feedback from the 2009 recruitment is that the overall quality of applications improved, leading to a overall higher fill rate (95%). Improved national recruitment processes also assisted fill rates with Paediatrics and Obstetrics & Gynaecology
(previously hard to fill) achieving 99% and 98% fill rates respectively.

2.16 Overall, the supply and demand for specialty training programmes appears to be well balanced and there are sufficient training opportunities to match the numbers coming through from Foundation Programme. There are some gaps in some specialties and geographies, reflecting the need for better alignment of the aspirations of UK medical graduates with the needs of the service and future demand for specific specialties. International recruitment remains available to fill less popular places in programmes. In 2008 and the first seven months of 2009, more than 1,500 international medical graduates passed the Professional and Linguistic Assessment Board part 2 examination (PLAB2)\(^1\) to register with the GMC to practise in the UK, providing a useful contingent supply route.

2.17 There are difficulties in recruiting to fill gaps in middle grades i.e. ST3 and above, to provide cover for doctors undertaking out of programme activities, on maternity leave or taking a career break. The Medical Training Initiative (MTI) was relaunched in February 2009 to meet the criteria of the new points-based immigration system. The MTI provides a route for doctors outside the EEA to take advantage of spare training capacity and benefit from up to two years specialty training in the UK before returning with new skills and experience. The Department is reviewing progress of the MTI with the Deans, the Academy of Medical Royal Colleges and NHS Employers to encourage further uptake.

Graduate Starting Salary Comparisons with Other Professions

2.18 For medical graduates entering their first post, total earnings remains very competitive, particularly once account is taken of the availability of posts. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in the high proportion of graduates that are immediately able to enter their chosen career. A recent survey by the Association of Graduate Recruiters\(^2\) (AGR) reported that in almost three-quarters of AGR employers graduate salary levels had not changed from 2008 to 2009 and that there has been a sharp rise in competition for graduate jobs. For example, the legal profession, with which medicine is often compared, had 31 applicants for each graduate vacancy. In contrast, in the 2009 recruitment round all graduates of UK medical schools were successful in securing a place on the Foundation Programme, with nearly 90% obtaining a placement within their first choice Foundation School.

2.19 Using the latest banding figures available from March 2009 and data taken from the AGR survey, Figure 2.2 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 (£31,066) is shown in green. The chart also shows the percentage of F1 doctors on each of the main pay bands with 88% earning £31,066 or more. This continues to stand up well against the starting salaries in other professions including investment banking and the legal profession, where there were respectively 82 and 31 applications for each graduate vacancy.

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\(^1\) The PLAB test is the main route by which international medical graduates demonstrate that they have the necessary skills and knowledge to practise medicine safely in the UK.

\(^2\) Recruitment Survey 2009, Association of Graduate Recruiters
Pay Progression

2.20 Most medical graduates achieve full registration after one year. At this point their basic pay rises to £27,523. With banding supplements, the average salary for F2 (second year) trainees is £39,083 and for those on the first point of the Specialty Registrar scale (third year trainees) the average salary is £42,940 (based on monitoring returns for March 2009). 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).

Effects of the New Deal Contract

2.21 Total duty hours for doctors in training have fallen considerably in recent years; the days of 80-hour weeks for junior doctors have long gone and the majority of doctors in training now work an average 48-hour week or less. 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. The table below shows the movement of PRHO/F1 pay since the implementation of the current contract in 2001. Over that period, basic salaries have risen by 26.7% and typical overall pay by 13.7% against inflation of 22.9% (using HM Treasury GDP deflator figures).
# PRHO/F1 Pay – 2001 to 2009

<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>2.2%</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>5.5%</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>8.5%</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>11.5%</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>13.6%</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>17.0%</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>20.2%</td>
</tr>
<tr>
<td>March 2009</td>
<td>£21,862</td>
<td>1.40</td>
<td>£30,607</td>
<td>26.7%</td>
<td>13.7%</td>
<td>22.9%</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.

### 2.22

Figure 2.3 below shows how the proportions of doctors in each pay band have changed since September 2006.

![Figure 2.3: Proportions by pay band since September 2006](image)

### 2.23

As we reported last year, we are pleased that the 2000 New Deal contract is working as intended and that doctors in the training grades are seeing the benefits of reduced hours and a more family-friendly working environment. But the contract is complex and places additional demands on employers in reviewing the banding of posts and dealing with appeals. In its Thirty-Seventh Report, the Review Body invited the parties to begin giving consideration to restructuring junior doctors’ pay from 2009 when the Working Time Directive 48-hour week comes into force.

### 2.24

We stated in our evidence last year that we would commission NHS Employers to look at the effectiveness of the current contractual arrangements and we have now done
this. The four UK Health Departments issued a remit for this work in May 2009 – a copy is at Annex B. We expect NHS Employers and employer representatives in the devolved administrations to submit a report to the Health Departments in November 2009.

NHS Staff Survey

2.25 For the 2008 NHS Staff Survey almost 290,000 NHS staff were invited to give their views on working in the NHS. The results show continuing improvement in the attitudes of staff in many areas as well as positive findings in new areas introduced to reflect the pledges made to staff in the new NHS Constitution.

2.26 As we reported in our evidence last year, job satisfaction now features as a ‘vital sign’ in the NHS Operating Framework, which NHS organisations are expected to improve over time. Consequently, it is one of the key indicators of the Care Quality Commission’s assessment process of NHS organisations.

2.27 The job satisfaction score continues to be derived from seven questions in the survey that concern staff satisfaction with the following aspects of their job:

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

2.28 The job satisfaction score for all NHS staff remains high, and has increased from 3.44 in 2007 to 3.51 in 2008 (on a scale of 1-5). As was the case last year, the job satisfaction score for doctors and dentists in training was higher than average at 3.52. While this score is a small reduction on last year (3.53), the difference is within the reporting tolerances of the survey.

2.29 The percentage of doctors and dentists in training reporting they are either satisfied or very satisfied with their levels of pay increased from 42% in 2007 to 44% in 2008. This is again significantly above the equivalent figure for NHS staff as a whole (36%). A further 27% of trainees were neither satisfied nor dissatisfied with pay levels.

2.30 Work pressure felt by doctors and dentists in training remains comparable to last year, falling from 2.89 to 2.88 (scale of 1-5). This score remains well below the average for all medical and dental staff (3.06) and all NHS staff (3.09). Quality of work-life balance for doctors in training is reported as high (3.14 on scale 1-5) and unchanged.

Conclusion

2.31 There are no specific recruitment and retention problems among doctors in training. There continues to be high demand for training posts and this remains one of the most satisfied NHS groups, particularly with respect to pay levels. In the circumstances, we ask the Review Body to recommend an award of up to 1% for this group.
CHAPTER 3: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

Overview

3.1 There continues to be evidence of healthy recruitment and retention among associate specialists, staff grade and specialty doctors:

- in the year to September 2008, the numbers of associate specialists increased by 164, or 5.4% (headcount); and staff grade and specialty doctors by 319 or 5.3% (headcount);

- three-month vacancy rates for this group of HCHS doctors was 3% in 2009 (which is slightly higher than the long-term vacancy rates for this group in the years 2005 to 2008, but less than the vacancy rates reported between 2002 and 2004); and

- according to the NHS Staff Survey, job satisfaction levels for this staff group increased from 3.47 to 3.52, over the last year.

3.2 Although transfer to the new contract was initially slow, with only 274 on the new contract by September 2008, there was significant progress in this over the first half of 2009. By the end of July, 4,100 doctors out of a total of 9,586 (headcount) in this staff group had transferred to the new contract.

General Position

3.3 New contracts for specialty doctors were introduced in April 2008. These contracts, which are being phased in over 2 years in England, offer staff grade doctors (now specialty doctors) and associate specialists substantial pay increases in return for reform. In particular, they offer 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.

3.4 Once fully implemented, the new arrangements will deliver average pay increases for staff grades of 5.2% from 1 April 2008 and 5% on 1 April 2009. They will deliver increases of 1.8% for associate specialists for each of these 2 years. Funding for these new contracts was included in PCT revenue allocations from 2008/09.

3.5 In addition to these increases in basic pay, the Department has also made available additional funding for the training and development of these doctors. This is discussed in more detail below.

3.6 These actions have done much to overcome the problems which the Review Body had previously identified with the pay, and terms of conditions, of these groups of staff. As a result, recruitment remains strong. Between 2007 and 2008, staff grade and specialty doctor numbers employed by the NHS have increased by 319 (headcount) and 215 (FTE).

3.7 As Statistical Table 7 illustrates, the three-month vacancy rates for this group of HCHS doctors was 3% in 2009. This is higher than the long-term vacancy rates for this group over the years 2005 to 2008, but less than the vacancy rates reported between 2002 and 2004. Medical vacancies routinely take more time to fill than other posts due to the rigorous selection process. In addition, as noted in paragraph 1.28, the increase in vacancies probably reflects a slight delay in filling new posts following
the increased investment in medical expansion this year, aided by the additional funding to support implementation of the EWTD from 1 August 2009.

**Monitoring the Implementation of the New Contract**

3.8 As we informed the Review Body last year, all parties agreed that the costs of implementing the new contractual arrangements should be monitored against the projected costs in the proposals submitted by NHS Employers and the BMA, using the Electronic Staff Record (ESR). A key concern was to ensure that the new contractual arrangements are implemented as intended in the proposals.

3.9 NHS Employers devised a methodology, agreed with the BMA, for looking at the effects of the implementation of the new arrangements, separate from other easily identifiable factors such as changes in the size of the workforce. It is less easy, however, to identify changes in service contribution – ie changes in individual doctors’ working patterns, agreed with employers, which would carry a cost not attributable to the introduction of the new contracts. NHS Employers has therefore looked at the changes to pay (using anonymised data from ESR) for each doctor transferring to the new contract. This has provided a means of assessing whether the contract is being implemented by employers as intended, and of spotting early warning signs if this is not the case.

3.10 The results of the first costing analysis will be available shortly and we plan to provide a report for the Review Body as part of our supplementary evidence.

3.11 The latest available data from ESR shows that there were 4,011 doctors on the new arrangements at the end of July 2009. The transfer of doctors to the new arrangements was initially very slow, and we have looked into the reasons for this.

3.12 Firstly, time and effort was invested in providing a comprehensive set of documentation, guidance and communications about the new arrangements. NHS Employers also ran roadshows for employers in England to explain the new arrangements and what employers needed to do. A clear understanding of the new arrangements is key to effective implementation.

3.13 Employers then had to write to all eligible doctors in their Trusts, offering them the opportunity to express an interest in transferring to the new contracts. Doctors were given 12 weeks to respond to this invitation. We know that some Trusts did not write out until late 2008. All doctors who responded, expressing an interest, have a guarantee of their pay being backdated to April 2008 once job plans have been agreed.

3.14 We did not set any target dates for completing this process. The experience of implementing the consultant contract showed that this was counter-productive, placing the focus on target dates (tied to back pay) at the expense of proper job planning.

3.15 NHS Employers reported a noticeable increase in enquiries from May 2009, suggesting that many trusts were engaged in the detail of job planning at that time. According to feedback from NHS Employer’s networks, the main reason for delays is the length of time needed to complete the process of job planning with each doctor. NHS Employers have reinforced the message that implementation of the contracts remains a priority for clinical directors.
Enhancing Opportunities for SAS Doctors

3.16 Recurrent funding of £12 million has been provided since April 2008 for specialty doctor career support, training and CPD.

3.17 To accompany this funding, the Department and NHS Employers jointly published *Employing and Supporting Specialty Doctors: A Guide to Good Practice* in April 2008. This was designed to help employers in getting the most out of their specialty doctor workforces, 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.

Credentialing

3.18 In our evidence last year we reminded the Review Body that 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.”

3.19 We reported that 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”.

3.20 Work has been taken forward to define the different ideas within the overall concept of credentialing (which has resulted in the dropping of the term ”modular”). The Postgraduate Medical Education and Training Board (PMETB) has been asked to lead further work to consider the options. To do this, and to ensure the engagement of stakeholders, it has established the Credentialing Steering Group - on which the BMA is represented. The issues to be addressed are complex and require widespread discussion with stakeholders but, if agreement can be reached, provide the opportunity to better recognise the skills and experience of specialty doctors. An initial report on this is expected from PMETB by the end of the year.

NHS Staff Survey

3.21 The results of the 2008 NHS Staff Survey show job satisfaction within the Speciality Grade and for Associate Specialists is high and has increased this year from 3.47 to 3.52 (scale 1 to 5), which is just above the high levels reported of all NHS staff (3.51).

3.22 Over a third (35%) of Speciality Grade and Associate Specialist doctors and dentists surveyed reported they are either satisfied or very satisfied with their level of pay. As last year, this is close to the pay satisfaction levels reported by all NHS staff (36%). A further 26% of Speciality Grade/Associate Specialists were neither satisfied nor dissatisfied with their pay levels.
3.23 Intention to leave jobs is reduced among Speciality Grade and Associate Specialist doctors and dentists, with survey scores falling from 2.55 to 2.46 (scale 1 to 5). This is higher than the average for all medical and dental staff (2.38) but well below the average for all NHS staff (2.59).

3.24 Work pressure felt by doctors and dentists in the Specialist Grade/Associate Specialists is comparable to last year, changing from 2.89 to 2.88 (scale of 1-5). This score remains well below the average for all medical and dental staff (3.06) and that of all NHS staff (3.09). Quality of work-life balance is reported as high and improved for this group, increasing from 3.30 to 3.35 (scale 1-5).

3.25 The percentage of staff in the Speciality Grade/Associate Speciality working extra hours has increased from 60% to 64%, while levels of flexible working remain unchanged at 66%. However, this does not appear to have impacted on perceptions of work pressure or quality of work-life balance.

Conclusion

3.26 There continues to be evidence of healthy recruitment and retention among associate specialists, staff grades and specialty doctors and job satisfaction levels have increased. We believe a pay award of up to 1% would be appropriate for this group.
CHAPTER 4: CONSULTANTS

Overview

4.1 There are no significant recruitment and retention or morale problems among consultant doctors in England:

- consultants remain well paid by any national or international comparison;
- they have excellent job security;
- their total reward package includes generous final salary pensions scheme and opportunities for flexible working;
- the NHS Staff Survey showed that consultants’ job satisfaction levels have increased; workforce pressure has reduced and the quality of work-life balance is high;
- the three-month vacancy rate remains very low at 1.1%, slightly higher than last year’s 0.9% record low, but well below the peak of 4.7% in 2003.

4.2 Consultants are among the better paid public sector groups, with basic salaries for those under the 2003 contract in the range £74,504 to £100,446. 61% of consultants also receive Clinical Excellence Awards (CEAs) of between £2,957 and £75,796 a year. Consultants’ average earnings per full time equivalent are £115,926. In line with the Government’s general approach to senior public sector salaries this year, the Department proposes that consultants should not receive any uplift to their salaries. As well as being in accordance with the general need for higher paid groups to show leadership in pay restraint, the Department believes that this is consistent with what is required to ensure long-term recruitment, retention, and clinical engagement.

4.3 The Department also believes that there is no justification for any increase in the values of CEAs this year.

General Position

4.4 Since 1997 the number of consultants (including Directors of Public Health) working in the NHS in England has increased by 12,586 (56.4%) to 34,910 (32,679 FTE) in 2008. Forecasts show increasing demand for consultants, with around 3,000 more consultant FTEs employed by 2010/11. This reaffirms the Government’s commitment to having more specialist doctors overall.

4.5 The NHS Information Centre’s latest vacancy survey shows that consultant vacancies remain low. The March 2009 three-month vacancy rate for medical and dental consultants was 1.1%, only a slight increase on the record low reported last year. The three-month vacancy rates for consultants since 2002 are shown below.
Year | Three-month vacancy rate for HCHS consultants
---|---
2002 | 3.8%
2003 | 4.7%
2004 | 4.4%
2005 | 3.3%
2006 | 1.9%
2007 | 1.2%
2008 | 0.9%
2009 | 1.1%

4.6 Of the 34,910 consultants (including Directors of Public Health) working in the NHS in England, 14,670 (42%) are aged 50 or over, and 3,519 are aged 60 or over. An analysis of the latest information on retention and retirements is at Annex C.

4.7 The overwhelming majority of consultants (95%) are now on the 2003 consultant contract, which applies to all new consultants and has eight pay thresholds ranging from £74,504 to £100,446. The remaining 5% of consultants are on the old pre-reform contract (a five point incremental scale rising to £80,186).

4.8 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 five years of the contract, consultants average earnings increased by 31% and we estimate that in the first seven years (to 2009/10) the increase was 39%. 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.

4.9 An analysis of the annual earnings for full-time employees in the UK for 2007/08 suggests that the average earnings of consultants in England over the same period was in the 98th percentile of 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) for 2008. 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).

4.10 As we explained to the Review Body last year, the NHS is still working to deliver the full benefits of the new consultant contract. This includes annual job planning which provides a more transparent and flexible framework for ensuring that consultants have the facilities and other support needed to carry out their responsibilities and duties and meet agreed objectives.

4.11 We reported last year that we had commissioned NHS Employers to deliver a Large Scale Workforce Change Programme from October 2007, and that the results of this would be communicated to the NHS in Autumn 2008. This programme focused on sharing good practice to deliver benefits to patients, staff and employers. Its specific overall aim was to help trusts and consultants to identify, articulate and share benefits and learning that have been secured through effective implementation of the contract.

4.12 Forty-seven NHS trust teams participated. The majority reported at the end of the programme that they were implementing the contract more effectively, using it to work together to agree and make essential changes which have the most impact on the
quality and consistency of care delivered to patients. NHS Employers produced briefing to summarise some of the findings, successes and learning from the programme, together with case studies and “Ten Top Tips for effectively implementing the consultant contract”.

Clinical Excellence Awards

4.13 As the Review Body will recall, in England the CEA scheme was introduced in 2003, replacing 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 £2,957 (CEA level 1) and £75,796 (CEA level 12) per annum. All levels of CEA, DA and DP are pensionable. The latest annual report of the Advisory Committee on Clinical Excellence Awards (ACCEA) estimated that 61% of eligible consultants are in receipt of a CEA (CEA, DP or DA) and that 13% of consultants hold a CEA at or above level 9, (including the national (bronze, silver, gold and platinum awards)) or a distinction award.

Percentage of eligible consultants in receipt of awards (CEA, DA or DP) by award level

<table>
<thead>
<tr>
<th>Award Level</th>
<th>% Consultants</th>
<th>Value of Award per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4 CEA/DP</td>
<td>38.5%</td>
<td>£2,957 (CEA level 1) - £12,816 (4 DPs)</td>
</tr>
<tr>
<td>5-8 CEA/DP</td>
<td>9.1%</td>
<td>£14,785 (CEA level 5) - £29,570 (CEA level 8)</td>
</tr>
<tr>
<td>L9 CEA/B</td>
<td>8.4%</td>
<td>£35,484 (CEA level 9) / £31,959 (B award)</td>
</tr>
<tr>
<td>L10/11 CEA/A</td>
<td>4.0%</td>
<td>£46,640 (CEA level 10) - £58,305 (CEA level 11)</td>
</tr>
<tr>
<td>L12 CEA/A+</td>
<td>0.8%</td>
<td>£75,796 (CEA level 12) / £75,889 (A+ award)</td>
</tr>
</tbody>
</table>

4.14 For 2009/10, the Department believes 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.

4.15 In previous years, the values of CEAs, distinction awards and discretionary points have been uplifted in line with the uplift awarded to consultants. This year, in light of the significantly changed economic and financial circumstances, consultants’ generous reward packages, strong recruitment and retention position and high satisfaction levels, the Department believes that the values of these awards do not need to be increased.

Staff Survey

4.16 In the 2008 NHS Staff Survey, the job satisfaction score for medical and dental consultants was 3.59 (on a scale of 1 to 5) – higher than 2007’s score of 3.51 and again well above the level reported for all NHS staff in 2008 (3.51). This confirms that consultants are one of the most highly satisfied staff groups within the NHS.

4.17 The numbers of consultants who reported a intention to leave their jobs in the Survey saw an equally significant fall from 2.35 to 2.26 (scale 1 to 5). This score is lower than the average for all medical and dental staff (2.38) and well below the average for all NHS staff (2.59).
4.18 Moreover, almost two-thirds (64%) of consultants reported they are either satisfied or very satisfied with their level of pay, compared to 61% in last year’s Survey. These levels are significantly higher than the pay satisfaction levels reported by NHS staff as a whole (36%). A further 21% of consultants reported that they were neither satisfied nor dissatisfied with their pay levels, meaning only 15% were dissatisfied with their pay.

4.19 Work pressure felt by consultants has reduced this year, falling from 3.31 to 3.25, although this is still above the average of all medical and dental staff (3.06) and for all NHS staff (3.09). Quality of work-life balance is reported as high and increasing from 3.15 to 3.26 (scale 1-5),

4.20 The percentage of consultants working extra hours remains similar to previous years rising by 1 percentage point to 83%. However, the percentage of consultants taking up flexible working options has also increased by 1 percentage point to 72%.

Conclusion

4.21 There are no significant recruitment and retention or morale problems among this high earning remit group. The Department proposes that consultants should not receive any uplift to basic salaries, and that this is in accordance with both wider Government policy this year, and with what is necessary to maintain recruitment, retention, and clinical engagement. Additionally, the Government sees no justification for any increase to the values of Clinical Excellence Awards, Distinction Awards and Discretionary Points this year.
CHAPTER 5: GENERAL MEDICAL PRACTITIONERS

INTRODUCTION

5.1 This section of evidence relates to general medical practitioners (GMPs) providing NHS primary care services, and to salaried GMPs directly employed by NHS organisations in England.

5.2 The Department’s policies for primary care, set out in the NHS Next Stage Review primary and community care strategy, are based on the overarching objectives of providing more responsive and accessible services, preventing ill health and reducing health inequalities, and continuously improving quality of services.

5.3 The DDRB is asked to make recommendations relating to GMPs with General Medical Services (GMS) contracts. These recommendations also inform the awards given by PCTs to contractors working under Personal Medical Services (PMS) agreements or other locally determined contractual arrangements.

5.4 Most of the doctors working in GMS are independent contractors: self-employed individuals or partnerships running their own practices as a small business. There are currently around 8,300 GP practices in England, and around 60% of practices (52% of GMPs) are on the national GMS contract.

5.5 Contractors with PMS arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are ultimately a local matter. However, the Government remains committed to maintaining, as far as possible, fair and equitable funding for the different contracting routes.

5.6 The Department of Health is looking to DDRB to recommend the level of overall gross uplift to be applied to GMS contract payments for 2010/11. The Department remains committed to ensuring a more equitable distribution of funding for GP practices, where funding follows the patient. The Department would therefore want to see any gross uplift applied in such a way as to continue to reduce reliance on the Minimum Practice Income Guarantee (MPIG).

5.7 For 2009/10, the BMA and Health Departments agreed a formula approach that provided a set of differential uplifts to apply to agreed components of the GMS contract. This approach was a significant step towards more equitable funding. The Department would want to see any gross uplift figure recommended by DDRB for 2010/11 to continue to achieve this goal. The Department hopes to present further evidence on the approach recommended for 2010/11 at the supplementary evidence stage, following the outcome of negotiations with the BMA.

SUMMARY RECOMMENDATION

GMS Contract Payments

5.8 Following higher than expected increases in GMP contractor pay resulting from the new GP contract, the Department has sought action to direct more of the Government’s additional investment in primary care into improving services. Through a combination of negotiated changes and DDRB recommendations, proportionately more money is being re-invested in services and GMP net earnings (as a proportion of gross investment) are moving back towards expected levels.
5.9 The Department considers that, in order to contribute to the financial discipline and efficiency improvements essential to respond to wider fiscal and economic challenges, the Review Body recommend an increase in average gross income sufficient to cover likely increases in expenses in 2010/11 with no uplift in GMP net income.

5.10 Given that the wider NHS is required to deliver 3% cash releasing efficiency savings in 2010/11, it is the Department’s belief that, to be fair and equitable, any uplift to GMP contractor payments should also assume efficiency improvements can be made in general practice. The Department considers a 1% cash releasing efficiency assumption to be realistic in the current climate. Paragraph 5.48 discusses how GMPs have previously been able to generate efficiency savings.

5.11 The Department believes this represents a fair deal, particularly as GMPs can increase their net income from other potential NHS earnings outwith the DDRB remit.

5.12 The Department believes a gross uplift of 0.5% in GMS contract payments would deliver sufficient increases to overall investment to cover the expected average increase in expenses. This estimate takes into account the fact that, under existing contractual arrangements, GMPs are directly reimbursed by the NHS for expenses such as premises and IT systems, so the gross uplift does not encompass increases in those reimbursable expenses.

**Salaried GMPs**

5.13 For salaried GMPs employed by PCTs or other NHS organisations, the Department recommends an uplift of up to 1%, in line with (non-consultant) hospital doctors.

**GMP Registrars**

5.14 The Department recommends that the Review Body holds the GMP registrar supplement at 45% for 2010/11.

**GMP Trainers**

5.15 The Department recommends that any uplift to the GP trainers’ grant should be no more than the increase which is proposed for (non-consultant) hospital doctors.

**GMP Educators**

5.16 The Department recommends that GMP educators should not receive any uplift to their pay scale. This is in accordance with what is proposed for consultant doctors, and in line with the Government’s wider approach to senior pay in the public sector this year.

**EVIDENCE SUPPORTING THE RECOMMENDATION FOR GMPs**

5.17 In summary, the Department’s proposal of a 0.5% maximum gross uplift to GMS contract payments for 2010/11 is based primarily upon the following key sources of evidence:

- the GP Earnings and Expenses Enquiry 2007/08, published by the NHS Information Centre on 16 September 2009, and agreed by representatives from the four UK health departments, NHS Employers and the BMA;

- the NHS Information Centre statistical bulletin General and Personal Medical Services in England 1998-2008 covering workforce trends;
5.18 The Department’s evidence supporting our recommendation, in addition to the evidence on the wider economic outlook provided in Chapter 9, is arranged under the following headings:

- trends in the earnings and expenses of GMPs;
- the workload of GMPs;
- the recruitment, retention and motivation of GMPs;
- the additional earnings potentials of GMPs; and
- efficiency savings.

TRENDS IN THE EARNINGS AND EXPENSES OF GMPs

5.19 Overall, since the introduction of the new GMS contract, significant new resources have gone into primary care. The NHS now spends over £8 billion per year on primary medical services compared to £5 billion in 2002/03, and GMPs have seen significant increases in profits from this additional investment.

Earnings Growth Since 2002/03

5.20 The following points set out the trends in GP earnings and expenses since the introduction of the new contract:

- GMP pay has increased significantly in cash and real terms relative to other NHS staff groups. Figure 5.1 shows the comparison of pay growth between GMPs, nurses and consultants in England. On a cash basis, pay has increased by 47% over the period 2002/03 to 2007/08 (2007/08 being the latest year for which we have definitive figures from HMRC). This compares to a cash increase of 31% for consultants and 21% for nurses over the same period;

- in real terms pay has increased by more than 29% for England over the same period, compared to 15% for consultants and 6% for nurses;

- taking account of the Department’s forecasts of GMPs’, consultants’ and nurses’ earnings for 2008/09 and 2009/10, GMP real terms pay has increased by 28% for England over the period 2002/08 to 2009/10, compared to 20% for consultants and 15% for nurses; and
- GMPs continue to retain more of their earnings as profit than in the past. Traditionally GMPs invested back 60% of their earnings back into their practice. This figure fell sharply to 55% in 2005/06, and although this has been reversed somewhat in recent years, investment in 2007/08 at 59% for England is still below traditional levels.

**Figure 5.1**

![Comparison of Growth in Net Earnings](image)

5.21 Figure 5.2, which is based on data provided by Her Majesty’s Revenue & Customs (HMRC), highlights the significant increases in both gross earnings and net income for the average GMP in England during the period 2002/03 to 2007/08.

**Figure 5.2**

![England - Contractor GMPs, G/PMS average gross earnings](image)

5.22 The 2004/05 figures are the first year when the effects of the new GMS contract were fully realised.
5.23 The figures in Table 5.1 represent the position for the average GMP. The table below shows the distribution of net income, or profit, received by groups of contractor GMPs on a UK basis between 2002/03 and 2007/08.

5.24 Table 5.1

<table>
<thead>
<tr>
<th>Numbers of UK GPMS GPs in different net income brackets (before tax)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Year</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>2002/03</td>
</tr>
<tr>
<td>2003/04</td>
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<tr>
<td>2004/05</td>
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<tr>
<td>2005/06</td>
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<tr>
<td>2006/07</td>
</tr>
<tr>
<td>2007/08</td>
</tr>
</tbody>
</table>

5.25 Table 5.1 demonstrates a very significant movement by GMPs into the higher income brackets since the introduction of the new contract. However, the number of very high earners (£150k+) has started to reduce year-on-year.

**Forecast Net Income, 2008/09 & 2009/10**

5.26 Table 5.2 sets out the Department’s current forecasts of movement in GMP net income for England (covering all sources of income, including that received for work undertaken privately). The Department will not be able to confirm the actual figures until around 18 months after the close of the individual tax years when HMRC will have the data.

5.27 The Department has therefore estimated GMP earnings and expenses for the years 2008/09 and 2009/10. These estimates are based upon:

- additional local PCT investment in GP services;
- changes to the earnings/expenses ratios;
- efficiency savings; and
- increases in the number of salaried GMPs (and associated costs).

Table 5.2

<table>
<thead>
<tr>
<th>England GPMS GMPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>2002/03</td>
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<tr>
<td>2003/04</td>
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<tr>
<td>2004/05</td>
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<tr>
<td>2005/06</td>
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<tr>
<td>2006/07</td>
</tr>
<tr>
<td>2007/08</td>
</tr>
<tr>
<td><strong>Estimates:</strong></td>
</tr>
<tr>
<td>2008-09</td>
</tr>
</tbody>
</table>
5.28 These figures demonstrate that, following unprecedented pay increases in the early years of the new contract, earnings have started to stabilise but still amount to a much larger cumulative increase than other staff groups. Over the period 2002/03 to 2009/10, the 28% cumulative real terms increase for GMPs compares favourably to 20% for consultants and 15% for nurses.

Earnings to Expenses Ratio

5.29 The Department expects GMPs to invest a proportion of the money they earn back into their businesses in order to maintain and improve services to patients. Historically this investment has been around 60% of earnings, but that reduced to 56% in 2005/06, meaning that GMPs were retaining a much higher proportion of their earnings as profit.

5.30 Table 5.3 shows that this trend started to reverse in 2006/07, and investment is gradually heading back to the historic level of 60%.

Table 5.3

<table>
<thead>
<tr>
<th>England GPMS GMPs</th>
<th>Financial year</th>
<th>Gross Earnings</th>
<th>Expenses</th>
<th>Expenses as a % of Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>2002/03</td>
<td>191,777</td>
<td>116,671</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>2003/04</td>
<td>212,467</td>
<td>127,672</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>2004/05</td>
<td>241,885</td>
<td>138,321</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>257,564</td>
<td>143,950</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>2006/07</td>
<td>260,764</td>
<td>149,198</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>266,110</td>
<td>155,971</td>
<td>59%</td>
<td></td>
</tr>
</tbody>
</table>

WORKLOAD OF GMPs

5.31 The Department’s evidence shows that the workload of GMPs has reduced significantly since the introduction of the new GMS contract, with a significant fall in the average number of hours worked per week.

5.32 Over the past ten years, the average number of patients per medical practitioner in England has gradually fallen each year, apart from 2000, from 1,809 in 1998 to 1,586 in 2008 mainly as a result of the increased number of GMPs (increase of 5,759 - 20% - since 1998).

5.33 There has also been a significant increase in the number of practice staff involved with direct patient care since 1998. There are now 3,600 – or 35% - more practice nurses, and 3,400 – or 200% - more other staff involved with direct patient care than in 1998.

5.34 The number of patients per practice has grown steadily each year from 1998 to 2008, rising from 5,624 to 6,555. At the same time, the number of practices has decreased year on year from 9,090 to 8,230, reflecting a move towards larger practices employing more GPs and registering more patients. This trend is also evident in the decline of single-handed GPs from 2,779 in 1998 to 1,408 in 2008.
5.35 Consultations have risen, with the average patient having 3.9 consultations each year in 1995, rising to 5.4 consultations each year by 2008. However, more patients are seen by nurses and other clinicians – 24% in 1995 and 38% in 2007 – rather than by GPs. Figure 5.3 shows the change. Additionally, more GP consultations are taking place over the telephone – 3% in 1995 and 12% in 2007. Figure 5.4 shows the relationship between growth in number of GMP consultations and growth in net income of GMPs in England. The growth in GMP earnings is considerably higher over the period than the growth in consultations, and net earnings per consultation have increased from £12 in 2001 to £19 in 2007.

**Figure 5.3**

![Graph showing percentage of consultations conducted by GPs and nurses from 1995 to 2007.]

**Figure 5.4**

![Graph showing percentage growth from previous year for number of consultations, income before tax, earnings per consultation from 2002 to 2007.]

5.36 The length of time GMPs spend on individual consultations has increased. This is likely to reflect the fact that patients are being cared for longer in primary care settings, and the incentives in the Quality and Outcomes Framework for more systematic evidence based medicine.

5.37 The time spent by a GMP on home visits has fallen by 63% since 1992/93 from around 22 patients to around 8 patients per week. In 1995, 9% of consultations were by home visit – this had reduced to 4% by 2008. Most GMPs have exercised their right to opt out of providing some services, such as out of hours care.
RECRUITMENT,RETENTION AND MOTIVATION OF GMPs

5.38 As the following evidence suggests, the Department considers that the recruitment and retention of GMPs is in a strong position, and does not see a case to justify increases to net pay.

5.39 Before the introduction of the new contract, GMP recruitment and retention was a real problem. Since then there have been dramatic improvements. A fifth worklife survey conducted by the National Primary Care Research & Development Centre in February 2009, which gave 1,300 responses from 3,000 GMPs (in England) selected, showed:

- overall worklife satisfaction is at 63%. The survey showed a decline in job satisfaction since the 2005 worklife survey. On a seven point scale, overall satisfaction reduced from 5.2 in 2005 to 4.7 in 2008. That should be viewed in the context of longer term trends, which show overall satisfaction continually higher than in the 2001 survey. Since the introduction of the new contract, overall satisfaction has improved significantly;

- working hours are on average 3 hours per week lower than before the introduction of the new GMS contract;

- job satisfaction remains generally high since the introduction of the new contract, and 83% of GPs aged under 50 say they have either no intention or only a slight intention of leaving direct patient care over the next five years; and

- overall, working lives have improved since the introduction of the new GMS contract, even taking account of some drift below the peak reported one year after its introduction.

5.40 The number of GMPs and trainee GMPs continues to grow. As at September 2008, there were 34,010 GMPs in England (excluding retainers and registrars). This is highest ever number and an increase of 1.9% on last year, with a further 2,170 practitioners joining the workforce. All of this increase relates to salaried GPs (with the number of GP providers remaining constant) and the Department expects the trend of increased numbers of salaried GPs to continue.

5.41 The estimated 3 month vacancy rate for GMPs has fallen from 2.4% in 2005 to 0.3% in 2009, maintaining the same level as in 2008 and representing the lowest level for a considerable time.

5.42 The number of GMP registrars is also very healthy. There are now 3,203, more than double the number in 1998, and an average growth rate of 8.3% per annum.

5.43 A recent report by the National Recruitment Office for GP training showed a 33% reduction in the number of doctors applying for general practice in 2009, reflecting the overall decrease in applicants for speciality training. The report suggests that the interest in GP training may be affected by the reduction in the registrars’ supplement, and a perceived shortage of partnership opportunities, so the Department does not believe that increasing the value of GMP contract payments would help to increase applications. Moreover, the Department’s 2010/11 recommendation for GP registrars will be beneficial, as it maintains the registrars’ supplement at existing rates, following a trend of year-on-year reductions.
5.44 The NHS has not experienced any significant difficulties in filling training places. There were 2,300 places in 2008 and around 6,000 applicants for 2,700 places in 2009 and the Department has plans in place to ensure that the expanding number of training places in the future will be filled. The Department has also made £100 million available in 2009/10 to upgrade over 800 GP surgeries to become Advanced Training Practices in areas that have historically had a lower provision of doctors.

5.45 The wider economic climate suggests there will be even more interest in public sector working, particularly in general practice where there is relative security with little chance of redundancy.

5.46 Seniority payments continue for long standing GMPs. These were negotiated under the new GP contract in 2003 as a retention incentive, particularly aimed at GMPs approaching retirement. These payments are, however, at odds with a practice-based contract, and the Review Body has raised concerns in the past about effectiveness of seniority payments, particularly whether GMPs in receipt of seniority payments were more productive. The Department has no evidence to suggest improved productivity. This is an area which the Department is considering as part of wider steps to move towards more equitable funding of GP practices as part of negotiations with the BMA.

5.47 The NHS Pension Scheme forms an important part of the overall GP reward package. As highlighted elsewhere in the evidence, the NHS Pension Scheme is very favourable compared to pension arrangements for comparable staff in the public and private sector. The Scheme is particularly favourable towards GMPs compared to other NHS staff groups. GMP earnings can fluctuate widely from year to year, according to the work that the individual practitioners carry out and how much is taken as profit. To take account of these fluctuations in earnings, GPs have a Career Average Pension arrangement in which their pensionable earnings are revalued by an annual uprating factor. This process is known as “dynamisation”. Since April 2008, the NHS Pension Scheme has revalued GP earnings for pension purposes by the Retail Prices Index plus 1.5%. The Scheme is also very favourable for GPs compared to other self-employed persons.

ADDITIONAL EARNING POTENTIAL

5.48 Unlike many other staff groups, GMP contractors have real scope to increase their net pay from sources other than the uplift to the GMS contract payments recommended by the Review Body. These are:

- additional income from a wide variety of professional activities outwith the NHS. In the Association of Independent Specialist Medical Accountants (AISMA) survey of 2007, on average 8% of total income was generated from sources outside NHS contracts. This represented, on average, an income of £22k per annum for a full-time equivalent GP;

- additional investment in local enhanced services. Over the last two years additional local investment in GP services has grown by over 47% from £250 million in 2007/08 to £370 million forecast for 2009/10. Assuming a conservative profit margin of 40%, this amounts to an extra potential 1.6% growth in pay; and

- improved performance against the Quality and Outcomes Framework (QOF). Since the introduction of the new contract, there has been an annual improvement in QOF performance of 1 to 2%. There was a fall in performance for 2008/09 of 1.5% due to lower scoring in the patient experience domain. Performance against the other three domains for 2008/09 showed an overall improvement of 0.5%. Additional funding is available if practices improve QOF performance in 2010/11.
Taking the additional income from local enhanced services and QOF improvements together, the Department estimates potential increases in pay of around £2,000 or 2% per GMP.

EFFICIENCY SAVINGS

5.49 Like the rest of the NHS, it is reasonable to expect GMPs to achieve efficiency savings on operating costs. The majority of efficiency savings for GMPs are likely to come from improvements to quality and level of services, but there is also scope to deliver cash-releasing savings from changes such as skill mix and administration.

5.50 The NHS has to deliver cash-releasing efficiency savings of 3% in 2010/11 (NHS Operating Framework 2009/10). The Department believes it is reasonable to expect primary care services to achieve cash-releasing efficiencies of up to 1%. There is evidence to suggest that GMPs generated cash-releasing efficiency savings in 2007/08 (the latest year for which we have HMRC pay data). Table 5.4 demonstrates that, despite zero uplift to contract payments in both years, GMPs experienced a lower reduction in net pay in 2007/08 than in 2006/07. This suggests GMPs generated private income or reduced expenses by around 0.5%, a clear indication that their businesses became more efficient.

<table>
<thead>
<tr>
<th>Year</th>
<th>Uplift</th>
<th>Price Inflation (CPI) Annual % Change</th>
<th>Movement in net pay*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>0%</td>
<td>2.3</td>
<td>-1.8%</td>
</tr>
<tr>
<td>2007/08</td>
<td>0%</td>
<td>2.3</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

* Taken from the NHS Information Centre report “GP Earnings and Expenses 2007/08”.

5.51 In its 2009/10 recommendation, the Review Body factored in an amount for price inflation based on RPIX at 3.8%. For most of 2009/10, however, RPIX has been significantly lower than 3.8% (quarter four currently forecast at 1.4%). This is likely to mean that for 2009/10 GMPs will receive additional net income over and above the 1.5% intended by the DDRB recommendation.

THE RECOMMENDED UPLIFT AND ITS IMPACT ON GMP CONTRACTORS’ PAY

5.52 The Department recommends a 0.5% gross increase to average GMP contract payments for 2010/11. Based on the assumptions for practice expenses set out below, this would mean no change in pay to GMPs, before earnings from other sources are taken into account. The Department believes that this represents a fair deal in the current economic climate. The Department sees no compelling evidence of issues around recruitment, retention and motivation of GMPs to justify an increase in this round, and unlike most other staff groups, GMPs have the capacity to increase their net earnings from other sources.

5.53 The formula which the Department has used to calculate the gross uplift required to cover forecast increases to practice expenses in 2010/11 is the formula developed by DDRB in making its 2009/10 recommendation, with updated indices and an added factor for efficiency:
Uplift_{year} = 0.449 \times X + (0.365 \times AfC_{2009/10} + 0.187 \times CPI_{2009Q4} - EFF)

Where: 
- \(X\) (desired net uplift) = 0.0%
- \(AfC_{2010/11} = 2.25\%\)
- \(CPI_{Q4} = 1.4\%\) (From "Forecasts for the UK Economy Sept 2009"
  HM Treasury website)
- Cash Releasing Efficiency assumption = 1%

5.54 The components of the formula are set out below, representing the forecast increased costs which a gross uplift to contract payments would have to cover:

- **Net GMP Income**: the Department’s recommendation is that there should be no increase in net income for GMPs for 2010/11. Based on 2007/08 HMRC data, net income represents 44.9% of non-reimbursed turnover.

- **Staff costs**: the Department’s assumption is that pay uplifts for practice staff in 2010/11 will generally follow Agenda for Change pay rates, meaning they will be no more than 2.25%. Based on 2007/08 HMRC data, staff costs represent 36.5% of non-reimbursed turnover. There is evidence to suggest that this assumption may benefit some GMPs as only 25% of practice nurses are currently paid at Agenda for Change rates (2008 Practice Nurse Salary Survey – undertaken by practicenursing.co.uk).

- **Business and Other Costs**: around 10% of business costs, particularly for premises and IT, are reimbursed directly by PCTs. The formula needs to reflect forecast increases in the remaining 90% of practice expenses that are not reimbursed by PCTs. The Department anticipates that these costs will rise by 1.4% based on the latest Consumer Price Index (CPI). The Department believes CPI to be the appropriate measure, as it is the main UK measure of inflation for macroeconomic purposes, and forms the basis for the Government's inflation target. Based on 2007/08 HMRC data, these costs represent 18.7% of non-reimbursed turnover. Since the announcement of the 2009/10 contract uplift (which assumed inflation at 3.8% based on latest forecasts), inflation has fallen significantly below the assumed level. This means GMPs are likely to have benefited from falling prices.

- **Efficiency Saving**: the Department’s assumption is that GMPs should deliver cash-releasing efficiency savings on costs of 1% (see paragraphs 5.48-5.49).

**Minimum Practice Income Guarantee (MPIG)**

5.55 The Department is committed to a more equitable system of basic funding for GP practices, based on numbers of registered patients and the relative needs of the registered population.

5.56 For 2009/10, all the parties agreed that the Review Body’s recommendation should be for a single gross uplift to be applied differentially across agreed components of the GMS contract. This approach has reduced reliance on correction factor payments and made significant progress towards more equitable funding by providing a 12.5% increase in global sum. This increased the price per patient from £56.20 in 2008/09 to £63.21 in 2009/10.

5.57 In 2008/09, correction factor payments made to practices under MPIG were worth £285 million, and covered 91% of practices. As a result of the 2009/10 Review Body recommendation, our modelling suggests correction factor payments will more than halve in value, to £131 million covering 68% of practices.
5.58 It was agreed in principle to use the 2009/10 or a similar formula for 2010/11, and the Department will supply further evidence on this at the supplementary evidence stage following negotiations with the BMA.

OTHER STAFF GROUPS

Salaried GMPs

5.59 As we reported in previous evidence, the salary range for salaried GMPs employed by primary care organisations (agreed May 2003) was designed to encompass the range of possible GMP roles, with starting pay, progression and review to be determined locally. The salary range for 2009/10 is £53,249 to £80,355. This is broadly in line with the pay range for associate specialist hospital doctors.

5.60 The Department recommends an increase to the minimum of the pay range for salaried GMPs in line with that which has been proposed for (non-consultant) hospital doctors - that is, an uplift of up to 1%.

GMP Registrars

5.61 The supplement paid to GMP registrars was introduced at a time when recruitment into general practice was poor, to ensure that doctors who opt to train for a career in general medical practice are not financially disadvantaged in relation to hospital doctors in training. GMP registrars receive this substantial supplement despite having working patterns that are less intense than doctors training in hospitals. In line with changes in the average banding supplement paid to hospital doctors, the GPR supplement was increased from 50% to 65% in 2003/04, and then reduced to 55% in 2007/08, 50% in 2008/09 and 45% in 2009/10. NHS Employers have reported that the average banding supplement paid to specialist registrars was 46% in April 2009. Given the need for strong recruitment into general practice, the Department asks the Review Body to hold the GMP registrar supplement at 45% for 2010/11.

GMP Trainers

5.62 The Department has indicated previously its intention to hold discussions around the future of the GMP trainers’ grant (£7,598 in 2009/10). These discussions have not yet taken place because of potential significant changes to the way training in general practice is funded.

5.63 The changes that arise out of the NHS Next Stage Review are intended to identify more accurately the cost of providing both undergraduate and postgraduate healthcare profession practice placements in NHS organisations and in primary care. They aim to devise a funding system that more appropriately recognises the costs incurred in training and to introduce a system of tariffs for NHS organisations, including GP practices, to provide such placements.

5.64 The review has made significant progress but has not yet been completed. Costing work has been completed and the new system of tariffs is being modelled. Discussions are also underway about the pace of any change and the need for protection of income during transition. The Department remains hopeful that it will begin implementation from April 2010 but recognises that further discussions with stakeholders, including the BMA, will be required. In the meantime, the Department continues to believe that the Multi Professional Education and Training (MPET) review, rather than the GMP trainers’ grant, will provide a more appropriate means of addressing issues in respect of the cost of providing training in general practice.
5.65 The Department, alongside the devolved administrations, is also working with the Royal College of General Practitioners (RCGP) to review the contents and requirements of the GP specialty training programme. It is clear that the wish of the profession to extend the length of GP specialty training programmes, particularly the amount of time spent in GP practice placements, will have a significant impact on the NHS budget and may change the responsibilities of GP trainers. However, until this report is received from the RCGP, the Department is not in a position to take a view on how significantly, if at all, the responsibilities of GP trainers in respect of their trainees will change.

5.66 The Department is still willing to commission NHS Employers to enter into discussions with the BMA around the GP trainers’ grant, with a view to making it fit for purpose within the new GP specialty training and funding architecture. However, it will not be in a position to do this until the new MPET funding mechanisms are agreed and it is clear how much of the educational costs that the BMA is highlighting as being incurred by GP practices, are funded by the MPET budget.

5.67 In the meantime, the Department recommends that any uplift to the GP trainers’ grant should be no more than the increase which is proposed for (non-consultant) hospital doctors – that is, up to 1%.

**GMP Educators**

5.68 A GMP Educators’ payscale was introduced in 2003/04 following agreement between the Department, COGPED and the BMA’s General Practitioners’ Committee. The Department has seen no evidence to suggest that this payscale needs to be amended. GMP Educators’ salaries are between £80,195 and £98,572, and this range is broadly on a par with that covering the basic salaries of consultant doctors.

5.69 The Department recommends that GMP educators receive no uplift in their salaries this year. This is in accordance with the Government’s wider approach to senior level salaries in the public sector.
CHAPTER 6: DENTISTS

INTRODUCTION

6.1 The Department is now well into the fourth year of the new arrangements for commissioning primary dental services in the NHS and there has been a major increase in dental capacity and an increase of about three quarters of a million in the number of patients seen in the latest 12 months.

6.2 In the last year:

- there has been a further increase in NHS dental activity. In 2008/09, dentists delivered 81.4 million units of dental activity (UDAs), 4.4 million more than in 2007/08, and access has risen with almost three quarters of a million additional patients seen in the last four quarters. (Source: NHS Dental Statistics for England: 2008/09 published by The NHS Information Centre).

- PCTs continue to commission new services to improve patient access, with no shortage of dentists offering to expand their services or establish new practices. The volume of services commissioned in the year up to June 2009 was 4.3% greater than for the year up to June 2008.

- the upward trend in the number of dentists providing NHS services continues, up again by a further 528 dentists, rising to 21,343 dentists in 2008/09 – added to the previous year’s increase of 655 dentists, this is an increase of 1,183 or 5.9% over the 20,160 in 2006/07.

- the Government’s investment in expansion of undergraduate dental education resulted in some 710 dentists qualifying in summer 2009 – 40 more than the 2005 baseline - with the number of new graduates expected to rise to 850 in 2010; this will help to sustain the more healthy workforce position.

- there was a further increase in Vocational Trainee places in 2008/09 and an increase in practices wishing to participate in the scheme.

6.3 The Department’s evidence sets out the further work underway this year by PCTs to:

- commission services that better reflect local needs; and

- transform patient access through a combination of new procurements to expand dental provision and continued work to support greater productivity from existing services.

6.4 However, there is still clearly further to go. The Department commissioned an independent review of NHS dentistry last year, to identify how to build on the 2006 reforms and deliver sustained improvements in patient access and in the quality and productivity of services. The recommendations of the review, which are set out in the evidence below, include piloting a range of changes to contracts to promote high quality services, a greater emphasis on prevention, and further improvements in access for patients. This will be done through close working arrangements with the NHS and the profession, including the BDA.

6.5 In this context, the key challenges for this pay round and for the foreseeable future are to:
• **support improvements in patient access**: Increases in contract values continue to have a direct effect on patient access to NHS dentistry: each 1% increase in gross contract values reduces the number of new patients for whom services can be commissioned by 400,000.

• **support the move to a greater focus on quality and productivity**. As part of the implementation of the independent review recommendations, the Department will be piloting the use of quality and access indicators in dental contracts (in addition to treatment given), encouraging better use of skill mix to drive efficiency in dental teams, and promoting more appropriate recall intervals for patients. The Department expects these efficiency gains to be shared between service providers (and their staff) and the NHS.

6.6 To support the objective of greater efficiency, the Department has taken up the Review Body’s suggestion – voiced at last year’s oral hearings – of recommending an explicit efficiency assumption as part of the calculations used to determine the overall gross increase in dental contract values. The NHS has been awarded over £2,250 million (net of patient charges) for 2009/10 to fund primary care dental services. With patient charge income, the gross resource available is likely to be in the region of £2,900 million. In the current economic and fiscal climate, it is increasingly important that decisions on NHS earnings growth for this sector (and for general medical practitioners) should be focused on explicit incentives to increase productivity and efficiency. This is already the case for other NHS directly commissioned sectors including the acute sector and community pharmacy.

**SUMMARY RECOMMENDATION**

6.7 The Department believes that the pay award for dentists in 2010/11 needs to be a simple recommendation for a small increase in net pay, based on restraint of gross contract values, and on projected movements in expenses and likely efficiency gains. This award should reflect:

• the current economic climate, and the need for a disciplined approach to public sector pay this year;

• high levels of earnings growth, which have exceeded the levels anticipated in the Review Body’s previous recommendations;

• the move in recent years within dentistry towards more preventative and simpler courses of treatment with a lower expenses element, which has contributed to this increase – these reductions in expenses were partly but not fully reflected in last year’s Review Body recommendations; and

• the positive supply of dentists and their willingness to contract for NHS work.

6.8 The NHS as a whole is being expected to achieve 3% efficiency savings for 2010/11. The Department thinks it would be reasonable to assume in the Review Body’s formula that dental contractors can achieve at least a 1% efficiency saving. This would begin to bring dentistry into line with other NHS commissioned services.

6.9 In view of all these factors, the Department asks that there should be a zero uplift in gross contract values. This (on current figures) would produce an increase of 0.6% in net income for self-employed General Dental Practitioners after applying an efficiency assumption of 1% to the expenses element of the contracts.
6.10 There are approximately 1,500 salaried primary care dental staff, paid in the range £31,344 to £74,166 (a pay range which is broadly analogous to Staff and Specialty Grade doctors). The Department proposes that these salaried dentists should receive an uplift of up to 1%, in accordance with that for non-consultant hospital doctors.

THE REVIEW BODY’S REMIT

6.11 The Review Body’s remit in relation to general dental practitioners has remained constant for a number of years. It is worth noting again, however, that by virtue of the new practice-based contracts introduced in 2006, the Review Body’s recommended uplift applies only to the income of those dentists, or dental bodies corporate, who hold provider contracts. The pay and conditions of individual performers are now set by the local dental market. It is also worth noting that the NHS Information Centre earnings figures only pick up profits arising from the payments to dentists as set out in their self-employed earnings tax returns, not profits made by the companies.

GENERAL DENTAL PRACTITIONERS: EARNINGS AND EXPENSES

Net Earnings

6.12 The data from the NHS Information Centre this year is hard to compare with the previous year’s data because of the effects of the transitional period between the old and new contracts. But it is clear that dentists continue to receive a good income. In particular, the average net profit after expenses for dentists in 2007/08 was £89,062. For dentists holding a contract this was considerably higher at an average of £126,807. The data also shows many dentists earning considerably more; some earned over £300,000. Dentists working for others still had an average net profit of £65,697.

6.13 The data showed that just over half, 54.0%, of gross payments to dentists was to meet their expenses. Significantly, the NHS Information Centre report again clearly shows that dentists’ earnings depend little on their NHS commitment. The most committed NHS dentists – those spending 75% or more of their time on NHS work – earn similar amounts on average (£93,891) to dentists who are mainly private (ie where NHS work is 25% or less of their time) (£97,299). Dentists doing a mixed amount of NHS and private work had an average of £101,151 in 2007/08.

6.14 A direct comparison of net profit in 2007/08 with 2006/07 is difficult for a number of reasons. The NHS Information Centre report a drop in average net profit from £96,135 in 2006/07 to £89,062 in 2007/08. However, the 2006/07 profit includes one-off payments from the winding up of the old contract arrangements; the 2007/08 figure is also affected by some dentist contract holders changing their business arrangements to become companies. These factors also influenced reported expenses in a similar way; average expenses fell from £110,120 in 2006/07 to £104,373 in 2007/08. The expenses percentage of gross income changed only slightly from 53.4% in 2006/07 to 54.0% in 2007/08.

Table 6.1: Gross income and net profit of primary care dentists 2004/05 to 2007/08

<table>
<thead>
<tr>
<th></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>£115,450</td>
<td>£89,919</td>
<td>56.2</td>
</tr>
<tr>
<td>2006/07</td>
<td>19,547</td>
<td>£206,255</td>
<td>£110,120</td>
<td>£96,135</td>
<td>53.4</td>
</tr>
<tr>
<td>2007/08</td>
<td>19,598</td>
<td>£193,436</td>
<td>£104,373</td>
<td>£89,062</td>
<td>54.0</td>
</tr>
</tbody>
</table>

Note: some double counting of expenses inflates both gross income and expenses but does not affect reported net income.
6.15 Information on dentists’ income compiled by the National Association of Specialist Dental Accountants (NASDA) which represents more than 20% of self-employed dentists, shows a small reduction in net profit for NHS practices in 2007/08 of 1% to £148,000. Nevertheless, net profit is 25% higher than 3 years earlier, in 2004/05, a period during which Review Body awards cumulated to 9.7%. Net profit on NHS practices of £148,000 exceeds average net profit of private practices of £136,500, a reversal of the situation before 2005/06.

Table 6.2: Net profit for the practice

<table>
<thead>
<tr>
<th>Type of practice</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>£90,400</td>
<td>£104,000</td>
<td>£118,000</td>
<td>£142,400</td>
<td>£149,500</td>
<td>£148,000</td>
</tr>
<tr>
<td>Mixed</td>
<td>£87,200</td>
<td>£98,800</td>
<td>£100,400</td>
<td>£129,600</td>
<td>£147,100</td>
<td>£140,700</td>
</tr>
<tr>
<td>Private</td>
<td>£100,100</td>
<td>£113,000</td>
<td>£124,700</td>
<td>£131,400</td>
<td>£130,900</td>
<td>£136,500</td>
</tr>
</tbody>
</table>

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

6.16 NASDA report that average net profit for associate dentists (those dentists with no share of ownership) decreased from £70,396 in 2006/07 to £70,299 in 2007/08. The average in 2005/06 was £70,695.

Wider Reward Package

6.17 The NHS has an excellent reward package for dentists, which 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;
- the opportunity to carry out simpler courses of treatment, where clinically appropriate, without financial detriment and to secure further efficiency improvements through changes in skill mix;
- generous maternity, paternity and sick pay arrangements (highly unusual for self-employed practitioners); and
- access to NHS capital and loans.

6.18 Dentists have excellent long-term financial security; 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 with regular cash flow, significantly reducing the cost of working capital compared to the previous system. It also allows agreed activity to be planned across the financial year to allow for holidays, training etc.

6.19 Following the conclusion of the NHS Pension Scheme Review in September 2007, the NHS Pension Scheme now has two sections. From 1 April 2008, various changes were made for existing members, now described as the 1995 section and new arrangements for new staff on or after 1 April 2008, described as the 2008 section. The table at Annex D summarises the benefit structure of the NHS Pension Scheme for practitioners.

6.20 Dentists’ pension benefits are calculated as 1.4% of their total pensionable pay, which is uprated every year, based on RPI plus 1.5%. As an example, a committed NHS dentist
whose total uprated pensionable earnings averaged £87,000 a year over a working life of 40 years could expect to receive a pension of £48,720 a year, which would be uprated on an annual basis. The value of the NHS Pension Scheme is set out and discussed in Chapter 8.

6.21 Under the Pensions Choice Exercise described in paragraph 8.8, Dental Practitioners are due to receive their Choice Statements between October and December 2010 (delivery will not be split by age) via the NHS BSA Dental Services in Eastbourne.

Expenses

6.22 Table 6.3 shows a continuation of the reduced practice expenses first seen in data on the Personal Dental Services pilots and seen for the new contract from sample data in two reports. The results were published by The NHS Information Centre in August in the report: Provisional Clinical Dental Report, England and Wales: Quarter 3, 31 December 2008 – Experimental Statistics. The calculated expenses ratio as reported by dentists on their tax returns to HM Revenue and Customs has fallen from 58.6% in 2004/05, for General Dental Service (GDS) dentists only, to 54% in 2007/08 for all dentists.

Table 6.3 Number of treatment items per 100 courses of treatment and incidences as percentage of courses 2003/04 and 2008/09

<table>
<thead>
<tr>
<th>Number of items per 100 CoT</th>
<th>2003/04</th>
<th>2008/09</th>
<th>Difference</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs</td>
<td>52.4</td>
<td>32.6</td>
<td>-19.8</td>
<td>-38%</td>
</tr>
<tr>
<td>Extractions</td>
<td>10.0</td>
<td>10.6</td>
<td>+0.6</td>
<td>+6%</td>
</tr>
<tr>
<td>Fillings</td>
<td>49.8</td>
<td>40.6</td>
<td>-9.1</td>
<td>-18%</td>
</tr>
<tr>
<td>Root-fillings</td>
<td>3.9</td>
<td>2.1</td>
<td>-1.7</td>
<td>-44%</td>
</tr>
<tr>
<td>Veneers</td>
<td>0.3</td>
<td>0.1</td>
<td>-0.2</td>
<td>-67%</td>
</tr>
<tr>
<td>Crowns</td>
<td>4.6</td>
<td>2.9</td>
<td>-1.6</td>
<td>-35%</td>
</tr>
<tr>
<td>Inlays</td>
<td>0.7</td>
<td>0.7</td>
<td>0.0</td>
<td>n/c</td>
</tr>
<tr>
<td>Bridgework</td>
<td>1.8</td>
<td>0.7</td>
<td>-1.1</td>
<td>-61%</td>
</tr>
<tr>
<td>Percentage of CoT with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal treatment</td>
<td>54.6</td>
<td>44.5</td>
<td>-10.5</td>
<td>-19%</td>
</tr>
<tr>
<td>Dentures</td>
<td>2.7</td>
<td>3.0</td>
<td>+0.3</td>
<td>+11%</td>
</tr>
</tbody>
</table>

Note: The difference may not equal the 2003/04 figure subtracted from the 2008/09 figure due to rounding.

6.23 The study published by the NHS Information Centre 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 major switch to Personal Dental Services (PDS). This study updated a provisional study which the Department mentioned in its 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.

6.24 The overall reduction in advanced treatments (crowns, bridgework and dentures) is about 27%. In table 6.4, the changes in individual treatment items are weighted together using 2003/04 expenditure.
Table 6.4: Advanced treatments: expenditure and change in incidences

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>2003/04 SPEND</th>
<th>% REDUCTION IN 2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veneers</td>
<td>£6 million</td>
<td>67%</td>
</tr>
<tr>
<td>Inlays</td>
<td>£17 million</td>
<td>0%</td>
</tr>
<tr>
<td>Crowns</td>
<td>£143 million</td>
<td>35%</td>
</tr>
<tr>
<td>Bridgework</td>
<td>£44 million</td>
<td>61%</td>
</tr>
<tr>
<td>Dentures</td>
<td>£91 million</td>
<td>increase of 11% which occurs in partials - no change in full dentures</td>
</tr>
<tr>
<td>Total</td>
<td>£301 million</td>
<td>27%</td>
</tr>
</tbody>
</table>

6.25 As shown in table 6.5, the reduction in the weighted average for other treatments is 16%.

Table 6.5: Other treatment: expenditure and change in incidences

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>2003/04 SPEND</th>
<th>% REDUCTION IN 2008/09</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>38%</td>
</tr>
<tr>
<td>Periodontal treatment</td>
<td>£174 million</td>
<td>19%</td>
</tr>
<tr>
<td>Fillings</td>
<td>£181 million</td>
<td>18%</td>
</tr>
<tr>
<td>Root fillings</td>
<td>£49 million</td>
<td>44%</td>
</tr>
<tr>
<td>Extractions incl. sedations</td>
<td>£42 million</td>
<td>-6%</td>
</tr>
<tr>
<td>Total</td>
<td>£540 million</td>
<td>16%</td>
</tr>
</tbody>
</table>

6.26 Dentists are carrying out about 30% 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.

6.27 The Department hopes to work jointly with the BDA and NHS Employers to examine expenses factors in more detail for next year’s evidence.

GENERAL DENTAL PRACTITIONERS: RECRUITMENT, RETENTION AND MOTIVATION

Supply of dentists

6.28 The most important aspect of the annual 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 is a relatively weak indicator: it is the volume of services they provide for the NHS that is more important. This continues to rise as seen in the increased numbers of courses of treatment provided (and the corresponding units of dental activity) and in the increased numbers of patients receiving NHS services. It is nonetheless encouraging that numbers of dentists are also continuing to rise, up by 1,183 or 5.9% between 2006/07 and 2008/09.

6.29 The best indicator of dentists’ willingness to contract and provide NHS services under the new contracts is the outcome of the tendering exercises undertaken by PCTs. There has been a strong response to tendering exercises all over the country, but this is most noticeable in areas that had previously suffered local shortages of NHS dentists. PCTs in these areas have been able to tender for new services and in many cases have arranged for patients identified by the PCT as seeking access to have priority in accessing these new services. The Department is now supporting PCTs through the Dental Access Programme in undertaking an even more ambitious round of
procurements, which have so far received a very positive response from dentists and potential providers.

6.30 The strong willingness of dentists to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services, demonstrates that levels of NHS income are not acting as a bar to recruitment and retention or to growth in NHS services.

Future workforce supply

6.31 In the short to 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 now in place. As a result, some 710 dentists qualified in summer 2009 - 40 more than the 2005 baseline - with the number of new graduates expected to rise to 850 in 2010 and 915 in 2011 before levelling at around 900 per annum from 2012. Meanwhile the popularity of dentistry among applicants to university continues to increase. There were 2,738 applicants from the UK as a whole for undergraduate dental degrees through UCAS for 2008/09. Applicant numbers were 2.4 times the number accepted. Applications are almost 50% higher than five years earlier in 2003/04.

6.32 The Department’s current estimates of future workforce supply strongly suggest that the supply of dentists will be able to meet demand for new services, even taking account of the major procurements in train. The Dental Practice Board of Medical Education England plans to update the dental workforce review published in 2004 taking account of the reduction in the complexity of treatment and gradual implementation of NICE guidelines for longer recall intervals and growth in skill mix. These changes are gradually allowing greater value for money (quality and productivity) to be obtained from existing investment in dental services and from the existing dental workforce, rather than having to rely exclusively on new procurements to increase capacity.

Motivation

6.33 The motivation of NHS dentists and the quality of their working lives was one of the main factors in the introduction of the new contracts, and has been covered again in the recent independent review of NHS dentistry. The new arrangements have led to:

- a reduction in complexity of treatment, which gives dentists more time to spend with patients and allows them to do more preventative work without financial penalty. This also gives dentists more time to spend on essential professional issues such as clinical governance and training;

- a guaranteed monthly income for pre-agreed levels of work across the whole year; and

- a reduction in working hours, with evidence from the NHS Information Centre dental working hours survey published in August 2008 showing that dentists are working an average of 37.0 hours per week in 2007/08 compared to 39.4 hours in 2000. (Source: Dental Working Hours England and Wales 2006/07 and 2007/08 published by The NHS Information Centre.)

6.34 As indicated in Professor Steele’s review, discussed at paragraphs 6.49-6.52 below, there remain a number of factors associated with the 2006 reforms which need to be improved to engage dentists fully in supporting further improvements to quality of care and patient access. There was no suggestion, however, from the review that levels of remuneration are a relevant factor. The key changes recommended by the review as a
way both of improving quality of care and of better engaging dentists and other dental care professions do not involve higher pay or greater investment, but rather moving towards more blended contract currencies with a stronger focus on quality of care and on prevention.

6.35 The Department is hoping to work with the BDA and NHS Employers on a joint survey looking at motivation and morale for next year’s evidence.

6.36 The increasingly mature relationship between PCTs and local practices should also help allay some of the concerns 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.

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

6.37 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. PCTs have powers which allow them to give additional targeted support to practices where appropriate, i.e. by varying contract values to reflect local costs or other factors. At PCT level, this action can include:

- taking account of dentists who specialise in difficult patients or complex procedures;
- assisting practices with decontamination issues, for example providing capital grants or loans;
- helping practices improve their buildings, such as disabled access 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 dentists; and
- designing variations to the contract to allow for high patient needs.

Vocational trainees and trainers

6.38 The increase in dental graduates referred to at paragraph 6.31 will create a need for a corresponding increase in places for vocational trainees. (Newly qualified dentists may not work in the NHS until they have completed one year’s vocational training.) The Department has been working with Postgraduate Dental Deans to identify the areas in which the additional training places should be provided. Although the numbers are challenging, the Department does not anticipate major difficulties because of increased interest from dental practices in applying to take vocational trainees. In addition, capital
funds have been made available to some SHAs for the development of ‘enhanced’
training practices, which are capable of taking one or more vocational trainees in
successive years - instead of the one-off placements made more generally in the past.

6.39 The Department has not identified any increases in trainer workload but are discussing
the future of VT schemes with the BDA in the context of the proposed two-year
schemes. Trainer workload will be included in these discussions.

ACCESS TO NHS DENTAL SERVICES

6.40 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 high quality services.

The requirement for NHS dentistry: meeting demand for services

6.41 All PCTs have now assessed the local demand for NHS dentistry and how this can best
be met. These assessments, and the progress made in meeting them, now form part of
the regular NHS performance management framework. All PCTs are seeking to meet
local demand for NHS dentistry by the end of the period covered by current NHS
Operating Framework – ie. March 2011. To support this objective, PCTs are:

- assessing local demand and need for dentistry, consulting the public, and
developing strategic commissioning plans to match the services commissioned –
and their location – to local needs and priorities;

- undertaking procurements to commission new capacity when required;

- 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; and

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

6.42 The indicator currently used to measure movements in patient access is the number of
people who receive care or treatment from an NHS dentist over a two-year period.
(NICE recommends that adults attend the dentist at least once every two years.) PCTs
and dentists have been adjusting to the new contract arrangements introduced in April
2006. After an initial fall in numbers of patients seen, due mainly to the numbers of
dentists who chose not to accept new contracts, the numbers seen have been
recovering steadily. As Table 6.6 shows, there has been steady increases in PCT
commissioning and in activity delivered since then. The Department expects these
trends to continue or accelerate as the impact of the Dental Access Programme is felt.
Table 6.6: PCT commissioning, activity delivered, patients seen

<table>
<thead>
<tr>
<th>Date</th>
<th>PCT commissioning UDAs</th>
<th>Dental activity delivered UDAs</th>
<th>Patients seen in the last 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2006</td>
<td>76.9 million (May 2006)</td>
<td>n/a</td>
<td>28.1 million</td>
</tr>
<tr>
<td>June 2006</td>
<td>78.1 million</td>
<td>73.65 million 2006/07</td>
<td>28.1 million</td>
</tr>
<tr>
<td>June 2007</td>
<td>78.6 million</td>
<td>76.96 million 2007/08</td>
<td>27.9 million</td>
</tr>
<tr>
<td>June 2008</td>
<td>81.0 million</td>
<td>81.35 million 2008/09</td>
<td>26.9 million</td>
</tr>
<tr>
<td>June 2009</td>
<td>84.5 million</td>
<td>-</td>
<td>27.7 million</td>
</tr>
</tbody>
</table>

Sources: Commissioning: Department of Health Dental Commissioning Monitoring (DC01) published on DH website. NHS Information Centre publication NHS Dental Statistics for England: 2008/09

6.43 Patient access is expected to improve further as the full effect of the newly commissioned services come fully into effect this year and there is further procurement of new services supported by the Dental Access Programme. As part of the programme, the Department is also developing a better indicator to measure how far people seeking access to NHS dental services are able to receive it. The current measure (patients seen) is not an accurate proxy for access, because there will always be people who do not wish to seek NHS services within a given two-year period.

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

6.44 Under the old dental remuneration system, where a Review Body uplift was applied to the value of each item of service thus potentially encouraging a dentist to undertake more NHS courses of treatments on more patients, it was argued 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 merely reduces the ability of PCTs to commission additional services and can therefore reduce patient access. Each 1% uplift on DDRB costs £29 million a year. This would provide access to NHS dentistry for 400,000 patients.

6.45 As set out earlier, there is no evidence to suggest the need to provide dentists with additional financial incentives (i.e. higher pay) to work for the NHS. The key to improving access further is to allow PCTs to use the available dental funding stream and any funding they wish to add from their main allocations to buy additional access, which will give dentists the opportunity to expand their NHS practice, and to support PCTs in working with dentists to improve productivity of existing services (e.g. by tackling unnecessarily frequent recall intervals).

6.46 The resources allocated to PCTs by the Department of Health for commissioning primary dental care services totalled some £2.3 billion in 2009/10. The Department gave PCTs indicative gross allocations of some £2.9 billion, taking into account indicative levels of income from patient charges. This is 50% more than expenditure in 2003/04. After adjusting for increases in dental remuneration and additional superannuation costs, this gross level of provision is £560 million more than dental expenditure in 2003/04, an increase of 24%.

6.47 NHS accounts data for 2008/09 shows that net expenditure for the year (i.e. after deducting income raised from patient charges) was £1,996.8 million. This increased expenditure goes directly to dentists and dental corporates and increases their income.

6.48 This high level of central investment was to enable PCTs to secure increases in patient access and quality of care, not to increase dentists’ remuneration except where they are providing additional services. Future funding will be in the context of a much tighter economic situation with a high emphasis on efficiency and increased value for money.
INDEPENDENT REVIEW OF NHS DENTISTRY

6.49 The Department has welcomed and accepted the recommendations of the independent review of NHS dentistry led by Professor Jimmy Steele. The review found that too many people still find it difficult to access services and that, when they do access services, there is an unwarranted variation in the quality of the care they receive. The Review team therefore focused on developing a deeper understanding of why people find it difficult to access services, what kind of services they want and need from the NHS, and the nature of the supply side, i.e. what drives dentist behaviours and how the system could work better to support clinicians. This was done through the use of focus groups with the public and dentists, short focused interviews with PCT commissioners, and research into the relationships between dentists and PCTs and how dentists respond to different incentives.

6.50 The Department will be working with the NHS and the profession (including the BDA) to implement the recommendations of the Review.

6.51 The major findings of the Review were:

i. Accessing NHS dental services is difficult for patients:
   a) due to capacity shortages in some places
   b) due to a lack of good information, in the places that patients look, on how to access services

ii. The quality of commissioning is patchy
   a) poor use of information and expert advice
   b) considerable variation in how commissioning is done, what services are provided to patients and the costs of NHS dental services

iii. A lack of clarity on what level of service patients are entitled to
   a) patients are unclear as to what is available on the NHS and whether or not they will get a quality service
   b) dentists are not consistent in what treatments they make available to patients, culminating in a lack of trust between patients and dentists
   c) there is a lack of a prescribed pathway for patients or comprehensive clinical guidance on appropriate treatments

iv. An underdeveloped quality agenda in dentistry
   a) a lack of standardised measures or definitions of what quality is
   b) lack of clinical leadership to drive up quality standards
   c) lack of emphasis on quality in how services are commissioned and in how dentists are remunerated

6.52 In response to the Review, the Department has set up a programme of work, which will improve quality and accessibility of information for patients and the public, develop clinical pathways and quality standards to help commissioners and guide dentists, and undertake pilots to test out how access, continuity of care and quality standards can best be reflected in contracts.

GENERAL DENTAL PRACTITIONERS: RECOMMENDATIONS FOR GROSS UPLIFT

6.53 The settlement for pay and expenses this year has to be seen in the context of the extremely difficult economic situation. Any increase in gross contract values should also take account of an explicit efficiency assumption. The NHS as a whole is expected to
make cash-releasing efficiency savings of 3% in 2010/11. The Department believes that it is reasonable to expect dental contractors to achieve at least a 1% efficiency saving.

**Expenses formula for dentists**

6.54 In recent years, the Review Body has used an approach based on a formula to help it determine the appropriate gross uplift for GDPs.

The Review Body's formula for 2009/10, as at paragraph 4.83 of the 38th Report is:

\[
\text{Uplift}_{\text{year}} = 0.50 \times x + 0.14 \times \text{HRPS}_{\text{ASHE}} + 0.065 \times \text{RPI}_{Q4} + 0.05 \times \text{RPI}_{Q4} + 0.245 \times \text{RPI}_{Q4} + 0.065 \times \text{NASDA}_{\text{LAB}}
\]

so \[\text{Uplift}_{\text{year}} = 0.50 \times x + 0.14 \times \text{HRPS}_{\text{ASHE}} + 0.36 \times \text{RPI}_{Q4} + 0.065 \times \text{NASDA}_{\text{LAB}}\]

where:

- \(x\) = net income uplift
- \(\text{HRPS}_{\text{ASHE}}\) = median increase in gross hourly pay for Health and Related Personal Services (HRPS) sector
- \(\text{NASDA}_{\text{LAB}}\) = % change in lab costs.

6.55 The NHS Information Centre report on clinical data shows that dentists' treatment patterns continue to show large reductions in treatments.

6.56 Introducing an efficiency element into the formula instead of the lab costs adjustment and applying it to the expenses elements of the formula gives:

\[
\text{Uplift} = 0.50 \times x + (1 - \text{EFF}) \times (0.14 \times \text{HRPS}_{\text{ASHE}} + 0.36 \times \text{RPI}_{Q4});
\]

where:

- \(x\) = increase in GDP remuneration;
- \(\text{EFF}\) = efficiency gain assumed to be 1%
- \(\text{HRPS}_{\text{ASHE}}\) = increase in staff costs;
- \(\text{RPI}_{Q4}\) = increase in other costs

6.57 On current prospects for RPI in the fourth quarter, the latest figures on staff wages and a 1% efficiency gain, a 0.6% increase in net pay would result from keeping gross contract values at the same level as now.

6.58 The Department is not able to suggest a better indicator than RPI for this year. Others such as the Producer Price Index have their own problems.

**GENERAL DENTAL PRACTITIONERS: CONCLUSION**

6.59 The pay award for dentists in 2010/11 should reflect the current economic realities and the continued excellent levels of income for all groups of dentists – especially for those holding contracts. The Department strongly believes that it is the right time to introduce an explicit efficiency assumption into the calculations for dental expenses. We ask that there should be a zero uplift in gross contract payments, which (on current figures) would produce up to a 0.6% increase in net payments to self-employed General Dental Practitioners after applying a 1% efficiency saving to the expenses element of the contracts. In this time of low or negative inflation, this recommendation would allow PCTs to commission more dental services and increase patient access. This would in turn enable dentists who provide these additional services to further increase
their NHS income, rather than deploying resources in ways that bring no benefits to the public and no efficiency gains.

OTHER DENTAL STAFF GROUPS

Salaried Primary Dental Care Dentists

6.60 There are around 1,500 salaried dentists (headcount) working in salaried primary dental care services in England, delivering a range of dental public health programmes and providing dental patient care, including specialised care, for a range of priority and at-risk patient groups. They also provide the staffing of Dental Access Centres. They are predominantly employed by the provider arm of PCTs and are an important and valued part of the overall dental workforce. The Department’s Transforming Community Services Programme should support further improvements in the quality of salaried primary dental care. We will be supporting the NHS in better defining the role of salaried dentists to ensure that full account is taken of their service contribution as part of local work to transform the quality and productivity of community health services.

6.61 We have asked NHS Primary Care Commissioning to work with the BDA and the NHS to develop a toolkit for use by PCTs in commissioning these services. A related element of work is a benchmarking exercise carried out by NHS Benchmarking. This work should enable a more informed understanding of the contribution of salaried services to the overall provision of dentistry and to oral health improvement.

6.62 For this year, the Department believes that salaried primary care dentists should benefit from any general uplift in pay which is considered appropriate for (non-consultant) medical and dental staff. An uplift of up to 1% would be appropriate.

6.63 Following the decision of the General Dental Council to recognise a new speciality of Special Care Dentistry, a small number of consultant posts and specialist training posts are being created, typically based within the salaried primary dental care service but with close links with other branches of dentistry. Appointments to those posts are being made on the relevant generic doctors and dentists Terms and Conditions of Service. Consultant and training grade staff in special care dentistry will therefore automatically receive the same uplift to pay and allowances as other medical and dental staff in those grades.

6.64 The Department has asked NHS Employers to discuss salaried dental services and any changes in recruitment and retention with their NHS members as part of their evidence. The anecdotal evidence which the Department has received so far is positive.

Dental Public Health Staff

6.65 An Oral Health Plan for England, “Choosing Better Oral Health”, published in November 2005, sets out the Government’s strategy for improving oral health and reducing oral health inequalities. That strategy 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”. In its response to the 2008 report of House of Commons Health Select Committee Inquiry into NHS dentistry, the Government accepted the Committee’s recommendation that PCTs should use specialists in dental public health to help commission primary care dental services, and referred to their professional leadership role locally. These views were endorsed in the report of the independent review of NHS dentistry led by Professor Steele which in its recommendations on strengthening commissioning concluded that “ready access to advice from a consultant [in dental public health] is essential in all PCTs”.

49
6.66 Work on a review of capacity and capability in dental public health in the NHS (to which the Department referred in last year’s evidence), has been continued beyond the originally-intended time-frame in order to reflect the findings of Professor Steele’s report and the policy on world class commissioning. The Department hopes to publish the report by the end of the year.

6.67 Dental public health staff are employed on the generic terms and conditions of service for hospital and public health doctors and dentists. They will therefore automatically receive the same uplift to pay and allowances as other medical and dental staff in the consultant and training grades.
CHAPTER 7: NHS FINANCES

General Economic Context

7.1 This chapter sets out the financial context for the proposals for uplifts, and the funding available up to 2010/11. 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.

7.2 The recent deterioration in the economy has fed into a weakening labour market in the UK. This has led to substantial falls in employment and vacancies, and rising unemployment and redundancies. This in combination with relatively low inflation creates an environment where it is unlikely that average earnings increases across the economy will be at similar levels to previous years.

7.3 This labour market weakening has made public sector employment an increasingly attractive option. Recruitment and retention of a high-calibre workforce will remain strong. Public sector earnings growth should be restrained. If we set the pay award above the necessary level to recruit and retain the right quality of staff, this will be at the cost of service developments and quality.

Past Funding Growth

7.4 The NHS has seen large increases in additional funding over the past decade with an average real terms growth of 6.0% per year between 1997/98 and 2007/08. Table 7.1 shows the NHS revenue figures from 2005/06 to 2010/11. The figures for 2009/10 and 2010/11 are planned expenditure, and represent the maximum spend available. Growth across the combined two years 2009/10 and 2010/11 is the lowest since 1997/98 and 1998/99.

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue Net NHS Expenditure: Plan Comparator</th>
<th>Revenue Net NHS Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>Real terms growth %</td>
</tr>
<tr>
<td>2005/06</td>
<td>72,150</td>
<td>6.8</td>
</tr>
<tr>
<td>2006/07</td>
<td>79,160</td>
<td>6.6</td>
</tr>
<tr>
<td>2007/08</td>
<td>86,525</td>
<td>6.4</td>
</tr>
<tr>
<td>2008/09</td>
<td>92,475</td>
<td>4.6</td>
</tr>
<tr>
<td>2009/10</td>
<td>98,217</td>
<td>5.2</td>
</tr>
<tr>
<td>2010/11</td>
<td>102,272</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Notes:
1. In the context of this table "plan" comparator reflects the funds made available to the NHS as part of the Spending Review Settlements. The high real terms increase in 2009/10 of 6.9% is a consequence of the 2008/09 NHS surplus, which created a lower baseline for the 2009/10 funding growth.
2. In Budget 2009 the DH contribution to HM Treasury’s new £5bn efficiency target for 2000/11 was announced at £2.3bn. Accordingly the DH revenue DEL was reduced by this amount. This manifests in lower growth in 2010/11 over 2009/10 of 2.6% although allocations to PCTs were unchanged with average growth of 5.5%.
Future Funding

7.5 The Department received its funding settlement for 2008/09 to 2010/11 as part of the 2007 Comprehensive Spending Review (CSR 2007). The Departmental Expenditure Limits (DEL) set by the Treasury represent absolute limits on NHS expenditure. There is no flexibility to bring forward expenditure. There is, however, flexibility to delay expenditure - i.e. to defer resources and expenditure into future years - but this is subject to approval by HM Treasury, and is limited by affordability constraints on public finances in future years. Pay awards now need to be affordable in the future.

7.6 The Department is contributing £2.3 billion in additional savings as part of £5 billion efficiencies in spending across the public sector in 2010/11 announced by the Chancellor of the Exchequer in April 2009. The Department’s revenue budget for 2010/11 has been adjusted from £104.6 billion to £102.3 billion - a 2.6% real terms increase compared to 2009/10. The 5.5% average growth in PCT allocations for the commissioning of local health services for 2009/10 and 2010/11 will not be affected. Increased efficiencies mean that the tariff prices paid for NHS work carried out will be built upon efficiency growth of 3.5% in 2010/11, compared to 3% in 2009/10.

7.7 The medium term consolidation announced in the Budget means that obtaining better value for money from the paybill is now even more important. Budget 2009 announced that current spending is set to grow at an average of 0.7% in real terms from 2011/12 to 2013/14. However this covers Annually Managed Expenditure (AME) and DEL. The Treasury has not yet set DELs beyond 2010/11.

7.8 Given the current financial climate and the uncertainty of what will happen in the future, stringent planning of how future resources should be used is essential.

The NHS Paybill

7.9 Pay (directly and not directly employed staff) is one of the most significant cost pressures, accounting for around 46% of NHS revenue expenditure and around 62% of hospital and community health services (HCHS) expenditure. As pay represents such a large proportion of the NHS budget, managing the paybill is key to ensuring that the NHS will be able to cope with any future slow-down in funding growth, and will enable employers and Trusts make the trade offs that tightening finances will inevitably bring.

Pressures on NHS Funding Growth

7.10 The Department’s overall purpose is to ensure better health and well-being, better care and better value for all. Competing priorities call upon the available limited funding. Funding is analysed across three broad areas:

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

7.11 Baseline pressures cover the costs of meeting existing commitments that are essential for the NHS: they do not cover additional and new activity. Baseline pressures are the first call on NHS resources. The HCHS paybill (including pay settlement) forms a significant part of these baseline pressures, along with prescribing (primary care and hospital) and primary care services. Overall, these three areas consumed around £60 billion in 2007/08 – just over 70% of available resources. Additionally there will be cost pressures arising from the general increase in cost of
goods and services, and the revenue cost of capital and demand-led programmes such as dentistry and ophthalmology.

7.12 Underlying demand is pressure due to general growth in activity levels. Although the level of funding growth available to the NHS in 2010/11 has lowered, the public’s expectation of its services has not diminished. If anything, expectations are higher as a result of the impact of the recession on people’s health and well-being. Previous recessions have seen an increase in suicide rates and GP consultations, especially for depression. In order to mitigate these risks, the Department has invested an extra £13 million towards the faster roll-out of “talking therapy” services, and of the provision of better information and advice to people experiencing depression. Additionally, the Department has used the resources freed up by lower VAT rates to develop complementary services to increase the availability of debt advice and family counselling. Further long-run factors such as population increases, demographic changes, and morbidity can all contribute to driving up demand. Table 7.2 below shows both the upward trend in hospital activity, and the volatility of this trend.

Table 7.2 Trends in hospital activity

<table>
<thead>
<tr>
<th></th>
<th>Elective admissions</th>
<th>Emergency admissions</th>
<th>Attendance (A&amp;E, Minor Injuries Unit &amp; WIC)</th>
<th>First Outpatient appointments (consultant led)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (000’s)</td>
<td>Growth %</td>
<td>Number (000’s)</td>
<td>Number (000’s)</td>
</tr>
<tr>
<td></td>
<td>2002/3</td>
<td>5,401</td>
<td>-</td>
<td>4,056</td>
</tr>
<tr>
<td></td>
<td>2003/4</td>
<td>5,589</td>
<td>3.5</td>
<td>4,327</td>
</tr>
<tr>
<td></td>
<td>2004/5</td>
<td>5,705</td>
<td>2.1</td>
<td>4,552</td>
</tr>
<tr>
<td></td>
<td>2005/6</td>
<td>5,833</td>
<td>2.2</td>
<td>4,750</td>
</tr>
<tr>
<td></td>
<td>2006/7</td>
<td>5,917</td>
<td>1.4</td>
<td>4,777</td>
</tr>
<tr>
<td></td>
<td>2007/8</td>
<td>6,236</td>
<td>5.4</td>
<td>4,795</td>
</tr>
<tr>
<td></td>
<td>2008/9</td>
<td>6,622</td>
<td>6.2</td>
<td>5,054</td>
</tr>
<tr>
<td>Average annual growth (2002/3 to 2008/09)</td>
<td>3.5</td>
<td>3.7</td>
<td>6.4</td>
<td>3.2</td>
</tr>
<tr>
<td>Maximum growth since 2002/3</td>
<td>6.2</td>
<td>6.7</td>
<td>18.3</td>
<td>8.9</td>
</tr>
</tbody>
</table>

7.13 Service development covers policy and manifesto commitments. These include legislative requirements and contractual obligations. These are new measures, agreed with HM Treasury as part of the Spending Review settlement. Examples include:

- the continuation of obesity and cancer reform programmes;
- the provision of high quality care for adults approaching end of life;
- improvements to maternity services;
- the implementation of the Carers’ Strategy;
- the wider improvement of patient experience; and
- increased access to psychological therapies.

7.14 Progress has already been made in a number of areas including:

- **Obesity.** £372 million has been allocated for *Healthy Weight, Healthy Lives*, to promote the achievement and maintenance of healthy weight over the period 2008/09 to 2010/11. PCTs received a total of £65.9 million for this in 2008/09, and a further £69 million was allocated for 2009/10.
• **Childhood obesity.** As a catalyst for changing parenting behaviour to address childhood overweight and obesity problems, a £75 million marketing programme over the period 2008 to 2011 is being implemented which will inform, support and empower parents in making changes to their children’s diets and levels of physical activity. Initial findings from the campaign suggest that it is succeeding in reaching out to the families and children who are most at risk, and the plan is now to extend the campaign to at-risk adults.

• **Maternity Matters** highlights the Government’s commitment to developing a high quality, safe and accessible maternity service through the introduction of a new national choice guarantee for women. This will ensure that, by the end of 2009, all women will have choice around the type of care that they receive, together with improved access to services and continuity of midwifery care and support. Such changes will require additional funding to ensure that the staff and systems needed to implement them are in place.

• **End of Life.** A commitment of £88 million in 2009/10 and £198 million in 2010/11 to provide support for implementation of the national End of Life Strategy – one of the key pathways of the Next Stage Review.

• **Carers.** In June 2008, the government launched a new strategy to support, help and improve the lives of carers. The Carers’ Strategy is underpinned by £255 million to implement some immediate steps alongside with medium and long-term plans. New commitments which are set out in the Carers’ Strategy include: £150 million towards planned short breaks for carers; £38 million towards supporting carers to enter or re-enter the job market; and £6 million towards improving support for young carers.

• The **Green Paper, Shaping the Future of Care Together** was published in July 2009, and sets out the vision for a new care and support system. The current system will not be able to cope with increasing and future pressures, and reforming it over the coming years will be a challenging task, which will place additional demands on funding.

7.15 Table 7.3 shows the disposition of additional resources in SR 2002, SR 2004 and CSR 2007. In the years of high pay growth in 2003/04 and 2004/05 (SR 2002) a smaller proportion of growth in resource was deployed to service developments and underlying activity than in 2005/06 to 2007/08 (SR2004). Due to the additional efficiency savings of £2.3 billion which are referred to in paragraph 7.6 above, the additional resources in 2010/11 are now smaller. Pay now represents 33% of the additional spend in CSR 2007 (compared to the estimate of 29% shown in last year’s evidence). As a consequence, the proportion of additional the money available to spend on service developments has gone down from 47% to 44%. Increasing the proportion of additional money spent on pay will lead to less money available for service development.

7.16 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.
Table 7.3 Disposition of additional revenue resources in SR 2002, SR 2004, and CSR 2007

<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>44%</td>
</tr>
<tr>
<td>Hospital and Community Services Pay (Price Only Component)</td>
<td>27%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Secondary Care Drugs</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>EEA Medical Costs, Welfare Food and NHS Litigation</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Primary Care Drugs</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>General Dentistry, Ophthalmic and Pharmaceutical Services</td>
<td>3%</td>
<td>3%</td>
<td>4%</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>3%</td>
</tr>
<tr>
<td>Pay for Not Directly Employed Staff</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

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

Long Term Impact of Settlement

7.17 A high pay settlement now will need to be maintained in future years. Pay awards for 2010/11 will be a recurrent cost in future years, and a high settlement now will lead to higher baseline costs going into the next Spending Review.

7.18 For every 1% increase in settlement for HCHS doctors above what is needed to maintain recruitment and retention, there will be around £100 million less money available to spend on current health policies and future health policies for years to come.

Conclusion

7.19 The funding available to the NHS is fixed and is deployed to cover baseline pressures, underlying demand and service developments. There is no additional resource available to fund excess costs and a higher pay settlement will therefore have implications on the money available for other service developments. Higher levels of pay would reduce funds available for service developments, and reduce the derived demand for workforce. A high settlement might therefore mean that doctors are unable to find posts in future years, and that some vital NHS priorities are delayed or only partially implemented.

7.20 The medical workforce is facing excellent recruitment and retention, as demonstrated by historically low vacancy rates. As a result of workforce reforms over recent years, staff are benefiting from a excellent overall remuneration package. The Department believes that the proposals made in this evidence will be a prudent balance between the public’s aspirations for continuing NHS service improvements on the one hand, and the supply, motivation and morale of medical workforce on the other.
CHAPTER 8: NHS PENSIONS AND TOTAL REWARD

NHS PENSION SCHEME

8.1 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 General Practitioners). 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.

8.2 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 NHSPS 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).

8.3 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 consultant in the NPA60 scheme with a 35 year career. They found that this was worth up to 22.5% of salary (compared with the 14% employer contribution required to fund benefits for all scheme members).

8.4 Following the conclusion of the NHSPS 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; and
• 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 will:

• 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; and
• receive extra pension for service earned up to NPA65 if they continue to work beyond NPA65.

8.5 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 this date, 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. The bands are linked to Agenda for Change pay points, and are consequently re-valued each April.

8.6 Data extracted from the Electronic Staff Record (ESR) as at April 2009 which records the pensionable pay of all staff employed in the NHS, shows that the average annual pensionable pay for a 59 year-old consultant (the year before normal pension age) was £109,218.

8.7 There has also been agreement to lift for future service the cap on earnings that count as pensionable which was in place as a statutory requirement for benefits built up between 1989 and 2006. This will mean a significant boost to the pensions of many doctors with a start date for pensionable service after 1989.

8.8 Further regulations are in the process of being made to come into effect from 1 October 2009. From July this year, NHS Pensions (NHSP), a division of an Arms Length Body, the Business Service Authority (BSA), will lead a Pensions Choice Exercise (PCE) for 1.3 million staff over almost 3 years. Staff will be offered the choice to remain in the 1995 section of the NHS Pension Scheme with a normal pension age (NPA) of 60, based on 1/80th accrual with a fixed lump sum, or move to the new 2008 section, which has a higher NPA of 65, an accrual rate of 1/60th, (with a
requirement, under the PCE, to take a lump sum equivalent to that provided for under the 1995 section 1) and more flexible benefits designed to encourage staff to work longer. For new entrants after 1 April 2008, there is no automatic lump sum, but members are free to give up part of their pension at the rate of 12:1 in order to secure a retirement lump sum. Eligible members of the 1995 section will receive a personalised pension statement which compares benefits in the 1995 and 2008 sections of the NHS Pension Scheme, an explanatory guide and a DVD to help inform their decision.

8.9 Given the scale of the exercise, the PCE will be delivered in a phased manner between July 2009 and 31 March 2012. During Phase One, Early Adopters involving a PCT and Foundation Trust in the South West will carry out the PCE. Lessons learnt will inform Phase Two. Under Phase Two, the PCE will be delivered regionally, currently planned from January 2010 and will start in the South West, moving up the country to the North East and finishing in Wales. Each SHA region will see two periods of Choice activity with staff aged 50 and over offered Choice during 2010/2011 and staff aged 49 and younger during 2011/2012. For efficiency reasons, all staff in smaller organisations, e.g. General Practices, will receive their Choice during 2010 aligned to their SHA region.

8.10 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. The table at Annex D summarises the benefit structure of the NHSPS for general medical and dental practitioners. 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 of 22.5% of pay (ie 14% employer contributions and 8.5% member contributions) actually contributed by 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:*

8.11 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 (LGPS), except for LGPS members who enjoy transitional protection of a facility to take an unreduced pension before that scheme’s normal pension age of 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:*

8.12 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
The 2008 Occupational Pension Scheme Survey will not be released until October 2009.

8.13 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 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. Survey results indicated that schemes in the private sector are a mixture of DB (around 25%) and increasingly DC (around 85%, which includes stakeholder pensions), costing employers on average around 8% of pensionable paybill in addition to salary costs.

8.14 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.

8.15 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% 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

8.16 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, wider reward packages, and job satisfaction.

8.17 This benefit package includes the following:

- the 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;
- the 30 days study leave available to doctors in training;
- 39 weeks of paid maternity leave (eight weeks at full pay, 18 weeks at half pay and 13 weeks at statutory levels);
- opportunities for flexible working; and
- extremely high levels of security of employment for doctors in the NHS - 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.

8.18 The survey of benefits and perquisites submitted to the Review Body 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, (26 weeks at full pay in the NHS, plus 26 weeks at half pay after 5 years service. In the private sector, this is typically 100% of base salary for 2 to 4 weeks, reducing to 50% of base salary);
- annual leave, (32 days after 7 years service as a consultant plus 10 public and statutory holidays, compared to 25 days plus 8 public holidays in the private sector);
- maternity/paternity leave; and
- flexible working, career breaks and sabbaticals (in respect of which 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.

8.19 The survey suggested that the NHS was behind private sector market practice in the provision of private medical insurance, life assurance, car allowances, and season ticket loans. The NHS does not provide season ticket loans, private medical insurance or status related car allowance. The best private sector practice is “4 x salary” life cover, compared to “2 x salary” life cover in the NHS (but the Review Body should note that this is an employee benefit of relatively low value).

8.20 Access to training and development is an important part of the overall package for doctors. An August 2007 Survey of more than 1000 new graduates by Ernst and Young indicated that 44% of them 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.

8.21 The chart below 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, childcare 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.

8.22 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 around £11,000 to a doctor in the second year of training, and around £14,000 to a doctor five years into training.
Notes:
Consultant: 42 days leave a year, 11 sessions worked, 5% on call allowance, 5 CEAs
SPR: five years into training, band 1A supplement, 40 days leave, 30 days paid study leave
F2: 2nd year 35 days leave, 30 days paid study leave
Assume doctors take NHS average of 11.7 sick days per year and compare with SSP
Compare leave entitlement with statutory 28 days.

8.23 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.

8.24 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 a doctor in training.
CHAPTER 9: EVIDENCE ON THE GENERAL ECONOMIC CONTEXT

Summary

9.1 Since full economic evidence was submitted in September last year, the impact of the global financial crisis on economic activity has been more severe than expected. Budget 2009 estimated a downward adjustment to the level of trend output of around 5 per cent between mid-2007 and mid-2010. The public finances have been profoundly affected by the global financial crisis, as lower trend output has led to a permanent loss of tax revenue.

9.2 In order to return to cyclically adjusted current balance by 2017/18, the Government announced a significant fiscal consolidation, with £5 billion additional recoverable efficiency savings in 2010/11 and lower current spending growth, at an average of 0.7 per cent in real terms from 2011/12 to 2013/14 (compared to the estimated 1.9 per cent in real terms that it had set for the current spending review period at the time of 2007 Comprehensive Spending Review). While the Government recognises that Pay Review Bodies are making decisions for 2010/11, from an affordability perspective, these decisions will have medium term implications for workforces and the Government’s finances through this unprecedented period.

9.3 2010/11 is expected to be a challenging period for the global economy. Budget 2009 forecast UK GDP growth of 1¼ per cent in 2010, with growth picking up progressively through 2010 and 2011. However, it recognised that the impact of the financial crisis on confidence and activity has led to particularly high levels of uncertainty over prospects for the economy in 2010/11.¹

9.4 Apart from affordability constraints, labour market indicators support restraint in 10/11. Vacancies are close to their lowest level since comparable records began in 2001 whilst unemployment and redundancies have risen sharply through the first half of 2009. Pay freezes have become more common in the private sector and average hours worked have fallen.² In the near-term employment intentions indicators are weak and continue to suggest that employment will fall further. Independent forecasters expect unemployment to remain elevated for some time to come. As in previous recessions, unemployment may not begin to fall back until well after GDP growth has picked up.

9.5 The weaker labour market has also had an impact on private sector pay. Average earnings growth (excluding bonuses) in the private sector has fallen to a historical low of 1.8 per cent (3 months to July) whilst public sector pay growth has remained strong at 3.6 per cent. Average earnings growth in the public sector includes both settlement and progression increments in contrast to the private sector, where spot rates are more common. The substantial fall in private sector earnings growth reflects actions by some employers, including high profile employers such as BT, British Airways and Honda to seek pay cuts and freezes in order to reduce the need for job cuts. A larger margin of spare capacity associated with higher unemployment and reduced working hours is

¹ “Given the nature of the global credit shock, the steep and synchronised world downturn, and the scale of the international and macroeconomic and financial policy response, all of which have intensified since the 2008 Pre Budget Report, the judgments on which the Budget 2009 forecast are based are subject to exceptional uncertainty” p190, “Budget 2009”, HM Treasury

² Per capita labour costs were widely reported to have fallen through 2009 (“Bank of England Agent’s Survey”, August 2009). Average hours worked have fallen by 1.6 per cent through the recession (ONS).
likely to keep wage growth subdued through 2010/11 even if labour demand begins to firm up.

9.6 These wider economic developments have two important implications for decisions on public sector pay:

- Firstly, given workforce reductions and wage restraint in the wider labour market, the increasing relative attractiveness of the total public sector package should lead to improvements in recruitment and retention that for most workforce groups, builds on the already very healthy position presented in last year’s evidence. This will be aided by an increase in the perceived value of defined benefit, index-linked pensions and greater job security in Pay Review Body workforces.

- Secondly, announcements in the Pre-Budget Report and Budget 2009 of slower spending growth in 2011/12 and beyond mean that from 2012, affordability will be significantly tighter and choices about the best use of public money to support public sector workers and public services will be even more important. With a backdrop of rising demand for public services, pay restraint will be a key factor to protect service quality in a tighter environment for spending and will be critical to managing the pay baseline for the next spending review period.

9.7 In coming to their decision for 2010/11, the Government asks the Review Bodies:

- to consider the implications that decisions on pay in 2010/11 will have for workforces and the Government’s finances in the medium term;

- to recognise that there are competing priorities for spending on pay which may contribute more to public servants’ ability to do their jobs and outcomes for the taxpayer;

- to note that since 1997, the government has invested significantly in frontline workforces both in terms of pay and workforce numbers;

- to note the broadly very healthy recruitment and retention position; and

- to recommend a targeted approach within workforces where possible, to deliver the best value for money.

9.8 Given evidence of strong public sector recruitment and retention, and an increasingly challenging affordability position into the medium term, Government evidence to Pay Review Bodies proposes settlements in the range of up to 1% across the board in 2010/11 with no uplift for senior groups.

9.9 Following this summary, the rest of this chapter presents detailed evidence on the general economic context, inflation, affordability and the wider labour market.
Economic context and outlook for the economy in 2010/11

9.10 The global credit crisis impacted on economic growth across all major economies in the second half of 2008 and early 2009. In the UK, Gross Domestic Product (GDP) fell by 2.4 per cent in the first quarter of 2009 and by 0.7 per cent in the second quarter. The decline in output has been widespread, with both manufacturing and services affected. Over the whole of 2009, the Budget forecasts that UK GDP will contract by 3½ per cent, with output stabilising in the second half.

9.11 As the global macroeconomic stimulus builds and credit conditions ease, the economy is forecast to pick up progressively through 2010 and 2011 with annual growth of 1¼ per cent in 2010 and above trend rates of growth from 2011. The margin of spare capacity that has opened up during the global downturn, the normalisation of credit conditions and the effects of significant macroeconomic policy stimulus will support above trend growth in 2011. Table 9.1 summarises Government and independent forecasts for GDP growth over this period:

Table 9.1: Forecasts for GDP growth 2009 to 2011

<table>
<thead>
<tr>
<th>Forecasts for GDP growth (per cent)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget 2009</td>
<td>-3¼ to -3¾</td>
<td>1 – 1½</td>
<td>3 ¼ to 3 ¾</td>
</tr>
<tr>
<td>Bank of England mode projection for Q4 (Aug. 2009)</td>
<td>-2.4%</td>
<td>2.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Avg. of independent forecasters (Sept. 2009)⁴</td>
<td>-4.3%</td>
<td>1.0%</td>
<td>-</td>
</tr>
</tbody>
</table>

9.12 While a pick up in economic output is expected over 2010/11, the Bank of England and other independent forecasters are unusually uncertain about prospects for economic growth in 2010 and 2011. Uncertainty in the Bank of England’s projections for GDP growth in 2010 Q2 (as measured by variance) has increased from 1.26 per cent of GDP in the August 2008 inflation report to 1.58 per cent of GDP in the August 2009 inflation report. The latest short-term independent forecasts for growth in 2010 range between −0.9 per cent and +2.2 per cent. An increase in uncertainty is likely to be reflected across the wider economy by a greater reluctance amongst employers to commit to making significant investments in input factors such as workforces until they perceive major downside risks have been overcome.

9.13 Therefore, higher uncertainty could imply a longer lag between economic growth returning, and any positive effect on the wider labour market in which the public sector competes. For example, after quarter on quarter growth returned in Q3 1992, it took a further 4 quarters before ILO unemployment

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³ Source: ONS
⁴ “Forecasts for the UK economy: A comparison of independent forecasts” September 2009, compiled by HM Treasury
⁵ Ibid.
started to fall. Recruitment and retention is therefore expected to continue to remain very healthy across the public sector throughout 2010/11, whether or not the economy returns to growth in this period.

_Inflation_

9.14 Driven by rising energy and food prices, CPI inflation rose steadily from the start of 2008 peaking at 5.2 per cent in September 2008. However, in line with expectations and last year's government evidence, global commodity prices have fallen sharply since the summer of 2008 and downward pressure has fed through to lower consumer prices for petrol, food and household energy with varying lags. Since then, inflation has fallen sharply, adding a boost to real income growth; CPI inflation dropped below target to 1.6 per cent in August while RPI inflation was −1.3 per cent in August.

_Figure 9.1: CPI, RPI and RPIX Historic Trends_

9.15 The unusually large difference between these two measures mainly reflects the impact of monetary policy easing on the cost of servicing mortgages, with the mortgage interest payment component of RPI inflation falling more than 45 per cent on a year earlier.

9.16 The Budget forecast is for CPI inflation to fall to 1 per cent by the end of 2009 and to remain below target during 2010, as the lagged effects of sterling depreciation and monetary policy are more than offset by downward pressure on prices from spare capacity and lower energy prices. Inflation is forecast to return close to the Bank of England’s 2 per cent target during 2011 as the lagged effects of monetary policy easing, build. Table 9.2 sets out forecasts for inflation published in Budget 2009, against latest figures from the Bank of England and the average of independent forecasters.

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Source: ONS (Gross Domestic Product: Quarter on Quarter growth CVM SA against the ILO unemployment rate (16+))
Table 9.2: Forecasts for CPI Inflation 2009 to 2011

<table>
<thead>
<tr>
<th>Forecasts for CPI Inflation (per cent change on a year earlier)</th>
<th>Q4 2009</th>
<th>Q4 2010</th>
<th>Q4 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget 2009</td>
<td>1%</td>
<td>1%</td>
<td>2¼%</td>
</tr>
<tr>
<td>Bank of England mode projection (Aug. 2009)</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Avg. of independent forecasters (Sept. 2009)</td>
<td>1.4%</td>
<td>1.7%</td>
<td>-</td>
</tr>
</tbody>
</table>

9.17 In the August 2009 Inflation Report, the Bank of England judged that the margin of spare capacity that is likely to persist over the forecast period will bear down on CPI inflation. At the same time the report also recognized that this effect would be partially offset by the upward pressure associated with the pass-through of sterling's depreciation to consumer prices. On examining the balance of risks, the Bank concluded that it is more likely than not that CPI inflation will be below the 2 per cent inflation target in the medium term.

9.18 While the government does not share the view that pay rises should track inflation indices such as CPI, low inflation does provide a supportive context for the real life perception of settlements by public sector workforces.

Labour market context

9.19 As output has contracted over the last year, firms have reduced their demand for labour. Average hours worked have been cut and, through the final quarter of 2008 and the first half of 2009, firms have shed labour aggressively, which has led to a sharp rise in unemployment. Although a return to growth is forecast for 2010, as explained in the economic context section above, labour market conditions are expected to remain tough.

Employment – Whole Economy

9.20 Since reaching a peak of 29.5 million in the 3 months to May 2008, employment has fallen by 650,000 to 28.9 million in the 3 months to July 2009. However, this masks clear differences between private sector and public sector employment. Despite falling whole-economy employment, between the first and second quarter of 2009 employment increased marginally across all components of the public sector including central government (and NHS), local government and public corporations.

9.21 Unemployment has risen to 2.47 million in the 3 months to July 2009, equivalent to an unemployment rate of 7.9 per cent, up from 5.5 per cent a year earlier.

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7 The increase in public sector employment is independent of the inclusion by ONS of the semi-publicly owned banking groups in the employment figures for public corporations.
9.22 The claimant count of unemployment reached 1.61 million in August 2009, the highest level since May 1997. Although GDP growth is expected to pick up going into 2011, the average of independent forecasts indicates that claimant count is expected to rise to peak of 2.16 million in the fourth quarter of 2010 and remain above 2 million in 2011.

Source: ONS, September 2009
9.23 The number of vacancies in the UK has fallen from more than 680,000 at the start of 2008 to 434,000 in the three months to August 2009. This is only slightly up on July’s figure of 427,000, which was the lowest figure since comparable records began in 2001. There were also 246,000 redundancies in the three months to July, an increase of 107,000 on a year earlier. All sectors and regions of the economy have been affected with 58 per cent of redundancies coming from the service sector and 37 per cent from manufacturing and construction. While redundancy data for the public sector is not published, redundancies in the education, health and public administration sector of the economy represented 6 per cent of total redundancies in the 3-months to June 2009. The public sector employs 21 per cent of the workforce (headcount).8

The private sector

9.24 Looking at the private sector specifically, there is some evidence that firms have cut or frozen pay and average working hours as an alternative to cutting jobs. The high profile example of Honda proposing pay cuts for its Swindon factory staff appears to have been replicated in at least some companies, including British Airways and BT. IDS data indicates that over half of settlements were pay freezes in the three months to mid-September 2009; although freezes are likely to have been concentrated among smaller employers and implying that they have covered less than a third of employees. At the aggregate level, average hours worked have fallen by 1.6 per cent through the recession.

9.25 Going forward, employment intentions indicators remain subdued. Private business surveys conducted by a range of institutions9 have picked up from the lows recorded in the first quarter of 2009. However, all of the intentions surveys continue to suggest that employers expect to be cutting back on employment, rather than expanding headcount. The Bank of England Agents (Agents survey, August 2009) reported that many firms were not recruiting, aiming instead to trim head count by maintaining freezes on replacement hires. Although most firms were comfortable now that they had made the bulk of the adjustment in headcount warranted by the weaker outlook for demand, a minority reported firm plans for further large-scale redundancies.10

Average earnings

9.26 With inflation easing through the first half of 2009, unemployment rising and perceptions of job security falling, settlements have slowed somewhat. IRS now reports that the mean private sector settlement has come down from 3.4 per cent last year to 2.1 per cent in July 2009. The slowdown in settlements has driven a slowdown in private sector average earnings growth (excluding bonus payments) over the past year, from 3.8 per cent to 1.8 per cent in the three months to July 2009 – well below trend and the lowest since the series began in May 1997. In the public sector, average earnings growth has exceeded private sector earnings growth since August 2008. Public sector average earnings growth was 3.6 per cent (excluding bonus payments) in the three months to July 2009, essentially unchanged from a year earlier (0.1 per cent lower).

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8 Source: ONS
9 For instance, the CBI, CIPS, BCC, Manpower, Bank of England, REC and EEF.
9.27 A particular feature of public sector reward packages is the extensive use of pay scales, while spot rates are more common in the private sector. Private sector wage settlements therefore relate more directly to actual growth in earnings (excluding bonuses) than is the case in the public sector, where the presence of progression associated with pay scales will add additional growth on top of the basic award. By taking these differences into account, average earnings growth is a more accurate reflection of actual changes in pay than settlements alone.

Figure 9.4: Public and private sector average earnings growth (seasonally-adjusted, 3-month average)

![Graph of Public and Private Sector Earnings Growth](chart.png)

Source: ONS, September 2009

9.28 Looking forward, leading indicators, such as the Recruitment and Employment Confederation’s ‘pay-index’, are consistent with whole economy average earnings growth continuing to slow a little going into the third quarter of 2009. The average of independent forecasters surveyed by HM Treasury in September is for whole economy average earnings growth to reach 1.4 per cent in 2009 and rise to 2.2 per cent in 2010. Around this average there is significant variation among the leading forecasters: Goldman Sachs are expecting average earnings growth to pick up to 4.4 per cent in 2010, whereas Capital Economics expect wage growth to slow sharply to -2.5 per cent next year.

9.29 Overall, higher unemployment, increased redundancies and falling vacancies reflect the extent to which the private sector has been affected by the shock to the economy. Higher unemployment and lower working hours has created a margin of spare capacity, which will serve to keep overall wage pressures low. Perceptions of greater job security for Pay Review Body workforces will increase the relative attractiveness of the public sector total reward package, improving further their ability to recruit and retain staff. The total reward section addresses the different aspects of the total compensation package in more detail.
Total reward and pensions

9.30 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.

9.31 Occupational pensions are a form of deferred pay, paid to employees upon their retirement rather than when it is earned. They are a more significant 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 defined benefit occupational schemes than private sector workers (90 per cent participation by serving employees versus 15 per cent as at 200711); 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.

9.32 Almost all public sector occupational pensions are defined benefit (DB)12 schemes, with negligible membership of Defined Contribution (DC) schemes. Pensions cost public sector employers around 16-17 per cent of pensionable paybill in addition to salary costs (on average across the public services), whereas schemes in the private sector are a mixture of DB and increasingly DC, costing employers on average around 13 per cent13 of pensionable paybill in addition to salary costs. The difference of around 3-4 per cent on average in the level of employer contribution represents the higher value of deferred pay in the public sector. However this comparison only applies to the 15 per cent of private sector employees who are active members of occupational pension schemes.

Table 9.3: Employer Contribution rates for selected Public Service pension Schemes 2008/09

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Employer Contribution rate (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Governmenta</td>
<td>19.5</td>
</tr>
<tr>
<td>NHS staffb</td>
<td>14.0</td>
</tr>
<tr>
<td>Teachersc</td>
<td>14.1</td>
</tr>
<tr>
<td>Civil Service</td>
<td>19.4</td>
</tr>
<tr>
<td>Armed Forcesd</td>
<td>25.6</td>
</tr>
<tr>
<td>Policeee</td>
<td>24.2</td>
</tr>
<tr>
<td>Judiciary</td>
<td>32.2</td>
</tr>
</tbody>
</table>

a: England & Wales only, average of LGPS funds (includes investment surpluses and deficits) from Results of 2007 Valuation
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: March 2009

12 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.
13 Occupational Pension Schemes Survey (OPSS) 2007, First Release for Private sector DC schemes,
9.33 If one looks at all employer sponsored pension provision in the two sectors i.e. if one essentially adds stakeholder arrangements in the private sector, then the comparison is 16-17 per cent for the public sector and 8 per cent for private (approx 25% DB, 10% DC, 65% Stakeholder\textsuperscript{14}).

Figure 9.5: Active members\textsuperscript{15} in public and private sector, 1991-2007

![Graph showing active members in public and private sector, 1991-2007.](image)

Source: GAD/ONS: March 2009

9.34 Figure 9.5 shows that the private sector has been steadily exiting from pension provision since 1991. This is due to factors such as increased longevity expectations and a reduction in optimism over investment returns. In comparison, over the same period, public sector pension provision has been broadly similar, and there are now many more active members in the public than in the private sector, despite the public sector representing only around 20 per cent of the UK workforce. In short, as the more generous DB pension schemes have become more costly, especially during the recent economic environment, 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 9.4 and Figure 9.6. More and more private sector companies have moved on to reducing benefits or closing DB schemes for existing staff as well as new entrants including Barclays, British Airways, Marks and Spencer and BP.

\textsuperscript{14} Occupational Pension Schemes Survey (OPSS) 2007, First Release for Private sector DC schemes, HMRC and ONS (ASHE data) for Private sector Stakeholder schemes

\textsuperscript{15} Active members are current employees who are building up rights to an occupational pension scheme.
Table 9.4 – Breakdown of Private Sector pension, active members 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Active members in private sector in 2007</td>
<td>3.6m</td>
</tr>
<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 open 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

Figure 9.6: Proportion of private sector employees participating in an occupational pension scheme, 1991-2004

9.35 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.

Fiscal context and affordability

9.36 The public finances have been profoundly affected by the global financial crisis. The projections set out in Budget 2009 for the underlying trend output components imply a downward adjustment to the trend level of output of around 5 per cent between mid-2007 and mid-2010. By permanently reducing the productive potential of the economy, a lower trend output will lead to a permanent loss of tax revenue.

16 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.
The latest public sector finance figures show that public sector net borrowing figures (PSNB) increased to £8.0 billion in July 2009, compared with a surplus of £7.8 billion in July 2008. Public sector net debt (PSND), expressed as a percentage of Gross Domestic Product (GDP), was 56.8 per cent at the end of July 2009, compared with 43.5 per cent at end of July 2008.

In response to economic developments, the Government set out a temporary operating rule in the Pre-Budget Report 2008: to set policies to improve the cyclically-adjusted current budget each year, once the economy emerges from the downturn, so it reaches balance and debt is falling as a proportion of GDP once the global shocks have worked their way through the economy in full. The fiscal projections in Budget 2009 are consistent with returning to cyclically-adjusted current balance and debt falling as a share of the economy by 2017/18. Figure 9.7 shows the planned fiscal consolidation in each financial year of the projection period.

Figure 9.7: Balancing the budget (from Budget 2009)

The Budget 2009 showed that public sector net borrowing (PSNB) is projected to peak at 12.4 per cent of GDP in 2009/10, as the economic downturn significantly reduces tax receipts, particularly from the financial sector. PSNB then moves to 11.9 per cent in 2011/12 before declining to 5.5 per cent of GDP by 2013/14 as the economy recovers and the Government takes action to ensure the sustainability of the public finances. Public sector net debt (PSND), including unrealised losses from financial sector interventions increases over the period to 2013/14. It then stabilises at around 79 per cent of GDP by the end of the forecast period.

Whilst it is right for borrowing to rise in the short term to absorb the global shock, Budget 2009 is clear on the need to reduce borrowing once the economy is recovering and the importance of bringing the public finances back into balance in the medium term. As a result, the Budget builds on the PBR to show a fiscal consolidation from 2010/11 onwards.
9.41 In the Budget, Government announced measures that will reduce government borrowing by £26.5 billion by 2013/14, including an additional £5 billion of recoverable value for money savings in 2010/11. The Government also set new assumptions for spending growth in the period from 2011/12 onwards. Real current spending will grow by an average of 0.7 per cent a year from 2011/12 to 2013/14, down from the average of 1.9 per cent a year that was set for 2008/9 to 2010/11 at the time of the 2007 Comprehensive Spending Review. It is therefore clear that spending growth overall will be tighter going forward.

9.42 More recently, the Government announced a tougher focus on efficiency at every level of government, and a need to make some hard choices in switching and prioritising spending, within and between departments. This means that as the economic situation develops over the coming months, where help is no longer needed the Government will end programmes. Where more is required it will reprioritise investment accordingly.

9.43 At an estimated £157 billion in 2008/09, spending on public sector pay represents about 50 per cent of department spending allocations (Resource DEL) with Pay Review Body workforces making up about 45 per cent of the total public sector paybill. As a significant element of spending for departments, managing public sector pay carefully remains central to delivering better value for money from public spending. The medium term consolidation announced in the Budget means that obtaining better value for money from the paybill is now even more important. With a backdrop of rising demand for public services, pay restraint will be absolutely crucial to protect service quality in a tighter environment for spending.

9.44 While the Government recognises that Pay Review Bodies are making decisions for 2010/11, from an affordability perspective, these decisions will have medium term implications for workforces and the Government's finances through this unprecedented period.

17 “Building Britain’s future” HM Government, June 2009
CHAPTER 10: EVIDENCE FROM THE WELSH ASSEMBLY GOVERNMENT

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

NHS Reform in Wales

10.2 The Welsh Assembly Government’s vision for the NHS in Wales is ‘to create world-class health and social care services in a healthy, dynamic country by 2015.’ Alongside this vision sit ‘One Wales’ commitments to abolish the internal market and put in place a strategy for the continual improvement of local services through the Public Service Improvement Programme.

10.3 This Programme sets out what the Assembly Government wants public services to be – focused on the needs of citizens, with citizens who are engaged and involved in the development of services and who receive services which are efficient, effective and innovative in their design and implementation – and recognising collaboration as the key to successful delivery of public services.

10.4 Health policy is increasingly focusing on health care delivered closer to home through integrated working across health and social care, with greater involvement of patients in decisions about their health and health care, as well as more public accountability and engagement of patients and communities in the design and delivery of services.

10.5 The NHS restructuring in Wales is nearing completion with the creation of 7 integrated Local Health Boards and 3 Trusts which abolish the boundaries between different organisations within the Health Service which hinder achievement of the above policy.

10.6 The National Advisory Board will be responsible for providing independent advice to assist the Minister in discharging her functions and meeting her accountabilities for the performance of the NHS in Wales. The National Delivery Group will be responsible for providing strategic leadership and management of the NHS and overseeing the development and delivery of NHS services.

Workforce Strategy

10.7 Designed to Work, the current workforce strategy was launched in July 2006 and implementation progress has been monitored over the last 3 years. With the establishment of the new organisations there is a need to develop a further Workforce and OD strategy to focus priorities and support the delivery of the emerging workforce agenda.

10.8 NHS Wales is facing significant financial challenge, which will continue for the foreseeable future. This will bring with it a very challenging workforce agenda which will need to focus on the structure, deployment and efficiency of the NHS workforce. The new strategy must ensure that these challenges are met, that it underpins and supports the delivery of all service and financial targets and the objectives of the recent NHS reform programme.

10.9 It must build on the progress made through the implementation of Designed to Work and other related initiatives which the Assembly has already developed. Work to develop this strategy commenced with a facilitated workshop in August with the new LHB Directors of Workforce and OD and representatives of the Trade Unions with completion planned for April 2010.
Workforce Numbers: Headline Figures

10.10 Between September 2007 and September 2008, the number of WTE directly employed NHS staff increased by 0.8% (560) to 71,467. Hospital medical and dental staff increased by 51 (1%) to 5,571 of which the number of hospital medical consultants increased by 74 (4%) to 1,893 wte. There were increases in the other hospital grades as follows:

- Associate Specialist 204 to 228 (12%).
- Specialist Registrars 1,326 to 1,765 (31%)
- Foundation House Officers 1 245 to 271 (10%)
- Foundation House Officers 2 238 to 260 (9%)

There were decreases in other hospital grades as follows:

- Senior House Officers 846 to 401 (53%)
- House Officers 82 to 62 (25%)
- Staff Grades 473 to 446 (6%)

10.11 There has been an 89% increase in medical student intake since 1999 (190 to 360). There are now 2,776 WTE training posts in Wales.

Workforce Planning

10.12 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.

10.13 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.

10.14 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.

Sustainability of Medical Workforce

10.15 There have been recent changes in medical workforce training, recruitment and pay and terms and conditions arrangements across the UK. The impact of New Deal, EWTD and national and overseas recruitment restrictions has had a significant impact on the availability and development of junior doctors with the NHS. These changes have led to a short-term shortage of juniors to provide services which are becoming critical and the sustainability of current medical staffing arrangements now presents a fundamental challenge to all healthcare organisations.

10.16 Work is needed urgently to address this issue which will include required improvements to the processes to recruit junior doctors to ensure that NHS Wales improves recruitment levels. A Junior Doctor Review Group has been formed with membership from all key stakeholders to look specifically at recruitment and retention. In addition the impact of EWTD needs further assessment and creative alternative staffing solutions need to be found as a matter of urgency. These solutions will include the development of other professionals to undertake work previously provided by doctors, further
development and implementation of Hospital at Night models of staffing, the extended hours working arrangements of consultant and other career grade medical staff and the efficient and creative deployment of junior medical staff through the development of different/joint rota arrangements.

Modernising Medical Careers – Specialty Recruitment

10.17 The first round of recruitment resulted in 81% fill rate but significant vacancies in paediatrics and core medical training. The second round resulted in 122 vacancies. Unfilled posts have been passed back to Trusts for filling with locums but there is no evidence of a large pool of doctors to fill these. Previous reliance on the contribution of overseas doctors presents an immediate and future threat to services, but also an opportunity to think longer term about service and workforce configuration.

Consultant Vacancies

10.18 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 57.0 (3.0%) in September 2007 to 29.8 (1.3%) in September 2008.

<table>
<thead>
<tr>
<th></th>
<th>30/9/2007</th>
<th>31/3/2008</th>
<th>30/9/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>4.0</td>
<td>6.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>4.0</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>-</td>
<td>3.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Dental Group</td>
<td>2.0</td>
<td>1.0</td>
<td>2.0</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>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T&amp;O</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1.0</td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>Urology</td>
<td>3.0</td>
<td>2.0</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>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td>3.0</td>
<td>1.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Histopathology</td>
<td>2.0</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Medical Microbiology</td>
<td></td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>General Medicine Group</td>
<td>12.0</td>
<td>5.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>1.0</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Community Health</td>
<td></td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>13.0</td>
<td>7.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Radiology</td>
<td>5.0</td>
<td>3.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>57.0</td>
<td>37.0</td>
<td>29.8</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Trust</th>
<th>30/9/2007</th>
<th>31/3/2008</th>
<th>30/9/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe Bro Morgannwg</td>
<td>-</td>
<td>1.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Cardiff and Vale</td>
<td>7.0</td>
<td>5.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>2.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Gwent Healthcare</td>
<td>16.0</td>
<td></td>
<td>3.0</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>9.0</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td>North Wales</td>
<td>6.0</td>
<td>17.0</td>
<td>6.0</td>
</tr>
<tr>
<td>North West Wales</td>
<td>15.0</td>
<td>6.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Powys LHB</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Velindre</td>
<td></td>
<td>2.0</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>57.0</td>
<td>37.0</td>
<td>29.8</td>
</tr>
</tbody>
</table>
EWTD and Hospital at Night

10.19 Compliance towards the August 2009 48-hours target has increased and in August stood at 75% as shown in the Table below.

10.20 There is a UK-wide shortage of certain specialties of doctors which is having an impact on our ability to meet the targets within the timescale. However, the NHS has worked extremely hard over the last four years to make the necessary changes to achieve compliance with the EWTD.

10.21 The Assembly Government submitted to the Secretary of State for Health 38 working patterns for derogation. This equates to roughly 6% of all working patterns or 189 of the 3,000 junior doctors in Wales.

10.22 Solutions must support patient 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>684</td>
<td>589</td>
<td>86</td>
</tr>
<tr>
<td>Cardiff</td>
<td>678</td>
<td>453</td>
<td>67</td>
</tr>
<tr>
<td>Cwm Taf</td>
<td>333</td>
<td>171</td>
<td>51</td>
</tr>
<tr>
<td>Gwent</td>
<td>451</td>
<td>336</td>
<td>75</td>
</tr>
<tr>
<td>Hywel Dda</td>
<td>297</td>
<td>297</td>
<td>100</td>
</tr>
<tr>
<td>North Wales</td>
<td>400</td>
<td>329</td>
<td>82</td>
</tr>
<tr>
<td>North West Wales</td>
<td>152</td>
<td>65</td>
<td>43</td>
</tr>
<tr>
<td>Powys</td>
<td>4</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Velindre</td>
<td>56</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Wales</td>
<td>3055</td>
<td>2300</td>
<td>75</td>
</tr>
</tbody>
</table>

Consultant Contract

10.23 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 three-stage approach to benefits realisation pending Consultant Outcome Indicators (COIs) being able to deliver useful and usable information.

10.24 The key findings from the fourth round of Reports which include the views of consultants, via local negotiating committees, as well as Trusts, are as follows:

- Average Consultant weekly working hours were 40.2 hours at March 2009, a reduction of 0.8 hours over March 2008, and down from 45.6 hours in December 2003.

- The total number of Consultants employed across Wales was 2,246 at March 2009, an increase of 108 on March 2008, and a rise of 40% since September 2003.

- Consultant vacancies were running at 1.3% at September 2008, compared with 1.7% in March 2008 and 9.5% in September 2003. All Trusts report being able to fill most posts with a good field of candidates and none report that recruitment has been more difficult.
• 2,233 additional sessions were being paid in total to Consultants in March 2009, slightly less than in March 2008. Consultants were receiving an average payment of almost 0.85 additional sessions for Direct Clinical Care (DCC) and Supporting Professional Activities (SPA), a reduction of just under 10% on the previous year.

• The average split between DCC sessions and SPA was 8.0 to 2.4 in March 2009, a decrease of 0.1 DCCs, and a marginal decrease in SPAs over the year. The net service delivery effects across Wales, taking account of the increased number of Consultants, was an extra 3.6% in capacity to undertake DCC activity, and an extra 2.8% in SPA activity, which in effect is an additional investment in service quality, over March 2008.

10.25 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 and 2009 reports. This work has been enhanced by the engagement of national Specialty Advisory Groups. A proposal to extend the project for a further two years is currently under consideration.

10.26 54% of Consultants participated in the 2009 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.

10.27 Trust reports quoted a range of evidence of changes in service delivery and clinical practice at local level which job planning had contributed or facilitated and that job planning was increasingly embedded. Trust databases generally showed evidence of changes to job plans in the past year and Trusts consider Consultants to be well engaged in the process.

**SAS Doctors**

10.28 The new SAS contract was effective from 1 April 2008. All new SAS Doctor appointments since then have been to the Specialty Doctor grade. The new agreement is being implemented on a coordinated timetable across Wales. For existing doctors, formal offers of a new contract will be made shortly, but with the option for individual doctors to defer making a decision until there has been UK clarification about pensionability of the enhanced rate for any out-of-hours work done by the doctor within their basic contract. It is important to ensure that the Job Plans that go with these offers have been signed off by all parties.

10.29 Nearly 250 doctors and dentists confirmed they wished to apply for regrading under the Window of Opportunity by the deadline of 31 March 2009. Trusts are currently considering these applications, which will then come to the Assembly for approval.

**Accommodation Review Group**

10.30 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.

10.31 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’s interim report was accepted by
the Minister with the result that F1 accommodation will continue to be provided free until 31 July 2010 but Trusts are aware of the tax implications.

**GP Workforce**

10.32 GMPs in Wales are employed on a similar basis to England. The major structural difference is that there are no Personal Medical Services contracts. Since the changes introduced in 2004, LHB’s have been encouraged to make full use of salaried contracts. This has created new employment opportunities for doctors who do not wish enter business as independent contractors. Recruitment and retention of GMPs in Wales has improved considerably since the new practice based contract was introduced. Reports to the Welsh Assembly Government suggest that there are now healthy numbers of applicants for new posts right across Wales. Whilst the vacancy rate appears to have risen slightly to 0.9% in 2008, there is no evidence of difficulties in filling posts. The GMP vacancy rate is below 1% for the third year in a row. We therefore support the Department of Health’s proposals for uplifts in 2010/11 for salaried and self-employed GMPs.

10.33 As at 30 September 2008, Wales had 1,940 practitioners, a 9% increase since 1998.

- 39.2% of practitioners are female;
- In Wales the average list size per practitioner was 1,605;
- 21.5% of GMPs in Wales are aged over 55, compared to 22.2% in England;
- At 30 September 2008 there were 198 GMP Registrars up from 110 in 2003;
- The number of GMP retainers was 70 (an increase of 180% since 1999);
- 3.6% of practitioners are single handed; and
- as at 31 March 2009 the three-month vacancy rate was 0.9%, compared with 0.2% in 2008, 0.9% in 2007 and 1.8% in 2006. The three-month vacancy rate per 100,000 population was 0.5.

**Key Data**

<table>
<thead>
<tr>
<th>Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMPs</td>
<td>1822</td>
<td>1816</td>
<td>1849</td>
<td>1882</td>
<td>1936</td>
<td>1940</td>
</tr>
<tr>
<td>Part time GMPs</td>
<td>21%</td>
<td>21%</td>
<td>22%</td>
<td>22%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Female GMPs</td>
<td>31%</td>
<td>33%</td>
<td>35%</td>
<td>36%</td>
<td>38%</td>
<td>39%</td>
</tr>
<tr>
<td>GMPs per 10,000 population</td>
<td>6.1</td>
<td>6.0</td>
<td>6.2</td>
<td>6.3</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>GMPs aged over 55</td>
<td>18%</td>
<td>19%</td>
<td>20%</td>
<td>19%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>3-month vacancy rate</td>
<td>3.1%</td>
<td>2.1%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Single handed GMPs</td>
<td>5.9%</td>
<td>5.4%</td>
<td>5.2%</td>
<td>4.4%</td>
<td>3.5%</td>
<td>3.6%</td>
</tr>
<tr>
<td>GMP registrars</td>
<td>110</td>
<td>115</td>
<td>103</td>
<td>152</td>
<td>165</td>
<td>198</td>
</tr>
<tr>
<td>GMP retainers</td>
<td>70</td>
<td>70</td>
<td>70</td>
<td>61</td>
<td>73</td>
<td>70</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>782</td>
<td>795</td>
<td>847</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* no figures available
10.34 The table above shows:

- there has been a 6.5% growth in the number of GMPs since 2003. (The total growth since 1998 is 9.1%);
- the number of female GMPs is increasing faster than the increase in overall number of GMPs;
- the percentage of vacancies lasting 3 months stands at 0.9%;
- the proportion of single handed GMP practices is 3.6% down from 5.9% in 2003; and
- the average list size per GMP has reduced from 1,708 in 1995 to 1,605 in 2008.

Dentists

10.35 The contractual arrangements for NHS dentistry in Wales are still very much in line with those in England. The recent independent review of NHS dentistry in England made a number of key recommendations which are similar to those stemming from the review undertaken in Wales in 2008 and our on-going work looking to give a greater focus to prevention, recognising and rewarding quality and improving access, particularly for those in deprived communities. As this work progresses in Wales through pilots to test new models, we will continue to work with Department of Health colleagues to examine how developments in England might complement and sit alongside the work recommended and planned by our review groups.

10.36 Specific differences between the position in England and Wales are highlighted in the following paragraphs.

Access

10.37 In Wales in 2008/09 dentists delivered 5.055 million units of dental activity (UDAs) which represented 167,000, or 3.4%, more than in 2007/08. Almost 47,000 more patients are accessing NHS dental service than a year ago.

Recruitment and retention

10.38 There are more General Dental Practitioners in the NHS in Wales than at any time in the past. There were 1,293 dentists recorded in 2008/09 compared to 1,247 in 2007/08 and 1,186 in 2006/07 - a 9% rise in 2 years. Additional investment in dental undergraduate training in Wales will see the number of dental students in Cardiff University increase to 78 from 2010 – up from 55 in 2003. The total spend on NHS dentistry in Wales continues to grow significantly. In 2008/09 it was £129.7 million, compared to £121.7 million in 2006/07, and £81.0 million in 2004/05.

Income and expenses

10.39 The Dental Earnings and Expenses, England and Wales 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 2007/08 was £89,062. For dentists in Wales the average is slightly higher at £93,924. For dentists with a contract the figures are £126,807 (£131,287 in Wales) and for dentists working for others £65,697 (£66,259 in Wales).
Review in Wales

10.40 The work of the dental contract review groups has continued during the year. In addition to the completed review of the Community Dental Service (CDS) in Wales (i.e. salaried dentists) a review of Vocational Training and the future of General Professional Training reported in January 2009 and work commenced in September 2009 to review orthodontics. All the groups have included representatives of the dental profession, the British Dental Association, Local Health Boards and patient groups.

10.41 Work continues towards future action in testing new models of dental care in Wales. A review group has been established to examine the following areas in detail:

- to review contract currency;
- to develop a robust contract performance monitoring process; and
- to consider a basket of performance indicators.

10.42 The issues with the new contract have centred on the currency of dental services and quality, creating difficulties in ensuring equitable high quality patient care within the current system.

10.43 It has been agreed by Ministers that a contract commissioning system using a ‘basket of indicators’ will need to be piloted in new practices as a Welsh Assembly Government initiative and the effects of incentives and changes in patient charge revenue will be reviewed over a specified time period.

The Community Dental Service

10.44 One Wales, the agenda for the government of Wales agreed between the Labour and Plaid Cymru Groups in the National Assembly, includes a commitment for greater public health focus and a strengthened Community Dental Service (CDS).

10.45 The CDS is playing an integral part in the delivery of a National Oral Health Action Plan for Wales which is providing a long-term plan of action designed to improve oral health. Two super pilot areas, which covered approximately half the child population of Wales, are set to expand to include the whole of Wales during 2009/10.

10.46 We would support the proposed uplift for 2010/11 of up to 1% for salaried GDPs.

Conclusion

10.47 As in previous years the Welsh Assembly Government shares the view of the Department of Health that the pay award for dentists in 2010/11 should be a recommended 0.6% increase in net payments 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. We support the proposed nil uplift in gross payments to self-employed General Dental Practitioners put forward by the Department of Health and the proposal to include an efficiency assumption of 1% as part of the calculations.

Employers Views

10.48 A questionnaire was sent to employees in Wales seeking their views on the key areas covered by the Review Body. The main findings were as follows:
In response to the three most significant priorities in assessing pay levels for 2010/11, the majority of Trusts cited recruitment, staff morale and the affordability 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 reduction in the number of posts.

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

The main difficulties in recruitment or retaining doctors were ST1 and ST2 in A&E and paediatrics. In order to resolve these, Trusts have made use of internal locum cover and introduced job plan and skill mix changes.

**NHS Wales Staff Survey**

10.49 In view of the major reorganisation of NHS Trusts and LHBs, it was agreed that the next all-Wales NHS Staff Survey would take place in 2010/11.

**Finance**

10.50 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 nine 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.

10.51 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.

**Health and Social Services MEG Allocation**

10.52 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></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>2.78</td>
<td>7.0</td>
</tr>
<tr>
<td>2005/06</td>
<td>4,671</td>
<td>202</td>
<td>4.5%</td>
<td>1.87</td>
<td>2.6</td>
</tr>
<tr>
<td>2006/07</td>
<td>4,888</td>
<td>217</td>
<td>4.6%</td>
<td>2.96</td>
<td>1.6</td>
</tr>
<tr>
<td>2007/08</td>
<td>5,141</td>
<td>253</td>
<td>5.2%</td>
<td>2.77</td>
<td>2.3</td>
</tr>
<tr>
<td>2008/09</td>
<td>5,353</td>
<td>212</td>
<td>4.1%</td>
<td>2.19</td>
<td>1.9</td>
</tr>
<tr>
<td>2009/10</td>
<td>5,615</td>
<td>262</td>
<td>4.9%</td>
<td>1</td>
<td>3.9</td>
</tr>
<tr>
<td>2010/11</td>
<td>5,833</td>
<td>218</td>
<td>3.9%</td>
<td>1.5</td>
<td>2.4</td>
</tr>
</tbody>
</table>

GDP deflators as at June 2009
Source of HSS DEL: 2008 Final Budget less transfers in for Youth Justice and CAFCASS

10.53 The position for 2009/10 and 2010/11 is based on the Final Budget approved by the National Assembly for Wales in December 2008, based on CSR 2007 baselines. It does not take account of any potential reduction in funding for Health and Social Services as a consequence of the 2009 UK Budget. The Budget reduced Welsh Assembly
Government baselines by £216 million revenue, equivalent to approximately 1.6%. The Welsh Assembly Government will publish a draft budget for 2010/11 in early Autumn, which will show how this baseline reduction has been managed across the MEGs. It is likely, however, that Health and Social Services baselines will be reduced, which will significantly constrain the ability to offer pay awards in 2010/11.

**Pay increase funding**

10.54 Taking account of the above, the annual cash increases outlined above currently provide additional funding for pay cost increases as follows:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>80</td>
</tr>
<tr>
<td>2010/11</td>
<td>75</td>
</tr>
</tbody>
</table>

This funding has to cover:

- the 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.

10.55 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></th>
<th>%</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>

10.56 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.

10.57 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**

10.58 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 – despite negative inflation across the whole economy, NHS Trusts are still experiencing cost increases for core supplies of at least 5% in 2009/10 and there is no evidence that this will diminish going forward into 2010/11.
- 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:
  o minimum of one family nurse per secondary school;
  o extra funding for palliative care;
  o new priority for mental health;
  o improved provision for long term conditions, such as stroke and diabetes; and
  o improved access to services, including well-being centres.

• Ongoing demands to meet service targets linked to public expectations. The table below shows the upward trend in hospital activity.

<table>
<thead>
<tr>
<th></th>
<th>Elective admissions (a)</th>
<th>Emergency admissions (a)</th>
<th>Attendance (A&amp;E &amp; Minor Injuries Unit) (b)</th>
<th>First Outpatient appointments (consultant led) (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (000's)</td>
<td>Growth %</td>
<td>Number (000's)</td>
<td>Growth %</td>
</tr>
<tr>
<td>2002/3</td>
<td>286.9</td>
<td></td>
<td>325.8</td>
<td></td>
</tr>
<tr>
<td>2003/4</td>
<td>301.7</td>
<td>5.2</td>
<td>331.9</td>
<td>1.9</td>
</tr>
<tr>
<td>2004/5</td>
<td>298.4</td>
<td>-1.1</td>
<td>330.8</td>
<td>-0.3</td>
</tr>
<tr>
<td>2005/06 (c)</td>
<td>295.0</td>
<td>-1.1</td>
<td>336.7</td>
<td>1.8</td>
</tr>
<tr>
<td>2006/7</td>
<td>367.9</td>
<td>4.3</td>
<td>336.2</td>
<td></td>
</tr>
<tr>
<td>2007/8</td>
<td>392.8</td>
<td>2.4</td>
<td>342.0</td>
<td>1.7</td>
</tr>
<tr>
<td>2008/9</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
</tbody>
</table>

2002/3 to 2007/8  36.9        3.0     5.5          15.3

(a) Provider spells excluding maternity and well babies. Some NHS activity using the independent sector is not included in the figures.

(b) Figures relate to consultant led out-patient services in Welsh NHS hospitals

(c) Following a review undertaken by the Corporate Health Information Programme, and subsequent approval by the Programme Board, in December 2006, the historic cleansing was removed from 1st April 2007. The cleansing of inpatient / daycase submissions was in place between 2001 and April 2007, as per the instructions of Welsh Health Circular WHC (2001) 090.

Data is available in the two formats in 2005/06

Summary

10.59 Existing funding baselines for 2009/10 and 2010/11 are based on the 2007 CSR settlement, which in itself, resulted in a significant reduction in real growth funding available from previous historic levels. These baselines are likely to be further reduced as a consequence of the 2009 UK budget which reduced Welsh Assembly Government (CSR 2007) baselines in 2010/11 by £216 million (1.6%). Whilst existing funding baselines provide for the ability to manage an average 2% NHS staff pay award in 2010/11, it is now unlikely that any pay award in 2010/11 can be afforded without significantly impacting on service provision.
Conclusion

10.60 The difficulties experienced this year in Wales with the recruitment of junior doctors are not directly pay related and consequently in view of the continuing healthy position in recruitment and retention generally and morale of the medical and dental workforce, the Assembly supports the suggested award of up to 1% for 2010/11 for non-consultant salaried doctors and no salary uplift for consultants.
CHAPTER 11: EVIDENCE FROM THE SCOTTISH GOVERNMENT HEALTH DIRECTORATES (SGHD)

SUMMARY

11.1 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 the evidence given elsewhere that represents a UK position.

11.2 The evidence sets out:

- the Scottish context
- specific information about medical and dental workforce
  - medical and dental workforce planning
  - education and training
  - general medical practitioners
  - dentists
- resources and affordability
- NHS pensions and total reward
- Scottish economic context

THE SCOTTISH CONTEXT

11.3 The Scottish Government’s action plan for NHS Scotland – Better Health Better Care was launched in December 2007. It set out an ambitious five-year action plan embedding quality at the heart of healthcare delivery. To continue to build on the many achievements so far, in June 2009 a new Quality Strategy was launched for discussion, setting out our vision for Scotland as a world leader in patient-centred healthcare quality.

11.4 The NHSS workforce is key to delivering these objectives and we are proud of the committed and dedicated workforce that chooses to work for the health service in Scotland. The workforce plays a significant role in delivering quality services to patients, their families and the general public within a modern health service. What we need to do now is sustain the huge amount of progress that has been made by NHSS and its stakeholders in relation to the workforce agenda and to accelerate this as we prepare for the challenges ahead which impact across the wider health and social care agenda.

11.5 That is why the Scottish Government published A Force for Improvement at the beginning of this year as a workforce framework providing a base from which policy and financial decisions can be taken across NHS Boards in partnership with other agencies. It sets out the workforce ambitions that NHSS aspires to meet through its workforce and the priorities and actions that will be required to take this forward in partnership. The implementation of the policy will ensure cohesion and coherence in delivering care by developing existing practice and
extending best practice to fill gaps in delivery, evidencing change and ensuring consistency across NHSS.

11.6 Clearly the medical and dental workforce are central to NHSS continuing to deliver high quality, patient-centred healthcare. Therefore it is important to note two significant pieces of ongoing work in Scotland – Reshaping the Medical Workforce which will support the Scottish Government’s policy to move towards a health service delivered by trained doctors and a Dental Workforce Review. Both of these pieces of work will ensure that NHSS employs a medical and dental workforce which can support the Scottish Government’s strategic direction in health policy.

11.7 The significance of the wider economic outlook is indeed a critical factor for NHSS and given the strength of recruitment and retention in the medical and dental workforce in Scotland, low inflation and an increasingly challenging affordability position into the medium term, it is essential that restraint is shown towards these pay groups.

SPECIFIC INFORMATION ON THE MEDICAL AND DENTAL WORKFORCE

Overview

11.8 At 30 September 2008 there were a total of 165,551 (headcount) staff in NHSS. The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland, at 30 September 2008 was 11,356.3 (WTE) an increase of 535.7 (4.95%) from 30 September 2007 (these numbers exclude GPs as only headcount is available for them). This represents changes across the medical and dental grades as follows:

- **Consultant** headcount numbers increased by 574 (14.2%) between September 2007 to September 2008. In WTE the figure was 4,276.5, an increase of 12.2% since September 2007. While we welcome the continued increase in consultant numbers we have to be cautious about the figures this year, as there has been a change in the way data is collected. Before the change in data collection the annual increase in consultants over the last 10 years has been around 2-5% per year\(^1\).

- **Staff and Associate Specialist** grade numbers increased by 181 (20.2%) (headcount) between September 2007 and September 2008. The total number in September 2008 was 1,078 (headcount), 886 WTE.

- The number of doctors (including registrars) employed in the **General Medical Service** was 4,916 - 195 more than September 2007. (GP numbers are not available by WTE although some survey-based information for 2009 is due to be published in autumn 2009). The number of GPs in Scotland has risen by 892 (22%) since 1998. As at 30 September 2008 there were 486 GP Registrars (headcount).

\(^1\) During July 2008, Medical and Dental information was migrated from the MEDMAN web based system to the Scottish Workforce Information Standard System (SWISS). This alignment provided the opportunity to capture all NHSS staff in post information in one system, which has resulted in more robust information being captured and reported.
The number of doctors in training was 5,833.9 (WTE) a decrease of 101.6 (1.7%). As there have been significant increases in the number of Specialty Training places the decline in trainee numbers is likely to be a recording issue.

Published figures show an increase of 667 in all NHS dentists between 30 September 1998 (2,411) and 30 September 2008 (3,078) – 27.6%. For the last year, September 2007 to September 2008, the increase was 159 (2,919 to 3.078) – 5.4%.

MEDICAL AND DENTAL WORKFORCE PLANNING IN SCOTLAND

11.9 The National Workforce Planning Framework sets out the workforce planning cycle for NHSS. NHS Boards work to an annual planning cycle, publishing new plans in April and Regional Workforce Plans in September of each year. The National Workforce Planning Framework is available online http://www.scotland.gov.uk/Publications/2005/08/30112522/25230

11.10 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.

11.11 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.

Medical Workforce Supply

11.12 Scottish Ministers are responsible for determining target supply training numbers for controlled NHSS staff groups (including doctors and nurses). The overarching principle is to ensure sufficient output in order to supply NHSS’s future demand thereby supporting the delivery of services, in a way that is both affordable and sustainable.

11.13 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 retirals 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.

11.14 For most specialties in Scotland, the national model is forecasting there will be an oversupply of consultants in the future resulting in a predicted number of CCT holders being unable to find employment in Scotland over the next 5 years (see table below). The Scottish Government is committed 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.

**Table 11.1 Supply of Doctors trained to CCT Level in Scotland to 2014**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Current Consultants (Headcount at 30/09/08)</th>
<th>Consultants 55 and over at 30/09/08</th>
<th>Estimated retirements 2009 - 2014</th>
<th>Projected CCTs to 10/08/14</th>
<th>Projected oversupply 2009-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>113</td>
<td>12</td>
<td>10</td>
<td>138</td>
<td>128</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>605</td>
<td>92</td>
<td>70</td>
<td>311</td>
<td>241</td>
</tr>
<tr>
<td>Diagnostic Specialties</td>
<td>493</td>
<td>113</td>
<td>79</td>
<td>198</td>
<td>119</td>
</tr>
<tr>
<td>Medical Specialties</td>
<td>1139</td>
<td>257</td>
<td>184</td>
<td>546</td>
<td>362</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>869</td>
<td>219</td>
<td>142</td>
<td>406</td>
<td>262</td>
</tr>
<tr>
<td>Mental Health Specialties</td>
<td>530</td>
<td>173*</td>
<td>95</td>
<td>250 **</td>
<td>155</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>206</td>
<td>45</td>
<td>27</td>
<td>163</td>
<td>136</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>237</td>
<td>45</td>
<td>33</td>
<td>153</td>
<td>120</td>
</tr>
<tr>
<td>Public &amp; Occ. Health</td>
<td>189</td>
<td>50</td>
<td>41</td>
<td>63</td>
<td>22</td>
</tr>
<tr>
<td>HCHS totals</td>
<td>4381</td>
<td>1006</td>
<td>681</td>
<td>2228</td>
<td>1547</td>
</tr>
</tbody>
</table>

* Consultants 50 and over are shown in mental health specialties as most in that age group retain MHO status and have opportunity to retire at 55
** 5 year projections for mental health specialties are estimated as CCTs are only decided 3 years in advance. There are 168 due to 2011.

**General Practice**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Principal &amp; salaried GPs (Headcount at 30/09/08)</th>
<th>GPs 55 and over at 30/09/08</th>
<th>Estimated retirements 2009 - 2014</th>
<th>Projected CCTs to 10/08/14</th>
<th>Projected oversupply 2009-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>4269</td>
<td>721</td>
<td>550</td>
<td>1460</td>
<td></td>
</tr>
</tbody>
</table>

**Reshaping the Medical Workforce**

11.15 It is Scottish Government policy to move towards a health service delivered by trained doctors and to reduce the reliance on doctors in training for front-line service delivery and manage the “bulge” of trainees out of the system. Under the current approach to planning the medical workforce, junior doctors are recruited primarily to replace junior doctors rather than consultants or other trained doctors grades. Maintaining that approach will result in significant numbers of junior doctors securing a Certificate of Completion of Training (CCT) but, even allowing for expected consultant vacancies, unable to find employment in Scotland over the next five years.

11.16 Securing a service delivered by trained doctors therefore requires a shift from the current approach to medical workforce planning towards one which will
increase the role of doctors trained to CCT level in the provision of 24/7 services; enhance the role played by specialty doctors and develop and deploy staff in extended roles in other disciplines where they can contribute most effectively to clinical care.

11.17 Using a methodology that has been produced for modelling the future medical workforce, NHS Boards are undertaking an exercise to look specifically at their future medical workforce requirements. The results from this will be available by the end of 2009.

**Medical Specialty Training Intake for 2010 - 2014**

11.18 When run-through Specialty Training was introduced in 2007, it was apparent that a large influx of trainees in most specialties at that time would result in a period where there would be a larger output of “trained” doctors with CCT a few years later.

11.19 As that group of doctors approach CCT it is the intention of the Scottish Government Health Directorates to set numbers for training that will ensure sufficient supply of trained doctors to meet the requirements of the NHS in future years but not necessarily to replace current numbers of trainees as they complete.

11.20 A methodology for setting numbers is currently being consulted with NHS Boards. This includes the assumptions being taken into account such as retiring consultants, leaving consultants, gender-shift and work life balance. The guidance suggests intake numbers for higher specialty or run-through training in each specialty for the period 2010-2014 and then sets out next steps for specialties where there are concerns or doubts about the proposed intake. Intake to a programme in any year should be set assessing the likely requirement for output from that programme in the period when that group is likely to complete training.

**General Practice Survey**

11.21 For 2008/09, we obtained agreement with the Scottish General Practitioners Committee (SGPC) of the BMA to support a National Primary Care Workforce Planning Survey, asking practices for information on medical and nursing clinical commitment in the practice in the past year and also on GP and nurse vacancies. Practices who participated received a small payment (around £215 for an averagely sized practice) by signing up to part A of the Management Information Directed Enhanced Service (DES) agreed with the Scottish General Practitioners Committee (SGPC) in November 2008.

11.22 The Survey was launched in January 2009 and aggregated results are now being analysed by ISD. The response rate for this survey was better than in previous years when it was not formalised as a DES. It is planned to conduct this Survey regularly (possibly annually) so that comparative data can be obtained for workforce planning purposes. The results from the survey are due to be published in the autumn of 2009.

**Gender Profile & Shift**

11.23 The latest published figures, at 30 September 2008, indicate that the number of consultants employed by NHSS has increased by 14.2% (headcount) from
4,045 in September 2007 to 4,619 in September 2008. Within these totals, 47% of the total medical workforce (7,470) are female, but only 8.5% work part time. Only 474 female consultants out of a total consultant workforce of 4,619 are working part time. Women make up 31% of the total number of consultants (1,432 in total) with the majority of these, 958, working full time. These figures would suggest that women are currently underrepresented at a senior clinical level.

11.24 In response to the current level of representation within the medical workforce a symposium has been held by the Royal College of Physicians and Surgeons of Glasgow (RCPSG) entitled, “The Future Medical Profession: a female workforce?”, which focused on key issues for the female medical workforce. Following the symposium the RCPSG produced a report based on the discussion at the event. Entitled “A Flexible and Functional Workforce”, the report included a series of recommendations and an accompanying action plan. The Cabinet Secretary for Health and Wellbeing has since written to RCPSG indicating that the Scottish Workforce and Governance Committee (SWAG) will be asked to establish a working group to look at the female medical workforce. The group will be asked to report back at the end of the year to the Cabinet Secretary.

Vacancies

11.25 The WTE medical and dental consultant vacancy rate decreased from 282.0 as at 30 September 2007 to 186.5 as at 30 September 2008. The six-month vacancy rate decreased from 163.2 to 69.0 over the same period. There is currently no information available on associate specialist or staff grade vacancies. Information on GP vacancies should be available shortly through the above mentioned National Primary Care Workforce Planning Survey.

Dental Workforce

11.26 The number of dentists providing NHS dental services in Scotland has consistently risen over the past 10 years to meet a number of policy drivers, including the Dental Action Plan target of an additional 50 dentists each year between 2004-2008, and the national target of 80% of all children aged 3-5 being registered with an NHS dentist by 2010/11.

11.27 Published figures show an increase of 667 (headcount) in all NHS dentists between 30 September 1998 (2,411) and 30 September 2008 (3,078) – 27.6%. For the last year, September 2007 to September 2008, the increase was 159 (2,919 to 3.078) – 5.4%.

11.28 Based on the current evidence there is likely to be a relatively large and sustained increase in the stock of NHS dentists in Scotland in the future. However, we are carrying out a review of the dental workforce to be completed by the end of 2010. This review will look at the skills mix of dental professionals and the impact of emerging roles such as Oral Health Therapists. The review will be completed by the end of 2010 and the findings will inform dental student intake for 2011.

11.29 Retention rates of dentists who qualified from a Dental School in Scotland are much higher than that of dentists who qualified elsewhere. This expansion of our own graduates combined with the recruitment and retention incentives already in place will ensure a continued growth in dentist numbers.
Turnover data

11.30 Latest information published by ISD indicates that the turnover of all staff in NHSS has decreased by 0.1%. Given the current economic downturn it is predicted that this figure will reduce further in the next year.

Table 11.2: TURNOVER DATA FOR NHS STAFF 2006/07(%) 2007/08(%)  

<table>
<thead>
<tr>
<th>Category</th>
<th>2006/07</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Agenda for Change Staff</td>
<td>7.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>7.0</td>
<td>9.7</td>
</tr>
<tr>
<td>Medical and dental support</td>
<td>-</td>
<td>7.4</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>6.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Allied health professions</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>Other therapeutic services</td>
<td>-</td>
<td>7.7</td>
</tr>
<tr>
<td>Personal and social care</td>
<td>-</td>
<td>14.1</td>
</tr>
<tr>
<td>Healthcare science</td>
<td>-</td>
<td>7.1</td>
</tr>
<tr>
<td>Emergency services</td>
<td>4.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Administrative services</td>
<td>9.2</td>
<td>8.9</td>
</tr>
<tr>
<td>Support services</td>
<td>10.9</td>
<td>10.4</td>
</tr>
<tr>
<td>Unallocated / not known</td>
<td>15.3</td>
<td>8.4</td>
</tr>
</tbody>
</table>

EDUCATION AND TRAINING

Dental Training

11.31 We have expanded the numbers of dental professionals in training between 2008 and 2013. In 2009, we estimate a total of 147 dentists will graduate from Scottish Dental Schools rising to 175 by 2010 and 176 by 2013.

11.32 The Scottish Government has committed to match the number of vocational training (VT) places in Scotland to the output of the Scottish Dental Schools. This has increased from 126 in 2005 to 160 in 2009. The dental bursary scheme introduced in 2006, which ties graduates into a minimum of 2 years and up to 5 years full-time in the NHS in Scotland, secured 97% of the 2007-08 students for Vocational Training registration.

Postgraduate Medical Training

11.33 Selection and recruitment in Scotland for 2009 has gone well. Scotland received 6,200 applications as part of the 2009 national recruitment round for 980 posts, these posts being a selection of specialty training posts at various levels and GP posts at level 1. Applicants could make unlimited multiple applications giving a national applicant pool of around 4000 junior doctors. The ratio of applicants to posts was on average 8:1 the range being 14:1 to 3:1 across the specialties.

11.34 The recruitment process in Scotland continues to be enhanced year on year with the partnership working between all key Scottish stakeholders becoming established and evidenced. Governance, transparency and quality remain the cornerstones of Scottish Medical Recruitment. The 2009 recruitment process involved one full round of recruitment for all specialties with available posts followed by a second round of recruitment for those specialties with remaining posts at the close of the first round. Offers to candidates were made as soon as possible following interview thus securing high quality trainees within
Scotland. Intrinsic to the offers process in Scotland is the option for trainees to state their order of preference to work within each of the four Scottish Deaneries. Offers are aligned to these preferences with over 80% of trainees receiving an offer for their first choice Deanery in 2009.

**Working Time Regulations**

11.35 Before the 1 August 2009 deadline, all Scottish Health boards had designed compliant rotas for the vast majority of junior doctors apart from a small number in highly specialised areas like Transplant, and Maxillo Facial Surgery and Neurosurgery.

11.36 In order to support services which require additional time to reach compliance the Scottish Government is in the process of taking up the option of a limited derogation secured by the UK Government under Article 21(5) of the European Working Time Directive. The latest Board reports show that the majority of the 17 health boards and special health boards which employ doctors in training are 100% compliant with the regulations. Overall, 98% of junior doctors were compliant with the 48 hour average working week approaching 1 August 2009. The Cabinet Secretary has agreed to consider requests for derogation from the Working Time Regulations for those areas who require more time and support to reach compliance. A high level Scrutiny Group, chaired by the Director General Health and including representatives of NHS boards, the Academy of Royal Colleges, NHS Education for Scotland, the BMA and SGHD has been set up to scrutinise applications and make recommendations to her. Those which the Cabinet Secretary approves will be included in an amended Schedule in the next revise of the Working Time Regulations. Derogation will allow doctors to work up to 4 hours extra each week for two, or exceptionally, three years to allow boards more time to provide solutions to their compliance problems.

**Doctors in Training**

11.37 New Deal compliance continues to be monitored and the latest statistics published by ISD show that 98.4% of juniors were fully compliant with the contract at 31 January 2009. Of the 82 doctors who monitored non-compliant, just over half are once more Specialty Training grades, most of whom work in small isolated rural units or supra specialties, like Oral Maxillo Facial and Transplant Surgery and Neurosurgery.

11.38 Arrangements to support the New Deal were subject to an internal review at a special meeting of the New Deal Review Board in March this year. Recommendations on future support were agreed by the Cabinet Secretary for Health and Wellbeing. The basis of the way forward is as follows:

- The New Deal Support Officer posts based with the Regional Workforce Directors should cease to exist at the end of the current fixed term contracts;

- In place of the Central Secretarial post there should be a new two person Central team of a Senior New Deal and Working Time Regulations (WTR) Adviser and a New Deal and WTR Adviser, tasked to help resolve any local and operational difficulties encountered by either employers or employees in the implementation of New Deal. They will collect and report to SGHD on New Deal compliance levels and support the achievement and
maintenance of WTR compliance for doctors in training and other NHS employees;

- The New Deal Review Board should cease to exist and New Deal issues should in future be discussed at the Tripartite meetings held between SGHD, NHS employers and the BMA Scottish Junior Doctors Committee.

**Average Pay Supplement by Grade and Rota**

11.39 The average banding supplement paid to junior doctors has reduced slightly this year to 55.4% as shown in the table below.

**Table 11.3: Average Pay Supplement by Grade and Rota**

<table>
<thead>
<tr>
<th></th>
<th>All Grades</th>
<th>Specialty Training / Registrar</th>
<th>FY2</th>
<th>FY1</th>
<th>Fixed Term Specialty Training</th>
<th>General Practice Specialty Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 2008 - Jan 2009</td>
<td>55.4%</td>
<td>55.2%</td>
<td>52.8%</td>
<td>56.7%</td>
<td>59.4%</td>
<td>55.8%</td>
</tr>
<tr>
<td>Feb 2008 - July 2008</td>
<td>55.8%</td>
<td>56.1%</td>
<td>52.9%</td>
<td>56.8%</td>
<td>58.7%</td>
<td>54.9%</td>
</tr>
<tr>
<td>Aug 2007 - Jan 2008</td>
<td>56.1%</td>
<td>56.1%</td>
<td>53.0%</td>
<td>57.6%</td>
<td>59.9%</td>
<td>54.9%</td>
</tr>
<tr>
<td>Aug 2005 - Jan 2006</td>
<td>63.0%</td>
<td>60.4%</td>
<td>63.2%</td>
<td>65.7%</td>
<td>66.7%</td>
<td>65.8%</td>
</tr>
<tr>
<td>Feb 2005 - July 2005</td>
<td>66.2%</td>
<td>64.0%</td>
<td>65.7%</td>
<td>70.6%</td>
<td>71.2%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Aug 2004 - Jan 2005</td>
<td>68.8%</td>
<td>67.4%</td>
<td>68.6%</td>
<td>72.2%</td>
<td>72.2%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Feb 2004 - July 2004</td>
<td>75.8%</td>
<td>73.2%</td>
<td>76.0%</td>
<td>79.3%</td>
<td>79.3%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Aug 2003 - Jan 2004</td>
<td>76.3%</td>
<td>72.9%</td>
<td>77.3%</td>
<td>78.7%</td>
<td>78.7%</td>
<td>78.7%</td>
</tr>
<tr>
<td>Feb 2003 - July 2003</td>
<td>81.7%</td>
<td>76.1%</td>
<td>84.6%</td>
<td>81.8%</td>
<td>81.8%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

11.40 It is anticipated that the continued service modernisation that is being undertaken by boards seeking to gain compliance with the Working Time Regulations will further reduce the pay of junior doctors and their banding supplements over the coming year. However, medicine continues to be an attractive career choice for well qualified university applicants and there continues to be competition for entry to medical education courses. Despite the current and anticipated falls in junior doctor pay subsequent to the reduction in their working hours, the salary levels still compare well with those of other professions where there is not the same relatively easy access to first employment in NHS training posts.

**Junior Doctors Contract**

11.41 SGHD is working closely with NHSS employers to produce a Scottish contribution to the scoping study and cost-modelling work being carried out by NHS employers across the UK and the other three Health Departments on the effectiveness and value for money of the current contractual arrangements for junior doctors. SGHD looks forward to contributing to this report when it is published at the end of 2009 and will consider the next steps in conjunction with the other UK Departments once it has had time to reflect on the findings of the study.
Travel and Relocation Expenses

11.42 In last year’s report SGHD reported that an interim agreement had been reached on travel and relocation for Specialty Trainees pending the outcome of an overall review of the future shape of the medical workforce in Scotland. The interim agreement ended on 31 July 2009. Work on re-shaping is continuing and indeed further work on junior doctor rotations which hopefully will ultimately help with travel and relocation issues is on-going with NHSS employers, NHS Education for Scotland (NES) and BMA Scotland. Therefore following discussions with NHS Scotland and BMA Scotland, it was agreed that the terms of the existing interim agreement would be carried forward until such time as a new agreement is reached.

Specialty Grade/ Associate Specialists

11.43 Over the last year, SGHD and NHSS employers have been working in partnership with BMA Scotland’s Staff and Associate Specialist Committee with the joint aim of implementing the new contract for this group of staff across Scotland as smoothly and effectively as possible. A series of regular meetings have taken place between these parties which have resulted in agreement being reached on a number of issues. This has subsequently been issued to NHSS as jointly-agreed guidance on issues such as Regrading, Window of Opportunity, Optional and Discretionary Points, Terms and Conditions etc.

11.44 Monitoring arrangements have also been agreed in relation to the implementation of the contract in Scotland and data from this exercise is currently being collected. Further information on this exercise will be reported to the Review Body in due course. However, early evidence suggests that there has been a 95% expression of interest in the new contract although the final uptake will not be known until the job planning exercise is completed.

Consultants - Review of Distinction Awards and Discretionary Points

Clinical Excellence Awards

11.45 In Scotland at present, the two distinct schemes - national Distinction Awards and local Discretionary Points continue to operate. At September 2008 there were 552 national award holders comprising 13.5% of all consultants. As at September 2009 that figure is estimated to be around 11.9% of the consultant population. The percentage of consultants retiring with a Distinction Award was 46.9% in 2005, 51% in 2006, 40% in 2007, 50% in 2008 and is estimated to be 47% in 2009. These existing schemes have been under review for some time. The work of the review group has been reported to and agreed by the Cabinet Secretary for Health and Wellbeing. A further group is in the process of being set up in order to translate the agreed framework into guidance for the NHSS to enable the new scheme to be implemented from 1 April 2010.

11.46 The new scheme will be known as the Scottish Clinical Leadership and Excellence Awards (SCLEA) scheme and will recognise and reward individuals who contribute over and above what is contractually expected with outstanding performance. The Scottish Advisory Committee on Distinction Awards (SACDA) will be replaced by a new body called the Scottish Advisory Committee on Clinical Leadership and Excellence Awards (SACCLEA). This body will continue to recommend awards at the highest levels but will also assume a new role in monitoring the allocation of the expanded discretionary
points scheme to ensure, for example, that different contributions are fairly recognised.

11.47 No additional funding will be made available for the new scheme and there will be no detriment to existing award holders as a result of its introduction. Awards will continue to be up-dated each year in line with Review Body recommendations. The current 0.35% formula for the payment of Local Excellence Awards will continue to apply.

11.48 The new scheme seeks to ensure equity of access and parity of opportunity between NHS consultants, clinical academics and senior academic GPs. Applications for all levels of award will be by self-nomination through an electronic form based on the SACDA Online system. Standardised forms across all levels of award will assist the management of applications and ensure uniformity of process. There will be a robust process to ensure the validity, value and relevance of information supplied in applications.

11.49 Table 11.4 sets out the 13 levels of the new scheme, levels 1 to 10 being administered by local health boards and levels 11 to 13 by SACCLEA. From this it can be seen that levels 1-8 of the current discretionary points scheme will remain, new levels 9 and 10 represent the former B award and will be added as additional discretionary points. The National Excellence Awards will continue to have three points but with more even financial distribution. The table has been constructed so that these awards can be related to the scheme operating in England to ease cross-border transfer. It should be noted that the table is for illustrative purposes only and the values may change as a result of further work on the new scheme.

<table>
<thead>
<tr>
<th>Local Excellence Award</th>
<th>Scottish Figures £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>3,204</td>
</tr>
<tr>
<td>Grade 2</td>
<td>6,408</td>
</tr>
<tr>
<td>Grade 3</td>
<td>9,612</td>
</tr>
<tr>
<td>Grade 4</td>
<td>12,816</td>
</tr>
<tr>
<td>Grade 5</td>
<td>16,020</td>
</tr>
<tr>
<td>Grade 6</td>
<td>19,224</td>
</tr>
<tr>
<td>Grade 7</td>
<td>22,428</td>
</tr>
<tr>
<td>Grade 8</td>
<td>25,632</td>
</tr>
<tr>
<td>Grade 9</td>
<td>28,830</td>
</tr>
<tr>
<td>Grade 10</td>
<td>32,033</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Excellence Award</th>
<th>Scottish Figures £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 11</td>
<td>38,440</td>
</tr>
<tr>
<td>Grade 12</td>
<td>54,720</td>
</tr>
<tr>
<td>Grade 13</td>
<td>74,255</td>
</tr>
</tbody>
</table>

11.50 The criteria for granting awards will be based on a range of explicit goals and objectives. Consultants will not have to fulfil all of these but some will be core, such as quality of care and meeting objectives. There will be six domains for both local and national applications and concrete examples of achievements by domain will be expected. The management citation will take into account the patient perspective and the consultant’s communication with patients, management and clinical colleagues. The six domains are as follows:

- Improvements in Service and Achievement of Service Goals;
- Audit, Clinical Governance, Promotion of Evidence Based Medicine;
- Administrative, Management and Advisory Activities;
• Research and Innovation;
• Teaching and Training; and
• Scope and Level of Professional Contribution to NHS.

11.51 Points 1-10 will be decided through a nationally agreed local employer process,
governed by standard processes and consistent with equal opportunities good
practice. The SACDA Online system will provide a mechanism and support for
this process. It will make it easy to input and collate peer review reports and to
distribute them to reviewing committees. A scoring system, similar to that
currently used by SACDA, will be used in the new scheme. SACDA Online
allows scores to be recorded and processed and this facility will also be
available to boards in relation to local awards. Consultants will be able to
receive information on their individual scores and ranking on request.

11.52 Governance arrangements will be put in place by boards communicating with
SACCLEA through their existing processes, such as board Remuneration
Committees, with electronic support for factual reporting provided by SACDA
Online. To be successful, the new scheme will have to win a reputation for
fairness and transparency.

11.53 The numbers of new high level awards are usually determined by SACDA in
the light of the available funding and the level of awards released back into the
system through retirement or resignation etc. However, as the number of
consultants that would be serious candidates for awards next year will not be
significantly different from this year and with the imperative of maintaining a
high competitive standard, we suggest that the number of available awards
should be similar to this year.

11.54 In previous years, the values of clinical excellence awards, distinction awards
and discretionary points have been uplifted in line with the uplift awarded to
consultants. As no uplift is recommended for consultants this year, it is
appropriate the value of these awards should also remain static.

GP Specialty Registrars

11.55 By the end of June, 355 posts had been filled out of the 394 posts in GP
programmes advertised this year. This was an exceptionally high number of
posts to fill. In previous years the maximum has been 300 and in future years
the number is expected to stabilise at around 280. The reason for the high
number of posts this year was the creation of a significant number of four year
programmes in general practice training, so recruitment was necessary to both	hree and four year posts. We do not envisage future difficulties in recruitment
to general practice as there is a steady stream of potential candidates coming
through foundation training and current estimates suggest the number of
available posts in general practice and specialty training in Scotland will begin
to reduce from 2010. However, the average banding supplement for doctors in
training is still over 55% in Scotland, so we recommend that the supplement
should be retained at 45% for the coming year.

11.56 Our intelligence suggests that it is becoming difficult for those who complete
GP training to secure full-time work. Partnership posts are rare and the growth
in salaried posts is well below the growth in available workforce. We have
anecdotal evidence of shifts in out of hours services being filled immediately by
doctors responding to text alerts and very few GPs who have completed
training in 2009 have secured anything other than locum work.
11.57 An initial meeting has been held with the BMA SGPC to discuss who should hold the contract for GP Specialty Trainees and SGHD will consult internally and with NHS Education for Scotland who operate the GPR Scheme in Scotland. SGHD will write to the SGPC proposing that another meeting should be held early next year. However, the pilot in the North/West of England where a PCT is acting as the single lead employer with a single contract covering a trainee’s entire training programme in hospital and in GP practice, is still underway. Conclusions from that pilot will help to inform future action in Scotland.

GENERAL MEDICAL PRACTITIONERS

Introduction

11.58 There are currently around 1029 GP practices in Scotland, and around 87% of practices are on the national GMS contract. Contractors with Section 17C arrangements operate within locally agreed contracts, and any uplifts in investment for these contracts are ultimately a local matter for Scottish Health Boards. However, the Scottish Government remains committed to maintaining, as far as possible, fair and equitable funding for the different contracting routes.

11.59 The Scottish Government is looking to the Review Body to recommend the level of overall gross uplift to be applied to GMS contract payments for 2010/11. The recommendation for 2009/10 which was implemented in full was generous given the adverse economic environment with many sectors in the wider economy experiencing pay freezes or reductions and the difficulties faced by public finances.

11.60 The Scottish Government like the UK Government remains committed to ensuring a more equitable distribution of funding for GP practices, where funding reflects the workload involved and patient need. We are currently examining the Scottish Allocation Formula with this in mind, but clearly any additional resources allocated via Review Body recommendations could be targeted to help achieve the Scottish Government’s aim of improving the health and wellbeing of all the people in Scotland.

11.61 For 2009/10, the BMA and four UK Health Departments agreed a formula approach that provided a set of differential uplifts to apply to agreed components of the GMS contract. This approach was a significant step towards reducing the number of practices reliant on the historical correction factor element of the Minimum Practice Income Guarantee (MPIG). In Scotland this removed an additional 254 practices from MPIG (resulting in a total of 315 practices or 31% with no correction factor). However, for GP practices with no or low correction factor, the methodology which involved repeated reallocation of the funding until all resources were expended resulted in significant increases up to 14%. We would prefer a slightly simplified formula for applying any gross uplift figure recommended by the Review Body for 2010/11. We would also favour a maximum level of increase in gross GMS allocations for all GP practices. We hope to present further evidence on this approach for 2010/11 at the supplementary evidence stage, following discussions with the Scottish BMA.
GMS Contract Funding

11.62 Following higher than expected increases in GMP contractor net income resulting from the introduction of the new GMS contract in 2004, the Scottish Government has sought action to direct more of the additional investment in primary medical services into improving services. However, in Scotland, although the trend in headline net income figures has been one of reduction in recent years (to 2007/08) there is still a substantial gap between the latest profit to expenses ratio (47:53 for 2007/08) compared with the expected level of 40:60.

11.63 We therefore consider that, in order to contribute to the financial discipline and efficiency improvements essential to respond to wider fiscal and economic challenges, the Review Body recommend an increase in average gross income sufficient to cover likely increases in expenses in 2010/11 only, with no uplift in GMS contract net income. We believe this represents a fair deal given the historical trend, the 2009/10 agreement as implemented, and the need to progress to a profit:expenses ratio closer to the target. We also recommend a maximum level of increase in gross GMS allocations, if any, is set for all GP practices.

11.64 We agree with the formula which the Review Body used for their 38th Report in 2009 to convert the gross figure to the net uplift figure as set out in paragraph 3.58 on page 44 of the report.

11.65 In summary, our proposal of an increase in average gross income sufficient to cover likely increases in expenses in 2010/11 only, with no uplift in GMS contract net income is based primarily upon the following key sources of evidence:

- GP Earnings and Expenses Enquiry 2007/08, published by the NHS Information Centre on 16 September 2009; and
- Investment in General Practice 2003/04 to 2008/09 published by the NHS Information Centre on 16 September 2009.

11.66 A zero percent net pay uplift in GMS contract payments would support the continuing move towards a 40:60 profit to expenses ratio, from the latest (2007/08) figure of 47:53.

11.67 Overall, since the introduction of the new GMS contract:

- We have seen significant new resources going into primary medical services. In Scotland investment in General Practice has risen from £504 million in 2003/04, the year before the introduction of the new GMS contract, to £705 million in 2008/09, an increase of 40%. The increase from 2003/04 to 2007/08 was 38%.
- GMPs have seen significant increases in net income from this additional investment over the period 2003/04 to 2007/08 (the latest year for which data on GP earnings is available), 32% in cash terms and 19% in real terms. Scotland has seen marginally higher increases than the UK (30% and 17% respectively). In particular, quality payments and enhanced services payments have increased substantially over the period.
• The 2009/10 settlement at a 2.39% gross uplift to the GMS contract was generous given the global recession and general adverse economic environment over the past year.

Trends in the earnings and expenses of GMPs

11.68 The following points set out the trends in GP earnings and expenses since the introduction of the new contract:

• Net income for GP contractors working under a GMS or Section 17C contract has increased significantly in cash and real terms. On a cash basis, net income has increased by 32% over the period 2003/04 to 2007/08 (30% UK).

• In real terms net income has increased by 19% for Scotland (17% UK) over the same period.

• In addition, the 2008/09 settlement meant a minimum gross increase for all GP practices of 0.7%, with many receiving increases of up to 14% if they had no existing or a very small correction factor.

• GMPs continue to retain more of their earnings as profit than in the past. Traditionally GMPs invested back 60% of their earnings into their practice. For Scotland, the figure for 2003/04 was 56%, falling sharply to 50% in 2005/06, before slowly reversing to 52% in 2006/07 and 53% in 2007/08, still well below the target of 60%. Detailed figures for 2007/08 and 2006/07 are shown below, with the England and UK figures included for comparison.

<table>
<thead>
<tr>
<th>Year</th>
<th>Scotland</th>
<th>England</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net income (£)</td>
<td>87,371</td>
<td>110,139</td>
<td>106,072</td>
</tr>
<tr>
<td>Expenses (£)</td>
<td>99,826</td>
<td>155,971</td>
<td>145,925</td>
</tr>
<tr>
<td>Gross income (£)</td>
<td>187,197</td>
<td>266,110</td>
<td>251,997</td>
</tr>
<tr>
<td>EER (%)</td>
<td>53</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>Profit (%)</td>
<td>47</td>
<td>41</td>
<td>42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Scotland</th>
<th>England</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net income (£)</td>
<td>89,468</td>
<td>111,566</td>
<td>107,667</td>
</tr>
<tr>
<td>Expenses (£)</td>
<td>96,586</td>
<td>149,198</td>
<td>139,694</td>
</tr>
<tr>
<td>Gross income (£)</td>
<td>186,054</td>
<td>260,764</td>
<td>247,361</td>
</tr>
<tr>
<td>EER (%)</td>
<td>52</td>
<td>57</td>
<td>56</td>
</tr>
<tr>
<td>Profit (%)</td>
<td>48</td>
<td>43</td>
<td>44</td>
</tr>
</tbody>
</table>

Recruitment and Retention of GMPs

11.69 We have no evidence to suggest particular difficulties in the recruitment and retention of GMPs, and therefore we do not see a case to justify increases to net pay. Health Boards have advised us that there are very few GP contractor
vacancies arising in Scotland. The number of contractor GPs has remained stable in Scotland at approximately 3,700 since 2003/04.

**Movement in Contractor GMP pay since the start of the new GP contract**

The table below, which is based on data provided by HMRC and published by NHS Information Centre, highlights the significant increases in both gross earnings and net income for the average contractor GP in Scotland during the period 2003/04 to 2007/08 in cash terms, and shows the movement of the expenses to gross income ratio, which remains well below the 60% target.

<table>
<thead>
<tr>
<th>Table 11.6</th>
<th>Scotland</th>
<th>Number of GPs</th>
<th>Gross earnings</th>
<th>expenses</th>
<th>Net income before tax</th>
<th>Expenses:gross income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>3,725</td>
<td>£149,470</td>
<td>£83,265</td>
<td>£66,205</td>
<td>55.7%</td>
<td></td>
</tr>
<tr>
<td>2004/05</td>
<td>3,771</td>
<td>£172,336</td>
<td>£89,640</td>
<td>£82,696</td>
<td>52.0%</td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>3,668</td>
<td>£181,324</td>
<td>£90,705</td>
<td>£90,619</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>2006/07</td>
<td>3,727</td>
<td>£186,054</td>
<td>£96,586</td>
<td>£89,468</td>
<td>51.9%</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>3,619</td>
<td>£187,197</td>
<td>£99,826</td>
<td>£87,371</td>
<td>53.3%</td>
<td></td>
</tr>
</tbody>
</table>

11.71 The equivalent figures in real terms are shown below.

<table>
<thead>
<tr>
<th>Table 11.7</th>
<th>Scotland</th>
<th>Number of GPs</th>
<th>Gross earnings</th>
<th>expenses</th>
<th>Net income before tax</th>
<th>Expenses:gross income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>3,725</td>
<td>£165,593</td>
<td>£92,247</td>
<td>£73,346</td>
<td>55.7%</td>
<td></td>
</tr>
<tr>
<td>2004/05</td>
<td>3,771</td>
<td>£185,761</td>
<td>£96,623</td>
<td>£89,138</td>
<td>52.0%</td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>3,668</td>
<td>£191,869</td>
<td>£95,980</td>
<td>£95,889</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>2006/07</td>
<td>3,727</td>
<td>£191,217</td>
<td>£99,266</td>
<td>£91,951</td>
<td>51.9%</td>
<td></td>
</tr>
<tr>
<td>2007/08</td>
<td>3,619</td>
<td>£187,197</td>
<td>£99,826</td>
<td>£87,371</td>
<td>53.3%</td>
<td></td>
</tr>
</tbody>
</table>

11.72 The table below shows the distribution of net income received by contractor GPs on a UK basis between 2004/05 and 2007/08:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range of Income before tax (£)</strong></td>
<td>Number of GPs</td>
<td>Percentage of GPs %</td>
<td>Number of GPs</td>
<td>Percentage of GPs %</td>
</tr>
<tr>
<td>£0 - £50,000</td>
<td>3,060</td>
<td>9.0%</td>
<td>2,000</td>
<td>5.9%</td>
</tr>
<tr>
<td>£50,000 - £100,000</td>
<td>15,440</td>
<td>45.6%</td>
<td>12,340</td>
<td>36.4%</td>
</tr>
<tr>
<td>£100,000 - £150,000</td>
<td>12,260</td>
<td>36.2%</td>
<td>14,530</td>
<td>42.9%</td>
</tr>
<tr>
<td>£150,000 - £200,000</td>
<td>2,490</td>
<td>7.4%</td>
<td>3,880</td>
<td>11.4%</td>
</tr>
<tr>
<td>£200,000 - £250,000</td>
<td>480</td>
<td>1.4%</td>
<td>820</td>
<td>2.4%</td>
</tr>
<tr>
<td>£250,000+</td>
<td>150</td>
<td>0.5%</td>
<td>310</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33,888</td>
<td>100.0%</td>
<td>33,875</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Earning to expenses ratio

11.73 The expectation is that GP contractors invest a given proportion of their gross earnings back into the practice in order to maintain and improve services to patients. Historically (prior to the new GMS contract) this investment has been approximately 60% of earnings, but in Scotland that reduced to 50% in 2005/06, meaning that GP contractors on average were taking half of their gross earnings as profit.

11.74 The table below shows that this trend began to reverse in 2006/07, although the percentage is still some way off the target of 60%.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Gross Earnings</th>
<th>Expenses</th>
<th>Expenses: Earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>£149,470</td>
<td>£83,265</td>
<td>56%</td>
</tr>
<tr>
<td>2004/05</td>
<td>£172,336</td>
<td>£89,640</td>
<td>52%</td>
</tr>
<tr>
<td>2005/06</td>
<td>£181,324</td>
<td>£90,705</td>
<td>50%</td>
</tr>
<tr>
<td>2006/07</td>
<td>£186,054</td>
<td>£96,586</td>
<td>52%</td>
</tr>
<tr>
<td>2007/08</td>
<td>£187,197</td>
<td>£99,826</td>
<td>53%</td>
</tr>
</tbody>
</table>

Impact of recommended uplift on GMP contractors pay

11.75 The Scottish Government’s proposal is an increase in average gross income sufficient to cover likely increases in expenses in 2010/11 only, with no uplift in GMS contract net income. This is based on the evidence set out above.

11.76 Our recommended uplift allows for zero increase to net pay to GMPs. We feel this represents a fair deal in the current economic climate. We see no compelling evidence of issues around recruitment, retention and motivation of GMPs to justify an increase in this round, and unlike other staff groups, GMPs have the capacity to increase their net earnings from other sources, namely efficiency savings and other income. In addition, GP contractors currently retain a greater percentage of gross income than the expected level of around 40%.

Minimum Practice Income Guarantee

11.77 The Scottish Government is committed to a more equitable distribution of funding for GP practices where funding reflects the workload involved and patient need, and we will work with Health Boards and BMA Scotland on this.

11.78 For 2009/10, all the negotiating parties were agreed that the Review Body’s recommendation should be for a single gross uplift to be applied differentially across agreed components of the GMS contract, with a repeated allocation being made until all resources had been expended. This had the effect of reducing practice reliance on MPIG, but also the unintended consequence of substantial increases for practices with no or low correction factor. The Scottish Government does not consider that an identical process would be acceptable for 2010/11, and we would recommend a maximum level of increase in gross GMS allocations, if any, is set for all GP practices. We hope
to present further evidence on this approach for 2010/11 at the supplementary evidence stage, following negotiations with BMA Scotland.

Salaried GMPs

11.79 We recommend an increase to the minimum of the pay range for salaried GMPs in line with that recommended by the Scottish Government for other directly employed doctors excluding consultants.

DENTISTS

Introduction

11.80 In Scotland general dental services (GDS) are provided by non-salaried and salaried principal general dental practitioners (GDPs). Assistants and vocational trainees also provide GDS on behalf of principal GDPs. The majority of GDPs are independent dentists who make arrangements with NHS Boards to provide GDS.

11.81 Payment to non-salaried principal GDPs is by means of item of service fees for each item of treatment undertaken and capitation and continuing care payments for each adult and child registered under NHS arrangements. Other grants and allowances are available depending on the individual GDP’s or the practice’s circumstances.

11.82 Salaried GDPs are remunerated on a salaried basis, rather than item of service, and are managed as part of the Salaried Dental Services. A number of additional allowances are available for salaried GDPs. Salaried GDPs are appointed where there is a gap in provision, eg in remote areas with low population density or where there are insufficient GDPs providing GDS to meet demand.

Workforce

11.83 The total number of GDS dentists (headcount) in Scotland has consistently risen and rose again at 31 March 2009 to 2,739. This includes non-salaried and salaried principals, assistants and vocational trainees.

11.84 The target within the Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland set a target to increase the number of dentists by at least 200 over the March 2004 number of 2,105, at an annual increase of at least 50 dentists per year. The target for an annual increase of at least 50 dentists was met in 2005 and the target to increase the number of dentists by at least 200 was met in 2006 and work continues to further expand the dental workforce.

11.85 The Aberdeen Dental School, the third in Scotland, opened in October 2008. 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>Expected Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009</td>
<td>147</td>
</tr>
<tr>
<td>July 2010</td>
<td>175</td>
</tr>
<tr>
<td>July 2011</td>
<td>157*</td>
</tr>
<tr>
<td>July 2012</td>
<td>174*</td>
</tr>
<tr>
<td>July 2013</td>
<td>176*</td>
</tr>
</tbody>
</table>

*additional Aberdeen Dental School graduates are included in these figures, graduating from July 2012.

11.86 The total number of dental students in the Scottish Dental Schools is now higher than at any time in the past 20 years.

11.87 We are undertaking a further dental workforce review which we hope to complete by the end of 2010. The policy objective is to align demand with supply of dental workforce as a whole taking account of attrition rates, age profiling, returners and new entrants to the NHS, salaried and private sector.

11.88 It is difficult to accurately forecast what supply is required due to the complexity of the dental care on offer to patients i.e. variations in demand, improving oral health, private care and the numbers using this provision set against GDS care.

11.89 This planned review will enable a more accurate estimate of future training numbers to meet patient requirements

**Recruitment and Retention**

11.90 A dental bursary was introduced in Scotland in 2006 for undergraduates studying at Dundee and Glasgow Dental Schools. Students can apply for a bursary of £4,000 per year on condition that they undertake to work in NHS dentistry in Scotland for up to five years following qualification. The bursary has been extended to include graduate students at the Aberdeen Dental School. Over 500 students are in receipt of a dental bursary. The first students in receipt of a bursary qualified in 2007. 181 dentists, including vocational trainees, who received a bursary are currently working in the GDS in Scotland.

11.91 In order to join a NHS Board dental list in Scotland a dentist has to have completed 1 years’ vocational training (VT) or be exempt or have experience equivalent to VT.

11.92 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, 91.5% in 2006 and 97.5% in 2007. In 2008 this increased again to 97.6% registering an interest for VT in Scotland and 96% actively pursued this interest. In 2009 again 97.3% of Scottish graduates registered an interest in VT in Scotland, with 95.1% of registered graduates pursuing a place.

11.93 The number of dental VT places in Scotland continues to increase. The total cohort size and breakdown into country of qualification between 2000 and 2009 is shown in table 11.10 below.
Table 11.10

<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>
<tr>
<td>2009</td>
<td>160</td>
<td>140</td>
<td>13</td>
<td>7</td>
<td>-</td>
</tr>
</tbody>
</table>

11.94 Vocational trainees taking up their VT year in Scotland can claim a recruitment allowance of £3,000, £6,000 if in a designated area. There were 146 claims from VTs in 2008/09, of which 42 were from designated areas and 104 from non-designated areas. This is an increase from 2007/08 where 135 claims were made. A summary of the claims in 2008/09 is shown in the table below.

Table 11.11

<table>
<thead>
<tr>
<th>REGION</th>
<th>NUMBER OF VDPS</th>
<th>TOTAL PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>10</td>
<td>£67,680</td>
</tr>
<tr>
<td>East</td>
<td>22</td>
<td>£91,368</td>
</tr>
<tr>
<td>North</td>
<td>11</td>
<td>£101,520</td>
</tr>
<tr>
<td>Calendar Scheme</td>
<td>6</td>
<td>£23,688</td>
</tr>
<tr>
<td>South East</td>
<td>34</td>
<td>£138,744</td>
</tr>
<tr>
<td>West</td>
<td>63</td>
<td>£230,112</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>146</td>
<td><strong>£653,112</strong></td>
</tr>
</tbody>
</table>

11.95 The number of VT numbers issued in Scotland has continued to rise. The figures are provided in table 11.12 below.

Table 11.12

<table>
<thead>
<tr>
<th>Year</th>
<th>01/02</th>
<th>02/03</th>
<th>03/04</th>
<th>04/05</th>
<th>05/06</th>
<th>06/07</th>
<th>07/08</th>
<th>08/09*</th>
<th>08/09**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total VT Numbers Issued</td>
<td>126</td>
<td>131</td>
<td>146</td>
<td>150</td>
<td>248</td>
<td>222</td>
<td>246</td>
<td>111</td>
<td>250</td>
</tr>
</tbody>
</table>

* VT numbers issued up until 23rd June 2009
** VT Numbers projected until 30th September, i.e. a full reporting year

11.96 A range of grants and allowances aimed at recruiting and retaining GDPs in Scotland have been introduced, as follows:

- GDPs joining a dental list in Scotland within 3 months of completion of training can claim a recruitment allowance of £10,000, £20,000 if in a designated area, paid over 2 years. Recipients have to undertake to provide the full range of GDS to all categories of patients for 3 years following receipt of the first payment and 80% of their earnings over the 3 years must be from GDS. A total of 99\(^2\) new claims were received in 2008/09 compared to 91 in 2007/08.

\(^2\) this does not include any allowances paid to salaried GDPs. Such allowances are paid locally by NHS Boards and information on uptake is not held centrally.
• A similar recruitment allowance exists for GDPs joining a dental list in Scotland for the first time or rejoining a list in Scotland after a break of 5 years. This allowance is £5,000, £10,000 if in a designated area. A total of 64* new claims were received in 2008/09 a slight fall from 71 in 2007/08.

• £667,800 was paid to 89* GDPs defined as providing GDS in a remote area compared to £662,400 paid to 87 GDPs in 2007/08.

• £105,800 was paid in sedation practice allowances in 2008/09 compared to £127,000 in 2007/08.

• £3,663,470 was paid to dentists under the deprived areas enhancement compared to £2,900,000 in 2007/08.

• £3,448,848 was paid to GDPs under the Scottish Dental Access Initiative (SDAI). Since April 2007 50 applications for grant under the SDAI have been accepted.

11.97 The following allowances are specifically aimed at meeting practice expenses:

• £25,578,409 in General Dental Practice Allowance (GDPA) payments were made in 2008/09 compared to £22,832,491 in 2007/08. The GDPA is to help address increasing requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision. All practices which provide GDS are entitled to receive 6% of accumulative gross NHS earnings paid through the GDPA while those that meet the NHS committed practice criteria are entitled to an additional 6%. From 1 April 2008 those practices that do meet the full definition of a NHS committed practice but have an average of 500 registered patients per dentist receive an additional 3% of accumulative gross NHS earnings, total of 9%. 83% of practice in Scotland were regarded as NHS committed, 10% of these met the secondary commitment criteria.

• £6,149,167 in notional reimbursement of practice rental costs was paid to dental practices in 2008/09 who met the NHS committed practice criteria compared to £6,636,639 in 2007/08. Reimbursement is the current market rent for the premises or the actual lease rent, whichever is the lower, where the dentist is a leaseholder or the notional rent where the dentist is the owner occupier. From 1 April 2008, those practices that do meet the full definition of a NHS committed practice but have an average of 500 registered patients have been able to apply for abated reimbursement of practice rental costs. A further £96,000 was paid to such practices.

• £1,054,760 was transferred to NHS Boards to meet directly all related costs for clinical and special wastes uplift for GDPs who meet the NHS committed practice criteria.

11.98 Information about the system which used to be in place to recommend a target average net income and target average gross income was included in the presentation given by the Scottish Government to the Review Body on 8 June 2009. The lack of dental earnings information due to Scotland’s exclusion from the HMRC and IC survey this year and alternative means of calculating dental earnings were also discussed at the 8 June meeting. Unfortunately, we have
been unable to find an alternative means of measuring dental expenses in the short timescale.

11.99  The intention had been that the amalgamation of the salaried GDS and community dental service would take place from 1 April 2009. Unfortunately, progress with implementation has been slow due to the need to address contractual issues and negotiations on this are still ongoing.

11.100 A sessional fee for practitioners working six three-hour sessions under Emergency Dental Service schemes is payable to part-time salaried dentists in Scotland. This fee has been reviewed as part of the Review Body process since 2005 but it only became apparent from the recommendations of the 38th Report that it is being uplifted by the GDP contract value uplift rather than the uplift for the salaried dentists. Whilst it is recognised that this has resulted in a higher value overall than if the salaried uplift had been applied each year it is our view that this needs to be rectified and we propose that from this year onwards the salaried uplift should be applied to this fee.

RESOURCES AND AFFORDABILITY

Introduction

11.101 This section sets out the financial context for our recommendations and the funding available up to 2010/11. It also highlights the challenges the Scottish Government Health Directorates face in a period of reduced funding growth whilst demand for services continues to increase alongside higher expectations of service quality.

11.102 Conditions in the Scottish labour market have deteriorated significantly since the economy fell into recession. Weaker demand in the economy has contributed to a decline in employment levels and a corresponding rise in unemployment levels. This trend is expected to continue for the foreseeable future as independent forecasts suggest that the Scottish economy will only experience a gradual recovery, with positive annual growth possibly returning following 2010/11. This in combination with relatively low inflation creates an environment where it is unlikely that average earnings increases across the economy will be at similar levels to previous years.

11.103 The NHS in Scotland has the difficult task of balancing pay and non-pay pressures, given the workforce has to be of sufficient size, expertise and motivation to deliver service improvements, drive up quality and meet underlying demand. If pay awards are set at an excessive level, this will be at the cost of service developments and quality. On the other hand, if the pay award is set too low we might damage morale, motivation and recruitment. The pay settlement needs to be sufficient to ensure the motivation of staff is maintained but bearing in mind the live economic context in the public sector and beyond.

Financial position and funding available

11.104 The Scottish Health Budget has seen significant increases in additional funding over recent years. The draft budget for 2010/11 of £10,790 million gives an increase of £292 million, the lowest percentage annual increase since 1997/98. Given the current financial climate and the uncertainty of what will happen in the future, stringent planning of how this additional money should be used is
essential and what is affordable for future years should also be considered. For example, a high pay settlement now will need to be maintained in future years - the 2010/11 settlement is a recurrent cost in future years.

11.105 The Draft Budget of the Scottish Government provides indicative funding for 2010/11. The budget set represents absolute limits on NHS expenditure in Scotland. There is no flexibility to bring forward expenditure or to exceed the budget. Details of recent revenue funding levels are as follows:

<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>8,356</td>
<td>644</td>
<td>8.35</td>
<td>6.12</td>
</tr>
<tr>
<td>2006/07</td>
<td>9,065</td>
<td>709</td>
<td>8.48</td>
<td>5.61</td>
</tr>
<tr>
<td>2007/08</td>
<td>9,699</td>
<td>634</td>
<td>6.99</td>
<td>3.97</td>
</tr>
<tr>
<td>2008/09</td>
<td>Estimated Outturn 10,122</td>
<td>423</td>
<td>4.36</td>
<td>1.32</td>
</tr>
<tr>
<td>2009/10</td>
<td>Plan 10,498</td>
<td>376</td>
<td>3.71</td>
<td>2.69</td>
</tr>
<tr>
<td>2010/11</td>
<td>Plan 10,790</td>
<td>292</td>
<td>2.78</td>
<td>1.26</td>
</tr>
</tbody>
</table>

11.106 NHSScotland was required to deliver 2% cash-releasing efficiency savings each year over the Spending Review period (2008/09 to 2010/11). Following the Chancellor’s 2009 Budget announcement of £5 billion efficiencies in spending across the public sector in 2010/11, the revenue Health Budget in Scotland has been reduced from the previously announced level of £10.933 billion to £10.790 billion.

**Pressures on NHS Scotland funding growth**

11.107 The Scottish Health Directorates’ overall purpose is to support services and initiatives designed to help people in Scotland to live longer and healthier lives with reduced inequalities; and to provide more sustainable, high quality and continually improving healthcare services close to home. Competing priorities call upon the available limited funding. Funding is analysed across three broad areas:

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

11.108 **Baseline pressures** cover the cost of meeting existing commitments that are essential for the NHS in Scotland and they do not cover additional and new activity. They are the first call on NHSScotland resources. The Hospital and Community Health Services (HCHS) paybill forms a significant part of baseline pressures accounting for around 51% of NHSScotland revenue expenditure and around 61% of HCHS expenditure. Additionally there will be cost pressures arising from the general increase in cost of goods and services, especially drugs and the revenue cost of capital and demand led programmes such as dentistry and ophthalmology.

11.109 **Underlying demand** creates service pressure due to general growth in activity levels. Although the level of funding growth available to the NHS in Scotland in 2010/11 has lowered, the expectation on NHSScotland services has not
diminished, if anything, they have increased as a result of the recession's impact on people's health and well being. Further factors such as changes to population, demographics, morbidity and rising public expectations can all contribute to driving up demand. Table 11.14 shows the trend in hospital activity in Scotland.

**Table 11.14 Trends in hospital activity in Scotland**

<table>
<thead>
<tr>
<th></th>
<th>Elective admissions</th>
<th>Emergency admissions</th>
<th>Attendance (A&amp;E, Minor Injuries Unit &amp; WIC)</th>
<th>First Outpatient appointments (consultant led)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (000's)</td>
<td>Growth %</td>
<td>Number (000's)</td>
<td>Growth %</td>
</tr>
<tr>
<td>2002/03</td>
<td>710</td>
<td>-</td>
<td>477</td>
<td>-</td>
</tr>
<tr>
<td>2003/04</td>
<td>743</td>
<td>4.6</td>
<td>478</td>
<td>0.2</td>
</tr>
<tr>
<td>2004/05</td>
<td>759</td>
<td>2.2</td>
<td>481</td>
<td>0.6</td>
</tr>
<tr>
<td>2005/06</td>
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<td>4.0</td>
<td>487</td>
<td>1.2</td>
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<tr>
<td>2006/07</td>
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<td>2.3</td>
<td>509</td>
<td>4.5</td>
</tr>
<tr>
<td>2007/08</td>
<td>811</td>
<td>0.5</td>
<td>532</td>
<td>4.5</td>
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<tr>
<td>2008/09</td>
<td>841</td>
<td>3.7</td>
<td>538</td>
<td>1.1</td>
</tr>
</tbody>
</table>

|                | Number (000's)      | Growth %             | Number (000's)                              | Growth %                                      |
| 2002/03 to 2008/09 | 18.5          | 12.8                 | 16.8                                        | 7.1                                          |

11.110 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 the Scottish Government as part of the Draft budget. In 2010/11 there are some developments but these have been significantly reduced due to the impact of the £5 billion reduction flowing from the Chancellor's Budget statement. Examples include:

- respond to the AH1N1 outbreak, including delivery of an immunisation programme as protection against the virus;
- develop and implement a Healthcare Quality Strategy which will ensure that NHSScotland becomes a recognised world-leader in healthcare quality;
- continue with the implementation of “Equally Well” which will reduce the current inequalities experienced in terms of health outcomes across Scotland;
- develop options to further enhance the care of Older People including a specific focus on Dementia and supporting Carers;
- deliver a number of major public health and health promotion programmes including the framework for action on alcohol misuse which will address Scotland’s relationship with alcohol; the Tobacco Prevention Action Plan; the Hepatitis C Action plan; strategies for sexual health, HIV, promoting healthy weight and tackling obesity and our work on mental health improvement and well-being;
- continue to deliver a reduction in Healthcare Associated Infection;
- continue to make good progress towards the 18 week Referral to Treatment standard ahead of target date of December 2011; and
- implement Better Cancer Care, An Action Plan that builds on NHS Scotland’s recent delivery of the 62 day urgent cancer target by introducing two new cancer targets to be delivered by December 2011 to ensure greater equity and patient centeredness.

11.111 Responsibility for determining services to meet local needs resides with NHS Boards in Scotland so there will be local variations on spending in specific services.

11.112 We need a level of pay award that will not damage supply or the morale and motivation of the medical workforce in the short-term but also one that avoids paying more than is necessary to achieve this.

**Balancing pay and sustaining services**

11.113 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 rates. Workforce and associated reforms (e.g. pensions) in recent years have also ensured that staff received benefits that extend to the longer term.

11.114 The impact of the current third year of the NHS Pay Review Body staff group will also have to be met from the available resources.

11.115 The funding envelope for the NHS in Scotland is fixed and there are no additional resources to fund excess costs. A higher pay settlement will therefore have implications on the money available for maintaining services.

11.116 For every 0.5% increase in settlement for doctors there will be around £6 million less money available to spend elsewhere.

**Conclusion**

11.117 The reduced funding settlement available to the NHS in Scotland is fixed and is deployed to cover baseline pressures, underlying demand and some specific service developments. Increases in expenditure in one area are at the cost of developments in other areas. Higher levels of pay would only reduce funds available for service developments.

11.118 The medical workforce is attaining good recruitment and retention levels. As a result of the workforce reforms over recent years, staff are benefiting from a very good overall remuneration package. We therefore support an award up to a maximum of 1% uplift for other employed doctors (juniors, SAS and salaried GPs) with 0% for consultants and believe this is a prudent balance between sustaining good services to the public and the supply, motivation and morale of medical workforce.

**NHS PENSIONS AND TOTAL REWARD**

**Information on the NHS Pension Scheme in Scotland**

11.119 The NHS Pension Scheme is an integral and valuable part of the NHS remuneration package. It compares very well with other occupational pension schemes and is an invaluable recruitment and retention tool. Recent reforms to the NHS Pension Scheme in Scotland have resulted in modernised,
improved pension arrangements which strike a balance between long term financial sustainability and retaining the scheme’s value to staff. Changes resulting from the reforms were introduced from 1 April 2008. In summary, the changes mean:

- the retention of a final salary scheme for both existing staff and new entrants;
- continuation of a normal pension age for 60 for existing staff, with an increase to 65 for new entrants;
- a fairer system of contribution rates, which will be tiered based on level of salary earned;
- increased flexibilities in how pension scheme members access their benefits, and increased choice on how the transition into retirement is made; and
- survivor benefits for all partners, not just spouses or civil partners, paid for life, paid for life;
- the ability to access a bigger tax free lump sum by giving up some pension.

11.120 Pension benefits and employee contributions in the Scottish NHS Pension Scheme mirror that of the scheme in England and Wales. However, following the recent Scottish Scheme valuation the employer contribution rate was reduced to 13.5% from 1 April 2009. As with England and Wales, arrangements have been put in place so that any future increases in scheme costs may be shared between employer and employees.

11.121 In Scotland it is intended to offer those members in the “1995 section” of the scheme the “choice” to move to “2008 section” of the scheme in early 2010. This will be a one off exercise which will be completed within a few months. In England and Wales this exercise is intended to start in January 2010 but will be carried out in stages over a period of 3 years.

SCOTTISH ECONOMIC OUTLOOK

Global Economy and the Effect on Scotland and the UK

11.122 The international financial crisis, or credit crunch, began in August 2007 and precipitated a general slowdown in the global economy. The crisis intensified in September 2008 following the collapse of US investment bank Lehman Brothers. The months that followed saw an extremely sharp decline in economic output amongst many advanced economies, as problems in financial markets began to affect businesses and consumers.

11.123 In response, large economic stimulus packages have been implemented in most advanced and many developing economies, to help sustain economic output. Further, the collapse in demand has led to a fall in global inflationary pressures, allowing central banks to significantly loosen monetary policy. Finally, many Governments have intervened to stabilise the banking sector. As a result, analysis in the IMF’s July 2009 World Economic Outlook suggests that the risk of another systemic banking failure occurring has now fallen, and that the second quarter of 2009 has seen rates of economic decline begin to slow.

11.124 The Scottish and UK economies have contracted as a result of these global events. Scottish GDP has fallen by over 5% since the middle of 2008 to Q1
2009. Comparable UK data shows a similar cumulative decline over the same period, and early estimates from the Office of National Statistics suggest that the UK GDP fell by a further 0.8% in 2009 Q2.

Long-Term Trends

11.125 Scotland’s long-term annual average growth rate, at 1.9%, is substantially below the UK average growth rate (2.4%). Over the past year there has been a slight narrowing in the gap in annual growth rates, with both Scotland and the UK contracting by 1.2% in the year to Q1 2009.

Growth Forecasts

11.126 Over the past few months commentators have revised their forecasts for the global economy to reflect the faster-than-expected improvement in financial conditions. Global output is now expected to decline sharply in 2009 before returning to growth in 2010. Despite the predicted global recovery in 2010, many advanced economies are still expected to only experience modest growth (close to zero) as the recovery is expected to be driven by emerging economies.

11.127 The Scottish economy is predicted to contract by around 3.4% in 2009, with growth expected to be close to zero in 2010. The latest forecasts for the UK predict a sharper decline in 2009 but a stronger recovery in 2010 compared to Scotland.

Wider Labour Market Conditions

Recent developments in Scotland & UK

11.128 The decline in Scottish output since the middle of 2008 has led to a significant weakening in the Scottish labour market as firms seek to reduce their workforce as a result of the sharp drop in demand in the economy. This has led to a reduction in the level of employment in Scotland, with 77,000 fewer people in employment in Scotland in the second quarter of 2009 compared to the same quarter the previous year.

11.129 The decline in employment has led to a marked rise in the number of people unemployed in Scotland. The unemployment rate has risen from 5.1% at the start of 2009 to 7.0% in Q2 2009. Although the Scottish unemployment rate still remains below the average for the UK as a whole (7.8%), the rate of increase in Scotland has been more marked over the past year.
**Wages**

11.130 Falling GDP and employment rates, rising unemployment, and a weak economic outlook for future years have slowed the rate of earnings growth. UK earnings (including bonuses) grew by 3.4% in 2008, significantly below the average annual growth rate of 4.2% seen between 1997 and 2007.

11.131 Annual growth in UK earnings (including bonuses) has been below the rate of annual CPI inflation from April-June 2008 to March-May 2009\(^3\), meaning that during this period average earnings have been growing more slowly than average consumer prices. Headline earnings growth briefly turned negative, falling by 0.3% in the year to Jan-March 2009, but have since strengthened, rising by 2.5% in the year to April-June.

11.132 Regular pay excluding bonuses have been less volatile, rising by 2.5% in the year to April-June 2009. This compares to a growth rate of 3.8% experienced in the year to April-June 2008.

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\(^3\) Calculated by comparing annual growth of the three-month moving average of the Average Earnings Index with annual growth of a three-month moving average of the Consumer Price Index.
11.133 Over the past 10 years, average earnings in Scotland (based on mean gross annual earnings) have remained around 5% below the earnings for the UK as a whole.

Outlook

11.134 Conditions in the Scottish labour market have deteriorated significantly since the economy fell into recession. Weaker demand in the economy has contributed to a decline in employment levels and a corresponding rise in unemployment levels. This trend is expected to continue for the foreseeable future as independent forecasts suggest that the Scottish economy will only experience a gradual recovery, with positive annual growth only returning in 2011.

11.135 These forecasts are broadly in line with the latest forecasts from the IMF and the OECD, with both predicting a gradual recovery with many advanced economies expected to experience only modest growth for the coming years. The weaker demand and the increase in spare capacity within the global economy is expected to result in low inflation in the coming years.
CHAPTER 12: EVIDENCE FROM THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES & PUBLIC SAFETY IN NORTHERN IRELAND

Summary

12.1 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 policy context;
- the medical and dental workforce;
- pay and workforce issues;
- affordability; and
- conclusions and pay proposals.

The Northern Ireland Context

Demographics

12.2 Changes in the size and composition of Northern Ireland’s (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 in a UK context, 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.

12.3 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

12.4 The global economic downturn is having a profound effect on the NI labour market. Following a decade of rapid employment growth this trend has now come to an abrupt end. Job losses have occurred in all sectors of the local economy. The services sector has witnessed a net reduction of 8,130 jobs (-1.4%) over the last year, whilst the manufacturing and construction sectors have contracted by 4,660 (-5.6%) and 5,780 (-12.9%) jobs respectively. The local unemployment rate has been on the increase since September-November 2008 and now stands at 6.7%¹, which is currently the fourth lowest of the UK regions.

12.5 Economic inactivity is a persistent feature of the NI labour market. This was the case during the past decade of unprecedented employment growth and remains a significant problem. The local working age economic inactivity rate is the highest of any UK region at 29.5% and this can only partly be explained by NI’s high full-time education participation. With unemployment on the increase, it will be exceptionally difficult to reduce the level of economic inactivity in the short to medium term.

¹ Source: Office for National Statistics, April - June 2009.
The Cost of Living

12.6 Figures produced by the Office for National Statistics (ONS) in 2004 suggested that the NI cost of living was 4.7% lower than the UK average in that year. 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\(^2\) indicates that consumer prices have since increased more in the UK (5.3% p.a.) than in Northern Ireland (4.7% p.a.) since 2004. This suggests that Northern Ireland’s cost of living has now reduced further relative to the UK as a whole.

The Public Sector Workforce

12.7 The public sector in NI employs 225,095 people or 30.0% of all in employment (26.6% when Reserved functions\(^3\) are excluded).

12.8 Pay Review Bodies (PRB) health staff groups account for 66,512 (29.6%) of public sector employee jobs in Northern Ireland. DDRB accounts for some 3,850 staff (1.7% of public sector employee jobs).

12.9 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 2007 was 7.9 – compared to a ratio of 6.0 for the private sector. For specialised professions (such as doctors and dentists) the number of applicants is likely to be a more direct function of the graduate output.

Public Sector Pay

12.10 Public sector pay in NI accounts for a significant share of the Departmental Expenditure Limit (DEL) budget. Estimates for the 2009/10 financial year indicate that pay costs will account for around 50% of Resource DEL. This means that each one per cent increase in the total paybill would equate to additional annual costs of £43.4 million.

12.11 Overall public sector earnings in NI, at £549.20 per week, are below the UK average (£581.90) but are higher than four other regions – Yorkshire and the Humber, (£548.00), Wales, (£544.60), the West Midlands, (£539.90) and the North East (£529.40). This reflects a relatively larger proportion in higher occupations in NI. At the level of individual occupational groups, NI 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 £517.06, compared to £568.89 for the UK as whole.

12.12 Public sector earnings in NI outstrip those of the private sector - the differential for public sector employees not working in protective services is 15.5%. NI private sector earnings, at £447.50 per week, are 22% below the UK average of £573.80. In addition, they are also significantly lower than any other UK region.


\(^3\) Reserved functions include the NI Office, Police Service of NI, NI Prison Service, UK Central Government and UK Public Corporations.
12.13 Although most regions (with the exception of London and the South East) exhibit a pay differential in favour of the public sector, the differential is not as pronounced as that found in NI. While the headline NI public-private sector earnings differential is 22.7%, 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 9.3% higher (i.e. adjusting for occupational mix), compared to 1.4% 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

12.14 On 24 May 2007, the NI Executive endorsed the principle of adherence to the UK Government’s public sector pay policy. This means that enforcement of pay growth limits is devolved to the NI Executive within the overarching parameters set by HM Treasury in its annual pay guidance circulars. Therefore, the Department of Finance and Personnel (DFP) Minister has the scope, within the parameters of the UK Government's pay policy, to approve pay remits for staff groups in most public bodies in Northern Ireland. The latest HM Treasury Pay Guidance for 2009/10 has a consolidated pay range of 1–4 per cent 'Increase for Staff in Post' (ISP). However, the Finance Minister has determined that an ISP limit of 3.25% will apply to all public bodies in Northern Ireland for the 2009/10 year.

12.15 The NI 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 NI DEL. The Executive’s control of public sector pay is 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 within the specific local labour market context.

The Policy Context

Improving Performance

Programme for Government 2008/11 targets

12.16 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; and
• continuing the resettlement programme for long-stay patients in mental health and learning disability hospitals.

12.17 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 (eg 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.

12.18 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; this required Trusts to achieve a 3% improvement in hospital workforce productivity over the period 2006/07 to 2008/09. Overall Trusts achieved a 6.7% improvement in hospital workforce productivity in this two-year period.

• reducing levels of absenteeism to 5.5% in the year to March 2010, and to 5.2% in the year to March 2011; the latest data on absenteeism shows an overall average rate of 5.5% during 2008/09; and

• ensuring that no more than 2% of operations are cancelled.

The Medical and Dental Workforce

12.19 There are around 78,000\(^4\) 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.

\(^4\)Total Staff in post. Excluding (approx 12,000) bank staff and staff with a whole-time equivalent of less than or equal to 0.03 reduces the total to 66,512 or 54,181.7 Whole Time Equivalent (Figures as at 31\(^{st}\) March 2009, Source: Human Resources Management System).
Distribution of HSC Workforce (WTE) by category at March 2009

- Medical & Dental, 6.6%
- Ambulance, 1.9%
- Professional & Technical, 11.5%
- Home Helps, 3.8%
- Social Services (excluding Home Helps), 12.0%
- Nurse Support Staff, 7.5%
- Qualified Nursing & Midwifery, 25.7%
- Administration & Clerical, 20.4%
- Support Services, 9.1%
- Estates Services, 1.3%

Source: Human Resources Management System

Workforce Growth

12.20 The whole-time equivalent of medical and dental staff has increased by 46.5% overall since 1999. There was an accelerating growth rate each year in the period 1999 to 2004, with a peak of 7% growth between 2003 and 2004. However, since 2007 the growth rate has slowed, with only a 1% growth in whole-time equivalent each year between 2007/08 and 2008/09. In the most recent period, 2008/09, this 1% growth has been a combination of a 3.7% growth in consultant WTE, a 0.4% decrease in training grades and a 0.2% increase in all other medical and dental grades.

Total HSC Paybill

12.21 Staff costs for medical and dental staff have increased by an average of £22.7 million each year over the last five financial years, reaching £342.5 million in 2008/09. The proportion of staff costs that are medical and dental has generally decreased in recent years from 18.8% of overall staff costs in 2005/06 to 17.1% in 2008/09. However, this may be due to unusually high payments (such as Agenda for Change arrears) in the other staff groups during this period.
Recruitment and Retention

Graduate Recruitment

12.22 The Department has invested in an increase in the local medical school which began in 2005. By 2010, the output from the medical school will increase by 40% on the 2005 numbers. Medical School graduates over the last five years are: 184 in 2005, 169 in 2006, 191 in 2007, 183 in 2008, and 198 to date in 2009. The School projects that 211 will qualify in 2010, when the first students relating to the expansion will graduate. It anticipates 267 medical students graduating in 2011 when the full impact of the expansion should take effect. In addition, it is encouraging that, locally, competition for places at the medical school remain high.

12.23 The trend remains strong for local graduates to be successful in gaining a place on the Foundation Programme, which is managed by the Northern Ireland Medical and Dental Training Agency. Successful Queen’s University graduate appointments in Northern Ireland were: 162 in 2005, 164 in each of 2006 and 2007, 178 in 2008 and 173 to date in 2009.

Medical and Dental Vacancies – Comparison to GB

12.24 Comparison of staff vacancy rates across UK Health Departments is extremely difficult due to the different methods of calculating vacancies and classifying staff. Table 12.1 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 increase in Medical and Dental vacancies in Northern Ireland from 1.2 in March 2006 to 2.0 by March 2009.
Table 12.1: Long-Term Vacancy rates in Health Service for England and NI

<table>
<thead>
<tr>
<th>TC</th>
<th>March 2006</th>
<th>March 2007</th>
<th>March 2008</th>
<th>March 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NI</td>
<td>England</td>
<td>NI</td>
<td>England</td>
</tr>
<tr>
<td>Admin &amp; Clerical ¹</td>
<td>0.9</td>
<td>0.8</td>
<td>0.9</td>
<td>0.6</td>
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<tr>
<td>Ancillary &amp; General</td>
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<td>1.1</td>
<td>N/A</td>
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<tr>
<td>Nursing, Midwifery &amp; Health Visiting ²</td>
<td>0.9</td>
<td>0.9</td>
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<td>0.5</td>
</tr>
<tr>
<td>Social Services</td>
<td>0.8</td>
<td>0.4</td>
<td>0.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Professional &amp; Technical</td>
<td>1.6</td>
<td>1.5</td>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Medical &amp; Dental ³</td>
<td>1.2</td>
<td>1.8</td>
<td>0.9</td>
<td>1.1</td>
</tr>
</tbody>
</table>

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

¹ England’s figures for Admin & Clerical also include Estates staff.
² England’s figures for Nursing include qualified staff only.
³ England’s figures for Medical & Dental exclude Doctors in training.

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

12.25 Table 12.2 shows the trend in current vacancies over the period 2005 to 2009.

Table 12.2: NI HSC Current Vacancies Rate %

<table>
<thead>
<tr>
<th>Terms &amp; Conditions Group</th>
<th>March 2006</th>
<th>March 2007</th>
<th>March 2008</th>
<th>March 2009</th>
</tr>
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<tbody>
<tr>
<td>Admin &amp; Clerical</td>
<td>2.7</td>
<td>2.3</td>
<td>1.9</td>
<td>1.6</td>
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<tr>
<td>Ancillary &amp; General</td>
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<td>3.1</td>
<td>3.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Nursing, Midwifery &amp; Health Visiting</td>
<td>3.0</td>
<td>3.5</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Social Services</td>
<td>3.7</td>
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<tr>
<td>Professional &amp; Technical</td>
<td>4.9</td>
<td>4.1</td>
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<tr>
<td>Medical &amp; Dental</td>
<td>3.0</td>
<td>2.4</td>
<td>2.4</td>
<td>3.8</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.

12.26 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 of posts available exceed the output of the local medical school. At the more experienced end, ie consultant level, the investments in specialist training
numbers in the late 1990s and early years of this decade are impacting on consultant vacancies in recent years.

**Workforce Planning**

12.27 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 five years to train a medical student and the DHSSPS currently commissions an annual intake of approximately 250 medical students.

**Workforce Plans**

12.28 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.

12.29 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.

12.30 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.

12.31 Following on from the previous review of the medical profession in 2006, the Department has just completed a further review of the medical profession. The review has taken account of the implementation of Modernising Medical Careers and the resulting changes to training and workforce structure. The review also considers the introduction of the new SAS contract and specialty grade, the continued implementation of EWTD and the impact of the new Tier 1 Visa system and its potential to affect recruitment of overseas doctors.

12.32 Key findings of the medical review are that:

- There has been a significant investment in the training of doctors since the last review, comprising an increase in the number of undergraduate places and the introduction of new systems for recruiting to and delivering post-graduate medical education;

- The medical workforce as a whole has increased by almost 400 headcount;
• Trends identified in the last review toward a higher proportion of women in the workforce and demands for more flexible working have continued;

• It is indicated that the demands placed on junior doctors groups by the EWTD can be addressed on a timely basis;

• A growth of 26% in the consultant workforce is anticipated, and this will be sufficient to meet demand;

• Growth projected in the junior doctors models coupled with the balance in the consultants model suggests there may not be sufficient consultant positions for all those competing for specialist training in the future;

• Shortfalls are predicted in the GP group, largely due to assumed high levels of demand for flexible working. There is lack of certainty surrounding the actual impact of work-life balance however the high proportion of women in the GP training group indicates a likelihood of increased demand; and

• Earlier average retirement age for consultants and GPs also indicates a loss of these professionals over the next 10 years.

Following this review, the workforce will be closely monitored to determine the actual workforce trends as compared to the modelling assumptions made.

12.33 A review of hospital dental workforce was completed earlier this year and the findings will form part of the overall dental workforce review, scheduled for late 2009. The key findings of the hospital dental review include:

• the Department is aware of the need to enhance interest in the academic path for paediatric dentistry;

• there is also a need to enhance recruitment of orthodontic consultants to the hospital sector; and

• the workforce supply in oral and maxillofacial pathology is in relative balance for the next 7 years, and the development of a regional network to help meet ongoing demand is under consideration.

A further dental review is scheduled for later this year and this hospital dental review will form part of the overall dental review.

12.34 The methodology for future workforce reviews is currently being refined and it is expected that Trusts will carry out more organisational-level workforce planning, integrating financial, service development and workforce planning streams. This will help better inform the regional workforce planning process.

Productivity and Workforce Planning

12.35 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 Northern Ireland can be improved and maintained. This work relates to all professional groups in the HSC.

12.36 As in other parts of the UK, it is important to seek sustained improvements in productivity. The 2004 Appleby report found a significant productivity gap in some aspects of health provision in Northern Ireland compared to similar services in England. Since we started measuring in 2007/08, hospital labour productivity has increased annually by about 3%, however our analysis suggests there are significant further productivity increases to be had.

12.37 DHSSPS has now developed a range of productivity indicators and these are monitored for all Trusts, with Trusts receiving bi-annual reports indicating progress and areas required or improvement. 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.

12.38 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.

12.39 The following PSA and Ministerial targets will be subject to intensive monitoring by the Department to ensure satisfactory progress is made:

- **hospital productivity** (PSA 9.1): each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
- **daycase rate** (PSA 9.1): each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2010 and 2011.
- **pre-operative length** (PSA 9.1): each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2010 and 2011.
- **absenteeism** (PSA 9.1): each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011.
- **greater use of generic drugs** (PSA 9.1): the level of dispensing of generic drugs should increase to at least 59% by March 010, and to 64% by March 2011.
- **cancelled operations** (PSA 9.1): from April 2009, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

**Pay and Workforce Issues**

**General Dental**

12.40 Negotiations with the Dental Practice Committee (DPC) of the British Dental Association on a new dental contract for practitioners in Northern Ireland are ongoing. While the intention has been to pilot a new contract late in 2009, this may now be delayed until next year.
12.41 In recent years, there has been evidence of a drift of dentists moving from the health sector to the private sector. This resulted in access difficulties in certain parts of Northern Ireland, most noticeably in the west of the province. Despite significant investment in 2007 in health service dentistry totalling £7.7 million, the drift and resultant budget underspend continued until the end of 2008/09. The bulk of the additional investment comprised £4 million recurrently in the practice allowance, specifically to address the issue of increasing overhead costs. Health service committed practices now attract payments of 11% of gross health service income through the practice allowance alone, and such practices will receive in excess of £30,000 in practice allowance payments.

12.42 In April of this year, in recognition of delays in negotiating the new Northern Ireland dental contract, and the negative reaction by the BDA to the 2009 Review Body settlement, the Minister agreed to substantially increase another allowance paid to dentists, the commitment payment. This effectively provided an additional payment of 1.5% of total General Dental Services spend through these substantial increases. The Commitment Allowance was introduced into the dental statement of remuneration over 10 years ago and is paid on a sliding scale, subject to the amount of money earned through Health Service treatments, to dentists with five years service or more. The more health service work a dentist carries out, the greater the reward through the Commitment Allowance. The Minister agreed to an increase of some 75% to 2008/09 payments, at a cost of over £1.2 million. At the upper end of the scale, committed health service dentists on high earnings can now earn almost £8,000 through the commitment payment alone.

12.43 The overall effect of the increased payments through allowances is to reduce the effect of item of service fees on overall health service income, with a corresponding increase in allowances, including capitation and continuing care and block payments such as the practice allowance. This can best be shown in the table below, which outlines the shift in percentage terms from item of service payments to block payments over the last three years:

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<tr>
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<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
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<tbody>
<tr>
<td>Items of Service</td>
<td>65.6%</td>
<td>62.3%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Capitation &amp; Continuing Care</td>
<td>21.6%</td>
<td>21.0%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Block Payments</td>
<td>12.7%</td>
<td>16.8%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

It should be noted that these percentages will change further in 2009/10, due to the increase to the commitment payment. The block payments percentage will therefore increase once again.

12.44 The Review Body’s last report notes that Northern Ireland retains the fee-per-item system, and the difficulty in identifying how appropriate the fee/cost relationship is. While the fees for items of service may not have kept pace with costs in all cases, the Department points out that substantial increases have been applied in various other payments, as outlined above. It is no longer the case therefore that the fee paid per item is the total remuneration applied.

12.45 In the Review Body’s last report, further details of the centrally funded allowances available to dentists in Northern Ireland were requested. As well as the practice allowance and commitment payments outlined above, the following are the primary allowances also paid to GDS dentists in Northern Ireland:
• Seniority Payment: paid to dentists aged 55 and above, with not less than 10 years service. The fee is approximately 10% of the accumulated gross health service fees paid.

• Vocational Training payments: Quality Assurance grant totalling £10,373 per annum, Charter Mark allowance totalling £1,000 per annum and postgraduate qualification allowance of £1,000 per annum – none of which are paid elsewhere in the UK; monthly grant of up to £753 per month plus reimbursement of trainee’s salary up to £2,510 per month.

• Re-imbursement of non-domestic rates: paid on a sliding scale of up to 100% of cost, depending on health service commitment.

A table showing all payments made under the relevant headings in the last three years is attached at Annex E.

12.46 The Review Body was informed last year that the Minister had approved a tender exercise for additional dental services. The contract in respect of this tender was awarded earlier this year, to Oasis Dental Care, for provision of an additional 38 health service dentists in 15 locations across Northern Ireland. This contract has been extremely well received politically and by the general public, and we aim to have the first practices opened by the end of this year, with all practices open within 12 months. This will provide access to health service dentistry to an additional 57,000 patients across the province, in areas which were deemed to be particularly problematic for access. The cost of the contract compares favourably with current rates of GDS expenditure.

12.47 Whether as a result of the additional competition posed by the award of the contract noted above, or the increased remuneration in allowances in the past few years, or as a result of the credit crunch, or as is more likely a combination of all these factors, GDS expenditure has actually risen in recent months. This reverses a trend going back several years. The evidence of this increased expenditure would indicate that some dentists are actually returning to health service dentistry in Northern Ireland.

Community Dentists

12.48 The Department has been in discussions locally with the BDA about the possibility of introducing a new contract for community dentists in Northern Ireland. A business case was prepared in May 2009 setting out the potential costs and benefits of such a contract, and is currently being considered by the Department. The proposals are therefore at an early stage. It should also be noted that implementation of such a contract in Northern Ireland requires not only the approval of Minister, but also of the Department of Finance and Personnel.

Doctors in Training

2009 Recruitment

12.49 The number of doctors in training has increased from approximately 1,190 in 1997 to 1,755 in 2009; this represents an increase of approximately 47% over the last ten years.
12.50 The recruitment process in 2009, as in 2008, was carried out by the local deanery, the Northern Ireland Medical and Dental Training Agency (NIMDTA). 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 395 posts to be filled (300 Core and Run Through, and 95 Fixed Term Specialty Training Appointments (FTSTA) and Locum Appointments in Training (LAT)). This rose to 401 by the end of selection. At the end of Round 1, the number of core and run through posts which were actually filled was 294 (98%), and the number of FTSTA and LAT posts filled was 58 (61% of the advertised 95).

12.51 Following the clearing process, and subsequent reduction in the fill rate, there were approximately 50 unfilled posts in total at 31 July 2009. The number of posts filled at 31 July 2009 was 351 (87.5% of posts available). The gaps were mainly in specialties such as emergency medicine, paediatrics, and obstetrics and gynaecology.

12.52 NIMDTA is taking steps to address the vacancies and it is hoped that a number can be filled through locum appointments and successful visa applicants. The Department has also invested in an additional 96 medical students, bringing the total number of enrolments to 250 per year.

EWTD

12.53 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. The work of ISG was transferred to the new regional Health and Social Care Board on 1 April 2009 in order to drive forward the EWTD targets.

12.54 At Autumn 2008 41% of doctors were compliant with EWTD 2009 requirements and 92% were compliant with New Deal. The monitoring data on New Deal and EWTD compliance for August 2009 is not yet available. Additional funding was provided in 2009 to help improve compliance (£3 million) and it is estimated that 80% of doctors will be compliant with EWTD by August 2009. The EWTD non-compliant posts are mainly in specialties such as obstetrics and gynaecology, paediatrics, anaesthetics, and surgery where solutions remain difficult. Obstacles to compliance have included recruitment difficulties, workforce planning (where projected future consultant needs no longer justify current numbers of training grade doctors), and major changes to the structure of the health care system in Northern Ireland (with a loss of key personnel).

12.55 In line with the process set out in Article 17 (5) of the EC Directive, the UK Government wrote to the EC in January, on behalf of the devolved administrations, notifying its intention to seek a limited derogation to the EWTD from August 2009 for exceptional cases. Derogation allows for a delay in implementing the full requirements of the Directive for a further 2 years or, very exceptionally, three years. During that time, a 52 hour maximum working week on average is allowable (instead of a maximum 48 hour working week). In
Northern Ireland a total of 16 rotas were considered as meeting the criteria for derogation, representing around 6-7% of the junior doctor population. ISG will continue to work closely with Trusts to improve the compliance rates of those rotas included in the derogation, and the compliance rates of all other rotas which are required to work a maximum of 48 hours from August 2009.

Specialty Doctors and Associate Specialists

12.56 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.

12.57 In Northern Ireland introduction of the contracts were approved on the basis that they were subject to transitional implementation arrangements over a two year period to ensure increases are in line with public sector pay policy. The transitional arrangements gave both groups of doctors half their pay increase in year 1 (1 April 2008) and the other half in year 2 (1 April 2009). Specialty doctors will receive on average a 5.2% increase in Year 1 and 5% in Year 2.

12.58 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.

12.59 The costs of the contracts are estimated at £1.4 million in Year 1 and £1.9 million in Year 2 based on 100% take up of the contracts. This funding has been allocated to the Board. These costs do not include additional funding for training and continuing professional development. The Department, due to financial constraints, was unable to include any additional funding for training and development in the pay modelling.

12.60 The increases in pay are effective from 1 April 2008 subject to doctors expressing an interest and agreeing job plans within specified periods. All Trusts have issued expressions of interest letters to doctors and the vast majority have indicated an interest in the new contracts.

12.61 The Department set up a contract implementation working group, which includes representatives from the BMA and Trusts, to take forward issues arising out of implementation of the contract. The project leads from each trust are represented on the group, and the group meets on a bi monthly basis. The group’s work to date has mainly involved finalizing discretionary points/optional points processes, and regrading processes to ensure doctors are on the correct pay point before moving to the new contract. The group also agreed new detailed guidance on job planning which has been issued to all Trusts.

12.62 The systems are now all in place to commence the job planning process and to start moving doctors on to the new contracts. Uptake of the contracts will be monitored through the bi-monthly meeting of the implementation working group.
Consultants

12.63 The new consultant contract was implemented in Northern Ireland with effect from 1 April 2004. 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. The average number of programmed activities was 10.95. Job planning is seen as a key element of the new contract. Effective job planning should help to improve productivity, efficiency and the quality of care for patients. The Department, the BMA, and employers agreed new regional guidance on job planning 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 process for employers and consultants. The Department continues to work with the BMA on the process for realising the benefits to be gained from the contract.

Clinical Excellence Awards

Background

12.64 The scheme in Northern Ireland is different in some respects to the awards schemes in the other devolved administrations. In Northern Ireland application is by self nomination only, and there are different rules on eligibility, and a different citation process. The scheme has evolved through three major reviews (2001, 2005 and 2008). The cost of the higher awards scheme in Northern Ireland is approximately £5.8 million.

Review 2008

12.65 As we reported in our evidence last year, following the review in 2008, the Department agreed to introduce a formula based approach to determine the number of lower awards, and to allocate an additional £200,000 in 2008 to trusts to help meet these costs. It was considered that a formula based system would provide a greater degree of consistency across trusts in the allocation of lower awards, and would 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. Trusts are required to meet the cost of allocating the minimum number of awards under the formula by taking into account the additional funding made by the Department, retirements of lower award holders, and the freeing up of lower awards when lower award holders receive higher awards. Trusts must report on the outcome of their lower awards process to the regional committee.

12.66 The Department also agreed that the regional committee should take over step 9 awards to help take some financial pressure off trusts and to free up more awards locally when step 9 higher awards are made to lower award holders. This change will be reviewed after three years.

12.67 For higher awards from 2005, awards were simply recycled as higher award holders retired, resigned or died. However, as part of the review in 2008 it was agreed that the available pot of money for higher awards should not only take account retirements, but should also take into account the increase in the eligible consultant population. In effect, the available pot for higher awards takes into account three key elements: any surplus of funding from the previous year, the value of any retirements during the relevant awards round, and the value of the...
increase in the eligible consultant population. The Department determines the available funding and advises the committee accordingly.

2008/09 Awards Round

12.68 The committee invited self nominations from all consultants in Northern Ireland for higher awards and a total of 89 applications were received. There were 45 applications for step 9, 23 applications for step 10 awards, 13 for step 11 awards and 8 for step 12 awards. The Department advised the Committee that there 17 higher awards available for allocation. The committee, following a rigorous scoring process, recommended 1 step 11, 6 step 10, and 10 step 9 awards. The committee decided not to recommend any step 12 awards.

12.69 A total of 10 step 9 awards were allocated to lower award holders (generating a total of 56 lower awards for recycling in Trusts). Step 5 was the lowest award held by a consultant receiving a step 9 award.

12.70 At the end of the 2007/08 awards round there were a total of 109 consultants in receipt of higher awards out of a consultant population of 1,236 (at 1 April 2008), representing 9% of all consultants.

12.71 Under the five year review process, 16 distinction awards were subject to review in this awards round. The committee recommended that 14 awards should continue for a further five years, and that the remaining two should continue for one year and that the consultants should be invited to resubmit further evidence after one year.

12.72 In 2008/09, 7.9% of all applications (7 applications) were from female consultants, with two awards being made to female consultants (compared to none last year). The overall proportion of higher awards held by female consultants is 7.3%. Females represent 28% of the consultant population in Northern Ireland. Female consultants do better at the lower awards level, holding 24% of all lower awards. It should be stressed that awards are granted to individuals solely on the grounds of merit. The committee does not positively discriminate in favour of any particular group.

12.73 The committee monitors the distribution of higher awards in a number of other areas including specialty, gender, ethnic origin and community background. The outcome of the monitoring process will be included in the committee’s annual report for 2008/09 due to be published in the autumn.

Lower Awards 2008-2009

12.74 This is the first year that the formula was introduced and it is hoped that the number of lower awards made will increase. However, at this stage, only two out of the five Trusts have reported on the outcome of their lower awards process. The Committee will be publishing its report on the lower awards process later in the year, when reports are received from all five trusts.
Equality

12.75 The Department is satisfied that the scheme is in line with equality legislation. The scheme in Northern Ireland is open to all eligible consultants to apply on an equal basis. Application is by self-nomination only and consultants are not relying on nominations from colleagues or others. The same assessment criteria and citation process apply to all eligible consultants on an equal basis. A robust scoring process has been introduced to determine which consultants should receive the available awards, and awards are made solely on grounds of merit. An independent external observer attends all committee meetings to ensure the processes are applied fairly. There is a fair gender balance on the committee, with five of the nine members being female. It is recognised that there is an under representation of female consultants at higher awards level, (compared to lower awards). The Committee considers the most appropriate way to address this issue is to encourage more applications for higher awards from female consultants. The Committee has started to meet senior award holders at the beginning of each awards round to review the process, and to advise senior award holders to encourage suitable consultants to apply, including suitable female consultants. The Committee stress that it will not discriminate in favour of any particular group or specialty; awards will only be made on merit. The eligibility criteria for higher awards (four lower awards must be held) was considered as part of the review in 2008. However, there was no strong desire to change the criteria. The Committee, in particular, feel that consultants should be required to demonstrate significant achievement locally before being eligible to apply for a higher award. It would be very exceptional, in any case, for a consultant to move to a higher award with few lower awards.

Affordability

TO FOLLOW AS SUPPLEMENTARY EVIDENCE

Pay Conclusion

12.76 DHSSPS operate within a fixed annual budget set by the NI Executive and there is no additional resource available to fund excess costs. Increasing the proportion of resources to be spent on pay will inevitably lead to less money being available to meet key service pressures and rising demand.

12.77 The Northern Ireland Executive is committed to implementing UK national pay policy as defined by UK guidance. The presumption is that the following Department of Health rationale for a pay settlement should apply to Northern Ireland:

- up to 1% for non-consultant salaried doctors – that is, doctors in training grades, Speciality Doctors, Staff Grade and Associate Specialists;

- up to 1% for salaried General Medical Practitioners, and salaried primary dental care dentists;

- no salary uplift for consultant doctors and no up-lift in the present levels of Clinical Excellence Awards;
- an uplift of 0.5% in gross GMS contract payments to self-employed General Medical Practitioners, which is intended to produce no increase in net payments; and

- no uplift in gross payments to self-employed General Dental Practitioners, which on current figures would produce a 0.6% increase in net payments after reasonable efficiency savings of 1% on increases.

However, the Executive reserves its position as the Pay Review Body considers the Northern Ireland evidence.
PAY METRICS (ENGLAND)
[The pay metrics will be updated to take account of the financial data for 2008/09 when this becomes available. The updated pay metrics will be provided at the supplementary evidence stage]

Historical figures
The historical pay metrics (up to and including 2007/08) have been estimated using pay bill data from NHS financial returns, NHS accounts, and Foundation Trust annual reports. Figures for 2008/09 onwards are projections (see below).

Workforce statistics up to and including 2008/09 are from the annual NHS workforce census. Figures for 2009/10 and 2010/11 are projections.

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.

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 2008/09 and 2009/10 have been projected from the 2007/08 actuals.

The workforce FTE figures for each staff group are taken from the September 2008 NHS census (published March 2009) for 2008/09 and, for 2009/10 and 2010/11 are supply projections produced by the NHS Workforce Review Team for DDRB 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 2008/09 and 2009/10 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 2007/08 actuals. Projections for 2010/11 have been calculated in a similar way, based on the 2009/10 projections, but with a range of general pay uplift figures for 2010/11.

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
Produced 090814 LP, WDAT

## HCHS Paybill (£million)

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<tbody>
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<td>2,276m</td>
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<td>864m</td>
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## Growth in HCHS Paybill

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## HCHS Paybill per FTE (£)

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<td>89,378</td>
<td>95,208</td>
<td>97,311</td>
<td>107,673</td>
<td>110,732</td>
<td>111,455</td>
</tr>
<tr>
<td>Total remit</td>
<td>58,965</td>
<td>64,367</td>
<td>71,636</td>
<td>75,604</td>
<td>85,000</td>
<td>90,199</td>
<td>93,987</td>
<td>95,224</td>
<td>98,076</td>
<td>100,008</td>
<td>101,354</td>
</tr>
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</table>

## Growth in HCHS Paybill per FTE

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>7.0%</td>
<td>10.2%</td>
<td>8.3%</td>
<td>3.8%</td>
<td>15.3%</td>
<td>10.7%</td>
<td>2.8%</td>
<td>4.7%</td>
<td>3.1%</td>
<td>2.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Training grades</td>
<td>7.7%</td>
<td>7.5%</td>
<td>15.7%</td>
<td>7.6%</td>
<td>9.0%</td>
<td>0.1%</td>
<td>-1.0%</td>
<td>0.1%</td>
<td>0.4%</td>
<td>1.2%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other*</td>
<td>9.0%</td>
<td>8.5%</td>
<td>9.4%</td>
<td>5.2%</td>
<td>12.0%</td>
<td>11.5%</td>
<td>6.3%</td>
<td>2.2%</td>
<td>2.0%</td>
<td>2.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total remit</td>
<td>8.0%</td>
<td>9.2%</td>
<td>11.3%</td>
<td>5.5%</td>
<td>12.4%</td>
<td>6.1%</td>
<td>1.7%</td>
<td>2.5%</td>
<td>2.9%</td>
<td>2.0%</td>
<td>1.1%</td>
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</table>
### HCHS Earnings per FTE (£)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Training grades</td>
<td>37,978</td>
<td>40,408</td>
<td>46,193</td>
<td>49,680</td>
<td>53,917</td>
<td>51,439</td>
<td>50,790</td>
<td>50,850</td>
<td>51,164</td>
<td>51,954</td>
<td>52,470</td>
<td>52,732</td>
</tr>
<tr>
<td>Other</td>
<td>51,346</td>
<td>55,099</td>
<td>59,556</td>
<td>62,555</td>
<td>69,703</td>
<td>73,679</td>
<td>78,330</td>
<td>79,934</td>
<td>81,580</td>
<td>88,549</td>
<td>91,188</td>
<td>91,435</td>
</tr>
<tr>
<td>Total remit</td>
<td>124,897</td>
<td>136,820</td>
<td>158,235</td>
<td>169,737</td>
<td>184,349</td>
<td>178,295</td>
<td>184,183</td>
<td>187,264</td>
<td>196,582</td>
<td>200,417</td>
<td>206,065</td>
<td>206,730</td>
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</tbody>
</table>

### Growth in HCHS Earnings per FTE

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11 SETTLEMENT SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>6.4% 9.1% 7.2% 3.7% 14.9% 5.3% 2.5% 4.6% 1.4% 3.2% 2.5% 1.0% 1.3% 1.5% 1.8% 2.0%</td>
</tr>
<tr>
<td>Training grades</td>
<td>8.4% 6.4% 14.3% 7.5% 8.5% -4.6% -1.3% 0.1% 0.6% 1.5% 1.0% 0.0% 0.3% 0.5% 0.8% 1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>10.7% 7.3% 8.1% 5.0% 11.4% 6.0% 6.0% 2.0% 2.1% 8.5% 3.0% 0.3% 0.5% 0.8% 1.0% 1.3%</td>
</tr>
<tr>
<td>Total remit</td>
<td>8.2% 8.0% 10.1% 5.5% 11.9% 1.0% 1.3% 2.4% 1.4% 3.1% 2.1% 1.2% 1.4% 1.7% 1.9% 2.2%</td>
</tr>
</tbody>
</table>

### HCHS workforce (FTE)

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11 SETTLEMENT SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training grades</td>
<td>30,499 31,204 32,005 33,932 36,402 40,654 43,295 45,422 46,051 48,298 50,296 50,819 50,819 50,819 50,819 50,819</td>
</tr>
<tr>
<td>Other</td>
<td>8,429 8,704 8,987 9,571 9,517 9,666 9,661 9,334 10,053 10,609 10,979 11,349 11,349 11,349 11,349 11,349</td>
</tr>
<tr>
<td>Total remit</td>
<td>60,338 62,094 64,055 68,260 72,260 76,462 82,568 85,975 87,533 91,586 95,421 97,798 97,798 97,798 97,798 97,798</td>
</tr>
</tbody>
</table>

### Growth in HCHS workforce (FTE)

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11 SETTLEMENT SCENARIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>4.8% 3.6% 4.0% 7.3% 6.4% 6.8% 5.2% 3.4% 2.6% 4.0% 4.5% 4.3% 4.3% 4.3% 4.3% 4.3% 4.3%</td>
</tr>
<tr>
<td>Training grades</td>
<td>1.4% 2.3% 2.6% 6.0% 7.3% 11.7% 6.5% 4.9% 1.4% 4.9% 4.1% 1.0% 1.0% 1.0% 1.0% 1.0% 1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.5% 3.3% 3.3% 6.5% -0.6% 1.6% -0.1% 2.8% 1.2% 5.5% 3.5% 3.4% 3.4% 3.4% 3.4% 3.4% 3.4%</td>
</tr>
<tr>
<td>Total remit</td>
<td>2.7% 2.9% 3.2% 6.6% 5.9% 8.6% 5.2% 4.1% 1.8% 4.6% 4.2% 2.5% 2.5% 2.5% 2.5% 2.5% 2.5%</td>
</tr>
</tbody>
</table>

**NOTES:**

1. Figures for NHS staff in England only, excluding agency
2. Includes estimates for Foundation Trusts, all years from 2004/05 onwards
3. Pay bill figures from Final NHS Accounts 2007/08 & Foundation Trusts Consolidated Accounts
4. Shaded figures are projections and subject to change
5. Projections for 2010/11 have been modelled for 5 different pay settlement scenarios (0.00, 0.25, 0.50, 0.75 and 1.00% pay settlement)
6. In 2004/05, responsibility for NHS pensions indexation shifted from HMT to NHS Employers
7. 'Training grades', includes Foundation Years 1 and 2, SHOs, HOs and all Registrar groups. Breakdown into previous groups is not possible due to Modernising Medical Careers (MMC)
8. 'Other' includes all non consultant medical & dental staff not in training posts. Includes associate specialists, staff grade and dental officers.
9. Workforce figures for 2009/10 and beyond are projections and subject to change. Figures assume staff group growth rates from original CSR settlement.
CONTRACTUAL ARRANGEMENTS FOR DOCTORS AND DENTISTS IN TRAINING: REMIT FOR SCOPING WORK

In Written Evidence to the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) in October 2008, the Department of Health stated that it would commission NHS Employers to conduct work to look at the effectiveness and value for money of the current contractual arrangements for doctors in training.

A UK-wide approach to this work has been agreed with the Health Departments in the devolved administrations.

NHS Employers, and the Health Departments and employers in the devolved administrations, are asked to consider:

- the current contractual arrangements for doctors and dentists in hospital training (the New Deal Contract introduced in 2000), identifying issues, strengths and weaknesses with clear evidence of all findings;
- evidence on the financial and other consequences of keeping the current contractual arrangements in place, and amending them;
- an appraisal of possible changes to the contractual arrangements, including a full assessment of all related costs, including pension costs for both employer and employee, and the cost of reform itself (which should begin from the assumption that any changes should be achieved with overall cost neutrality);
- a full assessment of the value-for-money gain of any potential reform in both cost and productivity terms; and
- the interface with contractual arrangements for doctors and dentists in the practice/community settings of GP or dental vocational training.

As stated in the Government’s evidence to the Doctors’ and Dentists’ Review Body, this work should take account of:

- the direction of travel resulting from the Government’s response to the Tooke Enquiry into Modernising Medical Careers;
- the NHS Next Stage Review (England);
- reshaping the Clinical Workforce (Scotland); and
- the current reform programme in Wales.

Findings to be presented to the Health Departments by November 2009.

14 May 2009
ANNEX C

RETENTION AND RETIREMENTS

1. The Department of Health is establishing a Centre for Workforce Intelligence (CfWI), to provide high quality analysis, evidence and intelligence to better monitor retirement & retention as part of our workforce planning assumptions and models. A procurement exercise is underway to identify a preferred supplier by November 2009. The Centre will not be fully operational until 2010.

2. When the Centre is fully operational it will provide strategic oversight and leadership on the quality of workforce planning across the healthcare system including that which is delivered by social care.

3. The Centre for Workforce Intelligence will:
   - align the whole system around a shared endeavour to improve and use high quality data, analysis, interpretation and modelling;
   - horizon scan for innovation and future service, workforce and labour market issues, such as retention and retirement rates, that are likely to have an impact on care pathways, and the health and social care workforce.

4. The available evidence is consistent with the workforce planning assumptions we have made. 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.

5. 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?**

6. Until the CfWI becomes operational, workforce modelling for the Department of Health will continue to be 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.

7. 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.

8. 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.

9. 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.

10. The consultant retirement rate, across all specialties, is currently estimated to be between 3 and 3.5%, using this methodology. This is expected to remain fairly constant over the foreseeable future.

**Data on early retirement intentions**

11. 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.

12. 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.

13. 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.

14. 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.

15. 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**

16. Table 1 below shows data from the NHS Pensions Division, part of the Business Services Agency. The table shows the number of consultants who received a pension award, from the NHS pension scheme between 1997 to

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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. As with previous years’ evidence, the figures relate to England and Wales as it has not been possible to dis-aggregate Welsh data for this exercise.

17. The total number of pension awards has increased over the period as the size of the workforce has increased. The number of age retirements is higher now than it was in the late 1990s, but this reflects the age profile of the current workforce rather than any change in retirement rates.

18. 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. 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.

19. 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>
</tr>
</thead>
<tbody>
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<td>1997</td>
<td>258</td>
<td>57</td>
<td>40</td>
<td>27</td>
<td>*</td>
<td>*</td>
<td>33</td>
<td>415</td>
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<tr>
<td>1998</td>
<td>295</td>
<td>52</td>
<td>43</td>
<td>19</td>
<td>*</td>
<td>*</td>
<td>35</td>
<td>444</td>
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<tr>
<td>1999</td>
<td>275</td>
<td>57</td>
<td>28</td>
<td>19</td>
<td>*</td>
<td>*</td>
<td>38</td>
<td>417</td>
</tr>
<tr>
<td>2000</td>
<td>294</td>
<td>54</td>
<td>30</td>
<td>11</td>
<td>*</td>
<td>*</td>
<td>26</td>
<td>415</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>
</tr>
<tr>
<td>2002</td>
<td>355</td>
<td>65</td>
<td>38</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>28</td>
<td>493</td>
</tr>
<tr>
<td>2003</td>
<td>322</td>
<td>60</td>
<td>32</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>31</td>
<td>452</td>
</tr>
<tr>
<td>2004</td>
<td>360</td>
<td>56</td>
<td>36</td>
<td>16</td>
<td>*</td>
<td>*</td>
<td>39</td>
<td>507</td>
</tr>
<tr>
<td>2005</td>
<td>357</td>
<td>48</td>
<td>38</td>
<td>9</td>
<td>*</td>
<td>*</td>
<td>41</td>
<td>493</td>
</tr>
<tr>
<td>2006</td>
<td>482</td>
<td>52</td>
<td>39</td>
<td>6</td>
<td>4</td>
<td>43</td>
<td>48</td>
<td>674</td>
</tr>
<tr>
<td>2007</td>
<td>596</td>
<td>59</td>
<td>24</td>
<td>6</td>
<td>3</td>
<td>77</td>
<td>37</td>
<td>802</td>
</tr>
<tr>
<td>2008</td>
<td>639</td>
<td>60</td>
<td>16</td>
<td>8</td>
<td>6</td>
<td>90</td>
<td>37</td>
<td>856</td>
</tr>
<tr>
<td>2009</td>
<td>640</td>
<td>41</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>77</td>
<td>35</td>
<td>56</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

20. 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.

21. 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 whom 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

22. The MCRG have calculated figures for five years after qualification (i.e. graduation from medical school in the UK) for six cohorts of doctors who qualified between 2000 and 1983. The most recent data therefore correspond to the qualifiers of the year 2000 and represent their working situation in September 2005. Data for the 2002 cohort in 2007 will be calculated in the coming months, when DH data for September 2007 become available.

23. 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.

24. The first part of the table (section (a)) shows a steady fall from 19.9% non-participation in the NHS among all qualifiers of 1988 in 1993, to 14.3% of all 2000 qualifiers in 2005.

25. 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 10.0% of 2000 qualifiers.

26. 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.

27. 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 not 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>2000</td>
<td>4237</td>
<td>14.3% (606)</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>2000</td>
<td>2766</td>
<td>10.0% (276)</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>2000</td>
<td>261</td>
<td>26.8% (70)</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: MCRG, Oxford University, Updated 10 July 2009
## BENEFIT STRUCTURE OF THE NHS PENSION SCHEME – PRACTITIONERS ON OR AFTER 1 APRIL 2008

<table>
<thead>
<tr>
<th>Provision</th>
<th>1995 Section</th>
<th>2008 Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Pension Age (NPA)</td>
<td>60</td>
<td>65</td>
</tr>
<tr>
<td>Pensionable Pay (PP)</td>
<td>Generally based on practitioners NHS income less expenses</td>
<td>Generally based on practitioners pensionable income, less expenses</td>
</tr>
<tr>
<td>Total Uprated Pensionable Pay (TUPP)</td>
<td>Sum of all PP. PP is revalued annually to retirement or exit. Before 01.04.2008 revaluation was by a factor determined by Sec. of State in consultation with BMA/BDA. Pensionable pay after 01.04.2008 is uprated by RPI plus 1.5%</td>
<td>Pensionable pay uprated annually by RPI plus 1.5%</td>
</tr>
<tr>
<td>Yearly Average of Uprated Pensionable Pay (YAUPP)</td>
<td>TUPP divided by the number of years of membership</td>
<td>TUPP divided by the number of years of membership</td>
</tr>
<tr>
<td>Relationship to Second State Pension (S2P)</td>
<td>Contracted Out</td>
<td>Contracted Out</td>
</tr>
<tr>
<td>Members’ Contributions</td>
<td>6% of PP, however, from 1 April 2008 rates will be progressive tiered contributions for all members based on whole pay – linked to AIC scales, currently: 5% - pay up to £20,224 6.5% - £20,225 to £66,789 7.5% - £66,790 to £105,319 8.5% - £105,319 and above</td>
<td>6% of PP, however, from 1 April 2008 rates will be progressive tiered contributions for all members based on whole pay – linked to AIC scales, currently: 5% - pay up to £20,224 6.5% - £20,225 to £66,789 7.5% - £66,790 to £105,319 8.5% - £105,319 and above</td>
</tr>
<tr>
<td>Benefits Payable on Retirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Normal Retirement</td>
<td>1.4% of TUPP Minimum 3 times pension but can take up to 25% of pension value as a lump sum</td>
<td>1.87% of TUPP May take up to 25% of pension value as lump sum</td>
</tr>
<tr>
<td>(1) Pension</td>
<td></td>
<td>Tier 1 - Accrued pension paid early. Tier 2 – Pension paid early and subject to enhancement (see separate ill health retirement entry)</td>
</tr>
<tr>
<td>(2) Lump sum</td>
<td></td>
<td>Tier 1 - Accrued pension paid early. Tier 2 – Pension paid early and subject to enhancement (see separate ill health retirement entry)</td>
</tr>
<tr>
<td>On Ill-Health Retirement (after completing 2 years service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits Payable on Death-in-Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Lump sum</td>
<td>2 times YAUPP</td>
<td>2 times YAUPP</td>
</tr>
<tr>
<td>(2) Widow’s, widower’s or surviving Civil Partner’s pension</td>
<td>50% of member’s Tier 2 ill health pension</td>
<td>50% of member’s Tier 2 ill health pension</td>
</tr>
<tr>
<td>Benefits Payable on Death-in-Retirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Lump sum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lower of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 5 times the pension less pension received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) twice YAUPP, less the retirement lump sum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% of Member’s Pension^a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Widow's, widower’s or surviving Civil Partner’s pension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lower of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 5 times the pension less pension received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) twice YAUPP, less the retirement lump sum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70/187ths of Member’s pension</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits on Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Less than 2 years’ service</td>
</tr>
<tr>
<td>Refund of member’s contributions</td>
</tr>
<tr>
<td>Benefits increased in deferment, payable from NPA</td>
</tr>
<tr>
<td>As an alternative to the benefits above, a cash equivalent transfer value may be paid</td>
</tr>
<tr>
<td>(2) 2 or more years’ service</td>
</tr>
<tr>
<td>Refund of member’s contributions</td>
</tr>
<tr>
<td>Benefits increased in deferment, payable from NPA</td>
</tr>
<tr>
<td>As an alternative to the benefits above, a cash equivalent transfer value may be paid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increases to Pensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) In payment</td>
</tr>
<tr>
<td>In line with increases in RPI</td>
</tr>
<tr>
<td>(2) In deferment</td>
</tr>
<tr>
<td>In line with increases in RPI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Enhancement on Ill-Health Retirement or Death-in-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>No enhancement on tier 1 ill health retirement.</td>
</tr>
<tr>
<td>On tier 2 ill health retirement service enhanced by up to 2/3rd perspective membership to NPA</td>
</tr>
</tbody>
</table>

Notes:

(a) In the 1995 Section, 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.
## NORTHERN IRELAND: SUMMARY OF PAYMENTS TO NI GENERAL DENTAL PRACTITIONERS 2006/07 to 2008/09

<table>
<thead>
<tr>
<th>Year</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>Gross Cost of Estimates</td>
<td>71,296</td>
<td>67,965</td>
<td>72,960</td>
</tr>
<tr>
<td>Personal Dental Services</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Superannuation</td>
<td>2,318</td>
<td>2,238</td>
<td>5,054</td>
</tr>
<tr>
<td>Seniority Payments</td>
<td>209</td>
<td>160</td>
<td>191</td>
</tr>
<tr>
<td>Relief of Pain Clinic</td>
<td>198</td>
<td>218</td>
<td>250</td>
</tr>
<tr>
<td>Vocational Training</td>
<td>599</td>
<td>552</td>
<td>595</td>
</tr>
<tr>
<td>Trainers' Grant</td>
<td>234</td>
<td>253</td>
<td>285</td>
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<tr>
<td>Clinical Audit</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Postgraduate Dental Training</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Peer Review Scheme</td>
<td>19</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>533</td>
<td>779</td>
<td>746</td>
</tr>
<tr>
<td>Compensation Payment for Early Retirement</td>
<td>48</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>Commitment Scheme</td>
<td>1554</td>
<td>1541</td>
<td>1501</td>
</tr>
<tr>
<td>Reimbs. of Non-Domestic Rates</td>
<td>713</td>
<td>657</td>
<td>636</td>
</tr>
<tr>
<td>Long-Term Sickness</td>
<td>19</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Quality assurance payment</td>
<td>0</td>
<td>92</td>
<td>453</td>
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<tr>
<td>N.I.Council PG MD Education</td>
<td>105</td>
<td>309</td>
<td>419</td>
</tr>
<tr>
<td>Statutory Charges</td>
<td>-16398</td>
<td>-15065</td>
<td>-16143</td>
</tr>
<tr>
<td>Refunds to Patients</td>
<td>37</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Refunds of Part Costs etc</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Canon Hygiene</td>
<td>314</td>
<td>259</td>
<td>289</td>
</tr>
<tr>
<td>Practice Allowance</td>
<td>3498</td>
<td>6486</td>
<td>7522</td>
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<tr>
<td>Special Waste</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reimbs. of Non-Domestic Rates</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net Cost of Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£65,297</td>
<td>£66,600</td>
<td>£74,803</td>
</tr>
</tbody>
</table>

| Gross Cost of Service | £81,695 | £81,665 | £90,946 |
### 2006/2007

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Percentage</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Fees (SQL)</td>
<td>£53,618,710.14</td>
<td>65.6%</td>
<td>IOS</td>
</tr>
<tr>
<td>Gross cost-Gross Fees</td>
<td>£17,677,749.05</td>
<td>21.6%</td>
<td>Cap&amp;CC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12.7%</td>
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</table>

### 2007/2008

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Percentage</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Fees (SQL)</td>
<td>£50,843,428.62</td>
<td>62.3%</td>
<td>IOS</td>
</tr>
<tr>
<td>Gross cost-Gross Fees</td>
<td>£17,121,955.96</td>
<td>21.0%</td>
<td>Cap&amp;CC</td>
</tr>
<tr>
<td></td>
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<td>16.8%</td>
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</tbody>
</table>

### 2008/2009

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Percentage</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Fees (SQL)</td>
<td>£53,000,499.25</td>
<td>58.3%</td>
<td>IOS</td>
</tr>
<tr>
<td>Gross cost-Gross Fees</td>
<td>£19,959,770.37</td>
<td>21.9%</td>
<td>Cap&amp;CC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19.8%</td>
<td>Block</td>
</tr>
</tbody>
</table>

### Key

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOS</td>
<td>Item of Service</td>
</tr>
<tr>
<td>Cap&amp;CC</td>
<td>Capitation and Continuing Care</td>
</tr>
<tr>
<td>Block</td>
<td>Block payments</td>
</tr>
</tbody>
</table>
STATISTICAL TABLES
LIST OF STATISTICAL TABLES

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