Department of Health

Review Body on Doctors' and Dentists' Remuneration

Review for 2008

Written Evidence from the Health Departments for the United Kingdom

November 2007

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Northern Ireland Assembly

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

The Scottish Government

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EXECUTIVE SUMMARY

Background

1. Public sector pay makes up about a quarter of Government expenditure, with an annual cost of over £135 billion. Pay Review Body (PRB) workforces make up about 40% of this total, with a combined pay bill of more than £50 billion per annum. The pay bill for this Review Body alone amounts to over £8 billion every year. As a result, the recommendations made by this Review Body are important to the Government not only because they will influence the delivery of health service policy, but because they will also have a significant impact on the overall Government pay strategy, public finances, the ability for Government to meet other spending pressures, and the level of inflation in the wider economy.

2. In considering what pay award to recommend to the Review Body, the Government has considered four key questions. First, what is the strategy for the delivery of health services in the future. Second, what do we need to pay to recruit, retain and motivate the staff to deliver this strategy, taking account of recent research into What Matters to Staff and the total reward package provided in public service. Third, can the NHS afford to devote these resources to pay without an unacceptable opportunity cost to other priorities such as the need to deliver Public Service Agreement targets, ensure value for money, improve access and satisfy growing public expectations. And, finally, are the implications of the proposed pay policy for this staff group acceptable in terms of the Government's legitimate wider considerations such as maintaining public sector pay policy and ensuring continuing macro-economic stability.

3. The current NHS strategy is to transform the NHS on two levels: firstly at a systems level, from a monolithic provider of care based on organisations to a more plural and open system, using reforms such as choice and contestability: secondly we are driving through transformation at a structural level – we are changing our model of care- by shifting the care we provide for patients outside of hospitals and into the community closer to home. This is happening at the same time as we seek to hold firm to the core NHS values of universality and fairness and to empower staff to deliver a high quality service. There are three stages in this journey of transformation and change.

4. The first stage of the current NHS reform journey started with the publication of the NHS Plan in 2000 and was about increasing investment to match European levels and building capacity. The extra resources were invested in more staff, more pay, more buildings, and these were accompanied by high profile targets to drive reductions in waiting times and improvements in the biggest killers such as cancer and heart disease.

5. The second stage of the journey saw the introduction of health reforms such as patient choice, practice based commissioning, payment by results, foundation trusts and independent treatment centres, which are giving patients and staff more levers to create a more responsive NHS.

6. We are now entering the third and most difficult part of change, which requires us to take investment and capacity on the one hand, together with the reforms on the other, and combine them to drive the necessary transformation to deliver real benefits for patients. The goal of transformation is to develop a healthcare system that meets the

growing needs and expectations of patients, whilst ensuring equitable access and affordability.

7. The recruitment, retention, motivation and morale of staff is key to delivering these objectives. During the first stage of reform, our priority was to increase the number of staff and improve their pay which had lagged behind that of the private sector and given rise to increasing vacancies and dissatisfaction. We have achieved this with an increase in NHS staff of more than 279,000 (26%) since 1997. Three-month vacancies are at record low levels and applications for clinical training are higher than ever before.

8. Pay has been an important part of this, but there is growing recognition that it is no longer the key issue that it was in the 1990s. Research we have undertaken into What Matters to Staff suggests that other issues are now becoming more important. These include understanding their role and how it fits into the bigger picture; having the skills and equipment to provide high quality care; being treated with respect, trusted and listened to; the ability to develop and achieve their full potential, and being well supported by their managers. A key part of our emerging workforce strategy is therefore to address these issues which we believe will enable us to engage staff more effectively to deliver high quality care. In short, we believe there is a strong correlation between staff satisfaction and patient satisfaction, but that staff satisfaction is about much more than just pay.

9. Pay levels, therefore, need to be set at the right level to ensure the recruitment, retention and motivation of sufficient staff to provide high quality public services whilst ensuring that sufficient funds are available to invest in service improvement to meet growing public expectations and provide good value for money for taxpayers. Any excess investment in pay will reduce the funds available for service improvement.

10. It is also important that the pay award for doctors and dentists for 2008/09 is considered in the context of recent pay and pensions reforms. In particular, the DH has modernised and improved the pay of consultants, GPs and general dental practitioners. It is currently considering proposals for changes to the pay of staff and associate specialists and it has recently announced proposals to reform the NHS Pension Scheme that will protect attractive final salary pensions, albeit with new tiered personal contributions that provide a closer link between individual contributions and the benefits received.

Summary of evidence

11. The following paragraphs outline the scope of the evidence that we have provided. This reflects the traditional format agreed with the Review Body secretariat. However, where possible, we have sought to address the concerns raised by the Review Body about our evidence last year.

12. The evidence demonstrates that despite increasing the size of the medical workforce by almost 36,000 since 1997, the introduction of pay and pensions reform, combined with continued high quality of medical training in the UK, has ensured that medical recruitment and retention remain buoyant and look set to remain so. In particular, there are 2.6 applicants for every place at undergraduate medical school. There were over 32,000 applicants for 23,000 posts in speciality training in 2007 and the competition ratios are forecast to increase to 3:1 in England in 2008. Moreover,

vacancies for consultant posts continue to fall and have now reached an all time low of 1.2%.

13. These facts confirm that training and careers in medicine in the UK are attractive both nationally and internationally. The Government, therefore, recommends that an headline pay award of 1.5% would maintain the balance between the need to deliver continued investment in service improvements, to maintain wider economic stability and to ensure the recruitment, retention and motivation of the salaried medical workforce. Details of the recommendations for other staff groups and the detailed evidence to support the recommendations are set out in the chapters as follows:

14. Evidence is provided in **Chapter One** of the UK economic position within which we would ask the Review Body to make recommendations. Evidence provides a background for the Review Body on the economic context, the fiscal context including the importance of the "golden rule" to the Government and use of CPI as the target inflation measure. There is also evidence about the attraction of the total rewards package for NHS staff and the value of existing flexibilities within the modern pay systems to address regional recruitment challenges. There is also evidence that, because of the attractive total pay packages available, staff morale issues are not related to levels of pay.

15. The NHS financial context is set out in **Chapter Two**. This explains that while the NHS financial position has improved over the last 12 months and the NHS is now expected to end 2007/08 with a surplus of about £1 billion, the forecast surplus is non-recurrent; much of it is committed and the balance is required to provide a modest contingency fund to cope with unexpected cost pressures. The Chapter also explains the impact of the recent CSR settlement. In particular, that revenue growth for health services will reduce in real terms from an average of 6.1% over the period from 1997 to 2008 to an average of 3.6% over the coming CSR period. This is much closer to the historical long term average of 3.3% but is significantly less than the 4.4% real terms growth that the Wanless Review said was required for 5 years from 2008 to keep pace with rising public expectations.

16. We believe these aspirations can be delivered within the CSR07 settlement, but only by controlling pay settlements to the level recommended by the Government and by delivering increases in the year on year efficiency improvements. So, pay should be considered in the context of the CSR period as a whole and not influenced by the surplus which, in effect, is largely committed.

17. Chapter two also notes that there is no separate ringfenced budget for pay. The paybill is met from general allocations, so the Review Body is reminded that a pay award higher than 1.5% will inevitably force PCTs to make commissioning decisions which may be based on the need to lose jobs or disinvest in services rather than local service improvement.

18. **Chapter Three** provides detailed evidence of the strong recruitment and retention position within the employed medical and dental staff within the NHS. We are in a position where domestic supply meets demand. We now have more than 125,000 doctors working in the NHS - 35,993 more than in 1997 - as well as record levels of doctors in training in UK medical schools and we do not need to rely on overseas doctors as much as we did in the past. This balance between demand and supply would be compromised by a high pay award as fewer doctors or other staff could be recruited compromising the NHS ability to deliver services and potentially destabilising the supply/demand match.

19. Vacancy levels continue to fall with the three-month vacancy levels in March 2007 standing at 1.2%. This compares with 1.9% in March 2006 and 3.3% in March 2004.

20. There has been much concern in recent time about either the closure or reduction in the attraction of pensions. The NHS will maintain its defined benefit scheme and evidence presented in **Chapter Four** shows that, while doctors and dentists will have to pay more from April 2008, the NHS pension scheme remains one of the most attractive available. The Chapter also emphasises that existing contractual arrangements for doctors should not be altered. The Government has delivered its commitment to consultants on pay and now trusts need the opportunity to drive patient benefits without the constraints of implementing a higher than affordable pay award. For doctors in training, while earnings have "flattened" as a result of the European Working Time Directive (EWTD), there continues to be continued scope for earnings growth, irrespective of the pay award and evidence that their banding payments maintain the overall competitiveness of their package. A decision on the proposed new contract for Staff and Associate Specialist (SAS) doctors is expected imminently. For all doctors groups, given the national job market, existing arrangements for recruitment and retention premia to address local challenges are sufficient including in London.

21. Our evidence on independent contractor GMPs is at **Chapter Five.** GP pay has been the focus of much public attention since the introduction of the new GP contract in 2003/04. The contract was introduced to address recruitment and retention problems within the profession and to increase the range and quality of services delivered to patients in the primary medical care environment. Investment in primary medical care increased by 52% over the first three years of the contract. Over the same period GP pre-tax take home pay, or profits, increased by around 55% to a UK average of almost £112,000 in 2005/06 – the latest date for which validated data are available. We intended GPs to have benefited from the new contract but we expected more in return. The proportion of income retained as personal profit has increased from 40% in 2003/04 to 45% in 2005/06. As a direct result the proportion of income invested in improving and expanding patient services has reduced from 60% to 55%.

22. Recruitment to the profession is strong, applications for GP training places far exceed the number of places available and morale is good. We now have more GPs than ever before - 33,091 (England) in 2006 compared to 28,046 in 1997 - and three-month vacancy levels have fallen, from 2.4% in 2005 to 0.8% in March 2007.

23. Detailed evidence on the position for NHS dentists is provided in **Chapter Six.** Information is given on the success of the contractual changes for primary dental services. PCTs are currently facing no significant difficulties in expanding services and indeed are able to commission additional services at improved levels of value for money, strongly suggesting that dentists and corporate bodies are attracted by the new contractual and remuneration packages available for NHS work. Information is also given on changes in treatment patterns including a reduction in the overall complexity of treatment: this has a major downwards effect on dental expenses and therefore the cost of providing a quality dental service.

24. Our evidence on Ophthalmic Medical Practitioners is at **Chapter Seven**. The Department of Health has agreed the 2007/08 sight test fee with the Optometric Fees Review Committee. Optometrists continue to carry out some 98% of NHS sight tests, and we believe the DDRB's previous recommendations about the joint negotiation of

a common fee for optometrists and OMPs continue to be relevant for this and future years.

25. Detailed evidence from the Welsh Assembly Government is included in **Chapter Eight,** the Scottish Health Departments in **Chapter Nine** and Northern Ireland Assembly **in Chapter Ten.**

26. **Chapter Eleven** provides conclusions and pay proposals for 2008/09.

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

WRITTEN AND STATISTICAL EVIDENCE
FROM THE HEALTH DEPARTMENTS

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CHAPTER 1: GOVERNMENT EVIDENCE ON THE GENERAL CONTEXT

1.1 Public servants are vital to the delivery of good public services and form a large part of the UK's workforce. Setting pay awards at the right level is key to our ability to recruit, retain and motivate valued public sector workers; to keeping within Government spending plans and to keep inflation under control.

1.2 Public sector pay makes up about a quarter of Government expenditure, with an annual cost of over £135 billion. Pay review body (PRB) workforces make up about 40% of this total, with a combined paybill of over £50 billion per annum. Therefore, PRB recommendations make a significant impact on the overall Government pay strategy; public finances; the ability for Government to meet other spending pressures; and the level of inflation in the wider economy. This impact is both direct and indirect, through signalling effects elsewhere in the economy.

1.3 Following significant recent investment in public services, in particular in front-line public sector pay, we are now facing a step-change in affordability constraints and also potential inflationary pressures. Therefore, it is vital that this year's pay review body recommendations fully take into account the wider fiscal and macroeconomic situation.

Fiscal and Macroeconomic Context

1.4 Thanks to the macroeconomic framework and microeconomic reforms that this Government has put in place, the UK economy continues to experience an unprecedented period of growth and stability. The UK economy has now grown for 60 consecutive quarters (since 1992Q3), by far, its longest unbroken expansion on record. It has also benefited from its longest period of sustained low and stable inflation since the 1960s and shown greater stability and stronger GDP growth than most of its major competitors. Low inflation has, in turn, provided the platform for record employment levels, higher investment, productivity and economic growth. Labour market conditions continue to be favourable and despite record employment levels and high oil prices we are not seeing any significant upward pressure on wages.

1.5 In order to ensure that this success continues, the Government is committed to maintaining macroeconomic stability and sound public finances.

Fiscal Context

1.6 The key issue with respect to the fiscal context is the amount of money available for current spending over the CSR period – fixed by our commitment to meet the golden rule (one of the Government's two fiscal rules that underpin fiscal policy, as set out in the *Code for Fiscal Stability,* HM Treasury 1998). The golden rule requires that "over the economic cycle the Government will borrow only to invest" so that current spending is not financed by borrowing. This means that the 'current budget' (the difference between current receipts and current expenditure, including depreciation) must be in balance or surplus over the cycle (the present cycle began in 1997/98). The Pre-Budget Report and Comprehensive Spending Review (PBR/CSR) 2007 (Annex B, Public Finances) has set out in detail the background to this and what it means for the CSR07 spending envelope. The key points are explained below, along with a brief historical background on the significance of the golden rule.

Historical background to the golden rule

1.7 During the last economic cycle, which ran from mid-1986 to 1997, the stated fiscal policy objectives changed on a number of occasions according to circumstance. With this lack of constancy, policy was not obliged to compensate for past slippages in the fiscal position. In contrast to the position before 1997, the Government's fiscal rules and objectives have remained stable over the last decade.

1.8 The Government's fiscal framework is designed to ensure the highest standards of transparency and openness apply to fiscal policy. Transparency is one of the Government's principles for fiscal management set out in the *Code for fiscal stability*. In the last decade, the introduction of strict fiscal rules and clear objectives for fiscal policy have put the public finances on a more sound and sustainable footing than in previous cycles. This period of fiscal stability has coincided with a period of economic stability, with low volatility of inflation and GDP growth.

Implications for spending envelopes

1.9 Table 1 shows the latest outturns and PBR/CSR 2007 projections for the main fiscal aggregates, as a percentage of GDP. Following a deficit of 3% of GDP in 1996/97, current budget surpluses of more than 2% were recorded in 1999/2000 and 2000/2001. Fiscal policy supported monetary policy during the economic slowdown in 2001 and 2002, with the degree of support moderating as the economy moved back towards trend in 2004. With the economy approaching trend levels in 2006/07, borrowing was lower compared with 2005/06, so fiscal policy was slightly tighter.

1.10 Recent disruption in financial markets has meant economic prospects have become more uncertain. Reflecting higher interest rates than markets expected at the time of Budget 2007, and some assumed feed-through from financial market disruption to tighter credit conditions and to household and company spending in the short term, GDP growth is forecast to slow to 2 to 2.5 per cent in 2008, below trend, before returning to trend rates from 2009. The result of this is a forecast slight loosening in fiscal policy in 2007/08.

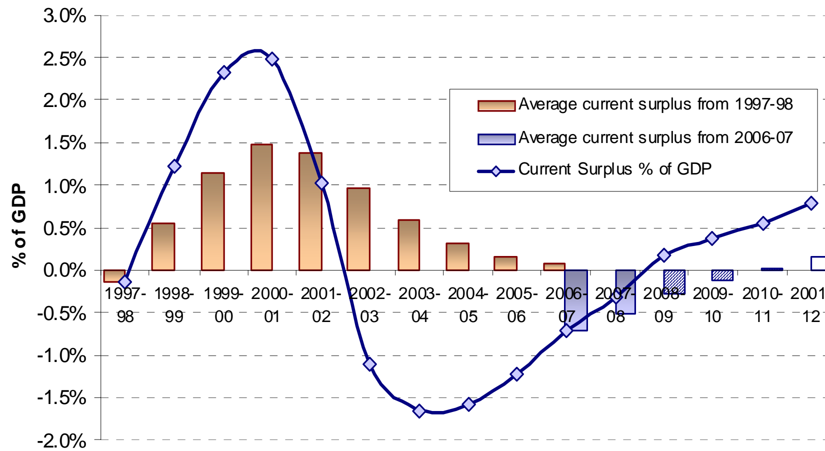
Table 1: Outturns and budget projections

	Per cent of GDP							
	Outturn		Estimate	Projections				
	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Fairness and prudence								
Surplus on current budget	-1.6	-1.2	-0.7	-0.3	0.2	0.4	0.6	0.8
Average surplus since 1997-1998	0.3	0.2	0.1	0.0	0.1	0.1	0.1	0.2
Long-term sustainability								
Public sector net debt	35.0	36.5	37.2	38.2	38.5	38.8	38.8	38.6
Economic impact								
Net investment	1.7	1.8	2.0	2.1	2.2	2.2	2.2	2.2
Public sector net borrowing (PSNB)	3.3	3.0	2.7	2.4	2.0	1.8	1.6	1.4
Cyclically-adjusted PSNB	3.2	2.8	2.5	2.4	2.0	1.8	1.6	1.4
European commitments								
Treaty deficit	3.2	2.9	2.8	2.5	2.1	1.9	1.7	1.5
Cyclically-adjusted Treaty deficit	3.1	2.7	2.6	2.5	2.1	1.9	1.7	1.5
Treaty debt ratio	40.5	42.7	43.5	44.3	44.4	44.5	44.4	44.1
Memo: Output gap	0.0	-0.5	-0.2	0.0	0.0	0.0	0.0	0.0

1.11 PBR/CSR 2007 fixed the nominal current spending envelopes for the CSR07 period (08-09 to 10-11) so that current spending grows by an average of 1.9% in real terms over these years. On

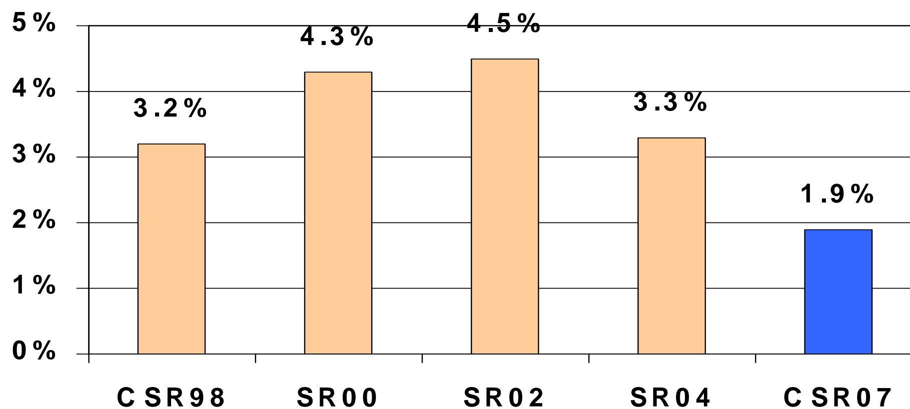
this basis, fiscal policy is set to tighten over the CSR, and the current budget is forecast to return to surplus in 2009/10 ensuring that the Government is on course to meet the golden rule in the next cycle (see Chart 1).

Chart 1: Surplus on the current budget



1.12 In other words, based on forecast economic growth and tax receipts, and ensuring sound public finances consistent with the fiscal rules, current spending can grow by up to 1.9% per annum in real terms over the CSR years (08/09, 09/10 and 10/11). This sets the spending envelope for the CSR, and as shown in Chart 2 represents a marked slowdown in spending growth compared to the significant increases in investment in recent spending review periods.

Chart 2: Total current spending growth over recent spending review periods



1.13 This is the tightest spending review in nearly a decade. From 1998 to 2004, spending envelopes have averaged 3.8% per annum (real). Thus, the fiscal context in which Review Bodies now operate is in contrast to previous years.

1.14 In particular, the period since 2000 saw Government make substantial investments in front line public services. This allowed for significant restructuring of key workforces, for example in health and education; increased reward for public sector workers; and a rapid expansion of the front-line public sector workforce.

1.15 Expenditure on pay is a very significant component of total resource spending (i.e. excluding capital spending), accounting for around a quarter of resource spending in aggregate across the public sector. Excluding items like social security benefits, pay accounts for around a **half** of remaining Departmental resource spending, though for some Departments this will be significantly higher.

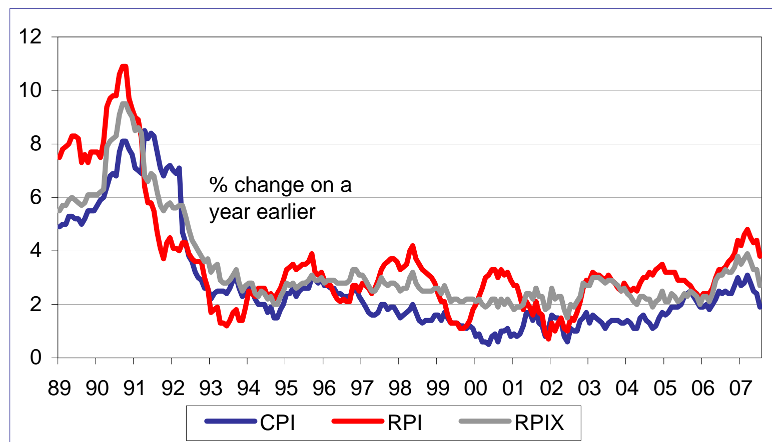
1.16 The Comprehensive Spending Review (and PBR 2007), published on 9 October, announced the resources available to departments over the years 2007-08 to 2010-11. The current spending in departments' budgets, i.e. that money available to meet recurring costs such as salaries, will grow on average at 1.8% per year in real terms1[2], less than half the rate of the previous spending round. All departments' pay costs must be met from these departmental allocations.

1.17 The Government has achieved a great deal in recent years with significantly increased investment in public services and increases in pay for frontline staff. We must now focus on making better use of existing resources and we cannot put the result of this investment or the success of the economy at risk by implementing unaffordable pay awards.

Economic Context

1.18 Stable growth and low inflation have provided the platform for record employment levels, productivity and economic growth and higher investment in public services has led to more and better paid public servants. This section sets out the current issues in respect of inflation trends, the historical context, and public sector pay awards. It also sets out the rationale in support of the CPI as the Government's primary measure of inflation.

Chart 3: Inflation trends 1989 - 2007



1.19 Whilst setting pay awards at the right level is key to the delivery of good public services the level of pay awards are also important to keeping inflation under control. The Bank of England considers pay restraint across the economy to be key to maintaining low and stable inflation. The public sector in itself forms a significant part of the economy and also sends an important signal to pay setters in the private sector. So if public sector pay awards are set too high this could lead to increasing inflationary

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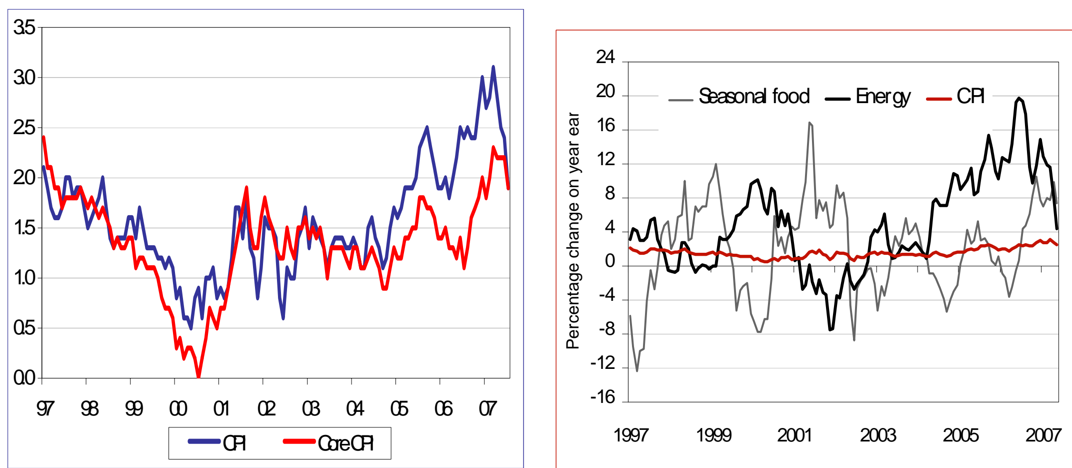
[1] Note this envelope, which is specifically relevant for pay spending, is a subset of the overall spending envelope of 1.9% mentioned earlier. The latter also includes demand led items of Annually Managed Expenditure, such as social security payments and debt interest repayments.

pressures. In a recent speech, the Governor of the Bank of England said "*…the belief that we could avoid the adjustment by pushing up our pay would lead to a self-defeating process of higher wages offset by higher prices. It is the task of the MPC to ensure that the process of adjustment does not lead to a persistent rise in inflation.*"[1]

1.20 Over the recent past, inflation has been boosted by temporary, unforeseen shocks; increases in energy prices, driven by developments in the oil and wholesale gas markets and higher food prices, which have been affected by a number of temporary domestic and global factors. Seasonal food and energy price inflation rates tend to be more volatile than headline inflation (see Chart 4). Inflation has also become increasingly volatile in recent months with more exaggerated seasonal patterns in goods such as furniture dominating the headline rate. Stripping out these short-term influences, underlying 'core' inflation (excluding energy and seasonal food) has remained low and generally under 2 per cent (1.7 per cent in September 2007). See Chart 4.

Chart 4: Core inflation trends



1.21 The Budget forecast was for inflation to return to around target in the second half of 2007 as temporary factors receded and announced utility price cuts were fed through. Inflation has fallen back from its peak earlier in the year and as at September 2007 stands at 1.8 per cent. In line with the Bank and other prominent external forecasters it is expected to remain around its 2 per cent target. And, in contrast to periods of higher inflation in previous decades, the credibility of the UK's monetary policy framework has so far kept inflation expectations anchored and earnings growth has remained subdued. Nevertheless, there remains a risk of second round effects of higher inflation feeding into inflation expectations and higher average earnings growth.

Table 2: Independent Forecasts (August)

CPI	2007 Q4	2008 Q4

1 Mervyn King, speech to Birmingham Chamber of Commerce, 23 January 2007

IMF (Calendar Year)	2.30	2.00
NIESR	2.00	2.10
Lehman Brothers	1.90	2.20
HSBC	1.80	1.60
ITEM Club	2.00	1.90
Bank of England	2.10	2.06

1.22 It is therefore important that wage setting be based on realistic inflation expectations consistent with the inflation target. High pay settlements in the public sector could encourage the same in the private sector. This would lead to higher interest rates and threaten growth and therefore job prospects. Therefore it is vital that we remain vigilant over inflation with awards consistent with the CPI target of 2%.

The use of CPI and RPI

1.23 The CPI methodology is the standard measure of inflation across the European Union and for the European statistical agency Eurostat. As such it represents international best practice and is a more comparable measure (than RPI) internationally.

1.24 There are a number of differences between the CPI and RPI measures of inflation, of which the most significant statistically is the methodology of constructing the index (the formula effect). The CPI formula better allows for the substitution between cheaper and more expensive goods and services within expenditure categories when relative prices change and so may be considered a more realistic depiction of consumer behaviour. The RPI does not reflect such changes in consumption patterns.

1.25 The CPI also has a wider population coverage and is more consistent with national accounts principles of consumer expenditure, so it shares a coherence with other economic statistics and gives a better picture of spending patterns in the UK.

1.26 As is well known, housing costs and mortgage interest payments are not included in the CPI, but included in the RPI. It is important to note, however, that both measures of inflation refer to the change in prices, rather than measuring the absolute cost of living (note also, the CPI and RPI are not intended to measure "the cost of living", the definition of which is very subjective). As such housing and mortgage interest costs are of interest only in so far as their costs may change at a different rate than the rest of the index.

1.27 Mortgage interest payments are an important part of household expenditure and so they are included in the RPI. But they will tend to rise if interest rates go up. So an increase in interest rates designed to reduce inflation would have the perverse effect of initially resulting in a rise in inflation. This temporary increase is needed to ensure that inflation is lower in the future. Hence, wage setting based on RPI rather than CPI is likely to exacerbate inflation. This point is also reflected in the relative volatility of RPI compared to RPIX (see Chart 3), where mortgage interest costs are the only difference between these two measures.

1.28 Over the medium term, we would expect the long-run difference between the CPI and RPI to be around ¾ percentage points. This is due to a number of effects, the largest of which is the formula effect, which accounts for approximately half a percentage point of the difference. The formula effect is due to the use of the geometric mean to aggregate prices at the elementary item level in the CPI, whereas the RPI uses the arithmetic mean. Analysis from the National Audit Office (Audit of assumptions for the 2006 Pre-Budget Report, Dec 2006, p.4) supports this assessment.

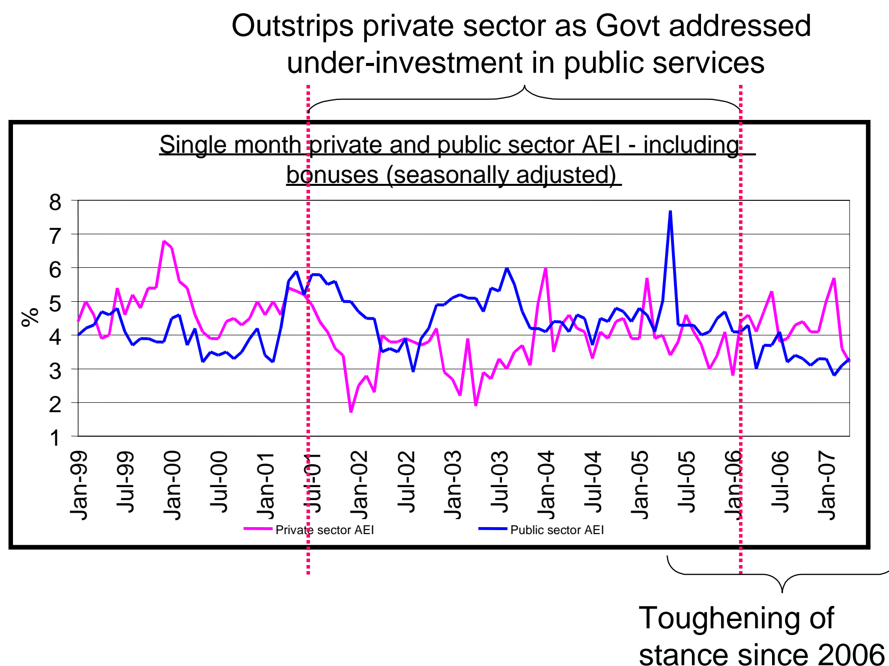
1.29 The remainder of the difference between RPI and CPI reflects differences in the coverage and weights applied to some goods and services. Part of this is due to the fact that the CPI includes spending by all private households whilst the RPI excludes the top four per cent of households by income and pensioners deriving at least three-quarters of their income from state benefits. Housing costs, council tax and mortgage interest payments account for the remainder of the difference.

Recent Developments in Pay

1.30 A period of low pay growth in the 80s and early 90s contributed to recruitment and retention problems across the public sector. Significant investment in public services has allowed us to overcome these widespread problems. This investment, and the increasing attractiveness of the total reward package for public sector workers, has helped deliver major growth in the numbers of key frontline workers since 1997 with over 79,000 more nurses, over 35,000 more doctors, 35,000 more teachers, 102,000 more teaching assistants and 14,000 more police officers.

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

Chart 5: Pay growth in the public and private sectors



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

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

- bonus payments.

1.33 Therefore we are keen that PRBs consider the impact of the headline award on:
- **paybill per head growth,** which gives an indication of resulting changes in average earnings; and
- **paybill growth,** which reflects the total cost to the employer.

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

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

1.36 Whilst pay growth is an important element of remuneration it is the relative *level* of public sector pay that determines whether it is set at the right level in the market to be a positive influence on workers, without being set so high to as to offer poor value for money. While it is not straightforward to calculate the correct "market rate" for a public sector worker, we can see the indirect influence of pay levels through their impact on recruitment, retention and morale. Though before we do this we should recognise that pay is only one aspect of a wider total reward package.

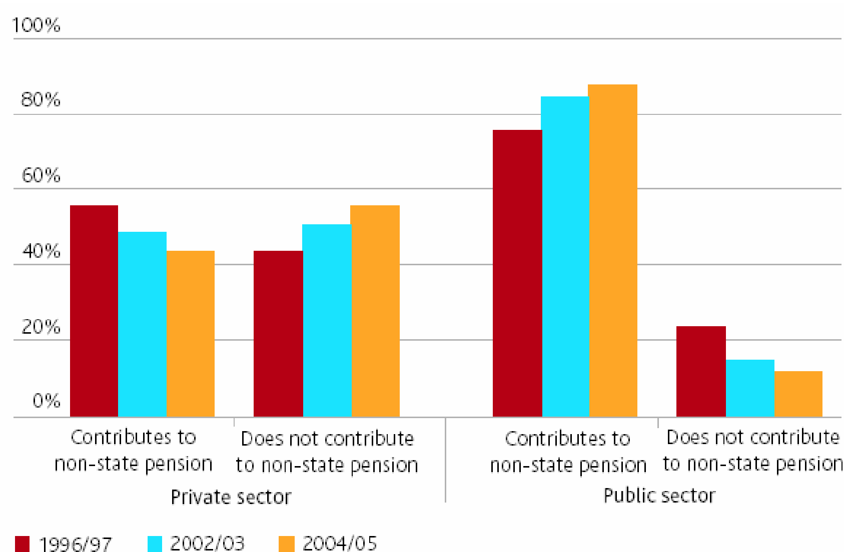
Public Sector Pensions Deal

1.37 An important part of the total reward package for public sector workers is their pension. The reason for this is two-fold:
- Public sector workers have greater access to these schemes than private sector workers (86% participation versus 44%); and
- pensions on offer in the public sector are more generous, on average, than those in the private sector.

1.38 Not only do public sector workers have greater access to occupational pension schemes, but the Pensions Commission's Final Report[1] shows that public sector participation in occupational pension schemes is increasing (from 76% in 1996/7 to 88% in 2004/05) at a time when participation across the private sector is decreasing (from 56% to 44% over the same period).

[1] *Implementing an integrated package of pension reforms*, Pensions Commission, April 2006

Chart 6: Participation in public and private sector non-state pension schemes: percentage of workforce



1.39 The type of occupational pension scheme available in the public sector is also worth more on average. Almost all public sector occupational pensions are defined benefit schemes (with a contribution rate of around 20% of pay), whereas schemes in the private sector are a mixture of defined benefit and increasingly defined contribution (with contribution rates of around 9% of pay).

Targeting Resources

1.40 The high-level story from recent years is that overall the total reward package on offer has reversed the significant problems of the 1990s and led to stable recruitment and retention of the right quality people, with significant increases in the number of frontline workers. In addition, evidence suggests that such morale issues as exist are related to a range of issues and not necessarily primarily pay. For the medical and dental workforce an illustration of the current recruitment, retention and morale situation is contained in chapters 3 and 6.

1.41 Recent pay growth and general improvements in total reward across the public sector have contributed to the current positive overall recruitment and retention situation. Remaining recruitment and retention problems tend to occur at hotspots within the workforce and the general overall pay award is clearly not the most cost-effective manner in which to deal with these. For example, it would not be affordable to raise the pay of the entire workforce by the amount necessary to deal with these limited issues and so any attempt would spread resources so thinly across the entire workforce that it would have little impact on problem areas.

1.42 Additionally, discussions with Departments on their pay strategies suggest that elements other than pay could be more effective in driving further improvements in recruitment, retention and morale. For example improved accommodation for the armed forces, training in the NHS and measures to tackle teachers' workloads are all important aspects of job satisfaction that are not directly pay related. However, due to the limit on available resources, pay awards above those proposed by Government will limit Government's ability make further improvements in these types of areas.

Local and Regional Pay

1.43 One specific area in which targeted measures are clearly useful is in furthering the local and regional pay agenda. OME has undertaken research that suggests that the public sector generally overpays workers outside of London and the South East. It therefore makes sense to use flexibilities to ensure that money goes to the areas where it is most justified. Indeed, many pay systems already incorporate mechanisms that allow for local pay flexibility, for example, local employers have the flexibility under the 2003 consultant contract to pay recruitment and retention premia of up to 30% where required.

Summary

1.44 Public servants are vital to the delivery of good public services and the Government remains committed to the support of those professionals in their efforts to deliver the best possible services. Whilst setting pay at the right level is vital to recruit, retain and motivate valued public sector workers, this must be achieved in a way that is consistent with macroeconomic stability in order to promote growth and job prospects for all.

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

1.46 Following recent pay growth, and the improving value of the wider public sector total reward package, the overall picture on recruitment and retention is healthy and high basic awards are no longer justified. General pay awards are also no longer the best solution to addressing remaining recruitment and retention hotspots and it is vital that Departments are able to focus their resources on the areas of greatest need, and with the greatest impact. Therefore it is, in the Government's view, vital that awards are consistent with the achievement of the CPI target of 2% and with the proposals that are set out in this written evidence.

CHAPTER 2: NHS FINANCES

INTRODUCTION

2.1 This chapter sets out the financial context for our recommendation, including the Department of Health's Departmental Expenditure Limits (DELs) for 2008/09 to 2010/11 as announced by the Chancellor as part of the 2007 Comprehensive Spending Review (CSR 2007).

2.2 Over the three CSR 2007 years NHS revenue funding will grow in real terms by an average of 3.7% per annum. This is a significantly less than the 6.1% real terms revenue growth enjoyed by the NHS from 1997/98 to 2007/08, although higher than the long run historic average of around 3.3%.

2.3 The reduction in funding growth is not matched by any lowering of ambition for the pace of improvements in the NHS. Through our Public Service Agreement (PSA) with HM Treasury, we are committed to continuing to grow services to meet underlying demand, and deliver further improvements to access, and in particular to make dramatic improvements to the quality of care. More details of the services planned and the financial implications are set out below.

2.4 Any increase in pay above the level recommended by the Department will put these service improvement plans at risk. Table 2.1 below provides a trend of the Hospital and Community Health Service (HCHS) paybill between 2003/04 and 2006/07. Around two thirds of expenditure within the HCHS is pay, so even very small changes in pay have a substantial effect on the affordability constraints of NHS organisations.

Table 2.1 Trends in the HCHS paybill

	2003/04	2004/05	2005/06	2006/07
DDRB	6,142m	7,077m	7,571m	7,930m
NHSPRB	20,825m	24,425m	26,443m	27,497m
Total HCHS	**26,967m**	**31,502m**	**34,015m**	**35,428m**

Source: Paybill reference: 071012

Notes: 1. Part of the 2004/05 growth is due to a transfer of pension responsibilities from the HMT to Department of Health.

2. Figures exclude agency costs.

2.5 Many of the non-pay costs cannot be directly controlled by NHS organisations, such as underlying increases in the cost of goods and services and increases in demand for expensive drugs. This means that any increase in pay settlements is likely to lead to lower levels of employment. Since many of the Government's aspirations for improving NHS services rely on the contribution of NHS staff, higher pay settlements also put at risk further improvements to NHS care.

2.6 The pay increases for 2008/09 become a recurrent pressure on the NHS. The Government has a three-year process of financial and service planning. Pay settlements above the planned level mean we would have to revise our plans for all three years. Where this happens on a significant scale it makes it difficult to encourage NHS organisations to develop robust three-year plans.

FUNDING AVAILABLE

NHS expenditure limits between 2008/09 and 2010/11

2.7 The Chancellor announced the funding envelope for the NHS as part of the 2007 Comprehensive Spending Review on 9 October 2007. The Departmental Expenditure Limits (DELs) set by HM Treasury represent absolute limits on NHS expenditure. There is no flexibility to bring forward expenditure – i.e. to spend more in an earlier year, with lower expenditure in future years. There is flexibility to delay expenditure – i.e. to defer resources and expenditure into future years – but this is subject to approval by HM Treasury, and limited by affordability constraints on public finances in future years.

2.8 As expected, the rate of growth is much lower than over recent years. Whilst real terms growth in total funding (revenue and capital) averaged 6% between 1997/98 and 2007/08, over the next three years the average real terms growth in total funding will be 4% per year.

2.9 Similarly, there will be a significant reduction in the annual rate of growth in revenue funding. Between 1997/98 and 2007/08, the average real terms growth in revenue funding was 6.1%, compared to the average annual rate of real terms growth in the 25 years prior to 1997/98 of 3.3%. In the three years from 2008/09, the annual average growth will be 3.7%, which is above the long run historic average but significantly below the average of the last ten years.

2.10 All pay costs must be met from within the NHS revenue DEL. If pay costs are higher than expected, other costs must be reduced. There is no flexibility to move funding between the revenue budget and the capital budget. Table 2.2 below sets out the revenue DEL, and the rates of increase, between 2005/06 and 2010/11.

Table 2.2 Departmental Revenue Expenditure Limits to 2010/11

Year		Revenue NHS Expenditure	Cash Growth	Cash Growth %	% real terms increase
		£m	£m		
2005/06	**Outturn**	74,168	7,294	10.9	8.6
2006/07	**Estimated outturn**	78,356	4,188	5.6	2.8
2007/08	**Estimated outturn**	86,848	8,492	10.8	7.9
2008/09	**Plan**	92,642	5,793	6.7	3.9
2009/10	**Plan**	98,499	5,858	6.3	3.6
2010/11	**Plan**	104,833	6,334	6.4	3.7

1. Figures may not sum due to rounding

Financial position

2.11 The NHS ended 2006/07 with a net surplus of £515 million. The latest forecast for 2007/08, as reported at Quarter 1, is for a year-end net surplus of £983 million.

2.12 The improved financial position has been delivered through the introduction of a stronger and more transparent NHS financial regime, increased focus on the improvement of data quality, strict financial targets set for the NHS and both managers

and clinicians right across the NHS working together to produce efficiencies and reduce deficits, whilst continuing to deliver improvements in services to patients. However, we recognise that many organisations, especially those in deficit, had to make tough decisions in order to deliver savings and restore financial stability.

2.13 Although the NHS has returned to financial stability, we believe the majority of the surplus at the end of 2007/08 will not be available for new service costs in 2008/09 and beyond, for the following reasons:

- We expect NHS organisations to continue to make modest surpluses in future years. Organisations need to plan on a small surplus so that they can respond to risks without returning to financial difficulty. An average surplus at organisational level of 0.5% would mean the NHS will underspend by around £500 million.

- Some of the NHS surplus is due to lower than expected expenditure relating to technical accounting items, such as impairments, cost of capital and provisions. Under the Treasury budgeting rules, this funding cannot be used for other types of expenditure (e.g. pay, goods and services, and drugs). Our current estimate is that this accounts for around £350 million of the surplus.

- The first call on expenditure in 2008/09 will be covering the full cost of the staged pay award in 2007/08, which we estimate will be around £190 million.

2.14 Finally, whilst the NHS as a whole has returned to financial stability, there are still a small number of NHS bodies with significant financial challenges. In 2006/07, there were 82 organisations in deficit, and 22 organisations are forecasting a deficit for 2007/08. Pay increases above those necessary to maintain appropriate levels of recruitment and retention will seriously risk these organisations remaining in deficit next year.

SERVICE PLANS

Demand for healthcare

2.15 The CSR settlement is significantly higher than the long-term average growth for the NHS, but this needs to be seen in the context of the ever increasing demand to improve health services, and the Government's ambition to continue the rate of improvements to access, quality and safety of NHS services. The Government is committed to a vision of NHS services that matches increasing public expectations for health care, and started to set out this vision in the CSR White Paper, and the interim Next Stage Review report by Lord Darzi "*Our NHS Our Future*".

2.16 The plans for meeting the pressures on the NHS over the next three years are set out below, using the following categories:

- Baseline pressures;
- Underlying demand; and
- Service developments.

2.17 The costs are summarised in table 2.3 below.

Baseline pressures

2.18 The first call on resources is the underlying increases in demand and rising cost pressures. This includes costs met directly by NHS organisations, but also other costs that are met directly by the Department of Health on behalf of the NHS.

2.19 Baseline pressures are expected to consume around 60% of the additional resources available and a significant proportion of this, around 49%, will be taken up by pay. Our financial planning is based on the suggested pay settlements set out in our evidence to the Pay Review Bodies, and includes an average of 1.6% pay drift on average across the HCHS.. The NHS paybill in 2006/07 was £36.6 billion (including agency staff). **Annex A** provides detail of the pay metrics.

2.20 There are a range of other commitments over the next three years - many of which are demand led - that need to be funded from overall NHS growth, and could be put at risk of delivering if a higher pay award was agreed. This includes the following:

- Drugs prescribed by GPs and in the hospital setting, which have an underlying growth rate of around 9% each year will form 18% of the baseline pressures. Expenditure in 2005/06 totals £10 billion. In addition, we anticipate this proportion to increase as new treatments become available through NICE recommendations.

- The underlying cost of goods and services which represent around 23% of overall NHS expenditure will rise by 2.7% each year and is expected to consume around 8% of baseline pressures.

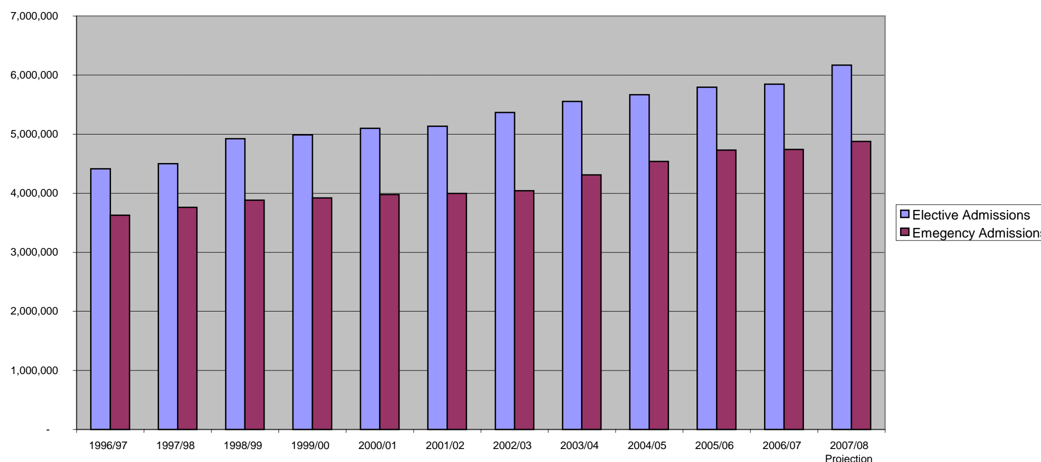
- Other additional investment making up baseline pressures include: European Economic Area (EEA) medical costs; investment in family health services such as dental and pharmaceutical services; the revenue consequences of capital investment, PFI revenue costs and central programmes such as the NHS Litigation Authority.

Underlying demand

2.21 Significant progress has been made to improve health services through our reform programmes and record investment. However, the demand for NHS services continues to rise.

2.22 The chart below shows that demand for elective and emergency admission has grown on average by 3% each year, taking total demand to 6.2 million (projected) elective admissions and 4.9 million (projected) emergency admissions by 2007/08.

Emergency and elective general & acute admissions, England



2.23 Attendance at A&E departments and Walk-in-Centres have also increased on average by 6.3% per year between 2002/03 and 2006/07.

2.24 Recent data from the Office for National Statistics indicate that there is an unexpected rise in births from 2006, which is expected to continue to 2010. This, coupled with our PSA commitment to provide safe, high quality maternity care for all, is likely to draw on a sizeable proportion of the resources available.

2.25 The Department is on target to deliver a maximum wait for patients of 18 weeks from GP referral to hospital treatment by 2008; however, significant investment is still required to ensure the achievement and sustainability of this target.

Service development

2.26 As part of the 2007 Comprehensive Spending Review settlement, the Department has an agreed set of Public Service Agreements (PSAs) which will shape the service developments over the next three years. The commitment to improvement continues through our ambitious programme of work over the next three years to deliver manifesto commitments and our significant contributions to new cross government priorities, for example PSAs on child and young-person health and tackling drugs and alcohol. Such achievements can only be made if resources are not diverted into unnecessary large increases in pay award.

Key service developments include:

- £75 million over the CSR period to reduce cancer waiting times still further, and doubling investment in palliative care;

- meeting public demand to confront healthcare associated infections, by investing a further £140 million to tackle the increase in cases of C. difficile, and sustaining the progress we have made in reducing MRSA, including an additional £130 million to introduce MRSA screening for all patients;

- increase support to children and families to tackle child obesity by raising awareness, working with local partners and developing knowledge about what works to tackle obesity;

- improve the health outcomes of people with long-term conditions by offering personalised care plans for vulnerable people most at risk through improved care in primary and community settings;

- implement the recommendation of the Cooksey Review, supporting the strategy to translate health research into economic and patient benefit to take ring-fenced funding for the National Institute for Health Research from the Department of Health to £1 billion by 2010/11; and up to £100 million for a new Health Innovation Council to drive a more innovative NHS;

- investing a further £170 million in the CSR period to expand the current programme of work on improving access to psychological therapy services for people suffering the prevalent long-term conditions of depression and anxiety disorders.

Additionally, other significant commitments over the next three years include:

- Implementation of the European Working Time Directive;

- The NHS Connecting for Health programme which supports the NHS in providing better, safer care by delivering computer systems and services that improve the way patient information is stored, accessed, and linking GPs and community services to hospitals.

2.27 The interim NHS Review has also pledged to improve GP access; accelerating steps to tackle under-doctored areas and reduce health inequalities, to include additional resources for over 100 new GP practices in areas with low provision, and providing greater choice and convenience for patients, including more flexible opening hours and greater choice of providers, including 150 new health centres open 7 days a week.

2.28 Table 2.3 summarises the cost implications of the baseline pressures, underlying activity demand and service development programme set out above. It shows that overall costs will match the increase in funding available within the DEL. However, to make the overall programme affordable, the NHS must deliver annual average efficiency savings of 3% per year.

Table 2.3: Cost pressures on NHS over the next three years (£bn)

	2008/09	**2009/10**	**2010/11**
Baseline pressures*	3.1	3.9	3.7
Underlying demand	1.2	0.7	1.4
Service improvements	1.4	1.4	1.2
Total forecast expenditure	**5.8**	**5.9**	**6.3**
Departmental expenditure limit	**5.8**	**5.9**	**6.3**

* Net of 3% efficiency (Figures may not sum due to rounding).

Link between pay and output targets

2.29 A forecast of our expenditure from 2007/08 to 2010/11 in terms of key inputs of health provision is shown below.

Table 2.4: Forecast input costs over the next three years

	2007/08	2008/09	2009/10	2010/11
Pay - directly employed staff	42.5%	43.3%	43.1%	43.3%
pay – not directly employed	2.4%	2.4%	2.4%	2.4%
Primary care services	14.2%	14.4%	14.4%	14.5%
Goods, supplies and other services	23.2%	22.0%	21.1%	20.2%
Primary and secondary care drugs	12.7%	12.6%	13.5%	14.2%
Other	4.9%	5.3%	5.4%	5.4%

2.30 Pay continues to form a significant part of NHS revenue spend accounting for around 46% of total expenditure (and around 60% of HCHS). Consequently, a small increase in pay award is likely to have a significant impact on the overall paybill, reducing the funds available for other activities.

2.31 Table 2.4 illustrates the balance of inputs needed to deliver the programme set out above and in table 2.3. We believe that despite rapidly rising costs in some non-staff costs – such as drugs and EEA medical costs – the proportion of expenditure on staff will remain fairly stable over the next three years.

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

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

2.34 Exactly what areas would be at risk from a large pay deal is impossible to say because decisions would be made locally, but it is very likely that higher pay settlements would lead to fewer staff than would otherwise be the case. For example, each additional 0.5% increase in pay for the DDRB's remit group adds around £46 million onto the pay bill. That additional cost would need to be met from allocations and locally this would translate as a major cost pressure. We know that nationally £46 million would fund 1,300 qualified nurses, or 480 doctors or 41,300 elective admissions.

2.35 Therefore, at a local level, PCTs and NHS trusts faced with this cost pressure will consequently have to limit unnecessarily the investment in services or numbers of staff. There are 152 PCTs so on average their allocation has to cover the pay cost for the services they commission. With an additional national pay pressure of £46 million, the average PCT will face unfunded costs of over £300,000. This would fund around 270 elective hospital admissions (at around £1000 per admission), which would mean the local NHS would employ fewer staff to deliver less activity. Alternatively, the funding could be used to fund an annual course of statins for around 1700 people (at £173 per annual course), or a course of chemotherapy for around 700 people (at around £432 per course of treatment).

CONCLUSION

2.36 The NHS has a challenging programme of work over the next three years. Although funding for health will continue to increase, the overall increase in health funding over the next three years is significantly lower than the growth enjoyed from 1997/98 to 2007/08.

2.37 Public expectations of the NHS continue to increase and the NHS has a responsibility to taxpayers to continue to make progress on improving services and to contribute to wider government objectives. We have shown in table 2.3 above that the 3.7% average real increase in revenue funding over the next three years is needed to cover the cost of:

- Baseline pressures. These are the unavoidable cost increases that must be met by the NHS, and include increased pay, the rising cost of drugs, and the increasing cost of goods and services;
- Underlying demand. Rising patient expectation, new technology and the need to deliver the 18 week target means the NHS needs to deliver year on year increases in activity;
- Service improvements. The Government has ambitious plans to continue the improvements in the quality and safety of NHS care, which is necessary to meet rising public expectations. The plans include commitments to reduce further the cancer waiting times, tackle healthcare associated infections, and improve access to primary care.

2.38 If pay increases are higher than currently planned, there is a very high risk that this programme will not be delivered. Whilst the NHS is currently in a sound financial position, we cannot expect surpluses to fund higher pay costs. It is essential that the NHS maintains a modest surplus to allow organisations to respond to risk without returning to deficit.

2.39 The cost of employing staff is by far the biggest single cost for the NHS – table 2.4 shows that pay costs account for around 45% of total expenditure, so a small increase in pay has a significant impact on overall cost pressures. Since many of the other cost pressures are not directly controlled by NHS orgnaisations – such as underlying inflation and the rising cost of drugs – high pay costs mean less staff will be employed than would otherwise be the case. Since service improvements and improved access rely on staff, higher pay increases also put at risk the delivery of key service improvements within the NHS.

CHAPTER 3: THE MEDICAL WORKFORCE CONTEXT

INTRODUCTION

3.1 This chapter sets the context for the medical workforce in England. Evidence is provided on the recent growth in medical workforce capacity, the current picture on recruitment and retention and finally issues that affect future demand for the workforce. This includes consideration of changes in participation rates and the implementation of the European Working Time Directive; and, evidence on recruitment, retention and motivation.

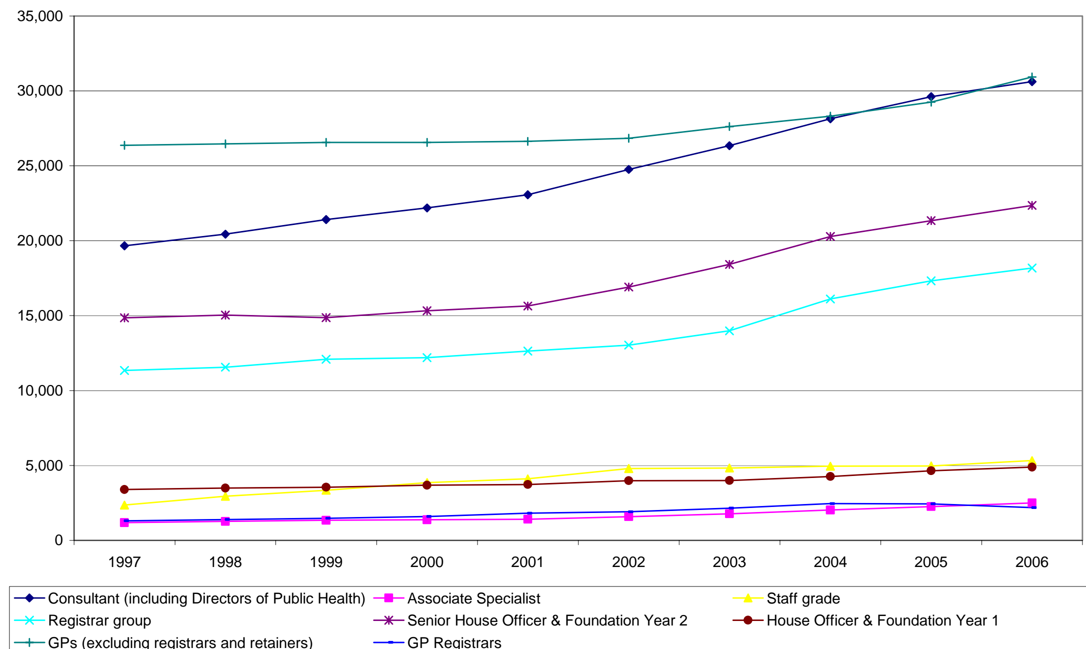
RECENT GROWTH IN THE WORKFORCE

3.2 The NHS has seen unprecedented levels of investment and a period of expansion in the workforce since 1997 in order to reduce waiting times, improve access to services and ensure high quality treatment and care. We now have more than 125,000 doctors working in the NHS - almost 35,000 more than in 1997 - as well as record levels of doctors in training in UK medical schools. We do not therefore need to rely on overseas doctors as much as we did in the past. We have reached a position where domestic supply meets demand.

Workforce numbers: headline figures

3.3 The chart below shows the significant growth in the medical workforce since 1997. Further detail can be found in the statistical tables provided by the Information Centre for Health and Social Care.

FULL TIME EQUIVALENT HCHS AND PUBLIC HEALTH SERVICE MEDICAL AND DENTAL STAFF: ENGLAND AT 30 SEPTEMBER



3.4 The latest annual census figures confirm that this growth continued during the year to 30 September 2006. In particular, the growth in doctors and hospital dentists and GMPS doctors in England for the year to September 2006 showed that:

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 2,690 (headcount) or 3.0% and 3,407 (FTE) or 4.1%;

- Consultant numbers increased by 881 (headcount) or 2.8% and 1,006 (FTE) or 3.4%;

- Associate specialist numbers increased by 276 (headcount) or 10.8% and 235 (FTE) or 10.4%;

- Staff grade numbers increased by 410 (headcount) or 7.4% and 359 (FTE) or 7.2%;

- Numbers in the registrar group (mainly specialist registrars) increased by 802 (headcount) or 4.5% and 867 (FTE) or 5.0%;

- The combined number of senior house officer and equivalent plus foundation house officer year 2 increased by 914 (headcount) or 4.2% and by 1,015 (FTE) or 4.5%;

- Foundation programme year 1 and pre-registration house officer numbers increased by 242 (headcount) or 5.2% and 245 (FTE) or 5.3%;

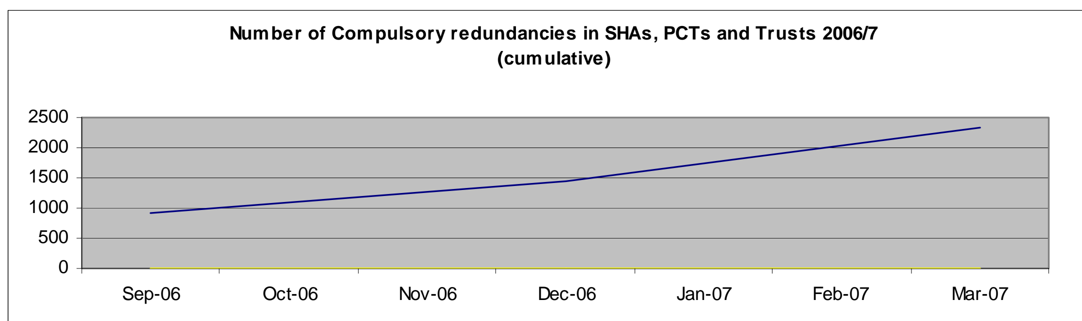
- GP numbers – excluding GP retainers and GP registrars – increased by 353 (headcount) or 1.1% and 1,683 (FTE) or 5.8%.

- GP registrars decreased by 286 (headcount) or -11.2% and the full time equivalent figure decreased by 2.44 or 10.0%.

Medical Redundancies

3.5 During the period since September 2006 there has been some evidence to suggest a slow down in this growth and even a modest reduction in the demand for medical staff in some organisations. In particular, some organisations have announced plans to reduce posts to generate savings and improve efficiency as part of measures to reduce financial deficits and in the context of reforms to deliver patient care closer to home.

3.6 In their last report, the Review Body commented that evidence on the extent of compulsory redundancies affecting their remit group, though not complete, did suggest that very few NHS medical staff faced compulsory redundancy. DH have collected data on the number of redundancies between 1 April 2006 and 31 March 2007, broken down by compulsory/voluntary and clinical/non-clinical. In total, 2,330 compulsory redundancies were reported (including 4 reported from 8 Foundation Trusts that sent in a return). Of these, only 2.5% were medical staff. This however might increase if the NHS were faced with an unaffordable increase in the medical pay bill as, while NHS trusts would continue to minimise any redundancies, unnecessary increases in pay levels would lead to further examination of potential savings and this would inevitably include medical pay costs.



RECRUITMENT, RETENTION AND MOTIVATION: CURRENT POSITION

3.7 Recruitment to the medical workforce is healthy – the total number of medically qualified doctors has increased by 41% since 1997 and medical school intake has increased by 72% since 1997.

3.8 The September 2006 workforce census shows that women now comprise 39% of the total medically qualified doctor workforce, up from 33% in 1997. We want the NHS to be a family-friendly, flexible employer that provides high quality working conditions for both men and women who want to work flexibly. Flexible working is one of the seven areas of modern HR practices on which almost all NHS organisations have been independently validated. We recognise the trend towards flexible working, and the need to ensure sufficient staff are available to provide high quality services.

3.9 There is a broad range of benefits available to all NHS staff including childcare, flexible working, continual professional development and evidence to demonstrate that staff are valued. These, coupled with effective social partnerships, and employment models improve staff recruitment and retention and help staff deliver transformational change.

3.10 The Department of Health meet with the main health unions and NHS Employers on a regular basis through the Social Partnership Forum to discuss debate and support the development and implementation of the workforce implications of policy.

3.11 Additionally, the Department has a contract with NHS Employers to provide services to NHS employing organisations, including the provision of guidance and support on good employment practice, with a view to continuing to improve the working lives of NHS staff as a path to better patient care.

NHS Staff Survey

3.12 The NHS staff survey conducted in October 2006 found that staff remained generally satisfied with their jobs, though the level of satisfaction varied between different types of organisations. This year was the first year that the Healthcare Commission have provided four separate reports covering Acute trusts, Mental health and learning disability trusts, PCTs and Ambulance trusts. Across the NHS, 240,580 staff within the four sectors were asked for their views and 128,750 staff responded, equating to an overall response rate of 53%. The job satisfaction key score is derived from seven questions which take into account issues such as recognition for good work, feeling valued by the trust, support from immediate managers and colleagues, freedom to choose their method of working, the amount of responsibility they are given and opportunities to use their abilities. Respondents give a rating between one and five, where one is very dissatisfied and five is very satisfied. The job satisfaction key score

for doctors and dentists has remained fairly constant over the 4 years of the survey, varying from 3.52 in 2003 to 3.53 in 2006.

Job Satisfaction and NHS Leadership

3.13 Job satisfaction is one indicator of staff morale and engagement. Key to improving and sustaining staff morale and engagement across the NHS is the work heralded in the NHS Chief Executive's Annual NHS Report to transform the NHS by reconnecting NHS purpose and priorities with the needs of NHS staff, patients and the public. To do this we must better understand the things that truly matter to our staff, patients and the public. The review of the NHS to be undertaken by the Health Minister, Lord Darzi, will build upon this. The Next Stage Review will engage with staff, as well as patients and the public, to see how a patient-centred, clinically-led NHS can be achieved. The interim findings of the review were published in October 2007 and set out much of the challenge ahead for the NHS.

3.14 To help us to better understand the things that matter to staff in the NHS in their day-to-day work, a piece of research has been commissioned from Ipsos MORI by the Department of Health this year. This research seeks to understand the emotional drivers that are present when staff deliver high quality services. It will inform improved staff engagement at a local and national level and also work on NHS purpose and values being undertaken as part of the constitution workstream of the Next Stage Review. Stronger staff engagement will help to improve staff motivation, job satisfaction and ensure that staff understand their key contribution to the NHS. The qualitative element of the research has been completed and this informed a larger, survey-based quantitative exercise, the results of which are being analysed. **Annex B** sets out some preliminary findings. These suggest that pay is no longer the key issue that it was in the 1990s. We expect to publish the full research findings before the end of the year, however the headline finding was that the top three factors that mattered to staff and how they linked to quality patient care were:

- I am treated with respect, trusted and listened to
- I have an interesting and worthwhile job
- I am able to provide high quality patient care.

Vacancy Rates

3.15 Table 18 shows the latest three-month vacancy rates for HCHS doctors (excluding doctors in training) by specialty and Table 19 summarises the available vacancy data by specialty over the period 2002 to 2006. The March 2007 mean three-month vacancy rate for medical and dental consultants was 1.2%. This compares with 1.9% in March 2006 and 3.3% in March 2004.

Turnover and Wastage

3.16 NHS staff are employed by individual NHS employers. Doctors can be expected to move between NHS employers as they progress their NHS careers. Our best information is a turnover rate of 9.8% in the total NHS workforce. However, this figure is based upon all leavers from NHS organisations including those who may be moving between NHS organisations, and not just those who are leaving the NHS.

3.17 An analysis of the latest available data on retention and retirements is at **Annex C**.

Electronic Staff Record (ESR)

3.18 The Electronic Staff Record (ESR) programme is being introduced to provide a single integrated HR and Payroll facility for all NHS organisations. The implementation of ESR is due to be completed by April 2008. Some 521 NHS organisations are already live on ESR (representing 1,051,303 staff) which provides us with a rich source of data on the workforce. We are currently exploring how we can use this data to better understand movement within the NHS. NHS organisations who make full use of ESR functionalities such as Self Service and Talent Management support staff empowerment enabling employees and managers to access directly their personal records.

FUTURE MEDICAL WORKFORCE DEMAND

3.19 The Department of Health has moved away from setting top-down workforce targets to a more devolved approach to workforce planning. For most staff groups, the local SHA is responsible for ensuring the right number of training places are commissioned from higher education institutions to maintain the workforce at the levels needed to deliver the service required by the PCT commissioners. Following the recent Health Select Committee report into workforce planning, the Department has now embarked on work in partnership with the SHAs, health trade unions, Royal Colleges and other stakeholders and experts to develop a new model for workforce planning. The aim is to develop a world class system of workforce planning for the NHS which will support the current position of local responsibility. This is firmly part of the *Our NHS Our Future* review of the NHS currently underway led by the Health Minister Lord Darzi.

3.20 The arrangements for undergraduate medical and dental commissions are reviewed periodically by a national Joint Implementation Group (JIG) comprising representatives of DH, SHAs, Department for Innovation Universities and Skills (DIUS) and the Higher Education Funding Council for England with expert support from the Workforce Review Team (WRT).

3.21 It is clear that medicine remains an attractive career option with strong competition for places in medical schools and for specialty training places in the NHS. In 2007, all places for GP training were filled in the first round of recruitment with a surplus of over 600 appointable applicants. Around 85% of specialist training places in the NHS were filled in the first round of recruitment and there are likely to be very few vacancies by the end of the second round of recruitment. The high level of applicants for specialty training has meant that this year, areas with long-standing recruitment difficulties have been able to fill their training places with good quality candidates and shortage specialties such as Obstetrics and Gynaecology have filled their places.

3.22 The number of UK medical school graduates is forecast to increase year on year until 2010/11 providing strong domestic competition for specialty training places in future. There is also strong international competition for specialty training places. Medical workforce planning to assess future supply and demand is based upon increased self-sufficiency, and modelling the outturn from UK medical training plus around 5% supply from outside the UK. This compares with the current medical workforce profile where over 40% of doctors in the training grades qualified outside the UK.

3.23 There is a tension between the move towards greater self-sufficiency and open market competition. The Department is consulting on proposals for managing applications for post-graduate and specialty training programmes from medical school graduates from outside the European Economic Area. The preferred option is that doctors from outside the EEA who do not have indefinite leave to enter or remain in the UK should be considered for post-graduate medical training places in the NHS, only if there is no suitable UK or EEA applicant. The aim is to agree an approach that can be

implemented for the 2008 specialty recruitment round. International medical graduates will continue to be able to apply for service posts in the NHS.

The Impact of Part-time Working

3.24 Table 16 shows the change in the number of part-time medical and dental staff by grade since 1995. As we reported in our evidence last year, the effects of part-time working are taken into account in the national workforce models. In general, this is done by assessing the current ratio of FTE to headcount and using analysis of historical data and judgement about future trends to determine how this ratio will change over time. The changes to participation are very much dependent on changes to the expectation of individuals (and are therefore difficult to predict). Workforce modelling considers a gradual reduction of participation as currently measured in the order of less than 1% pa over the short term as realistic. This assumption is based on evidence that the ratio has been stable in recent years. The table below shows the FTE to headcount ratio for consultants since 1999. Across the whole of the HCHS sector in England, the ratio between FTE and Headcount in 2006 was 0.93.

Year	Headcount	FTE	Ratio
1999	23,321	21,410	0.92
2000	24,401	22,186	0.91
2001	25,782	23,064	0.89
2002	27,070	24,756	0.91
2003	28,750	26,341	0.92
2004	30,650	28,141	0.92
2005	31,993	29,613	0.93
2006	32,874	30,619	0.93

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

European Working Time Directive

3.26 Another factor which may have a significant impact on the balance between supply and demand for medical staff is the implementation of the European Working Time Directive (EWTD). This legislation already applies to the majority of staff but its implementation for junior doctors is being phased in over a number of years. The maximum working hours for doctors in training was reduced to 56 in August 2004 and the NHS is now planning to implement the 48-hour week from August 2009.

3.27 The University of Sheffield has completed the first phase of an independent research project to assess the impact of changing working patterns and reduced working hours on medical training. This included a detailed and systematic review of available literature as well as an analysis of individual and group interviews with key stakeholders.

3.28 The scoping report identified the shifting emphasis from the traditional apprenticeship model of training to a model where an increasing proportion of training is provided `off the job' by means of simulation, wet labs and e-learning. It also revealed largely negative perceptions about the impact of the WTD on training and real challenges for craft specialties such as surgery. However, whilst the scoping revealed that the WTD had challenged the traditional apprenticeship model of training, it also provided

opportunities to enhance medical training in a modern healthcare system. The report also identified that organisational culture was crucial to the effectiveness of clinical training.

3.29 The second stage of this independent research project has now commenced, which includes developing practical tools to support the training of doctors. The challenge is to provide a working environment that facilitates both `on the job' training and also transfer of learning from `off the job' training activities to `on the job performance'. This will reflect the following key elements from the scoping phase:

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

POSTGRADUATE MEDICAL TRAINING

3.30 Significant reforms to postgraduate medical training have been introduced in the last couple of years called Modernising Medical Careers (MMC). These do not have a direct impact on pay as agreement was reached with the BMA that the existing pay-scales should be used for trainees in the new training structure. However, they represent major changes for junior doctors that have implications for the progression of their careers and their morale. Consequently, in evidence in recent years, we have outlined the key initiatives in postgraduate medical training. An update on progress is attached at **Annex D**.

MEDICAL TRAINING NUMBERS

Undergraduate education

3.31 There is evidence of good recruitment into medicine. Medical school intake has increased by 72% since 1997. 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 2006 entry, the average UCAS tariff points of accepted applicants to medicine and dentistry were 421 and 388 respectively compared with 413 and 381 for entry in 2004.

3.32 The number of UK applicants to study medicine at UK universities has increased again over last year. Table 3 shows the ratio of applicants to accepted applicants for each year since 1986. The number of UK applicants to medical schools has risen more rapidly than the number of available places with, in 2006, an average of 2.6 applicants for every medical school place. In 2006, 59% of UK accepted applicants were female compared with 58% in 2005 and 60% in 2004.

3.33 In last year’s evidence, we reported that the Department was a member of the Inter-Departmental Group set up to implement recommendations of the *Gateway to the Professions* Report. The Department’s Pre-Registration Education and Training team continues to liaise with colleagues in the Department for Innovation Universities and Skills (DIUS) on the implementation of Gateway recommendations through the Inter-Departmental Working Group and to support healthcare bids to the Gateway Development Fund. This includes providing support to the Widening Participation in Learning Strategy Unit’s successful bid to fund the “Growing Our Own Professionals” project which is now underway in Thames Gateway.

Postgraduate medical training

3.34 As part of the MMC reforms, the Foundation Programme was introduced in August 2005 and new specialty training programmes were introduced in August 2007. This meant:

- the Foundation House Officer (FHO) Year 1 replaced the old PRHO grade from August 2005;
- the FHO Year 2 replaced the first year of the SHO grade from August 2006; and
- the new specialty registrar grade was introduced in August 2007 that will replace the old (post-Foundation) SHO and specialist registrar grades.

3.35 As the latest data available is from the pre-specialty training reform workforce census of September 2006, evidence needs to be considered from both that source (based on the grade structure in place at that time) and in the light of the experience of recruitment to specialty training in 2007 (reflecting the new grade structure).

Foundation House Officer Year 1

3.36 In the light of the increase in medical school graduates resulting from the increased intakes in recent years, funding was provided for an extra 319 Foundation Programme Year 1 (PRHO) posts in England in 2005/06, an additional 354 posts in 2006/07 and 772 posts in 2007/08. The MMC Foundation Programme office is overseeing the development of foundation programmes and the creation of the appropriate number of Foundation Programme Year 1 and Year 2 posts needed in England over the coming years. The number of Foundation Year 1 (PRHO) posts has increased from 3,398 in 1997 to 4,905 in 2006.

Senior House Officers & equivalents and Foundation House Officer Year 2

3.37 Between 1997 and 2005 the number of SHOs and equivalents employed by the NHS increased by 6,636 (44.2%), from 15,006 to 21,642. In August 2006, the first doctors officially took up posts as Foundation Year 2 doctors (rather than first year SHOs) as part of the MMC reforms and NHS Trusts were asked to record them as such in the September 2006 NHS workforce census. Unfortunately, some NHS Trusts did not accurately identify all doctors in FHO Year 2 posts, and it is therefore impossible to provide a totally accurate number of such doctors. However, we can report that between 2005 and 2006 the combined number of SHOs & equivalents and FHO Year 2s increased by 914 (4.2%) to 22,556.

3.38 Competition for entry into specialty training programmes remains extremely high, particularly in popular areas such as London and in popular specialties. At the start of October 2007, the fill-rate of posts on the Medical Training Application Service (MTAS) was 90-95% in the UK.

Registrar Group Doctors

3.39 Between 1997 and 2006, the number of registrar group doctors employed by the NHS increased by 6,899 (57.9%) from 11,909 to 18,808. In the period 2005 to 2006 the figure increased by 802 (4.4%).

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

3.41 Early predictions for specialty recruitment in 2008 suggest that competition ratios for training posts could be even higher, in the order of 3:1.

GPs AND GP REGISTRARS

3.42 Between 1997 and 2006 the number of GPs (excluding retainers and registrars) increased by 5,045 (18%), from 28,046 to 33,091. In the period 2005 to 2006 the figure increased by 343 (1.1%).

3.43 Salaried GPs (GMS Other and PMS Other) represent 16.3% of the GP (excluding retainers and registrars) workforce, compared with 3% in 1997. In September 2006, the number of GMS Other and PMS Other (salaried) GPs had increased by 4,554 (538.3%) from 846 to 5,400 since 1997, of which all but 239 of this increase had occurred since September 2002. This compares with growth in the number of contracted GPs of 491 (1.8%) in the same period. In aggregate these two groups have provided an increase in GPs (excluding retainers and registrars) of 5,045 (18%) between 1997 and September 2006.

3.44 Between 1997 and 2006 the number of GP Registrars employed by the NHS increased by 935 (69.6%) from 1,343 to 2,278. In the period 2005 to 2006 the figure decreased by 286 (11.2%) from 2,564 to 2,278. The number of GP registrars has stabilised at historically high levels. The number of GP Registrars has risen by 75% from its lowest point in 1996. Although there has been a slight fall in numbers in 2006, the number of GP Registrars is still higher than any year prior to 2004.

3.45 General practice is an increasingly attractive option for junior doctors. In the 2007 recruitment, there were more suitable applicants than available training posts. All GP training programmes were filled by the end of the first round of recruitment.

ASSOCIATE SPECIALISTS AND STAFF GRADES

3.46 Between 1997 and 2006 the number of Associate Specialists employed by the NHS increased by 1,479 (109.5%) from 1,351 to 2,830. In the period 2005 to 2006 the figure increased by 276 (10.8%).

3.47 Between 1997 and 2006, the number of Staff Grade doctors employed by the NHS increased by 3,380 (132.2%) from 2,557 to 5,937. In the period 2005 to 2006 the figure increased by 410 (7.4%).

3.48 There is evidence of healthy recruitment and retention in these grades. The introduction of MMC will offer these doctors more opportunities to undertake further training and progress their careers.

CONSULTANTS

3.49 Between 1997 and 2006 the number of Consultants employed by the NHS increased by 11,400 (53.1%) from 21,474 to 32,874. In the period 2005 to 2006 the figure increased by 881 (2.8%).

INTERNATIONAL SUPPLY

3.50 The Department has invested in UK medical training and education. As a result the NHS is moving to a position of greater self-sufficiency and we are no longer centrally recruiting international doctors. Despite this the UK remains an attractive destination for international doctors who continue to apply for employment and training in UK and make an important contribution to the NHS.

CONCLUSION

3.51 Recent growth in the medical workforce has been sustained for a number of years. We continue to see a large number of new applications to medical school with medicine seen as an attractive career option. This has resulted in a very healthy recruitment and retention position which we believe will continue to be the case for some time.

CHAPTER 4: HCHS AND OTHER SALARIED DOCTORS PAY AND CONDITIONS OF SERVICE

INTRODUCTION

4.1 This chapter updates the Review Body on pay and conditions of service for employed doctors and hospital dentists in England. It sets out the overall package available to these staff groups, including proposed changes to the NHS Pension Scheme (NHSPS), the situation with regional and local pay pressures, the effects on average earnings growth of incremental progression, investment in pay reform for this remit group and the specific details of the key staff groups and the implications for overall recommendations.

4.2 Pay is only one element of the total reward package which staff receive. Other key elements include pensions, annual leave, opportunities for flexible working and work/life balance, career development and access to training.

NHS PENSION SCHEME

4.3 The DH has recently concluded extensive negotiations with trade unions and announced proposals to revise the NHSPS with effect from 1 April 2008. The proposals maintain a final salary pension scheme for NHS staff, protect normal pension age (NPA) for existing staff whilst introducing NPA 65 for new staff. Personal contributions will also be changed with the introduction of increased tiered personal contributions for most staff. Overall, these changes represent an improvement in the value of NHS pensions, once longevity is taken into account, which is why it is proposed that staff contributions should increase to pay for these improvements.

4.4 Under the existing NHSPS most employees contribute 6% of their pensionable pay, which represents a net payment of 3-4% after tax-relief. NHS employers pay 14% of pensionable pay towards the benefits package, which includes:

- Index-linked pension for life from age 60 of up to one-half pensionable pay at retirement;
- Unreduced pension from age 55 for many health professionals in post before 1995;
- One-off tax-free lump sum equal to three times annual pension;
- A range of family benefits; and
- For mental health officers, double pension accrual after 20 years, so that 40 years service can be accrued in 30 years.

NHS Pension Scheme review

4.5 The review of the NHSPS was undertaken by a partnership of NHS Employers and NHS Staff Side. On 21 September, the Review Partners announced they had completed their report and made recommendations to Health Ministers. Department of Health Ministers announced that they had accepted these recommendations and would now prepare consultation on draft regulations bringing the changes into effect from 1 April 2008. A summary of the main proposals is given below:

- **Existing members will:**
  - Retain their 1/80ths final salary pension and 3x pension lump sum
  - Retain their normal pension age (NPA) of 60 (55 for health professionals and mental health officers in post before 1995)

- Retain their current minimum pension age (MPA) of 50
- Gain the facility to commute further pension (up to a total of 25%) at the rate of £12 lump sum for each £1 foregone
- Gain the ability to nominate non-married/civil partnership partners for survivor pension cover for membership from 1988. Surviving partners will be able to retain their current pensions for life even if they enter into new partnership.

- **New entrants will:**

- Receive an index-linked, final salary pension, but with improved, 1/60ths accrual
- Have retirement benefits calculated on the average of the best three consecutive years in the members 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
- Have a NPA of 65 and a MPA of 55
- Gain the facility to take up to 25% of their pension as a tax-free lump sum, at the rate of £12 for every £1 of pension foregone
- Gain lifetime survivor pensions for nominated partners
- Gain the ability to draw-down part of their pension whilst continuing to work and build-up further pension
- Receive extra pension for service earned up to NPA65 if they continue to work beyond NPA65

4.6 The new arrangements will maintain a high quality, defined benefit, final salary scheme as an integral part of the NHS reward package. The employer contribution may rise to 14.2% from 2008 until 2016, but will be no more than 14% from 2016. In future, both existing and new entrant employees will pay tiered contributions according to the level of their whole time equivalent pensionable income. This will ensure that personal contributions better reflect the proportionally greater benefits that higher paid staff receive in a final salary pension scheme.

4.7 The higher employee pension contributions represent a transfer of reward from current to deferred pay, rather than a reduction in net remuneration. NHS pensions continue to be a very valuable benefit, and the closure of defined benefit schemes by some other employers means that the overall NHS employment package is becoming more competitive. The Review Body may wish to take this into account in assessing pay levels needed for purposes of recruitment and retention.

Comparability of the NHS Pension Scheme

Public Sector:

4.8 This section outlines the comparative value of the revised NHSPS. Most of the biggest public sector pension schemes have recently completed their reviews. These are not expected, on the assumptions underlying the reviews, to lead to any major changes in relative value between the aggregate memberships of the biggest schemes. Comparisons have therefore been based on the benefit structures before the reviews.

4.9 On a "net of member contributions" basis, the NHSPS is relatively less valuable than the civil service arrangements but broadly equivalent to the Teachers' Pension Scheme. It is slightly more valuable than the Local Government Pension Scheme, except for LGPS members who enjoy reserved rights to a normal pension age of less than 65. If the effects of NHS pay modernisation are as anticipated for the purpose of the NHSPS review, the NHSPS is expected to move closer to the upper end of the comparable

public sector arrangements in terms of overall benefit value, but under the proposed cost-sharing arrangements the “net of member contributions” value would remain broadly constant.

4.10 Brief details of the main public sector schemes are as follows:

- **Teachers scheme** - new arrangements were introduced in January 2007 retaining final salary 1/80th accrual and NPA 60 for existing members, whilst introducing a final salary 1/60th and NPA 65 for new members and cost sharing. Contribution rates in the Teachers’ scheme have been 14.1% of pensionable pay from employers, and 6.4% from employees.

- **Civil service scheme** - new arrangements were introduced in July 2007, retain final salary and NPA 60 for existing members and introduced a career average revalued earnings (CARE) scheme ‘Nuvos’, NPA 65 for new members, cost sharing and a 20% cap on employer contributions in 2012. Employee contribution rate to Nuvos is 3.5%.

- **Local government scheme** - has retained final salary and will introduce tiered contribution rates in April 2008. Cost sharing and employer cap will be introduced but details remain under discussion. Employer contributions to the Local Government Scheme are set locally and vary by local authority, but currently average around 13-14% of pensionable pay plus in most cases significant additional contributions being paid to address accumulated deficits. Employee contribution rates are also set at 5.0% or 6% of pensionable pay, but will move to tiered arrangements from April 2008. The contribution rates will then be 5.5% for members earning up to the full-time equivalent of £12,000, 5.8% £12,001-14,000, 5.9% £14,001-18,000, 6.5% £18,001-30,000, 6.8% £30,001-40,000, 7.2% £40,001-75,000 and 7.5% over £75,000. The earnings will be based on pensionable pay in the previous financial year or what would have been full-time pensionable pay for that individual.

- **NHS Pension Scheme** - under the NHSPS review agreement, new and existing staff will also pay tiered contributions on their whole salaries depending on the level of their full time equivalent pensionable income. The proposed rates are 5.0% for staff earning up to £19,165, 6.5% for staff earning £19,166 to £63,416, 7.5% for staff earning £63,417 to £99,999 and 8.5% for staff earning £100,000 and more, (where the first two contribution thresholds were linked to Agenda for Change pay points 17 and 49 respectively, and are expressed as April 2006[1] levels). The majority of members will therefore be required to pay an extra 0.5% on top of their existing contribution rate, but around 300,000 lower earning members will pay a rate 1% less. The highest earning members will pay a rate 1.5% or 2.5% higher. The main intention of this proposal was to reduce the cross-subsidy within the scheme between those with higher and lower rates of career pay progression and those who tend to do better in terms of career progression and often in terms of longevity will pay more than at present.

Private Sector:

4.11 Statistics taken from the first release of the ONS Occupational Pension Scheme Survey, 2006 (released July 2007) indicate that in April 2006, the NHSPS compared favourably

[1] The NHS Trades Unions have not formally accepted the 2007 pay offer as yet therefore pay details effective from 1 April 2006 have been quoted.

with UK private sector occupational pension schemes. Employer contributions to defined contribution (DC) schemes averaged at 5.8% of pay with employer contributions to open, defined benefit (DB) schemes similar to the NHSPS averaging at 14.2% of pay. However, it should be noted that the latter figure could include significant additional contributions being paid by private sector employers to address accumulated deficits, a situation which does not apply in the case of the NHSPS. It is therefore possible that the underlying cost of benefits accruing in DB schemes in the private sector is materially less than 14.2%, and the cost when DC schemes were also included would be lower still.

4.12 Care should be taken when comparing contribution rates in that the rates will vary according to the funding methodology and actuarial assumptions adopted. Also, where private sector employers offered a pension scheme to new staff, the proportion offering a defined benefit scheme continued to decline, to just over 60%, so that nearly 40% of members were offered only a DC arrangement under which they face all investment risks. Corresponding employee contribution rates were 3.0% (DC) and 4.9% (DB) respectively. It should also be noted that the 4.44 million membership of both open and closed private sector DB and DC arrangements shown in the ONS survey represents only around a quarter of total private sector employees.

REGIONAL AND LOCAL DIMENSIONS

4.13 London weighting is paid to HCHS doctors and dentists, GMP Registrars and salaried GMPs. In the last two reports, the Review Body agreed with our recommendation that London weighting should not be increased since recruitment and retention of doctors is less difficult in London than elsewhere in England. We would agree with the Review Body's judgement not to revisit this decision unless the evidence indicates that labour market conditions in London have changed.

4.14 The latest evidence on the distribution of medical and dental consultants and on the geographical and specialty variations in medical and dental vacancies (Statistical Tables 17 and 18) show that London continues to have higher than average consultant numbers (8.7 consultants per 10,000 population compared with an England average of 6.5) and lower vacancy rates (the three-month vacancy rate in London is 0.7% compared with an England average of 1.2%). We would ask the Review Body to agree that the rates of London weighting (£2,162 for non-resident staff and £602 for resident staff) should continue to be held steady in cash terms.

4.15 In our evidence for the 2006 review, we reported on the findings of the research we had commissioned from Aberdeen University into the effectiveness of regional pay to help address localised recruitment and retention issues for various NHS staff groups. In relation to doctors, this found no evidence that greater pay differentiation would be appropriate in tackling comparative recruitment and retention problems. Doctors operate in a national/international labour market. As the Review Body is aware, under the 2003 consultant contract there is provision for employers to pay a recruitment and retention premium of up to 30% of normal starting salary under certain circumstances. We are not seeking any further regional/local differentiation in doctors' pay for 2008/09.

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

4.16 As the Review Body noted in their last report, the existence of incremental pay scales means that, for most HCHS medical staff, the average increase in earnings will be

significantly above the level of the uplift as, in addition to the headline award, doctors who are not yet at the top of their pay scale have the opportunity to progress up the pay scale. For example, excluding the annual pay award, the pay of a specialty registrar who is not yet at the top of the scale increases by between 4.1% and 8.1% per annum (depending on the point they are on in the pay scale). The table at **Annex E** illustrates the combined effect of incremental rises and Review Body awards on individual doctors' pay by taking some illustrative examples over a five-year period.

4.17 The Review Body asked for information on the distribution of doctors by pay point to assess what proportion of doctors would potentially receive increments in addition to the annual pay award. Unfortunately, this information is not yet available within the Electronic Staff Record (ESR) Data Warehouse but work is underway to develop this field within the data warehouse for future use. Indicative figures produced by The Information Centre suggest that very few consultants on the new contract have reached the maximum pay threshold (Threshhold 8); around 25% are below Threshold 5 and therefore eligible for annual pay progression, and around 70% are on thresholds 5-7 and therefore eligible for pay progression in 1-5 years.

Pay drift

4.18 The NHS pay bill increases year-on-year as a result of a number of pressures, including workforce growth, the pay settlement and increases in the rates of employers' national insurance and pension contributions. In addition, it often increases significantly beyond the impact of these factors: this is termed pay or earnings drift. Pay drift is caused by many factors and local decisions, including new contracts, other changes to national pay arrangements, changes in the rate of workforce growth, changes in skill mix and the European Working Time Directive. This makes pay drift very volatile and difficult to predict.

4.19 In calculating the pay metrics at **Annex A**, we have used data from NHS Financial Returns and Foundation Trusts annual reports, coupled with NHS workforce census statistics to estimate total paybill and paybill per head over the last 10 years. We have additionally used NHS accounts data together with pension and NI rates applicable to NHS employers to estimate earnings and earnings per head. These paybill data reflect actual costs incurred by the whole NHS in England, and their accuracy is assured by reconciliation to the independently audited NHS accounts. The Information Centre has recently started to publish average earnings statistics using data from the NHS Electronic Staff Record. These should provide the basis for a sound time series going forward in the longer term, but in the absence of a time series, we consider that the DH metrics at Annex A provide the best estimate of earnings growth.

4.20 In the last few years, the main driver of pay drift for consultants has been the new contract. Over the last four years, pay drift for consultants has averaged 3.6% per year. In 2006/07, pay drift for consultants was 1.4% and we expect it to decrease a little further in future years as the new contract effects drop out. We predict that it will amount to 1.1% in 2007/08 and 1.0% in 2008/09.

4.21 For doctors in training, the main drivers of drift have been increased recruitment and the European Working Time Directive. These have reduced average earnings, although individual doctors' pay levels have been protected and will have increased as they move up incremental pay scales and grades. For the training grades, we predict that negative drift will continue in the short term, at 3% in 2007/08 and 2% in 2008/09 in line with the continuing reduction in working hours. In 2008/09 this negative drift is combined with the 0.33% increase in average earnings for the year resulting from the

hangover from the staged 2007/08 pay award to give the net drift of -1.7% shown in Annex A.

CONSULTANTS

4.22 Existing consultants are employed on either the old pre-reform contract (a five point incremental scale rising to £77,300) or the new post-October 2003 consultant contract which has eight pay thresholds ranging from £71,822 to £96,831. All new consultants are appointed on the new contract. At October 2005, fewer than 13% of consultants remained on the old contract; they have the opportunity to transfer to the new contract if they wish to do so.

4.23 The 2003 contract was designed to provide, over time, a 15% increase in career earnings and a 24% increase in the maximum basic salary. As **Annex A** highlights, average earnings per head for consultants have increased significantly since the introduction of the new contract; in the first three years of the contract, consultants average earnings have increased by 24%. 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. For example, if consultants are awarded a 1.5% uplift in 2008/09, we forecast that average earnings per head for consultants will rise by 2.5%.

4.24 The 2003 contract is based on a basic working week commitment of 10 programmed activities (PAs) each of which has a timetable value of four hours (with the exception of work done in premium time). Additional PAs that attract additional pay can be arranged by agreement between the consultant and his/her employer through annual job planning. Consultants are required to offer an additional PA to their NHS employer before undertaking any private work.

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

4.26 On 19 April 2007, the National Audit Office (NAO) published their report on the consultant contract. Their findings show that the contract has helped to align consultants' pay levels with their contribution to the NHS. The report showed that the contract has helped to deliver some of the key aims of this pay reform:

- consultants' hours have reduced in line with the European Working Time Directive, whilst the proportion of their working time spent on direct clinical care has increased;

- pay drift decreased in 2005/06;

- the contract has improved trusts' management of consultants, which could lead to improved productivity (although the report states that it is too early to assess the impact on productivity);

- there has been no increase in private practice;

- Trusts are able to secure additional consultant time at plain time rates; and

- the number of consultants has increased beyond the normal rate of expansion.

4.27 The NAO identified that the contract has the capacity to provide further benefits, but has yet to be fully used to achieve these. Work is already in progress in the NHS - eg on productivity measures, and spreading best practice, in getting the benefits of the contract. We expect the Public Accounts Committee report to be published later this year, and a full Government response will be published subsequently.

Clinical Excellence Awards

4.28 The Clinical Excellence Award (CEA) scheme, introduced in 2003, replaced the previous consultant reward schemes – discretionary points (DPs) and distinction awards (DAs) – though awards made under these previous schemes remain in payment until award holders retire or are awarded a CEA. 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 £2,850 (CEA level 1) and £73,068 (CEA level 12). All levels of CEA, DA and DP are pensionable. The Advisory Committee on Clinical Excellence Awards (ACCEA) have reported that as at June 2007, 59% of eligible consultants held an award (CEA, DP or DA) and 13% of consultants held a CEA at or above level 9 or a distinction award (representing between £34,200 and £73,068 each).

4.29 For 2008/09, we believe that the numbers of new bronze, silver, gold and platinum awards should again be determined by the ACCEA having regard to the available funding and the number of awards released at each level through retirements, resignations, withdrawals and progression through the scheme. We propose that the value of clinical excellence awards, distinction awards and discretionary points should be increased in line with the award we propose for all salaried medical grades..

NON-CONSULTANT CAREER GRADES

4.30 In May 2004 the Secretary of State for Health announced that the Government had accepted in full the recommendations of the '*Choice and Opportunity*' report about modernisation of the non-consultant career grades. As a first step in taking the recommendations forward, the Department of Health commissioned the NHS Confederation to scope the need for a detailed review of NCCG pay and terms and conditions of service, so that we can best recognise, value and reward these doctors.

4.31 The NHS Confederation delivered a report in December 2004. They made a number of recommendations regarding reform of the structure of the pay scale and the introduction of a more robust contractual mechanism along the lines of the consultant contract, but found no evidence or argument for significant alteration of the overall pay range.

4.32 The Government accepted the NHS Confederation's recommendations and, in January 2005, the Department of Health asked NHS Employers to enter into negotiations with the BMA for new contractual arrangements.

4.33 The two parties submitted proposals for a new contract to the Department of Health and the Devolved Administrations in November 2006. The Government subsequently sought further information in light of the NAO report into the consultant contract to ensure that any new contract for staff grade and associate specialist (SAS) doctors would deliver benefits for doctors, patients and the wider NHS and provide value for

money for the taxpayer. This information has been received and the proposals are being considered by Government A decision is expected imminently and we will provide the Review Body with further information should there be movement during this year's round.

HOSPITAL DOCTORS AND DENTISTS IN TRAINING

4.34 The introduction of the New Deal contract for junior doctors in 2000 provided a mechanism for rewarding these doctors appropriately for the hours they worked 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 junior doctors 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. The banding multipliers are now free-standing and reviewed annually by the Review Body. For posts which comply with the New Deal, the banding supplements are currently: Band 1C – 20%; Band 1B - 40%; Bands 1A and 2B – 50%; Band 2A – 80%. Doctors in non-compliant posts are paid a Band 3 supplement of 100%.

4.35 Compliance with the New Deal is monitored by NHS Employers. Since March 2005, 98% of doctors in training have been fully compliant with the New Deal compared with 88% in March 2004 and 71% in 2001. Tables 9 and 10 show the latest data on New Deal compliance in England analysed by grade and by specialty.

4.36 As we reported last year, whilst total duty hours for doctors in training have fallen considerably since the introduction of the New Deal contract, for many doctors from a maximum of 72 to 56 per week, there has not been a corresponding drop in average earnings.

4.37 For example, the table below shows the movement of PRHO/F1 pay from the implementation of the new contract to the end of the current pay period. Over that period, basic salaries have risen by 23.9% and typical overall pay by 15.2%, against inflation of 20.2% (using HM Treasury GDP deflator figures).

4.38 The reduction in typical pay since 2004 results from the reduction in working hours, as the New Deal and the Working Time Directive impact on working patterns. We expected doctors' earnings to fall with hours as a result of the New Deal, as the disincentive to higher hours in the form of high multipliers took effect. These reductions in total pay must be weighed against the benefits of reduced hours and a more family-friendly working environment.

PRHO/F1 Pay – 2001 to 2008

Date	Basic salary	Average multiplier	Typical Pay	Increase on 2001 (basic pay)	Increase on 2001 (total pay)	Inflation (GDP deflator)
March 2001	£17,260	1.56	£26,926	0.0%	0.0%	0.0%
March 2002	£17,935	1.57	£28,158	3.9%	4.6%	2.4%
March 2003	£18,585	1.74	£32,338	7.7%	20.1%	5.6%
March 2004	£19,185	1.71	£32,806	11.2%	21.8%	8.7%
March 2005	£19,703	1.60	£31,525	14.2%	17.1%	11.7%
March 2006	£20,295	1.57	£31,863	17.6%	18.3%	13.9%
March 2007	£20,741	1.52*	£31,526*	20.2%	17.1%	17.0%
March 2008	£21,391	1.50**	£31,017**	23.9%	15.2%	20.2%

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

* The multiplier is taken from the latest figures available being those from September 2006.

** The multiplier is estimated from previous trends, and inflation based on HMT estimates.

4.39 By summer 2009, all doctors in training should be working no more than 48 hours a week and, as a consequence, will receive a maximum supplement of 50% of basic salary. As we reported last year, we are pleased that working hours and average multipliers are falling and would not want to see any adjustment at this time to a system which is working as intended.

Salary comparisons with other professions

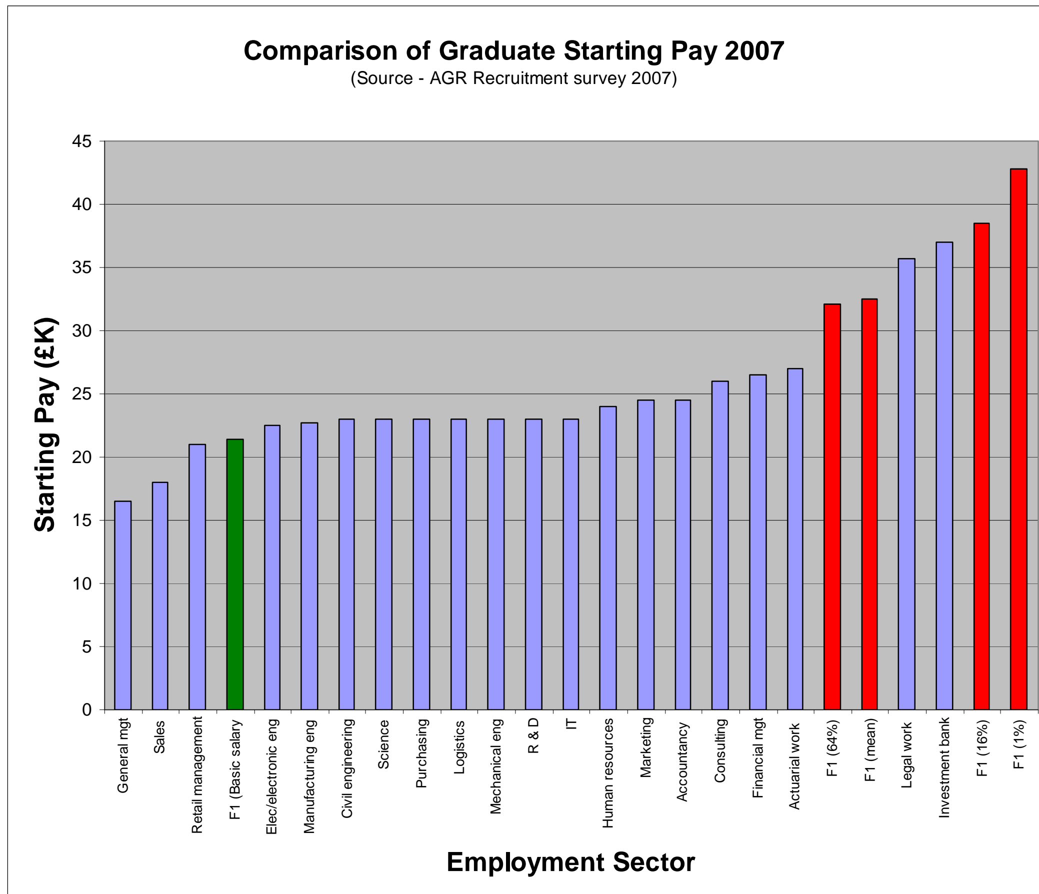
4.40 For medical graduates entering their first post, total pay remains very competitive, particularly once account is taken of the availability of posts. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in their ability to enter their chosen career. All medical students can reasonably expect to obtain an NHS training post on graduation; indeed in the 2007 recruitment round 93% were able to take up a post in their first choice location. This compares with a mean of 29.2 applications per vacancy in the general graduate marketplace; the legal profession, with which medicine is often compared, attracted 29 applicants for each vacancy, and no employer reported fewer than 10 applicants per graduate vacancy.

4.41 A recent survey by the Association of Graduate Recruiters[1] reported that between 2006 and 2007 the median starting salary was expected to have risen by 2.4% (against the 2.5% awarded to doctors in the same period). In respect of starting salaries for 2008, 15.9% of the employers surveyed expected pay to remain static at 2007 levels, 39.8% believed that salaries would rise to reflect the rise in the cost of living, while 19.4% expected pay to rise by more than the cost of living. About a quarter were not prepared to commit to a figure.

4.42 The chart below shows a comparison between the pay of junior doctors in their first post and the pay of graduates entering other professions using data taken from the AGR survey. The four columns in red, as in previous years' evidence, show the range of actual starting pay for first year Foundation (F1) trainees (ignoring the value of accommodation currently provided free in the pre-registration year). Basic F1 salary is shown in green for reference. Using the latest banding figures available from

[1] Recruitment Survey Summer 2007, Association of Graduate Recruiters

September 2006, the chart shows the percentage of doctors on each of the three main pay bands in addition to the mean, which for F1 trainees is £32,514, with 81% earning £32,087 or more. This continues to stand up well against other professions, comparable with and in some cases exceeding even the starting salaries for investment banking and legal work, where there were respectively 26 and 29 applications for each vacancy.



4.43 Most junior doctors, in all grades, earn in excess of basic salary through the banding multipliers. The average banding supplement in September 2007 for compliant posts is expected to be of the order of 50% based on previous trends; the results of monitoring carried out in October 2007 are expected to confirm this. In their last report, the Review Body commented that juniors' total earnings appeared good, but that the level of basic pay appeared lower than comparator groups. They noted, however, that this did not appear to be a deterrent to recruitment.

Banding Multipliers

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

4.45 In their last report, the Review Body invited the parties to start giving consideration to restructuring junior doctors pay from 2009, including the banding multipliers. Our continued view is that it is too early to do so. The banding supplements are at an appropriate level to reflect hours and intensity and we wish to see the full effects of the

European Working Time Directive (EWTD) and of *Modernising Medical Careers* (MMC) before introducing any changes. However, some changes have been made to junior doctors' pay scales as a result of the introduction of new *MMC grades*. In particular, the PRHO, SHO and SpR pay scales have been mapped across to the new MMC grades on a cost-neutral (or cost-minimal) approach to ensure no detriment to the pay of doctors in training.

4.46 We would also point out that we are concerned to ensure an adequate supply of training places for the increasing number of students leaving medical school. We would therefore ask the Review Body to take into account the NHS need to be able to fund adequate training places in setting pay as funds used in unnecessary pay awards will inevitably reduce those available to fund additional training places.

Accommodation Costs for First Year Foundation Trainees

4.47 Changes to the Medical Act made in August 2007 remove the requirement for pre-registration doctors to be employed in a 'resident medical capacity'. This is likely to result in the withdrawal of free accommodation for First Year Foundation (F1) trainees from August 2008. We recognise that doctors may argue that they are losing a significant benefit which should be replaced by a substantial increase in salary. We believe that the removal of the residency requirement for F1 trainees is an improvement in their conditions of service and reflects the improvements in their working hours. As salaries are already competitive even without free accommodation (which is reportedly not used by a third of trainees), and taking into account the virtual guarantee of a post on graduation, there is no case for increasing salaries to reflect this change.

GENERAL MEDICAL PRACTITIONER SERVICES

GMP Registrars

4.48 The Review Body will recall that the supplement paid to GMP registrars (currently 55% of basic salary) is intended to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged in relation to hospital doctors in training. As the Review Body commented last year, GMP registrars receive this substantial supplement despite having working patterns which are less intense than doctors training in hospitals. The average banding supplement paid to hospital doctors has fallen to 52% in England, and we believe that there should be a further reduction in the supplement paid to GPRs. We would ask the Review Body to reduce the GPR supplement to 50% for 2008/09.

GMP Trainers

4.49 The flat rate grant paid to GMP trainers is currently £7,287. In addition, in 2005/06 and 2006/07 a £750 supplement, recommended by the Review Body in its 34th Report, was paid to GMP trainers to boost their continuing professional development. We noted, in agreement with the BMA and the Committee of General Practice Education Directors (COGPED), that the Review Body's 36th Report did not require the payment of this supplement in 2007/08.

4.50 As we reported in our evidence last year, Ministers in England accepted the recommendations in the report of an independent review of GP trainers' pay, incorporating views from the Department of Health, the BMA and other stakeholders, which was completed in June 2006. In its 36th Report, the Review Body acknowledged

that further work was required to develop the proposals and indicated that progress would be expected. Unfortunately this further work has been delayed in 2007. This is largely due to the unprecedented demand for resources to address the issues in postgraduate medical training arising from the difficulties with the recruitment and selection process used for the implementation of new specialty training programmes as part of the Modernising Medical Careers initiative. However, the Department is now liaising with COGPED to map out a process for how this work can now be taken forward.

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

GMP Educators

4.52 A GP educators' payscale was introduced in 2003/04 following agreement between the Department of Health, COGPED and the BMA's General Practitioners' Committee. We have seen no evidence to suggest that the GP educators' payscale needs to be amended and ask that the Review Body recommend an uplift in the GP educators payscale of no more than the increase we are seeking for other salaried doctors.

Salaried GMPs

4.53 As we reported last year, the salary range for salaried GMPs employed by Primary Care Organisations, which was agreed in May 2003, was designed to be wide enough to cover the range of possible roles that salaried GMPs might be required to undertake, with starting pay, progression and review determined locally. The model terms and conditions of service for salaried GMPs are intended to be the minimum, with employers free to offer more favourable terms to reflect local needs and circumstances. The salary range for 2007/08 is £51,332 to £77,462. The Department of Health has seen no evidence to suggest that the current salary range is inappropriate.

4.54 The table shows the average net income of a salaried GMP based on information provided by HM Revenue and Customs (HMRC):

UK GPMS GMPs

Financial Year	**Average Total Net Income £**
2002-03	45,907
2003-04	47,069
2004-05	45,560
2005-06	46,905

Notes:

The figures in the table above are averages and include the incomes of both full and part-time GMPs. The figures also include income from all sources, including private.

See detailed 2002-03, 2003-04, 2004-05 and 2005-06 HMRC figures and explanation at:

http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-2002-03

http://www.ic.nhs.uk/servicesnew/GMPsearnex04

http://www.ic.nhs.uk/pubs/GMPsearnex0405/earnexrep/file

http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-enquiry-2005-06--initial-results

4.55 In 2005/06, the average net income of a salaried GMP was £46,905 based on HMRC figures. The results of a recent workload survey (see below) indicates that the average

salaried GMP works 23.8 hours per week. This suggests that a full time salaried GMP receives around £74,000 per annum.

4.56 The Department and others will not be able to estimate with any authority the average income of a salaried GMP for 2006/07 until the Inland Revenue survey of GMPs' earnings and expenses is published (usually some 18 months after the end of the tax year). This means that the 2006/07 figures will not be available until Autumn 2008 at the earliest.

4.57 On 31 July 2007, the Information Centre for Health and Social Care (IC) published the results of its 2006/07 UK General Practice Workload Survey. The IC's Workload Survey report, which has been agreed by representatives from the four UK Health Departments, NHS Employers and the BMA, provides an overview of the workload and skill mix of general practices in the UK in 2006/07. It is the first such survey since 1992, and more importantly since the introduction of the new GP contract in April 2004. It provides a clear indication of the impact the new contract has had on GMP workloads.

4.58 The headline message from the survey is that the average salaried GMP works 23.8 hours per week, (which compares favourably with the average self-employed GMP who works nearer 36 hours per week – and a full time self-employed GMP who works nearer 42 hours per week). This evidence suggests that salaried GMPs are more likely to work flexible part-time hours than their self-employed counterparts.

4.59 The evidence suggests that there are no problems with recruiting or retaining salaried GMPs. Increasingly, practices are employing salaried GMPs. As at September 2006, there were 33,091 GMPs (excluding retainers and registrars), of which 5,400 (some 16%) were salaried. This reflects a marked change over a short period. In September 2005 there were 32,738 GMPs of which 3,398 (a little over 10%) were salaried. This trend toward salaried GMPs is expected to continue in the future. 2006 census data indicates that about 93% of salaried GPs in England are employed by GP practices and 7% by primary care organisations.

CHAPTER 5: INDEDENDENT CONTRACTOR GENERAL MEDICAL PRACTITIONERS

INTRODUCTION

5.1 General medical practitioners (GMPs) can earn income from a wide variety of professional activities. The majority of GMPs (we estimate about 85%) are independent contractors, all of whom operate under a "practice based" contract arrangement.

5.2 Earlier this year, the Review Body recommended a zero increase in independent contractor GMP pay for 2007-08. In its Thirty Sixth Report, the DDRB outlined the basis for its recommendation (paragraph 3.30 of the Thirty-Sixth Report refers). The DDRB based its recommendation on a number of factors which, when taken together, led the Review Body to the conclusion that , for the year 2007/08, GMPs' workload and current pay level did not warrant any increase to their overall pay.

5.3 The Government appreciates that this situation may not be static in future years. Much of the thrust of current Government health policy is the shift from services delivered in secondary care to delivering a greater proportion of these services in primary care, closer to patients' homes, and provided in a more familiar and reassuring setting. This policy has recently been endorsed by the Royal College of General Practitioners report *The Future Direction of General Practice: A roadmap* and is being given further weight by the NHS Next Stage Review.

5.4 The Government intends that GMPs should be rewarded where they take on additional work of this kind. However, Primary Care Trusts (PCTs) will commission additional services of this kind either out with the GMS contract, or as enhanced services. Such investment may lead to increases in GP pay, but this would be determined locally, based on the provision of additional services and continuing improvements to patient care.

5.5 Much of the following updates the information we provided to the DDRB in our last round of evidence. The updates strongly confirm that the factors used by the DDRB to determine its recommendation for GMP pay under the GMS contract in 2007/08 are still pertinent when considering a recommendation for 2008/09.

SUMMARY

5.6 Overall, the Government sees no justification for uplifting GMP pay for 2008/09 in the absence of corresponding improvements in the level and quality of services provided**.**

5.7 The Government has invested significant extra funding in GP services, both to improve services and reward GMPs. We expect GMPs to invest a proportion of the money they earn back into their businesses in order to maintain and improve patient services. Historically this investment has been in the order of 60% but by 2005/06 this had reduced to 55%. This means that GMPs now retain a significantly higher proportion of their earnings as profit.

5.8 Since the introduction of the new GMS contract:

- **there has been significant growth in investment in primary medical care**
  - ➢ the new GMS contract was backed by a guaranteed 36% increase in resources in England – over the period 2003/04 to 2005/06. The increase in resources over the same period was actually 52%.

- the NHS now spends £7.8 billion on primary medical services compared to £5.1 billion in 2002/03

- **GMP pay has increased significantly in cash and real terms relative to other NHS staff**

  - on a cash basis, pay has increased by 55% over the period 2003/04 to 2005/06 (the period for which HMRC data is available). This compares to a cash increase of 25% for consultants and 12% for nurses over the same period
  - in real terms by in excess of 43% over the same period, compared to 15% for consultants and 4% for nurses.
  - UK GPs are already the best paid in Europe and possibly wider

- **GMPs are retaining a much higher proportion of their earnings as profit**

  - traditionally GMPs reinvested 60% of their earnings back into their practice. This figure fell sharply in 2004/05 and, still further in 2005/06 and is now 55%, i.e. for every £1 of their earnings GMPs took 45 pence as profit in 2005/06, compared to 40 pence in 2003/04
  - many of the costs incurred by practices (such as premises) are reimbursable and most other costs (such as practice staff salaries) are controlled by practices themselves

- **GMP workload has decreased significantly**

  - the number of hours worked per week has fallen significantly (the latest evidence suggests a reduction of 7.2 hours per GMP, i.e. a fall of some 17%)
  - thanks to workforce growth, the average GMP is looking after fewer patients. The average list size for each GMP has fallen from 1,820 in 1996 to 1,610 in 2006 - a reduction approaching 12%
  - the average number of patients seen by a GMP in surgery consultations has dropped from 122 a week in 1992/93 to 88 a week in 2006/07 (a reduction of nearly 30%). Whilst in total the number of consultations undertaken within general practice has increased over recent years, much of the increase has effectively been borne by increases in the role and number of practice nurses
  - the time spent by a GMP on home visits has fallen from 8.8 hours (22 patients) a week in 1992/93 to a current figure of 3.3 hours (8 patients) – a reduction of some 63%
  - the time a GMP spends on telephone consultations has gone down from 3.5 hours a week in 1992/93 to a current figure of 2.4 hours – a reduction of 31%. Both the volume of telephone consultations per week and the amount of time per patient have decreased
  - by 2006 there were 62.1 practitioners per 100,000 population compared to 54.5 in 1995 – an increase of just under 14%
  - most GMPs have exercised their right to opt out of providing some services, e.g. out of hours care.

- **job satisfaction has increased significantly**

- morale has improved, largely due to increases in pay, reductions in workload and improved work-life balance through out-of-hours opt out (although some GPs still do some out of hours work)
- job satisfaction scores among GMPs are generally high and have risen since the new GP contract was introduced
- GMPs (particularly those working part time) have a higher level of leisure time satisfaction than hospital doctors and scores in this area have risen over recent years
- there has been a sharp rise in GMP satisfaction with career prospects over the period 2002 to 2005
- the new GP contract has made it more financially practicable and affordable for GMPs to work part time. One in four GMPs now work part time compared to one in seven a decade ago

5.9 There is no evidence to suggest that there are any problems with recruiting or retaining GPs**:**

- we continue to see strong growth in GMP numbers, though many of these are flexible workers and salaried GPs rather than partners;
- as at September 2006, there were 33,091 GPs (excluding retainers and registrars), the highest number ever and an increase of 353 on last year;
- the estimated 3-month vacancy rate for GPs has fallen from 2.4% in 2005 to 0.8% in 2007
- the number of GP Registrars is also very healthy. There are now 2,278 in total which is 935 (70%) more GP Registrars than in 1997;
- with a high level of demand for places. In 2007, approx 9,000 UK doctors made 22,000 applications for 3,862 advertised posts.
- general practice now provides new, more flexible, well paid and exciting career opportunities.

5.10 Taken together, these facts provide no justification for an increase in GMP pay for 2008/09 in the absence of corresponding improvements to the level or quality of services provided. Moreover, excessive or unaffordable pay increases to any staff group will affect the wider NHS, and could potentially lead to staff losses. These would be unlikely to affect GMP contractors directly as, under the nGMS contract, no self-employed GMP contractor is at risk of redundancy, or of losing their contract with their PCT. Any losses would therefore fall disproportionately on other staff groups.

5.11 If the Review Body did decide to recommend any uplift for GMP pay for 2008/09, it would be essential in our view that such a recommendation were dependent on:

- changes to other GMP income streams
- the achievement of efficiency gains by general practice, which as a minimum would have to be consistent with the measured expectations placed by Government on other sectors within the NHS
- improving equity of income distribution, i.e. movement on the Minimum Practice Income Guarantee
- improvements to the Quality and Outcomes Framework
- realigning the earnings to expenses ratio

5.12 We also believe that if the DDRB were to recommend any uplift on GMP pay, it should consider the case for a balancing mechanism to address the significant shift in the expenses to earnings ratio and levels of funding above that negotiated through the Gross Investment Guarantee. It is principally these factors that have led to a disproportionate increase in GMP pay/practice profits.

BACKGROUND

5.13 The new GMS contract introduced a fundamental change to general practice, moving away from remuneration based on incomes for individual doctors to a practice-based contract. Significant aspects of the new arrangements included:

- workload control (the ability to opt in and out of services);
- new and significant earning opportunities relating to additional work or improved quality provision;
- an explicit focus on the delivery of high quality care based on best practice with a robust evidence base through the Quality and Outcomes Framework;
- greater engagement and accountability between practices and PCTs, supported through performance monitoring.

5.14 It is worth reiterating the points we made in the introduction to our evidence for the 2007/08 round:

- GMP remuneration and the new General Medical Services (nGMS) contract are not one and the same thing. There is no direct or sole relationship between nationally agreed contract income and overall GMP remuneration.
- the nGMS contract provides practices with a level of income for taking on the responsibility for delivering particular services to patients. The practice also receives income outside the contract, either for services provided under local arrangements with PCTs or for work undertaken for the private sector. Some practices also receive income under national dispensing arrangements.
- The contract is with the practice (a legal entity), not individual GMPs.
- These practice-based organisations contain a mix of professions (eg nurses and practice managers), not just GMPs, all of whom either draw pay or earn a “profit” from the income the practice receives for providing services, including that received through the nGMS contract.

5.15 For these reasons, a complex relationship exists between:

- the income that practices receive from the different funding streams available both within and outside the contract
- the way earnings and expenses are shared (as profit or as net pay) between the different members of the practice
- the pre-tax profits or “take-home pay” of individual GMPs

5.16 This complexity is evident when attempting to assess the effect on GMP pay of uplifting different income streams. Therefore, whilst we recognise the DDRB’s legitimate role in making recommendations on GMP remuneration, we consider that it is not reasonable or practicable to expect the DDRB to price any elements of the new GMS contract.

INVESTMENT IN GENERAL PRACTICE 2003/04 TO 2007/08

Gross Investment Guarantee

5.17 The Government promised significant investment in primary medical care (an increase of 36% in England over the level of investment in 2002/03) in return for delivery of a wider range of higher quality services.

5.18 Negotiators of the original nGMS contract agreed to measure the guaranteed 36% increase in resources for the three-year period ending 2005/06, through the Gross Investment Guarantee (GIG). The England GIG and actual spend figures (based on PCT expenditure returns) are detailed in the table below. This information shows that for all three years there was more investment by the Government than was guaranteed.

5.19 The GIG only applied to the first three years of the new contract. Since then, investment in general practice has levelled out. The NHS now spends £7.8 billion on primary medical services compared to £5.1 billion in 2002/03:

Financial Year	**Guaranteed Investment (GIG)**		**Outturn**		**Over**
	£ billion	**Cumulative % increase**	**£ billion**	**Cumulative % increase**	**£ billion**
2002-03 (baseline)	5.1				
2003-04	5.6	10%	5.8	14%	0.2
2004-05	6.2	22%	6.9	35%	0.7
2005-06	6.9	36%	7.7	52%	0.8
2006-07			7.8	53%	
2007-08			7.8	53%	

5.20 This level of investment will increase in future years as a consequence of the package of measures announced in the interim report on the NHS Next Stage Review. The report gives a Government commitment to establish at least 100 new GP practices in deprived areas and at least 150 new GP-led health centres across the country.

5.21 These measures represent a significant new investment in primary care and existing GP practices (or GP federations), who will have the opportunity to bid for this work alongside other potential providers.

RISING GP PROFITS

2002/03 to 2005/06

5.22 The following table, which is based on information provided by HMRC, shows the significant increase in gross earnings, percentage profit and net income for the average GMP during the period 2002/03 to 2005/06:

UK GPMS GMPs						
Financial Year	**Gross Earnings**	**Total Expenses**	**Net Income (before tax)**			**Expenses to Earnings Ratio**
	£	**£**	**£**	**% Annual Increase**	**% Cumulative Increase**	
2002/03[(1)]	183,136	110,822	72,314	-	-	60.5
2003/04	201,630	120,064	81,566	12.8	12.8	59.5
2004/05	230,096	129,926	100,170	22.8	38.5	56.5
2005/06 [(2)]	245,020	135,016	110,004			
2005/06 [(3)]	246,987	135,016	111,971	11.8	54.8	54.7

(1) Based on GB results and restated to equivalent UK basis

(2) Headline 2005/06 figures

(3) Headline 2005/06 figure restated for estimated 2004/05 PCO Clawback

Note:

The figures in the table above are averages and include the full range of general practitioner results, including dispensing doctors. However, the inclusion of dispensing doctor results does not significantly distort the average picture. The figures also include income from all sources, including private.

See detailed 2002-03, 2003-04, 2004-05 and 2005-06 HMRC figures and explanation at:

http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-2002-03

http://www.ic.nhs.uk/servicesnew/GMPsearnex04

http://www.ic.nhs.uk/pubs/GMPsearnex0405/earnexrep/file

http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice

5.23 The 2003/04 figures incorporate only a small proportion of the changes and increased investment associated with the new GMS contract. Financial year 2003/04 was, to a large degree, one of transition from the old contract to the new, which effectively only came fully into effect from April 2004.

5.24 The 2004/05 figures are the first year when the effects of the new GMS contract are fully apparent.

5.25 In 2005/06, the Quality and Outcomes Framework (QOF) payment to practices increased from £77.50 per point to £124.60. Overall, practices gained in excess of a further £0.4 billion in their annual earnings, which largely translated to an increase in profits, helped by their increased ability to delegate functions to nurses.

5.26 On 31 October, the NHS Information Centre published the 2005/06 GP Earnings and Expenses Report. Part of their analysis involves an adjustment to the earnings and net profit figures in order to take into account a change (since 2003/04) in the way employers' superannuation contributions feature in the HMRC provided data. This adjustment, which reduces the reported earnings/net profit figures, is essentially designed to enable comparison between 2005/06 and figures reported for earlier years.

5.27 The Information Centre report shows that there has been a significant increase in the adjustment year-on-year between 2004/05 and 2005/06. In 2005/06, the adjustment totals £11,764 per GP against a total adjustment of £6,234 in 2004/05. Whilst the adjustment is made up of broadly four components, the report does not quantify their individual effect on the earnings/net profit figures. However, the analysis provided in the report suggests that a significant proportion of the £5,530 increase in 2005/06 can be attributed to a "one-off" payment of superannuation contributions that related to 2004/05. Further, it would be reasonable to estimate that this one-off payment, known as PCO clawback, deflated the reported 2005/06 net profit figure by £1,967.

5.28 This figure assumes that on 1 April 2004, GPs (in assessing what superannuation contributions to pay over to the Pensions Agency during 2004/05) forecast a 5% increase in their 2004/05 superannuable income.

5.29 It should be noted that on 1 April 2004, GPs would not have had access to their 2003/04 results. The only firm information available at that time would have been the 2002/03 GP pay figures, which reflected broadly a 5% increase on the year before. It also seems to be the trend that GPs tend to under-state their forecast superannuation contributions, possibly due to cash planning considerations. However, what marks out 2004/05 is the scale of the clawback figure likely to be involved and its distorting effect.

5.30 In other years, the scale of under-payment is probably modest, i.e. a small under forecast in superannuation contribution payments caught up the following year. In 2004/05 the actual increase in superannuable pay was over 18%, a figure very few GPs, if any, factored into their forecasts.

5.31 The Table at paragraph 5.22 reflects the increase in GP pay/practice profits when restating the 2005/06 figure to take account of the one-off nature of PCO clawback relating to 2004/05. We believe this figure is more representative of the underlying increase in GP pay/practice profits in 2005/06.

5.32 The figures in the table contained at paragraph 5.22 reflect the position for an average GMP. The table below shows the distribution of net income, or profit, received by individual GMPs in 2003/04, 2004/05 and 2005/06:

UK GPMS GPs – net income (before tax)						
Financial Year	**Less than £50k**	**£50-£100K**	**£100-£150k**	**£150-£200k**	**£200-£250k**	**More than £250k**
2002-03	7,842	20,493	3,875	221	0	0
2003-04	5,138	19,883	6,469	904	222	0
2004-05	3,060	15,442	12,264	2,492	475	154
2005-06	2,001	12,342	14,534	3,876	815	307

5.33 The table demonstrates a dramatic movement by GMPs into higher income brackets over the three years since the new GP contract was introduced. Overall, 19,532 GMPs in the UK (58%) received £100,000 or more as net income in 2005/06, with just over 3% earning more than £200,000. This compares to 2002/03, when some 4,096 GMPs (13%) received a net income of £100,000 or more.

5.34 The 2005/06 income/profit figure of £111,971 includes those sums earned by part time GMPs. If these are taken out of the equation, we estimate the income/profit share of a GMP working full time to be around £136,000.

2006/07 & 2007/08

5.35 The Department will not be able to confirm the average GMPs earnings, expenses and net incomes for 2006/07 until the Inland Revenue survey of GMPs earnings and expenses is published (usually some 18 months after the end of the tax year). This means that the 2006/07 figures will not be available until Autumn 2008 at the earliest. Similarly, the information for 2007/08 will not be available until Autumn 2009. However, based on the HMRC figures produced for 2002/03, 2003/04, 2004/05, and 2005/06, and other available data, we have produced GMP pay/profit estimates for the period 2006/07 to 2007/08. These estimates factor in assumptions on:

- PCT investment in general practice
- changes to the earnings/expenses ratios
- efficiency savings within general practice
- increases in the number of salaried GPs (and associated costs)
- decreases in the number of "profit sharing" GMPs
- the extent to which GMPs may have benefited from the release of resources from the secondary care sector, supported by Practice Based Commissioning. We believe that many GPs will have been able to release resources to develop primary care services.

5.36 Our estimates suggest that GMPs have been successful (more than the Department originally envisaged) in driving down their costs (and maintaining profits) in response to the 2006/07 negotiated settlement and the DDRB's recommendation for 2007/08.

5.37 The table below details current DH forecasts on total GMP pay/practice profits (includes all sources of income, including that received for work undertaken for the private sector):

Year	**Year on Year Cash Increase (%)**	**Cumulative Cash Increase (%)**
HMRC data:		
2003/04	13%	13%
2004/05	23%	39%
2005/06	12%	55%
Estimates:		
2006/07	1%-2%	56%-57%
2007/08	0%-1%	56%-59%

5.38 These figures suggest that on a cash basis, total GMP pay/practice profits will rise by an estimated 59% over the period 2003/04 to 2007/08. Over the same period, the cumulative increase in the earnings of consultants and qualified nurses was 31% and 22% respectively. Based on HMT's latest GDP deflator, in real terms, total GMP pay/practice profits will rise by an estimated 35% over the same period. Comparable figures for consultants and nurses are 15% and 7% respectively.

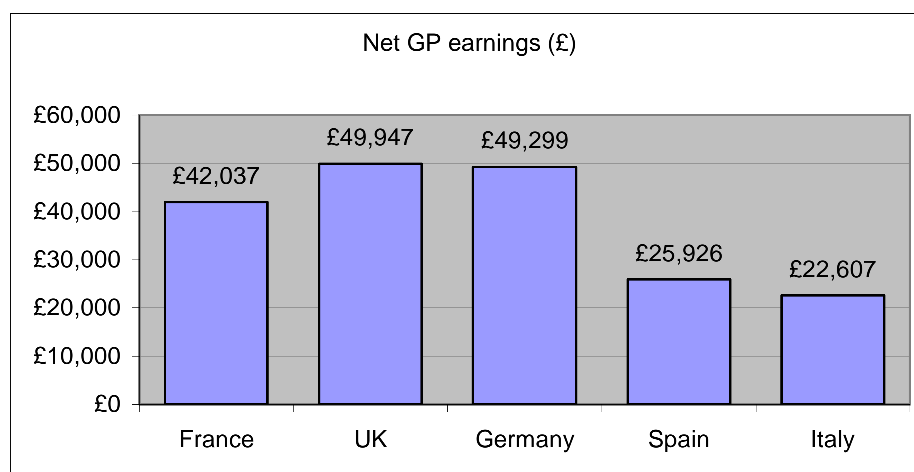
5.39 We anticipate that the pay position of independent contractor GMPs remains very favourable relative to other professional groups:

INTERNATIONAL COMPARISON

5.40 A report by the Health Policy and Economic Research Unit published in 2005 showed that, as at 2004, UK GMPs' earnings were broadly comparable with their fellow professionals in other countries and that their position on the "earnings board" had improved significantly in that year. The report acknowledged that the new GMS contract had contributed considerably to this, as had the advantages, in terms of earnings, of being self- employed.

Average Remuneration of Self Employed GPs (OECD data) **US $ exchange rate**				
	2001	**2002**	**2003**	**2004**
Canada	80,066	79,876	91,475	101,271
Germany	82,143	88,460	108,639	122,020
Switzerland	117,242	132,211	160,206	180,442
United Kingdom	81,899	91,967	109,453	151,959
United States	135,036	141,923	147,458	150,702

5.41 Evidence taken from the research firm Stethos' GP survey (and supported by the BMA in their 2005 Memorandum of Evidence to the Review Body) suggests that UK GP earnings at that time were ranked the highest in Europe. The following table shows the comparisons published in 2005 between GPs' earnings in the UK compared with their European equivalents. The figures in the table below are after tax:



5.42 It is likely that GMP pay will continue to compare well against European counterparts for the foreseeable future.

EXPENSES TO EARNINGS RATIO

5.43 GMPs are expected to invest a proportion of the income they earn back into their businesses in order to maintain and improve patient services. Historically this investment has been in the order of 60% but in 2004/05, this reduced to 56.5%. The ratio has fallen further in 2005/06 (to between 54.7% and 55.1%).

5.44 The Government had no reason to believe that GMPs' behaviour would change to the extent it has in response to the additional investment the Government made in general practice services. The table below highlights the change in behaviour:

UK GPMS GMPs			
Financial Year	**Gross Earnings (£)**	**Total Expenses (£)**	**Expenses to Earnings Ratio (%)**
2002-03[(1)]	183,136	110,822	60.5
2003-04	201,630	120,064	59.5
2004-05	230,096	129,926	56.5
2005-06[(2)]	245,020	135,016	55.1
2005/06 [(3)]	246,987	135,016	54.7

(1) Based on GB results and restated to equivalent UK basis

(2) Headline 2005/06 figures

(3) Headline 2005/06 figure restated for estimated 2004/05 PCO Clawback

5.45 The corollary to a decreasing expenses to earnings ratio is that GMPs now retain a significantly higher proportion of their earnings as profit. On average, GMPs in 2005/06 retain 45 pence out of every £1 they earn, compared to 40 pence for every £1 in 2003/04.

5.46 The Government invested significant extra funding in GP services, both to improve services and reward GMPs. The Government expected a certain level of profits to be invested back into GP services, to bring about further improvements in services for patients. This has not been the case. Independent contractor GMPs have chosen to pay themselves more, and invest a reducing proportion of their income back in to their practices, than in previous years, by a margin of 5 percentage points.

5.47 To put this into context, the average earnings of a GP in 2005/06 were circa £247,000. Instead of making a profit as the Government expected of circa £100,000 (equivalent to 40 pence in the £) with the balance being invested in providing services for patients, GPs made a profit in excess of £111,000. This is a difference in excess of £10,000 (over 12%) per GP.

5.48 Based on 2005/06 results, we estimate that it would require a reduction in GMP pay/practice profits of some 11% to return the expenses to earnings ratio to 60%. If GMP pay/practice profits were to reduce marginally in the three-year period 2006/07 through to 2008/09, we believe that this would contribute to a correction in the expenses to earnings ratio, which is currently out of balance.

General Practice Expenses

5.49 The latest information available on general practice expenses is contained within the HMRC data from 2005/06 and 2004/05. For GPMS GMPs, average expenses in 2005/06 (allowable for tax purposes) were £135,016 and in 2004/05 £129,927. Broadly, these expenses are broken down as follows:

	2005/06		**2004/05**	
Type	**£000**	**%**	**£000**	**%**
Business	13	10	13	10
Premises	13	9	12	9
Employee	79	58	74	57
Car & Travel	2	1	2	2
Interest	3	2	3	2
Depreciation	1	0	1	0
Other[(1)]	26	19	23	18
Capital Allowances	2	1	2	2
Total	**135**	**100**	**130**	**100**

(1) Net of disallowed expenses

5.50 As demonstrated above, the GMP percentage profit has increased significantly as the proportion of income used for expenses has reduced. Some of the expenses incurred by practices are directly reimbursable by PCTs (in the case of premises). The largest element of cost relates to employees, where practices determine their own rates of pay, which may or may not be related to Agenda for Change rates. While it is reasonable to expect that, in a competitive market, staff will expect pay rises in line with those received by other NHS staff, GMPs, who run their own businesses, will determine how they handle these expenses within their overall income.

5.51 There is evidence to suggest that GMPs are driving down their costs (and maintaining profits) in response to the 2006/07 negotiated settlement and the DDRB's recommendation for 2007/08:

- In April 2007, the BMA issued guidance to GMPs *"Safeguarding patient services, maintaining cost effectiveness"* which identified measures to help practices with their business planning, in particular to maintain financial balance and improve practice efficiency.
- The Personal Social Services Research Unit (PSSRU), which conducts research on a wide range of health and social care issues with a view to informing and influencing policy and practice, undertakes an annual estimation of practice staff unit costs. This estimate includes not only salaries and employers' on-costs, but also indirect costs such as revenue and capital overheads, training and travel costs. The PSSRU estimate that in 2005/06 the basic salary of a practice nurse was £21,118, compared to £23,355 in 2004/05, i.e. a fall of 9.6%.
- Increasingly, practices are employing salaried GMPs. As at September 2006, there were 33,091 GMPs of whom 5,400 (some 16%) were salaried. This reflects a marked change over a short period. In September 2005 there were 32,738 GMPs of whom 3,398 (a little over 10%) were salaried. In summary, the number of salaried GMPs increased by 2,002 over the year and the number of profit sharing GMPs fell by 1,649. This trend toward salaried GMPs is expected to continue in the future.

5.52 Employing salaried GPs increases the costs of a practice. However, the above figures suggest that the residual profit (shared by fewer profit sharing GMPs) will increase. The following illustrates the point: If the number of salaried GMPs continues to increase by 2,000 per annum (and the number of profit sharing GMPs continues to fall by 1,650), the effect of this will broadly be to:

- increase practice expenses overall by some £120m, i.e. 2,000 multiplied by the average earnings (plus oncosts) of a salaried GMP in 2005/06 (say £60,000)
- increase the pool of profit (shared by fewer profit sharing GMPs) by some £185 million, i.e. 1,650 multiplied by the average profit in 2005/06 (£112,000).

Taken together the effect will be to increase residual profit by circa £65 million per annum – which we estimate will increase GMP pay/practice profit by around 2% per annum.

5.53 This is further evidence that GMPs can and do adjust their behaviour to increase their profits. GMPs as self-employed business people have greater control over profits through the way they manage their businesses, by determining their skill mix for example, and this gives them significant flexibility to make efficiencies within their business to sustain or increase profits.

JOB SATISFACTION

5.54 In the National Primary Care Research & Development Centre (NPCRDC) 2005 GP job satisfaction survey (not yet published), GPs reported on average a £19,000 increase in income (which is consistent with HMRC figures) and a four-hour reduction in working week since the 2004 survey.

5.55 A postal survey of English doctors was conducted in February 2004 and September 2005. Questionnaire items included: job satisfaction (7 point scale), hours worked, income and impact of the nGMS contract. Responses were available from 2,105 doctors in 2004 (53.6% response rate) of whom 1,349 also responded in 2005 (64.1% response rate).

5.56 The mean scores on the overall job satisfaction item across all the national GP surveys conducted since 1987 are shown in Figure 1 (1998 to 2005 scores adjusted to distributions of age and sex in the latest GMS Statistics database).

5.57 This highlights the improvement in overall job satisfaction back to levels observed before the introduction of the 1990 contract.

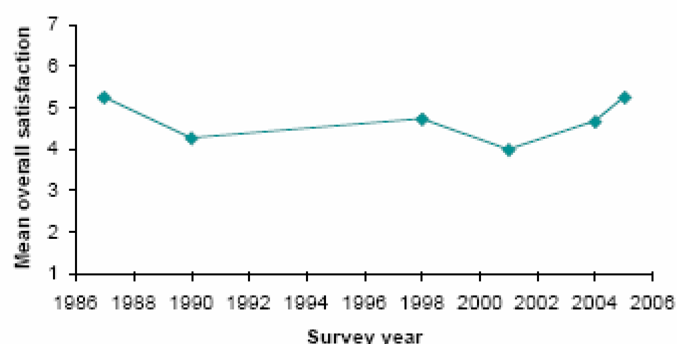


Figure 1. Mean overall job satisfaction scores of random samples of the GP workforce over time

5.58 The mean 2004 and 2005 overall job satisfaction scores for those GMPs responding in both years were 4.58 and 5.17 respectively, representing an increase in satisfaction of 0.59 points (an increase of 13%); continuing an upward trend in satisfaction from 3.98 in 2001 - an increase of 1.19 points (some 30%). The greatest improvements in satisfaction between 2004 and 2005 were with remuneration and hours of work.

5.59 Results drawn from the UK Medical Careers Research Group (UKMCRG) Studies show:

- job satisfaction scores among GMPs are generally high (averaging 19.9 on a scale from 5 to 25) and have risen since the new GP contract was introduced (from 19.5 to 19.9)
- GMPs (particularly those working part-time) have a higher level of leisure time satisfaction than hospital doctors (6.5 compared with 5.7 – out of 10) and scores in this area have risen over recent years
- part-time GPs, both men and women, were substantially more satisfied with their leisure time than were full-time GPs. The new GP contract has made it more financially practicable and affordable for GMPs to work part time. One in four GMPs now work part time compared to one in seven a decade ago
- there has been a sharp rise in GMP satisfaction with career prospects over the period 2002 to 2005 (from 68% satisfied to 76% satisfied).

5.60 A total of 399 GPs from the UK, France, Italy, Germany and Spain took part in a recent poll carried out for French GP magazine, Le Generaliste, and reported in GP magazine in the UK. The results of that survey, published on 24[t]October 2007, showed that GPs in the UK report the greatest satisfaction in Europe when it comes to pay. More than half (57%) were satisfied with their current pay compared with 44% in France, 29% in Italy, 18% in Spain and 12% in Germany.

5.61 A survey conducted by the BMA between June and July 2007 and to which 11,000 GPs responded showed:

- 53% of GPs felt their morale had fallen over the last five years
- 63% believed that NHS changes over the past decade had made it harder for them to practise good medicine
- only 52% would recommend a career as a GP to an undergraduate.

5.62 It is worth comparing this to the results of a 2001 BMA survey, which showed that:

- 66% of respondents felt their morale was low or very low
- 65% said their morale had deteriorated over the previous five years
- 28% were considering a career change

5.63 While the BMA's latest survey indicates lower levels of satisfaction than the earlier NPCRDC and UKMCRG studies, it still shows improved satisfaction compared to its 2001 survey. This improvement may reflect the significant increase in pay and decrease in workload that have occurred since the new GP contractual arrangements were introduced.

WORKLOAD

5.64 It is clear that the new GMS contract offers real opportunities for improving services and the working lives of GMPs and practice staff through different ways of working and utilising skill mix in different ways. GMPs can choose to change the balance of work between members of the primary care team, for example, developing the roles of nurse practitioners or of health care assistants. It is likely that practice nurses, practice managers and other members of the practice team undertake much of the work arising from the QOF.

5.65 Evidence that this is happening in practice is demonstrated by the findings of the Nottingham University research. While the overall UK consultation rate rose from 3.9 consultations per patient-year in 1995 to 4.8 consultations per patient-year in 2004, the UK consultation rate for GMPs has remained almost constant. However, the UK consultation rate for nurses increased from 0.8 consultations per patient-year in 1995 to 1.6 in 2004, and the UK consultation rate for other clinicians increased from 0.09 consultations per patient-year in 1995 to 0.2 in 2004. This suggests that practice nurses and other practice staff are taking on a greater proportion of practice workload than previously was the case.

5.66 In our submission to DDRB last time, we flagged that evidence was beginning to emerge that GMP workload has decreased. The 2005 National Survey of GP Job Satisfaction conducted by NPCRDC, now confirms that the reported number of hours worked per week fell by approximately 4 hours between 2004 and 2005.

5.67 Further evidence is now available that confirms a significant decrease in GMP workload. On 31 July 2007, the IC published the results of its 2006/07 UK General

Practice Workload Survey. On the same day it also published a study identifying trends in general practice consultation rates.

5.68 The IC's Workload Survey report, which has been agreed by representatives from the four UK Health Departments, NHS Employers and the BMA, provides an overview of the workload and skill mix of general practices in the UK in 2006/07. It is the first such survey since 1992, and more importantly since the introduction of the new GP contract in April 2004. It provides a clear indication of the impact the new contract has had on GMP workloads. The study identifying trends in general practice consultation rates covers the period 1995 to 2006.

5.69 The headline messages from both the survey and the study are that:

- The average self-employed GMP is working significantly fewer hours (the weekly average dropping from 43.5 hours in 1992/93 to 36.3 hours in 2006/07 (a fall approaching 17%). Much of the fall is attributable to a reduction in their out of hours commitment.
- The average number of patients seen by a GMP in surgery consultations has dropped from 122 a week in 1992/93 to 88 a week in 2006/07 - a reduction of nearly 28%. We also know, however, that the length of these consultations – possibly an indicator of complexity of the consultation - has increased (from 8.4 minutes per consultation in 1992/93 to 11.7 minutes in 2006/07). Whilst in total the number of consultations undertaken within general practice has increased over recent years, much of the increase has effectively been borne by increases in the role and number of practice nurses.
- There has also been a significant reduction in the time spent by a GMP on home visits (falling from 8.8 hours (22 patients) a week in 1992/93 to a current figure of 3.3 hours (8 patients) – a reduction of some 63%.
- The amount of time a GMP spends on telephone consultations has gone down (declining from 3.5 hours a week to 2.4 hours – a reduction of 31%). The volume of telephone consultations has also decreased.

GMP SUPPLY

5.70 As we report in Chapter 3, we have no evidence to suggest that there are any problems with recruiting or retaining GMPs. Overall GMP numbers continue to grow, an increasing proportion of which are salaried. As at September 2006, there were 33,091 GMPs (excluding retainers and registrars), an increase of 353 over 2005 levels and the highest number ever. In 2006, the number of salaried GMPs rose to 5,400, an increase of 2,002 over the previous year. This trend toward salaried GMPs is expected to continue in the future.

5.71 Of the 33,091 GMPs in 2006, only 7,060 (21%) were aged 55 and over. The number of GMPs expected to reach retirement age each year up to 2010/11 rises only gradually and is significantly less than the anticipated number of doctors completing GMP training each year.

5.72 The estimated three-month vacancy rate has fallen from 2.45 in 2005, to 1.1% in 2006 and 0.8% in 2007.

5.73 The number of GP Registrars is also very healthy. There are now 935 (70%) more GP Registrars than in 1997. Although slightly fewer GP Registrars in 2006 (2,278), this is still an increase of 69% since 1997 – and higher than any year prior to 2004. What is more, there is a high level of demand for places. In 2007, approximately 9,000 UK doctors made 22,000 applications for 3,862 advertised posts.

5.74 The Information Centre statistical bulletin General and Personal Medical Services in England 1996-2006, published April 2007, states: "*The number of practitioners rose at an average annual rate of 1.8% between 1996 and 2006. This is higher than the rate of growth in the population, so that by 2006 there were 65 practitioners per 100,000 population compared to 57 in 1996*".

EFFICIENCY

5.75 The joint BMA/NHS Employers publication "Revisions to the GMS contract 2006/07 *Delivering investment in general practice*" contains the following references:

Paragraph 1.10 "*All parties recognised the responsibility of the four health departments and NHS Employers to achieve and demonstrate on-going improvements in efficiency and value for money as part of normal on-going negotiations or commissioning processes within the NHS.*
This normal process of refinement, revision and improving value for money will apply to future GMS negotiations as it applies to other NHS services".

Paragraph 1.25 "*The negotiating parties agreed and recognised that the QOF is a "living thing" which will be subject to a process of change and improvement over time as part of the negotiation process. It is expected that changes will be negotiated with reference to those elements of the QOF where science and evidence has moved on, or which are no longer necessary, or where the workload has been shown to have changed, and in the context of the value for money agreement described above*".

5.76 If the Review Body were to consider any recommendations on uplifts to GMP pay, we consider it essential that this should be dependent on:

- achievement of efficiency gains by general practice, which as a minimum would have to be consistent with the measured expectations placed by Government on other sectors within the NHS
- improvements to the Quality and Outcomes Framework.

GMP SENIORITY PAYMENTS

5.77 In its 2007 Report, the Review Body suggested that we should consider whether seniority payments comply with the spirit of the recently introduced age discrimination legislation. We have looked very carefully at this issue and, having taken appropriate advice, have concluded that it is unlikely that the current GMP seniority scheme would be found to be discriminatory on those grounds. The relevant Regulations make it lawful to discriminate in relation to the terms offered to workers (including partners) where the aim is to reflect a higher level of experience, to reward loyalty or to increase or maintain the motivation of the worker.

5.78 Of greater concern to the Department is the fairness of the current seniority scheme. Significant seniority payments are made to individual GMPs and this is increasingly anomalous in the context of a practice-based contract for services. There is now a range of non-GMP partners, such as nurses and practice managers, who are signatories to the contract. To single out GMPs as the only partners eligible to receive seniority payments for historic reasons is increasingly difficult to justify and could potentially lead to challenge by a non-GMP partner. This is an area we will wish to consider further in the future.

5.79 We propose that seniority payments should remain at current values in 2008/09. Given that projections for GMP earnings show a profit increase of over 50% over the period 2002/03 to 2005/06, there seems no good reason to increase seniority payments at this time.

CHAPTER 6: DENTISTS

Introduction:

6.1 The new arrangements for commissioning primary dental services in the NHS have now been in place for some 18 months. The transition to a system of locally commissioned services has been challenging for the NHS and for dentists but a clear pattern has been emerging showing:

- services commissioned with a focus on the needs of patients
- better working arrangements for dentists
- patient access has stabilised over the first twelve months of the reforms with local recommissioning of services working well
- if a dentist ceases to provide NHS services, the local NHS is now able to bring in new services as a replacement
- the NHS is now beginning to build on this more secure platform to further improve patient access.

6.2 It is notable that, in 2006/07:

- PCTs commissioned more services than were delivered in the last year of the old system
- there are numerous examples of PCTs commissioning new services to improve patient access with little shortage of dentists offering to expand their services or establish new practices
- the trend in the number of dentists providing NHS services is now upward again
- the Government's investment in expansion of undergraduate dental education will help to sustain this more healthy workforce position.

6.3 In our evidence this year, we will concentrate on the key issues in the Review Body's remit:

1. the recruitment and retention of NHS dentists, especially the ability of PCTs to commission new or additional services in all parts of the country;
2. the motivation of dentists and the effect of the new system on their working lives;
3. regional and local variations, and the ability of PCTs to deal with local issues;
4. the requirement for NHS dentistry and how well this is currently being met;
5. the availability of funding for NHS dentistry and the impact of pay awards on access to services; and
6. the running costs of the service and the change in the expenses element.

6.4 We believe that the pay award for dentists in 2008/09 should be a simple recommendation for an increase in net pay and expenses which reflects the changes in the supply of dentists, their willingness to contract for NHS work and the change in the type of work provided, particularly the move to more preventative and simpler courses of treatment with a lower expenses element.

The context: The first year of the reforms

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

- Access to services: the location and volume of services were previously decided by dentists, not by the NHS. When some dentists began to drift away from the NHS in the 1990s, significant access problems emerged in some areas
- Remuneration system: dentists were paid on a fee-per-item system which created incentives for more invasive and complex treatment and increased costs – not consistent with reducing disease incidence
- Patient charges: there were over 400 patient charges for different treatments, which caused confusion for patients and made it unclear what was NHS and what was private treatment.

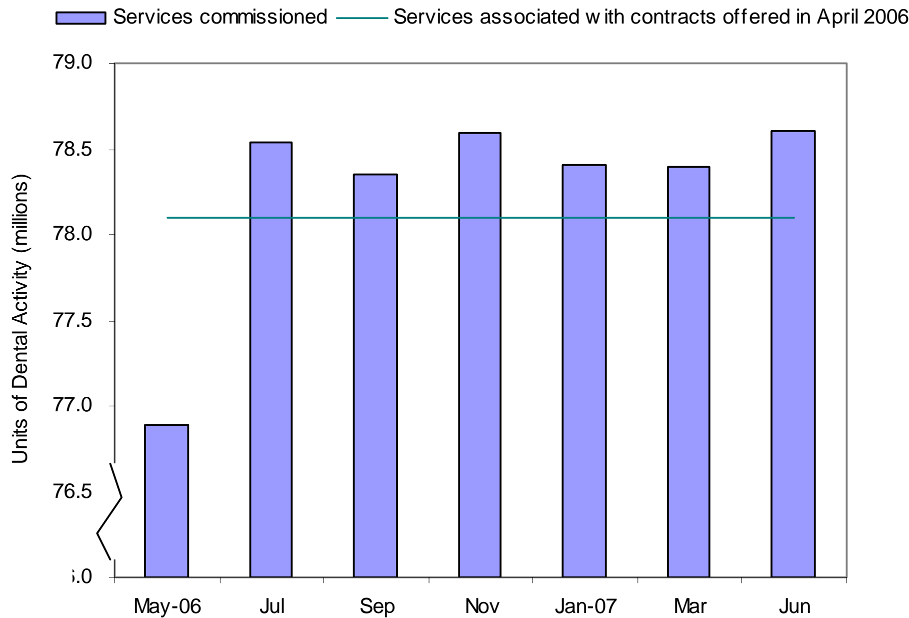
6.6 The new system was designed to:

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

Table 6.1: Old and new dental contracts

Old national contract	New local contracts
Separate fees for each individual item of treatment (fee-per-item) created a 'treadmill' effect.	Provide security and predictability of agreed annual NHS income, in return for carrying out an agreed number of courses of treatment each year (with a simple weighting to reflect relative complexity).
Dentists wishing to provide simpler courses of treatment, e.g. with greater emphasis on prevention, were financially penalised.	Dentists can carry out less complex and invasive courses of treatment without financial penalty. This allows dentists to spend more time on prevention and is likely to reduce average workload and expenses.
A committed NHS dentist earned around £80,000 on average per year, with a further £80-90,000 for practice expenses.	A committed NHS dentist should continue to earn the same average gross income. Less complex courses of treatment should typically result in lower expenses and higher net income.

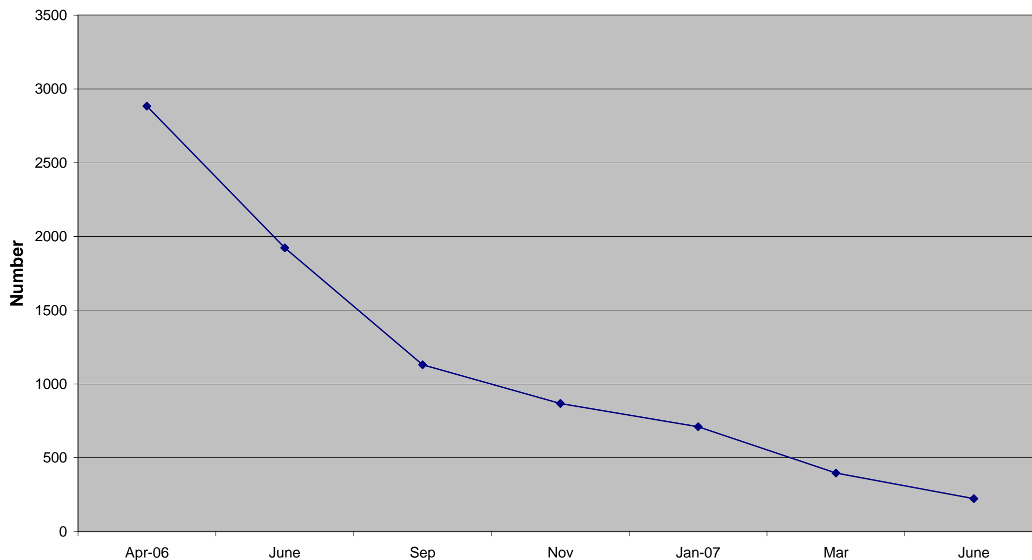
6.7 Despite the predictions of the British Dental Association (BDA) of a mass exodus of dentists, the vast majority of practices signed up to the new system. The 1,050 contracts rejected in the run up to 1 April 2006 represented less than 4 per cent of NHS dental services. Many of these dentists were already mainly private and had very low numbers of NHS patients. However, this is not to underestimate the inconvenience for the patients affected. The Department and the NHS attached great priority to commissioning replacement services. The figure below shows that, within three months the volume of services commissioned by the NHS exceeded the volume of services reflected in all the contracts offered to existing dentists in the run-up to April 2006. As newly commissioned services open and build up capacity, this should translate into increasing levels of patient access.



Source: Department of Health form DC01
Excludes specialist services, including orthodontics

6.8 There were also initial concerns, repeatedly emphasised by the BDA, that a high proportion of those contracts which were signed "in dispute" between the dental provider and the PCT would result in further dentists leaving the NHS. In fact, in over 99 per cent of cases, the disputes process has ended with dentists deciding to stay with the NHS. Overall, there were some 2,884 contracts signed in dispute in April 2006. By June 2007 these had fallen to just 223 and we expect the remainder to be settled within the next few months. To date, the contractor has not accepted the outcome in only 18 cases.

Number of unresolved disputes



6.9 We do, however, recognise that the focus in the first year of the reforms has been on the initial priorities of commissioning new services (including the replacement of the minority of new contracts offered that were not taken up), monitoring patient courses of treatment, and monitoring expenditure and patient charge income. As we move into the next phase of the transitional period, the Department is supporting PCTs to increasingly focus on the wider aspects of commissioning, including measures to support and improve quality and oral health.

6.10 Overall, eighteen months into the new system, we have a much more secure basis for developing dental services over the coming years. The local NHS now has, for the first time, both a statutory duty to provide dental services and the flexibilities needed to develop services to reflect local needs. In many areas, patients are already experiencing the positive results of this in terms of new or developed services. The progress already made by dentists and PCTs is remarkable and provides a strong basis for the future improvement of NHS dentistry.

The Review Body's Remit

1. Recruitment and retention

6.11 The most important aspect of the pay review system is to ensure that there is a sufficient incentive for dentists to provide NHS services. 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. It is nonetheless encouraging that numbers of dentists are similar to those in March 2006 (just before the reforms) and significantly higher than 3-4 years ago. At the end of March 2007, there were around 21,000 dentists listed on NHS contracts. After adjusting for some salaried dentists now included in this count for the first time, this is likely to be around 500 fewer dentists than in March 2006, but (as explained above) many of the dentists who decided not to take up new NHS contracts in April had relatively few NHS patients. The numbers are significantly higher than the 18,800 dentists providing NHS services in March 2003.

6.12 Under the new contracts, one of the key indicators of dentists' willingness to provide NHS services has been the success 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. Table 6.2 below shows just some examples of these newly commissioned services and the benefits achieved.

6.13 The recommissioning and placing of new (additional) work and contracts has brought a response from a variety of providers including corporate bodies, partnerships and existing practices seeking to expand. It is now the case that dentists want to take on more NHS dental work, and the largest criticism is that PCTs are not willing to commission additional services. This suggests that NHS dentistry is now seen as a valuable commodity and, to dentists, is no longer seen as poorly remunerated when compared with private work.

6.14 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 clearly demonstrates that there are little if any shortages of dentists and there is certainly no national recruitment and retention problem.

Table 6.2: Examples of commissioning new dental services

PRIMARY CARE TRUST	EXAMPLE
Cumbria	The North Cumbria PCTs were the first to undertake an open national tender following well-publicised access problems in the area. The procurement exercise was so successful that it rapidly became an example for other PCTs. Two providers were appointed, bringing eight new dentists into the area. Around 20,000 patients across Carlisle and Penrith are now benefiting from these new services. Cumbria PCT has now commissioned over 62,000 new dental places since April 2006. Its dental helpline has so far enabled some 66,000 people to be offered places at new NHS dental practices.
Leicestershire County & Rutland	In a move to address longstanding access problems, the PCT carried out a tendering process to establish new services in areas where NHS dental care needs were highest. The PCT appointed three providers to provide services across four new dental practices and to extend an existing practice. This is bringing 17 additional, full time dentists into practice across the two counties.
Milton Keynes	Milton Keynes is an area of rapid population growth, but existing practices were unable to take on new adult NHS patients. To improve access, the PCT looked to establish a new practice in one of the high need areas identified in their oral health needs assessment. Following an external tender, they identified a provider to establish a new practice with capacity to take on approximately 8,500 patients.
Devon	Devon has had long-standing difficulties meeting demand for NHS services. In the last 18 months, Devon PCT has found an NHS dentist for 37,000 patients previously on the PCT waiting list. This has been through a combination of investing in new practices in Exeter, Kingsbridge and Newton Abbot - and expanding current NHS practices in Chulmleigh, Barnstaple, Torrington, Newton Abbott and Teignmouth.
Yorkshire	In Wakefield, 8,000 patients have been placed with a new practice and the practice plans to take on a total of 16,000 patients over the next two years.
Oldham	Oldham PCT negotiated new contracts to establish two new practices and bring an additional dentist into an existing practice. At full capacity, these new services should provide NHS treatment for at least 8,000 extra patients. The PCT has also expanded NHS orthodontic services and increased funding for its community dental service to expand services for children.

Recruitment: The future workforce supply

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

6.16 It is difficult at this stage to update the conclusions of the 2003 workforce review to assess the optimum level of future workforce supply. If sustained, the levels of interest among existing dentists in undertaking additional NHS work and the continued ability of practices and corporate bodies to benefit from overseas recruitment, will have significant implications for our workforce strategy. In order to update our workforce assumptions, we will also need to assess the impact of the new contractual arrangements on levels of patient access, which will hinge on a range of factors including the value for money secured through new contracts and the frequency of patient recall. It is too early to assess these factors, but the current trend in reduced complexity and longer

recall intervals should mean that more patients can be seen by the current dental workforce.

2. Motivation

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

- the implementation of 5% less courses of treatment for same contract value on transfer to the new contracts (for GDS dentists) gave them more time to spend with patients for the same levels of remuneration 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.
- The regular payments made to providers under the contracts gives a guaranteed monthly income for pre-agreed levels of work across the whole year.

6.18 We recognise that any transitional period has some "stress" but believe that this has now passed as the system has bedded down. We also acknowledge that some dentists criticise the three banded system for weighted courses of treatment because it does not recognise the levels of work done within each course of treatment. PCTs have also asked for a better indicator of clinical workload. We have taken account of these issues and have recently announced our intention to enhance the data provided by dentists to give a better indication of the clinical workload: although it will remain a relatively simple system to use and administer. This is intended to begin in April next year and should answer many of the criticisms from the profession that the current system does not allow for fair comparisons between practice workloads.

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

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

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

6.20 This allows PCTs to take full account of local expense and workforce issues (for example high rents or shortages of dental nurses) when setting contract values. Contract remuneration (which is based on Pay Review Body recommendations) covers both the expenses involved in running a practice (including premises and equipment) and net income for the dentists who provide services. The new system also gives more explicit powers to PCTs to give additional targeted support to practices where appropriate. To support this, the Department has made available £100 million capital funding over two years to help improve the quality of premises and equipment and support the costs involved in opening new practices. Patients are already seeing the results of this additional investment, for instance:

Table 6.3: Examples of Dental Capital Funding

PRIMARY CARE TRUST	EXAMPLE
County Durham	County Durham PCT has used its capital to support the development of three new practices in Willington, Chester-le-Street and Easington.
Devon	Devon PCT has used capital funds to help establish new practices in Tavistock and Exmouth, re-locate a practice in Bideford into new premises with better clinical and reception areas, and help a number of practices with improving access for patients with disabilities and upgrading infection control arrangements.
North Tees	North Tees PCT has used part of its dental capital funding to support four local practices in their development. Two of the practices have relocated to new premises, improving the patient environment and increasing capacity. The two other practices have expanded their existing surgeries. Capital investment has also been used to refurbish a PCT-owned health centre into a three-surgery dental practice, and the PCT is currently undertaking a tendering exercise for a a provider to open the practice in October 2007.

6.21 One of the most important factors in building confidence and retaining dentists in NHS contracts is the quality of the commissioning relationship between PCTs and dentists. During the first year of the reforms, some of the most productive relationships have come from areas where the NHS and the profession have collaborated closely on specific projects, for instance in developing new clinical governance frameworks, agreeing how to deploy new capital funding, or developing new systems for sharing information electronically.

6.22 There are also good examples of dental practices working collaboratively with PCTs to develop new services (e.g. minor oral surgery outside traditional hospital settings) and to support the training and education of dental students.

Table 6.4: Examples of practices working with PCTs to develop new services

PRIMARY CARE TRUST	EXAMPLE
Tower Hamlets	The PCT has worked with an established GDS to develop minor oral surgery services in primary care. Based on a similar service set up in Derbyshire, the dentist providing the service is a specialist in oral surgery, who provides 2-3 sessions per week in a primary care setting. The service has run for a full 12 months and has had an excellent response from patients and practitioners. It has reduced waiting times for treatment and provided more convenient access for local patients.
Sheffield	The Taptonville dental practice in Sheffield has been developed to provide 'outreach' training facilities for students from the University dental school. Most students go on to work in primary care settings. With experience in both a dental teaching hospital and a primary care dental practice, students are better equipped to develop their careers in either secondary or primary care.

6.23 The new and increasingly mature relationship between PCTs and their local practices should also help allay some of the concerns currently expressed about 'goodwill' value. When a dental practice is sold, the practice owner may derive goodwill value from the sale if patients are likely to go on receiving services from the new practice. Under the

new arrangements, a practice has to have a contract with the local PCT to provide services, and NHS contracts cannot be legally assigned to a second party. The PCT is therefore responsible for deciding whether, and on what terms, to offer a contract to a new practice owner. However, this does not prevent practices having a goodwill value, so long as the practice is providing services that are valued by the PCT and local patients and so long as the practice discusses any proposed sale or transfer with the PCT early in the process. This enables the PCT to consider whether there are any changes it would like to see in the services being provided. These arrangements are likely to support and even increase the goodwill value of practices that are providing a valued service for NHS patients.

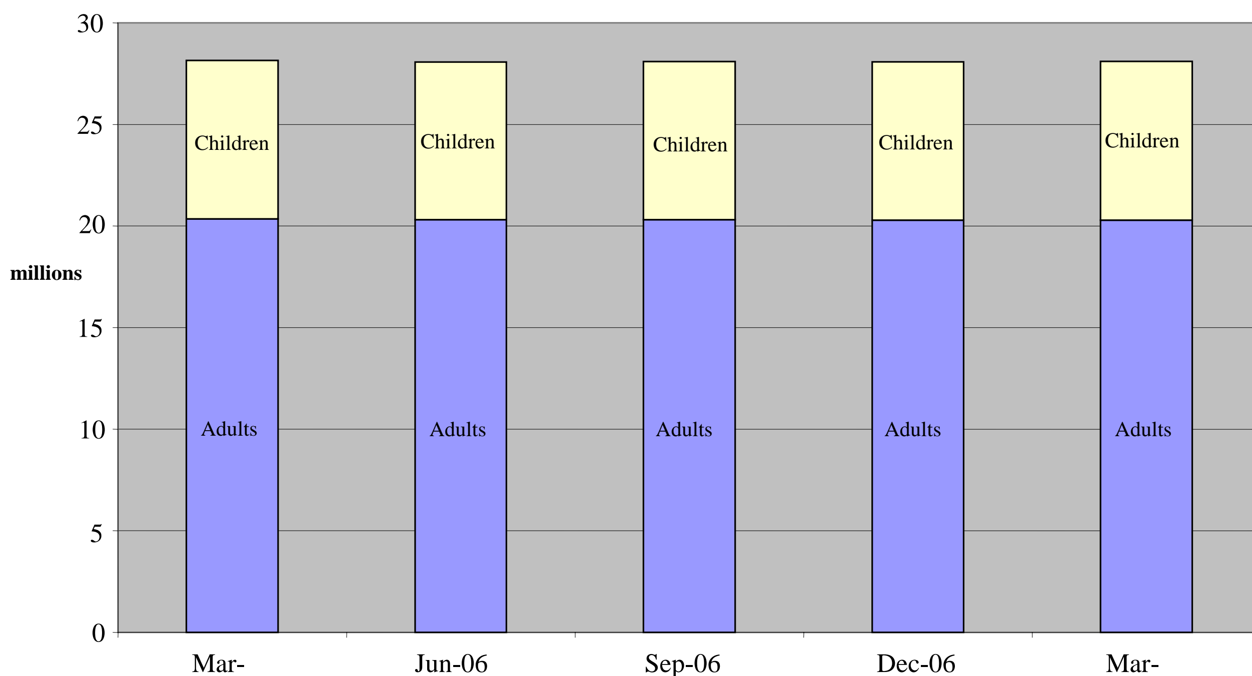
4. The requirement for NHS Dentistry: Meeting demand for services

6.24 The new system allows PCTs to assess the local demand for NHS dentistry and how this might be best provided. In effect service requirements are now set locally according to local decisions on demand and need, there are no central targets beyond the expectation (and new statutory requirement) that PCTs must provide or commission primary dental services to reflect local requirements. At PCT level, this action will include:

- carrying out local needs assessments, consulting the local public, and developing strategic commissioning plans to match the services commissioned – and their location – to local needs and priorities
- ensuring that, where services are commissioned but not fully delivered, the practices involved put in place measures to make good the shortfall in delivery, or the relevant resources are re-invested in other practices that have the capacity to deliver the required service
- working with practices to ensure appropriate patterns of patient attendance (in line with NICE guidelines on recall intervals) and treatment (i.e. providing all appropriate care within a single course of treatment), in order to ensure effective use of resources. For instance, some patients with good oral health, who may traditionally have been recalled at intervals of six months or so, may need to attend less frequently under the NICE guidelines, which could free up appointment slots for other patients
- monitoring and benchmarking numbers of patients seen to help understand reasons for variations and create sustained focus on improvement.

6.25 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 will therefore be their ability to support improved patient access to services. The number of people who receive care or treatment from an NHS dentist over a two year period is generally agreed to be a good measure of access. (The National Institute for Health and Clinical Excellence recommends that adults attend the dentist at least once every two years.) As the figure below shows, this measure of access has remained stable at national level during the transition to the new arrangements.

6.26 Patient access is expected to improve as the full effect of the re-commissioned and additional services come into effect this year.



Source: Information Centre for Health and Social Care

6.27 Under the old dental remuneration system, where a DDRB 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 arguable that a higher increase could lead to improved patient access. This is now not the case. Increasing the value to dentists of the base contracts merely reduces the ability of PCTs to commission additional services and can actually reduce patient access. Each 0.1% uplift on DDRB costs £2.5 million a year. This would provide access to NHS dentistry for 40,000 to 50,000 patients.

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

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

6.29 The resources allocated to PCTs by the Department of Health for commissioning primary dental care services totalled some £1.8 billion in 2006/07. The Department gave PCTs indicative gross allocations of some £2.4 billion, taking into account indicative levels of income from patient charges, together with £40 million capital funds for practice improvements.

6.30 NHS accounts data for 2006/07 shows that net expenditure for the year (i.e. after deducting income raised from patient charges) represents 98.5% of the £1.8 billion allocated, and is some £400 million or 30% higher than in 2003/04. However, it is clear that some PCTs, particularly those who had to commission a higher than average volume of new services, did not fully spend their allocation in-year. This reflects the time needed to commission new services, particularly if large tenders are involved, and for those services to come on stream. In other areas, PCTs will have spent more, either

because patient charge income has been lower than anticipated (see below) or because they have spent additional resources from their main PCT budget on commissioning services

6.31 The indicative gross allocations issued to PCTs assumed that around £600 million would be raised from patient charges (assuming the full gross budget was spent in-year). The Information Centre for health and social care report on patient charge income for 2006/07 report that £475 million was raised from courses starting and ending in that year. Although some PCTs have received lower than expected levels of patient charge income during the first year this does not have any effect on the annual service levels agreed at the start of the year with dental practices. A practice's NHS income and the annual services it agrees to provide in return are not affected by how much money is raised from charges. Some PCTs, however, may have deferred commissioning new services while they establish the reasons for low charge income. Clearly, as the newly commissioned services come on stream patient charge income will rise.

6.32 The Department provided guidance ('NHS Dental Services – Patient Charge Revenue Factsheet') to help PCTs and practices assess the local factors affecting charge income. These factors include changes in the mix of patients (charge-payers and charge-exempt patients) receiving NHS care and the number of charge-free treatments given to patients who would normally pay charges. In some cases, a reduction in charge income may reflect a conscious decision to target new services at particular population groups, e.g. children's orthodontic services or services for more deprived areas. In other cases, income was initially depressed by reporting errors, which should now become much less frequent as a result of additional validation checks and monitoring reports introduced by the NHS BSA.

6.33 As the new arrangements settle down further, we anticipate that there will be much greater stability of patient charge income. In order to support PCTs further, the Department increased funding allocations for 2007/08 to allow for slightly lower levels of patient charge income as a proportion of gross expenditure.

6. Expenses and pay elements:

6.34 The settlement for pay and expenses this year has to be seen in the context of the Government's targets on inflation of 2%.

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

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

6.36 The new dental contracts provide dentists with the long-term financial security they did not have under the old item of service system. General Dental Services (GDS) contracts are open-ended and allow dentists to agree their services and delivery pattern with PCTs along with any necessary variation to allow for staff changes etc. This provides a

regular income stream every month, a month in arrears: a major improvement on the previous system where claims had to be submitted and agreed after the conclusion of the course of treatment with payment taking another four weeks on average. This improves cash flow and financial planning and significantly reduces the cost of working capital. It also allows agreed activity to be planned across the financial year to allow for holidays, training etc.

6.37 Although the transition period for the new contracts and the associated guarantees for dentists and ring fencing arrangements for PCT dental budgets were set at three years from April 2006, we do not expect any major changes to take place at the end of this period. PCTs and their dental providers should be building up long term, mutually beneficial working relationships. PCTs are highly unlikely to sever service contracts, provided there has been no serious breach of contract requirements or service standards. The main significance of the three-year period is that, during this period, money from contracts that lapse through retirement, dissolution of practices, etc has to be used by the PCT to re-provide more dentistry. This gives real stability; neither before nor after the transitional period can a PCT unilaterally reduce the remuneration given to a provider.

6.38 We will also be continuing to supply dentists with details of how many regular patients they have, ie. those seen by them in the previous 24 months and not subsequently seen by another practice. This "practice list" (a complete version is available to dentists on request) enables dentists to keep track of their patients and demonstrate the size of the practice if they wish to sell, helping to maintain the "goodwill" value of the practice.

NHS Pensions

6.39 Dentists' pension benefits are calculated as 1.4% of their total pensionable pay, which is uprated every year. As an example, a committed NHS dentist whose total pensionable earnings averaged £87,000 per 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 4. Table 6.5 below sets out the benefits for GDPs.

Table 6.5: Benefit structure of the NHS Pension Scheme – Practitioners

Normal Pension Age (NPA)	60
Pensionable Pay (PP)	Generally based on practitioners NHS income less expenses
Total Uprated Pensionable Pay (TUPP)	Sum of all PP. PP is revalued annually to retirement or exit by a factor determined in a manner to maintain its value.
Yearly Average of Uprated Pensionable Pay (YAUPP)	TUPP divided by the number of years of membership
Relationship to Second State Pension (S2P)	Contracted in
Members' Contributions	6% of PP, however, from 1 April 2008 rates will be progressive tiered contributions for **all members** based on whole pay – linked to AfC scales, currently: 5% - pay up to £19,165; 6.5% - £19,166 to £63,416 7.5% - £63,147 to £99,999 8.5% - £100,000 and above
Benefits Payable on Retirement On Normal Retirement (1) Pension (2) Lump sum On Ill-Health Retirement (after completing 2 years service)	 1.4% of TUPP 3 times pension Benefits as on normal retirement, increased in proportion to enhanced services (see separate entry for ill-health retirement)
Benefits Payable on Death-in-Service (1) Lump sum (2) Widow's, widower's or surviving Civil Partner's pension	 2 times YAUPP 50% of member's pension payable on ill-health[a]
Benefits Payable on Death-in Retirement (1) Lump sum (2) Widow's, widower's or surviving Civil Partner's pension	 The lower of (a) 5 times the pension less pension received (b) twice YAUPP, less the retirement lump sum 50% of Member's Pension[a]
Benefits on Withdrawal (1) Less than 2 years' service (2) 2 or more years' service	 Refund of member's contributions Benefits increased in deferment, payable from NPA As an alternative to the benefits above, a cash equivalent transfer value may be paid
Increases to Pensions (1) In payment (2) In deferment	 In line with increases in RPI In line with increases in RPI
Service Enhancement on Ill-Health Retirement or Death-in-Service Actual Service: 2 to 5 years 5 to 10 years 10 to 13 1/3 years More than 13 1/3 years	 No enhancement Service doubled[b] Service enhanced to 20 years[c] Extra 6 2/3 years service

Notes:
(a) Only service from April 1988 accrues for widowers' and surviving civil partners' benefits. Additional contributions may have been paid to improve these contingent survivors' pensions. Certain short term (up to 6 months) survivors' pensions may be paid in addition.
(b) Subject to a maximum enhancement of the potential service to age 65.
(c) Subject to a maximum enhancement of the pensionable service to age 60.

Expenses

6.40 We will not have evidence this year from the normal expenses and income surveys on the effect of the new contracts, although some effect of the earlier Personal Dental Services pilots are now visible including reduced practice expenses. However, there is irrefutable evidence now provided about the broad effects of the new contracts on the key drivers of practice expenses which must be taken account of in this pay round if we are to avoid a major downwards correction in future years.

6.41 The study published by the NHS Information Centre compared the reported incidences of the most common dental treatments in 2007 with incidences in 2003/04. 2003/04 was the last year before dental practices began to switch to Personal Dental Service (PDS) in substantial numbers. This shows 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 6.6 below:

Table 6.6: Number of treatment items per 100 courses of treatment and incidences as percentage of courses 2003/04 and 2007

	2003/04	2007	DIFFERENCE	
Number of items per 100 CoT	**Items**	**Items**	**Items**	**% change**
Radiographs	53.2	31.5	-21.7	-41%
Extractions	10.5	11.5	1.1	+10%
Fillings	49.7	45.0	-4.7	-9%
Root-fillings	3.9	2.0	-1.9	-49%
Veneers	0.3	0.1	-0.2	-67%
Crowns	4.5	2.3	-2.2	-49%
Inlays	0.7	0.3	-0.4	-57%
Bridgework	1.9	0.9	-1.0	-47%
Percentage of CoT with				
Examination	78.6	81.9	3.3	+4%
Periodontal treatment	54.5	47.8	-6.7	-12%
Dentures	2.8	2.9	0.1	+4%
Full upper and lower dentures	0.5	0.4%	-0.1	-20%
Partial dentures	2.0	2.1%	0.1	+5%

Note: The difference may not equal the 2003/04 figure subtracted from the 2007 figure due to rounding.
Source: Dental Treatment Band Analysis England 2007 Preliminary Results. The Information Centre for Health and Social Care. October 2007.

6.42 The overall reduction in advanced treatments: crowns, bridgework and dentures is about 35%. In the table below, the changes in individual treatment items are weighted together using 2003/04 expenditure.

Table 6.7: Advanced treatments: expenditure and change in incidences

TREATMENT	2003/04 SPEND	% REDUCTION IN 2007
Veneers	£6 million	67%
Inlays	£17 million	57%
Crowns	£143 million	49%
Bridgework	£44 million	47%
Dentures	£91 million	0% with a reduction in full dentures offsetting an increase in partials
Combined total	£301 million	35%

6.43 The reduction in the weighted average for other treatments is 11%.

Table 6.8: Other treatment: expenditure and change in incidences

TREATMENT	2003/04 SPEND	% REDUCTION IN 2007
Examination	£151 million	-4%
Radiographs	£43 million	41%
Periodontal treatment	£174 million	12%
Fillings	£181 million	9%
Root fillings	£49 million	49%
Extractions Inc sedations	£42 million	-10%
Combined total	£640 million	11%

6.44 Dentists are carrying out 40% fewer advanced treatments and about 15% fewer other treatments after taking into account the reduction of 5% in weighted courses of treatment under the new contract.

6.45 This evidence clearly shows that dentists are carrying out simpler courses of treatment with a notable reduction in complexity within each treatment band which must mean lower expenses (as a proportion of gross remuneration) and therefore higher net incomes (or profits). The reduction in the frequency and complexity of treatment is desirable and forms part of the expected benefits of the reforms, it is also consistent with actual patient needs. 80% of restorative treatment carried out is the repair and replacement of existing restorations in adults born and brought up before the advent of fluoridated toothpaste in the 1970s. Since then, dental health has improved considerably across the country and amongst all age groups. There are still regional variations but on average older children in England have the best dental health in Europe. As successive cohorts move into adulthood they will take with them increasingly both the need for less treatment and also less complex treatment

6.46 This reduced complexity allows dentists to spend more time with patients and give more preventative advice. We do not, therefore, expect the Review Body to penalise dentists by removing the remuneration element of the time released by this reduced activity. However, the consumables and appliances costs will significantly reduce with a major effect on practice expenses. This must be taken account of in the expenses element of the settlement and we, therefore, will propose later in our evidence an amendment to the recently used DDRB formula to include an offsetting allowance for this expenses element. This change in complexity of treatment is on top of the reduction in consumables and lab costs (which make up around 30% of dental expenses) which derive directly from the 5% reduction in the weighted courses of treatment – as implemented in the new contracts.

6.47 The trend towards reduced expenses is backed by a two other information sources, the Specialist Dental Accountants who provide an annual assessment of dental expenses and the reduction in the length of time taken to complete a course of treatment - a good indicator of the complexity of the treatment - as reported last year.

6.48 We agree that the major changes to the dental contracts now mean that it is essential to undertake a new workforce and expenses survey. This has been discussed in the Dental Working Group and we would ask this group to set out the necessary remit for such a survey. We do not, however, believe that we can ignore the emerging evidence of changes in workload and expenses in this pay round. If we wait for the evidence to fully emerge we would face the possibility of a sharp reduction in expenses in future rounds and the risk of repeating the mistakes of the 1990's as dentists face a possible reduction in gross earnings to compensate.

Evidence on income and expenses published by The Information Centre for Health and Social Care (The IC)

6.49 The data provided by the IC showed that a dentist's income depends on their business arrangements. In the general dental service (GDS), net income after expenses for practice owners was £114,100 in 2005/06. For dentists working for practice owners the average was £61,100. This figure is affected by some part-time working, the men alone averaged £71,100. For non-associate dentists, those who work on their own or in joint partnership, average income was £94,600. The income includes earnings from both NHS and private dental work.

6.50 The Personal Dental Service (PDS) was the model for the new dental in GDS. contract. Earnings for personal dental service (PDS) dentists were higher than for GDS dentists. The IC estimate that average income for dentists with a contract were £127,900 in 2005/06. For dentists who performed dentistry but who were not providers, the average was £65,900. It is very notable that the expenses ratios are lower in PDS than

Expenses ratios 2005/06

	GDS	PDS
Practice owner/contract provider	67.8%	59.5%
Associate dentist/dental performer	33.4%	13.0%

6.51 Between 2004/05 and 2005/06, the expenses ratio for non-associate GDS dentists fell slightly from 58.3% to 57.8%. This change may be affected by some dentists switching out of GDS in this period.

6.52 For dentists with a high commitment to the NHS, with between 67% and 100% of their earnings coming from the NHS, the income and expenses figures for the past three years are:

Income and expenses for non-associate dentists with high NHS commitment

Year	Population	Average gross earnings	Average expenses	Average net income	Expenses ratio
2003/04	1,908	£166,420	£86,630	£79,790	52.1%
2004/05	1,595	£180,190	£96,580	£83,610	53.6%
2005/06	1,207	£190,737	£94,577	£96,159	49.6%

6.53 In the two years between 2003/04 and 2005/06, average net income for highly committed NHS dentists increased from £79,800 to £96,200, an increase of 20.5%, markedly above the levels recommended by the Review Body. The expenses ratio for

these dentists in 2005/06 was 49.6% which is lower than the reported values in 2003/04 and 2004/05.

6.54 The increase in earnings for dentists with high NHS commitment and subdued increases in expenses is reflected in figures complied by the National Association of Specialised Dental Accountants (NASDA). Defining NHS practices as those where NHS fees are 80% or more of the total, the time series for laboratory costs and material costs together with total fees is:

NHS dental practices: turnover; laboratory fees; materials costs; cost of sales

	2001/02	2002/03	2003/04	2004/05	2005/06
Number of practices	149	75	163	143	128
Turnover	£244,200	£230,700	£275,000	£311,400	£356,700
Laboratory fees	£24,300	£21,700	£24,300	£24,800	£22,700
Materials	£17,200	£14,400	£17,500	£18,800	£19,900
Cost of sales = lab fees + materials	£41,600	£36,100	£41,800	£43,600	£42,600
Cost of sales as % of turnover	17.0%	15.6%	17.1%	14.0%	11.9%

6.55 Cost of sales as a percentage of turnover fell between 2001/02 and 2005/06 from 17.0% to 11.9%.

6.56 Net profit increased during the four-year period from £86,500 to £142,400, a rise of 64.6%. As a percentage of turnover, it increased from 35.4% to 39.9% because costs increased less fast than turnover.

NHS dental practices: net profit

	2001/02	2002/03	2003/04	2004/05	2005/06
Net profit	£86,500	£90,400	£104,000	£118,000	£142,400
Net profit as % of turnover	35.4%	39.2%	37.8%	37.9%	39.9%

6.57 It is very notable that net profit for NHS practices in 2005/06 overtook net profit for private practices.

Net profit for NHS, mixed and private practices[1]

	2001/02	2002/03	2003/04	2004/05	2005/06
NHS	£86,500	£90,400	£104,000	£118,000	£142,400
Mixed	£79,800	£87,200	£98,800	£100,400	£129,600
Private	£94,300	£100,100	£113,000	£124,700	£131,400

[1] NHS are practices where NHS fees are 80% are more. Private are practices where private fees are 80% or more. Mixed practices are other practices

Expenses formulae for dentists

6.58 In recent years the Review Body has used an approach based on a formula to assist it to determine the appropriate recommendation for GDPs.

6.59 The DDRB formula for the uplift in 2007/08 (para 4.52 of DDRB report) was:

$$\textbf{Uplift}_{\textbf{2007/08}} = \textbf{0.45*x + 0.1705*y + 0.3795*z;}$$

where:
x = increase in GDP remuneration;
y = increase in staff costs;

z = increase in other costs

6.60 For the 2007/08 uplift, DDRB used the following values for x, y and z.

- x - was the average uplift which DDRB recommended for the remit groups working in the Hospital and Community Health service (HCHS) sector. DDRB calculated the average increase to be 2.0%.
- y - was the annual percentage change in the median hourly rate of Healthcare and Related Personal Service Sector of 3.3% (in year to April 2006).
- z - was taken as the increase in RPI which was 4.0% (RPI in year to last quarter of 2006).

6.61 We have examined various aspects of the formula used by the Review Body in recent years and wish to suggest some improvements. One of the key elements of dental expenses is the cost of equipment and consumables. The current formula expects these to increase at RPI, but an examination of the real cost of dental supplies over the last year shows a very competitive market. The main supplier, the Dental Directory, which has nearly 50 per cent of the UK market, has not increased prices since January 2005, and its new catalogue (due September 2007) shows that they are continuing to freeze prices of some 5,700 products and reduce the prices of another 840 products by an average of 2.1%. The average price increase of the other products is only 1.9%. The weighted increase for all these items is only 0.75% per annum over this period. This is a clear indicator of a lower than anticipated increase in costs.Allowing the formula to make different assumptions for consumables would allow this kind of evidence (that relates specifically to dentistry) to be taken into account.

6.62 The formula also needs to allow for the effect of changes in treatment volumes on expenses.

These two changes give a revised formula of :

Uplift2008/09= (0.45*x) + (0.1705*y) + (0.0825*vc) + (0.0825*ic) + (0.0825*vl) + (0.0825*il) + (0.2145*zo)

where:

- x = increase in GDP remuneration;
- y = increase in staff costs;
- c = consumables costs with a weight of 8.25% obtained from their 15% share of expenses which are 55% of the total
- vc = change in volume of consumables
- ic = change in unit costs (inflation) for consumables.
- l = laboratory costs with a weight of 8.25% obtained from their 15% share of expenses which are 55% of the total
- vl = change in volume of laboratory items
- il = change in unit costs (inflation) for laboratory items.
- Zo = remainder of other costs.

The latest information on these values is:

- x = 1.5% the Governments' recommendation on pay;
- y = 3.3% increase in year to April 2006;
- v_c = 15% reduction in consumables (based on evidence from complexity of courses of treatment)
- i_c = 0.75%, the evidence from the suppliers;

v_l = 40% reduction in laboratory costs (based on evidence from complexity of courses of treatment)

i_l and z_o = 4.1%, the increase in RPI in year to July 2007

	Uplift	Pay assumption	Staff costs	Consumables	Laboratory costs	Other expense costs
Weight	100	45	17.05	8.25	8.25	21.45
Volume		-	-	-15%	-40%	-
Inflation		1.5%	3.3%	0.75%	4.1%	4.1%

The result of applying all of these adjustments to the formula using current values would be an uplift of -2%.

6.63 We recognise that the reductions in complexity of treatment identified in the Information Centre report may exceed the levels we will see once the reforms are fully bedded down, particularly after the introduction of the clinical data set from April 2008. The Review Body may also wish to make different assumptions about inflation in laboratory costs. However, even allowing for only a 10% reduction in the volume of consumables and laboratory costs – and even allowing for (say) 3.0% inflation in consumables, this still means that an uplift of just over 1.0% gives a net increase of 1.5%.

Dentists' concerns

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

6.65 There are concerns that these arrangements are not sufficiently sensitive to changes in the health needs of patients (e.g. a Band 2 course of treatment counts the same towards a dentist's annual service requirements, whether that course of treatment includes a single filling or several fillings) and that there is no explicit financial reward for more time spent on preventative activity. In our view, these concerns overlook the fact that the new contracts pay dentists the **same** overall income as before, in return for carrying out 5% cent **fewer** courses of treatment than under the old GDS system – and that the removal of the fee-per-item system supports dentists in carrying out simpler courses of treatment. Some courses of treatment will cost more than the average for that band, others will cost less than average. This averaging effect is the inevitable consequence of abolishing the unpopular fee-per-item system. But, if courses of treatment are generally simpler than before, there would have to be a significant change in the oral health needs of a dentist's patient base to cause an increase in overall costs. The data from the recent sample survey of complexity within banded courses of treatment published by the NHS Information Centre on 4 October clearly shows that dentists are providing simpler courses of treatment and, therefore, dentists' net earnings are growing.

6.66 It is clear, however, that more needs to be done to ensure that dentists and commissioners have enough information to judge if a case mix or treatment patterns have significantly changed and adjust the remuneration appropriately in these circumstances. Some PCTs have addressed this issue by providing for additional remuneration (or lower initial annual service requirements) in cases where dentists take on more patients from areas with traditionally poor access to services and higher oral health needs. The Department recognises, however, that there is a strong case for

having more easily accessible data on the treatments carried out within each band so informed judgements can be made. We are currently undertaking a project to identify future information requirements for commissioning NHS services and managing dental contracts. We will work with the NHS and the profession as part of this project to identify an improved clinical data set that will allow PCTs and practices to look more clearly at the relationship between treatment patterns and local health needs. The Department will also support PCTs in developing a range of indicators that can be used to measure quality, patient experience, access to services and other measures, these will be available over the next year.

6.67 Dentists have also complained that PCTs are recovering money when contracts have not been achieved, and that this so called “clawback” means they do not, in fact, have a predicable income as promised. We consider that it is unreasonable for providers to expect to retain contract payments for services which were not delivered. An allowance of up to four per cent underperformance is already built into the contracts: a provider must exceed this before any recovery can take place. Allowing further underdelivery without the option of recovering payments would, in effect, penalise providers who **have** delivered their contracted levels of service.

6.68 A further concern expressed by some dentists is that the primary legislation does not allow them to charge NHS patients for missed appointments. The working group, including BDA representatives, set up to devise a new system of patient charges unanimously recommended that dentists should not be able to charge for missed appointments. The Department has worked with NHS Primary Care contracting to produce guidance illustrating a range of ways in which practices can minimise missed appointments without recourse to financial penalties.

Local issues (including decontamination and endodontics)

6.69 As noted above, the new arrangements for NHS dentistry now allow, and indeed encourage, PCTs, to take specific account of any local factors, which may influence expenses in the main contract value for each provider. This might include local high costs for practice staff, rents, property or specific recruitment issues in the area (for example persuading dentists to come and work in less desirable or remote areas). This means that there is no need to include such factors in the general, national contract value uplift as they are best dealt with at local level by the commissioners of the service. Including a national uplift factor would reduce the money available to target at such “hot spot” areas and would significantly reduce flexibility to increase access in areas of highest needs.

6.70 The same logic also applies to the changes in dental practice necessitated by new decontamination rules for endodontics. A copy of the Department’s guidance on this issue is at **Annex F**, but the overall impact of the need to move to single use instruments is very low for most practitioners and is likely to be more than offset by the reduction in endodontics treatments. The best method of dealing with this, for those few practitioners who will incur additional costs, is for PCTs to take direct account of the costs locally depending on individual circumstances.

Access to NHS capital funding

6.71 Health minister Rosie Winterton announced in May 2006 that NHS dental practices and their patients will benefit from a programme of capital investment. £100 million of capital investment has been made available to the NHS, through SHAs, over two years to take forward infrastructure improvements for NHS primary dental care services. This builds on the £80 million capital investment already going towards modernising dental

education establishments and supporting the 25% expansion in dental training places. This direct access to additional capital funding (PCTs can already use their normal capital allocations to invest in primary care dentistry) and will further reduce pressure on practice expenses, particularly where practices are planning large scale investments.

Conclusion

6.72 This first year of the dental reforms has helped lay much more secure foundations for the future. There is much that the NHS can be proud of, particularly the success in agreeing new contracts for over 96% of previous services and in commissioning new services to replace lost capacity. These newly commissioned services will not only provide additional patient access but will also increase the income from patient charges, which were down in the first year of the reforms. The next stage is to move to a more flexible and creative process of local commissioning, based on developing services more fully to meet patient needs. Successful commissioning will rely more and more on enabling PCTs, dentists and other stakeholders to understand the characteristics of existing services and the extent to which they reflect local needs.

6.73 It is clear that the introduction of the new dental contracts has led to significant changes in the provision of dental services and the complexity of treatment delivered by individual dentists. There is an urgent need for a new workforce and expenses survey and this is currently being agreed by the Department of Health, the NHS Information Centre and the BDA with the objective of delivering additional data for next year's pay round. However, it is already crystal clear from the emerging data that dentists are providing shorter, less complex, courses of treatment with a consequent drop in practice expenses which must be taken account of.

6.74 The two key factors in improving access (see above) are reforms to how services are delivered (through better commissioning and better use of NICE guidelines) and steady, sustained growth in local investment. Sensible local commissioning decisions are at the heart of increasing patient access and these will be seriously undermined by increasing remuneration beyond the modest levels we suggest. NHS dentistry is now very attractive to providers at the current cost levels as is shown by tendering exercises. Any pay increase beyond those suggested will directly reduce the money available locally for improving access. Each additional 0.1% on pay costs around £2.5 million, which (allowing for additional patient charge revenue), would otherwise purchase services for some additional 40,000 patients.

6.75 If the data from the IC complexity study is correct (and it is a large and statistically valid sample) then the average complexity of advanced dental treatments have fallen by about 40%, with other treatments falling by about 15%. This means that the changes to expenses and consumables have increased dentists' net incomes by 10.1%, and so a pay increase of 1.5% would in effect increase dentists' average net income by **9.3%** (if expense inflation is 4.1% and allowing for lower expense volume from the 5% reduction in weighted courses of treatment).

6.76 Our review of the formula used by the Review Body to inform decisions (paras 6.58-6.63 above) strongly suggests that the formula needs to be adjusted to allow assumptions to be made about changes in complexity of treatment and to allow for different assumptions about inflation in laboratory costs and in costs of consumables. Even on the most cautious and conservative assumptions about levels of complexity (once the reforms are fully bedded down), the formula indicates that a 1.5% increase in net income requires at most a 1.0% increase in gross contract payments (see para 6.63 above). We, therefore, consider that an increase in gross contract payments of 1.5%, which would allow for any unanticipated increases in expenses, would be appropriate at this time.

6.77 In brief:

- Recruitment and retention are healthy (with significantly more dentists in the NHS than in 2003)
- PCTs are having no problems commissioning new services
- Recruitment of graduates to the profession is up (with good career prospects, stability in career etc.)
- Complexity of treatment is down, leading to costs falling, and increased profits Dentists' earnings are growing.

6.78 All the above argues for an award of no more than 1.5%, which can be applied to the GDS dental contract values. We would expect most PDS agreements to have a similar uplift applied but the specialist nature of some of the services commissioned, e.g. for orthodontics, mean that PCTs need to have more flexibly in uplifting contract values for this group.

SALARIED PRIMARY DENTAL CARE DENTISTS

6.79 There are some 1500 salaried dentists (headcount) working in salaried primary dental care services (SPDCS) 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. These staff are predominantly employed by the provider arm of Primary Care Trusts and are an important and valued part of the overall dental workforce.

6.80 The Terms and Conditions of service of this staff group are largely those inherited from local authorities, which were responsible for these services until 1974. They are inappropriate for the conditions of NHS dentistry in the 21st century.

6.81 In early 2003, the BDA agreed a three-year pay deal for salaried dentists in England. As part of that agreement, the Department undertook to carry out a wide-ranging review of roles, pay structures, and career opportunities for salaried dentists. The review took place from the autumn of 2003 to the summer of 2004 and was published for formal consultation in December 2004 as *Creating the Future – Modernising Careers for Salaried Dentists in Primary Care*. The consultation proposals received widespread support.

6.82 We reported to the Review Body last year that, following that review, we had asked NHS Employers to enter into detailed negotiations with the BDA to develop new career and pay structures.

6.83 Those negotiations have proceeded during the last year and the BDA and NHS Employers will have reported separately to you on those negotiations. The Department has kept in close touch with progress and has been pleased at the very constructive approach taken by both parties. They reported to us that they had concluded negotiations based on a summary agreement which they had agreed should be effective from 1 June 2007, subject to Government approval and a ballot of salaried dentists which the BDA would conduct. We have supplied the Review Body with the draft agreement presented to us by the BDA and NHS Employers.

6.84 The proposed agreement has been considered within government and we are satisfied that it represents an affordable deal which will bring significant benefits for patient care

and employers as well as giving staff a clear career framework and progression, all based upon a competency framework and annual appraisal process developed jointly by NHS Employers and the BDA. The BDA negotiators have told us that they are in a position to actively commend the proposed agreement to staff.

6.85 The proposed agreement is about to go to ballot and an update will be provided in supplementary and/or oral evidence.

6.86 Subject to a favourable outcome to the ballot, all parties will be looking to secure the earliest possible implementation so as to start the realisation of the benefits described above. The Department has asked Primary Care Contracting to work with the BDA and NHS Employers on the design and delivery of a support programme to assist PCTs with implementation and which will complement work which the BDA will do to support staff through the transition and translation of individuals from the old to new Terms of Service.

6.87 The implementation of the new Terms of Service will give individual members of staff a pay uplift which will vary between individuals depending on their present job and how they assimilate into the new competency-based career structure. We have agreed that, over and above that individual uplift, all salaried dental staff should benefit from the general uplift in pay considered appropriate for medical and dental staff grades. We consider that, having regard for all the general circumstances, a pay uplift of 1.5% would be appropriate and we ask the Review Body to so recommend.

DENTAL PUBLIC HEALTH STAFF

6.88 We reported last year that we had published an Oral Health Plan for England. "*Choosing Better Oral Health*" was published in November 2005. As part of the Choosing Health family, it sets out the Government's strategy for improving oral health and reducing oral health inequalities. In the section on workforce we stated that "*PCTs will firstly wish to consider the advice that they receive on meeting the oral health needs of their residents and that Consultants in Dental Public Health are trained specifically to assess oral health needs and provide advice on how these needs should be met*". More recently, as part of a drive to secure oral health improvement, we have produced a toolkit for dentists "*Delivering Better Oral Health*" launched in September 2007 to assist individual practitioners in developing a health improvement component to their clinical practise, and to assist PCTs in commissioning for oral health improvement.

6.89 The clinical quality, patient safety and health improvement components of dentistry are all ones in which dental public health consultants play a key role, as their formal training and competencies specifically equip them to provide specialist expertise and undertake an advocacy and leadership role in relation to this agenda. They therefore represent an important element of NHS management capability in both SHAs and PCTs and their expertise needs to be suitably utilised and deployed. There are, however, significant workforce issues arising from the relatively low numbers of these staff. This has manifest as significant gaps in some parts of England, and in other areas of single-handed consultants having to work across large geographical areas spanning a number of NHS organisations.

6.90 We reported last year that the Department was considering how to take forward a review which had been commissioned by the previous Chief Dental Officer and undertaken in 2003/04 of the capacity of dental public health staff. We have now established a wide-ranging review of capacity and capability in dental public health in the NHS, which is being undertaken as part of the Department's work to strengthen the wider public health workforce as well as our work to develop commissioning capacity

in dentistry. The review, led by the Department, is working with an external stakeholder group drawn from the wider public health community, NHS management, and dentistry, the latter including the BDA. It will report early in 2008.

6.91 Dental public health staff are employed on terms and conditions of service which are exactly comparable with, but are currently separate to, their counterparts in hospital medicine and dentistry and in public health medicine. We have been in discussion with the BDA for a number of years about the desirability of fully incorporating those staff in the main hospital medical and dental/public health medicine terms and conditions of service, in order to ensure that these staff experience no delay in receiving the benefits of changes to pay, allowances, and other terms of service. Arising from recent discussions with the BDA we are hopeful that it may be possible to achieve full incorporation before the next annual cycle of Review Body consideration.

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

CHAPTER 7: OPHTHALMIC MEDICAL PRACTITIONERS

Summary

7.1 The Department of Health has agreed the 2007/08 sight test fee with the Optometric Fees Review Committee, which represents optometrists and ophthalmic medical practitioners (OMPs). Agreement has also been reached on the payment for loss of earnings associated with undertaking continuing education and training during 2007.

7.2 We remain firmly of the view that there should be a common sight test fee for optometrists and OMPs. Optometrists continue to carry out some 98% of NHS sight tests, and we believe the DDRB's previous recommendations about the joint negotiation of a common fee continue to be relevant for this and future years.

Background

7.3 Between 31 December 2005 and 31 December 2006, the number of OMPs who held contracts with Primary Care Trusts in England and Local Health Boards in Wales to carry out NHS sight tests decreased from 479 to 406, and the number of optometrists increased from 8,692 to 9,102. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

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

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

7.6 In January 2007, the Department published the findings of a review of General Ophthalmic Services. The main focus of the review was to assess how to support the NHS in making greater use of community-based services to improve patient experience and patient choice.

7.7 The review concluded that there is clear potential to develop more accessible, tailored eye care services for patients by making greater use of the skills that exist among eye care professionals in both primary and secondary care. However, the types of services needed will vary locally depending on a range of factors, including patient needs, existing resources and capacity, the profile of the eye care workforce locally, and current patterns of service utilisation. The main output of the review was a toolkit to help PCTs and practice based commissioners assess local needs and design and commission services to meet these needs.

7.8 The review also confirmed the case for maintaining the present system for sight testing services with no fundamental changes to the system of demand led sight testing with fees continuing to be set nationally after negotiation with the Optometric Fees Review Committee.

CHAPTER 8: EVIDENCE FROM THE WELSH ASSEMBLY GOVERNMENT

Summary

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

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

8.2 The NHS in Wales has a clear strategic vision, the delivering of world class healthcare by 2015. *Designed for Life* sets out the direction of travel and specific requirements for the NHS through a series of three-year strategic frameworks:

- Redesigning Care 2005 – 2008 which is focused on:
    - Reconfiguration
    - Clarity on the major care streams
    - Sorting out processes e.g. commissioning, workforce planning
    - Ending long waiting times
- Delivering Higher Standards 2008 – 2011 will focus on improving the quality of services that are delivered, centred around six domains: safety, effectiveness, patient focus, equity, timeliness and efficiency. Significant emphasis will be placed upon the implementation of quality standards and the measurement of more clinically focussed indicators.
- Ensuring Full Engagement 2011 – 2014

Regional Reconfiguration

8.3 The First Minister announced on 6 June 2007 that there would be an immediate moratorium on changes at Community hospital level and a commitment that, where changes are agreed at District General Hospital level, they will not be implemented until related community services are in place. The Minister for Health and Social Services is considering the reconfiguration process so far and the lessons that can be learnt, in particular the proposals for those parts of Wales that have yet to gain public support.

Community Services Framework

8.4 This was issued in April 2007 and sets out what Local Health Boards (LHBs) and partners should do to improve services in the community that enable people to live healthy, fulfilled and independent lives. This framework covers the period 2008 – 2011 to align with local health, social care and well-being Strategies which are the key way in which LHBs and Local Authorities plan to improve the health of their resident populations. It identifies that more must be done to promote and protect health, to protect and maintain independence, to support self-care and carers. It also identifies that care should be managed as close to home as possible and that gaps in care must be filled and connections made.

8.5 The Framework requires that LHBs and partners must identify the community services needed and how they will be created; produce the first round of proposals outlining the strategic plan for community services by December 2007 and see through the resultant changes.

Access 2009

8.6 This aims to reduce the waiting time from primary care referral to definitive treatment to a maximum of 26 weeks by December 2009. This includes waiting times for diagnostic tests and therapy services.

Workforce Strategy

8.7 The HR and Workforce Strategy for Wales, *Designed to Work*, was launched in June 2006 and identified the key themes and priorities and workforce challenges for NHS Wales and its partners and creates a framework for organisations to develop workforce strategies and implement them in partnership with staff, users and social care providers.

8.8 Theme 1 - Developing a new approach to role design and innovative work systems to meet patients' needs

8.9 The implementation of Agenda for Change and ESR have been a significant resource drain on the HR team and has resulted in only limited energy being invested on the future workforce agenda. any Trusts have or are in the process of re-structuring their HR functions to separate the operational work agenda from the strategic development and change work streams. This will enable Trusts to give appropriate priority and focus to the workforce modernisation agenda.

8.10 Skills for Health are an integral partner in delivering the change agenda in Wales. They will ensure that the tools that will facilitate the development of the workforce are available to enable services to be organised around patients and service users; leading to a patient-centred approach across sector boundaries.

Pay Modernisation Benefits

8.11 Service pressures and pressure to achieve targets are forcing the speedy delivery of benefits. Many of these targets will be realised through innovation, workforce efficiency and role modernisation.

Theme 2 – *Creating an organisational and workforce development planning system to deliver Service change*

8.12 The implementation of KSF has been slower than desired with a number of Trusts reporting that there is limited enthusiasm from staff. There is clearly a need to refocus and re-energise work on KSF. All Trusts have however implemented the ESR and E-KSF interface which will help the development of accurate training records and activity reporting linked to individual KSF needs.

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

8.13 The implementation of ESR has been a significant success. Especially noteworthy is the implementation of NHS Jobs which has virtually eradicated the requirement to advertise jobs in journals and magazines. All organisations report very positive volumes of responses to adverts placed on the NHS Jobs web site and a strong recruitment market. There are no significant recruitment or retention difficulties.

Workforce Numbers: Headline Figures

8.14 Between September 2005 and September 2006, the number of WTE directly-employed NHS staff increased by 3% (2,350) to 70,620. Hospital medical and dental staff increased by 472 (10%) to 5,332 of which the number of hospital medical consultants increased by 100 (6%) to 1,727. There were increases in the other hospital grades as follows:

- Associate Specialist 149 to 187 (25%).
- Specialist Registrars 823 to 871 (6%)
- Senior House Officers 1260 to 1411 (12%) and
- House Officers 257 to 391 (52%).

8.15 There has been a 17% increase in the number of dental undergraduate places in Cardiff from October 2004. There is an intake of around 65 students each year.

8.16 We have more than doubled the annual medical student intake (190 to 338 plus 70 places at Graduate Entry Scheme in Swansea) from 1998 to 2006. There are over 2,200 doctors in training in Wales of which 811 are Specialist Registrars working in all specialty areas to gain the Certificate of Completion in Training to enable them to apply for consultant posts. The Deanery is currently going through a process of reorganising these posts along with 1,100 SHO posts to develop run through training with a start date of entry in August 2007.

Workforce Development Programme for 2007/08

8.17 A review of workforce planning in Wales identified a range of problems with existing approaches. To address these, a Task and Finish group identified a number of principles that needed to be applied to the new system:

- Workforce planning needs to be fully integrated with service and financial planning so that plans could reflect the major changes in service delivery that are planned and anticipated for the future, but also provide for input and advice from staff and professional representative bodies.

- It needed to address future workforce capability in terms of skills, roles and ways of working in teams rather than simply numbers in individual professional groups.

8.18 The full system will come into force in 2008/09 with transitional arrangements adopted for 2007/08. The implementation plan, currently under development includes workforce planning tools and models, a benchmarking data base and a training and education programme to improve skills in workforce modelling and planning at all levels in provider and commissioning organisations.

Consultant Vacancies

8.19 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 102.3 (5.4%) in March 2006 to 59.5 (3.0%) in March 2007.

	31/3/2006	30/9/2006	31/3/2007
A&E	5.4	2.4	4.4
Anaesthetics	8	4	1
Clinical Oncology			
Dental Group	-	1	1
General Surgery	3	-	1
ENT	-	4	2
T&O	7	2	1
Ophthalmology			
Urology	1	2	2
Cardio-Thoracic Surgery			
Plastic Surgery			
Pathology	-	-	
Haematology	5	3	3
Histopathology	9.6	8	2
Medical microbiology	1	3	1
Blood Transfusion	-	-	
Paediatrics	4	3	4
General Medicine	20.5	12.4	14
Obstetrics & Gynaecology	-	-	1.5
Community Health	-	1.5	
Psychiatry	28.4	13	15.6
Radiology	9.4	2	6
	102.3	61.3	59.5

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

	30/3/2006	30/9/2006	31/3/2007
Bro Morgannwg	9	3	4
Cardiff and Vale	8	3	6
Carmarthenshire	4	2	
Ceredigion & Mid Wales	2	-	
Conwy & ‘Denbighshire	9	8.4	5
Gwent Healthcare	11	-	15.6
North East Wales	9	2	1
North Glamorgan	9	7	4
North West Wales	13.9	17.4	15.4
Pembrokeshire & Derwen	18.4	12.0	6
Pontypridd & Rhondda	2	1.5	0.5
Powys LHB	-	1	
Swansea	7	1	2
Velindre	-	-	
National Public Health Service	-	2	
Welsh Blood Service	-	1	
Total	102.3	61.3	59.5

8.20 The vacancy rate for other Doctors and Dentists (excluding Training Grades) has also fallen in the last six months from 4.9% to 1.1%. Most Trusts report being able to fill most posts with a good field of candidates and half consider recruitment to have improved in the past year. These improved vacancy rates are a direct result of robust recruitment and retention and show that pay is about right at present.

EWTD and Hospital at Night

8.21 EWTD and New Deal compliance is excellent with current compliance levels at 98/99% as shown in the Table below. Most Trusts are showing evidence of beginning to plan for the 2009 48-hour target and current all Wales compliance levels stand at 33%.

8.22 Hospital at Night continues to be a concept which assists Trusts in achieving compliance with EWTD. However this alone is not enough and joint working of rota participants, clinical directors, risk managers and postgraduate organisers will need to continue.

8.23 The focus is now shifting to encompass Hospital at Weekend and Hospital at Day. This makes the maintenance of the Hospital at Night Project Board at local level important with their remit being extended to include the above.

Consultants Contract

8.24 The Assembly has adopted a three stage approach to benefits realisation:

- WAO audits of each Trust to ensure proper implementation of job planning
- requirement for Trusts to produce an Annual Report on the Contract; and
- development of Consultant Outcome Indicators as the longer-term tool to help identify service benefits

8.25 The Assembly used information from the audits to ensure a consistent and justifiable basis for decisions to fund additional sessions

8.26 The Trust Annual Reports have showed that average consultant weekly working hours have reduced from 46.3 hours in December 2003 to 41.5 in March 2007. This includes all their NHS commitments, including management and other activities. The average level of sessions paid per consultant has fallen from 11.5 in December 2003 to 10.6 in March 2007. Average Direct Clinical Care (DCC) sessions have reduced from 9.3 to 8.2 with average Supporting Professional Activities (SPA) marginally increasing from 2.2 to 2.4.

8.27 The average level of paid additional sessions has fallen by over 20% (partially due to the effect of increased consultant numbers – 2,023 at March 2007, an increase of 120 on March 2006) to 1.02 per consultant for DCC and SPA activities and 1.24 including management and other activities.

8.28 In addition, all Trusts report that significant benefit is being derived from the enhanced dialogue with clinicians which has enabled service change and a balancing of priorities. The implementation of the CHKS project is making solid progress and gradually receiving more acceptance from clinicians. This is a holistic framework of specialty specific, outcomes based indicators designed to inform job planning by giving each Consultant and their employer an individual annual report covering their performance against a range of indicators felt by the profession to best reflect that specialty, together with appropriate local and national comparators.

EWTD COMPLIANCE WITH 2007 WORK AND REST REQUIREMENTS
for period ending January 2007

TRUST	F1 Number In Post	F1 Number Compliant	F2/SHO Number In Post	F2/SHO Number Compliant	SpR Number In Post	SpR Number Compliant	Flexi Number In Post	Flexi Number Compliant	Total In Post	Total Compliant	Total %
Bro Morgannwg	23	23	111	111	44	44	13	13	191	191	100.0
Cardiff & Vale	59	59	244	244	329	329	32	32	664	664	100.0
Carmarthen	25	25	84	82	16	14	2	2	127	123	96.9
Ceredigion	9	9	35	35	0	0	1	1	45	45	100.0
Conwy & Denbigh	18	18	94	94	39	39	2	2	153	153	100.0
Gwent	39	39	240	240	118	101	18	18	415	398	95.9
NEWT	18	18	81	81	48	48	4	4	151	151	100.0
North Glam	14	14	86	86	16	16	0	0	116	116	100.0
NWW	15	15	17	17	33	33	2	2	67	67	100.0
Pembroke	9	9	71	71	8	8	16	16	104	104	100.0
Ponty & Rhondda	18	18	80	80	45	45	6	6	149	149	100.0
Powys	0	0	4	4	0	0	0	0	4	4	100.0
Swansea	32	32	190	186	141	135	14	14	377	367	97.3
Velindre	0	0	0	0	30	30	7	7	37	37	100.0
TOTALS	279	279	1337	1331	867	842	117	117	2600	2569	98.8

Proposed New UK-Wide Contract for SAS Doctors

8.29 SAS Doctors are a particularly important part of the Welsh medical workforce, comprising 22% of our employed doctors and dentists (as opposed to 15% in England and 14% in Scotland), and make an important contribution to service delivery.

8.30 It has been widely recognised that this group of doctors – who historically have often been recruited from overseas – have had limited career opportunities and little professional development, which has often prevented them from making their most effective contribution to service delivery.

8.31 The proposed agreement provides for a clear career structure and professional development reflecting their demonstrated contributions and skills, with a new system of job planning mirroring that of Consultants to channel their contributions to service modernisation effectively. The estimated cost of the agreement for Wales is £5.5 million in the first year, rising to about £8 million p.a. as the contract is fully implemented.

8.32 If the proposed agreement is not supported by the Public Sector Pay Committee or is not voted in on a UK-wide basis in a subsequent ballot of doctors, the Assembly is likely to be approached by the BMA about introducing it (possibly with some modifications) in Wales. We would want to gain Ministerial support on how then to respond, particularly if we thought of going ahead in Wales.

GP Numbers

8.33 As at 30 September 2006, Wales had 1882 practitioners, a 6% increase since 1998.

- 36% of practitioners are female
- In Wales the average list size per practitioner was 1,650 the same as in England. The range across LHBs in Wales was from 1,332 in Gwynedd to 2,031 in Rhondda Cynon Taf
- 20% of GPs in Wales are aged over 55, compared to 21% in England
- At 30 September 2006 there were 152 GP Registrars
- The number of GP retainers has increased to 61 (2 ½ times the number in 1999)
- 4% of practitioners are single handed.
- As at 31 March 2006 the three-month vacancy rate was 1.8%, down from 2.1% in 2005. The three-month vacancy rate per 100,000 population was 1:1.

8.34 Recruitment and Retention of GPs in Wales has improved considerably since the implementation of the new practice based contract. There is clear evidence that patterns of employment and skill mix in primary care have started to change. More salaried doctors, practice nurses and health care assistants have been employed. In BMJ Careers in 2002, the number of GP principal positions advertised in Wales was 132; the number of salaried GP positions advertised was 12. By 2006 this ratio had changed to 22 principals and 25 salaried positions. The GP vacancy rate has dropped to its lowest level for many years and anecdotally we understand that there are far fewer vacancies available generally. In Blaenau Gwent for example they now have no

vacancies at all whereas four years ago they simply could not attract candidates despite having a number of vacancies.

8.35 In 2002, Rhondda Cynon Taff LHB established a Primary Care Support Unit in response to the imminent retirement of GPs. It started with two salaried GPs and two practice nurses. The Unit now employs 34 salaried GPs and 12 practice nurses and for its latest advertisement it attracted 34 candidates. The PCSU has proved successful in attracting salaried doctors to RCT. It has supported "struggling practices" and facilitated professional development across general practice as a whole.

Key Data

	2003	**2004**	**2005**	**2006**
GPs	1822	1816	1849	1882
Part time GPs	21%	21%	22%	22%
Female GPs	31%	33%	35%	36%
GPs per 10,000 pop'n	6.1	6.0	6.2	6.3
GPs aged over 55	18%	19%	20%	19%
3-month vacancy rate	3.1%	2.1%	1.8%	0.9%
Single handed GPs	5.9%	5.4%	5.2%	4.4%
GP Registrars	110	115	103	152
Practice Nurses	782	795	847	*

* no figures available

8.36 The table above shows:

- There has been a 3.2% growth in the number of GPs since 2003. (The total growth since 1998 is only 5.8%.)
- The number of female GPs is growing and 2/3 of GP Registrars are female.
- The percentage of vacancies lasting three months or longer has fallen to 0.9%.
- The proportion of single handed GP practices has fallen to 4.4%.
- The number of practice nurses grew by 8.3% in two years.

8.37 At the same time the average list size per GP has reduced from 1708 in 1995 to 1643 in 2006.

GMP Registrars

8.38 The average banding supplement paid to hospital doctors has fallen to 57% in Wales and is expected to fall further by April next year. We would support the proposal therefore to reduce the GMP Registrar Supplement to 50% for 2008/09.

Dentists

8.39 The investment of £30m additional funding for the contract has made a noticeable difference in access. Problems are confined to a very few areas including Pembrokeshire, Ceredigion and Anglesey. Work continues to improve the position in these areas and further progress is expected over the next few months so that everyone in Wales who wants access to a NHS dentist will be able to get one.

8.40 The latest Dental workforce data shows 1,186 dentists recorded on the 'Payments Online' system at 31 March 2007. This compares with 1087 at 31 March 2006 and 975 in June 1999.

8.41 We share the DOH view that the pay award for dentists in 2008/09 should be a simple recommendation for an increase in net pay and expenses which reflects the changes in the supply of dentists and the change in the type of work provided, particularly the move to simpler courses of treatment with a lower expenses element.

8.42 In 2006 we introduced similar reforms to those being launched in England. The main differences were as follows:

- over the course of the year dentists were expected to provide a certain number of courses of treatment weighted by their complexity. However this was 10% fewer (5% in England) than the courses of treatment carried out in the test period, while the dentist still received 100% value of the contract. There was also a tolerance level of 5% in Wales (4% in England) associated with the level of activity before this triggered a discussion between the dentist and the Local Health Board; and

- vocational training and clinical audit and peer review remained centrally funded and administered in Wales.

8.43 There were similar concerns expressed by the BDA about the number of dentists who would reject the new contract or reduce their commitment to the NHS. In fact, some 97% of dentists providing NHS care signed up for the new contract and the contracts signed by these accounted for a little over 95% of NHS dental services being provided prior to 1 April.

8.44 The introduction of the new contract has to a large extent stabilised the provision of NHS dental services and improved access for patients. LHBs have been able to bring in new services if a dentist leaves or reduces their NHS commitment and have found little shortage of takers for new or expanded contracts when offered. There has on occasion been a time-lag in commissioning and delivery of services due to recruitment processes and other issues such as meeting planning and procurement requirements.

8.45 We also have recognised the concerns expressed by dentists and some LHBs about certain operational aspects of the contract. As a result the Minister has asked for a review of the dental contract following its first full year of operation by Spring 2008.

8.46 Finally on salaried dentists we have agreed with the profession that once final agreement is reached on the proposed new pay and career structure, similar proposals will be submitted to our Minister for approval.

Employers Views

8.47 A questionnaire was sent to employers in Wales and the main findings were as follows:

- In response to what would be the impact on services of a higher pay award than was deemed affordable, the majority of Trusts referred to a reduction in the quality of care, as a result of a reduction in staff numbers, although not necessarily via redundancies;

- On the question of whether the recruitment situation had improved or deteriorated over the last 12 months, the majority of responses showed it had improved or stayed the same;

- In terms of the reasons for staff leaving their organisation, the three most common reasons were other NHS employment, relocation and retirement;

- On the issue of morale the majority of responses indicated that morale had stayed the same over the previous 12 months.

NHS Wales Staff Survey

8.48 Arrangements are underway for the Staff Survey 2007 which is taking place from September to October and will remain focussed on staff morale. A report of the findings will be included in next years evidence.

Finance

8.49 NHS organisations must plan to operate within their available resources and all will be required to achieve efficiency savings to meet their commitments through continued reductions in the cost of service delivery. These cash releasing efficiencies will meet baseline cost increases, in addition to savings required to meet financial targets in approved strategic change and efficiency plans. Commissioners will need to achieve savings through more effective provision of services, which may in some situations, require disinvestments.

8.50 LHBs and Trusts are expected to achieve and deliver the annual priorities from within the financial allocation notified to them. The exception is where specific funds are held centrally to support the achievement of targets.

8.51 For the financial year just gone, the deficit was £28m. Individual Trust repayment plans were part of the Strategic Change and Efficiency Plans for 2007/08.

8.52 The Comprehensive Spending Review (CSR) provided Wales as a whole with average annual real-terms growth of 1.8% between 2008/09 and 2010/11. The Health budget will, however, get less than this. The following figures are from the Assembly's draft Budget Tables and must be taken as provisional until the Assembly votes for its final Budget for 2008/09 in December.

	Health DEL £M	**Cash Growth £M**	**Cash Growth %**	**GDP deflator [1]**	**Real Terms Growth**
2004/05	4,279	289	7.5	2.72	4.6
2005/06	4,628	349	8.2	2.12	5.9
2006/07	4,983	356	7.7	2.44	5.1
2007/08	5332	348	7.0	2.66	4.2
2008/09	5563	231	4.33	2.67	1.62

[1] GDP Deflators as at 30 September 2007

8.53 The consequential impact of the CSR is expected to significantly reduce the flexibility to manage financial pressures in NHS Wales in 2008/09. NHS organisations will need to make efficiency savings of at least 2% to meet ongoing service costs. This is in addition to eliminating underlying deficits which NHS organisations are currently forecasting are equal to approximately 1% of total funding.

Conclusion

8.54 There are no recruitment and retention problems for DDRB staff with a continuing fall in vacancy rates across the board. In view of the impact of the Comprehensive Spending Review which will significantly reduce the flexibility to manage financial pressures in NHS Wales in 2008/09, an increase of no more than 1.5% would seem to be the most balanced option.

CHAPTER 9: EVIDENCE FROM THE SCOTTISH GOVERNMENT HEALTH DIRECTORATES (SGHD)

SUMMARY

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

9.2 The evidence sets out:

- A The Scottish Context
- B Specific information about individual medical staffing groups
- C Dental Services in Scotland
- D Workforce
- E Working Time Regulations
- F Efficient Government
- G Regional Pay
- H NHS Finance in Scotland
- I Conclusion and Pay Proposals for 2008-09

A. THE SCOTTISH CONTEXT

Background

9.3 In 2005, *Building a Health Service: Fit for the Future* set out a series of challenges to health and wellbeing arising from an ageing population, persistent health inequalities and a growth in long term conditions. It recognised an increasing demand for health and care services and changes to the pattern of demand, such as increases in the number of emergency admissions and age related conditions such as dementia.

9.4 Since 2005, NHS Scotland has embarked on a long term programme of change designed to shift the balance of care to meet key healthcare challenges. This is designed around the evolving model of healthcare described below:

Current View	Evolving Model of Care
Geared towards acute conditions	Geared towards long term conditions
Hospital centred	Embedded in communities
Doctor dependent	Team based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventive care
Patient as passive recipient	Patient as partner
Self care infrequent	Self care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low tech	High tech

9.5 In order to deliver these changes, a Delivery Group was established in 2005 to:

- Ensure a renewed and explicit focus on key objectives, targets and measures across the health portfolio;
- Strengthen performance management between each NHS Board and the Scottish Executive by introducing local delivery plans of agreed, sharply focussed, quantified local actions;
- Work with more timely and reliable management data enabling accurate tracking of Boards' performance; and
- Make specific interventions to support and improve performance where the need arises.

New Administration in Scotland

9.6 On 3 May 2007 the Scottish Parliamentary elections took place and for the first time since devolution in 1999 a Scottish National Party (SNP) administration was elected. The new government has identified a series of core strategic objectives, supported by a streamlined Cabinet and a health and wellbeing portfolio that has been extended to incorporate responsibility for some of the key determinants of health such as sport, housing, regeneration, social and financial inclusion, homelessness, and poverty. The strategic objective for health and wellbeing is to help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare. Every government portfolio is challenged to work in an integrated way to contribute to the achievement of this objective.

9.7 In August 2007, the Government launched a period of discussion in order to inform a new strategy and action plan that will build on the established framework for change in health services and reflect new insights, learning and opportunities that have emerged since 2005. The discussion document, *Better Health, Better Care*, seeks to stimulate a dialogue around seven broad themes:

- Improving our **patients' experience of care**, delivering care as locally as possible and ensuring that both they and their carers are involved in the design and delivery of the care they receive;
- Securing **best value** from our investment by maximising efficiency and productivity to ensure that our services are sustainable over the longer term;
- Encouraging everyone to **take responsibility** for their own health and wellbeing and prevent health problems arising wherever possible;
- Focussing on **tackling health inequalities** in everything we do;
- Working in partnership to provide **anticipatory care** and improve services for **long term conditions;**
- Investing in early intervention and prevention to **give children the best possible start** in life; and
- Ensuring continuous **improvement** in services, with a determined focus on patient safety.

9.8 The new strategy and action plan will be published before the end of 2007.

Last Year's DDRB Recommendations

9.9 On 14 March 2007, following the publication of the DDRB's Thirty-Sixth Report, the then Minister for Health and Community Care, Andy Kerr, announced that the Scottish Executive had accepted the DDRB's recommendations on pay levels for 2007/08 for doctors and dentists and would implement these pay awards to all doctors and dentists in full and without staging from 1 April 2007. This represented a significant step for the Executive, as our normal practice has been to implement NHS pay awards in Scotland

in line with the other UK countries. On this occasion however, after very careful consideration of the situation, Scottish Ministers decided to depart from the position taken by the other three countries and implement the DDRB recommendations in full. This decision was taken on the grounds that the Scottish Executive Health Department's (SEHD's) planning assumptions for 2007/08 had budgeted for a rise in line with the recommendations made by the Health Pay Review Bodies, and that these were therefore affordable in Scotland.

9.10 Whilst SEHD accepted the pay recommendations, Scottish Ministers rejected the DDRB recommendation on additional funding for distinction awards in Scotland to cover the newly eligible senior academic GPs. As previously stated in our evidence, the Health Directorates do not consider it appropriate to increase the funding on the grounds that the level of dilution of the awards to the pre-existing consultant body is not considered sufficient to justify any extra resources and also in view of the current on-going review of the distinction awards scheme.

B. SPECIFIC INFORMATION ABOUT MEDICAL STAFFING GROUPS

Hospital Consultants

9.11 The proportion of consultants on the new contract in NHS Scotland as at September 2006 is 98.5%. The average number of programmed activities agreed in NHS Scotland at September/October 2006 remains at the previous level of 11.5.

9.12 During 2006/07 efforts have been concentrated on embedding the annual consultant job planning process into the on-going service planning process and on realising benefits from the investment made in this group of staff. We have asked NHS Boards to give explicit examples of how they have used the contract to support the delivery of agreed service redesign and performance targets e.g. in relation to waiting list targets in their Pay Modernisation Benefits Realisation Plans. From the information received it is clear that the job planning process is being used in a number of areas to explicitly link the consultants' time and skill mix with the priorities of the NHS Board and the intention is to further build on these examples in support of our strategic approach in aligning pay along with other workforce factors to support recruitment, retention and productivity.

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

Review of Distinction Awards and Discretionary Points

9.14 In our evidence last year we reported that the then Minister for Health and Community Care, Andy Kerr, had established a Group in October 2006 to review the Distinction Awards and Discretionary Points schemes. Since that time the Group has met on several occasions and taken both oral and written evidence from key stakeholders (ie NHS Employers in Scotland, the BMA, the Scottish Advisory Committee on Distinction Awards (SACDA), the Universities and the Royal Colleges). The Group is continuing its deliberations and will make recommendations to the Cabinet Secretary for Health and Wellbeing on the shape of a new scheme in the near future.

Staff and Associate Specialist (SAS) Doctors

9.15 Between May 2005 and November 2006 the Scottish Government and NHSScotland employers participated in UK discussions on a new contract for Staff and Associate Specialist doctors. An agreement was reached in November 2006 and was passed to Health Ministers in the four countries for ratification. Andy Kerr, the then Scottish Minister for Health and Community Care approved the new contract in January 2007. Having been agreed by UK Health Departments and Ministers the contract was then forwarded by the Department of Health to the Public Sector Pay Committee for consideration in relation to implementation in England. As this report is drafted the Public Sector Pay Committee continue to consider the contract.

9.16 Dependent on the outcome of that process the Scottish government may either implement the contract as part of a general UK implementation following PSPC approval or be required to make a decision as to whether the contract will be implemented in Scotland should such approval not be forthcoming.

Doctors in Training

9.17 New Deal compliance is normally monitored by NHS Boards twice a year and the figures are forwarded to Information and Statistics Division (ISD) who publish the levels of compliance on their website. Because of the pressures of MMC Speciality Recruitment this year, Boards were advised at an early stage that they were not required to report the results of the August 2006 to January 2007 monitoring round to ISD for publication. Further to this it was agreed between NHS employers in Scotland and BMA Scotland that the current round of monitoring (February to July 2007) would be suspended, with the exception of non-compliant rotas, which were still to be monitored over a suitable representative period. This decision was in recognition of the resources the Boards had to direct towards MMC. There will not therefore be any figures to show the levels of New Deal compliance in Scotland throughout these two monitoring periods.

9.18 The latest published figures relate to the period February to July 2006. 96.8% of junior doctors in Scotland were fully compliant with the New Deal contract. Only 164 doctors (3.2%) remain non-compliant. A number of these work in small specialities, like neurosurgery, where national service redesign is planned.

9.19 The arrangements to support New Deal were reviewed in 2006. The members of the New Deal Review Board, formerly the Implementation Support Group, agreed a set of recommendations which were approved by the then Minister for Health and Community Care, Andy Kerr. These were for the existing arrangements, with minor changes, to continue until 2009 when a decision will be taken about merging the work with the Service.

Junior Doctors

<u>Average Pay Supplement by Grade and Rota</u>

9.20 NHS Scotland continues to make significant investment in modernisation projects such as Hospital at Night. These projects aim to reduce the dependency of multiple tiered working out of hours and will help reduce the number of hours worked by Training Grade Doctors. This continues to drive down average banding supplements as indicated in the latest available figures produced by Information and Statistics Division (ISD).

Average Pay Supplement by Grade and Rota

	All Grades	Specialist Registrar	Foundation Year 2	Foundation Year 1
February 2006 - July 2006	62.0%	59.7%	62.0%	65.7%
August 2005 - January 2006	62.7%	59.9%	63.2%	65.8%
February 2005 - July 2005	65.8%	63.6%	65.9%	69.1%
August 2004 - January 2005	68.9%	67.5%	68.6%	72.2%
February 2004 - July 2004	75.8%	73.2%	76.0%	79.3%
August 2003 - January 2004	76.3%	72.9%	77.3%	78.7%
February 2003 - July 2003	81.7%	76.1%	84.6%	81.8%

9.21 Whilst we do accept that, as in the other UK countries, there has been a decrease in junior doctors total pay in relation to inflation, this does need to be balanced against the benefits that this group have gained from a reduction in their working hours and the resultant improvement in work life balance. We anticipate that hours will continue to decrease as we move towards compliance with the Working Time Directive. The levels of salary remain competitive in relation to other professions and there is no evidence of any problems in attracting students into medical schools in Scotland, or in filling training posts in the NHS for medical graduates. In our view the wage system for juniors is working in the way that it is intended to work and we do not feel that an adjustment to this system is necessary at this point.

PRHO/FY1 Accommodation

9.22 Following the repeal of Sections SS10 – 13 of the Medical Act 1983 the statutory requirement for FY1 Doctors to be contractually resident in or conveniently near to the hospital ceased from 1 August 2007.

9.23 The Management Steering Group of Scottish employers agreed at their meeting on 12 September to recommend to the Service that Health Boards make no change to their current practice in relation to FY1 doctors till the August 2008 intake. We concur with the Department of Health's view that the removal of the residency requirement for F1 trainees represents an improvement in their conditions of service, reflecting the improvements in their working hours. We also agree with the view that, as salaries are already competitive even without free accommodation, there is no case for increasing salaries to reflect this change.

GP Registrars

9.24 The average banding supplement for hospital doctors in training in Scotland was 60% in the monitoring period to February 2006. This suggested that it was an appropriate time to reduce the banding supplement for GP Registrars. As from 1 April 2007 the supplement for all new GP Registrar contracts was reduced to 55%. NHS Boards in Scotland continue to work towards a 50% average pay supplement, although we do not have definitive current information on the average level of supplement as monitoring was temporarily suspended as part of the implementation process for MMC. In light of the anticipated reduction in average supplements we would support a reduction in the banding supplement for GP Registrars to 50%.

C. DENTAL SERVICES IN SCOTLAND

Dental Services

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

9.25 The consultation on *Modernising NHS Dental Services in Scotland* (2003) resulted in the launch of policy proposals in the form of a three-year *Action Plan for Improving Oral health and Modernising NHS Dental Services in Scotland 2005*. The measures outlined in the *Action Plan* are designed to address Scotland's poor oral health record, provide better access to NHS dental services for patients and provide an attractive package for professional staff that are recruited to, and remain within, the NHS. The *Action Plan* can be viewed at: http://www.scotland.gov.uk/library5/health/apioh-00.asp

9.26 The first two years of the *Action Plan*s are now complete and most targets have been met. The Scottish Government is committed to investing an additional sum of £150 million over three years in order to achieve the goals. This amounts to £45 million in 2005/06, £100 million in 2006/07 and £150 million in 2007/08. Cumulatively, this amounts to £295 million over three years. Of this, £237 million will go to primary care dental services. A breakdown of the funding for NHS dentistry for 2006/07 is provided below:

FUNDING – 2006/07

Forecast spend of £272.899 m on general dental services

£5.86m	Rent re-imbursement payment
£2.5m	Practice Improvement Funding
£1.6m	Emergency Dental Services
£8m	Oral Health
£9.1m	Education & Training
£1.09m	Scottish Dental Access Initiative
£0.59m	Vocation training golden hellos
£21.6m	General Dental Practice Allowance
£0.59m	Remote Areas Allowance
£2.75m	Deprived Areas Allowance

Fees

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

Total Number of NHS Dentists in Scotland

9.28 The table at **Annex G** shows the headcount of dentists in Scotland by service sector as at 30 September 2006 for the years 1995 to 2006. This information can also be viewed on the NHS NSS ISD website at:

http://www.isdscotland.org/isd/Dental-workforce.jsp?pContentID=4670&p_applic =CCC&p_service=Content.show&

9.29 The table at **Annex H** shows the turnover of dentists over the period 2002 -2006.

9.30 The total number of dentists registered to provide NHS treatment has consistently risen. Increases have occurred in all dental services.

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

Allowances for Independent General Dental Practitioners

Vocational Trainee (VT) Golden Hellos

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

9.33 There have been 139 claims from VTs in 2006/07, of which 38 claims were from designated areas and 101 from non-designated areas. This is an increase from 126 last year. The total VT allowance paid was £596,797, an increase from last year of £90,863.

9.34 The take-up of the allowance in designated areas has risen this year and the total extra payment for 2006/07 is £114,000.

9.35 Data on the Scottish dental school output shows an annual increase in the number of dental graduates taking up posts in Scotland. In 2004, 86% of the total Scottish graduates were registered for VT in Scotland, rising to 90.5% in 2005 and 91.5% in 2006. In 2007 this increase again to 97.6% registering an interest for VT in Scotland and 93.5% actively pursued this interest.

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

Expected Graduation Date	Total Number Expected Graduates
July 2008	134
July 2009	164
July 2010	174
July 2011	150
July 2012	140 (+)*

*There may be additional graduations for July 2012 as the Scottish Government have committed to opening a third Scottish dental school, located in Aberdeen.

9.37 Student intakes are expected to stabilise at around 155. The total number of dental students in the Scottish Dental Schools is now higher than at any time in the past decade.

9.38 The number of dental VT places in Scotland continues to increase. The total cohort size and breakdown into country of qualification between 2000 and 2006 is shown in the table below:

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1 Designated areas are classified as Arran within Ayrshire & Arran, Borders, Dumfries and Galloway, Fife, Grampian, Highland, Orkney, Shetland and the Western Isles NHS Boards.

NUMBER OF VTs BY THE COUNTRY IN WHICH THEY QUALIFIED					
		COUNTRY OF QUALIFICATION			
VTCohort Year	**Number in Cohort**	**Scotland**	**Other UK**	**Abroad**	**Unknown**
2000	100	77	11	1	11
2001	94	78	14	-	2
2002	101	89	7	-	5
2003	101	90	8	1	2
2004	113	88	15	6	4
2005	126	95	15	15	1
2006	138	111	22	5	-

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

VT NUMBERS ISSUED (2001 to 2006)					
Year	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**
Total VT Numbers Issued	126	131	146	150	248

General Dental Practice Allowance

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

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

9.42 The total practice allowance paid in 2006/07 was £21,643,706 rising from £4,068,375 in 2004/05 and £15,422,380 in 2005/06. It should be noted that the amount payable per practice was increased in 2005/06 to 6% of accumulative gross practice earnings. Those practices who meet the new definition of NHS commitment are entitled to receive an additional 6% of accumulative gross practice earnings for each quarter that they meet the conditions of entitlement to payment. In the last quarter of the financial year 2006/07, 69% of dental practices qualified for this allowance.

Remote Area Allowance

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

9.44 £595,200 was paid in 2006/07 a further increase in the total amount of allowance paid from £323,700 in 2004/05 and £448,500 in 2005/06. However, it should be noted that

this allowance has been increased from a maximum of £6000 in 2004/05 to a maximum of £9000 in 2005/06.

9.45 The total number of claims has risen to 84 in 2006/07 from 59 in 2005/06. This figure does not take into account the number of claims from salaried dentists. Allowance to salaried dentists is paid locally and as such the information on uptake is not held centrally.

Sedation Allowance

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

9.47 The total allowance paid in 2004/05 was £77,000 which decreased to £63,000 in 2005/06. This was the second consecutive year that the total sedation allowance paid had decreased. To address the decrease in claimants a review of the terms of the allowance was undertaken. As a result the allowance has been increased and the minimum number of sedation treatments under GDS which a practice requires to undertake in order to receive the allowance has been reduced from 50 to 40. These changes came into effect on 1 April 2006 and this financial year shows an increase in the amount that has been paid with £101,000 being paid.

Rent Reimbursement

9.48 In 2006/07 £5,865,202 notional rent reimbursement was paid to dental practices in Scotland who met the new NHS commitment criteria.

9.49 A further £562,537 was paid in the same period for Orthodontic practices backdated to 1 October 2005.

Recruitment and Retention Allowance

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

9.50 This allowance is available to all new dentists when their name is first included on a dental list within 3 months of completing their training. Recipients must undertake to provide the full range of general dental services to all categories of NHS patients during each of the 3 years following receipt of the first payment. A total of 99 new claims were received in 2006/07, as compared to 70 in 2005/06. The total amount paid was £915,000

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

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

9.52 The total number of claims in 2004/05 was 27, with a total amount paid of £87,500. The total number of claims in 2005/06 had fallen to 10, and the total amount paid was £27,500. In 2006/07 the number of claims has increased to 58 and £195,000 has been paid. However, this figure does not take into account the number of claims from salaried dentists. Allowance to salaried dentists is paid locally and as such the information on uptake is not held centrally.

Scottish Dental Access Initiatives (SDAI)

9.53 The Scottish Government has paid over £1.08 million to NHS Boards under the Scottish Dental Access Initiative Scheme to general dental practitioners who are willing to make a sustained commitment to the NHS, and who wish to establish a new practice or extend existing practices in areas where general dental service availability is poor. Until 1 April 2007 up to £100,000 was paid by the Scottish Government to assist in setting up new dental practices and up to £50,000 to expand existing practices. From April 1 2007 this initiative has been devolved to NHS Boards and the funding has been increased to a grant of, for example, £100,000 towards the cost the set up of a new or purchase of an existing practice with £25,000 per additional surgery over and above the first and up to £50,000 towards the cost of extending an existing practice for each of the first two surgeries and £25,000 per additional surgery over and above the first 2. Funding under this initiative is also available for the relocation of practices.

9.54 In the past year, over £11,000 has also been paid under the SDAI return to work scheme to dentists returning to work after a break of 5 years or more.

Deprived Areas Allowance

9.55 From 1 April 2006 a Deprived Areas Allowance of £9000 was introduced. This can be claimed by those dentists who serve disadvantaged urban areas and for 2006/07 £2,750,400 was paid to those dentists who provide general dental services in a SIMD (Scottish Index of Multiple Deprivation) area 5, or DEPCAT 7 i.e. the most deprived areas.

Management and Funding of Dental Clinical and Special Wastes

9.56 With effect from 1 April 2006 arrangements are now in place for the management of waste under the NHS Boards Clinical Waste Consortia. For 2006/07 over £1m was transferred to NHS Boards who are asked to meet the costs for clinical and special uplift for dentists who fulfil the requirements for NHS committed practices.

Review of Salaried Services

9.57 The Review Body requested evidence on the outcomes of negotiations for the review of salaried services. **Annex I** outlines the operation of the current salaried services.

9.58 A review of the salaried services was undertaken by the Scottish Executive. A copy of the report is being sent to the Review Body members under separate cover.

9.59 The report recommends that the current Community Dental Service and the Salaried General Dental Service should combine to form a new Scottish Public Dental Service. The Chief Dental Officer has appointed a Project Implementation Board to take forward work on the recommendations of the Report and the Board is due to submit its report to the Chief Dental Officer by the end of 2007.

Dentists from Overseas

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

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

9.62 The total number of dentists from EC/EEA who have been recruited to an NHS Board between 23 June 2006 and 16 July 2007 is 98.

D. WORKFORCE AND PAY STRATEGY

9.63 The Scottish Government Health Directorates' objective is to protect, promote and improve the health, quality of life and wellbeing of people in Scotland by working with NHS Scotland to build a world-class workforce for NHS Scotland. SGHD continues to work on five key areas to achieve this aim:

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

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

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

9.65 At 30 September 2006 there were 158,522 staff in NHSScotland. The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland increased by 378.1 WTE or 3.95% in 2006. This represents changes across the medical and dental grades as follows:

- Consultant numbers increased by 133.8 WTE (3.8%)
- Staff and Associate Specialist grade numbers increased by 5 WTE (0.8%)

- Specialist Registrar numbers decreased by 41.5 WTE (-2.6%)
- Senior House Officer (figures include FY2) numbers increased by 229.8 WTE (8.4%)
- House Officer/FY1 numbers increased by 27.0 WTE (3.5%)
- GP numbers (excluding Registrars) increased by 56 Headcount (1.3%)
- GP Registrar numbers increased by 1 Headcount (0.3%)

9.66 More detailed workforce data are presented at Tables 25-32. GP numbers are no longer available by WTE. It should also be highlighted that consultant numbers are currently at a record high with 3,765 consultants in post as at 31 December 2006. This is an increase of 13.6% since 2002.

Workforce Planning in Scotland

9.67 Published, in August 2005, *the National Framework for Workforce Planning* set out workforce planning arrangements for NHSScotland, following the publication of workforce baseline reports at national, regional and local levels in 2004 which provided the starting point for workforce planners at all levels. The approach taken in the Framework is one of integration with service and financial planning, education and training and regulation to ensure alignment. The 3 tests of affordability, availability and adaptability are seen as vitally important to all workforce plans.

9.68 The workforce planning cycle that has been set out requires that the 3 planning regions in Scotland publish their workforce plans in September. NHS Boards publish their plans in April and the National Workforce Plan is published in December each year.

9.69 The plans provide forecasts for each staff group to ensure that the shape of the future NHS workforce meets the changing patient need and service model. They also inform training numbers to ensure that demand is aligned with supply and underpin training and development for extended and new roles.

9.70 The development of workforce plans is continuing to be challenging for NHSScotland and there is an expectation that the plans will be developed and more integrated with service and financial plans over a period of time as and when data sources improve and workforce planning expertise grows. NHSScotland now has the infrastructure and capacity in place at local, regional and national levels to take workforce planning forward in a coherent and consistent way.

Medical Workforce Supply

9.71 In determining the number of specialty training places for August 2007 (including general practice), our planning has also needed to support smooth implementation of the final phase of MMC, with a focus on sustaining service delivery and providing opportunities for existing senior house officers who are eligible, to continue their training in Scotland. For these reasons, the number of substantive ('run through') specialty registrar posts will be increased in 2007 beyond demand, with the prospect of a further, similar increase in 2008. In 2007, the number of *substantive* specialty training posts in Scotland will increase by almost 50% for hospital specialties and an additional 50 places are being created in the GP training programme.

9.72 In addition, there will be a number of fixed-term specialty registrar posts to ensure that the total number of specialty training posts (substantive and fixed term) in August 2007

will at least equal the current number of senior house officer, specialist registrar and general practice registrar posts in Scotland.

Vacancies

9.73 The WTE medical and dental consultant vacancy rate decreased from 7.8% in 2005 to 7% in 2006. The 6 month vacancy rate remained the same at 4.2% over the same period.

9.74 Currently, no information is available on Associate Specialist, Staff Grade or GP vacancies.

Improving Data

9.75 Development of the Scottish Workforce Information Standard System (SWISS) continues, to establish a comprehensive system to collect and store information describing the NHS workforce in Scotland. Collection of additional information on statutory registration and organization structures is included in the next phase of implementation. In addition the outline business case for an electronic employee support system is being developed. This system will support decision-makers to take informed decisions on future workforce needs.

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

9.76 The Foundation Training programme has been successfully implemented in Scotland in 2007.

9.77 Implementation of Specialty Training has been particularly resource intensive. 9,400 applications were received for 2,600 Specialty Training posts in Scotland. Following the well- publicised difficulties with selection and recruitment, largely based around alleged failings with the on-line Medical Training Application Service (MTAS); and the recommendations of the UK Review Group established to review the recruitment and selection procedures, the decision was made in Scotland to interview all eligible applicants to Scottish training programmes. A contingency recruitment and selection timetable - developed in full consultation with the BMA Scottish Junior Doctors Committee (SJDC) to support the interview all approach - was implemented; and Scotland has now appointed sufficient numbers of doctors to its training posts to support continuity of patient services across NHSScotland from August 2007. Particularly pleasing has been the high proportion of graduates from Scottish medical schools who have successfully secured posts in Scotland.

9.78 We have, throughout, maintained a flexible and pragmatic approach to the recruitment of our junior doctors within the UK-wide approach to recruitment; and have developed solutions to address concerns raised about the recruitment process in partnership with all key Scottish stakeholders. Implementation of these same solutions would not have been possible without the full support of NHSScotland; and we would wish to formally acknowledge the substantial support given by the Service in ensuring the successful implementation of Specialty Training recruitment in 2007.

9.79 Despite recent challenges, we remain of the view that UK MMC represents a much improved system of selection, recruitment and training; will shorten the journey time to consultant/GP level; and mean more patients being treated by trained doctors rather than doctors in training.

9.80 We will continue to adapt the selection and recruitment process in the light of experience, to ensure our NHS continues to attract the best possible candidates; and will reflect on the lessons from the recruitment and selection process this year, and the outcomes from the independent Tooke Review of MMC, to develop Scottish solutions that ensure doctors trained in Scotland continue to have every opportunity to work and develop their careers in Scotland.

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

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

9.82 In recognition of this The NHS Careers campaign was launched in March 2006 and is still ongoing. The campaign aims to raise awareness of career opportunities within NHSScotland amongst the adult population of Scotland, encouraging them to consider a career within the organisation.

9.83 There have been two campaign phases: a 2006 campaign ran over the period 6 March – 29 May 2006 and consisted of TV, cinema, radio and press advertising and was supported by online activity and outdoor advertising. The second phase ran from 8 January to 5 March 2007 and used a newly edited version of the 2006 TV commercial. This commercial sought to raise public awareness of the variety of NHSScotland careers on offer, and called for "more good people" to consider the value of becoming part of the NHS Workforce team. The TV was complemented by press advertising, radio, cinema, online and PR support.

9.84 Figures collated from the first phase of the campaign March 2006 to date show that there have been over 160,000 visits to the campaign website www.infoscotland.com/nhs . The campaign dedicated 0845 number has received over 8000 calls since March 2006. These enquiries included requests for general NHS Scotland careers information and our careers brochure and also more specific career/training advice e.g. return to nursing. The Reputation and Attraction Unit in the Scottish Government Health Directorate continue to take calls from the public interested in a career in NHS Scotland on a daily basis.

9.85 Full in-depth analysis of the campaign is currently underway and initial results are very positive, showing that the key objectives of the campaign are being met.

Vacancies

9.86 Latest available consultant vacancy figures confirm that as at 30 September 2006 there were 271 consultant vacancies, this is a slight decrease from the previous year's figure of 300 as at 30 September 2005. However, we are continuing to work with Health Boards in Scotland to reduce the number of vacancies and thereby increase the number of consultants in post. Measures to reduce consultant vacancies include:

- Matching the career aspirations of doctors about to complete their training with current and expected consultant vacancies. This matching scheme seeks to improve the flow of information between doctors in training and health boards and to retain newly qualified doctors by alerting them to jobs available in Scotland.

- An Advance Appointment Scheme established in July 2006 to aid the transition to consultant grade. The scheme aims to aid the retention of CCT holders by facilitating their induction into the consultant grade, and provides funding to facilitate an induction to their first consultant post, where they can work for a short period in tandem with the outgoing consultant just about to retire or to leave their post. In the first year of the scheme funding was awarded to seven NHS Boards to provide an induction for 19 newly appointed consultants over periods ranging from 3-6 months, providing funding totalling £497,298.

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

- Placing a further advert in the British Medical Journal. An advert was placed in the BMJ in June and July of 2006 promoting Scotland as a place to work and directing the reader to consultant vacancies on the SHOW vacancy database. The advert stimulated a lot of interest with the link to the Scotland's Health on the Web vacancy database receiving over 850 hits. A repeat of this advert is being considered and we are currently working with Boards to ensure all consultant vacancies are placed on SHOW to maximise the benefit of repeating this advert.

9.87 We are also in the process of reviewing the recruitment process for consultants and in the summer of 2007 commissioned an independent research project by Work Psychology Partnership into best practice in senior medical recruitment as part of the review of Appointment Advisory Committees. The research incorporated a literature review and analysis of best practice recruitment principles as well as a series of interviews with 40 key stakeholders, including medical directors, consultants, specialist registrars, chief executives and HR directors. Work Psychology Partnership presented a draft final report of the findings of the review to a meeting of the Stakeholder Group on 14 September 2007. Based on the findings of the research undertaken by Work Psychology Partnership stakeholders have helped shape policy options. The Cabinet Secretary for Health and Wellbeing will review the report and determine the way forward.

Staff Retention

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

9.89 Good career prospects associated with personal development plans and access to continuous professional development that enables our staff to maintain their skills and knowledge base and provide better care to patients clearly plays a part in helping to retain staff. How we treat our staff is also important and proper application of

Partnership Information Network policy guidance on dealing with employee concerns and dignity at work is essential. There does however have to be a recognition that managers need to be able manage, but this has to done fairly and consistently.

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

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

Partnership working

9.91 The open and transparent way NHSScotland works with staff and their representatives, and develops its strategies in partnership, plays a major part in our current success and industrial harmony in NHSScotland both locally and nationally. This is carried out through a range of means, including national partnership bodies that consider strategic service and workforce issues; and through local partnership structures and an Employee Director (chair of the local trade unions and professional organisations) sitting on each organisational Board as a non-executive director. The Staff Governance Standard, which is enshrined in legislation, has also been reviewed to take account of changed national partnership structures, although the basic principles remain the same. This is essentially a system of corporate accountability for the fair and effective management of staff, and under this Standard, staff can expect to be:

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

9.92 The Staff Governance Standard is about how NHSScotland staff are managed, and how they feel they are managed. It is underpinned by the 12 policy guidelines which aim to provide consistency of treatment for staff across Scotland. These documents cover topics such as *Managing Health at Work* to *Dignity at Work*. NHS employers are required to adopt the policy guidelines. The Standard is monitored through the Self Assessment Audit Tool and the Staff Survey.

Staff Survey

9.93 The most recent staff survey (a census rather than a sample survey) took place in 2006 and achieved a 33% response rate. Key strengths are: high level of intention to remain working for the NHSScotland in 12 months time; their job makes good use of their skills and abilities; staff are clear about what they are expected to achieve in their job; staff are very positive about the support they get from work colleagues; satisfaction with the overall benefits package; and feel that performance reviews accurately reflect performance and help staff focus on improving their performance.

9.94 Opportunities for improvement exist to improve communication, particularly the way change is managed. Staff wish greater involvement in decisions and have a negative perception of how open and honest communication is from senior management and the Board and to whether senior managers are focused on meeting patients/clients needs. There appear to be issues with how staff feel they are treated with low levels of satisfaction on treating staff with dignity and respect and offering equality of opportunity; NHS Boards taking staff safety during their journey to work seriously and the level of violent/aggressive incidents and bullying, harassment and discrimination experienced.

9.95 The Scottish Workforce and Staff Governance Committee (SWAG), which is a partnership committee comprising trades unions, professions, NHS Employers and SGHD, have considered the outcomes from the staff survey, and work is ongoing to address the issues at both local and national level.

Healthy Working Lives

9.96 Healthy Working Lives is about the integration of all policies and processes which impact on the health and well-being of the workforce. The Working Well in NHSScotland Group has been set up to bring together all the strands that influence the health, wellbeing and safety of staff; and will promote an integrated approach to improving the wellness of the workforce. An implementation Group has been set up to take forward the recommendations of the recent OHSS Review. The key outcomes from the review are predicated on delivering Healthy Working Lives and rehabilitation policies, they are:

- National standards and policy development, establishment of an Occupational Health and Safety Planning and Advisory Group;
- Regional planning and local service delivery;
- Provision of an integrated OHSS service;
- Establishment of a commercial brokering arm; and
- Provision of OHSS services to the wider NHS, public and private sector to promote the Healthy Working Lives concept.

9.97 This links directly to policies on rehabilitation and getting people back into the workplace and to enabling the workforce to work for as long as they are able.

Safer Workplace

9.98 NHS employers, the trade unions and professions are committed through the Staff Governance Standard to providing staff with a safe and secure environment. We recognise more needs to be done to change the attitude and culture of the public and to getting them to appreciate that being abusive or violent does not help anyone. The Health Directorates has invested significant time and resources in the last few years on measures aimed at reducing violence and abusive behaviour towards NHSScotland staff. Among the measures that have been taken are poster campaigns, provision of personal alarms or panic buttons, CCTV installation, improved lighting (internal and external), installation of door entry systems and fixed seating and fittings. NHS employers also have the sanction to withdraw treatment in specific circumstances.

OHSXtra

9.99 An important part of the Healthy Working Lives agenda, is a dedicated rehabilitation service for NHS staff. It provides quick access to physiotherapy, occupational therapy

and counselling services with the aim of improving staff health and morale and will help NHS employers in their efforts to reduce sickness absence to 4% by March 2008. The OHSxtra model was initially piloted in NHS Lanarkshire and NHS Fife and the final report from the two pilots will be published in July 2007. The report is expected to show that the current model with adaptations is a "spend to save" model and therefore fit for purpose. Following a bidding process funding to cover a period of one year has been provided to six other NHS Boards (NHS Ayrshire and Arran, NHS Borders, NHS Forth Valley, NHS Grampian, NHS Highland and NHS Tayside). Each Board has been funded on the basis that provided the pilot report shows the project is spend to save then they will fund for a further year from their own resources. Further funding has been set aside to role out to those Boards not so far funded.

Emergency Workers (Scotland) Act 2005

9.100 The Emergency Workers Act provides legal protection to nurses, doctors, midwives and ambulance workers in any area of the hospital grounds and to anyone helping an emergency worker in the community. The new Scottish government have a manifesto commitment to extend this Act to cover all NHS employees.

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

9.101 The challenge facing those concerned with Reward in the public sector is how to ensure our strategies fulfil the legitimate aspirations of staff in a climate of limited funds and a tightly defined public sector pay policy. These aspirations rightly include a reasonable level of annual pay uplift but in fact extend far beyond this into a number of other measures which employers can employ to make staff feel valued members of the NHS family.

9.102 Clearly effective reward management is crucial if organisations are to attract and retain motivated, loyal and competent people who will deliver the NHS business objectives. We acknowledge that in return for their time, talent, effort and results people expect financial rewards such as salary, benefits, bonuses or promotions.

9.103 However, it is also clear that the outcome of the Governments Comprehensive Spending Review will lead to a tight fiscal situation across the public sector, with less money in relative terms available to meet the aspirations of staff than has been the case in recent years. The Government’s current public sector pay policy seeks to maintain pay rises in line with the Consumer Price Index inflation target of 2%.

9.104 With the Retail Price Index in the year to July running at 3.8%, this creates difficulties in trying to balance the expectations of staff with the need to ensure that levels of public sector pay do not cause inflationary pressure.

9.105 These realities mean that as public sector employers we need to consider pay as part of an overall reward package rather than as a stand alone issue.

9.106 In SGHD’s view other forms of reward such as recognition of competence, achievement, responsibility, influence, and personal growth will form increasingly important parts of the psychological contract between NHS staff, employers and the Health Directorates, necessitating a sophisticated approach to meeting people’s needs and aspirations.

9.107 Within NHS Scotland we have modernised pay for almost all of the 150,000 staff who work there through the consultant and GMS contracts and Agenda for Change.

9.108 Although the financial aspects of pay modernisation are clearly of great importance to staff, it is in our view the whole reward package including pay, pensions, training, education, career development and support in delivering a high level of care to patients that will allow NHSScotland to recruit, retain, and motivate its workforce. NHS Scotland staff recognised the value of the overall rewards package to them in the 2006 Staff Survey.

9.109 As pay forms part of an overall reward strategy, the reward strategy forms one part of an integrated workforce strategy which, as outlined earlier includes other elements such as, workforce planning, health care related education and training, recruitment and reputation issues, and better employment practice.

NHS Pensions Scheme

9.110 In 2002, the UK Government published its Green Paper on occupational pensions reform entitled "*Simplicity, security and choice: working and saving for retirement*". Among other things, the paper highlighted the increasing costs of providing public service pensions due to demographic changes, in particular changing working patterns and increasing longevity, and recommended that public service pensions schemes, including the NHS pension scheme in Scotland, should be reviewed.

9.111 In line with the green paper recommendation, the then Scottish Ministers agreed that a review of the NHSPS in Scotland should be carried out, and that it should be undertaken in partnership between the NHS trade unions, NHS employers and the then Scottish Executive. The framework within which the review operated was that long term financial security should be achieved (in line with the cost envelope set by the Public Services Forum in 2005) while ensuring that the scheme met the needs of a 21st century, diverse workforce. Also key was ensuring that the pension scheme retained its value as a recruitment and retention tool.

9.112 The approach taken by the review of NHS pensions for Scotland was to piggyback onto the separate but parallel review for NHS England and Wales. In effect, pension developments for England and Wales would be considered from the perspective of the Scottish workforce. This process, which has been of value in the past with pension development, was designed to retain the consistency of pension provision across the UK Health Services, while allowing scope for Scottish specific solutions, should these be necessary.

9.113 Agreement has now been reached on the reform of NHS pensions in Scotland, and modernised, improved pension arrangements which strike a balance between long term financial sustainability and retaining the scheme's value to staff will be introduced from 1 April 2008. In summary, reform will 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 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.

9.114 The NHS pension scheme is a valuable part of the overall reward package for NHS staff in Scotland, particularly when placed in the context of the closure of defined benefit schemes by some other employers. We expect that pension considerations will remain a real factor in determining recruitment and retention decisions in relation to existing and potential NHS staff and would ask that the Review Body include this in their assessment of headline pay increases.

E. WORKING TIME REGULATIONS (WTR)

Junior Doctors

9.115 NHS Boards in Scotland continue to implement appropriate aspects of the Hospital at Night (H@N) approach. A self assessment tool adapted from the National Workforce Projects in England continues to allow Scottish boards to assess their progress towards implementing this approach. Over 99% of junior doctors are compliant with the current WTR limits and around 47% are already working 48 hours or less a week. We are supporting and working with boards to design rotas down to 48 hours now wherever possible so that efforts can concentrate on the smaller units and specialities which will have the greatest difficulty in meeting this target by 2009.

9.116 SGHD has contact with board employees who have responsibility for WRT and H@N. We share information, good practice examples and practical support in relation to follow up on action plans. We recently hosted a H@N Forum and another is planned for September. Our WTR adviser visits the boards to discuss progress in meeting the requirements of the WTR for junior doctors. Our regional New Deal Support Officers are trained in the requirements of the WTR and provide a source of expertise for the boards, particularly in relation to rota design.

Consultants

9.117 Information published by ISD on 30 January 2007 for the period to 30 September 2006 shows an improvement in the number of consultants working 48 hours a week or less. Only one NHS board declared that it still had consultants working more than 12 averaged programmes activities a week and have signed the opt out from the WTR. Under the new consultant contract, consultants have to report their private work to their employer. NHS employers in Scotland have been reminded that any employees who work more than 48 hours a week should sign the opt out.

F. EFFICIENT GOVERNMENT

9.118 SGHD continues to make a significant contribution to the Efficient Government Efficiency Programme to the 3 year target of savings of £525 million by 2007/08. In 2006 SEHD reviewed and updated measures on consultant related productivity to reflect some key service patient target requirements and recognise the multi-disciplinary nature of service delivery. Current indications are that NHS Scotland is on course to meet this target.

9.119 Current indications demonstrate that there is a need to accelerate progress on the challenging requirement of reducing the sickness absence rate in NHS Scotland to 4% by 31 March 2008 if this target is to be met.

G. REGIONAL PAY

9.120 The position on regional pay has not changed markedly since last year and we are not therefore currently considering any further measures on this front.

H. NHS FINANCE IN SCOTLAND

9.121 This section sets out the financial context for our recommendation, including the SGHD Departmental Expenditure Limits (DELs) for 2008/09 to 2010/11.

9.122 Over the three CSR 2007 years NHSScotland revenue funding will grow in real terms by an average of 1.3% per annum. This is a significantly less than the 5.7% real terms revenue growth enjoyed by NHSScotland from 1997/98 to 2007/08. The reduction in funding growth is not matched by any lowering of ambition for the pace of improvements in the NHSScotland. We are committed to continuing to grow services to meet underlying demand, and deliver further improvements to access, and in particular to make improvements to the quality of care.

9.123 Any increase in pay above the level recommended by the SGHD will put these service improvement plans at risk. Around two thirds of expenditure within the HCHS is pay, so even very small changes in pay have a substantial effect on the affordability constraints of NHSScotland.

9.124 Many of the non-pay costs cannot be directly controlled by NHSScotland, such as underlying increases in the cost of goods and services and increases in demand for expensive drugs. This means that any increase in pay settlements is likely to lead to lower levels of employment. Since many of the Government's aspirations for improving NHS services in Scotland rely on the contribution of NHS staff, higher pay settlements also put at risk further improvements to NHS care.

9.125 The pay increases for 2008/09 become a recurrent pressure on NHSScotland. The Government has a three-year process of financial and service planning. Pay settlements above the planned level mean we would have to revise our plans for all three years. Where this happens on a significant scale it makes it difficult to encourage NHSScotland to develop robust three-year plans.

FUNDING AVAILABLE

NHS expenditure limits between 2008/09 and 2010/11

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

9.127 The rate of growth is much lower than over recent years. Whilst real terms growth in total funding (revenue and capital) has been an averaged 5.7% between 1997/98 and 2007/08, over the next three years the average real terms growth in total funding will be 1.3% per year.

9.128 All pay costs must be met from within the NHS revenue DEL. If pay costs are higher than expected, other costs must be reduced. There is no flexibility to move funding between the revenue budget and the capital budget. The table below sets out the revenue DEL, and the rates of increase, between 2005/6 and 2010/11.

Year	Revenue NHS Expenditure	Cash Growth	Cash Growth %	% real terms increase
	£m	£m		
2005/06	8,356	644	8.35	6.12
2006/07	9,065	709	8.48	5.55
2007/08	9,692	627	6.91	4.0
2008/09	10,135	443	4.57	1.29
2009/10	10,503	368	3.63	0.85
2010/11	10,950	447	4.25	1.46

SERVICE PLANS

Demand for healthcare

9.129 The following sets out the plans for meeting the pressures on the NHS in Scotland over the next three years

Baseline pressure

9.130 The first call on resources is the underlying increases in demand and rising cost pressures. This includes costs met directly by the NHS in Scotland, but also other costs that are met directly by the Scottish Government Health Directorates on behalf of the NHS in Scotland.

9.131 Baseline pressures is expected to consume around 70% of the additional resources available and a significant proportion of this will be taken up by pay. Our financial planning is for a 2% pay settlement and 1.6% pay drift on average across the HCHS; this is consistent with the Government's CPI inflation target. The NHS paybill in 2006/07 was £4.6 billion (including agency staff).

9.132 There are a range of other commitments over the next three years - many of which are demand led - that need to be funded from overall NHS growth, and could be put at risk of delivering if a higher pay award was agreed. This includes the following:

- Drugs prescribed by GPs and in the hospital setting, which have an underlying growth rate of around 9% each year will form 25% of the baseline pressures. Expenditure in 2005/06 total £1.145 billion. In addition, we anticipate this proportion to increase as new treatments become available.

- The underlying cost of goods and services which represent around 25% of overall NHS expenditure will rise by 2.7% each year and expected to consume around 15% of baseline pressures.

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

SERVICE DEVELOPMENT

9.133 The commitment to improvement continues through our ambitious programme of work over the next three years to deliver manifesto commitments. Such achievements can

only be made if resources are not diverted into unnecessary large increases in pay award.

Key service developments include:

- Support for the NHS to achieve a maximum wait of 18 weeks from GP referral to treatment for routine patients, by the end of 2011 (£90m)
- free eye tests for everyone (£27m)
- phasing out prescriptions charges for those who still pay them (£20m)
- reducing the harm done by misuse of alcohol (£20m)
- introducing HPV immunisation to reduce the risk of cervical cancer (£46m)
- Extended opening hours for GP surgeries to help make primary care more accessible, especially to working people so that they do not need to take time off work to see their GP (£10m)
- a new screening programme to detect MRSA colonisation of hospital patients at admission, and thereby prevent the spread of infection, reduce serious illness, and release hospital resources for use by other patients (£11m)
- adding to the existing national screening programmes to help detect potentially serious illness early and to target anticipatory treatment (£16m).
- reducing smoking (£3m)
- actions to help people tackle obesity in support of our diet and physical activity strategies(£11m).
- actions to strengthen primary care services in the most deprived areas of Scotland, identifying those at particular risk of preventable, serious ill health (£12.5m)
- Provision of antiviral drugs, vaccines, protective equipment and other countermeasures for healthcare workers and the general population in the event of a flu pandemic (£5m)

Link between pay and output targets

9.134 Pay continues to form a significant part of NHS revenue spend. Consequently, a small increase in pay award is likely to have a significant impact on the overall paybill reducing the funds available for other activities.

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

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

9.137 Exactly what areas would be at risk from a large pay deal is impossible to say because decisions would be made locally, but it is very likely that higher pay settlements would lead to fewer staff than would otherwise be the case. For example, any additional increase in the paybill for the DDRB's remit group would need to be met from

allocations and locally this would translate as a major cost pressure. We know that £1 million would fund 28 qualified nurses, or 10 doctors or 426 elective procedures.

Conclusion

9.138 The NHS in Scotland has a challenging programme of work over the next three years. Although funding for health will continue to increase, the overall increase in health funding over the next three years is significantly lower than the growth enjoyed since 1997/98 to 2007/08.

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

9.140 NHSScotland staff form a crucial part in meeting these challenges. However, the Scottish Government's significant investment in increased staff numbers and pay reform have provided the increased capacity and stable recruitment and retention situation necessary to meet these challenges. High pay awards would lead to a reduction in staff employed and put at risk the delivery of key services within the NHS in Scotland.

I. CONCLUSION AND PAY PROPOSALS FOR 2008-09

9.141 In formulating our recommendation to the Review Body we have taken into account the evidence available to us on recruitment and retention for the groups covered by the DDRB, the overall reward package available to NHSScotland staff, and a series of difficult affordability issues faced by NHSScotland.

9.142 On recruitment and retention it is clear that staff numbers across groups covered by the Doctors and Dentists Review Body are increasing, with more staff in all groups apart from Specialist Registrars. In particular it is worth noting that consultant numbers in Scotland are at a record high, with 3,765 consultants in post as at 31 December 2006. This represents an increase of 13.6% in the consultant workforce since 2002. The general picture on recruitment and retention across the medical workforce is positive and we would argue that there is an absence of any evidence that a high cost of living increase is necessary to deal with problems in this area.

9.143 As outlined in the previous section, we see pay as part of the overall reward package available to NHSScotland staff rather than a stand alone issue, and view the whole reward package including pay, pensions, training, education, career development, and support in delivering a high level of care to patients as key to ensuring that NHSScotland continues to recruit, retain, incentivise, and motivate its workforce.

9.144 Finally, there is clear evidence that over the next three years the level of resource available to NHSScotland, while still increasing, will increase at a significantly lower level than has been the case in recent years. While real terms growth in total funding (revenue and capital) between 1997/98 and 2007/08 averaged 5.7%, over the next three years the average increase will be 1.3% per annum. As well as staff pay, the available resources will need to cover underlying increases in demand and rising cost pressures as well as continuing to fund the service development necessary to meet the legitimate healthcare aspirations of the Scottish people.

9.145 In considering the level of pay award for the staff covered by the DDRB we have had to strike a balance between rewarding NHS medical staff appropriately and meeting our

responsibility to taxpayers to improve services and contribute to wider government objectives, such as lessening health inequalities and dealing with increased demand for healthcare in Scotland.

9.146 The Scottish Government therefore recommends an increase of 1.5% for all Scottish medical staff. In our view a 1.5% rise is affordable, appropriate in the context of trends in medical salaries over recent years, and will enable us to resource the competing priorities which must be financed from within a tight budget. In the context of this fixed funding envelope, the cost of a pay increase which is higher than we have planned for will mean that other costs will require to be reduced, risking a reduction in the numbers of staff employed by NHSScotland or the delivery of key services.

CHAPTER 10: EVIDENCE FROM THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES & PUBLIC SAFETY IN NORTHERN IRELAND

SUMMARY

10.1 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.

10.2 The evidence sets out:

1. The Northern Ireland Context;
2. Northern Ireland Executive Pay Policy;
3. The Northern Ireland Health Sector;
4. The Policy Context;
5 The HSC Medical Workforce;
6 Pay and workforce issues;
7 Clinical Excellence Awards
8 Affordability; and
9 Conclusions and pay proposals.

1. The Northern Ireland Context

Demographics

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

10.4 These population projections, in conjunction with levels of deprivation in Northern Ireland, 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

10.5 Employment has grown rapidly over the past decade in Northern Ireland. The local unemployment rate, currently at 3.4%[1] is currently the lowest of all the UK regions. However, there are hidden structural problems in the local labour market. Economic inactivity is the highest of any UK region at 27.1% and this can only be partly explained by Northern Ireland's high full-time education participation. In a context of a historically low claimant count the level of long-term unemployment and incapacity claims are significant obstacles to maximising the pool of actively available labour.

The Cost of Living

[1] Source: Office for National Statistics May-July 2007.

10.6 Latest data produced by the Office of National Statistics (ONS) suggests that the cost of living in Northern Ireland in 2004 is 4.7% lower than the UK average. However, this still puts Northern Ireland's cost of living above the North East of England, Scotland and Wales.

The Public sector Workforce

10.7 The Public sector in Northern Ireland employs just over 194,200 people or 27.1% of all employee jobs. This rises to 30.1% when "Reserved" functions[1] are included. On either measurement this is a significantly higher share compared to around 20% for the UK. This is in part due to the lower employment rate in Northern Ireland[2] and the greater need for public services due to the demographic structure of the population and its socio-economic status. While the relative size of the public sector in Northern Ireland has been declining this is due to growth in private sector employment as opposed to downsizing in the public sector.

10.8 Pay Review Bodies (PRB) health staff groups account for 58,661[3] (30.2%) of public sector employee jobs in Northern Ireland.

10.9 Monitoring returns to the Equality Commission provide insight into recruitment difficulties experienced by both the public and private sectors. In more recent years the number of applicants per post filled has declined to around six for the public sector as a whole – a rate now very similar to that of the private sector. There are, however, significant variations within the public sector with the number of applicants per post consistently higher for District Councils and consistently lower in the Health sector.

Public sector Pay

10.10 Public sector pay in Northern Ireland accounts for an increasing share of the Departmental Expenditure Limit (DEL) budget. Estimates for the 2007-08 financial year indicate that pay costs will account for 56% of Resource DEL. This means that each one per cent increase in the pay bill would equate to additional annual costs of £42 million.

10.11 Overall public sector earnings in Northern Ireland are relatively high (£535.50 per week) and only marginally below the UK average of £546.40 per week – this reflects a relatively larger proportion in higher occupations in Northern Ireland. However, this average is 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 Northern Ireland is £503.27, compared to £534.94 for the UK as whole.

10.12 In Northern Ireland public sector earnings outstrip that of the private sector - the differential for public sector employees not working in protective services is 16.8%. However, private sector earnings, at £430.90 per week in Northern Ireland, are 20% below the UK average of £535.90. In addition they are also significantly lower than any other UK region. For each major occupational group, private sector earnings in Northern Ireland are the lowest of all the UK's regions[4].

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[1] Reserved functions include the NI Office, Police Service of NI, NI Prison Service, UK Central Government and UK Public Corporations.

[2] If NI's employment rate equalled the UK average the current level of public sector employment would amount to a 27.2% share of employee jobs.

[3] Includes some personal social services care staff but excludes homehelps, student nurses and bank staff

[4] Source: Annual Survey of Hours and Earnings (ASHE) 2006

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

10.14 While the headline public-private sector earnings differential is 23.8% in Northern Ireland, this reduces to 17.6% when the UK occupational structure is imposed. Moreover, taking an equivalent job in the Northern Ireland private sector the expected earnings in the public sector are 6.5% higher (i.e. adjusting for occupational mix), compared to 1.5% 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).

2. Northern Ireland Executive Pay Policy

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

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

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

10.18 The latest HM Treasury Pay Guidance for 2007/08 now has a consolidated pay range of 1.5 – 4.0 per cent for Increase for Staff in Post (ISP). It also states that '*the expectation is that for this year Civil Service pay awards will average below 3.5 % ISP*'[1].

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

10.20 Under devolution, HM Treasury has a limited role in terms of public sector approvals and control. The Statement of Funding Policy between HM Treasury and the Devolved Administrations (DAs) requires the DAs to 'consult' with HM Treasury on pay issues. However, the previous Chancellor**,** Gordon Brown**,** has deemed public sector pay a 'key macro-economic variable' which therefore is determined by the HM Treasury alone. This view was restated by the then Chancellor in his 2007 budget statement which stated that '*over the 2007 CSR period controlling pay spending will be essential*

[1] Increase in staff in post/previously earnings growth made up of cost of living and incremental entitlement etc

in delivering value for money from public spending and keeping inflationary pressures in check. The Government has made clear that pay settlements must be consistent with the achievement of the CPI inflation target of 2 per cent'.

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

'*The DEL of the devolved administration will be adjusted downwards to compensate for costs incurred by the United Kingdom Government as a result of the actions of a devolved administration'*

And

'*Where decisions taken by any of the devolved administrations or bodies under their jurisdiction have financial implications for departments or agencies of the United Kingdom Government …. the body whose decision leads to the additional cost will meet that cost.'*

3. The Northern Ireland Health Sector

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

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

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

10.24 A twenty-year regional strategy for health and wellbeing, *A Healthier Future*, published in 2004 constitutes a vision for health and social care and contains a series of commitments for improving health and wellbeing. These objectives are supported by 16 Public Service Agreement (PSA) commitments, which in turn are supported by Priorities for Action (PFA), which outline 10 key Ministerial priorities. The Ministerial priorities include; promoting healthy ways of living, better integrated care and support in the community, improving access to hospital services, giving looked after children a better start in life, modernising mental health and learning disability services, continuing with restructuring under the review of public administration and providing modern, fit for purposes facilities and equipment.

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

4. The Policy Context

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

Improving Services

Developing Better Services

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

Improving Performance

PSA Targets

10.28 The HSC workforce is embedded within strategic planning at every level of the organisation. The Priorities and Budget 2005 - 2008 states that the budget allocation will enable reform (resulting from new terms and conditions for doctors) to be taken forward. This will encourage staff recruitment and retention, enable new ways of working, and improve productivity and quality in services. It is principally through such improvements in the productive time of existing staff that the Department expects to generate its share of non-resource releasing efficiency savings.

10.29 PSA targets for example require the HSC to:

- Ensure that 95% of those waiting are admitted within 12 months by March 2008;
- Increase day case activity by 10% by March 2008; and
- Reduce average length of stay by 10% by March 2008.

10.30 The CSR2007 has committed departments to cumulative efficiency cash savings of 3% per year in real terms to March 2011. This can only be achieved through efficiency gains and service improvements by:

- Making direct cost savings in procurement, overhead expenses, etc.; and
- Improving service effectiveness and throughput so as to treat more people in primary care, speed the patient journey through hospital, and provide appropriate and prompt community care.

Review of Public Administration

10.31 The Review of Public Administration reforms for health and social care focus on current management structures and administrative support services. The reform of the HSC is intended to free up resources previously used in management and administration to improve front line services. The first stage of this restructuring has been completed whereby 19 Trusts were reconfigured to 6 New Trusts from 1 April 2007. The proposed second phase of the restructuring of the four Health and Social Services Boards and the Agencies was due to happen in April 2008 but this has been deferred pending further consideration of the structures by the Health Minister and the Northern Ireland Executive. It is unlikely that this part of the restructuring will now not take place until April 2009 at the earliest.

HR Strategy "*The Employer of Choice*"

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

- Workforce Planning;
- Retention, Return, Recruitment and Reward;
- Improving Working Lives;
- Equality and Fairness;
- Education and Training; and
- Employee Relations.

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

Workforce Learning Strategy

10.34 A Workforce Learning Strategy for the HSC has been developed on a partnership basis and will address and recommend the way forward in all aspects of learning throughout the HSC organisations. The strategy recognises a need for "*the continuous development of skills, knowledge and understanding that are essential for*

employability and fulfilment". To achieve this staff should develop the habit of learning throughout their health and social care career, as well as providing the right range of learning opportunities in a timely and accessible manner. The strategy provides a development framework for individuals, teams and organisations and aims to:

- Equip staff with the skills and knowledge to work effectively and flexibly in caring for patients and clients;
- Support staff to grow, develop and realise their potential;
- Support changes and improvements in patient and client care;
- Enable staff to take advantage of available career opportunities;
- Maximise the return on investment in training and education; and
- Link and empower existing workforce learning/training strategies.

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

Independent Review of Health - The Appleby Report

10.36 An Independent Review of Health & Social Care Services in Northern Ireland was carried out by Professor John Appleby in 2005. The overall aim of the review was to consider the resourcing of health and social services and to consider how reforms leading to targeted and sustainable investment, effective and efficient delivery structures and appropriate incentive systems can result in improved service delivery. The review report was published in August 2005. The review stated that whilst concern was expressed about staff shortages, Northern Ireland does not appear to be deficient in terms of the number of health & social care staff compared to the rest of the UK. It also noted that, like the rest of the UK, labour productivity in the health & social care sector appears to have fallen since 1998/99. The review concluded that although the Northern Ireland health & social care sector did not appear to have been significantly under-resourced up until now, looking forward it will come under increasing pressure to replicate the improvements in health outcomes envisaged for the UK by Sir Derek Wanless.

Information and Communication Technology

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

5. The Medical and Dental Workforce

Health and Social Care Employers Survey

10.38 The following is the findings of a questionnaire survey completed by HSC employers.

- **Q1. What factors do you consider to be the most important in assessing what pay uplift would be appropriate for staff?**

  The majority view is that a pay award in line with inflation is the most that could be afforded. The ability to recruit staff in a competitive market was also highlighted as a major consideration for the level of pay uplift.

- **Q2. What would be the impact on services of a higher pay award than you deem affordable?**

  The majority of employers were unanimous in agreeing that a higher than inflation pay award would impact on planned patient services, could lead to a direct impact on planned growth and ultimately result in targets not being met.

- **Q3. How do you define affordability?**

  In the main affordability was living within the allocated budget.

- **Q4. How do you think the pay awards should be structured for Medical and Dental Staff?**

  The majority of employers favoured a percentage increase rather than a flat rate increase and that the same level should be applied to both medical and non-medical staff groups.

- **Q5. Would you welcome a multi-year pay deal?**

  There was strong support for a multi-year (preferably three year) pay deal. This was on the basis that it would enhance planning of resources and service provision whilst providing some stability and assurance for staff on future increases.

- **Q6. Has the recruitment situation improved or deteriorated over the last 12 months in your trust?**

  The majority of employers reported that recruitment and retention of medical and dental staff is fairly stable with pockets of local difficulties in a few specialities, e.g. Paediatrics.

- **Q7. What local recruitment and retention premia and any other initiatives are being used to address any difficulties?**

  All employers reported that it had not been necessary to pay recruitment or retention premia to consultants.

- **Q8. Temporary staffing**

  Almost all employers reported that the use of locum and agency staff over the past twelve months had remained the same with around 2% of the pay bill being spent on locum cover.

- **Conclusion**

- The majority of employers have stressed that an affordable pay settlement is necessary to ensure the continued development of patient services, planned growth and the achievement of agreed service targets.

- A generic three-year pay uplift across all staff groups was seen by the majority of employers as a stabilising factor facilitating enhanced planning of resources and service provision.

- Morale within medical and dental staff has remained the same with the annual job planning process for consultants having a positive impact. However, some difficulties over the recruitment process for junior doctors has impacted on morale.

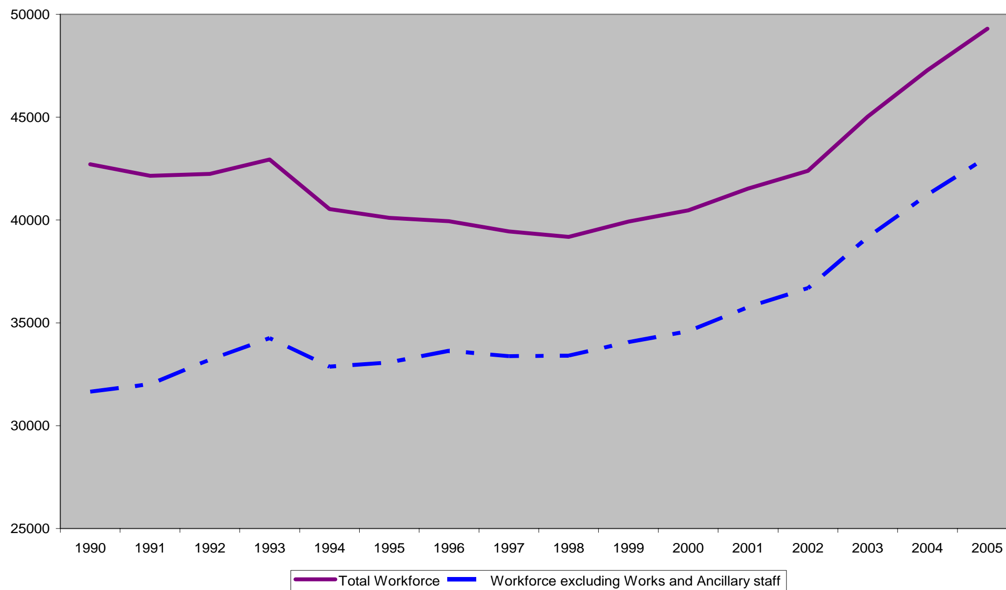
General Employment Figures

10.39 There are just over 75,000[1] 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.

10.40 The largest grouping in the HSC workforce is Qualified Nursing & Midwifery staff (26%), followed by Administrative & Clerical staff (23%). Compared to 1997, the number of qualified Nursing & Midwifery staff has risen by approximately 19%, whilst there has been a 39% increase in Administrative & Clerical staff.

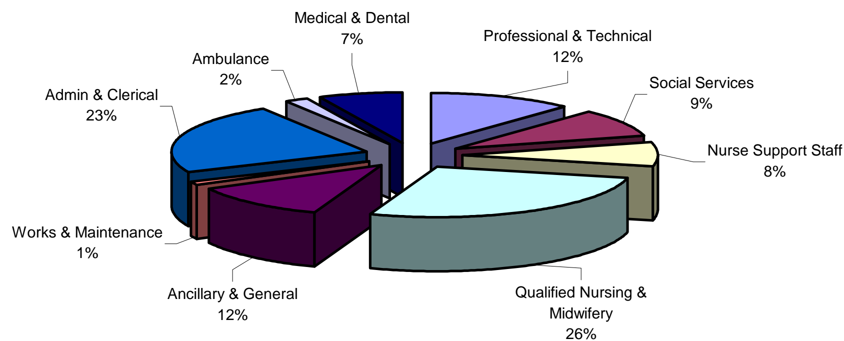
[1]Total Staff in post. Excluding (approx 16,000) Bank Staff, home help and student nurses reduces the total to 57,293 or 49,303.4 Whole Time Equivalent.

HSC Workforce Numbers (Whole Time Equivalent, WTE basis) for 1990-2006



Source: DHSSPS

Distribution of HSC Workforce by Category (2006)



Source: DHSSPS

<u>Growth</u>

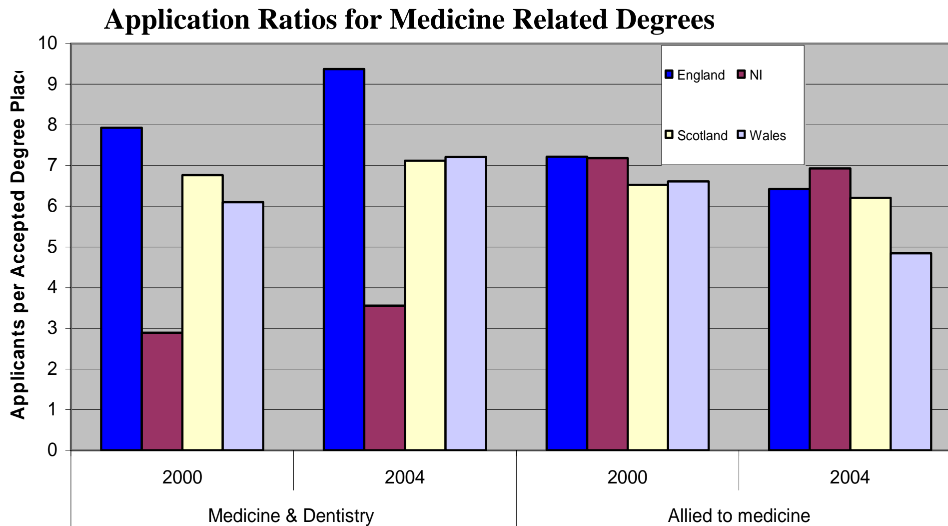
10.41 The HSC workforce fell overall during the early 1990's but rose from 1997 onwards. The main reason for the fall was a decline in the numbers of Works & Maintenance and Ancillary & General staff. Excluding these two groups, the HSC workforce followed a general upward trend with an increase in staff of approximately 1,000 per year for the period 1990-2006. In terms of headcount, females account for 79% of the HSC workforce whilst part-time workers account for 45% of the workforce (2006 figures).

10.42 Staff costs for the HSC workforce have increased by 40% between 2001 and 2006 to reach over £1.5bn. Roughly three fifths of this increase can be attributed to an increase in staff numbers with the remainder relating to average cost per staff member.

Recruitment and Retention

Graduate Recruitment

10.43 The Independent Review of Health reported that the picture in terms of recruitment can sometimes be confusing since the recruitment procedure begins with student choices on degree courses.



Source: UCAS

10.44 The number of applicants per acceptance for degree courses for Professions Allied to Medicine was higher than that for the rest of the UK[1]. However, the ratio for medicine & dentistry courses at Northern Irish institutions was significantly lower than the rest of the UK[2]. The Review reported that this latter ratio of around 3:1 is not viewed by DHSSPS as being particularly low and the view from the Appleby consultation process was that recruitment was not a significant problem.

10.45 The Review speculated that a possible reason for the lower ratio might be that Northern Irish students are selecting not to go into medicine because of higher qualifications requirements. As a broad indication of this, 93.9% of successful Northern Irish applicants to medicine & dentistry degree courses had the equivalent of three 'A' Level passes at A grade or better, compared with 84.1% for the UK as a whole[3].

<u>Vacancies – Comparison to GB</u>

10.46 Comparison of staff vacancy rates across UK Health Departments is extremely difficult due to the different methods of calculating vacancies and classifying staff. The table below sets out a broad comparison of long-term vacancy rates. Northern Ireland has lower vacancy rates than England across the majority of staff groups. Although it is clear that vacancy rates will vary within broad staff groups it has not been possible to

[1] There was some variation between the professions allied to medicine with Nursing (2.85) having a lower ratio than Physiotherapy (7.89), Dietetics (6.11), Occupational Therapy (7.10), Podiatry (7.07), Radiography (7.23) and Speech & Language Therapy (12.87)

[2] For Medicine alone the ratio was 3.73:1

[3] In terms of Allied to Medicine Degree Course which includes Nursing, Ophthalmic and Pharmacology the percentages were 35.2% for NI and 23.7% for the UK.

make comparisons with GB for those areas where there are said to be staff shortages – as a result it is difficult to say whether the high vacancy rates reflect UK wide or more localised problems for these staff groups.

Three-month Vacancy rates in Health Service for England and NI

CATEGORY	NI (Sept 05)	NI (Mar 06)	England (Mar 05)
Medical and Dental	1.5	1.1	3.1
Nursing, Midwifery and Health Visiting	0.8	0.8	1.9
Social Services	0.2	0.9	N/A
Admin and Clerical	0.6	0.9	N/A
Professional and Technical	1.6	1.5	2.4
Ancillary and General	1.5	1.4	1.3

Source: DHSSPS, NHS

Vacancies: Changes Over Time

10.47 Generally speaking, the vacancy rate for HSC staff has improved over the last few years. The table below indicates that over the period 2003 to 2006 the vacancy rate fell for Medical and Dental staff groups in the HSC.

HSC Staff Vacancies Rate %

CATEGORY		
	WTE Sept-03	**WTE Sept-06**
Admin & Clerical	3.8	2.8
Ancillary & General	5.9	3.5
Nursing, Midwifery & Health Visiting	2.8	3.0
Social Services	4.9	3.7
Professional & Technical	5.4	4.9
Medical & Dental	3.2	3.0

Source: NI HSC Workforce Census March 2006

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

Workforce Planning

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

Workforce Plans

10.50 In September 2001, DHSSPS commenced a series of uni-professional workforce reviews (i.e. a review of each profession separately – such as Dietetics, Dental, Social Services, etc.) covering the main groups employed within the HSC. The workforce planning cycle comprises a major review 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.

10.51 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.

10.52 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.

Productivity and Workforce Planning

10.53 The DHSSPS, like the NHS, targets areas such as improvements in productivity and the use of staff at different grades as additional means of meeting the workforce requirements. The Independent Health Review also highlighted this issue and it indicated that Health Sector labour productivity has been falling across the UK since the late 1990s. It also suggested that health sector productivity in Northern Ireland was approximately 9% below that of England for 2005/2006.

10.54 The need to improve productivity has been recognised by DHSSPS and they have been charged with meeting productivity targets. Budget 2005-2008 indicated that £225m out of the £474.2m efficiency savings over the next three years will come from the more productive use of health and social care professionals' time. These savings could fund increases in front line capacity (costing £135m) and the quality of services (costing £90m). However, the Independent Health Review noted that it was not clear from the information set out in the accompanying Efficiency Technical Notes[1] how the improved service will actually be achieved. Indeed, the main activity appears to be the collection of data on performance which, although valuable, in itself will not directly lead to significant improvements.

10.55 DHSSPS plans to make better use of the front-line staff time in the HSC through opportunities created by the terms and conditions reforms in the new contract for consultants and the General Medical Services (GMS) contract. The benefits should accrue in terms of increased activity, shorter waiting times, higher quality of patient and client care and longer consultation times.

10.56 DHSSPS have factored in skill mix benefits and productivity improvements into their workforce reviews. The scope for enhanced use of skill-mix and multi-professional delivery of care is now routinely explored as part of the workforce planning reviews. The potential for increasing productivity through new or different ways of working has

[1] Departments have produced Efficiency Technical Notes providing specific and quantified information on the actions departments will take over the next three years to deliver their efficiencies.

also been explored. The following themes have been identified as offering scope for early work on improving productivity:

- Benchmarking;
- Reducing complexity and bureaucracy;
- Shared services; and
- Service improvement.

10.57 Within the range of factors to be benchmarked both within Northern Ireland and compared to England are:

- Finished Consultant Episodes/ Admission per consultant /medical staff;
- Use of Agency staff;
- Wasted bed days;
- Sickness absence rates;
- Staff turnover rates; and
- The Skills mix ratios of professionally qualified staff to supporting grades.

10.58 Much of the improvement in reducing complexity and bureaucracy will be achieved through the structural re-organisation resulting from the Review of Public Administration.

10.59 A Service improvement programme is currently underway with the aim to "tackle bottlenecks in service delivery chains, which contribute to inefficient use of resources and delays in service delivery". The programme aims to improve access for patients and clients by engaging clinical teams in redesign to reduce waits and delays at all stages of the care pathway. The programme consists of a number of projects selected from across the HSC.

10.60 By addressing the areas set out above, it is anticipated that productivity can be improved through different means – improved working practices and work scheduling should enable staff to work more efficiently, eliminating time lost for example through duplication, travel time between cases etc. In other areas such as sickness absence, reduction in these levels for some groups will result in reduced expenditure on the employment of agency staff to cover the absence.

Pay Determination

Health Sector Pay Comparisons

10.61 Pay comprises 55% of total DHSSPS resource Departmental Expenditure Limit (DEL). The table below provides a high level comparison of pay in the health sector in Northern Ireland to that of the UK and some of its regions. Generally speaking, despite some variations, it suggests that levels of pay are fairly similar across the UK.

Health Sector Pay Comparisons across the UK (2006)

	NI	NE	Sco	Wales	UK
Caring Personal Service Occupations SOC Group 61.	322.2	318.2	317.7	310.5	319.6
Difference to UK average	0.8%	-0.4%	-0.6%	-2.9%	-
Health And Social Welfare Associate Prof'ls SOC Group 32	516.7	494.2	503.3	484.5	512.8
Difference to UK average	0.7%	-3.6%	-1.9%	-5.5%	-
Health Professionals SOC Group 22	1160.5	1439.0	1249.6	1360.9	1267.7
Difference to UK average	-8.5%	13.5%	-1.4%	7.4%	-

Source: 2006 Annual Survey of Hours and Earnings

6. Pay & Workforce Issues

Pay Across the NHS

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

General Dental

10.63 DHSSPSNI is currently involved in negotiations with the Dental Practice Committee (DPC) of the British Dental Association (BDA), with the aim of agreeing a new dental contract for practitioners in Northern Ireland. We hope to pilot the new contract in 2008.

10.64 As in England, there has been a steady drift of dentists moving from the health service to the private sector. This has resulted in increasing access issues in various parts of Northern Ireland. Following representations from the BDA that additional funding was required to encourage dental practitioners to remain in the Health Service, the Health Minister agreed to provide an additional £2m recurrently in the practice allowance with effect from April 2007. It was hoped that this significant investment in the 361 dental practices in the province would slow the drift into private practice.

10.65 Over the course of 2007, it has become apparent that dentists were continuing to opt for private practice in many areas. In September 2007 the Minister agreed to a further substantial package of financial measures, back-dated to April 2007, to a total estimated cost of £4.4m. This included a further recurrent £2m towards the practice allowance, specifically to address the profession's main concern with the dental contract, increasing overhead costs. The effect of this will be to increase the percentage of practice allowance paid to Health Service committed practices from 8% to 11%. On average, Health service committed practices will now receive an annual practice allowance of £29,600 compared with £21,500 previously.

10.66 The remainder of the £4.4 m was made up of £1.5 non-recurrent to assist Health Service dentists to improve sterilisation and infection-control procedures, £500k recurrently in additional vocational training allowances paid to dental practitioners, and

£400k to resource new salaried dental service posts in those parts of the country most affected by access issues.

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

General Medical

10.68 The GMS Contract is UK wide and any changes or revisions to it are applied consistently across the four Health Departments. The contract is a practice-based contract and therefore does not distinguish between GP earnings and the levels of investment Practices make for the delivery of services. It is for GPs to determine how much they take out of the contract by way of profit. The Department of Health (England) has submitted evidence on the contract and we are content this reflects the Northern Ireland position.

7. Clinical Excellence Awards

10.69 A new Clinical Excellence Awards scheme was introduced in Northern Ireland in 2005. It aimed to combine distinction awards and discretionary points into a single more graduated scheme. The broad rationale for the scheme is to "ensure recognition of exceptional personal contributions made by individual doctors who show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of the Health and Personal Social Services".

10.70 There are 12 levels of award under the new scheme. The first nine steps are decided by employer committees. The three highest steps (steps 10-12) are decided by the regional committee (Northern Ireland Clinical Excellence Awards Committee). The scheme is open to consultants with at least three years experience at consultant level. Consultants are normally expected to move through the steps one step at a time; however, consultants with four lower awards or discretionary points may apply for a higher award (step 10).

10.71 In Northern Ireland applications for clinical excellence awards can only be made by self nomination. In the first year of the new scheme (2005/06) the regional committee received 105 applications for higher awards and made 9 awards (8 step 10s and 1 step 12). In the second year (2006/07) the regional committee received 91 applications and made 17 awards (14 step 10s and 3 step 12s).

10.72 At the end of the 2006-2007 awards round there were 109 consultants in receipt of a higher award (out of a consultant population of 1126 at 1 April 2006). 523 consultants were in receipt of at least one lower clinical excellence award or discretionary point.

10.73 Under the old scheme trusts determined the minimum number of discretionary points for allocation by applying the ratio of 0.35 points per eligible consultant. The Department had concerns about the potential for costs to increase in the new scheme, given the wider eligibility pool. The Department advised trusts that they should no longer apply the eligibility formula and that awards should, instead, be recycled as existing award holding consultants retire or leave. Trusts were also advised that they had discretion to allocate more awards but had to do so within existing budgets.

10.74 At the end of the first year (2005-2006) a total of 71 lower clinical excellence awards were made, with nine trusts (out of 18) deciding not to make any awards. The Department wrote to trusts in 2006 expressing disappointment about the lack of local

awards. At the end of the second year (2006-2007) there was some improvement, with a total of 110 lower clinical excellence awards made and five trusts deciding not to make any awards.

10.75 The Department determines the number of higher awards that should be allocated by the regional committee. Under the old scheme a number of new distinction awards were made available each year based on the growth in the eligible consultant population. When the new scheme was introduced the Department decided that no new higher awards should be made available, but that higher awards should be recycled as existing higher award holders retire or leave.

10.76 The changes on how the number of lower and higher clinical excellence awards should be determined were subject to review after three years. We are now in the middle of the third year and a review is due to commence shortly with the aim of putting any new arrangements in place for the start of the next awards round in April 2008.

10.77 The Department does not propose making any recommendation on the number of new awards that should be made at higher level for 2008-2009. The Department wishes to await the outcome of our internal review.

8. Affordability

10.78 The Northern Ireland Executive faces similar constraints on affordability as the other parts of the UK. While total spending power is higher per capita, the application of the Barnett Formula (under HM Treasury's Statement of Funding Policy to the Devolved Administrations), means that the rate of growth in spending is lower than in England. Over the Comprehensive Spending Review (CSR) period 2008-09 to 2010-11, the Northern Ireland Executive's DEL will grow by 1.7% real per annum (1.2% if reduced baseline is taken into account), compared to around 3.5% per annum (on resource DEL) for Department of Health in England. Hence if pay continues to increase at or around the same levels as in England, there is a greater proportionate impact on other policy areas (e.g. if the resources required for a given pay settlement were to be diverted from other services - within Health and Social Care or from other sectors - or additional revenue raised).

10.79 Against that background, the Executive has agreed to adopt the HM Treasury Pay Policy locally, and hence in seeking a recommendation from the Review Body, the prime considerations are in respect of the need to secure the recruitment and retention of the workforce needed for the service, in the context of labour market conditions both locally and more widely, given that some health professionals are mobile within the UK, within the island of Ireland, and internationally.

10.80 As in other parts of the UK, it is important to seek sustained improvements in productivity. The Appleby report found a significant productivity gap in some aspects of health provision in Northern Ireland compared to similar services in England. If productivity gains were to become a feature of the Review Body's recommendations across the UK, there would be scope to apply that in Northern Ireland as part of a wider reform programme. The recommendation from the Pay Review Body relating to the Northern Ireland health sector will be considered by the Executive within the framework of the HM Treasury pay policy.

9. Conclusion

10.81 The Executive is committed to implementing UK national pay policy as defined by UK guidance. The presumption is that the Department of Health rationale for pay settlement in the region of 1.5% should apply to Northern Ireland but the Executive reserves its position as the Pay Review Body considers the Northern Ireland evidence.

CHAPTER 11: CONCLUSIONS AND PAY PROPOSALS

11.1 The NHS is on a journey of transformation. The first stage was to increase investment and build capacity. This required significant improvement in pay which has been achieved for most of this remit group through the introduction of new contracts for consultants, GPs and dental services. Proposals are currently being considered for staff grade and associate specialist doctors and we would hope to have a decision on these before presenting oral evidence to the Review Body in December 2007. Consideration will be given to reforming the pay for junior doctors once the EWTD has been achieved and the implications of MMC are more clear. In the meantime, the current policy of banding payments remains an essential element of our strategy to reduce junior doctors' working hours.

11.2 The next stage of reform reflects a slowdown in the rate of growth of NHS capacity and the resources available. The emphasis is therefore moving away from expansion of the workforce towards changing the model of care, reducing inequality and meeting rising patient expectations whilst maintaining and building on recent improvements in financial management. This requires the NHS to realise the full benefits of the considerable recent investment in new contracts and to ensure that any further investment in pay is carefully judged. This means balancing the need to recruit, retain and motivate staff against the need to maximise the funds available to meet non-pay cost pressures and deliver ambitious service improvements. These include accelerating drug costs, delivering the target for a maximum wait of 18 weeks from GP referral to start of hospital treatment, continuing the reduction of healthcare acquired infection and addressing the challenges set out in the recent report by Lord Darzi, *NHS Next Stage Review – our NHS our future*.

11.3 In determining this balance, the Government has taken account of the fact that independent research by Sir Derek Wanless has proposed that the NHS needs real terms investment of 4.4% per annum for the next five years to deliver public expectations. The Government has also noted that vacancies are at record low levels; that applications for medical school are their highest since records have been maintained: and, that high quality applications for post-graduate medical and dental training exceed the number of places available. This confirms that recent investment in pay reform has ensured that medical and dental careers in the UK remain attractive both nationally and internationally.

11.4 Moreover, recent research into What Matters to Staff has confirmed that pay is no longer the issue which causes most concern. Other issues are increasingly important, such as job satisfaction; having the time, equipment and skills to deliver high quality care; and, the opportunity to develop to fulfil individual potential.

11.5 It is therefore the whole reward package that is important to staff and in this respect the NHS provides much more than most, including generous entitlement to both annual leave and sickness leave, flexible hours, excellent career development opportunities, improved access to childcare and the increasingly rare opportunity to participate in a secure final salary pension scheme with a contribution from employers of up to 14.2% and above average benefits in the event of premature retirement on grounds of ill health or injury.

11.6 The Government has therefore concluded that the balance between the interests of staff and those of patients would best be served if :

- GP pay were to be maintained at current levels (ie no cash or real terms increases that are not directly linked to improvements in the level and quality of services);
- Primary dental care contract values were increased by 1.5% to allow for a reasonable pay rise after allowing for the fall in practice expenses;
- Basic pay for salaried doctors and dentists (excluding staff grade and associate specialist grades) were to be increased by 1.5% with effect from 1 April 2008;
- Clinical excellence awards were to be increased by 1.5%;
- Separate arrangements were to apply for staff and associate specialists doctors in accordance with the Government's forthcoming decision on joint proposals from NHS Employers and the BMA.

11.7 The Government believes that these recommendations are reasonable, affordable and consistent with the need to maintain macro-economic stability through compliance with public sector pay policy. It would also stress that whilst there have been some inflationary pressures during the last year, these are receding and the CPI measure of inflation that is used by the Bank of England appears to be stabilising at around 2.0%. Indeed, it has been 1.8 to 1.9% for the last 3 months and the gap between CPI and RPI continues to close. This rigorous control of inflation can only be maintained by a disciplined approach to pay.

11.8 We would also urge the Review Body not to misinterpret the forecast surplus for 2007/08 as a signal that the NHS can afford higher pay rises. The NHS has worked hard to achieve financial balance and is determined to maintain a surplus of around 0.5% as a cushion to help cope with unforeseen contingencies and the peaks and troughs of demand that are inherent in a more open, plural system. Failure to do this would be imprudent and could force the NHS back into redundancies and problems finding appointments for newly qualified staff. Pay restraint is therefore important in creating a stable environment for existing staff to deliver NHS care. Moreover, financial balance is not uniform across the NHS and there remain a significant minority of NHS organisations with serious financial challenges. High pay rises could destabilise their ongoing recovery with an impact on the NHS as a whole rather than just those few organisations in current difficulty.

11.9 Finally, whilst we acknowledge that the Review Body has not been persuaded in the past to take account of pay progression in assessing increases in headline pay, we remain convinced that the prospect of significant incremental progression softens the impact of pay awards that are below inflation. This is particularly relevant in the NHS where most staff join to pursue a full career and where many doctors will see rises of between 4% and 8% without any increase in headline pay. This compares very favourably with the national average increase in total annual earnings which the latest figures show were only 3.5%.

ANNEX A

PAY METRICS (ENGLAND)

Historical figures

The historical pay metrics (up to and including 2005/06) have been estimated using pay bill data from NHS financial returns, NHS accounts, and Foundation Trust annual reports, together with workforce statistics from the annual NHS workforce census.

Figures for 2006/07 are based on provisional financial returns and Foundation Trust annual reports together with workforce numbers from the September 2006 NHS census. These figures are best estimates based on an incomplete set of returns which are in the process of validation. Figures for 2007/08 are projections (see below).

The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors' employees, GPs, other GP practice staff or family dentists and their staff.

The pay bill figures come from the NHS financial returns and Foundation Trust annual reports. The latter do not include a breakdown by staff group, so this has been estimated using the NHS financial returns. Pay bill per full-time equivalent (FTE) employee has been calculated by dividing pay bill by the FTE number of staff.

Earnings and earnings per FTE figures have been estimated from the pay bill and pay bill per FTE figures using NHS accounts data together with the NHS Pension Scheme and National Insurance rates and thresholds which apply to NHS employers. These figures have been re-estimated this year to reflect more accurately the appropriate NI rates. This has not changed the all HCHS figures, but has re-distributed NI costs between staff groups. This has resulted in higher earnings and average earnings figures for NHSPRB staff and lower figures for DDRB staff.

Some minor changes have also been made to 2004/05 figures. This takes account of some small errors identified in the Financial Returns.

Note that, in years when the number of staff in higher paid staff groups has grown by more than the number in lower-paid groups, the average earnings figure for all staff has increased as a result.

Pay bill and pay bill per FTE figures had a step increase in 2004/05 when responsibility for the cost of pensions indexation was transferred from the Treasury to NHS employers.

Projected figures
Figures for 2007/08 and 2008/09 have been projected from the 2006/07 estimates.

The workforce FTE figures for each staff group are supply projections produced by the NHS Workforce Review Team for DDRB staff, and demand projections produced by DH for NHSPRB staff. These have been selected as the best available forecasts. Projections for medical and dental groups have been modelled individually, taking into account information on current numbers employed by the NHS, age profiles, historical retirement trends, training numbers, international recruitment, wastage, historical career trends and participation rates as appropriate.

Projections for 2007/08 have been calculated for each staff group by applying the general pay uplift, projected workforce growth, estimated earnings drift and estimated on-costs drift to the 2006/07 estimates. Projections for 2008/09 have been calculated in a similar way, based on the 2007/08 projections, but with a range of general pay uplift figures.

Earnings drift for each staff group has been estimated using a combination of analysis of historical earnings growth together with estimates of the cost of specific drivers. These drivers include recent and planned NHS pay reform and the forthcoming national increase in minimum holiday entitlement. Other drift will arise from previous changes to national pay arrangements; occupation and grade drift (skill mix change); local pay decisions; and use of other earnings, eg use of overtime, use of recruitment & retention premia and bonuses.

On-costs drift has been estimated using the projected earnings per FTE figures together with expected increase in employers' pension contribution rate and the published and expected national insurance rates and thresholds relevant to NHS employers.

Pay metrics for DDRB remit (England)

HCHS Medical Paybill (£million)[1]

											2008/09[4]				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,3]	2007/08[4]	0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	1,581m	1,773m	2,024m	2,278m	2,538m	3,114m	3,681m	3,983m	4,231m	4,548m	4,798m	4,846m	4,871m	4,883m	4,895m
Training grades[6]	1,193m	1,302m	1,432m	1,699m	1,938m	2,266m	2,532m	2,668m	2,745m	2,784m	2,847m	2,876m	2,891m	2,898m	2,905m
Other medical[7]	432m	483m	541m	611m	685m	763m	864m	920m	955m	1,058m	1,111m	1,122m	1,128m	1,130m	1,133m
total HCHS med	3,207m	3,558m	3,997m	4,589m	5,161m	6,142m	7,077m	7,571m	7,930m	8,390m	8,755m	8,844m	8,889m	8,911m	8,934m

Growth in HCHS Medical Paybill[1]

											2008/09[4]				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,3]	2007/08[4]	0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	10.4%	12.1%	14.2%	12.6%	11.4%	22.7%	18.2%	8.2%	6.2%	7.5%	5.5%	6.6%	7.1%	7.4%	7.6%
Training grades[6]	7.6%	9.1%	10.0%	18.7%	14.1%	16.9%	11.7%	5.4%	2.9%	1.4%	2.2%	3.3%	3.8%	4.1%	4.3%
Other medical[7]	10.1%	11.8%	12.0%	13.0%	12.1%	11.4%	13.3%	6.5%	3.8%	10.8%	5.0%	6.1%	6.6%	6.9%	7.1%
total HCHS med	9.3%	11.0%	12.3%	14.8%	12.5%	19.0%	15.2%	7.0%	4.7%	5.8%	4.4%	5.4%	5.9%	6.2%	6.5%

HCHS Medical Paybill per FTE (£)[1]

											2008/09[4]				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,3]	2007/08[4]	0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	77,394	82,813	91,224	98,788	102,509	118,213	130,819	134,513	138,169	142,212	143,581	145,036	145,764	146,128	146,492
Training grades[6]	39,659	42,695	45,898	53,100	57,125	62,241	62,276	61,633	60,434	59,491	58,387	58,990	59,291	59,442	59,592
Other medical[7]	52,515	57,257	62,125	67,969	71,528	80,127	89,378	95,208	96,108	102,260	103,277	104,318	104,839	105,099	105,360
total HCHS med	54,583	58,965	64,367	71,636	75,604	85,000	90,199	91,699	92,240	94,135	94,217	95,177	95,657	95,897	96,138

Growth in HCHS Medical Paybill per FTE[1]

											2008/09[4]				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,3]	2007/08[4]	0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	6.3%	7.0%	10.2%	8.3%	3.8%	15.3%	10.7%	2.8%	2.7%	2.9%	1.0%	2.0%	2.5%	2.8%	3.0%
Training grades[6]	5.8%	7.7%	7.5%	15.7%	7.6%	9.0%	0.1%	-1.0%	-1.9%	-1.6%	-1.9%	-0.8%	-0.3%	-0.1%	0.2%
Other medical[7]	5.2%	9.0%	8.5%	9.4%	5.2%	12.0%	11.5%	6.5%	0.9%	6.4%	1.0%	2.0%	2.5%	2.8%	3.0%
total HCHS med	6.2%	8.0%	9.2%	11.3%	5.5%	12.4%	6.1%	1.7%	0.6%	2.1%	0.1%	1.1%	1.6%	1.9%	2.1%

HCHS Medical Earnings per FTE (£)[1]

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2]	2005/06[2]	2006/07[2,3]	2007/08[4]	2008/09[4]				
											0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	68,350	72,736	79,321	85,069	88,222	101,331	106,722	109,338	112,491	115,848	117,006	118,176	118,761	119,054	119,346
Training grades[6]	35,024	37,978	40,408	46,193	49,680	53,917	51,439	50,790	49,927	49,293	48,461	48,946	49,188	49,309	49,430
Other medical[7]	46,378	51,346	55,099	59,556	62,555	69,703	73,879	78,330	79,145	84,192	85,047	85,884	86,303	86,512	86,722
total HCHS med	48,204	52,178	56,371	62,066	65,463	73,280	74,031	75,010	75,585	77,223	77,344	78,116	78,501	78,694	78,887

Growth in HCHS Medical Earnings per FTE[1]

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2]	2005/06[2]	2006/07[2,3]	2007/08[4]	2008/09[4]				
											0.00%	1.00%	1.50%	1.75%	2.00%
Consultants[9]	6.3%	6.4%	9.1%	7.2%	3.7%	14.9%	5.3%	2.5%	2.9%	3.0%	1.0%	2.0%	2.5%	2.8%	3.0%
Training grades[6]	5.7%	8.4%	6.4%	14.3%	7.5%	8.5%	-4.6%	-1.3%	-1.7%	-1.3%	-1.7%	-0.7%	-0.2%	0.0%	0.3%
Other medical[7]	5.1%	10.7%	7.3%	8.1%	5.0%	11.4%	6.0%	6.0%	1.0%	6.4%	1.0%	2.0%	2.5%	2.8%	3.0%
total HCHS med	6.2%	8.2%	8.0%	10.1%	5.5%	11.9%	1.0%	1.3%	0.8%	2.2%	0.2%	1.2%	1.7%	1.9%	2.2%

HCHS Medical workforce[1]

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08[8]	2008/09[8]
Consultants	20,432	21,410	22,186	23,064	24,756	26,341	28,141	29,613	30,619	31,978	33,415
Training grades[6]	30,091	30,499	31,204	32,005	33,932	36,402	40,654	43,295	45,422	46,803	48,755
Other medical[7]	8,223	8,429	8,704	8,987	9,571	9,517	9,666	9,661	9,934	10,345	10,756
total HCHS med	58,746	60,338	62,094	64,055	68,260	72,260	78,462	82,568	85,975	89,125	92,925

Growth in HCHS Medical workforce[1]

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08[8]	2008/09[8]
Consultants	3.9%	4.8%	3.6%	4.0%	7.3%	6.4%	6.8%	5.2%	3.4%	4.4%	4.5%
Training grades[6]	1.7%	1.4%	2.3%	2.6%	6.0%	7.3%	11.7%	6.5%	4.9%	3.0%	4.2%
Other medical[7]	4.7%	2.5%	3.3%	3.3%	6.5%	-0.6%	1.6%	-0.1%	2.8%	4.1%	4.0%
total HCHS med	2.9%	2.7%	2.9%	3.2%	6.6%	5.9%	8.6%	5.2%	4.1%	3.7%	4.3%

Notes:
1. Figures for NHS Staff in England only & exclude agency
2. Includes estimates for Foundation Trusts
3. Provisional NHS financial returns figures for 2006/07 have been used to estimate growth. Final figures are expected in November 2007.
4. Figures in grey are projections and subject to change. Growth includes hangover from staging of settlement in the previous year.
5. In 2004/05 responsibility for the cost of pensions indexation shifted from HMT to NHS employers.
6. All medical training grades, includes Foundation years 1&2, house officer, senior house officer and all registrar groups.
Breakdown of training grades into previous registrar and HO/SHO groups is not possible because of MMC.
7. All non-consultant medical & dental staff not in training posts. Includes associate specialists, staff grade and dental officers.
8. Workforce figures for 2007/08 and 2008/09 are projections and subject to change.
9. In 2006/07, consultants pay settlement was staged (1% in April, 2.2% in November) giving an overall settlement uplift of 1.5% in the year.

ANNEX B

WHAT MATTERS TO STAFF

<u>The research</u>

We have recently undertaken extensive research on what matters to staff in the NHS. One of the objectives of the research was to gain a better understanding of what is important to staff in delivering high quality care. We started by looking at work that already existed, and asked partner organisations to inform both the desktop research and the scope of the new research. This qualitative research found a number of factors that mattered to staff in the NHS, which were then tested through quantitative research.

The quantitative research consisted of a survey of randomly selected staff from 50 NHS Trusts and a range of GP practices from across the country and all staff groups, from which we received over 9,000 responses.

<u>The findings</u>

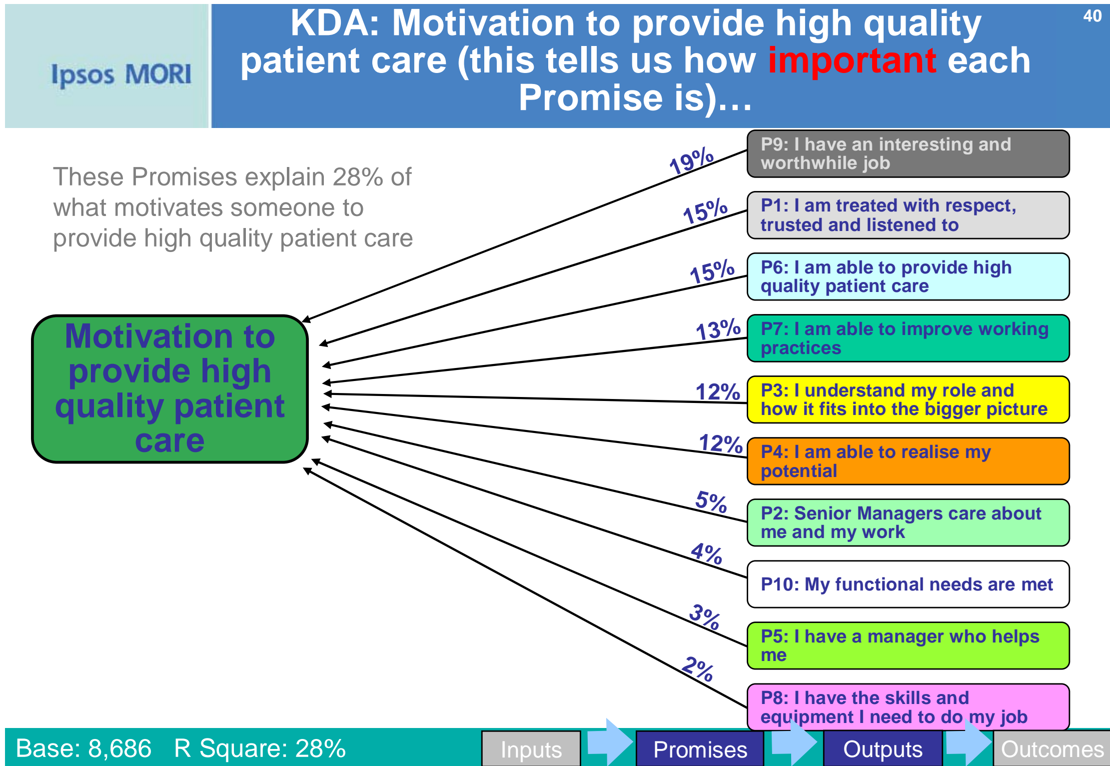
The work found that there were ten factors that mattered to staff:

1. I am treated with respect, trusted and listened to
2. I have a manager who helps me
3. I have an interesting and worthwhile job
4. I understand my role and how it fits into the bigger picture
5. I have the skills and equipment I need to do my job
6. I am able to provide high quality patient care
7. I am able to realise my potential
8. I am able to improve working practices
9. Senior managers care about me and my work
10. My functional needs are met. This factor comprises the following elements:

    - I am satisfied with the pay and benefits I receive
    - I am satisfied with the staff facilities where I work
    - I feel that my job is secure

<u>The importance of each factor</u>

We then analysed the relationship between each factor and staff's motivation to provide high quality care. This showed us how important the factors are for this motivation. The results were as follows:



This shows that the "functional needs" factor has a very low importance in contributing to staff's motivation to provide high quality care. This was true for both clinicians and non-clinicians, as well as for staff in NHS organisations and ISTCs.

We also looked at the factors' importance for staff's advocacy of their team, their Trust or Practice, and the NHS as a whole. Different factors are important for each of these, but in all cases the "functional needs" factor was relatively unimportant, never reaching more than 13%..

We also correlated the 10 factors with the results of the Healthcare Commission's inpatient survey and the results of MORI's public satisfaction tracker survey. Functional needs did have a medium-to-weak correlation to public satisfaction ($R^2 = 0.31$) but were weakly correlated to patient satisfaction ($R^2 = 0.17$).

ANNEX C

RETENTION AND RETIREMENTS

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

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

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

How are retirement rates modelled?

4. Workforce modelling for the Department of Health is now performed by the NHS Workforce Review Team (WRT)[1], hosted by the South Central SHA. The WRT comprises an expert team of professional advisers, workforce modellers, information analysts and project managers, who provide insightful and independent advice and modelling to the Department on workforce issues.

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

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

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

8. The current estimates of consultant retirement rate remains constant (at around 2.5%) with no major expected increases expected in the immediate future.

New data on early retirement intentions

9. The Medical Careers Research Group (MCRG) produced a report last year of the seventh survey into the 1977 medical cohort of UK graduates. This remains the most up-to-date study available on the retirement intentions of doctors approaching the age when some of them might to start to consider early retirement.

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

10. The MCRG study sought views from those doctors who qualified in 1977. There was a median age of 51 years at the time of the survey and they 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.

11. A total of 37% of NHS doctors among the 1977 respondents said they would definitely not or probably not stay on to retirement age. This compares favourably with the survey of the 1974 cohort in which 51% were of this opinion. The seventh survey also demonstrates that the top three reasons given for considering early retirement were family reasons/more time for leisure, maintaining good health and pressure of work. When asked what would encourage them to stay until normal retirement, workload reduction and shorter hours were the issues raised; not the need for more pay.

12. While the MRCG survey suggests a reduction in the level of intentions to retire early, 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.

13. 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.

14. We will continue to use the MCRG data to monitor trends in stated early retirement intentions over time and 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

15. Table 1 below shows the number of consultants who received a pension award, from the NHS pension scheme between 1997 to 2007 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

16. The table replaces the evidence provided in previous years by the NHS Pensions Agency. This data is now held by the NHS Pensions Division, part of the newly formed Business Services Agency[1]. The data is presented in a slightly different format to previous years' evidence, which accounts for the small differences between this series and that shown in the previous evidence[2.]

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

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

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

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

Year end 31 March	Age	Ill-health	Deferred Pension Benefits	Redundancy	Agreed Voluntary Early Retirement (AVER)	Voluntary Early Retirement (VER)	Unknown	Total Pension Awards
1997	258	58	32	27	*	*	32	**407**
1998	296	52	32	19	*	*	34	**433**
1999	275	57	25	18	*	*	37	**412**
2000	294	55	24	11	*	*	24	**408**
2001	338	66	37	11	*	*	28	**480**
2002	355	65	29	7	*	*	26	**482**
2003	325	59	20	7	*	*	30	**441**
2004	361	56	27	14	*	1	33	**492**
2005	357	45	27	9	*	1	37	**476**
2006	470	52	22	6	4	42	41	**637**
2007	571	57	7	6	3	76	31	**751**
TOTAL	**3900**	**622**	**282**	**135**	**7**	**120**	**353**	**5419**

* AVER and VER Data for 1997 – 2005 is not separately captured in this extract.

18. 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.

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

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

21. For this year's evidence we have re-provided an analysis from the MRCG on overall wastage rates five years after qualifying. Table 2 below shows the MCRG's estimates of numbers of doctors not practising medicine, and numbers not practising medicine in the UK, five years after qualification. The figures are minimum estimates, because they exclude non-respondents who are registered as doctors in the UK.

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

Table 2: Patterns of Retention – Five Years After Qualification

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

ANNEX D

REFORM OF POSTGRADUATE MEDICAL TRAINING

Foundation programme

1. In 2007, the number of places available for the first year of Foundation Training was set to provide sufficient for all those graduating from medical school plus 8% headroom for other applicants. The number of places for the second year of Foundation Training was set to ensure all those completing the first year should be able to find a place. As a result, 93% of all individuals were able to obtain their first choice foundation school. Comparable data for previous years is not available but the outcome was generally regarded as a success.

2. The first foundation programme graduates left the system this August 2007 and were eligible to apply for GP or specialty training places. The programmes for GP and Specialty training were set by the Royal Colleges and approved by the Postgraduate Medical Education and Training Board (PMETB). The recruitment and selection to the new Specialty Registrar posts as part of MMC was through a national web-based application system called Medical Training Application Service (MTAS). A separate system was used for recruitment into GP training.

General Practice Specialty

3. General practice has been developing a competency-based recruitment system over the last seven years. The process was incremental with each stage validated, and with deaneries converging their systems into a national process ready for MMC.

4. The 2007 recruitment into general practice was successful for both applicants and for the service. Applicants went through a fair, open and competitive process. The service was able to fill all vacancies in all parts of the country.

Specialty training

5. Implementation of MTAS for non-GP specialty recruitment highlighted significant problems with the MMC Programme which were reported heavily in the Press. The problems were the result of a high number of applicants, and shortcomings in the recruitment process and computer system. The DH has apologised to applicants for these difficulties.

6. Perhaps the biggest real issue was the fact that there were 32,000 applicants to 23,000 training posts. The important thing to note is that 29,000 of the applicants were already working in the NHS so whilst many people will not have got the training post they wanted this does not mean they will be unemployed as they were able to return to their non-training post or apply for another non-training post.

7. The Department took a number of immediate actions to deal with the problems in the recruitment process (eg perceived weaknesses in shortlisting). This included working with the professions and the service in the form of the Review Group led by Professor Neil Douglas, which advocated a revised approach for the remainder of the 2007 recruitment process, including guaranteed interviews for all applicants, a further increase in the number of training posts, and the provision of a transition package to avoid the loss of appointable but unsuccessful applicants.

8. A revised programme structure, processes and team have been put in place, including a project team to plan the 2008 implementation and avoid a recurrence of the problems faced in 2007.

9. The then Secretary of State also commissioned an independent review by Sir John Tooke into the wider aspects of MMC strategy. Sir John has engaged with the service, the professions and junior doctors and produced an interim report for consultation on 8 October 2007. He will produce a final report by December 2007. The Department has welcomed the interim report and looks forward to hearing the results of Sir John's consultation. It will then carefully consider the final recommendations before responding formally.

10. The scale of changes possible for the 2008 recruitment is limited given that recruitment starts in January, so Sir John's recommendations do not cover 2008 but will need to be considered for implementation in 2009 and beyond. In the meantime, the DH has consulted on the changes required for 2008 and has published a number of policy decisions for that recruitment round (eg. locally run process including local application process, national timetable, no limit on number of applications,) all of which are compatible with Sir John's interim recommendations.

11. The implementation and principles behind MMC are now being investigated by the Health Select Committee.

12. While very serious, the problems with speciality recruitment in 2007 have not reduced the attractiveness of medical training in the UK. Indeed, early predictions suggest that the ratio of applicants to potential training posts in 2008 is expected to increase to 3:1 if International Medical Graduates continue to be eligible to apply. This shows that specialty training in the UK is still a highly desired occupation and there is no need to increase the pay of junior doctors.

ANNEX E

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

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

Column (a) shows the actual basic pay for a doctor for the years from 1 April 2003. An individual doctor would progress incrementally each year as well as receiving a pay award based on Review Body recommendations and the figures include both elements.

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

Column (c) shows the cumulative percentage increase over basic pay at 1 April 2003.

For example, a new staff grade starting on 1 April 2003 on the minimum of the scale would have received basic pay of £29,060. By November 2007, the doctor would have progressed to point 4 of the pay scale and the doctor's basic salary would have increased to £42,882 - an increase of 47.6% over 4 years. The basic salary of a consultant with thirty years seniority who transfered to the new contract has increased from £78,195 in April 2003 to £96,831 in April 2007 – an increase of 23.8%. A consultant who was on the maximum of the scale on 1 April 2003 and who chose to remain on the pre-2003 contract has had a salary increase of 9.3% over 4 years.

GRADE	YEAR	(a) ACTUAL BASIC SALARY £	(b) ANNUAL % INCREASE (of which DDRB headline award)	(c) CUMULATIVE % INCREASE
SHO	1 April 2003 (minimum)	23,940		
	1 April 2004 (point 1)	26,235	9.6 (2.7)	9.6
	1 April 2005 (point 2)	28,720	9.5 (3.0)	20.0
	1 April 2006 (point 3)	31,087	8.2 (2.2)	29.9
	1 Nov 2007 (point 4)	33,472	7.6 (2.1)	39.8
SpR	1 April 2003 (point 2)	29,470		
	1 April 2004 (point 3)	31,658	7.4 (2.7)	7.4
	1 April 2005 (point 4)	34,337	8.5 (3.0)	16.5
	1 April 2006 (point 5)	36,860	7.3 (2.2)	25.1
	1 Nov 2007 (point 6)	39,278	6.6 (1.7)	33.3
Staff Grade	1 April 2003 (minimum)	29,060		
	1 April 2004 (point 1)	32,289	11.1 (2.7)	11.1
	1 April 2005 (point 2)	35,854	11.0 (3.225)	23.4
	1 April 2006 (point 3)	39,298	9.6 (2.4)	35.2
	1 Nov 2007 (point 4)	42,882	9.1 (2.4)	47.6
Consultant (0 years seniority on transfer to new contract)	1 April 2003 (minimum)	65,035		
	1 April 2004	68,196	4.9 (3.225)	4.9
	1 April 2005 (threshold 3)	73,699	8.1 (3.225)	13.3
	1 Nov 2006 (threshold 4)	77,569	5.3 (2.2)	19.3
	1 Nov 2007 (threshold 5)	80,812	4.2 (1.3)	24.3
Consultant (30+ years seniority on transfer to new	1 April 2003	78,195		
	1 April 2004 (threshold 7)	85,780	9.7 (3.225)	9.7
	1 April 2005 (maximum)	93,768	9.3 (3.225)	19.9
	1 Nov 2006 (maximum)	95,831	2.2 (2.2)	22.6
	1 Nov 2007 (maximum)	96,831	1.0 (1.0)	23.8

contract)				

Consultant (15 years seniority on transfer to new contract)	1 April 2003 (threshold 5) 1 April 2004 (threshold 5) 1 April 2005 (threshold 5) 1 Nov 2006 (threshold 6) 1 Nov 2007 (threshold 7)	73,290 75,654 78,094 85,153 91,495	 3.225 (3.225) 3.225 (3.225) 9.0 (2.2) 7.4 (1.1)	 3.225 6.6 16.2 24.8
Consultant (remaining on pre-2003 contract)	1 April 2003 (maximum) 1 April 2004 (maximum) 1 April 2005 (maximum) 1 Nov 2006 (maximum) 1 Nov 2007 (maximum)	70,715 72,483 74,658 76,300 77,300	 2.5 (2.5) 3.0 (3.0) 2.2 (2.2) 1.3 (1.3)	 2.5 5.6 7.9 9.3

ANNEX F

DEPARTMENT OF HEALTH'S GUIDANCE FOLLOWING NEW DECONTAMINATION RULES FOR ENDODONTICS

Gateway reference: 8304
PRIMARY CARE DENTAL SERVICES: GUIDANCE ON SINGLE-USE INSTRUMENTS FOR ENDODONTIC PROCEDURES
To: PCT CEs, PCT DoFs, PCT Commissioners, SHA DoFs, SHA Primary Care Leads.

SINGLE-USE INSTRUMENTS FOR ENDODONTIC PROCEDURES

1. In issuing guidance on the use of single use instruments for endodontic treatments, the Department's first priority has been patient safety and the need to act quickly on the early findings from the research being undertaken by the Health Protection Agency into vCJD.

2. The CDO wrote to all dentists in England on the 19th of April, this was followed by interim guidance using initial costings from dental equipment suppliers: these costs have stabilised and form the basis for this guidance. This note confirms the interim guidance and advises PCTs on their continued handling of the cost implications for dentists of moving to single-use reamers and files.

3. In estimating the cost implications, the Department was able to take account of historical GDS data showing that the average (mean) number of root canal treatments per dentist per year was 43 and (by virtue of the skewed distribution of such treatments) the median number was 22. This suggested that, for the great majority of practitioners, the additional costs per year were likely to be marginal and could well be offset by reductions in other practice expenses.

4. We recognise, however, that there are some practitioners who undertake an unusually high number of root canal treatments, for whom the additional costs will be more significant. Historical GDS data show that, although the median number of cases per year was 22, a group of around 10% of practitioners undertook an average of about 180 cases per year.

Factors affecting additional costs

5. The additional costs for practitioners will depend on a range of factors including:
   - the number of root canal treatments undertaken in the reference period
   - the number of root canal treatments currently undertaken
   - the extent to which practitioners already dispose of instruments for some or all of these treatments after a single use
   - the average frequency with which multi-use instruments have previously been replaced, bearing in mind that these instruments have a limited life span
   - the average number of instruments used for each treatment
   - the type of instruments used for different treatments and their previous cost
   - the current cost of single-use instruments.

Additional costs

6. Data from suppliers suggests that around 70% of instruments previously supplied to dentists were stainless steel and around 30% were nickel titanium. Costs for manufacturers' own brand re-

usable instruments were around £10 per pack of 6 for stainless steel. Nickel-titanium prices averaged around £20-25 per pack of 6.

7. A practitioner undertaking 25 treatments a year, using an average 8 instruments per treatment and previously replacing instruments after every 6 treatments would therefore have incurred average expenses of some £80 per year. A practitioner undertaking 200 treatments a year would have had annual average expenses of some £600.

8. The most recent information seen by the Department from dental suppliers indicates that single-use stainless steel instruments can now be purchased for less than £5 per pack of 6 and single-use nickel titanium instruments for less than £10 per pack of 6 (and at least one major dental supplier has already announced lower prices).

9. On this basis, the new average costs could be some £220 for a practitioner undertaking 25 treatments per year or some £1,700 for a practitioner undertaking 200 treatments a year, an additional average cost of around £140 or £1,100 respectively.

10. These examples if anything exaggerate the average additional cost because they take no account of previous single use of instruments.

11. We will continue to examine costs associated with this change in practice but do not intend to issue further guidance unless there is a notable change. PCTs should use this guidance to inform any action they take to provide recognition for practitioners facing significant additional costs as a result of moving to single-use instruments. Any additional recognition for costs, whether through additional contract payments for 2007/08 or through a reduction in required units of dental activity for 2007/08, will need to be achieved from within existing PCT allocations for 2007/08.

12. Where practitioners have expressed concerns about additional costs, we would advise PCTs to seek further information from practices about how these costs are made up. In doing this, PCTs may wish to seek specific information on the specific factors set out above. This should enable PCTs and practices to establish whether the additional costs are at the margins or whether there are more significant cost pressures involved.

13. Where PCTs envisage providing additional remuneration (or a reduction in units of dental activity) to recognise these additional costs, they may wish to begin to discuss with practices what evidence would have to be provided about the numbers of root canal treatments carried out since the move to single-use instruments, for instance post operative x-rays.

14. PCTs should, where necessary, remind practices holding a contract to provide mandatory services that they remain under a contractual duty to provide endodontic treatments where this is the most clinically appropriate treatment for the patient (assuming the treatment is within the practitioner's clinical competence and the patient agrees to the treatment). Practices are **not** allowed to apply any additional patient charge in relation to these or any other treatments.

[ends]

ANNEX G

NHS SCOTLAND DENTAL WORKFORCE STATISTICS
HEADCOUNT AS AT 30 SEPTEMBER

	Sep-96	Sep-97	Sep-98	Sep-99	Sep-00	Sep-01	Sep-02	Sep-03	Sep-04	Sep-05	Sep-06
All dentists [1]	**2,323**	**2,358**	**2,411**	**2,462**	**2,465**	**2,488**	**2,550**	**2,583**	**2,617**	**2,669**	**2,842**
Annual Change	**..**	**35**	**53**	**51**	**3**	**23**	**62**	**33**	**34**	**52**	**173**
Annual % change	**..**	**1.5%**	**2.2%**	**2.1%**	**0.1%**	**0.9%**	**2.5%**	**1.3%**	**1.3%**	**2.0%**	**6.5%**
General Dental Service	**1,871**	**1,913**	**1,955**	**1,999**	**2,002**	**2,048**	**2,078**	**2,112**	**2,156**	**2,267**	**2,434**
Non-salaried dentists	**1,833**	**1,877**	**1,918**	**1,952**	**1,954**	**1,992**	**2,015**	**2,040**	**2,070**	**2,100**	**2,202**
Principals	1,721	1,747	1,789	1,827	1,823	1,856	1,881	1,903	1,919	1,933	2,025
Assistants	37	48	45	44	39	40	36	38	41	46	40
Vocational DPs	82	89	94	93	101	104	109	111	122	136	147
Salaried dentists [2]	**41**	**39**	**39**	**48**	**50**	**60**	**67**	**77**	**93**	**187**	**275**
Hospital dentists [3]	**309**	**311**	**325**	**338**	**327**	**321**	**311**	**313**	**294**	**302**	**308**
Community dentists	**266**	**276**	**284**	**280**	**296**	**287**	**343**	**329**	**349**	**363**	**401**
OMF Surgeons [3,4]	-	-	-	-	-	17	18	23	22	27	32
All dentists including OMF Surgeons [3,4]	**2,323**	**2,358**	**2,411**	**2,462**	**2,465**	**2,505**	**2,568**	**2,606**	**2,639**	**2,696**	**2,874**
Annual Change	..	35	53	51	3	40	63	38	33	57	178
Annual % Change	..	1.5%	2.2%	2.1%	0.1%	1.6%	2.5%	1.5%	1.2%	2.2%	6.6%

Source:ISDScotland(http://www.isdscotland.org/isd/Dental-workforce.jsp?pContentID=4670&p_applic=CCC&p_service=Content.show&)

Notes

[1] Data for previous years have been revised. Double counting between the three different services and within the GDS has now been eliminated.

[2] Due to improvements in the collection of information on GDS salaried dentists, figures from September 2005 include some GDS salaried dentists not previously recorded.
There are a number of cases where a salaried post will be recorded under a generic name and not under the name of a specific dentist. Numerous dentists may work in this post at any given time. For years prior to September 2005 it was assumed that, since there was no Named individual recorded, a permanent dentist was not in post. As a result, all posts recorded without a named individual were previously excluded form GDS salaried dentist counts.
However information is now available on the individuals who fill these posts. These dentists can now be included in the GDS salaried dentist count which has resulted in a significant increase in the number of salaried dentists.

[3] Specialists in oral and maxillofacial surgery are no longer present in tables showing hospital dentists. They now appear in tables showing specialists in hospital medical surgery. Historical data, from 1996 to 2006, have also been amended.

[4] These data are presented for consistency with historical dental workforce statistics. In future, OMF surgeons will be omitted in the presentation of dental workforce data. North Region includes Grampian, Highland (including part of NHS Argyll and Clyde from 2006), Orkney, Shetland, Tayside and Western Isles. Each Region includes Borders, Fife and Lothian.
West Region includes Ayrshire and Arran, Argyll and Clyde (up to 2006), Forth Valley, Greater Glasgow (up to 2005), Greater Glasgow and Clyde (from 2006), Lanarkshire and Dumfries and Galloway.

NHS SCOTLAND
TURNOVER OF DENTISTS[1]

	2002/03	2003/04	2004/05	2005/06
All NHS dentists	**7.4%**	**8.1%**	**7.7%**	**7.9%**
Hospital	21.4%	23.0%	13.4%	19.0%
GDS	7.3%	8.0%	8.8%	6.8%
Community	19.0%	13.0%	13.8%	19.9%

Source: ISD Scotland

[1] Some dentists work in more than one sector. If a dentist leaves a sector but still continues to work in the NHS they are counted as a leaver for that sector but not in the overall total.

ANNEX I

DENTAL SERVICES IN SCOTLAND

Community Dental Services

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

2. The CDS has adapted to meet the demands of patients with special needs, primarily those with complex clinical conditions and/or challenging behaviour. Consequently, there has been a reduction in numbers of routine child patients treated by the CDS, the extent of which varies from area to area. There has been a rise in the number of adult patients treated, with a concentration on the client groups who have special needs. The dental public health role has been maintained and, with the recent introduction of the National Dental Inspection Programme, this has strengthened.

General Dental Services (GDS)

3. The remit of the Salaried General Dental Services (GDS) is the same as that of overall GDS (i.e. the main primary care dental service), except that salaried GDPs are remunerated on a salaried basis, rather than item of service and are managed as part of the Salaried Dental Services. Recent figures indicate that there are currently 275 salaried GDP posts established in Scotland. Due to recruitment difficulties, not all these posts are filled. There is no recognised appropriate level of dentist to population ratio across Scotland so levels of salaried practitioners will depend on local circumstances, influenced by demand and need. The provision of GDS is often driven, in the main, by market forces and will, therefore, encourage dentists to provide services in areas with dense population levels. Consequently, when there is a shortage of dentists, remote areas, with low population density, are likely to be adversely affected. The availability of NHS GDS has decreased over time and, in an attempt to meet demand, there has been an increase in the numbers of salaried GDPs, particularly in rural areas. In some areas the demand for such services has given rise to long waiting times.

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TABLE 1

UK Medical Schools - Admissions, First qualifications and UCAS A Level Tariff Scores of Accepted Applicants

Academic Year	2002/03	2003/04	2004/05	2005/06	2006/07
Actual intake of pre clinical students	6,752	7,544	7,883	7,914	8,042
Applicants Accepted through UCAS	6,959	7,667	7,955	7,821	8,011
Number obtaining first qualification	4,641	4,805	5,176	5,576	n/a
Home Domiciled Applicants Accepted through UCAS	6,287	6,953	7,262	7,106	7,176
Total number of "A Level" Home Domiciled Applicants Accepted through UCAS	4,686	4,990	5,245	5,046	4,957
Total Band Distribution for "A-Level" home domiciled accepted applicants					
Tariff Scores	**%**	**%**	**%**	**%**	**%**
>=540	8.77	7.64	8.26	8.27	10.05
>=480 <=539	17.43	16.31	19.05	20.74	23.26
>=420 <=479	19.10	19.58	18.40	19.69	18.74
>=360 <=419	25.99	27.82	28.17	29.20	30.00
>=300 <=359	25.84	25.65	23.31	19.29	15.45
>=240 <=299	1.84	2.12	1.72	1.53	1.53
>=180 <=239	0.83	0.68	0.82	0.91	0.71
>=120 <=179	0.17	0.18	0.21	0.34	0.22
>=080 <=119	0.02	0.02	0.06	0.04	0.04
Grand Total	100	100	100	100	100
Average A Level Tariff Score of "A Level" Home Domiciled Applicants Accepted through UCAS.	407	404	409	413	421

Source: Higher Education Funding Council for England Universities and Colleges Admissions Service.

Notes:

2003/04 and 2004/05 data have been revised. 2006/07 data is provisional

"A Level" applicants are those who were known by UCAS to have held 2 or more GCE A Level passes but **excluding** those who were known to also hold a Degree, Partial Degree Credits BTEC HNC/HND, SQA HNC/HND or other SQA qualifications that yielded a higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

Tariff Scores reported are those that were (or for 2001/2 would have been) allocated exclusively to GCE A level passes. Any other tariff points for those qualification(s) that may have contributed to the applicant's Total Tariff Score are excluded from this analysis. In many instances the presence of other qualifications (e.g. AS levels, Scottish Highers, Key Skills) would have meant that an applicant would have recorded a higher Total Tariff score.

UCAS Tariff includes a range of qualifications. There is no limit upon the number of qualifying qualifications that can contribute to an applicant's score. Details of the UCAS Tariff can be found at http://www.ucas.com/candq/tariff/index.html.

GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A - 120, B - 100, C - 80, D - 60, E - 40.

TABLE 2

UK Dental Schools - Admissions, First qualifications and UCAS A Level Tariff Scores of Accepted Applicants

Academic Year	2002/03	2003/04	2004/05	2005/06	2006/07
Actual intake of pre clinical students	958	983	1,000	1,210	1,173
Applicants Accepted through UCAS	926	948	989	1,187	1114
Number obtaining first qualification	749	779	800	813	n/a
Home Domiciled Applicants Accepted through UCAS	872	864	917	1,114	1042
Total number of "A Level" Home Domiciled Applicants Accepted through UCAS	700	694	718	854	812
Total Band Distribution for "A-Level" home domiciled accepted applicants					
Tariff Scores	**%**	**%**	**%**	**%**	**%**
greater than 539	2.71	2.30	1.80	2.80	3.82
480 to 539	7.71	6.20	8.10	8.10	11.21
420 to 479	16.86	16.10	18.00	20.00	18.23
360 to 419	30.57	33.10	30.10	33.60	37.68
300 to 359	39.57	40.50	39.80	33.50	26.23
240 to 299	1.86	1.00	1.30	1.10	1.85
180 to 239	0.57	0.60	0.60	0.70	0.62
less than 180	0.14	0.10	0.30	0.20	0.37
Grand Total	100	100	100	100	100
Average A Level Tariff Score of "A Level" Home Domiciled Applicants Accepted through UCAS.	375	373	375	381	388

Source: Higher Education Funding Council for England Universities and Colleges Admissions Service.

Notes:

(1) 2004/05 data has been revised. 2006/07 data is provisional

(2) "A Level" applicants are those who were known by UCAS to have held 2 or more GCE A Level passes but **excluding** those who were known to also hold a Degree, Partial Degree Credits or SQA qualifications that yielded a higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

(3) Tariff Scores reported are those that were (or for 2001/2 would have been) allocated exclusively to GCE A level passes. Any other tariff points for those qualification(s) that may have contributed to the applicant's Total Tariff Score are excluded from this analysis. In many instances the presence of other qualifications (e.g. AS levels, Scottish Highers, Key Skills) would have meant that an applicant would have recorded a higher Total Tariff score.

(4) UCAS Tariff includes a range of qualifications. There is no limit upon the number of qualifying qualifications that can contribute to an applicant's score. Details of the UCAS Tariff can be found at http://www.ucas.com/candq/tariff/index.html .

(5) GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A - 120, B - 100, C - 80, D - 60, E - 40.

TABLE 3

UK applicants and accepted applicants for medicine 1986 to 2005 [1]

Year of Entry	Number of Applicants	Number of Accepted Applicants [1] [2]	Ratio of Applicants to Accepted
1986	8,249	3,841	2.1
1987	7,955	3,805	2.1
1988	7,691	3,823	2.0
1989	8,051	3,898	2.1
1990	7,941	3,960	2.0
1991	7,960	3,953	2.0
1992	8,718	4,080	2.1
1993	10,072	4,292	2.3
1994	10,416	4,363	2.4
1995	10,031	4,235	2.4
1996	10,016	4,471	2.2
1997	9,946	4,577	2.2
1998	9,742	4,683	2.1
1999	8,996	4,871	1.8
2000	8,506	5,229	1.6
2001	8,563	5,675	1.5
2002	10,071	6,287	1.6
2003	12,728	6,953	1.8
2004	15,172	7,262	2.1
2005	16,783	7,106	2.4
2006	18,949	7,176	2.6

Source: UCAS Department of Research and Statistics

Notes
[1] These figures include those graduates who have applied to undergraduate medical degrees through UCAS. These figures do not include students who have applied directly to medical school.
[2] Applicants naming medicine at least once on an application form

UK applicants and accepted applicants for medicine by gender 1994 to 2005

Year of Entry	Applicants			Accepted Applicants			Ratio of Applicants to Accepted Applicants		
	Total	Female	Male	**Total**	Female	Male	**Total**	Female	Male
1994	**10,416**	5,334	5,082	**4,363**	2,275	2,088	**2.4**	2.3	2.4
1995	**10,031**	5,074	4,957	**4,235**	2,126	2,109	**2.4**	2.4	2.4
1996	**10,016**	5,143	4,873	**4,471**	2,425	2,046	**2.2**	2.1	2.4
1997	**9,946**	5,198	4,748	**4,577**	2,482	2,095	**2.2**	2.1	2.3
1998	**9,742**	5,123	4,619	**4,683**	2,605	2,078	**2.1**	2.0	2.2
1999	**8,996**	4,942	4,054	**4,871**	2,767	2,104	**1.8**	1.8	1.9
2000	**8,506**	4,842	3,664	**5,229**	3,043	2,186	**1.6**	1.6	1.7
2001	**8,563**	5,014	3,549	**5,675**	3,355	2,320	**1.5**	1.5	1.5
2002	**10,071**	6,012	4,059	**6,287**	3,846	2,441	**1.6**	1.6	1.7
2003	**12,728**	7,556	5,172	**6,953**	4,286	2,667	**1.8**	1.8	1.9
2004	**15,172**	8,719	6,453	**7,262**	4,347	2,915	**2.1**	2.0	2.2
2005	**16,783**	9,411	7,372	**7,106**	4,138	2,968	**2.4**	2.3	2.5
2006	**18949**	10570	8379	**7176**	4218	2958	**2.6**	2.5	2.8

Source: UCAS Department of Research and Statistics

TABLE 4

UK Dental Schools
Number of Home Applicants and Accepted Applicants for Dentistry[1]

Year of Entry	Number of Applicants[2] [3]	Number of Accepted Applicants	Ratio of Applicants to Accepted Applicants
1989	1,636	802	2.0
1990	1,578	795	2.0
1991	1,525	762	2.0
1992	1,595	798	2.0
1993	1,696	776	2.2
1994	2,458	838	2.9
1995	2,765	810	3.4
1996	2,659	871	3.1
1997	2,358	779	3.0
1998	2,011	773	2.6
1999	1,695	805	2.1
2000	1,688	811	2.1
2001	1,560	848	1.8
2002	1,677	872	1.9
2003	1,865	871	2.1
2004	2,147	917	2.3
2005	2,690	1,114	2.4
2006	2,577	1,042	2.5

Source: UCAS Department of Research and Statistics.

Notes
1. These figures include those students from the UK who have applied to undergraduate dental degrees through UCAS. These figures do not include students who have applied directly to dental school.

2. Applicants naming dentistry at least once on an application form.

3. The number of applications submitted per applicant changed over the years. From 1989 to 1993, the maximum was 5 applications. In 1994 it rose to 8 applications and was reduced to 6 applications in 1996, although the recommended number for dentistry remained at 5.

Table 5

Hospital, community health service and public health service medical and dental staff. Great Britain at 30 September

	1999		2000		2001		2002		2003		2004		2005		2006		Percentage growth 1999 to 2006	
	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE
Great Britain																		
Total	83,744	72,236	85,474	74,045	87,932	76,358	91,953	81,381	96,000	85,723	102,963	93,503	107,239	97,382	.	101,470	.	40.5
Consultant [1]	27,851	25,639	29,000	26,485	30,552	27,523	31,999	29,344	33,799	31,034	36,038	33,388	37,719	34,956	.	.	.	.
Registrar Group	14,628	13,927	14,631	13,993	15,139	14,452	15,975	15,146	16,931	16,216	19,318	18,573	20,537	19,752	.	.	.	.
Senior House Officer	18,451	18,057	18,698	18,480	19,144	18,920	20,700	20,450	22,458	22,144	24,489	24,165	25,718	25,336	.	.	.	.
House Officer	4,491	4,431	4,586	4,578	4,631	4,621	5,025	5,004	5,033	5,023	5,313	5,298	5,687	5,665	.	.	.	.
Associate Specialist/ Staff Grade	6,382	5,644	7,238	6,258	7,846	6,612	8,308	7,494	8,496	7,693	9,098	8,248	9,439	8,447	.	.	.	.
All Other Staff	11,941	4,538	11,321	4,253	10,620	4,230	9,946	3,942	9,283	3,612	8,707	3,830	8,139	3,225	.	.	.	.
England																		
Total	70,000	60,338	71,688	62,094	73,846	64,055	77,031	68,260	80,851	72,260	86,996	78,462	90,630	82,568	93,320	85,975	33.3	42.5
Consultant [1]	23,321	21,410	24,401	22,186	25,782	23,064	27,070	24,756	28,750	26,341	30,650	28,141	31,993	29,613	32,874	30,619	41.0	43.0
Registrar Group	12,682	12,085	12,730	12,199	13,220	12,629	13,770	13,031	14,619	13,989	16,823	16,112	18,006	17,313	18,808	18,180	48.3	50.4
Senior House Officer	15,239	14,866	15,501	15,322	15,830	15,642	17,135	16,912	18,698	18,419	20,601	20,283	21,642	21,337	18,863	18,662	23.8	25.5
Foundation Year 2 [2]	.	.	.	.	.	.	.	.	.	.	.	.	.	.	3,693	3,690	.	.
House Officer [3]	3,606	3,548	3,691	3,683	3,742	3,733	4,010	3,989	4,003	3,994	4,273	4,259	4,663	4,645	4,905	4,890	36.0	37.8
Associate Specialist/ Staff Grade	5,283	4,679	6,067	5,236	6,595	5,513	7,035	6,377	7,256	6,608	7,761	6,977	8,081	7,226	8,767	7,820	65.9	67.1
All Other Staff [4]	9,869	3,750	9,298	3,468	8,677	3,474	8,011	3,194	7,525	2,909	6,888	2,689	6,245	2,435	5,410	2,114	-45.2	-43.6
Scotland [5]																		
Total	9,273	8,126	9,325	8,164	9,646	8,465	10,256	9,072	10,409	9,293	10,660	9,568	10,876	9,787	11,203	10,163	20.8	25.1
Consultant [1]	3,138	2,935	3,195	2,982	3,306	3,091	3,411	3,195	3,513	3,285	3,593	3,358	3,724	3,494	3,847	3,625	22.6	23.5
Registrar Group	1,330	1,234	1,287	1,192	1,321	1,240	1,532	1,441	1,544	1,461	1,666	1,587	1,695	1,623	1,646	1,582	23.8	28.2
Senior House Officer	2,203	2,185	2,201	2,175	2,335	2,304	2,528	2,499	2,685	2,650	2,729	2,704	2,761	2,732	2,993	2,962	35.9	35.6
House Officer	696	695	718	718	716	716	803	803	798	797	802	802	767	766	793	793	13.9	14.1
Associate Specialist/ Staff Grade	632	534	656	550	684	573	690	578	691	579	718	589	760	627	777	638	22.9	19.5
All Other Staff [6]	1359	543	1,359	547	1,358	543	1,364	556	1,251	521	1,215	529	1,222	546	1,172	564	-13.8	3.9
Wales [7]																		
Total	4,503	3,782	4,651	3,895	4,621	3,908	4,857	4,163	4,860	4,208	5,435	4,715	5,499	4,860	..	5,332	.	41.0
Consultant [1]	1,433	1,271	1,496	1,300	1,528	1,361	1,578	1,421	1,596	1,432	1,777	1,591	1,862	1,673	..	..	.	.
Registrar Group	625	610	661	652	631	611	733	733	707	696	840	803	866	839	..	..	.	.
Senior House Officer	1,041	1,035	1,043	1,040	999	993	1,020	1,020	1,102	1,102	1,201	1,194	1,269	1,260	..	..	.	.
House Officer	193	192	197	197	185	185	210	210	234	234	247	246	257	257	..	..	.	.
Associate Specialist/ Staff Grade	481	432	528	477	586	533	585	528	572	526	673	608	666	596	..	..	.	.
All Other Staff [8]	730	242	726	231	692	225	731	250	649	220	697	273	579	235	..	..	.	.

Source: Medical workforce census.

Figures have been rounded to the nearest 10. Percentage changes are based on unrounded figures.

Some staff work in more than one location, in more than one nation. The sum of figures for England, Scotland and Wales therefore often differ from figures for Great Britain.

[1] The grade of Consultant also includes Directors of Public Health.

[2] F2 is the grade of Foundation Programme Doctors in their second year in England.

[3] Includes Foundation Programme Doctors in their first year in England.

[4] The English 'Other' includes Hospital Practitioner, Clinical Assistant, Senior Dental Officer, Dental Officer, Community Dental Officer, Clinical Medical Officer
Senior Clinical Medical Officer, Dental Clinical Director, Dental Ass Clinical Director, Other (Med Practs doing part-time work) and Other (Salaried Dental Practitioner)

[5] Scotland data for 2003 and 2004 have been revised.

[6] Includes Senior clinical medical officer, Clinical medical officer, Clinical assistant (para 94 appt. - medical), Clinical assistant (para 107 appt. - dental), Hospital practitioner, Limited specialist,
Clinical director, Assistant clinical director, Chief / Assistant chief administrative dental officer, Senior dental officer, Dental officer, Dental adviser, Medical Adviser, Assistant prescribing adviser, Other.

[7] Welsh data is not available for 2006. All NHS organisations in Wales were live on ESR by the end of November 2006. Therefore, the September 2006 Census is the first year that the ESR
data warehouse has been used to extract the entire staff census. Unfortunately, problems were encountered with the extract of Medical and Dental staff. Data has proved to be unreliable and
consequently, meaningful detailed analysis cannot be produced. Only an overall estimate of FTE has been published for 2006; which should be considered provisional and subject to change.

[8] The Welsh 'Other' includes Hospital Practitioner, Clinical Assistant, Senior Dental Officer, Dental Officer, Clinical Medical Officer
Senior Clinical Medical Officer, Assistant Clinical Director of Community Dental Service, Dental Assistant and Other.

' . ' denotes not applicable

' .. ' denotes not available.

TABLE 6

Hospital and Community Health Services Medical Staff by Grade
England at 30 September

full time equivalents and percentage change [1]

	1996	2001	2003	2004	2005	2006	Percentage Change 1996-2006	Percentage Change 2001-2006	Percentage Change 2004-2006	Percentage Change 2005-2006
All staff	51,785	61,580	69,550	75,659	79,646	83,070	*60*	*35*	*10*	*4*
Consultant [2]	18,125	22,558	25,758	27,549	28,995	29,995	*65*	*33*	*9*	*3*
Associate specialist	1,030	1,356	1,723	1,958	2,185	2,411	*134*	*78*	*23*	*10*
Staff Grade	1,961	3,999	4,700	4,817	4,816	5,163	*163*	*29*	*7*	*7*
Registrar group [3]	10,453	12,370	13,708	15,811	16,979	17,837	*71*	*44*	*13*	*5*
Senior House Officer	13,681	15,233	17,942	19,785	20,816	18,182	*33*	*19*	*-8*	*-13*
Foundation Year 2	.	.	.	.	.	3,687	.	.	.	.
House Officer & Foundation Year 1	3,212	3,676	3,960	4,228	4,618	4,866	*51*	*32*	*15*	*5*
Hospital Practitioner	184	181	205	211	198	178	*-3*	*-2*	*-16*	*-10*
Clinical Assistant	1,791	1,446	976	859	713	578	*-68*	*-60*	*-33*	*-19*
Other Staff	1,347	761	577	442	326	173	*-87*	*-77*	*-61*	*-47*

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

TABLE 7

Hospital and Community Health Services Medical Staff by Grade and Nature of Contract

England at 30 September 2006

	Numbers						Full time equivalents (FTE)					
	All staff	Full time	Maximum part-time	Part time	Honorary	Fixed Term Appointment	All staff	Full time	Maximum part-time	Part time	Honorary	Fixed Term Appointment
All grades	89,411	74,581	1,209	11,002	2,391	228	83,070	74,581	1,209	5,756	1,349	175
Consultant [1]	32,113	24,819	1,131	4,367	1,732	64	29,995	24,819	1,131	3,015	983	46
Associate Specialist	2,712	1,941	78	674	6	13	2,411	1,941	78	381	2	9
Staff Grade	5,719	4,497	-	1,145	49	28	5,163	4,497	-	621	22	24
Registrar group [2]	18,449	16,822	-	1,243	349	35	17,837	16,822	-	777	207	31
Senior House Officer	18,376	17,821	-	392	105	58	18,182	17,821	-	236	68	56
Foundation Year 2	3,690	3,677	-	5	8	-	3,687	3,677	-	2	8	-
House Officer & Foundation Year 1	4,879	4,826	-	34	15	4	4,866	4,826	-	22	14	4
Hospital Practitioner	862	3	-	858	-	1	178	3	-	175	-	0
Clinical Assistant	2,215	91	-	1,975	126	23	578	91	-	439	44	3
Other Staff	396	84	-	309	1	2	173	84	-	88	0	1

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

' 0 ' denotes a figure less than five and more than zero

' - ' denotes zero

TABLE 8

Hospital and Community Health Services Medical Staff by Grade and Sex

England at 30 September

full time equivalents

	1996			2001			2006		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	51,785	35,271	16,514	61,580	40,535	21,045	83,070	52,470	30,600
Consultant [1]	18,125	14,623	3,502	22,558	17,515	5,044	29,995	22,160	7,835
Associate Specialist	1,030	725	305	1,356	929	427	2,411	1,528	883
Staff Grade	1,961	1,358	603	3,999	2,765	1,234	5,163	3,337	1,826
Registrar group [2]	10,453	7,150	3,303	12,370	7,828	4,541	17,837	10,954	6,882
Senior House Officer	13,681	8,132	5,549	15,233	8,423	6,810	18,182	10,159	8,023
Foundation Year 2	.	.	.	.	.	.	3,687	1,759	1,929
House Officer & Foundation Year 1	3,212	1,667	1,545	3,676	1,845	1,831	4,866	2,068	2,797
Hospital Practitioners	184	148	36	181	140	41	178	124	54
Clinical Assistant	1,791	1,082	710	1,446	842	604	578	319	259
Other staff	1,347	387	960	761	249	513	173	62	111

percentages

	1996			2001			2006		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	100	68	32	100	66	34	100	63	37
Consultant [1]	100	81	19	100	78	22	100	74	26
Associate Specialist	100	70	30	100	69	31	100	63	37
Staff Grade	100	69	31	100	69	31	100	65	35
Registrar group [2]	100	68	32	100	63	37	100	61	39
Senior House Officer	100	59	41	100	55	45	100	56	44
Foundation Year 2	.	.	.	.	.	.	100	48	52
House Officer & Foundation Year 1	100	52	48	100	50	50	100	43	57
Hospital Practitioners	100	80	20	100	77	23	100	69	31
Clinical Assistant	100	60	40	100	58	42	100	55	45
Other staff	100	29	71	100	33	67	100	36	64

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

TABLE 9

Junior Doctors' Hours: New Deal Compliance - Analysis by Grade
England at 30 September 2006

	FULL SHIFTS		PARTIAL		HYBRID		ON CALL		FLEXIBLE		OTHER		SUMMARY		
	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	% outside targets
PRHO/F1	4273	30	17	0	26	0	16	0	13	0	158	5	4503	35	0.8%
SHO/F2	14944	43	428	10	462	8	1153	33	206	0	581	81	17774	175	1.0%
SPR	7677	33	516	19	941	27	3549	210	1131	4	584	136	14398	429	2.9%
Totals	26894	106	961	29	1429	35	4718	243	1350	4	1323	222	36675	639	1.7%

Notes

All figures rounded to the nearest whole number, percentages worked out on un-rounded numbers

1 New deal contracted hours targets. Average weekly contracted hours must not exceed 56 for full shifts, 64 for partial shifts, 72 for on-call rotas.

2 For full compliance with the New Deal:

- actual hours of duty must not exceed contracted hours of duty for any work pattern.
- contracted hours must be within the New Deal targets as defined by the working pattern
- work intensity and rest periods must be within acceptable limits as defined by the working pattern and in line with definitions in HSC 1998/240 so that actual

hours of work, in all working patterns, do not exceed 56 a week.

3 A hybrid working arrangement is a working pattern in which junior doctors' out-of-hours duty comprises work of substantially different levels of intensity due to different clinical responsibilities. As a result the post or placement comprises elements of two or more distinct working arrangements, usually combined with a time limit of one month or less.

4 These figures represent the latest data on compliance within the English regions only. Similar data is collected and validated within Scotland and Wales and their compliance figures will be referred to within the text of the written evidence and/or reported separately to the DDRB when validated.

TABLE 10

Junior Doctors' Hours: New Deal Compliance - Analysis by Specialty
England at 30 September 2006

	FULL SHIFTS		PARTIAL		HYBRID		ON CALL		FLEXIBLE		OTHER		SUMMARY		
Specialty	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	Posts complying in full	Posts outside targets	% outside targets
Medicine	8432	28	116	0	265	4	835	26	303	2	240	74	10191	134	1.3%
Surgery	5881	39	335	22	458	8	1641	113	190	2	72	32	8577	216	2.5%
O&G	2283	0	71	0	51	0	24	1	61	0	32	11	2522	12	0.5%
Pathology	280	0	9	0	51	5	346	19	74	0	192	20	952	44	4.4%
Anaesthetics	3145	2	114	0	264	8	37	10	127	0	49	9	3736	29	0.8%
Paediatrics	2922	7	47	7	67	2	45	3	150	0	61	3	3292	22	0.7%
A&E	2270	0	25	0	37	0	11	0	58	0	34	9	2435	9	0.4%
Radiology	197	0	68	0	60	0	400	35	113	0	127	10	965	45	4.5%
Psychiatry	1213	23	153	0	143	0	1172	18	219	0	53	13	2953	54	1.8%
Dentistry	234	7	23	0	33	8	115	18	11	0	131	40	547	73	11.8%
Public Health	10	0	0	0	0	0	92	0	44	0	78	1	224	1	0.4%
General Practice	27	0	0	0	0	0	0	0	0	0	254	0	281	0	0.0%
Total	26894	106	961	29	1429	35	4718	243	1350	4	1323	222	36675	639	1.7%

Notes

All figures rounded to the nearest whole number, percentages worked out on un-rounded numbers

1 New deal contracted hours targets. Average weekly contracted hours must not exceed 56 for full shifts, 64 for partial shifts, 72 for on-call rotas.

2 For full compliance with the New Deal:

- actual hours of duty must not exceed contracted hours of duty for any work pattern.
- contracted hours must be within the New Deal targets as defined by the working pattern
- work intensity and rest periods must be within acceptable limits as defined by the working pattern and in line with definitions in HSC 1998/240 so that actual

hours of work, in all working patterns, do not exceed 56 a week.

3 A hybrid working arrangement is a working pattern in which junior doctors' out-of-hours duty comprises work of substantially different levels of intensity due to different clinical responsibilities. As a result the post or placement comprises elements of two or more distinct working arrangements, usually combined with a time limit of one month or less.

4 These figures represent the latest data on compliance within the English regions only. Similar data is collected and validated within Scotland and Wales and their compliance figures will be referred to within the text of the written evidence and/or reported separately to the DDRB when validated.

TABLE 11

Hospital and Community Health Services Medical Consultants [1] by Age Band

England at 30 September

numbers and percentages [1]

	1996	2001	2003	2004	2005	2006
All ages: total	19,808	25,130	28,034	29,917	31,246	32,113
Percentage	*100*	*100*	*100*	*100*	*100*	*100*
Under 35	558	569	629	509	611	582
Percentage	*3*	*2*	*2*	*2*	*2*	*2*
35-39	3,782	4,518	4,876	4,842	5,118	5,112
Percentage	*19*	*18*	*17*	*16*	*16*	*16*
40-44	4,588	5,993	6,647	7,043	7,325	7,680
Percentage	*23*	*24*	*24*	*24*	*23*	*24*
45-49	4,159	5,254	6,080	6,454	6,729	6,795
Percentage	*21*	*21*	*22*	*22*	*22*	*21*
50-54	3,100	4,339	4,581	4,965	5,142	5,451
Percentage	*16*	*17*	*16*	*17*	*16*	*17*
55-59	2,215	2,886	3,496	3,867	4,038	4,130
Percentage	*11*	*11*	*12*	*13*	*13*	*13*
60 and over	1,406	1,571	1,725	2,237	2,283	2,363
Percentage	*7*	*6*	*6*	*7*	*7*	*7*

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

Table 12: Figure 1: Hospital and Community Health Services medical staff by grade England at 30 September 2006 (FTE)

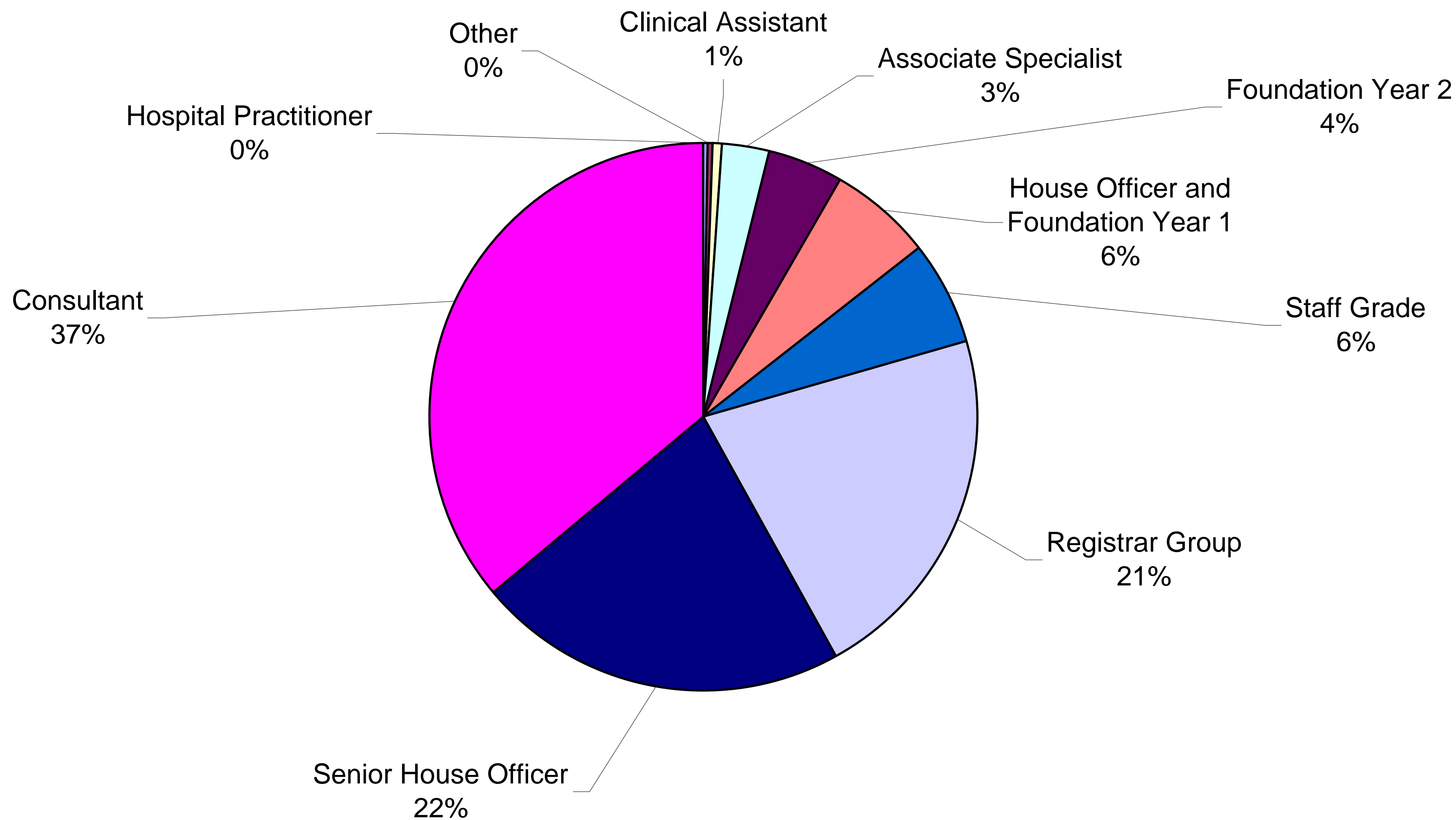

TABLE 13

Hospital and Community Health Services Dental Staff by Grade

England at 30 September

full time equivalents and percentage change

	1996	2001	2003	2004	2005	2006	Percentage Change 1996-2006	Percentage Change 2001-2006	Percentage Change 2004-2006	Percentage Change 2005-2006
All staff	2,448	2,475	2,710	2,803	2,922	2,905	*19*	*17*	*4*	*-1*
Consultant [1]	478	505	582	592	618	624	*31*	*24*	*5*	*1*
Associate specialist	44	52	57	72	75	84	*91*	*62*	*17*	*12*
Staff Grade	47	107	128	132	150	162	*245*	*51*	*23*	*8*
Registrar group [2]	264	259	280	301	334	343	*30*	*32*	*14*	*3*
Senior House Officer	403	409	477	498	521	480	*19*	*17*	*-4*	*-8*
Foundation Year 2	.	.	.	.	.	3	.	.	.	.
House Officer & Foundation Year 1	52	57	34	31	27	25	*-52*	*-56*	*-19*	*-7*
Hospital Practitioner	19	12	16	17	17	15	*-21*	*25*	*-12*	*-12*
Clinical Assistant	118	106	93	77	81	77	*-35*	*-27*	*0*	*-5*
Other staff	1,023	967	1,042	1,083	1,100	1,093	*7*	*13*	*1*	*-1*

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

TABLE 14

Hospital and Community Health Services Dental Staff by Grade and Nature of Contract

England at 30 September 2006

	Numbers						Full time equivalents (FTE)					
	All staff	Full time	Maximum part-time	Part time	Honorary	Fixed Term Appointment	All staff	Full time	Maximum part-time	Part time	Honorary	Fixed Term Appointment
All Staff	3,909	2,057	23	1,662	159	8	2,905	2,057	23	748	75	3
Consultant [1]	570	430	20	-	119	1	505	430	20	-	54	0
Associate Specialist	57	51	3	-	2	1	56	51	3	-	1	1
Staff Grade	138	117	-	-	21	-	125	117	-	-	8	-
Registrar group [2]	325	314	-	-	11	-	323	314	-	-	9	-
Senior House Officer	473	472	-	-	1	-	473	472	-	-	1	-
Foundation Year 2	3	3	-	-	-	-	3	3	-	-	-	-
House Officer & Foundation Year 1	24	24	-	-	-	-	24	24	-	-	-	-
Hospital Practitioner	1	-	-	-	-	1	0	-	-	-	-	0
Clinical Assistant	21	14	-	-	4	3	16	14	-	-	2	0
Other Staff	1,492	632	-	857	1	2	1,093	632	-	460	0	1

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Notes:
Figures have been rounded to the nearest ten.

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

' 0 ' denotes less than 5 and more than zero
' - ' denotes zero

TABLE 15

Hospital and Community Health Services Dental Staff by Grade and Sex

England at 30 September

full time equivalents

	1996			2001			2006		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	2,448	1,378	1,070	2,475	1,334	1,141	2,905	1,506	1,399
Consultant [1]	478	420	58	505	417	89	624	477	148
Associate Specialist	44	28	16	52	32	19	84	49	34
Staff Grade	47	25	22	107	61	46	162	74	88
Registrar group [2]	264	172	92	259	165	95	343	194	149
Senior House Officer	403	236	167	409	213	196	480	259	221
Foundation Year 2	.	.	.	.	.	.	3	.	3
House Officer & Foundation Year 1	52	23	29	57	20	37	25	12	13
Hospital practitioners	19	15	4	12	7	5	15	10	6
Clinical Assistant	118	76	42	106	69	37	77	44	33
Other staff	1,023	383	640	967	350	617	1,093	388	705

Percentages

	1996			2001			2006		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	100	56	44	100	54	46	100	52	48
Consultant [1]	100	88	12	100	83	18	100	76	24
Associate Specialist	100	64	36	100	62	37	100	59	41
Staff Grade	100	53	47	100	57	43	100	46	54
Registrar group [2]	100	65	35	100	64	37	100	57	43
Senior House Officer	100	59	41	100	52	48	100	54	46
Foundation Year 2	.	. .	.	.	.	.	100	.	100
House Officer & Foundation Year 1	100	44	56	100	35	65	100	47	53
Hospital Practitioner	100	79	21	100	58	42	100	64	36
Clinical Assistant	100	64	36	100	65	35	100	57	43
Other staff	100	37	63	100	36	64	100	35	65

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Notes:

[1] The grade of Consultant also includes Directors of Public Health.

[2] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R).

' 0 ' denotes less than 5 and more than zero