

Review Body on Doctors' and Dentists' Remuneration

Review for **2006**

**Written Evidence from
the Health Departments
for Great Britain**

September 2005

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SCOTTISH EXECUTIVE



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

Review Body on
Doctors' and Dentists'
Remuneration

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EXECUTIVE SUMMARY

1. This year sees a significant change in our evidence to the Review Body. Following the establishment of NHS Employers on 1 November 2004, the Government evidence will provide a high level strategic overview of the issues affecting the Review Body's remit groups. NHS Employers will provide separate evidence to represent the views of employers.
2. Evidence is provided to the Review Body of the medical workforce, in the context of the reform of postgraduate training, implementation of the Working Time Directive and evidence on recruitment and retention. There is clear evidence of a continuing healthy position on recruitment and retention within this remit group. The number of students in medical and dental schools continues to rise, consultant numbers are up, vacancy rates are down and we continue to see significant increases in doctors recruited to the NHS across the country.
3. Average earnings in the health sector grew strongly in 2004/05 at 6.1% (compared with 4.5% in 2003/04), significantly above both the private sector and public sector averages, and well above the rate which would be consistent with stable inflation in the economy at large. The growth was largely driven by growth in medical pay following the introduction of the new consultant contract.
4. Earnings growth for doctors is likely to continue to be relatively strong in 2006-07 as the consultants who opted for the new contract may move through pay thresholds towards the new maximum and as Staff and Associate Specialist grades begin to benefit from the proposed reforms. On the basis of pay reform alone, growth in consultant earnings is expected to be 2.55%.
5. As we reported last year, the distribution of doctors is likely to be influenced by a range of non-pay factors including the location of medical schools and opportunities for teaching and research. Four new medical schools and four new centres of medical education opened between 2000 and 2003. A significant number were in areas that have often struggled to recruit UK qualified doctors and where vacancy rates are higher than the national average. At the same time, a significant number of places were allocated to existing medical schools that proposed to create new undergraduate training opportunities in NHS Trusts that had suffered similar problems. This significant initiative will not only attract students to those areas where vacancy rates were higher than the average, but they will also attract consultants who will provide the training to students.
6. There continues to be a good level of commitment to the new consultant contract introduced in 2003. In a recent study undertaken by the BMA, around 86% of all consultants were now working to the new contract. We are confident that that figure will continue to rise and the Department of Health will be surveying all NHS organisations in October 2005 to determine the latest position on consultant contract implementation.
7. We accept that there will continue to be some consultants who will want to continue working to the old contract but there remains the opportunity for all consultants to move to the new contract at any time. The 2003 new contract is expected to deliver over time, a 15% average increase in a consultant's career earnings and provides a 24% increase in the maximum basic salary. These opportunities of the new contract

are therefore available to all consultants and as a result, we do not see any need to seek differential pay awards for the two contracts.

8. The Government accepted the recommendations of the NHS Confederation report *Pay and Terms of Conditions of Service for Non-Consultant Career Grade Doctors and Doctors Working in Community Hospital*). In January, the Government provided a mandate to NHS Employers to enter into negotiations with the BMA on behalf of the Department of Health, for a new contract for Staff and Associate Specialist doctors. Funding of up to £75 million was also made available for the new contract, with a view to the new arrangements being agreed in April 2006. It is important that the new contract is delivered as a result of those negotiations, and we therefore do not want to prejudice the outcome.
9. We continue to see increasing numbers of students applying for medical school places and an increase in the numbers of doctors in training. The Review Body's last report commented that the contract for doctors in training should be reviewed as the working arrangements and the training structure for junior doctors will have altered significantly within the next few years. We believe that the current pay structure for hospital doctors in training meets the current needs without amendment at least for the time being. We would not wish to consider changes to the current pay system for doctors in training until we have seen the effects of the Working Time Directive and the SiMAP/Jaeger rulings and are clear about what pay arrangements will be needed to support Modernising Medical Careers.
10. The Department of Health commissioned Aberdeen University to conduct research into the effectiveness of regional pay in relation to addressing localised recruitment and retention issues for various staff groups. Within that study, the Aberdeen researchers looked at the medical staff within this remit group. Their findings demonstrated that there is no local labour market in relation to doctors. They suggested that the varying vacancy patterns across the country, indicated that doctors operated within a national labour market and found no evidence that greater pay differentiation would be appropriate in tackling comparative recruitment and retention difficulties. Therefore, we do not see the need to develop local or regional pay flexibilities beyond the existing recruitment and retention premia currently contained in the 2003 consultant contract.
11. Data from the Office of National Statistics' Annual Survey of Hours and Earnings (ASHE) shows growth in medical earnings between 1997/98 to 2003/04 was 6.75% per annum of which we estimate that around 2.5% per annum was a consequence of pay modernisation. Against this background of sustained growth, a strong recruitment position (with large year on year increases in staff in post) and low inflation, we recommend that a modest general pay uplift of no more than 2.5% should be sufficient to meet NHS needs and ensure continued workforce stability during this period of change.
12. Our evidence highlights the significant investment Government has earmarked to support improvements in access to dentistry and support an expanded workforce: both dentists and allied professionals including dental therapists and hygienists. Against this background, we consider that an increase in gross fees of no more than 2.5%, in line with the pay uplift we are seeking for other groups of doctors and dentists in the NHS, represents a fair deal for dentists and ensures that available resources are used to best effect to benefit patients.

**REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION
THIRTY-FIFTH REVIEW**

**WRITTEN AND STATISTICAL EVIDENCE
FROM THE HEALTH DEPARTMENTS**

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CHAPTER 1: THE MEDICAL WORKFORCE CONTEXT

SUMMARY

- 1.1 This chapter sets the context for consideration of issues around remuneration including the reform of postgraduate medical training, implementation of the Working Time Directive and evidence on recruitment, retention and motivation. It shows that the recruitment position has continued to improve with further increases in doctor numbers and no problems in attracting high quality students to take up the increased number of medical school places.

Introduction

- 1.2 This year sees a significant change in our evidence to the Review Body. Following the establishment of NHS Employers from 1 November 2004, the Department's evidence in this area will provide the high-level strategic overview to reflect the new roles and relationships. Since the workforce strategy *HR in the NHS Plan* was published in 2002, there has been a significant move to devolve to NHS organisations in line with *Shifting the Balance of Power*. In addition, the approach to workforce planning has changed with a move away from nationally prescribed targets for medical and dental numbers to much greater reliance on local planning to maximise workforce capacity to support the delivery of services.
- 1.3 The Department of Health is developing a workforce strategy for health and social care aiming for publication by Autumn 2005. The developing strategy involves significant engagement with a wide range of stakeholders and needs to take account of a rapidly developing policy agenda.
- 1.4 In the meantime two interim statements on the workforce strategy have been issued¹. The first, *Delivering the NHS Improvement Plan: The Workforce Contribution*, was published in November 2004; the second, *A Workforce Response to Local Delivery Plans: A Challenge for NHS Boards*, was released in August 2005. The essential message in these statements is that NHS employers should place more emphasis on working differently and more productively, rather than aim to increase staff numbers alone. A combination of good human resources practices with a focus on high impact service delivery changes will provide the best means for meeting the challenging demands facing the NHS.

REFORM OF POSTGRADUATE MEDICAL TRAINING

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

Modernising Medical Careers (MMC)

- 1.6 We successfully introduced Foundation Programmes (covering the previous PRHO year and first year of SHO training but with a new unified curriculum) in August 2005. These are two-year structured programmes providing trainees with a basic grounding in clinical skills and non-clinical skills, as well as providing opportunities to gain broad experience in a range of different specialties and settings.
- 1.7 Our development of the programmes has been informed by evaluation of a range of pilots. Some of these, focusing on the second Foundation year, are continuing and will consequently shape further development of the programmes.

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

- 1.8 Introduction of these Programmes represents a significant change. At a local level this involved deaneries working with stakeholders to devise and manage new programmes. At a national level agreement was reached on a comprehensive, competency-based curriculum for the Foundation Programme. We published this along with the *Operational Framework for Foundation Training*, the Foundation training portfolio and *The Rough Guide to the Foundation Programme* (produced jointly with the BMA) in March 2005. These documents can be found on the Modernising Medical Careers website www.mmc.nhs.uk
- 1.9 We secured funding in 2005/06 for deanery infrastructure to support implementation and facilitate provision of career guidance. Further funding is available for 2006/07 and 2007/08 to support placements in general practice, academic medicine and a number of smaller specialties as part of the second year of Foundation training.
- 1.10 We are developing new national recruitment arrangements and competency-based assessment tools which are subject to continuing evaluation and refinement. All aspects of the Foundation Programme will be evaluated thoroughly.

Specialist Training

- 1.11 We will introduce newly structured specialist training programmes from August 2007 (that is, following completion of Foundation Programmes by the first cohort of trainees). This provides an opportunity to organise specialist training to best meet the needs of patients and the NHS. There has been extensive consultation with all stakeholders and much debate within the profession and the service on the most appropriate way to for it to be organised and this is now the key focus of MMC. The same broad model will apply to GP training.
- 1.12 As a result, a proposed medical training and career structure has been published with a view to it receiving approval from Ministers in the four UK Health Departments before the end of 2005.
- 1.13 In summary, this structure proposes to deliver a career framework for all doctors that:
- improves patient safety
 - facilitates service development in a way that reflects patient choice.
- 1.14 To this end, training and the end-product of training will be shaped by service need and will offer a workforce both of specialists and GPs trained to Certificate of Completion of Training (CCT) level and doctors who may not have reached CCT-level but are credentialed in defined competences. Those holding CCT would be eligible to enter the Specialist or GP Registers as appropriate.
- 1.15 Appointment to consultant posts for those on the Specialist Register would continue to be determined by service need and will not be affected by the MMC reforms. There is however a need to examine and structure much post-CCT learning and CPD to ensure that doctors are helped to change and develop their practice according to patient need.
- 1.16 Where doctors have achieved a credentialed level of competence, before the completion of training, they may apply for service jobs outside of the training ladder that they are explicitly competent to perform. This will allow the service to 'draw down' the explicit skills they need. These jobs, linked with the reform of the current Non-consultant Career Grades (NCCGs) will be competency-defined with direct reference to training curricula. This step-off facility would be matched by a 'step-on' route for those wishing to return to training.
- 1.17 Training for specialist and GP roles would directly follow the Foundation Programme. This in effect means that over time the SHO grade as it is known would be managed out of existence,

although this would be a gradual process that would not begin until 2007 taking some years to complete.

- 1.18 Following approval, there will be a significant and challenging agenda of work to develop the arrangements and ensure a smooth transition from the current structure. A key element of that would be to address issues of pay and terms and conditions, which might need to be the focus of evidence to the DDRB as early as 2006. However, it is clear that with a competency-based training and career structure it will be possible to map remuneration to defined levels of competence – a concept that fits neatly with the current negotiations around a new contract for staff grades and associate specialists.
- 1.19 For the time being however the new structures can be run by adapting existing pay and grading arrangements.

Non-consultant Career Grades (NCCGs)

- 1.20 A key strand of MMC is parallel reform of the NCCGs. Through the Government's approval of the recommendations of *Choice and Opportunity*, we are committed to providing greater opportunities for NCCG doctors. However, it is clear that reform in this area cannot be taken forward in isolation and, particularly, proposals must link closely to the three initiatives below:

- Proposed specialist training model and NCCGs

Paragraphs 1.11-1.19 above explain the development of the proposed new model for the medical training and career structure. The aim is a career framework that provides appropriate opportunities for doctors to develop rewarding careers as well as delivering the medical workforce required by the NHS to meet patient and service need. The competency-based model proposed explicitly maps the competences to be acquired through training to the skills required to practise in service (NCCG) posts. This would bring greater clarity to the training and career pathways open to doctors would facilitate movement into and out of training to reflect individual and service needs.

- Ongoing negotiations over a new contract

NHS Employers and the BMA are currently in negotiation over a new contract for staff grades and associate specialists (see para 2.18).

- The impact of Postgraduate Medical Education and Training Board (PMETB) assessments

From 30 September 2005 NCCG doctors have been able to apply to PMETB to have their qualifications, training and experience recognised as sufficient to be placed on the Specialist Register (see below), or to be prescribed the “top up” training required to reach that level.

Postgraduate Medical Education and Training Board (PMETB)

- 1.21 The Government established PMETB in October 2003. It will replace the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) as the competent authority for postgraduate medical training in the UK. It will assume its full statutory responsibilities on 30 September 2005.
- 1.22 The new arrangements give greater involvement for patients and the NHS in setting the standards and approving the curricula for postgraduate medical education and training. For the first time, the system will deal properly with doctors training outside the European Economic Area (EEA), giving them a route to apply for registration which will take account of their

qualifications, training and experience, wherever gained. The new organisation will also bring together the arrangements for general practice and specialist training in one organisation.

- 1.23 Significant progress has been made in the last year to ensure PMETB is ready to assume its responsibilities.
- 1.24 A key aspect of PMETB's agenda is the potential benefit to some NCCG doctors. The legislation establishing PMETB will provide a new flexibility to be applied when assessing a doctor for the Specialist Register and for the new GP Register which will allow the totality of a doctor's experience, training and qualifications to be considered together. It also allows assessments of doctors new to the UK to be conducted on the basis of "competency" rather than the current method used by the Royal Colleges of matching each component of the doctor's training against the training currently required in the UK.
- 1.25 A new facility, in order to meet current standards and not compromise patient safety, will be the power to prescribe a short period of "top-up" training in order to overcome any perceived deficiency. There will also clearly be implications for workforce planning.

WORKING TIME DIRECTIVE

- 1.26 The Government is committed to the overall aims of the Working Time Directive (WTD). The NHS implemented the WTD for doctors in training across all specialties from 1 August 2004, including an interim maximum 58-hour working week. This progress is a testament to the dedication of NHS staff.
- 1.27 The Department of Health continues to offer help to the NHS with the WTD, although implementation is a local matter. On 17 August 2005, the final evaluation report on the Hospital at Night Pilot projects was published². The pilots demonstrated that improving patient care, doctors' working lives and their training is achievable, whilst complying with the WTD. The project was a partnership between the Department of Health, the NHS Modernisation Agency, the British Medical Association and the Royal Colleges.
- 1.28 The SiMAP and Jaeger European Court of Justice rulings made implementation of the WTD more demanding. They ruled that all time spent on-call in hospital counted as work and reduced flexibility regarding the timing of rest breaks. We have continued to press for changes to the Directive to address the difficulties from the SiMAP and Jaeger rulings.
- 1.29 The SiMAP and Jaeger rulings have virtually ended the traditional resident on-call pattern of working. Some doctors and Royal Colleges raised concerns about the nature of some of the recently introduced local shift patterns. The Department of Health has reminded NHS employers of guidance which has been previously issued that supports, through careful planning, the implementation of more creative shift patterns. Working patterns should strike a balance between services designed around patients and services that support doctors' working lives and their training.
- 1.30 The Department of Health is working with all key stakeholders to support the NHS with full implementation of the WTD for doctors in training from August 2009. The National Workforce Projects (NWP) have been appointed as the lead organisation to bring together the work of the NHS on the WTD. NWP will support NHS organisations to reduce maximum working hours of doctors in training across the NHS to 48. NWP will also work closely with the new national WTD Stakeholder Group, which held its first meeting on 26 July 2005.
- 1.31 As well as overseeing new pilot projects, NWP will be reminding the NHS of helpful work already undertaken including the 20 national WTD pilots. These along with the Hospital at Night pilots demonstrate innovative ways of delivering services while complying with the

² Available on the Department at Health website at <http://www.dh.gov.uk>

requirements of the WTD. The pilots covered a range of areas such as skill-mix, redesign of rotas, new roles and redesign of services.

RECRUITMENT, RETENTION AND MOTIVATION

Workforce Numbers: headline figures

1.32 The statistical tables provided by the NHS Health and Social Care Information Centre show a strong position in relation to workforce numbers. There were further increases in the numbers of doctors and dentists and GMPs doctors in Great Britain in 2004:

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 7,780 (FTE) or 9.1%;
- Consultant numbers increased by 2,353 (FTE) or 7.6%;
- Associate specialist and staff grade numbers increased by 555 (FTE) or 7.2%;
- Numbers in the registrar group (mainly specialist registrars) increased by 2,358 (FTE) or 14.5%;
- Senior house officer numbers increased by 2,021 (FTE) or 9.1%;
- Pre-registration house officer numbers increased by 275 (FTE) or 5.5%;
- GP numbers - excluding GP retainers and GP registrars - increased by 677(FTE) or 2.1%;
- GP registrars increased by 309 (FTE) or 12.3%.

Entry to the medical workforce

1.33 The provisional UK medical school intake figure in autumn 2004 was 7,932. This is 56.7% more than in autumn 1997, and 4.4% more than in autumn 2003. The planned UK autumn 2005 intake was exceeded in both 2003 and 2004.

1.34 There are no problems in attracting new recruits of the right quality into medicine. Medicine and dentistry remain very attractive careers and continue to attract high quality candidates with average tariff points considerably higher than the average for all subjects. For 2004 entry, the average UCAS tariff points of accepted applicants to medicine and dentistry were 409 and 375 respectively compared with 404 and 373 for entry in 2003.

1.35 Table 3 shows that the number of UK applicants to study medicine at UK universities has increased again over last year. The number of UK applicants to medical schools has risen more rapidly than the number of available places with, in 2004, an average of 2.1 applicants for every medical school place. In 2004, 60% of UK accepted applicants were female compared with 62% in 2003. As at 24 March 2005, there were 10% more UK applicants to medical schools for 2005 entry than applied for entry in 2004 and 96% more UK applicants than applied for entry in 2000.

Pre-Registration House Officers (PRHOs)

1.36 In the light of the increase in medical school graduates resulting from the increased intakes in recent years, funding has been provided for an extra 319 Foundation Programme Year 1 (PRHO) posts in England in 2005-06. A Foundation Programme Workforce Group is overseeing the creation and distribution of the appropriate number of Foundation Programme Year 1 and Year 2 posts that will be needed in England over the coming years

Senior House Officers (SHOs)

- 1.37 Competition for entry into SHO training posts remains extremely high, particularly in popular areas such as London and in popular specialties. There are also a significant number of trust doctor and other non educationally-approved posts at SHO equivalent level with locally employed terms and conditions, which are included in the SHO figures quoted in this evidence, for which competition is also high. There has been no reduction in the combined number of SHO training posts and Foundation Programme year 2 pilot posts and evidence from the deaneries indicates a small increase.
- 1.38 Information from deaneries indicated that in early August 2005 around 136 PRHOs did not at that time have a training post to progress to in the NHS. Deaneries ensured that PRHOs were made aware of further recruitment opportunities as they arose and the number of PRHOs seeking training posts continued to reduce through the following weeks. The vast majority of PRHOs successfully secured their next post for training or took planned time out of training to increase their experience or travel. We are not aware that existing SHOs are experiencing significantly greater delays or difficulties this year in obtaining their next SHO post, although this may not always be in their first choice of location or specialty.
- 1.39 We value highly those doctors in whose education and training we have invested heavily, and recognise that they have made a substantial commitment to the medical profession and a future career in the NHS. We want these doctors to progress and develop their careers in the NHS where we see them as the doctors of the future, delivering modernised patient centred services.
- 1.40 In the longer term, we are also entering the first stages of the Modernising Medical Careers implementation programme. As a result, the number of SHO posts in the NHS will change as the new training programmes are introduced. We are keeping a close watch for any impacts this may have on doctors in training.

Specialist Registrars (SpRs)

- 1.41 The NHS Plan target in England of 1,000 more SpRs by March 2004 over the September 1999 baseline was achieved by September 2003. The September 2004 census showed that Registrar Group numbers had now exceeded the target by 3,141. As *Modernising Medical Careers* is implemented, SpR numbers will be increasingly driven by inputs into the training system.
- 1.42 Central funding was made available for 117 additional SpR posts in 2004/05 and a further 82 posts in 2005/06. The main specialties to benefit from these allocations were clinical radiology and histopathology.

GPs and GP Registrars

- 1.43 The NHS Plan target in England of 2,000 extra GPs (excluding registrars, retainers and locums) by March 2004 over the October 1999 baseline was achieved in December 2003. The March 2005 census shows this target has now been exceeded by 1,727 GPs. The NHS Plan target in England of 550 more GP Registrars by March 2004 over the October 1999 baseline was achieved in June 2003 and in March 2005 the target had been exceeded by 365 GPRs.

Non-Consultant Career Grades

- 1.44 There is no evidence of any general recruitment and retention problems in these grades. Non-consultant career grade FTE numbers in Great Britain have risen an average of 9.4% a year since 1997 and increased by 7.2% between 2003 and 2004. The implementation of *Modernising Medical Careers* will offer these doctors more opportunities to undertake further training and progress their careers.

Consultants

- 1.45 The NHS Plan target in England of 7,500 more consultants by March 2004 over the September 1999 baseline was achieved in December 2004. The March 2005 census shows this target has now been exceeded by 389 consultants. In addition, the manifesto commitment to increase the number of consultants and GPs in England by 10,000 by September 2005 over September 2000 was achieved in March 2005.

The Impact of Part-time Working

- 1.46 As we reported in our evidence last year, the effects of part-time working are taken into account in the national workforce models. In general, this is done by assessing the current ratio of FTE to headcount and using analysis of historical data and judgement about future trends to determine how this ratio will change over time. The current short-term workforce projections for consultants and junior doctors assume that the 2002 ratio is held for the next six years. This assumption is based on evidence that the ratio has been stable in recent years. The table below shows the FTE to headcount ratio for consultants since 1999. Across the whole of the HCHS sector in England, the ratio between September 2003 and September 2004 was 0.90. (Quarterly figures cover consultants only).

FTE to headcount ratio for Consultants in England

YEAR	Headcount	FTE	Ratio
1999	23,321	21,410	0.92
2000	24,401	22,186	0.91
2001	25,782	23,064	0.89
2002	27,070	24,756	0.91
2003	28,750	26,341	0.92
2004	30,650	28,142	0.92
Dec-04	30,863	28,419	0.92
Mar-05	31,210	28,822	0.92

Source: NHS Health and Social Care Information Centre Medical and Dental Workforce Census

- 1.47 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.
- 1.48 The Department recognises that working patterns are changing as a result of a range of factors including the increasing number of female doctors. However, the desire to work on a part-time basis is not confined solely to women doctors but is increasingly a way of life for all doctors. The Department of Health is committed to ensuring the modern NHS operates more flexibly and is creative in its working arrangement to maintain an appropriate work/life balance for all staff.

Initiatives to improve recruitment, retention and return

- 1.49 The employment of international healthcare professionals has made a significant contribution to the workforce of the NHS. All recruitment has been underpinned by a Code of Practice, which was updated and strengthened in 2004. All health professionals work in an increasingly global market where demand for their services continues to increase. Therefore the NHS will need to continue to be recognised as an attractive employer in the international arena, as well as in the UK. It is anticipated that the entry of new member states to the European Union in May 2004

will also increase the number of health professionals from the EU who come and work with in the NHS.

- 1.50 Likewise with the drive to improve working lives. Evidence from the second staff survey – albeit spanning all staff groups - reinforces last year’s results and shows that in key areas, eg job satisfaction, the position has been one of consolidation and in some cases improvement.
- 1.51 In areas where we have pump primed initiatives eg the Flexible Career Scheme, the policy now - in line with *Shifting the Balance of Power* – is to devolve funding to reflect the progress made in terms of new attitudes to flexible working. The Department of Health will no longer hold central funds and the principles of embedding, mainstreaming and devolution have been endorsed by the GPC on behalf of the profession, for example, the recently negotiated Primary Care Development Scheme. The aim of the new scheme is to allow optimum targeting. The identification of areas with difficulties in GP recruitment and the way that support is provided will be left to local discretion, using local knowledge, and the principles agreed with the GPC.

Future Workforce Requirements

- 1.52 The bulk of NHS investment goes into staff and the workforce needs to change to be able to respond to the challenges facing NHS organisations. Much has already been achieved in terms of :
- Growth in staff numbers. Between September 1997 and September 2004, the number of doctors employed in the NHS in England increased by over 27,400;
 - Increase in new roles (eg GP with special interest);
 - Encouraging results from the second national staff survey undertaken by the Healthcare Commission in relation to – for example – job satisfaction.
- 1.53 Taken together these show an encouraging picture. Albeit there is more to do, it is clear that the current levels of pay are appropriate to address the recruitment, retention and motivation of doctors in the NHS. Where there are pressures, mechanisms are already in place at local level for them to be addressed.
- 1.54 Targets were originally set to expand workforce numbers in England and at halfway through the NHS Plan period there has been massive growth, with most of those key targets now attained. In future, Local Delivery Plans will set out the workforce requirements needed to achieve service objectives rather than relying on the development of national workforce assumptions. The role for the Department of Health in England is now to:
- Provide national models and assumptions where needed;
 - Ensure that local plans are sufficiently integrated, coherent and realistic to deliver national objectives; and
 - Provide national support to do what only the Department can do eg in relation to regulatory reform/international recruitment etc.

Productivity

- 1.55 While sufficient numbers still need to come through to replenish and refresh the workforce, this and any overall expansion must increasingly also be linked to growth in productivity. Improving productivity and efficiency are critical to the successful delivery of services. As part of the spending review 2004, the Department of Health committed to achieving annual efficiency benefits in England of at least £6.5 billion by 2007/08. Up to £2.9 billion of the expected gains are expected to come from making better use of staff time (Productive Time). Productive Time aligns the modernisation strategies for People (Pay and Workforce Reform), Process (10 High Impact Changes) and Technology (NHS Connecting for Health) in order to maximise service improvement.

- 1.56 Although there is no local target on efficiency, national payment tariffs will reduce annually by 1.7 per cent from 2005-06, requiring organisations to implement efficiencies to deliver their service within budgets. Organisations currently above national tariffs will need to realise further efficiency gains to eliminate overspend.
- 1.57 Overall the funding to organisations will still be increasing over time and individual local efficiency savings will be recycled into providing a proportion of increased capacity or service provision requirements.

CONCLUSION

- 1.58 The overall workforce expansion over the last five years has led to a healthy equilibrium. NHS organisations in England now have a lot more freedom to develop the workforce capacity they think they need to provide services, within an overall strategic framework set by the Department of Health and supported by NHS Employers. The NHS cannot afford to be complacent and will need to maintain downward trends in vacancy rates in most groups of staff but the evidence suggests that the current pay levels are appropriate to address the recruitment, retention and motivation of doctors in the NHS.

CHAPTER 2: HCHS AND GMS PAY AND CONDITIONS OF SERVICE

SUMMARY

- 2.1 This chapter sets out our evidence on pay and conditions of service for doctors and hospital dentists.

REGIONAL AND LOCAL DIMENSIONS

- 2.2 The Pay Review Bodies have been asked to have regard to regional and local labour markets and their effects on recruitment and retention. The Government wants to see public sector pay systems that increase the sector's flexibility and responsiveness, so that the public sector contributes to increased overall flexibility of the economy as a whole.
- 2.3 In January, the Department of Health commissioned Aberdeen University to conduct research into the effectiveness of regional pay to help address localised recruitment and retention issues for various staff groups. With regard to doctors, the results of the Aberdeen research are in line with our evidence to the Review Body over the last two years. The research found that the pattern of vacancies differed between doctors and non-medical staff. In the case of doctors, the highest vacancies are found in the North and the West Midlands and the lowest vacancies are found in London and the South West. The research suggested that doctors operate in a national labour market and found no evidence that greater pay differentiation would be appropriate in tackling comparative recruitment and retention difficulties.
- 2.4 Statistical Tables 18 and 19 show the latest information on the distribution of medical and dental consultants and on the geographical and specialty variations in medical and dental vacancies. The March 2005 mean three-month vacancy rate for medical and dental consultants was 3.3%. This compares with 4.4% in March 2004 and 4.7% in March 2003. There continue to be comparatively greater recruitment and retention problems in parts of the north and midlands but the variation in vacancy rates is not as marked as in earlier years. The variation in vacancy rates between specialties remains more pronounced with highest vacancy rates in accident and emergency medicine, public health medicine, psychiatry and radiology.
- 2.5 As we reported last year, the distribution of consultants is likely to be influenced by a number of non-pay factors including the location of medical schools, opportunities for teaching and research and opportunities for private practice. The additional medical school places which were allocated to existing and new medical schools over the last few years were expected to lead to improvements in the distribution of doctors and to help tackle comparative recruitment and retention problems. As consultant numbers increase, and with the establishment of these new centres of medical education and research, we expect the variation in vacancy rates to reduce.
- 2.6 There is already provision under the 2003 consultant contract for employers to pay a recruitment and retention premium of up to 30% of normal starting salary under certain circumstances. In addition, London weighting is paid to HCHS doctors and dentists, GMP Registrars and salaried GMPs.
- 2.7 Given this dynamic position and the existing provision for employers to pay recruitment and retention premia to consultants where appropriate, we are not seeking any further regional/local differentiation in doctors' pay for 2006/07.

London Weighting

- 2.8 As at September 2004, there was an England average of 6.1 consultants per 10,000 population compared to 5.8 consultants for the same population group in the previous year. Table 18 shows that, as last year, in four of the five London SHAs consultant numbers are above the mean and are the four highest in England. Table 19 shows that the three-month vacancy rates in London are below the levels found in some other parts of the country, the vacancy rates in South West London and North Central London SHAs (1.1% and 1.4%) being the second and third lowest in England. The evidence suggests that NHS Trusts are able to recruit and retain doctors at the current levels of London weighting. We can see no case for London weighting to be increased in 2006/07 and we would ask to Review Body to agree that the rates of London weighting (£2,162 for non-resident staff and £602 for resident staff) should be held steady in cash terms.

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

- 2.9 The Review Body is reminded that in addition to the annual pay uplifts awarded following Review Body recommendations, doctors on incremental pay scales who are not yet at the top of their pay scale have the opportunity to progress up the pay scale. For example, excluding the annual pay award, the pay of a specialist registrar who is not yet at the top of the scale increases by between 4.2% and 5.3% per annum (depending on the point they are on in the pay scale). The table at **Annex A** illustrates the combined effect of incremental rises and Review Body awards on individual doctors' pay by taking some hypothetical examples over a five year period.
- 2.10 For example, a new consultant starting on 1 April 2001 on the minimum of the scale would have received basic pay of £50,810. Having progressed up the consultant scale, and assuming transfer to the new contract, by 1 April 2005 the doctor would be receiving £75,899 – an increase of 49.4% over 4 years.
- 2.11 Data from the Office of National Statistics' Annual Survey of Hours and Earnings (ASHE) shows growth in medical earnings between 1997/98 to 2003/04 was 6.75% per annum of which we estimate that around 2.5% per annum was a consequence of pay modernisation.

HOSPITAL CAREER GRADES

CONSULTANTS

- 2.12 There has been very good take up of the 2003 consultant contract - the BMA reported that their survey (June 2005) indicated that less than 14% of consultants remained on the old contract. The old contract is now closed though consultants who remain on it still have the opportunity to transfer to the new contract if they wish to do so.
- 2.13 The 2003 contract was designed to provide, over time, a 15% average increase in a consultant's career earnings and will also mean a 24% increase in the maximum basic salary. The job planning process is key to the new contract, providing a stronger, unambiguous framework of the consultant's contractual obligations. This should enable consultants to better manage their workload and should have a positive impact on morale and retention. The DH National Survey of Consultant Contract Implementation, published in February, showed that, as at 29 October 2004, the average number of programmed activities in agreed job plans was 11.17.
- 2.14 The Job Planning Toolkit and Guidance, published by the Consultant Contract Implementation Team in January, has been well-received. The Consultant Contract Benefit Realisation Team is working with SHAs to embed job planning, ensure that the benefits of the contract are

realised and used to support service improvements and disseminate examples of good practice. NHS Employers provide an expert service to support employers in implementing the contract.

- 2.15 Consultants' pay has increased significantly in recent years. Earnings growth will continue to be strong in 2006/07 as consultants progress through their pay thresholds towards the new maximum. The consultant workforce continues to grow and the new contract enables them to better manage their workload. For 2006/07, for consultants on both the pre-2003 and the 2003 contracts, we believe that a pay uplift of no more than 2.5% would be sufficient to maintain the current healthy recruitment and retention position and continue to motivate staff.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

- 2.16 The clinical excellence award (CEA) scheme is now in its second year. The new scheme replaced the previous consultant reward schemes - distinction awards and discretionary points - though awards made under these previous schemes remain in payment until award holders retire or are awarded a CEA. The CEA scheme comprises both local and national awards and is open to all consultants with at least one year's service at consultant level. The Advisory Committee on Clinical Excellence Awards issues annual guidance for each award round and is responsible for overseeing the scheme. As part of the August 2003 framework for the CEA scheme, it was agreed that the BMA and NHS Confederation should report on the operation of the new scheme after two years. We expect this work to start after the completion of the current (2005/06) award round and to be completed in time to inform the 2007/08 awards round.
- 2.17 For 2006/07, we propose that the value of clinical excellence awards, distinction awards and discretionary points should be uplifted by no more than 2.5% in line with the pay uplift we are seeking for consultants.

NON-CONSULTANT CAREER GRADES

- 2.18 The NHS Confederation's scoping report, *Pay and Terms and Conditions of Service for Non-Consultant Career Grade Doctors and Doctors Working in Community Hospitals* recommended that there should be a negotiation of new contractual arrangements for staff grade and associate specialist (SAS) doctors including non-GP qualified doctors working as clinical assistants and hospital practitioners. In January, the Government announced that they had agreed up to £75 million for a new SAS contract and that NHS Employers had been asked to enter into negotiations with the BMA on behalf of the Department of Health on new contractual arrangements to be implemented from April 2006. The negotiations commenced in May and are still underway. We do not want to pre-judge the outcome of these negotiations and propose that the staff grade and associate specialist pay scales should be uplifted by no more than 2.5% in 2006/07.
- 2.19 The negotiations do not extend to trust grade (or non-standard grade) doctors who are employed on local contracts. The basic pay and terms and conditions of employment of non-standard grade doctors are broadly similar to comparable training grade doctors, and we are not aware of any compelling problem with the way these doctors are paid or with their contracts of employment. We have previously suggested that any issues of concern are likely to be addressed by policy initiatives already being put in place - in particular Modernising Medical Careers, and the negotiation of new contractual arrangements for staff grade and associate specialist (SAS) doctors. Doctors who are appointed to SAS grade posts will, of course, be on the national terms and conditions that are agreed for those grades. It will continue to remain open to NHS trusts to use local contracts where this is appropriate to local needs. These contracts, together with remuneration, are entirely local matters.

HOSPITAL DOCTORS AND DENTISTS IN TRAINING

- 2.20 The introduction of the current contract in 2000, with banding multipliers used to reward doctors for the frequency and duration of their out-of-hours work, provided a financial incentive to NHS trusts to reduce the working hours of junior doctors. In addition, since August 2004, doctors in training have been covered by the Working Time Directive with a legal requirement to comply with the interim maximum 58 hour week. This has driven improved compliance against the New Deal contract. NHS Employers continue to monitor compliance with the New Deal, and as at March 2005 98% of doctors in training were fully compliant compared with 96% in September 2004, 88% in March 2004 and 71% in 2001.
- 2.21 Whilst total duty hours for doctors in training have fallen considerably in recent years, for many doctors from a maximum of 72 to 56, there has not been a corresponding drop in earnings.

PRHO Pay – 2001 to 2005

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

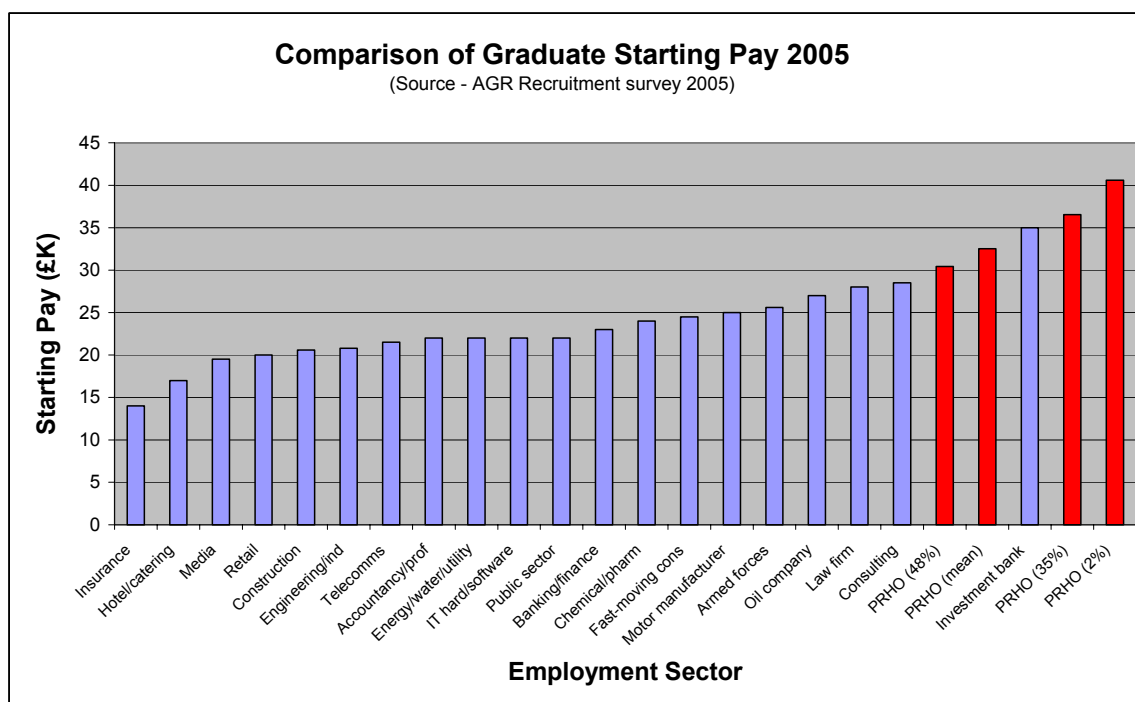
(The multiplier is the average of that for all full-time trainees in post)

- 2.22 The table shows the movement of PRHO pay since the implementation of the new contract. In that period basic salaries have risen by 13% and overall pay by 16.4%, against overall inflation of 11.5% (using HM Treasury GDP deflator figures). The reduction in overall pay in the last year is as a direct result of the reduction in working hours as both the New Deal and the European Working Time Directive impact on working patterns. This is to be expected, and will continue as 2009 approaches, by when all juniors should be working no more than 48 hours a week. They will then as a consequence receive a maximum supplement of 50% of basic salary, the actual amount depending on the intensity of work. Total pay will continue to properly reflect actual work done on the same agreed basis as at present and may well reduce, but any reduction must be weighed against the benefits of reduced hours and a more family-friendly working environment.

Salary comparisons with other professions

- 2.23 For graduates entering their first PRHO post, salaries remain very competitive. A recent survey by the Association of Graduate Recruiters³ reported that between 2004 and 2005 half of the employers surveyed raised pay by the cost of living or less, while half raised pay by between 5% and 17%. While this may appear high, the figures must be seen in context; some of the highest rises were in companies trying to catch up with prevailing market rates, and the employer reporting the 17% increase still lags 10% below the national median.
- 2.24 Over a quarter of employers questioned in the AGR's survey expected graduate starting salaries in 2006 to rise by less than the cost of living. In the sectors usually compared with medicine, including law, consulting and investment banking, rates have been frozen. Median salaries in these areas have remained unchanged for the last four years, although some movement may be anticipated next year.

³ AGR Recruitment Survey 2005, Association of Graduate Recruiters



2.25 The above chart, using data taken from the survey, shows a comparison between the pay of junior doctors in their first post and the salaries of graduates entering other professions. The four columns for Medicine, as in previous years' evidence, show the range of actual starting pay for PRHOs (ignoring the value of accommodation currently provided free in the pre-registration year). The chart shows the percentage of doctors on each of the three main pay bands in addition to the average, which for PRHOs in 2005 is £32,533, with 37% earning £36,531 or more. This continues to compare favourably with other professions, exceeding even the starting salary for investment banking.

2.26 It is important to understand the difference in employment prospects between graduates from medical schools and those from business, accountancy and law schools with whom doctors often compare pay. While the AGR survey does not claim to include all employers, it does cover the principal ones. In particular, it reported on sixteen principal employers, mainly from the investment banking, consulting and legal sectors, who “together are recruiting over 1,700 graduates in 2005”. Intakes to English law schools alone number some 19,000 a year (2004). Even if 1,700 is a low estimate of the better paid openings, it would be reasonable to assume that such opportunities are available to only a small proportion of graduates and that, whilst the earnings of some may be comparable to those of medical graduates, many will earn considerably less. An average of 33 applicants applied for each post across the organisation types in the AGR survey, but competition between graduates for posts is likely to be even more intense for those posts where starting pay is at the upper end of the range where PRHO pay currently sits. A separate survey of more than 16,000 students carried out by High Fliers Research, which was reported in the Guardian⁴, found only 36% of graduates expected to start graduate-level jobs after university.

2.27 By comparison, the number of first hospital posts open to graduates from UK medical schools is in excess of the total number graduating each year. Most graduates from UK medical schools will find a suitable post, although some may need to be realistic about location – there is a limit to the number that can train in London, for example - and will have the opportunity to progress through a well-established and comparatively well paid career structure. Such opportunity on graduation is almost without parallel in Western society. This forms part of a peerless level of opportunity and expectation from entry to medical school to completion of specialist training. While longer than in other professions, for virtually all medical students this

⁴ Students lose confidence in graduate job market, Donald MacLeod, Guardian Newspaper, April 21, 2005

process delivers planned access to training from graduation to consultant status with the consequent benefit that position delivers in terms of status and financial reward.

- 2.28 We remain committed to ensuring a continued upward trend in the number of trainees in the NHS. Given the level of current applications both to medical schools and at all levels of training, we believe this can be achieved with an uplift for 2006 of no more than 2.5%.

Banding Multipliers

- 2.29 Banding multipliers, used to reward doctors for the frequency and duration of their out of hours work, are now free-standing and reviewed annually by the DDRB with the review of basic pay.
- 2.30 The 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.

Review of Pay System for Doctors in Training

- 2.31 The Review Body's last report commented that the contract for doctors in training should be reviewed as the working arrangements and the training structure for junior doctors will have altered significantly within the next few years. We believe that the current pay structure for hospital doctors in training meets the current needs without amendment at least for the time being. We would not wish to consider changes to the current pay system for doctors in training until we have seen the effects of the Working Time Directive and the SiMAP/Jaeger rulings and are clear about what pay arrangements will be needed to support Modernising Medical Careers.

Flexible Medical Trainees

- 2.32 Agreement has been reached between the Junior Doctors' Committee of the BMA, NHS Employers, the UK Health Departments and the Conference of Postgraduate Medical Deans (COPMeD) on revised arrangements for flexible training for doctors. Part of the agreement is that funding of £7 million, which was previously used to subsidise flexible training salaries, will be reallocated to incentivise family-friendly practices and expand flexible training.
- 2.33 The major benefit of this agreement is that pay for flexible trainees will become pro rata to pay for full timers. The fact that this has not been the case previously has been a deterrent to NHS Trusts using flexible trainees. The change will reduce the cost to NHS employers of flexible trainees and it is hoped that the new scheme will double the number of flexible trainees over the next three to five years.

GENERAL MEDICAL PRACTITIONER SERVICES

GMP Registrars

- 2.34 The supplement paid to GMP registrars is intended to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged in relation to hospital doctors in training. The supplement was increased from 50% to 65% in 2003/04 to maintain the relativity between the pay of the two groups and help protect GMP registrar recruitment given increases in the average banding supplement paid to hospital doctors
- 2.35 At the current level of 65% of basic salary, the GMP registrars' supplement is above the UK average paid to hospital trainees (60%) but below the average for hospital trainees in Scotland

(69%). There is a risk that a reduction in the GPR supplement at this stage would be likely to impact on GPR recruitment. In the circumstances the Department of Health would be content for the supplement to remain at 65% for 2006/07.

GMP Trainers

- 2.36 The flat rate grant paid to GMP trainers is currently £7,024. For 2006/07 we would ask the Review Body to uplift the trainers' grant by no more than 2.5% in line with the increase we are proposing for salaried doctors and dentists.
- 2.37 In its 34th Report, the Review Body recommended a £750 supplement for GMP trainers to boost their continuing professional development (CPD). We accept that the development of GP education and training is growing in importance particularly with the advent of the Modernising Medical Careers Foundation Programme which will include GP placements for some trainees in its second year. We have some reservations, however, about the recommendation in its present form.
- 2.38 It is not clear, for example, how the supplement can be linked effectively with the assessment of GP's individual development needs which is part of the GP appraisal system. That system is predicated on the principle that the development needs of GP trainers, like any other GP or hospital doctor, are identified and set out in a personal development plan. Such plans will reflect a great variety of development needs and it is difficult to see how a blanket supplement is the best way of targeting support against personal development plans. We cannot assume that if the development needs of GP Trainers are in excess of other GPs – itself not a foregone conclusion – they will be met effectively through the recommended supplement. Of course, many development needs can be met effectively without incurring a direct cost or requiring an extra payment. Indeed, a payment to GP Trainers without a supporting and expensive policing system raises problems of accountability.
- 2.39 It may also be that the Review Body was not made aware of existing provision to address the development needs of GPs. We currently fund a GP Higher Professional Fund. For 2005/06 this stands at £3 million and though it is intended to help new GPs we understand that it is not all used for this purpose. The postgraduate deaneries who administer it already have some flexibility over its use.
- 2.40 Finally, the Health Departments did not have the opportunity to submit evidence on this question before the Review Body made its recommendation. Our position is therefore that we would wish to conduct further work on the proposal with a view to submitting evidence next year on the best way of supporting development in this important area. We would hope to submit joint evidence with the BMA on a way forward.

GMP Educators

- 2.41 The GP educators' payscale was uplifted by 3% with effect from 1 April 2005. This was determined outside of the DDRB process, but it is proposed future consideration of amendments to the payscale should be included as part of the overall DDRB deliberations so that it can be considered as part of the package of rewards for general practitioners.
- 2.42 The GP educators' payscale, introduced in 2003/04, was agreed by the Department, the Committee of General Practice Education Directors and General Practitioners' Committee of the BMA. Whilst the vital role of GP educators is acknowledged, no evidence has been presented to the Department that there is any recruitment and retention problem that would warrant review of the payscale. We would ask the Review Body to uplift the payscale by no more than 2.5% in line with the increase we are proposing for other salaried doctored and dentists.

Salaried GMPs

- 2.43 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. As we reported last year, 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 Review Body uplifted the salary range by 3.225% for 2005/06, giving the current salary range of £49,248 to £74,816, and asked the parties to consider the formulation for uprating the range in future years. The Department of Health has seen no evidence to suggest that the current salary range is inappropriate and would ask the Review Body to uplift the minimum and maximum by no more than 2.5% in line with the increase we are proposing for all other salaried doctors and dentists in the NHS.

GMPs providing service in community hospitals

- 2.44 The NHS Confederation's scoping report, *Pay and Terms and Conditions of Service for Non-Consultant Career Grade Doctors and Doctors Working in Community Hospitals* also made recommendations regarding GPs providing service in acute and community hospital settings. In summary, these recommendations, which Ministers accepted, were that:
- the current remuneration arrangements (staff fund arrangement and casualty payments) for GPs providing service in community hospitals are no longer appropriate;
 - there is now a range of more flexible contracting models and mechanisms (eg locally enhanced services, salaried GPs, service level agreements with practices) which could more appropriately be used to commission services provided by GPs in acute and community hospital settings; and
 - local commissioners should determine the most appropriate model for contracting for these services, and should negotiate the level of remuneration locally.
- 2.45 In its Thirty-Fourth Report, DDRB expressed the hope that a sensible framework could be agreed within which negotiations could be conducted locally by PCOs and GMPs. As this is a matter for local discussion, there is nothing to negotiate at a national level – the report recommended better use of *existing* mechanisms. It is open to the representative organisation of GMPs and PCOs, who will be conducting local negotiations, to agree a framework for those negotiations. We will shortly be communicating this view to GPs and to commissioners.
- 2.46 DDRB also recommended “*that Ministers give careful consideration to the case for providing appropriate additional funding for PCOs to meet any increased costs for medical staffing cover for community hospitals.*” The NHS Confederation's report suggested that, given the existing variation in models used between localities, there could be cost implications in moving to new arrangements; but also that there could be savings from the use of more appropriate contracting as well as improved remuneration for doctors working in community hospitals. We would only be able to take a view on this issue once there has been an implementation of clear mechanisms, used effectively locally, for securing these services where that is appropriate to local need.

Independent contractor GMPs

- 2.47 As the Review Body is not required to make recommendations on remuneration for independent contractor general medical practitioners (GMPs) working under the new primary medical care contracting arrangements (e.g. General Medical Services (GMS), Personal Medical Services (PMS)), our evidence focuses on updating the Review Body on implementation and on the arrangements underway for review of the contract.
- 2.48 Investment in primary medical care services in England is guaranteed to increase from £5 billion in 2003/04 to at least £6.8 billion in 2005/06 – a £1.8 billion (36%) increase – including significant investment in infrastructure. Current forecasts are that the guaranteed increase will be significantly exceeded (an increase in investment of at least 40% (over £2 billion) on 2003/04 levels).
- 2.49 The scale of increase is not only good news for patients (through increased investment in local services), but it is also very good news for those who deliver services (GMPs) where they capitalise on the new earning opportunities (Quality and Outcomes Framework and Enhanced Services).
- 2.50 As a result GMPs, as the main providers of primary medical care services, would appear to be benefiting from significant above-inflation increases in net incomes, at least equivalent to, if not better than the planned increase in investment under the contract.
- 2.51 Arrangements for the overall review of the contract (for implementation from April 2006) are underway with reviews established for the Quality and Outcomes framework, the payments formula for practices' core services and Dispensing Doctors. NHS Employers are leading on the whole process of review based on changes that the Department wish to see negotiated.
- 2.52 Whilst there have clearly been considerable financial and workload benefits for practices, it is less clear whether the wider-NHS and patients are seeing comparable benefits from the levels of investment made.
- 2.53 In evidence to the Review Body last year, the BMA raised concerns about enhanced services spend. It was clear from the forecasts received that some PCTs would not meet their individual floor spend targets in 2004/05 – mostly due to slow uptake/part-year effect of new schemes but also the statutory requirement placed on PCTs to achieve financial balance. A flexible approach was agreed with the BMA's GPC such that PCTs and Local Medical Committees could agree to vire local underspends against the floor in 2004/05 to 2005/06. In these cases, we are effectively monitoring spend against the floor over a two-year period rather than on an annual basis.
- 2.54 The contract promised higher financial returns for higher quality. Average achievement nationally against the QOF was published on 31 August. It is clear practices have been scoring highly against the framework and will therefore benefit from the financial incentives attached.
- 2.55 In last year's Review Body evidence the BMA also raised concerns about equity between treatment of GMS and PMS contractors. We remain clear that financial inequity between GMS and PMS practitioners, caused through inequitable, unfair and non-transparent funding decisions by PCTs is invidious and divisive. Likewise, a similar inequity between PMS and GMS practitioners is equally invidious and divisive. We have encouraged PCTs of the need to be able to demonstrate that their current agreements are fair, reasonable and transparent. Recognising that failure to do so may result in practices seeking to use the comprehensive appeal processes that are in place. However, it should be recognised that financial differences between the earnings of GMS and PMS contractors may be legitimately due to the complexity and range of services that PCTs negotiate outside of national agreements.

CONCLUSION

- 2.56 Over the last few years we have invested significantly in growing the medical workforce and in our pay modernisation agenda to more fairly reward doctors for their hard work and commitment. Doctors' earnings have increased dramatically in recent years. **Annex C** shows that average earnings in the health sector grew strongly at 6.1% in 2004/05, significantly above both the private sector and public sector averages, and well above the rate which would be consistent with stable inflation in the economy at large. Earnings growth for doctors is likely to continue to be relatively strong in 2006/07 as the consultants who opted for the new pay system continue to progress towards the new maximum, and as staff grades and associate specialists begin to benefit from the proposed reforms. Against this background, and the overall strong recruitment position (with large year-on-year increases in staff in post), we recommend that a modest general pay uplift of no more than 2.5% should be sufficient to meet NHS needs and ensure continued workforce stability during this period of change.

CHAPTER 3: DENTISTRY

GENERAL PRIMARY DENTAL CARE SERVICES

Summary

- 3.1 Our evidence this year is submitted against a background of major reforms to primary care dental services, now confirmed for April 2006, and the significant programme of investment announced by the Government in July 2004 to rebuild NHS dentistry and tackle workforce issues. We expect to have recruited or bought back into the NHS the equivalent of 1,000 dentists by October 2005, increasing access to NHS dentistry and significantly improving local recruitment and retention of NHS dentists. The April 2006 reforms will build on this progress.
- 3.2 As part of its commitment to work with the profession, the Government consulted the profession's representative bodies on these reforms and, following representations, allowed additional time for the introduction of the new arrangements. We are now completing consultation on the final aspects of these reforms before implementation in April 2006.
- 3.3 The proposed new contractual framework for General Dental Services (GDS) is based on the experience and learning from Personal Dental Services (PDS) pilots and on discussions with key stakeholders including the British Dental Association (BDA). The new framework is designed to take dentists off the so-called "item of service treadmill". This will free up capacity in ways that improve the quality of dentists' working lives, allow a more preventive approach to dental care, and improve access to services. The framework builds on the successes of the pilot PDS arrangements, which now include over 33% of dentists and 30% of dental practices.
- 3.4 Our evidence highlights the significant investment Government has earmarked to expand the dental workforce (including dentists, dental therapists and hygienists) and support improvements in access. Against this background, the Government considers that an increase in gross fees of no more than 2.5%, in line with the pay uplift we are seeking for other groups of doctors and dentists in the NHS, represents a fair deal for dentists and ensures that available resources are used to best effect to benefit NHS patients.

Introduction

- 3.5 Over the past year we have made major changes to the way dentistry is delivered in England with 33% of dentists now working under PDS pilot arrangements. These pilots have been based on the principles set out in the consultation *Framework proposals for primary dental services in England from 2005*. From April 2006, we are consolidating these changes and making the benefits available to all dentists, either through new local GDS contracts or through permanent PDS arrangements. The aim is to deliver the Government's vision for NHS dental services which:
 - offer improved access to high quality treatment for patients
 - reduce the focus on intervention and allow increased prevention to improve oral health
 - give a fair deal and improved working lives to dentists and their teams.
- 3.6 This evidence sets out the steps we have taken over the last year to increase recruitment and retention and provide a basis for further expansion in workforce capacity, together with the ways in which workforce expansion has been used to improve local access to services. We go on to report progress towards introducing the April 2006 reforms, including the new contractual framework and the new system of patient charges. We also set out the benefits of the new

arrangements, both for dentists (in terms of improved working lives and the potential impact on practice expenses) and for NHS patients (in terms of improved oral health and improved access to services), and the support being given to Primary Care Trusts (PCTs) in preparing for implementation and realising these benefits.

- 3.7 A new Statement of Dental Remuneration was introduced from 1 April 2005 to implement the increase of 3.4% in fees and commitment payments recommended by the Review Body in its Thirty-Fourth Report.

Recruitment and Retention

- 3.8 As evidence to the Review Body in previous years has shown, the number of dentists in the General Dental Services has been growing each year but at the same time there has been a downward trend in overall NHS commitment. Under the current GDS arrangements, dentists are able to switch from NHS to private work with relative ease and with very little notice to the NHS or patients. Private practice, which is relatively less regulated, has been an increasingly attractive option for dentists and one with which the NHS has found it difficult to compete. The Government has taken a number of steps over the years to address these problems, but it has become increasingly clear that the current remuneration system (based on 'item of service') has been a major factor in the decline in dentists' NHS commitment.

- 3.9 This is a key reason for the reforms we are introducing from April 2006, based on a move to local commissioning of dental services within a contractual framework that abolishes 'item of service' fees and allows a much greater focus on prevention and health promotion. These fundamental reforms will tackle head-on the traditional concerns raised about NHS dentistry by the profession, by the Review Body and by other expert bodies and will make the NHS a much more attractive option for dentists. The reforms are based closely on the learning and experience from PDS pilots, which have now attracted over a third of dentists including a significant return to NHS dentistry from existing practitioners. Our approach to these reforms, and their benefits for patients and dentists, are set out in more detail below.

- 3.10 Over the last year, as well as preparing for these reforms, we have made significant progress in recruiting dentists, expanding workforce capacity and improving access to services. By October 2005, we will have provided the equivalent of an additional 1,000 whole time dentists through:

- 'buying back' extra NHS capacity from existing dentists, equivalent to 350 dentists, supported by £50 million central Government funding (£35 million capital grants and £15 million recurrent revenue funding)
- recruiting 650 dentists from both domestic and international activity.

As a result of the Government's various measures, we expect investment in primary care dentistry to be some £250 million a year more in 2005-06 compared with the equivalent spend in 2003-04.

- 3.11 Domestic recruitment has been achieved by attracting dentists back from career breaks and through offering more flexible working patterns.
- 3.12 International recruitment has benefited from clearing by December 2004 the backlog of dentists waiting to sit the necessary international qualifying examination to allow dentists who have qualified outside the EU to practise here. This has involved working with the GDC to improve the frequency of International Qualifying Exams.

- 3.13 The additional dentists brought into the NHS through international and domestic recruitment have been targeted to areas where access has previously been most difficult, for instance Cornwall, Shropshire, Cumbria and Essex.
- 3.14 From October 2005, there will be an extra 170 undergraduate training places in England (a 25% increase), supported by capital investment of up to £80 million over four years starting from 2005-06 and additional revenue funding rising to £29 million a year by 2010-11. A joint implementation group comprising the Higher Education Funding Council for England and the Department have invited bids from higher education institutions for location of the additional places.

PDS expansion

- 3.15 Alongside this major recruitment exercise, we have continued to invest in expanding PDS. Since last year, the numbers covered by PDS pilots have expanded from 3,500 dentists in 1,300 dental practices to over 6,700 dentists in 2,400 practices. Around 33% of dentists are now in PDS. These dentists are enjoying new ways of working, which are proving very popular with patients and helping to tackle access in areas with previously low NHS provision.

Workforce Planning

- 3.16 We are now completing the substantial programme of action to increase dental workforce capacity announced in July 2004, which was underpinned by the 2002 Dental Workforce Review. The review sought to identify the dental workforce (dentists and professionals complementary to dentistry) required to deliver modern future services in both the NHS and the private sector. It took account of the balance between NHS and private sector work, developments in skill mix, and the impact on recruitment and retention of the current GDS remuneration system.
- 3.17 The 2002 review pre-dated the development of the Government's plans for devolving commissioning of general dental services to Primary Care Trusts and the recommendations of the National Institute of Clinical Excellence (NICE) on recall intervals. The review was also unable to take account of the forthcoming abolition of the 'item of service' remuneration system, which has been cited as a major reason for dentists reducing their commitment to the NHS. The changes already made through PDS pilots, the forthcoming reforms in April 2006 and the implementation of the NICE guidelines are likely to have significant implications for workforce capacity and demand.
- 3.18 Although time has moved on since the modelling for the dental workforce review was done, the report contains important contextual information. The Department took this into account in drawing up plans, now delivered, to recruit the equivalent of 1,000 more dentists and fund 170 extra training places for dental undergraduates - a 25% increase on current student intakes. This already represents a substantial increase in dental workforce. It reflects the general thrust of the workforce review, while recognising that future workforce planning will need to take into account the positive impact of the new factors outlined above.

Reforming NHS primary care dental services

- 3.19 As set out above, our *Framework proposals for primary dental services in England from 2005* set out the principles underpinning the proposed move to local commissioning. This framework also set out the key elements of proposed transitional arrangements designed to protect dentists' livelihoods and ensure stability during the period of change, whilst ensuring the NHS and patients get a fair return for NHS investment in dental services.
- 3.20 The Department consulted the BDA, General Dental Practitioners' Association, British Orthodontic Society, British Association for the Study of Community Dentistry and the Faculty

of General Dental Practitioners on this framework document. They gave unanimous support for the direction of travel and the proposal to move away from the GDS ‘item of service’ remuneration system. There was concern, however, that there was insufficient time to implement the new system in 2005 and that PCTs might not have the capacity to manage this.

- 3.21 In July 2004, the Department announced its strategy for reforming NHS dentistry in England in statements to Parliament, followed up by further announcements in January 2005 and July 2005. These announcements explained that, following consultation, the proposals would proceed later than originally planned but would be backed by significant new investment.
- 3.22 We have now published draft regulations governing the new GDS contracts and permanent PDS arrangements that (subject to Parliamentary approval) will come into effect from April 2006. We have submitted copies of the draft regulations alongside this evidence.
- 3.23 We are also now completing consultation with the public and the profession on the proposed new system of patient charges. The response so far has shown broad agreement that we should change the current system of patient charges and item of service payments and that the new system will offer a better deal for patients and dental professionals, especially in respect of increased clarity and reduced bureaucracy.

NHS dental reforms: benefits for dentists

- 3.24 The proposed new contractual framework for local commissioning, reflected in the draft regulations for new GDS contracts and permanent PDS agreements, builds on experience and learning from PDS and on extensive discussion with the profession and the British Dental Association. In line with the underpinning principles set out in our evidence last year, the new contractual framework provides important guarantees for dentists in respect of:
- the right to a base contract for all dentists in contract with a PCT immediately before the change (including the ongoing option of self-employment for associates)
 - gross turnover protection for a three year transition period (now 2006/07 – 2008/9) in return for a commensurate level of NHS commitment
 - the ability for dentists to manage their own workload, and to offer a more preventative approach to patient care, moving off the so-called ‘treadmill’ associated with the ‘item of service’ remuneration system
 - moving responsibility for arranging out-of-hours services from dentists to PCTs
 - minimising bureaucracy
 - ensuring that practices will not bear any financial risk as a result of changes in the way patients’ charges are set.
- 3.25 Under the new contractual arrangements, dentists will no longer be monitored and paid on the basis of the individual treatments they provide. To ensure transparency and value for money, dentists will be expected to undertake – in return for their annual contract value – an agreed number of courses of treatment that are weighted to reflect the complexity of treatment provided. Experience of PDS indicates that, when freed from the ‘item of service’ system, dentists generally carry out at least ten per cent (weighted) fewer courses of treatment, thereby freeing up practice capacity. Under the new contractual framework, dentists will be expected to undertake 95 per cent of their historic level of weighted courses of treatment, thereby sharing this freed-up capacity fairly between dentists and the NHS. Further details are set out in the draft regulations that have been submitted to the DDRB.

- 3.26 In addition, early evidence from PDS suggests that the opportunity to focus on prevention and health promotion enables dentists to change their behaviour significantly once the item of service system is removed. This means that the average number of interventions within each course of treatment is likely to reduce.
- 3.27 The combination of these two changes (a reduction in the expected number of courses of treatment and a likely reduction in the average number of interventions within each course of treatment) have a number of powerful benefits for both dentists and patients. For dentists, it means a reduction in overall workload, together with the opportunity to spend more time with patients, the opportunity to focus more on prevention and health promotion, and a likely reduction in practice expenses as a result of fewer and less complex interventions.
- 3.28 The new arrangements will also help dentists deliver services in more innovative ways. For instance, changes in skill mix will increasingly allow more straightforward tasks to be carried out by other registered dental care professional groups. From next year, it will become possible to extend the roles of other groups following appropriate training and statutory registration. This will enable dentists to concentrate on the more complex activities. This in turn should release major efficiency savings to the practice, increasing the relative value of the new contracts.

Practice expenses

- 3.29 The DDRB asked us in its last Report to review practice expenses. The initial analysis of the latest expenses data suggests that dental expenses have fallen, but we will comment further when the data have been finalised.
- 3.30 We are working with the BDA to assess movements in income and expenses and are considering with both BDA and OME officials how this analysis might be strengthened in the future. In doing this, we will need to take account of how expenses are likely to be affected under the new arrangements. Given that we are now only a few months away from a major change in the way dentists are remunerated, it will be important to allow the changes to settle before properly assessing their impact on expenses. For reasons set out above, we would expect practice expenses to fall (all other things being equal) as a result of the intended shift towards fewer courses of treatment, fewer interventions on average within the typical course of treatment, and greater emphasis on prevention and health promotion.
- 3.31 Another key feature of the new arrangements is the additional support that PCTs can give to providers of primary care dental services. The Health and Social Care Act 2003 (by virtue of new section 28R, inserted in the 1977 Act) gives PCTs a power to assist and support providers and prospective providers of primary dental services and primary medical services, allowing the needs of primary care dentistry to be considered alongside other NHS services. Support and assistance can include financial support and the provision of premises on such terms as the PCT thinks fit. This will enable PCTs, for example, to increase primary dental services capacity by giving financial assistance to establish or extend dental practice premises if they judge this to be a local priority. This is an important change. It gives PCTs far greater flexibility to deal directly with local recruitment and retention issues and means that, at national level, contract values do not need to increase by more than inflation.
- 3.32 The new commissioning framework and devolution of financial resources from April 2006 will also give PCTs greater flexibility to deal with practice expenses. Local schemes will need to evolve carefully but, for example, in high cost areas the PCT could agree a direct reimbursement of premises costs or contribute to staff wages as has been the case for some years in general medical practices. The PCT, or the NHS more widely, could use its purchasing power to provide some services directly, such as special waste removal or bulk purchase of procedure gloves or other commonly used dental materials in agreement with its independent providers. The PCT could also agree a range of dental laboratory services with accredited

laboratories for the provision of NHS appliances at more competitive rates and directly reimburse providers if they choose to use these services. We would not wish to stifle local innovation and flexibility by imposing new arrangements from the centre, particularly in advance of assessing the impact of the new service arrangements on practice expenses.

Benefits for NHS patients

- 3.33 As set out above, the new local commissioning arrangements, combined with the national contractual framework, will free up capacity within dental practices in ways that have already been seen in PDS pilots. As well as generating improvements in the quality of dentists' working lives, this will enable dentists to see more NHS patients, particularly as they start to implement the new NICE guidelines on recall intervals (which are reflected in the draft contract regulations). The new local commissioning relationship will better enable PCTs and dentists to work together to improve patient access.
- 3.34 The move away from 'item of service' will, as set out above, also enable dental practices to focus more on prevention, oral health promotion and general public health promotion. In order to support practices in this change of direction, we will shortly be publishing an Oral Health Plan for England as part of the 'Choosing Health' delivery programme. This will have the dual function of providing dental practices with information on how best to develop a public health approach and helping PCTs adopt an evidence based approach to commissioning dental services to improve health.
- 3.35 The Oral Health Plan builds on the guidance that the Department has issued to Strategic Health Authorities on water fluoridation, which is a key driver for improved oral health. In March 2005, both Houses agreed regulations which enable Strategic Health Authorities to move forward on fluoridation where there is public support.
- 3.36 Our greater emphasis on health improvement is supported by provisions in the Health and Social Care (Community Health and Standards) Act 2003, which gives power to confer on PCTs dental public health functions. We will shortly be publishing Public Health Regulations, which identify the functions of PCTs in relation to dental public health. These functions will include school screening, oral health promotion and local oral health surveys to help plan services. PCTs may involve other agencies in discharging dental public health functions, such as independent contractors or dental practices. For example, a PCT might wish to involve a dental practice in providing an oral health promotion or smoking cessation programme. The draft regulations governing GDS contracts and permanent PDS agreements make clear that dental public health services may be included as additional services in dentists' contracts from April 2006.

Support for PCTs

- 3.37 The move to local commissioning represents a major change for PCTs' responsibilities in this area. Together with the NHS Primary Care Contracting Team, the Department has run a series of workshops and training events on local commissioning for all PCTs in 2005, including a series of events specifically aimed at PDS contracting. The Department has also issued commissioning guidance to PCTs at key points in the process. PCTs have already demonstrated their ability to move significant numbers of dental practices to new working arrangements through PDS pilot schemes. The Department will continue to ensure that PCTs are well supported in the run up to April 2006 and able to complete the new contracting process on time.

Conclusion

- 3.38 The past year has seen major changes in NHS dentistry, with over a third of all NHS dental services now provided under new contracting arrangements (PDS) and a significant change in

work patterns for the dentists involved. We are now committed to make these benefits available to all NHS dentists from April 2006. The Government has made an unprecedented level of investment in dentistry and finalised the strategy to rebuild NHS dentistry through the move to local commissioning from April 2006 and the associated reform of remuneration systems. This has been strengthened further by the recruitment of over 1,000 additional dentists and increases in undergraduate places to increase the future dental workforce.

- 3.39 These changes will take dentists off the so-called treadmill and significantly reduce their workload for the same remuneration. They will ensure that both dentists and patients benefit from freed-up capacity. Against this background, and taking into account the likely reduction in practice expenses, the Government considers that an increase in gross fees of no more than 2.5%, in line with the pay uplift we are seeking for other groups of doctors and dentists in the NHS, represents a fair deal for dentists and ensures that available resources are used to best effect to benefit patients. We also consider that a simple recommended percentage increase which we can then apply to 2006/07 contact values is the best way to ensure the smooth delivery of the new contracting system and its benefits in April 2006.

SALARIED PRIMARY DENTAL CARE SERVICES

- 3.40 In the Autumn of 2002 we agreed with the BDA a three-year pay deal for all salaried primary care dentists working in the Community Dental Service and in salaried PDS pilots, including Dental Access Centres, and for salaried general dental practitioners. The agreement was for 10% over the three years comprising an uplift across all grades of 3.225% each year in 2003/04, 2004/05 and 2005/06.
- 3.41 The current year is the last of those three years and a new determination will be needed from 1 April 2006. We take the view that salaried dentists should receive the same general uplift of salary and associated fees as applies to other groups of doctors and dentists in the NHS.
- 3.42 In view of the major programme of work described below to modernise pay and career structures for salaried dentists we also take the view that it would not be appropriate to make any changes to existing salary structures and associated fees and allowances other than to apply the general uplift described above.
- 3.43 We reported last year in our main evidence, and gave an update in supplementary evidence, on the major review of the salaried primary dental care services led by the Chief Dental Officer involving input from key stakeholders – patients, the profession including the BDA, and NHS management.
- 3.44 The review developed a vision of the world of dentistry in the light of the reforms contained in the 2003 Health and Social Care Act, and the contribution to be made by salaried dentists in that new world. The review also developed views about the future requirements for education, training, career structures and leadership and management of salaried dentistry to equip salaried dentists for that world. This led to the development of a set of principles about the underpinning grade and pay structures which would be needed to give effect to those changes.
- 3.45 These views and principles have now been the subject of a formal, wide consultation with all key stakeholders running from mid-December 2004 to the end of March 2005. We published these high-level principles in *Creating the Future – Modernising Careers for Salaried Dentists in Primary Care*, which we provided to DDRB late last year. This included proposals to change the pay and grading structure for all salaried dentists to bring them into line with the structures more generally existing in dentistry and in the wider medical and dental workforce.

- 3.46 The Department has received over two hundred responses from individuals and organisations comprising a scoring by respondents of each proposal and, in many cases, considerable additional comment on some or all of the proposals.
- 3.47 The proposals made in *Creating the Future* will require detailed work and negotiation to translate into a new pay and grading structure. Some of the proposals are relevant to dentistry beyond the salaried service. We anticipate being able to provide an update to DDRB during this round of evidence on how the Government intends to take forward these proposals.
- 3.48 We reported last year that we were commissioning qualitative research about the factors which make salaried employment attractive, to identify with greater clarity what factors make a rewarding career in the SPDCS. All salaried dentists in England were surveyed by questionnaire and a small sample subsequently assisted with detailed interviews. The BDA has provided considerable assistance in the conduct of that research undertaken for us by NHS Partners and the BDA input has contributed to the very high response rate of around 66% to the questionnaire survey. This research will help to inform decisions about next steps with the career modernisation programme for salaried dentists, both generalists and specialists.
- 3.49 Finally, we can report on the organisational development (OD) programme for salaried dentists for which we have made available £400,000 across England. In helpful discussion with the BDA we agreed that these funds should be applied to a nationally organised OD programme and that the programme should have three elements: awareness-raising road-shows, a resource pack for all SPDCS dentists, and the provision of OD facilitators to be made available to enable and support local OD work in each salaried dental service in England.
- 3.50 This programme is being managed on our behalf by an SHA and is intended to assist and support salaried dentists to prepare for the move to local commissioning of all dentistry from April 2006.
- 3.51 Seven road-shows were held during May and June 2005 in venues around England. They were widely advertised with help from the BDA and were open without charge to all salaried dentists in England – some 1,400 in total. It was pleasing to note that some 800 salaried dentists attended. The local facilitation programme will be delivered during the autumn and winter of 2005 by an external company and will be accompanied by distribution of the resource pack.

CHAPTER 4: OPHTHALMIC MEDICAL PRACTITIONERS

Summary

- 4.1 We ask the Review Body to note that the sight-test fee for 2005-06 is covered by a three-year agreement with ophthalmic medical practitioners (OMPs) and optometrists. Negotiations will take place this year for the fee for 2006/7 and possibly subsequent years with the representatives of contractors. These negotiations will also cover the payment, which it has been agreed should be made for loss of earnings associated with undertaking continuing education and training.
- 4.2 We remain firmly of the view that there should be a common sight test fee. Optometrists continue to carry out some 97% of NHS sight tests, and we believe the DDRB's previous recommendations about the joint negotiation of a common fee continue to be relevant for future years.

Background

- 4.3 Between 31 December 2002 and 31 December 2003, the number of OMPs registered to provide General Ophthalmic Services in Great Britain decreased from 674 to 644, and the number of optometrists increased from 8,812 to 9,161. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.
- 4.4 In the period April to September 2004, 5.47 million sight tests were paid for by Primary Care Trusts in England and Local Health Boards in Wales. This was 2.5% more than the total for the period October 2003 to March 2004 (5.33 million) and 5.9% more than the period April to September 2003 (5.16 million). Within these figures, the proportion of sight tests carried out by OMPs for April to September 2004 was 2.9%.
- 4.5 The surveys which we have conducted into the working patterns of optometrists and OMPs show that the majority of OMPs practise part-time. The 2003-04 survey showed that 52% of practising OMPs also held other appointments (mainly as hospital doctors).
- 4.6 A review of General Ophthalmic services is being undertaken by the Department of Health. The review aims to consider whether present arrangements meet patient need and support wider Department of Health objectives, and make recommendations for change if necessary. The Department aims to complete the review in early 2006.

CHAPTER 5: THE GOVERNMENT'S PLANS FOR PUBLIC SPENDING LIMITS & DELIVERY OF SERVICES AND OUTPUT TARGETS

Introduction

- 5.1 This chapter sets out the financial context for our recommendations including the Departmental Expenditure Limits (DELs) for 2005/06 until 2007/08 as announced in the Chancellor's 2005 Budget Statement.
- 5.2 As detailed in the earlier chapters, the primary argument for this year's recommendation is the healthy recruitment and retention position. However, it is also crucial to consider the constraints of affordability. Around two thirds of health service spending is on pay, so even very small changes in pay have a substantial effect on the ability of PCTs to manage the substantial non-pay spending pressures that the health service faces.
- 5.3 The annual pay bill increases as staff numbers increase, however, there are other reasons for the increase; the annual settlement, an element of pay reform and pay drift. Between 2002/03 and 2003/04, the first year of the new consultant contract, the pay bill for medical and dental consultants rose from £2,537 billion to £3,113 billion, an increase of 22.7%, and the corresponding staff numbers rose by 6.4% from 24,756 to 26,341. The basic settlement was 3.225%. For the period 2001/02 to 2002/03, the consultant salary scale was uplifted by 3.6%, staff numbers increased by 7.3% and the consultant pay bill rose by 11.4%.
- 5.4 The key points of the plan for spending limits are:
- Current financial pressures. Even in the current period of unprecedented funding growth, the NHS has faced financial difficulties. In 2004/05 the NHS has failed to achieve overall financial balance. The audited accounts show that the NHS as a whole will end 2004/05 with an overall deficit of around £250 million.
 - On top of these existing challenges, NHS reforms such as payment by results, patient choice, Foundation Trusts and practice-based commissioning will create significant new financial risks. Individual NHS trusts will find that their income becomes far more volatile and unpredictable, as money follows the patient and patients exercise their right to choose alternative providers. NHS organisations will need flexibility over their finances in order to manage these risks and avoid running up deficits or breaching their statutory spending limits. In the light of the likely slowdown in overall NHS funding from 2008/09, this makes it even more important to be cautious in terms of additional spending commitments imposed on the NHS.
 - Likely resource constraints going forward. In 2002, the Chancellor accepted Derek Wanless's "fully engaged" spending recommendation for the five years to 2007/08, which was for annual average spending growth of 7.1%. By 2007/08 the Government will have achieved its aim of bringing UK health spending up to the European average. No decisions have yet been taken for the Comprehensive Spending Review which will allocate resources for the period from 2008/09 to 2010/11. However historically (since 1948) average spending growth on health has been at a rate of 3.1%.
- 5.5 An analysis of progress against the Department's Public Service Agreement (PSA) targets is contained in the fifteenth annual *Departmental Report*⁵ published on 21 June 2005. Further information on progress in service improvement is set out in the 2005 *Chief Executive's Report to the NHS*⁶.

⁵ Available on the Department of Health website at <http://www.dh.gov.uk>

⁶ Available on the Department of Health website at <http://www.dh.gov.uk>

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

(NB: These figures are for England only, see chapters 7 and 8 for Wales and Scotland)

5.6 Pay awards for NHS staff must be set within a framework that considers:

- The Department of Health's spending limits set by the Chancellor in his Budget statement;
- The effect of the Government's challenging plans against a range of output targets for the delivery of services including those of the Public Service Agreement and the NHS Plan; and
- The anticipated rate of inflation in the economy as a whole.

5.7 Pay costs are not funded separately by the Department of Health. The pay bills are met at PCT level from the overall funding for PCTs which is made available in the unified allocation. This allocation covers around 80% of the total DEL (78.6% in 2004/5). Any large increases in pay will inevitably have an effect on the amount available for PCTs to spend on commissioning new services. Pay is an integral part of the total cost of any patient service and PCTs routinely need to make decisions on what services to commission based upon patient need. Currently, approximately 60% of a Trust's budget is spent on pay.

5.8 If excessive pay awards are agreed, there would be an inevitable impact upon the cost of the patient services delivered by NHS providers. The PCT commissioners would have to consider the impact of such increased costs when determining their commissioning strategies. Higher costs could mean the PCTs not investing in some service areas. Exactly what areas would be at risk from a large pay deal is impossible to say as decisions would be made locally. However, it is clear PCTs would need to consider slowing down some priorities and changing others.

5.9 In previous years the Review Body has asked about the opportunity cost of relative pay increases. The specific effect is a matter for local decision but the Review Body may wish to be aware that for each additional 0.1% increase in NHS pay translates as the equivalent of :

- 1000 Nurses; or
- 525 Doctors; or
- 30,000 elective procedures.

5.10 The areas of business PCTs could look at in response to a large pay deal could include:

- Achievement of PSA targets
- Implementation of NICE
- Not increasing staff numbers

5.11 The DELs for 2003/04 and beyond are shown in the table below.

Departmental Expenditure Limits ⁽¹⁾

	NHS DEL (£m)	Cash Growth (£m)	Cash Growth	GDP Deflator ⁽²⁾	Real Terms Growth
2003/04	63,001	-	-	-	-
2004/05	69,706	6,705	10.6%	1.98%	8.5%
2005/06	76,387	6,681	9.6%	2.50%	6.9%
2006/07	84,324	7,937	10.4%	2.70%	7.5%
2007/08	92,643	8,319	9.9%	2.70%	7.0%

Notes: (1) Figures are consistent with the resources announced by the Chancellor in the 2004 Spending Review.

(2) As at 16 March 2005.

5.12 These increases are not a benchmark for pay settlements. Moreover, the growth in revenue funding, to fund pay amongst other things, is less than the overall average growth of 7.3% real terms. Average real terms growth in capital is 23.2% per year and the average real terms growth in revenue is 6.5% per year over the 5-year period (2003/04 to 2007/08). The use of the overall DEL also needs to be considered against the Government's ongoing commitment to the modernisation of the NHS, in particular the objectives set out in the NHS Plan including PSA Targets and the impact of underlying demand pressures such as clinical negligence, EEA medical costs, access to NHS dentistry and NHS Connecting for Health.

5.13 This sets out the range of things that need to be funded from overall NHS growth, not necessarily what PCTs could cut due to a higher pay award. A lot of it is demand led:

- Delivery of the standards and targets set out in the NHS Plan, Public Service Agreements and National Service Frameworks;
- Implementation of NICE appraisals and guidelines;
- The increasing demand for services supplied by GPs and dentists;
- The year-on-year rises in demand for hospital services shown by the increases in emergency admissions and attendances at A&E departments; attendances at A&E Departments have increased from 2002/03 by 18% in 2003/04 and a further 8% in 2004/05. The number of emergency admissions has increased from 2002/03 by 8% in 2003/04 and a further 12% in 2004/05.
- The cost and demand for drugs, with drugs bill pressures up provisionally 3% per year from 2004/05. Whilst a PPRS renegotiation limited increases in 2004/05, the long run trend remains at about 10%. Currently approximately 15% of annual budget is spent on the drugs bill.
- The costs of increasing staff numbers, training opportunities, and medical school places;
- The three major programmes of NHS pay reform embodied in 'Agenda for Change', the new consultant contract and the new GMS contract. Approximately 1-5% of annual budget is spent on GMS.
- The resources to meet demand in terms of capital investment for new hospitals and equipment, the IT infrastructure; and training and development for the growing NHS workforce.

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

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

- 5.15 In line with the cross-Government timetable attached to the 2004 Spending Review, a new Department of Health PSA was agreed which covers the financial years 2005/06 to 2007/08. This PSA, which is set out at **Annex B**, forms the basis for the national targets for the NHS and social care which were issued in July 2004 in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08*. The Planning Framework describes the vision for services over the three-year period, and identifies the national priorities and targets which NHS organisations will build into their local plans.
- 5.16 The new Planning Framework:
- Sets out a focused set of national priorities, reducing the number of new national targets from 62 in the last planning round to 20 for the three years to 2007/08;
 - Includes a framework for local target setting. Fewer national targets create more headroom for local targets set in response to local population needs; and
 - Incorporates the *Standards for Better Health*, which were published after a three-month public consultation. The standards set out the levels of quality and safety that all NHS patients can expect from the services they receive. They also set the agenda for continuous improvements in quality and safety across the full spectrum of NHS healthcare.

Output Targets

- 5.17 Output targets provide a clear focus for planning and delivery and for measuring the return on the unprecedented levels of investment the Government is committing to such improvements. The targets form part of the wider context within which the Review Body considers its recommendations and the Review Body's remit requires it to have regard to the Health Departments' output targets for the delivery of services, as well as the funds available within Departmental Expenditure Limits, and the need to recruit, retain and motivate doctors. However, as we have previously reported, the link between pay and output targets is multi-faceted and we do not believe it is possible to quantify in any precise way the impact which the DDRB's recommendations on pay in one year will have had on the achievement of output targets in the next. Nor would it be meaningful to attempt to do so given the complex factors at play.
- 5.18 Affordability, and the other cost pressures, are crucial factors in any consideration of the links between pay and output targets. If the extra resources which have been committed by the Government are diverted into unnecessarily large pay increases the service improvements necessary to meet output targets cannot be delivered;

Summary and Conclusions

- 5.19 The Government is committed to modernising services for patients and improving the working life of NHS staff, including modernising the pay system. Although the headline figures show large growth in the DELs, a responsible approach to pay is crucial if we are to achieve all the objectives set out in the NHS Plan. The Government's commitments to the modernisation of the NHS and the range of additional cost pressures set out above, including increased activity and expansion of the workforce in line with NHS Plan targets, mean that there will be significantly less money available than may first seem.
- 5.20 Therefore:

- affordable pay settlements are an essential part of delivering the agenda for improvements for patients and staff set out in the NHS Plan; and
- the Government's commitment to keep public spending within the DELs and to invest in pay modernisation needs to be a key factor in determining pay in the coming year.

CHAPTER 6: GOVERNMENT EVIDENCE ON THE GENERAL CONTEXT

- 6.1 The 2004 Spending Review (SR04) set out government targets and expenditure plans for the three years from 2005/06 to 2007/08 for the whole public sector, including the sectors covered by the Pay Review Bodies (PRBs). Within this context, the PRBs will want to make recommendations about the appropriate resource allocation to pay in the context of Government objectives, the affordability constraints of SR04 and the recruitment, retention and motivation position of their sectors.

SR04

- 6.2 SR04 made announcements about the need to deliver efficiency improvements of at least £20 billion per year across the public sector by 2007/08 with the aim of releasing resources to front-line service delivery.
- 6.3 The implementation of these changes will involve making use of, for example, information technology initiatives, relocation of staff and changes to working practices. Much of the planned efficiency gains will come from more productive use of working time in the relevant sectors. The Department of Health has been set a target to deliver efficiency benefits worth £6.5 billion by 2007/08 (equivalent to 2.7% per year) as part of SR04. These benefits include both cost efficiency and the value of service quality improvements and will be made in the following areas:
- Productive Time (freeing up the time of front-line staff)
 - Procurement
 - Adult Social Care
 - Corporate Services (eg finance, HR and IT)
 - Public Policy, Funding & Regulation (Central Departments and Arms Length Bodies)
- 6.4 Up to £2.9 billion of the expected gains are expected to come from the Productive Time work stream.

Affordability

- 6.5 SR04 was significantly tighter than SR02. Within tight affordability constraints, it is important that resources needed for service improvement are not absorbed by pay, except to the extent necessary to help run an effective public sector. The Government considers it important that pay rises in the public sector are set at sustainable rates.

Recruitment, retention and motivation

- 6.6 Within what is affordable, pay increases should be at levels which are necessary to respond to the particular circumstances and requirements of the group concerned, where the outcome would be to improve service delivery by addressing specific recruitment and retention problems, support diversity and equal pay or where significant reform is to be achieved.

Local Pay

- 6.7 Local pay arrangements can be an effective way of addressing local recruitment and retention pressures, and can ensure resources are targeted to where they are needed most. More information on local pay is provided elsewhere in the evidence.
- 6.8 The Government wants to see public sector pay systems that increase the sector's flexibility and responsiveness, so that the public sector contributes to increased overall flexibility of the

economy as a whole. The Government notes in particular that while the existence of high quality public sector jobs in a region can play a vital role in ensuring the economic prosperity of that region, if pay rates are misaligned the prosperity of the region can be damaged. For example, if public sector pay rates are high relative to those in the private sector then more productive labour will be sucked in to the public sector and economic growth and prosperity will be hampered.

- 6.9 Evidence of public sector pay surpassing private sector pay could include information about private sector pay in comparable jobs in the local area or evidence of large numbers of applications for public sector jobs in the area compared with what might be expected in the private sector or elsewhere in the public sector.

Earnings growth and pay-bill growth

- 6.10 There are several pay metrics used across the public sector, each of which is designed to provide different information about the impact of a pay decision.
- 6.11 The **Average Earnings Index** measures the speed at which earnings are growing across the whole economy, in the public and private sectors. This is a paybill per head measure obtained by dividing the total amount paid by the total number of employees paid.
- 6.12 However, PRBs will want to exercise caution when using the AEI in pay considerations if their pay remit group has witnessed any changes in composition. As a paybill per head measure, the index is very sensitive to skill and workforce composition and a change in either of these will produce a mis-leading picture of pay growth. For example, if a sector has recently undergone a programme of up-skilling, the AEI will increase even if earnings growth remained unchanged. Similarly, if paybill savings are reallocated back into the paybill the AEI will be depressed and will mask the true level of earnings growth. Therefore AEI cannot be guaranteed to provide a true picture of earnings growth at either a whole economy level or for a subset, requiring care to be taken with any comparison.
- 6.13 Rather, for a picture of how average earnings of existing employees remaining at the same grade have changed over time, it is more appropriate to consider **earnings growth**. This is calculated through a bottom-up approach which identifies all the elements of increases, including progression increases, bonuses, allowances, overtime and any other elements of take-home pay that affect those staff within a grade. It is therefore a good indication of how an individual's pay packet will be affected by pay progression and revalorisation.
- 6.14 To understand how a decision affects just revalorisation, **headline award/basic settlement** should be considered, as this is simply the average headline increase in base pay and excludes these other elements of take-home pay such as performance bonuses and progression. As an earnings growth measure it is not sensitive to compositional changes.
- 6.15 However, despite the compositional problems of a paybill per head measure, **paybill** and **paybill per head** should still be considered, as they give a good measure of affordability through providing an indication of the funding required by the employer to implement the pay deal. Paybill records the earnings increases, and includes the net effect of all other increases received from the pay system such as bonuses and changes to non-pay elements such as pensions, NICS, etc. Aggregate paybill will also include any notional pay-bill savings from staff turnover (ie, when those leaving or promoted are replaced by employees paid at a lower point on that pay range) reallocated to pay as well as reflecting compositional changes. Paybill per head divides the paybill by the total number of full time equivalent staff employed by the organisation.
- 6.16 Given the different strengths and weaknesses of each of the above measures, it is clearly critical to consider all these metrics when making pay recommendations.

Inflation

- 6.17 Inflation is the rise in the price level over time which results in a general fall in the purchasing power of money. The Office of National Statistics (ONS) calculates inflation using several measures.
- 6.18 The **Consumer Price Index (CPI)** measures the average change from month to month in the prices of consumer goods and services and has replaced the **Retail Prices Index excluding mortgage payments (RPIX)** in its use as the Bank of England's inflation target since the Pre Budget Report in November 2003. The Chancellor wrote to the Chairs of the Pay Review Bodies to inform them of the change.
- 6.19 The CPI measure of inflation has certain clear strengths for pay purposes over the old RPIX measure because of the way it is calculated – in particular it takes account of consumer behaviour in terms of substitution away from more expensive goods and brands. Therefore, CPI is a better measure of the amount on average needed to keep people as well off as before, than the RPIX.
- 6.20 Nonetheless, the RPIX will remain available and can be taken into account in pay negotiations in the private sector and elsewhere. The RPIX is calculated as the weighted average of changes to the prices of a 'basket' of goods that represent the expenditure of UK households, but excludes mortgage interest payments. This makes it less sensitive to changes in interest rates.
- 6.21 The **Retail Price Index (RPI)** is similar to the RPIX, but includes mortgage interest payments.
- 6.22 The data in **Annex C** provides percentage changes in CPI, RPI and RPIX. It is important to note that too much emphasis should not be placed on a single month's inflation figure. Monthly movements in the CPI and other inflation measures can reflect several different factors and for this reason it is the underlying trends that should be considered.
- 6.23 The data shows that CPI and RPIX inflation has been controlled at low levels over the last 12 months. Indeed, inflation over the past 3 years has remained relatively steady, with CPI averaging at 1.3% and RPIX averaging at 2.4% per annum. Treasury anticipates that this period of stable inflation will continue.
- 6.24 Government expects CPI inflation to return to target by mid 2006. The forecast for RPI (in September) is for inflation to fall in 2005/06 and 2006/07, before rising again 2007/08 and remaining constant at 2¾% thereafter. This is in line with the July average of independent forecasts, which predict CPI will be 2% in 2005 and also 2% in 2006. The comparable figures for the RPI (of which RPIX is a derivative) are 2.5% in 2005 and 2.3% in 2006.

Economic Context

- 6.25 PRB recommendations are forward looking and therefore information about the future prospects of the economy is particularly important. The macro-economy is in a strong position. GDP growth in the UK has now been unbroken for 50 consecutive quarters, which - on the basis of quarterly national accounts data - is the longest sustained expansion on record. Economic growth is expected to remain strong with the Budget forecasting GDP growth between 3 and 3.5% for 2005/6 and between 2.5 and 3% for 2006/7. The UK is currently benefiting from its longest period of sustained low and stable inflation since the 1960s. Interest rates, at 4.75 per cent, are low by historical standards, and long-term interest rates are around their lowest levels in over 40 years. As regards the labour market, unemployment levels are close to their lowest levels since the 1970s and employment is at a record high. This strength in the economy is not resulting in any significant upward wage pressure in the private sector as the data on earnings growth shows.

CHAPTER 7: EVIDENCE FROM THE NATIONAL ASSEMBLY FOR WALES

SUMMARY

- 7.1 This Chapter has been prepared by the Health and Social Care Department (NHS Wales) to complement the evidence from the other Health Departments and draws attention to any policies that are distinctive to Wales.

DESIGNED FOR LIFE: CREATING WORLD CLASS HEALTH AND SOCIAL CARE FOR WALES IN THE 21ST CENTURY

- 7.2 In May the new Health and Social Care Strategy for Wales for 2005/2015 was issued. It sets out the vision for the next ten years and what must be done to achieve it. It continues along the path set out in Improving Health in Wales and Building for the Future. It also draws on the recommendations of the Wanless Review and Making the Connections and also reflects the excellent work undertaken locally in preparing Local Health, Social Care and Well-Being Strategies and Local Action Plans.
- 7.3 Designed for Life recognises that health services in Wales will in the coming years be more explicitly organised around three regional networks to focus upon the delivery of care services, based on models of managed clinical networks. It is intended that by April 2006, all three regional offices of the Health and Social Care Department will have finalised their overall programme for re-organising the secondary care sector.
- 7.4 The transition to a new pattern of health services will require a restructuring of the workforce, new ways of working, changes in practice and improved efficiency, as well as greater support for carers and for supporting service users to do more for themselves. These key changes must be brought together in a process of managed change and innovation in employment practices, skills, job definitions, education and training and staff location to support reconfiguration and service improvement.
- 7.5 The strategy also makes it explicit that there is a real requirement to establish a new process for workforce planning and commissioning of education. An integrated model of whole system workforce re-design will be developed as part of the National Leadership and Innovation Agency to enable improved alignment between the strategic direction of the service and the development of workforce capacity and capability in Wales.
- 7.6 A Workforce Development, Education and Commissioning Unit will be established by 1 April 2006 to provide strategic leadership and action. It will be set up as part of the National Leadership and Innovation Agency and will have the following core functions: workforce planning; education and training commissioning; workforce development; development of standards in education and training; changing the workforce; and working with social care. It will also make explicit the connection between innovation/best practice in service delivery and educators who are able to respond and offer modern teaching, learning and career development solutions.
- 7.7 The Strategy will be backed by a proposed investment plan that will see capital spending tripled in the next three years, rising to £309m in 2007/08. It envisages major secondary care rationalisation. Medical Royal Colleges are driving change by refusing to back specialist services that are too scattered. The secondary care plans to be produced by the Regional Offices will also propose centralising specialist services.
- 7.8 Mid and West Wales are due to deliver theirs by September, South East Wales by December and North Wales by March 2006. There is not sufficient revenue to staff all the new units proposed under the capital spending plan and new hospitals are expected to produce savings.

7.9 Key milestones for 2006:

- recruit 3000 extra nurses and 400 doctors
- access to primary care staff within 24 hours of requesting an appointment
- 95% of patients to spend less than 4 hours in A&E
- 80% of GP practices to achieve at least 700 points in the quality and outcomes framework
- 15% reduction in delayed transfers compared to 2004/05
- new NHS financial information strategy
- all patients to be seen within 12 months for a first outpatient appointment.

WORKFORCE STRATEGY

7.10 Workforce planning for the medical profession provides the central hub to any major service expansion or reconfiguration. The Deanery will become closely linked to the changes proposed for education commissioning. This is deemed particularly important as roles and responsibilities of healthcare professionals are changing in response to the need to address working practices following the introduction of the EWTD and modernising medical careers.

Workforce Numbers: Headline Figures

7.11 There were further increases in the number of doctors and dentists and GMPS doctors in Wales in 2004.

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 507 (FTE) or 12.0%;
- Consultant numbers increased by 160 (FTE) or 11.2% which is line with achieving the target of 525 extra consultants by 2010;
- Associate specialist and staff grade numbers increased by 92 (FTE) or 18.1%;
- Numbers in the registrar group (mainly specialist registrars) increased by 113 (FTE) or 16.7%;
- Senior house officer numbers increased by 114 (FTE) or 10.5%;
- Pre-registration house officer numbers increased by 12 (FTE) or 5.1%;
- GP registrars increased by 5 (No) or 4.5%.

7.12 The number of medical students in training has been increased by 57% since 1999 which will feed into additional numbers of junior doctor posts eventually supporting the recruitment of more consultants and GPs. Since April 2001 a total of 89 extra SpR posts have been approved with central funding.

7.13 An international medical recruitment jobs fair hosted in Cardiff in March resulted in the successful appointment of 6 consultants with further applications ongoing. In addition an on-line application form is being piloted in 4 NHS Wales organisations (18 were received in July, 38 in August).

7.14 The table below shows the FTE to headcount ratio for consultants since 1999. Across the whole of the HCHS sector in Wales, the ratio between September 2003 and September 2004 was 0.90.

Year	Headcount	FTE	Ratio
Sept 1999	1,378	1,220.7	0.89
Sept 2000	1,441	1,250.5	0.87
Sept 2001	1,471	1,312.1	0.89
Sept 2002	1,526	1,376.9	0.90
Sept 2003	1,567	1,416.9	0.90
Sept 2004	1,720	1,549.2	0.90

PAY AND CONDITIONS OF SERVICE

Consultant Vacancies

7.15 The following tables show how the three-month vacancy rate for medical and dental consultants has fallen from 176.4 to 119.3 between September 2003 and March 2005. The breakdown by specialty is as follows:

	30/9/2003	30/9/2004	31/3/2005
A&E	27	4	5
Anaesthetics	8	15	8
Clinical oncology	1	2	2
Dental Group			
General Surgery	8.5	3	6
ENT			
T&O	3	9	6
Ophthalmology	2.2		
Urology	2		
Cardio-thoracic surgery			
Plastic Surgery	2		
Pathology	1		
Haematology	2.5	4	4
Histopathology	3	7.5	7.5
Medical Microbiology	2	4	2
Blood Transfusion	1.6	1.7	0.8
Paediatrics	14	5	6
General Medicine	41.8	37.2	32
Obstetrics & Gynaecology	5	3	
Community Health		5.6	7.4
Psychiatry	43	29.4	18
Radiology	9	14.6	14.6
	176.6	145.0	119.3

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

	30/9/2003	30/9/2004	31/3/2005
Bro Morgannwg	18.2	17	5
Cardiff and Vale	9	9	9
Carmarthenshire	29.8	7	8
Ceredigion & Mid Wales	5	3.3	6.1
Conwy & Denbighshire	2	7	10
Gwent Healthcare	24.5	27.4	16
North East Wales	15	10	4
North Glamorgan	7	9	9
North West Wales	29	18	18
Pembrokeshire & Derwen	17.5	13	13
Pontypridd & Rhondda	4	5	2
Powys LHB	3	2.6	3.4
Swansea	11	6	7
Velindre	1.6	10.7	8.8
	176.6	145.0	119.3

- 7.16 The vacancy rate for other doctors and dentists (excluding training grades) has also fallen in the last six months from 5.8% to 4.6%. These improved vacancy rates are a direct result of robust recruitment and retention and show that pay is about right at present.

Consultant Contract

- 7.17 The new consultants' contract in Wales is designed, through its rigorous job planning process, to ensure that benefits for the service are realised. The three stage review assesses current workload against the wider clinical team situation and then agrees an acceptable individual plan. A key message in all the preparation and training for this process is that increased effectiveness and modernisation to best practice standards is expected and in particular, as part of the agreement, the BMA has recognised the part changes to doctors' practice and adapting to new methods of working have in improving patient care.
- 7.18 In addition to the £17m funds already issued, there is £23m further funding currently being distributed to meet the costs of additional consultant sessions. This has resulted in some consultants benefiting in an increase in pay of 35% since April 2003 while the maximum of the consultant scale has increased by 24% in the same period.
- 7.19 The Audit Wales Office has carried out a comprehensive audit on all trusts to ensure that their initial round of job planning process has been rigorous and gives both value for money and benefits to the service.
- 7.20 An important step in ensuring that benefits are realised is the involvement of CHKS in developing a standards framework which can be used at employer level. CHKS Ltd, the leading provider of analytical benchmarking to the NHS, has signed a five-year deal with the Welsh Assembly Government to provide all 14 hospital trusts in Wales with a clinical indicator programme to drive clinical excellence and inform consultant workload planning and modernisation. The programme integrates information analysis, benchmarking and consultancy to support the implementation of the new Consultant Contract.
- 7.21 Following the introduction of the Consultant Contract in December 2003, hospital trusts are required to produce detailed reports on consultant profiles to use in job planning and resourcing. In order to do this effectively they require in-depth, current and easily accessible information.

- 7.22 The Welsh Assembly selected CHKS to provide the data analysis, benchmarking and consultancy based on a number of factors. Firstly, the Assembly felt that CHKS could provide the level of depth of information and format required for comprehensive job planning and consultant profiling across all 14 Trusts. Secondly, having seen the effectiveness of CHKS' benchmarking programmes in trusts across England and Wales, the Assembly was confident that they could deliver exactly what was required in order for the consultant contract to work throughout Wales.
- 7.23 The data is broken down and analysable by many individual elements of a consultant's work and will allow useful and meaningful comparisons to be made against similar consultants elsewhere.
- 7.24 The long term use of this benchmarking data, properly managed and discussed, will be a very powerful driver for future modernisation and innovation. Moreover as the data is constantly updated improvement will continue to be accrued rather than stop once a threshold has been passed. It will be launched in September in time for the next round of job plan reviews, though it will take several years to realise its full potential.

Doctors in Training

- 7.25 NHS Trusts in Wales have continued to make significant progress in achieving New Deal compliance. Overall the compliance rate within Wales has increased to 89.3% as at 31 March 2005 compared with 88.3% in September 2004. Similarly EWTD compliance has increased to 92.1% compared with 73.4% in September.
- 7.26 The attached tables will be used as the basis for an All Wales Guidance document – 'Working Towards 2009' which will provide a plan on how EWTD compliance can be achieved by that date.

EWTD Compliance as at 31 August 2005

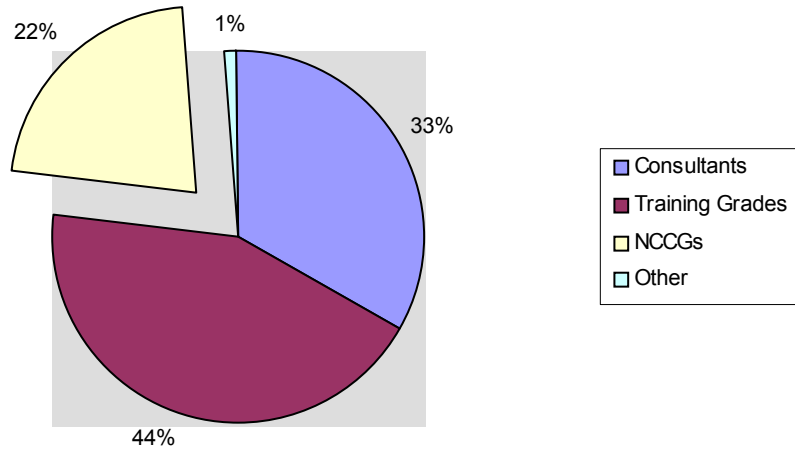
Trust	PRHO Number Compliant	Number In Post	SHO Number Compliant	Number In Post	Flex Number Compliant	Number In Post	SpR Number Compliant	Number In Post	Total Compliant	Total In Post	Total %
Bro Morgannwg	18	18	102	102	8	8	28	28	156	156	100.0
Cardiff & Vale	56	57	267	271	32	32	193	259	548	619	88.5
Carmarthen	23	23	75	77	0	0	6	19	104	119	87.4
Ceredigion	10	10	31	31	0	0	0	0	41	41	100.0
Conwy & D	18	18	88	91	0	0	35	36	141	145	97.2
Gwent	33	33	212	226	14	14	87	92	346	365	94.8
NEWT	18	18	79	79	3	3	42	43	142	143	99.3
North Glam	13	13	83	83	0	0	14	16	110	112	98.2
NWW	14	14	90	90	2	2	34	34	140	140	100.0
Pembroke	9	9	52	52	2	2	6	6	69	69	100.0
Ponty & Rhondda	16	16	71	78	8	8	31	40	126	142	88.7
Powys	0	0	0	0	4	4	0	0	4	4	100.0
Swansea	28	28	144	178	14	14	98	129	184	349	81.4
Velindre	0	0	8	8	0	0	24	24	32	32	100.0
	256	257	1302	1366	87	87	598	726	2243	2436	92.1

**New Deal Compliance
Ministerial Return 31 March 2005**

Trust	PRHO Number Compliant	Number In Post	SHO Number Compliant	Number In Post	Flex Number Compliant	Number In Post	SpR Number Compliant	Number In Post	Total Compliant	Total In Post	Total %
Bro Morgannwg	18	18	102	102	8	8	28	28	156	156	100.0
Cardiff & Vale	49	57	224	253	32	32	193	268	498	610	81.6
Carmarthen	22	22	68	75	0	0	3	19	93	116	80.2
Ceredigion	7	8	16	18	0	0	0	0	23	26	88.5
Conwy &D	15	15	88	91	0	0	34	35	137	141	97.2
Gwent	33	33	209	223	14	14	86	91	342	361	94.7
NEWT	15	15	79	79	3	3	43	43	140	140	100.0
North Glam	13	13	78	78	0	0	11	15	102	106	96.2
NWW	14	14	90	90	2	2	34	34	140	140	100.0
Pembroke	8	8	52	52	2	2	7	7	69	69	100.0
Ponty & Rhondda	12	12	70	82	9	9	25	39	116	142	81.7
Powys	0	0	4	4	0	0	0	0	4	4	100.0
Swansea	28	28	151	178	14	14	86	129	279	349	79.9
Velindre	0	0	8	8	14	14	30	30	52	52	100.0
	234	243	1239	1333	98	98	580	738	2151	2412	89.2

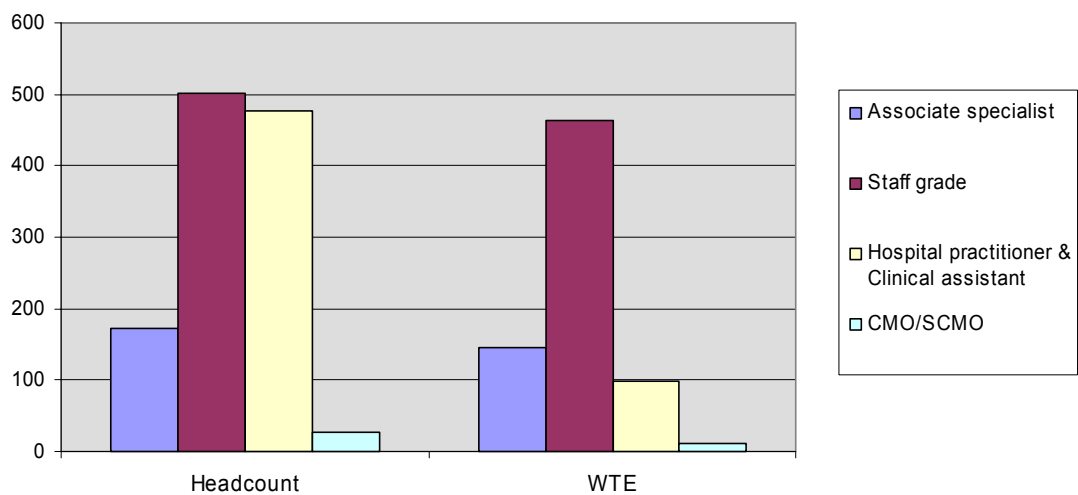
Non Consultant Career Grades

7.27 NCCGs make up approximately 22% of the hospital medical workforce in Wales, in terms of headcount. The chart below illustrates the relative proportion of the NCCG workforce compared with the consultant grade and the training grades.



Source: National Assembly for Wales 2004 Medical and Dental Workforce Census

7.28 Associate specialists and staff grades make up the vast majority of whole-time equivalent NCCGs on National Terms and Conditions. The chart and table below illustrate the relative size of the different grades that collectively constitute the non-consultant career grades (with the exception of trust grades). It is apparent that clinical assistants and hospital practitioners and other Community Health Service Staff produce a relatively small whole-time equivalent (WTE) compared to their headcount, indicating that there are significant numbers of part-time workers in the grades.



Source: Assembly for Wales 2004 Medical and Dental Workforce Census

Table 1: Headcount and WTE NCCGs by grade

Grade	Headcount	WTE
Associate Specialist	172	144.79
Staff Grade	501	463.56
Hospital Practitioner/Clinical Assistant	476	99.61
Other CHS	27	11.91
Total	1,176	719.87

- 7.29 Analysis of NCCG contracts also shows that whilst the majority of staff grades and associate specialists are on whole-time contracts, almost all of the hospital practitioners and clinical assistants are on part-time contracts. This is because hospital practitioners and clinical assistants primarily work in general practice.
- 7.30 Approximately 35% of staff grades and associate specialists, and 61% of clinical assistants/hospital practitioners are female, compared to an average of 47% for all grades.
- 7.31 A major consideration of the current review of NCCGs is that any new agreement supports service modernisation and maximises the contribution and motivation of this group of staff for the benefit of patient care.

GENERAL MEDICAL SERVICES

- 7.32 The data available on numbers of GPs and vacancies in Wales paints a similar picture to England. The last GMS census showed that the number of GPs (wte) per 10,000 population in England and Wales was about the same at between 5 and 6. The growth rate in overall GP numbers over the previous ten years was also the same at 5%. What was significant though was that in Wales the number of female and part time doctors increased by 10% respectively and the number of GPs aged over 55 went up by almost a quarter. Hence our recruitment and retention work has reflected these demographic changes. The GP Vacancies Survey for England and Wales 2005 also shows much similarity between England and Wales. The Welsh vacancy rate is 2.1% with England's at 2.4%. The average number of 3 month GP vacancies per 100,000 patients is 1.3 in Wales and 1.4 in England.
- 7.33 Earlier this year we published a report into GP Recruitment and Retention in Wales. The report was based on a series of research projects. Similar to the approach being adopted in England the research found that central initiatives to improve recruitment and retention had not been entirely effective. It suggested that initiatives to attract and retain doctors would be more effective if designed and implemented locally. The report also stressed the need to:
- Offer a range of job options to GPs throughout their careers
 - Make best use of skill mix, new roles and new ways of working
 - Provide adequate support in terms of personal welfare and development
 - Extend the provision of appropriate education and training
- 7.34 In response we issued advice that pointed LHBs to the findings of the report and withdrew the Golden Hello Scheme. This gave LHBs added greater flexibility in how they expended their recruitment and retention monies. LHBs were asked to start

developing recruitment and retention plans and a number of them have been visited to discuss their local issues and advice offered on best practice. A recruitment and retention conference will take place in November.

7.35 Some other actions that are in train include:

- Improving primary care workforce planning and data collection
- Looking at alternative means of providing GMS services
- Improving retainer schemes to reduce the workload of senior GPs and encourage special interest development
- Looking to introduce Physician Assistants to work in primary care
- Reviewing occupational health provision.

7.36 The Assembly is currently taking part in the overall review of the new GMS contract with NHS Employers. On salaried GPs we are not aware that the present terms and conditions cause any impediment to recruitment and retention particularly as the employer is able to offer more favourable terms to reflect local needs.

GENERAL DENTAL SERVICES

Background

7.37 The evidence this year reflects the reforms planned for April 2006 and a significant programme of investment announced to revitalise NHS dentistry in Wales.

7.38 *Routes to Reform, A Strategy for Primary Dental Care in Wales* acknowledged the need for reform of primary dental care services, in particular the need for a new General Dental Service contract in Wales. The central aims of reform were identified as:

- moving away from the restrictions of the detailed and inflexible existing fee for-item system in GDS and giving dentists a predictable pattern of earnings and the opportunity to practice more preventive dentistry;
- services being locally sensitive;
- improving the patient experience, including providing a readily understood system; and
- improving access to NHS dentistry.

7.39 The legislation to assist in enabling these changes to happen was included in the Health and Social Care (Community Health and Standards) Act 2003 (the 2003 Act) and will come fully into effect in Wales on 1 April 2006.

7.40 The 2003 Act gives LHBs a new responsibility for primary dental services. This means LHBs will have a legal obligation to ensure the delivery of primary dental services in their area. Primary dental care will remain 'catchment' based rather than provided only for residents of the LHB. LHBs can commission the services required to meet this obligation, or provide them themselves.

- 7.41 These changes will be accompanied by devolution of the centrally held GDS budget which will go to LHBs to commission dental services. Preparatory work on these budgets is underway. Central to this commitment is the new way that money allocated for dentistry will be managed as part of the local NHS budget as a whole. LHBs will have the duty to maintain the devolved allocations earmarked for dentistry. In addition, LHBs can use the money they already spend on salaried dental services to develop more integrated primary dental care arrangements. LHBs will also have the opportunity to prioritise local dental services, if they consider this necessary. These safeguards and flexibility do not exist under the present system.
- 7.42 The draft National Health Service (Dental Charges) (Wales) Regulations and the draft The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 and The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006 are currently being consulted upon.
- 7.43 A Transitional Order will set out the mechanism by which a dentist's courses of treatment under old GDS during the 12 month period from 1 October 2004 to 30 September 2005 are converted into the equivalent units of dental activity. In Wales it is proposed that, following this calculation, the total number of units to be provided under a GDS contract will then be reduced by 10% without any loss of income and will then form the baseline for future monitoring of the GDS contract. Additionally, following discussions with the BDA Wales we are proposing that 5% under delivery over the year will be accepted before this triggers a discussion between the contractor and the LHB. We believe that such a tolerance is fair to the contractor in view of the major reform dental practices will have to absorb.
- 7.44 This is in line with the reasoning outlined in *Routes to Reform, A Strategy for Primary Care Dentistry in Wales* that the reform process should involve moving away from the "fee per item treadmill" of the current remuneration system and is consistent with the Welsh Assembly Government's agreement that an access dividend will not be sought automatically or be the opening basis for contract discussions. In allowing dentists more time with patients and for professional and practice development the Assembly Government also confirms its commitment to help improve the working lives of dentists and their teams.

Support for LHBs and Dental Practices

- 7.45 In May 2004 £5.3m was made available over 3 financial years to allow LHBs and dentists to prepare for the introduction of the new dental contract in April 2006. The resources would also allow more patients to receive NHS dental care and some of the monies are targeted at those areas facing particular problems. The £5.3m is being allocated as follows:
- £1.5m in 2004-05 to improve access and to support LHBs, local dental committees and dentists to help prepare for the changes; and
 - £1.9m in both 2005-06 and 2006-07 to help improve access and support implementation.
- 7.46 The £1.5m in 2004-05 was specifically targeted at those LHBs where problems of access were most immediate as follows:

- £550,000. The equivalent of £1,000 per dental practice (pro rata on NHS commitment). This was in response to the DDRB recommendation that some financial assistance to practices was required to assist them to prepare for the new contractual arrangements.
- £440,000. £20,000 to each LHB in terms of supporting the dental change agenda allowing them to support leadership in LHBs; improve organisational development to successfully implement the contract; support Local Dental Committees; developing dental leadership skills; improve communication and review and update dental competencies in line with the development of the dental reforms.
- £510,000 targeted at the 6 LHBs (£85,000 each) where access problems to GDS was most acute. These LHBs have implemented a range of initiatives such as directly employing a salaried dentist, the support of emergency dental sessions, additional access schemes, support of GDS/CDS interface working and the creation of a bursary scheme.

7.47 On 26 April 2005 a further statement was issued regarding the implementation of dental reforms in Wales. This included the roll out of PDS in Wales and confirmation that the new contractual arrangements will be implemented by April 2006.

Personal Dental Services

7.48 It was also announced that £5m would be made available in 2005-06 to support PDS in Wales. At the time it was considered important that dental practices who wish to convert to PDS ahead of the new arrangements were able to do so, therefore providing the necessary flexibility in working practices which dentists have been asking for and also providing the opportunity to enhance services and access.

7.49 In agreeing PDS schemes LHBs were requested to ensure that a similar commitment to the NHS as under the GDS was maintained. However, it is important to highlight the difference in our approach to that being taken in England. The Department of Health have asked that in agreeing 'like for like' PDS schemes a minimum of 5% additional NHS patients should be treated within the existing contract value i.e. based on historic baseline resources (and Doctors and Dentists Review Body uplift). Again we consider that this is in line with the reasoning outlined in *Routes to Reform: A Strategy for Primary Care Dentistry in Wales*.

7.50 Since we issued specific Wales step by step guidance in July this year, gauged upon the number of applications currently being assessed by the ourselves and Local Health Boards information on the quantity of applications currently being processed, we anticipate that by end of September over 10% of current GDS provision in Wales will have moved into PDS arrangements.

Clinical Governance, Training and Development

7.51 Clinical Audit became a Terms of Service requirement from September 2001. The GDS Wales Clinical Audit and Peer Review programme is now well established and some 90% of GDPs went through the central scheme during its first cycle, a major achievement. The Welsh Central Assessment Panel and the Welsh General Practitioner Committee have expressed unanimous support for the principle of maintaining dental CAPR in Wales as a centrally funded and administered programme. We have

considered this advice and agreed that CAPR in the GDS/PDS in Wales will continue to be centrally organised, governed and funded post-April 2006.

Workforce, Recruitment and Retention and Improving Access

- 7.52 Last year we implemented a 17% increase in dental undergraduate places at the Cardiff Dental School and we will be maintaining that level of entry. We are discussing with key stakeholders the viability, in time, of further expansion.
- 7.53 Vocational Training has been a successful educational programme and has also made a positive contribution to the workforce in Wales. Following advice from the Committee for Vocational Training Wales, which was supported by the Welsh General Practitioner Committee, dental Vocational Training in Wales will be maintained as a centrally funded and administered programme once the new contractual arrangements for NHS primary dental care are in place from April 2006.
- 7.54 The Welsh Dental Initiative still retains great interest from the profession and the funding continues to be fully allocated. Over the past two years 11 new practices opened and 37 have expanded.
- 7.55 Many of the PDS pilots approved have included an element of growth in return for increased access. To date this has resulted in the registration of over 10,000 additional NHS patients.

Salaried Primary Dental Care Services

- 7.56 The Chief Dental Officer of England has carried out a review of salaried primary care dental services in England. The Welsh Assembly Government held observer status on both the Steering and Reference Groups of this review.
- 7.57 In August 2005 we published "*Bridges to the Future - Proposals for Developing Salaried Primary Care Dental Services in Wales: A Consultation Paper*". This highlights the key challenges facing the salaried dental services in Wales and offers suggestions of ways forward.
- 7.58 We agreed with representatives of the profession in Wales that we would consider the outcome of the Department of Health Review. Therefore, besides consulting on the future organisational structure of Salaried Primary Care Dental Services we are also consulting on issues surrounding education, roles and career pathways for salaried dentists, clinical leadership and principles supporting pay and grading in this document.
- 7.59 In the light of these developments, we agree with the Department of Health's view that an increase in gross fees of no more than 2.5% would represent a fair deal for dentists.

FINANCIAL STRATEGY

- 7.60 Over recent years, NHS pay and price inflation has equated to an average of 4% per annum. In addition, unavoidable cost pressures associated with workforce or clinical developments have increased the annual funding requirements. In any year these can typically add anything over 5% to the increased costs of the NHS.
- 7.61 While NHS settlements in earlier years have generally funded the majority of cost increases, all NHS Trusts have needed to make additional efficiencies of about 1% per annum to meet local cost pressures. In 2005/06 the need to fund pay modernisation costs has meant that additional cost pressures have not been funded, resulting in a 3.31% funding shortfall on hospital and community services budgets. This equates to approximately £95m.
- 7.62 NHS Trusts were required to contribute to efficiency programmes as part of addressing the deficits inherited by Local Health Boards from the former Health Authorities. All Trusts have reported that they have had to absorb cost pressures arising from clinical developments, for example to maintain pathology and radiology accreditation.
- 7.63 Within primary care, Local Health Boards are facing pressures in meeting the costs of the Quality and Outcomes Framework of the new GMS Contract. Savings from the price reduction on 4 generic drugs and the cost of branded medicines under the Purchase Price Regulation Scheme have been used to part fund the new Pharmacy Contract and LHBs are needing to cover prescribing cost and volume increases from within the 2% increase in prescribing allocations in 2005/06.
- 7.64 The NHS in Wales will therefore enter the next three-years with a level of resources that will challenge commissioners and providers in their efforts to make changes while maintaining service levels and quality. Financial discipline is essential.
- 7.65 A financial environment will be created that encourages Health and Social Care to innovate and change without going down the expensive, inequitable and unsustainable route of market mechanisms. In addition, linking to performance management, it will be necessary to ensure that poor performance is not rewarded and good performance is.
- 7.66 As a result the financial regime in Wales will be reviewed. Key proposals that will be considered will include incentives e.g. the introduction of standard tariffs for activity.
- 7.67 The Programme Budgeting Project will enable the NHS better to understand the current utilisation of resources and plan investments for the future. It will also develop further work on costing case mix activity, which will be of particular importance in helping NHS Trusts in Wales to cost the activity needed to achieve the new waiting times targets.
- 7.68 The NHS will also need to use financial information alongside performance data to make the most of the funding currently invested in services. At a time of limited financial growth, improved productivity e.g. through reduced length of stay, increased daycase rates and better use of physical resources, will be essential if this strategy is to be delivered.

7.69 The following figures are from the Assembly's draft Budget tables and must be taken as provisional until the Assembly votes its final Budget for 2006/07 in December.

	Health DEL* £M	Cash Growth £m	Cash Growth %	GDP deflator (1)	Real Terms Growth
2003/04	3,982				
2004/05	4,279	297	7.5	2.09	5.3
2005/06	4,628	349	8.2	2.50	5.5
2006/07	4,987	359	7.8	2.70	4.9

*Figures at draft Budget Stage

(1) GDP Deflators as at 30 June 2005

7.70 The Assembly is committed to continue to introduce pay modernisation for all NHS staff groups alongside the new contractual arrangements being introduced in the other UK countries. Following the introduction of the new Consultants Contract (December 2003) and Agenda for Change (October 2004) the Assembly is negotiating the introduction of the Non-Consultant Career grades and a revised unsocial hours regime under Agenda for Change. The Assembly also has its own targets for growth in NHS staff in Wales.

7.71 Employers in Wales have been surveyed about their wishes for the 2006/07 pay round. There was a high degree of agreement on two issues:

- A long term rather than short term settlement was preferable. Most organisations would prefer another three year deal although a minority would prefer two years. None wished for a one year only deal. The main reasons for this view were the need for long term stability during a period of major pay and conditions change, the need for better long term planning and forecasting and the desire to avoid adversely impacting on staff morale due to the uncertainty created by annual awards which may be implemented well after the normal due date of April 1st each year.
- An identical level of pay uplift across all staff groups including doctors and dentists. This was seen to be important from a fairness and morale maintenance perspective even though most doctors have recently benefited from structural changes which were considerably more generous than the Agenda for Change settlement for other NHS staff.

CONCLUSION

7.72 In view of the clear evidence of a continuing healthy position on recruitment and retention and growth in average earnings for the health sector, the Assembly concurs with the Department of Health's recommendation for a modest general pay uplift of no more than 2.5% across all doctors groups.

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

SUMMARY

- 8.1 This chapter has been prepared by the Scottish Executive Health Department (SEHD) to complement evidence from the Department of Health in England and the National Assembly for Wales. It sets out where circumstances, initiatives and policies within NHSScotland (NHSS) are distinct from elsewhere in Great Britain (GB) and confirms SEHD's endorsement of evidence given elsewhere that represents a GB position.
- 8.2 The evidence sets out:
- A The Scottish context;
 - B Specific information about individual staff groups;
 - C Workforce planning;
 - D The position in relation to recruitment, retention and motivation of medical and dental staff across NHS Scotland;
 - E Education and Training;
 - F Staff Governance;
 - G The current position on regional pay;
 - H Workforce Performance and Effectiveness;
 - I Affordability and the competing demands for investment.

A. THE SCOTTISH CONTEXT

- 8.3 Over the past year three reports have helped set the current context for health service priorities in Scotland.
- 8.4 In May 2005 Professor David Kerr delivered his report *Building A Health Service Fit for the Future* outlining a framework for service change over the next twenty years. The report looks towards a health service anchored in communities, built on fully integrated services, and more responsive to the healthcare needs of an ageing population. The main themes are:
- more care in the future will be delivered in a non-hospital setting, through staff like health visitors, practice nurses, physiotherapists, pharmacists and family doctors.
 - Currently care can be reactive, hospital centred and geared towards acute conditions. The future focus will be on integrated, anticipatory care, embedded in communities and geared towards long term conditions.
 - Priority should be given to care in deprived areas to reduce health inequalities.
 - Emergency care will be separated from planned care so that planned care can be taken forward faster for patients and with fewer cancellations for them because of emergencies.
 - Everyone needs to take more responsibility for their own wellbeing and adopt preventative measures.
 - More regional planning for hospital based services, with new networks of hospitals sharing the responsibility for providing key elements of acute care.

- 8.5 The report has been endorsed in principle by the Scottish Executive, which will publish its full response in October 2005.
- 8.6 Professor Kerr's report was preceded in December 2004 by the publication of *Fair to All, Personal to Each – The Next Steps for NHS Scotland*, which outlined enhanced targets for access to health services in Scotland:
- No patient will wait more than 18 weeks from GP referral to an outpatient appointment;
 - No patient will wait more than 18 weeks from a decision to undertake treatment to the start of that treatment – down from the current 9 month maximum wait guarantee;
 - Patients will be able to rely on shorter maximum waits for specific conditions:
 - 18 weeks from referral to completion of treatment for cataract surgery;
 - 4 hours from arrival to discharge or transfer for accident and emergency treatment;
 - 24 hours from admission to a specialist unit for hip surgery following fracture; and
 - 16 weeks from GP referral through a rapid access chest pain clinic or equivalent, to cardiac intervention.
- 8.7 An additional target for diagnostic tests has since been announced:
- No patient will wait more than 9 weeks for any MRI or CT scan and other diagnostic tests.
- 8.8 In August 2005, the *National Workforce Planning Framework 2005* was published. This framework will build on the baseline report published in 2004 and will support workforce planning at NHS Board and regional level. The regional workforce plans will be published in January 2006 and NHS Board plans published in April 2006. Guidance in the form of a Health Department Letter (HDL) will be issued to Boards to assist their planning.

B. STAFF GROUPS

Hospital Consultants

- 8.9 This section updates progress on the implementation of the new consultant contract in NHSScotland and responds to issues raised by the Review Body in their Thirty-Fourth Report.
- 8.10 The number of consultants who have moved onto the new contract in NHS Scotland as at June 2005 is 3,298 (96%). Only 57 (1.7%) consultants in Scotland have not taken up the contract. The average number of programmed activities agreed in NHS Scotland at October 2004 is 11.5. There is a clear understanding that extra programmed activities are not permanent and they are regularly reviewed.
- 8.11 In their last report the Review Body raised the issue of recruitment and retention premia for consultants. Employers in Scotland have agreed that such premia should only be applied on a collective basis across Scotland to ensure a consistent and fair application.

To date this element of the new contract has not been utilised and this reflects the fact that recruitment pressures have more to do with a lack of availability of candidates and the professional quality of posts on offer rather than with remuneration.

- 8.12 As far as the benefits of the new contract regarding recruitment and retention are concerned, it is still too early to draw conclusions as to what the impact has been. The latest figures which were taken from the annual census in September 2004 show a reduction in the over 6 month vacancy rate (from 3.4% in 2003 to 3.0% in 2004) although it is premature to demonstrate any trend arising from this.
- 8.13 However a very significant investment has been made in consultant pay. We firmly believe that any recruitment and retention pressures arising from remuneration and working conditions have been fully addressed by the new contract and that any remaining pressures are to do with a misalignment between supply and demand and the availability of attractive posts in terms of professional content. We are therefore of the view that the key focus should now be on generating more effective workforce planning that produces a healthy supply of candidates for posts in the future, coupled with service redesign that ensures Scotland can offer sufficiently attractive jobs.
- 8.14 SEHD is also commissioning an academic study by the Health Economics Research Unit (HERU) of Aberdeen University to assess the impact of the contract on both workload and morale. The study will replicate a study carried out prior to the implementation of the new contract which examined consultant morale. This will enable comparisons to be made between the old and new contracts. The study will be undertaken in late 2005 and completed by Spring 2006.
- 8.15 Anecdotal evidence suggests that consultant morale has been positively affected by the new contract.
- 8.16 Health Boards have been undertaking job plan reviews for consultants during the summer months of 2005 and are planning further reviews between December 2005 and February 2006. This timetable will enable service objectives for consultants to be set and then reviewed, followed by the necessary assessments with regard to pay progression. In future years job plan reviews are anticipated to take place on an annual basis between December and February. This timetable will also link with the consultant appraisal process.
- 8.17 The next survey of consultant job plans will be undertaken as part of a national statistics data collection process. This exercise will take place on 30 September and corresponds with other national data collection exercises led by the Information and Statistics Division of NHS National Services Scotland. This survey is an annual exercise at present although planned changes to data collection will enable more regular provision of statistics in the future. A financial assessment will also be undertaken at the same time to update the assessment made in 2004. Audit Scotland is also undertaking an assessment of the implementation of the new contract by Health Boards and is expected to report in January 2006.
- 8.18 The implementation of the contract has been overseen by a National Partnership Steering Group (NPSG). This group, which includes representation from SEHD, the British Medical Association (BMA), NHS Employers, the Universities and the Consultant Contract Pay Modernisation Team, has worked in partnership to address issues emerging from implementation. Where possible national agreements have been reached and Pay Modernisation Team letters have been issued to NHSScotland, jointly signed by all parties. Examples of this work include an agreement on external duties,

fee paying work and a Health Department Letter (HDL) on educational supervision and the Universities. Further planned work includes the development of an agreement with NHS Education for Scotland on how education and supervision is handled as MMC and PMETB comes into play.

- 8.19 The Pay Modernisation Team is continuing to monitor the situation regarding the new contract for clinical academic consultants through the National Partnership Steering Group for the Consultant Contract.

Review of Distinction Awards and Discretionary Points

- 8.20 The Scottish Executive is committed to conducting a review of the current Distinction Award and Discretionary Points schemes for consultants. Scottish Ministers are currently considering the parameters for this review with a view to the review commencing in early 2006.

Staff and Associate Specialist (SAS) Doctors

- 8.21 The Scottish Executive is participating in the on-going UK review of pay, terms and conditions of Staff and Associate Specialist (SAS) doctors. Scottish Ministers have agreed a funding package of £5m over 3 years to underpin this. We will wish to ensure that the review meets our goals of maximising the contribution that this staff group can make to the NHS through provision of a clear competency-based career framework. The Executive and NHS Scotland employers are holding regular meetings with the relevant BMA committee in Scotland to discuss issues arising from the review as they emerge.

New General Medical Services Contract

- 8.22 The Review Body is not required to make recommendations on remuneration for independent contractor general medical practitioners working under the new primary medical care contracting arrangements. The guaranteed increase in investment in this service has been significantly exceeded, with investment of 42% between 2002-03 and 2005-06. This has led to significant above-inflation increases in income for GPs. Scotland is fully participating in the current review of the nGMS contract (for implementation in 2006-07), which includes a review of the Quality and Outcomes Framework and the formula for allocating resources.
- 8.23 We believe that the greatly enhanced benefits for GPs arising from the new contracts (including in particular the removal of the responsibility to provide Out of Hours services) will make general practice much more attractive as a career option for trainee doctors and address many recruitment and retention pressures affecting general practice.

Doctors in Training

Compliance with the New Deal contract

- 8.24 There has been significant progress in NHS Scotland in achieving compliance with the New Deal for Junior Doctors. The most recent statistics (January 2005) show an increase in New Deal compliance from 85% to 91%. While there remain some difficult areas of non-compliance, 99% of doctors in training are now working 56 hours a week or less. There remain challenges, particularly in smaller rural hospitals and smaller specialties, in ensuring that sufficient amounts of compensatory rest are given promptly. The Scottish Executive's response to *Building a Health Service Fit for the Future*, (<http://www.show.scot.nhs.uk/sehd/nationalframework/Reports.htm>) due in October 2005, will outline the steps to be taken in ensuring sustainable and safe local services across Scotland, addressing the difficult areas which still give rise to New Deal non-compliance.
- 8.25 The table below is a breakdown by grade of New Deal compliance rates at January 2005.

Grade	Compliance rate %
PRHO	94%
SHO	92%
SpR	90%

Average New Deal Pay Supplement

- 8.26 Although the average New Deal pay supplement has reduced in recent years, there is still significant investment being made in supplements, as evidenced by the figures in the table below. This shows that the average supplement paid to all grades of hospital trainees for the August 2004 to January 2005 monitoring period was 68.8% of basic salary, a higher average than in England. NHSScotland is working to reduce this as it moves towards further reducing hours for doctors-in-training.

Average Pay Supplement by Grade and Rota

	All Grades	Specialist Registrar	Senior House Officer	House Officer
August 2004 - January 2005	68.8%	67.4%	68.6%	72.2%
February 2004 - July 2004	75.8%	73.2%	76.0%	79.3%
August 2003 - January 2004	76.3%	72.9%	77.3%	78.7%
February 2003 - July 2003	81.7%	76.1%	84.6%	81.8%

System for managing non-compliance

- 8.27 SEHD continues to support NHSScotland in its on-going efforts to achieve full compliance and earlier this year issued NHS HDL (2005)21 to NHSScotland Boards setting out a new system for managing non-compliance for SHO and SpR grades. The system was devised by a sub-group of the New Deal Implementation Support Group Project Board and involved all three partners represented on the Project Board (Scottish Executive Health Department, BMA Scottish Junior Doctors Committee, NHSScotland representatives). The system involves a cumulative series of breaches in relation to

non-compliance and distinguishes between serious and non-serious breaches. It provides a clear framework for supporting Boards with difficult cases of SHO and SpR non-compliance, relying on partnership working to address problem areas through actively managed action plans linked to local service redesign.

Flexible Trainees

- 8.28 We welcome the recent UK agreement to amend the flexible trainee scheme for junior doctors, which should encourage Boards in Scotland to take on more individuals who wish to train on a less than full time basis. NHS Circular PCS(DD)2005/7 was issued to NHSScotland Boards by SEHD detailing the new scheme and procedures. This scheme will help Boards retain part-time trainees within the medical workforce and assist with career development and work/life balance for other doctors training in the NHS.

New Deal Support to NHSScotland

- 8.29 With compliance figures now robustly over 90%, support for New Deal implementation has transferred from a national infrastructure to a local level. The New Deal Implementation Support Group (ISG) regional teams transferred to regional workforce networks on 1 September 2005. This provides an opportunity to integrate the junior doctors’ safe hours agenda into a wider ‘whole systems’ approach by NHS Boards to redesigning the clinical workforce. Such an approach will be essential in tackling the few remaining difficult areas of New Deal non-compliance.

Junior Doctor Numbers

- 8.30 The table below details the number of doctors in training in Scotland at January 2005. The numbers of Senior House Officers (SHOs) and Specialist Registrars (SpRs) have steadily risen in recent years. The latter have increased by 30% from 2001 as a result of a Ministerial commitment to increase the number of training posts by 375. There is no shortfall in demand for places at medical schools in Scotland.

Grade	Headcount
PRHO	760
SHO	2409
SpR	1248
Totals	4417

GP Registrars

- 8.31 The number of GPs working in NHS Scotland, which proportionately is higher than in England, shows a consistent year on year increase in numbers over the 10 years to 2004. The WTE number of GPs increased from 3,417 in 1994 to 3,663 in 2004, an average of 0.7% per annum. GP Registrar places are administered by NHS Education for Scotland. For the period 2003-04 to 2005-06 additional funding has been made available to increase the annual number of GP registrar places to 280, up by 30 per annum from the previous complement of 250 places. In order to achieve an effective alignment between supply and demand we are building a better evidence base around the dynamics which impact on the GP workforce, to inform GP registrar numbers through a clearer understanding of the future requirements for GPs which takes into account the changing role of the GP in relation to the wider primary care team and the future direction of primary care services.

Dental Services

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

- 8.32 The consultation on *Modernising NHS Dental Services in Scotland* (2004) resulted in the launch of policy proposals in the form of the *Action Plan*. The measures outlined in the *Action Plan* are designed to address Scotland's poor oral health record, provide better access for patients to NHS dental services and provide an attractive package for professional staff who are recruited to, and remain within, the NHS. The *Action Plan* can be viewed at <http://www.scotland.gov.uk/library5/health/apioh-00.asp>.
- 8.33 Over the next 3 years SEHD will invest an additional £150m to achieve the goals outlined in the *Action Plan*. It is important to note that the profession and others consulted wished to retain a Scotland wide approach, with some element of local flexibility, rather than go down a path of local contracting as in England. This is essentially because Scotland is dealing with similar oral health and access problems across the country, and the scale of operation is such that centrally co-ordinated action in partnership with NHS Boards and the professional groups is seen as the most appropriate way forward. For this reason Scotland's investment is presented as a single large central sum, rather than a small headline increase backed up by funding from other sources at a local level where necessary.

Allowances for Independent General Dental Practitioners

- 8.34 Last year SEHD committed to providing DDRB with a report to compare this year's and last year's uptake of allowances. This year DDRB has requested further information on practice cost allowances. SEHD are now in a position to update DDRB on the uptake of allowances (figures are for the whole of Scotland) and to link these where possible to recruitment and retention of General Dental Practitioners.

Vocational Trainee (VT) Allowance

- 8.35 The criteria of this allowance changed in 2004-5 to make a one off payment of £3000 available to all VTs, with an additional payment available to VTs who took up post in a designated area¹. Recipients must be 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, and must complete their vocational training.
- 8.36 There have been 123 claims from VTs in 2004-5 and the amount paid out was £456K of which £87K (19%) was paid out in relation to designated areas.
- 8.37 The original criteria included only VTs who took up post in a designated area, therefore comparison of uptake can only be made using the number of claims made in a designated area in 2003-4 and 2004-5. This year has seen a 20% increase in VTs claiming this allowance in a designated area and the total increase paid out in relation to the designated area was £17K (£70K in 2003-4 rising to £87K in 2004-5).

¹ Designated areas are classified as Borders, Dumfries and Galloway, Grampian, Highland, Orkney, Shetland and the Western Isles NHS Boards. Within Argyll and Clyde Health Board designated areas are Cambeltown, Dunoon, Lochgilphead, Lochgoihead, Oban, Rothesay, Tarbert, Isle of Mull, Iona, Colonsay, Tiree, Islay and Jura.

- 8.38 Early data on the Scottish dental school output already shows an increase in the number of dental graduates taking up posts in Scotland. In 2002 80% of graduates undertook VT in Scotland, which has risen this year to 86%. This figure may rise further still as a number of posts are still to be filled.
- 8.39 In 2002 there were 5 VTs from dental schools outwith Scotland. In 2005 this rose to 28 (an increase of 460%). This substantial increase is probably related to the introduction of the new incentive payments.
- 8.40 The take-up of this allowance demonstrates an increase in recruitment in the designated areas, and the increase in VT numbers in Scotland overall provides early evidence of the success of the new arrangements this year.
- 8.41 SEHD also has evidence to show that there has been a substantial increase in the numbers of current UK VTs and GPTs (General Professional Trainees) applying for a VT number in 2004 as compared to any of the previous three years. Application for a VT number allows a qualified dentist who has completed VT or GPT to practice NHS dentistry in Scotland. The percentage change year on year in UK VT and GPT applications for a VT number has been:

- 2000-01: **+2.6%**
- 2002-03: **+1.3%**
- 2003-04: **+22.2%**

While this is not evidence of take-up of the VT allowance in itself, it does help to demonstrate the improved recruitment and retention we are experiencing at this end of the workforce in Scotland.

Golden Hello Allowance

- 8.42 The golden hello is available to all new dentists when their name is first included on a dental list within 3 months of completing their training. Recipients must undertake to provide the full range of general dental services to all categories of NHS patients during each of the 3 years following receipt of the first payment.
- 8.43 The amount and method of payment of the allowance has changed slightly this year compared to 2003-4 and 2002-3 but comparable figures show that in 2004-5 there were 69 claims from newly qualified dentists, a 25% rise from the 2003-4 total of 55 which itself was a 25% rise from the 2002-3 total of 44.
- 8.44 This shows a steadily increasing trend of newly qualified dentists taking up the allowance and shows the positive recruitment and retention effects of this allowance.

General Dental Practice Allowance

- 8.45 This allowance can be claimed by dentists in a practice based on the average gross NHS practice earnings for the financial year prior to the claim and must be made within the first 6 months of the financial year.
- 8.46 The allowance is to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.

- 8.47 The percentage uptake of practices of this allowance in 2003/4 was 68%. This has increased by 11% in 2004/5 to 79%. The number of claims has increased by 95 from 604 in 2003-4 to 699 in 2004-5.
- 8.48 The total Practice Allowance cost in 2003-4 was £2,522,500, rising to £4,068,375 in 2004-5. However, it should be noted that the amount payable per practice in 2004-5 was increased by 50% from the previous year. The maximum payable per dentist for average gross practice earnings in 2003-4 was £3K and this increased in 2004-5 to £4.5K. In 2005-6 we will increase the allowance to 6% of gross earnings and this will be paid automatically. In most cases this should lead to a doubling of the amount payable per practice.
- 8.49 The take-up of this allowance does not specifically represent recruitment and retention since the intention was to compensate NHS dentists for the rising costs of running a practice. It is therefore an indirect measure of retention only, in that the increase in uptake could represent dentists choosing to fund the rise in practice costs through the NHS rather than moving to the private sector to raise this money.

Remote Area Allowance

- 8.50 This allowance is paid annually in a lump sum to each qualifying dentist. Payments are subject to abatement on a sliding scale relating to NHS earnings. The dentist's name must be included on a list and the dentist must be a remote dentist who has to travel at least 90 minutes by car from the practice address to their local Postgraduate Centre.
- 8.51 There has been a 20% increase in claims in 2004-5 compared to 2003-4 (54 claims rising to 65 claims). The increase in value (total allowance paid) has risen from £135K to £323.7K (140%) but it should be noted that this is mostly due to an increase in the value of the allowance from a maximum of £3000 in 2003-4 to £6000 in 2004-5.
- 8.52 There has been a review of the amount and criteria for this allowance in 2005/6. We intend to increase the allowance to £9000 and extend the definition of a 'remote area'.

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

- 8.53 This is a new allowance introduced in 2004-5 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 £5000 is paid over a two-year period. There is an additional £5000 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 3 years in exchange for the allowance.
- 8.54 There have been 27 claims for this allowance (8 of these in designated areas). The total amount paid for 2004-5 was £87.5K. As this allowance was only introduced in the financial year 2004-5, no prior information is available for comparison.

Sedation Allowance

- 8.55 This allowance is paid to a practice which provides a minimum amount of both types of sedation and is subject to abatement related to percentage NHS earnings.
- 8.56 There has been a decrease of 19% in the number of claimants in 2004-5 compared to 2003-4, from 53 to 43. This is because 7 of the previous years' claimants made less than the minimum required number of sedation claims and the other 3 dentists did not submit a claim for the allowance. Therefore the total Sedation Allowance paid in 2004-5 was £77K, compared to £100.25K in 2003-4, a decrease of £23,250 (23%).
- 8.57 This allowance is not a direct measure of recruitment and retention, but the decrease in claimants could indicate that the allowance is not meeting the different circumstances of sedation practices and it is being reviewed.

Scottish Dental Access Initiatives (SDAI)

- 8.58 Grants under the SDAI are available to those dentists wishing to establish new or expand existing NHS dental practices in areas of high oral health need or unmet demand. Grants for every 50 sessions of GDS completed in the first year are also available to encourage dentists returning to the profession after an absence of 2 years or more to join established NHS practices.
- 8.59 The number of grants accepted by health boards under the SDAI in 2004 was 11. In 2005 the number of grants accepted by health boards was 20. This represents an 82% rise in the number of SDAI grants accepted.

Allowances for Salaried Services

- 8.60 New grants and allowances for salaried services were introduced on 1 April 2004. Details of the grants and allowances available are contained in **Annex E**. SEHD do not yet have comprehensive information on the uptake of these and their impact on recruitment and retention.

Free Dental Examinations

- 8.61 *A Partnership for a Better Scotland: Partnership Agreement* published in May 2003 made a commitment to systematically introduce free dental checks by 2007. Statutory provisions were made for the introduction of this policy in the Smoking, Health and Social Care (Scotland) Bill, which was debated in Parliament and passed on 30 June. SEHD are now in discussion with the dental profession about the detailed planning and implementation of free dental examinations to include a more extensive oral health assessment.

Rewarding dentists for capital invested in NHS dentistry

- 8.62 The *Action Plan* committed us to providing infrastructure support for dentists. SEHD will:
- Provide recurring financial support for existing premises which meet agreed standards through a new reimbursement scheme to meet rental or equivalent costs.
 - Provide improvement funding to bring existing premises up to standard and to provide child friendly practices.

- Support financially the move of practices to new premises, including 3rd party developments.
- Develop incentives to open up new facilities or take over existing practices in areas of high need/demand.
- Introduce a comprehensive programme of support for information technology in practices including the salaried services.
- Provide recurring financial support to practices for approved clinical systems.
- Connect all practices to NHS net.
- Fund the communication costs of practices using NHS net.

8.63 The level of support will be dependent on the extent of NHS commitment.

Benefits Realisation from Pay Modernisation

8.64 In order to performance manage the benefits from pay modernisation SEHD issued a Health Department Letter HDL (2005)28 on 1 July 2005 which outlines the arrangements for ensuring delivery of benefits from the new pay systems. This HDL (available at <http://www.show.scot.nhs.uk/sehd/mels/HDL2005>) asks NHS Boards to develop benefits delivery action plans by 30 September 2005 to describe how they are delivering the benefits of pay modernisation, and to produce progress reports at 31 March 2006 showing attainment of benefits against measurable performance indicators.

C. WORKFORCE PLANNING

8.65 The *Scottish Health Workforce Plan 2004 Baseline* (Scottish Executive, April 2004) marked the beginning of a crucial phase in workforce planning. Since then significant progress has been made. Three important publications and new legislation have provided a fresh context within which to plan future workforce needs.

8.66 *Fair to All, Personal to Each – The Next Steps for NHSScotland* (Scottish Executive, December 2004) builds on existing commitments to improve patients' access to healthcare by setting new targets to further reduce waiting times across NHSScotland. These new standards have workforce implications.

8.67 In January 2005 the Health Committee of the Scottish Parliament reported on its inquiry into workforce planning in NHSScotland with the publication *Reshaping the NHS? Workforce Planning in the National Health Service in Scotland*. This noted that while encouraging initial work had been undertaken to develop workforce planning in NHSScotland there were still barriers to be overcome to ensure effective planning. It also noted the impact that workforce issues have on the design of services.

8.68 In May 2005 the Scottish Executive published *Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland* on the shape of Scotland's health services over the next 20 years. This provides the overall vision for the future shape of NHSScotland in years to come. A key aspect is planning the workforce required to deliver the services envisaged over the next twenty years.

8.69 From 30 September 2004 the *NHS Reform (Scotland) Act 2004* made it a statutory duty for all NHS Boards to have in place arrangements for workforce planning. That duty underscores the fact that strategic workforce planning cannot be done at national level alone. The Act also obliged NHS Boards to collaborate across boundaries where appropriate. Regional workforce planning arrangements are now well established, with workforce planning capacity in place and operating in each Board. Baseline workforce

profiles have already been produced for each Board and regional and Board workforce plans will follow by the end of this financial year.

- 8.70 The *National Workforce Planning Framework (Scottish Executive, August 2005)* establishes the framework within which future staff numbers will be planned based on workforce projections made by each NHS Board and by the three workforce planning regions. This framework will allow NHSScotland to align workforce planning with service and financial planning, education and training, regulatory support and organisational structures.
- 8.71 Initial regional workforce plans will be produced by January 2006, with Board workforce plans following by April 2006.

D. RECRUITMENT AND RETENTION

8.72 The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland increased by 253.9 (WTE) or 2.7% in 2004. For individual staff groups this represents changes as follows:

- Consultant numbers increased by 73.3 (WTE) or 2.2%;
- Associate specialist and staff grade increased by 9.8 (WTE) or 1.7%;
- Specialist Registrars increased by 126.0 (WTE) or 8.6%;
- Senior House Officers increased by 54.0 (WTE) or 2.0%;
- Pre-Registration House Officer numbers increased by 4.8 (WTE) or 0.6%;
- GP numbers (Principals and other) increased by 13.0 (WTE) or 0.4%

8.73 The most recent vacancy figures (at 30 September 2004) showed that there were 288 (headcount) medical and dental consultant vacancies, an increase of 43 (or just under 18%) from 245 in September 2003. The 6 month vacancy rate decreased to 3.0% from 3.4% in 2003.

8.74 NHSScotland is Scotland's largest employer and therefore subject to trends in the wider labour market as well as changes specific to NHSScotland. 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.

8.75 Pay modernisation has provided improved terms and conditions to incentivise individuals to join and stay in the NHS including a number of non-financial incentives such as flexible working conditions; and the opportunity for self-development through quality training and learning. We consider this to have placed NHSScotland in a strong position in terms of recruitment and retention of doctors. Additionally Scotland has a number of programmes for dentists aimed at encouraging them to take up posts in Scotland and provide NHS services.

8.76 The national Staff Governance Standard, which seeks to make NHSScotland an exemplar employer, provides for the high standards of employer practice which support retention of staff. Staff governance measures include 12 Partnership Information Network (PIN) publications, which prescribe mandatory minimum standards of

employment practice for NHS Scotland employers, and the Occupational Health and Safety Strategy *Towards a Safer Healthier Workplace*.

- 8.77 SEHD also expects the current UK-wide review of the NHS Pension Scheme to aid recruitment and retention. One of the aims of the review is to ensure that the NHS pension scheme meets the needs of a modern NHS and its staff by making benefits more appropriate for today's workforce. This is the first time the scheme has been fundamentally reviewed since its inception in 1948. The review recognises the importance of the scheme in supporting the recruitment and retention of staff and encouraging those staff who have left to return to the NHS.
- 8.78 There are particular challenges in recruiting and retaining staff to work in remote and rural areas and in some cases elsewhere outside the larger teaching hospitals, where the quality of the professional environment is not as rich and where there may be a need to re-design some posts. A further pressure is exerted in specialties where Scotland is competing with international and wider UK pressures on recruitment of nurses and doctors across the UK.
- 8.79 With its strong medical school/teaching hospital base Scotland generates a healthy supply of doctors in training, although a number of training grade doctors are English-domiciled and therefore look south of the Border when they reach consultant grade. There is thus a continuing challenge to retain doctors when they gain consultant status, particularly in shortage specialties. Work is ongoing to improve retention rates in support of the Executive's Partnership Agreement commitment to aim to increase the consultant workforce by an extra 600 consultants.

Workforce Expansion

- 8.80 *A Partnership for a Better Scotland: Partnership Agreement (Scottish Executive, May 2003)* contains a number of targets that relate to the medical and dental workforce as follows:
- We will aim to introduce further measures to attract and retain GPs;
 - We will aim to increase the number of consultants in the NHS by 600 by September 2006 and continue to build on that increase thereafter;
 - We will further pursue mechanisms which encourage preventative dentistry and design reward measures to support that objective.
 - We recognise the need for an increase in the number of dentists and dental graduates in Scotland. We will undertake an assessment for the reasons for the shortfall in the number of dentists in some areas of Scotland and the options for addressing that.
 - We will expand the capacity for dental training facilities in Scotland by establishing an outreach training centre in Aberdeen. We will consult further on the need for its development to a full dental school.
- 8.81 Further assessments of required increases in the medical and dental workforce will be informed by the workforce planning arrangements described above.

Consultant Expansion Programme

- 8.82 There are a number of significant drivers which will impact on the number of consultants required over the next year and beyond. These include sustained compliance with Working Time legislation and the impact of reduced working hours for junior doctors, the new consultant contract, as well as fundamental changes to doctors' training through *Modernising Medical Careers (MMC)* and the resultant shift towards a trained doctor-delivered service (as recommended in *Future Practice* <http://www.scotland.gov.uk/library5/health/fpmr.pdf> and *Securing Future Practice* <http://www.scotland.gov.uk/library5/health/sfpnmw.pdf>).
- 8.83 The Executive has a £5.2m action plan in place to develop strategies aimed at supporting Health Boards in achieving significant consultant expansion in the near term future, and 375 extra SpR places have been established since 2001 to help ensure there is a healthy supply to meet expansion plans. We are working with NHS Boards to develop a more proactive approach in filling vacancies, retaining current consultants and recruiting from external sources. This includes a number of strategies, such as:
- ***Flexible Careers*** Looking at the development of flexible career and retirement options to maintain skills and expertise within the system for longer. Such schemes can help to attract and retain staff by, for example, offering the ability to return from retirement or “step down” their commitment prior to retirement.
 - ***Managed Placement Scheme*** This scheme is being developed to provide an alternative to Health Boards to making either a substantive consultant appointment or a temporary locum appointment. The scheme will provide structured employment for doctors who are on the Specialist Register and require supported experience at the appropriate grade for a fixed period. The posts will be at consultant or associate specialist grade for a period of 6 months, renewable for a further 6 months, and carry job descriptions and person specifications provided by the Health Board. Mentoring assessment and appraisal will be provided to the doctor during the period of appointment by the employer and host Health Board.
 - ***SpRs*** We are developing a scheme for matching Specialist Registrars (SpRs) about to sit their Certificate of Completion of Specialist Training (CCST) with existing/prospective vacancies. This will help to improve supply/demand planning, identify shortages and provide advance notice of further development requirements.
 - ***Refugee Doctors*** We are developing a scheme which will enable the recruitment of suitably qualified refugee doctors already in the UK.
 - ***Induction*** We are establishing a consistent induction process for new consultants which will develop best practice and result in a set of framework guidelines.
 - ***On-line Applications*** We are making it easier for consultants to apply for jobs by developing an on-line application system.
 - ***International Recruitment Pilot Scheme*** We are working closely with colleagues in the Department of Health in England to introduce a pilot scheme which will recruit overseas doctors from Italy and India and have them in post by September 2006.

- 8.84 At present, exit interview data is not held centrally. Health Boards are encouraged to do exit surveys, however, and in the future it is expected that data on leaving will be collected through the new Scottish Workforce Information Standard System (SWISS).

Conclusion

- 8.85 Overall, we believe that current recruitment and retention pressures arise from non-pay rather than pay factors. Remuneration and working conditions have greatly improved for consultants, GPs and doctors-in-training in recent years and we believe remaining recruitment and retention pressures are to do with a misalignment between supply and demand and the availability of attractive posts in terms of professional content. We are therefore of the view that the key focus should now be on generating more effective workforce planning that produces a healthy supply of candidates for the posts in the future, coupled with service redesign that ensures Scotland can offer sufficiently attractive jobs.

E. EDUCATION, TRAINING AND CAREER DEVELOPMENT FOR DOCTORS

Modernising Medical Careers

- 8.86 Following the launch of the policy document *Modernising Medical Careers* (MMC) in February 2003, MMC was further developed in April 2004 through the publication of *The Next Steps*, the UK strategy statement which took forward arrangements for the MMC training reforms and signalled a commissioning date for new Foundation Programmes from August 2005.
- 8.87 The UK strategic overview and direction for the MMC framework – covering principles and standards plus co-ordination of the implementation work of the four UK countries - is provided by a UK MMC Strategy Group, which is chaired in turn by each of the 4 UK Chief Medical Officers.
- 8.88 Each of the four UK countries has its own detailed MMC implementation arrangements, which are taken forward in line with the agreed policy framework as defined by the UK Strategy Group. In Scotland, Modernising Medical Careers is overseen by the MMCScotland Delivery Group. The MMCScotland Delivery Group advises on strategies for the effective transition between current and new postgraduate medical training arrangements.
- 8.89 The work of the MMCScotland Delivery Group and its partners in taking forward detailed implementation in Scotland is also supported by focussed activities which include the following:
- Deliberations of the MMCScotland Delivery Group are informed by the findings of two short life working groups commissioned by the Executive:
 - the first led by Professor Sir John Temple and tasked to review medical career structures in Scotland; and
 - the second led by Sir Kenneth Calman and tasked to review basic medical education in Scotland.
 - Detailed operational work led by NHS Education for Scotland in collaboration with NHSScotland Boards and partners, including:
 - reconfiguring current training posts into new, educationally coherent and approved Foundation Programmes with placements in a range of service settings;

- provision of an educational infrastructure to support new Foundation Programmes, including the appointment of named Foundation Tutors for each programme; and
 - support for the development of new assessment, appraisal and portfolio arrangements.
- The creation of separate sub-groups to the MMCScotland Delivery Group to explore detailed aspects of implementation and to inform the Group's work programme in specific areas, including:
 - *MMC Communications* – relaying the key policy messages to NHSScotland and other partners; and
 - *HR Issues* – to advise NHSScotland on new arrangements for issuing contracts for Foundation Programme doctors.
- 8.90 Other work streams will be established to support and inform the implementation arrangements in Scotland as the policy develops.
- 8.91 NHS Education for Scotland are also taking forward on behalf of SEHD detailed work to assess the immediate and longer term service impact of implementing MMC and to propose solutions for successful implementation. Aspects supporting this work include:
- the creation of an *MMC Solutions Group* for Scotland, working with NHSScotland and the SEHD to assess any initial service delivery hotspots associated with the introduction of MMC and to advise on actions required;
 - a series of focused workshops with NHSScotland to explore service and financial consequences of MMC implementation; and
 - regular contact with NHSScotland to gather information on local issues and plans and to provide an advisory role in determining appropriate local actions to support safe service delivery during MMC implementation.
- 8.92 Over 800 new medical graduates successfully commenced new 2-year Foundation Programmes in Scotland from 1 August 2005. The operational framework for Foundation Programmes in Scotland was published on 1 August 2005 and appears on the MMCScotland website at www.mmc.scot.nhs.uk.

A Review of Basic Medical Education in Scotland

- 8.93 Last year's evidence reported that the Scottish Executive was considering Professor Sir Kenneth Calman's report into a review of basic medical education in Scotland. The Executive published its response to Sir Kenneth's recommendations on 29 June 2005. Key elements of the Executive's response include:
- provision of an additional 100 medical graduates in Scotland, achieved through providing additional clinical training places across the four Scottish clinical medical schools for those students who enter St Andrews university for their medical education;
 - support for Sir Kenneth's proposals for universities to review their selection processes and to widen access to medical education;
 - support for the introduction of a fast-track graduate-entry medical degree course in Scotland;
 - support for the establishment of a Board of Medical Education for Scotland, to co-ordinate activity across the five medical schools (ie 4 clinical medical

schools: Edinburgh, Glasgow, Aberdeen and Dundee plus St Andrew's) in line with Sir Kenneth's recommendations.

- 8.94 Implementation of the Executive's response to Sir Kenneth's review will increase Scotland's output of medical graduates from approximately 800 to around 900 each year, an increase of 12.5%. SEHD, the Scottish Higher Education Funding Council (SHEFC) and Scotland's universities will work together over the next few months to support the delivery of these proposals as outlined in the Executive's response.

F. STAFF GOVERNANCE

- 8.95 Staff governance is a key policy area and NHSScotland as employers are now legally accountable under the NHS Reform (Scotland) Act 2004 for ensuring staff governance in the same way as they are responsible for clinical and financial governance. The Staff Governance Standard has been revised in partnership and recently reissued as part of a comprehensive tool kit which includes a self assessment audit tool, staff survey and associated guidance. The Standard specifies that staff are entitled to be:

- well informed;
- involved in decisions which affect them;
- treated fairly and consistently; and
- provided with an improved and safe working environment.

- 8.96 Individual Health Board compliance with the Standard is monitored by Audit Scotland.
- 8.97 Partnership Information Network (PIN) policy and practice are minimum standards of best practice, prepared and agreed in partnership, which NHS Scotland employers are expected to meet or exceed as part of their delivery of the Staff Governance Standard. The publication of the fixed-term contracts PIN earlier this year was preceded by twelve PINs, covering various areas of employer/employee relations such as Family Friendly Policies, Dignity at Work, Equal Opportunities and Management of Employee Conduct. A number of these are now under review and being updated.
- 8.98 New PIN guidelines on managing recruitment and staff induction are currently in preparation. The Managing Recruitment PIN contains a model exit interview form and guidance on how this should be used in relation to the recruitment process. This document should be complete and ready for issue to NHS Scotland in autumn 2005.
- 8.99 *Healthy Working Lives: Improving Health, Improving Safety, Improving Patient Care* presents an action plan to help make NHS Scotland the employer of choice by actively promoting staff and public health, removing workplace inequalities and maximising employment opportunities.
- 8.100 *OHS Extra* - a £500,000 project - will shortly be piloted in NHS Fife and NHS Lanarkshire. This will provide access for staff to physiotherapy, occupational therapy and counselling services aimed at improving staff health and reducing sickness absence. An on-line health improvement and occupational health screening project is being piloted by Greater Glasgow Primary Care Operational Division. The project is designed to provide evidence to show that health promoting activities can improve health, reduce sickness absence and improve productivity. Both of these pilot projects link directly to NHS Scotland's commitment to reduce sickness absence over the period 2005-06 to 2007-08.

- 8.101 SEHD has worked with staff and NHSScotland employers to introduce occupational health and safety standards of care to bring health and safety to the fore and encourage year on year improvement in service provision to protect staff from harm. Over £1m has been spent on projects aimed at reducing accidents and incidents, including £370,000 on violence and aggression. This resulted in the December 2003 launch of the *Gonnae no dae* that zero tolerance campaign posters and CDs. This was repeated in December 2004 with £400,000 funding to tackle violence and aggression locally. SEHD is in the process of developing a strategy for action to tackle violence and aggression towards staff and is working with colleagues in the Scottish Executive to promote a culture shift in behaviour attitudes to make clear that abusive behaviour towards public sector staff is unacceptable.
- 8.102 In addition the law has been strengthened to make it a criminal offence to interfere with an emergency worker during the course of an emergency: this includes ambulance staff and other NHS staff working in an emergency situation. A highly acclaimed latex, hand and glove policy has issued and SEHD is working in a UK context to promote a UK Manual Handling Passport.
- 8.103 The Staff Governance Standard sets a framework for ensuring that NHS Scotland is an exemplar employer, supporting, protecting and developing its staff to the maximum. In this way it serves to motivate and incentivise staff to join and stay in the NHS through non-pay mechanisms, an important compensating factor when considering the level of pay award which should be provided.

Working Time Regulations

- 8.104 SEHD is fully committed to the Working Time Regulations (WTR). By making sure that no NHS employee works excessive hours we will not only improve their working lives but also ensure that no patients are treated by tired staff.
- 8.105 The Working Time Regulations affect doctors-in-training in particular. New Deal monitoring of the level of compliance by hours indicates that 99% of doctors in training are now working 56 hours a week or less. This is a good indicator of compliance with the WTR standard of 58 hours from 1 August 2004 and 56 hours from 1 August 2007. A Specialist Adviser on the WTR has been seconded to SEHD to support Boards in responding to the operational impact of the WTR.
- 8.106 SEHD organised two successful seminars this year, one in Inverness and the other in Stirling, to assist NHSScotland Boards in achieving working time compliance. Examples of good practice that have been successfully implemented in various Boards were presented and information on the *Hospital at Night* approach was disseminated at these and other venues. A further seminar is due to take place later this year in the Borders.
- 8.107 Initiatives are underway in NHSScotland that will see the continued implementation of *Hospital at Night* schemes and the redesign of various NHS services. This will lead to a further reduction in the average hours worked by junior doctors, with the remaining hours being used to utilise and provide appropriate, supervised training opportunities.

G. REGIONAL PAY

- 8.108 The position on regional pay has not changed markedly since last year and we are not therefore currently considering any further measures on this front. Given that the delivery of pay modernisation is still at an early stage SEHD is not yet able to measure

the effect of new pay systems on pay differentials in addressing local recruitment and retention pressures. The new consultant contract in Scotland does allow for recruitment and retention premia to be applied if it is felt there is compelling evidence to provide extra incentives over and above base pay.

H. WORKFORCE PERFORMANCE AND EFFECTIVENESS

8.109 Delivering improved workforce performance and effectiveness in NHSScotland is seen as increasingly important, particularly following the significant investment in pay reform. A Workforce Performance and Effectiveness Group has been established to provide:

- an assessment of the impact on productivity of pay modernisation;
- formal advice and recommendations to the National Workforce Committee (NWC) on action to be taken to increase productivity and effectiveness in health;
- new models of organising skills and resources;
- the creation of productivity measures for NHSScotland;
- guidance to NHS Boards on practices and evidence relevant to productivity and effectiveness in NHSScotland.

8.110 High level workforce productivity indicators will be published within the coming year. Each NHS Board will be expected to review the factors that affect workforce productivity to ensure that they are benchmarking appropriately against their colleagues in Scotland. Particular emphasis will be placed on reducing staff absence across Scotland and increasing consultant productivity. It is expected that time released by these two initiatives will be reinvested back into the workforce, thereby increasing output for the same level of input. NHS Boards will need to account for this when developing their workforce plans.

Efficient Government – Time Releasing Savings – Increasing Consultant Productivity

8.111 The Scottish Executive published its Efficient Government Plan *Building a Better Scotland: Efficient Government – Securing Efficiency, Effectiveness and Productivity* on 29 November 2004. The Efficient Government Plan contains measures to deliver £745m of annually recurring cash-releasing efficiency savings and £300m of recurring time-releasing savings by 2007-08. As part of this initiative, the Executive has recently published Technical Notes for time-releasing savings from workforce productivity measures covering Increasing Consultant Productivity. The technical notes provide information on the projects and how the savings will be measured, monitored and delivered. On consultant productivity, Boards will be expected to demonstrate an increase in consultant productivity by 1% per annum over the next 3 years.

8.112 Increasing consultant productivity should have a positive impact on waiting times and will enable Health Boards to understand how consultants and clinical teams are working and how service re-design and improvement can enhance consultant productivity with the aim of improving overall patient care. It is estimated that the planned savings will yield the equivalent of £22m in 2005-06, £46.5m in 2006-07 and £73.9m in 2007-08.

I. AFFORDABILITY

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

- The totality of funding set for the Scottish Executive Health Department;
- The Scottish Executive's commitment to deliver the key national priorities and other standards set out in *Building a Better Scotland*; and
- The Government's inflation target for the economy as a whole of 2.5%.

8.114 There is no doubt that the recent significant increases in staff pay have had a major impact on Health Boards' budgets and that excessive pay uplifts on top of these would have an opportunity cost on the ability of Boards to develop and extend responsive services to patients. Each rise of 0.5% in the paybill equates to £24 million in Scotland, which is equivalent to employing an extra 800 nurses or 260 doctors. This inevitably would have to be taken from key priorities such as health improvement, tackling health inequalities, providing the most efficacious drugs or reducing waiting times.

8.115 The Scottish Executive Health Department's provisions for 2005-06 to 2007-08 are set out in the following table:

	2005-06	2006-07	2007-08
Total (£m)	8814	9545	10293
Cash Growth (£m)	752	731	748
Cash Growth (%)	9.33%	8.29%	7.84%
GDP Deflator	2.50%	2.70%	2.70%
Real Terms Growth	6.66%	5.45%	5.01%

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

- Meeting growing demand for health services – providing fairer access to more services locally and adopting medical advances;
- Developing, improving and meeting the additional costs associated with the demand led primary care services;
- Expanding diagnostic capacity and throughput and reduce waiting times for outpatient, inpatient or day case treatment;

- Improving the quality of NHS services to better meet the needs of patients, with particular priority to cancer, coronary heart disease, stroke and mental health;
- Growth in the number of prescriptions and the prescribing of new drugs. Costs are expected to continue to rise by 10-12% per year, which will account for around £90 million per year;
- Securing a more flexible workforce – equipping them to deliver a more patient-focused service;
- Resources to meet demand for capital investment for new hospitals and equipment, the IT infrastructure, and training and development of the NHSScotland workforce.

8.117 NHS Boards have been allocated revenue allocations for 2005-06 comprising a minimum increase of 7.0% with an average increase of 7.6% and a maximum increase of 9.2%. NHS Boards have been notified of indicative increases of an average increase of 7.25% for 2006-07 and 6.5% for 2007-08.

8.118 The Scottish Executive is committed to improving health and revitalising the NHS and community care services in Scotland. New initiatives are being developed to create a step change in improving health. Pay clearly plays an important part in this process but it is only one element.

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

- The totality of funding available to the Scottish Executive Health Department. The increases in NHS resources shown above provide a fixed budget for the NHS in Scotland. There are no resources over and above this to fund any excess costs arising from pay settlements
- The Department's ongoing commitment to the modernisation of NHSScotland
- Affordability and the competing demands for investment
- The Government's inflation target of 2.5%

G. CONCLUSION

8.120 The level of pay award being considered should take account of:

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

8.121 SEHD supports the Health Departments' recommendation of a general uplift of no more than 2.5%, which we believe fairly balances affordability with the continuing requirement to secure sufficient levels of recruitment and retention.

IMPACT OF INCREMENTAL RISES ON PAY FOR HCHS DOCTORS

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

Column (a) shows the actual basic pay for a doctor at 1 April each year from 2001. 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 2001.

For example, a new consultant starting on 1 April 2001 on the minimum of the scale would have received basic pay of £50,810. Having progressed up the consultant scale, and assuming transfer to the new consultant contract, by 1 April 2005 the doctor's basic salary would have increased to £75,899 - an increase of 49.4 % over 4 years. A consultant who was on the maximum of the scale on 1 April 2001 and who chose to remain on the pre-2003 contract has had a salary increase of 12.9% over 4 years.

GRADE	YEAR	(a) ACTUAL BASIC SALARY £	(b) ANNUAL % INCREASE (of which DDRB headline award)	(c) CUMULATIV E % INCREASE
SHO	2001 (minimum)	22,380		
	2002 (point 1)	24,745	10.6 (3.6)	10.6
	2003 (point 2)	27,150	9.7 (3.225)	21.3
	2004 (point 3)	29,532	8.8 (2.7)	32.0
	2005 (point 4)	32,116	8.7 (3.0)	43.5
SpR	2001 (point 2)	27,545		
	2002 (point 3)	29,850	8.4 (3.6)	8.4
	2003 (point 4)	32,460	8.7 (3.225)	17.8
	2004 (point 5)	35,016	7.8 (2.7)	27.1
	2005 (point 6)	37,796	10.8 (3.0)	37.2
Staff Grade	2001 (minimum)	27,170		
	2002 (point 1)	30,455	12.1 (3.6)	12.1
	2003 (point 2)	33,820	11.0 (3.225)	24.5
	2004 (point 3)	37,178	9.9 (2.7)	36.8
	2005 (point 4)	40,900	10.0 (3.225)	50.5
Consultant (with transfer to new contract)	2001 (minimum)	50,810		
	2002 (point 1)	56,470	11.1 (3.6)	11.1
	2003 (new contract)	66,065	17.0 (3.225)	30.0
	2004	70,328	6.5 (3.225)	38.4
	2005	75,899	7.9 (3.225)	49.4
Consultant (remaining on pre-2003 contract)	2001 (maximum)	66,120		
	2002 (maximum)	68,505	3.6 (3.6)	3.6
	2003 (maximum)	70,715	3.2 (3.225)	6.9
	2004 (maximum)	72,483	2.5 (2.5)	9.6
	2005 (maximum)	74,658	3.0 (3.0)	12.9

SPENDING REVIEW 2004 PUBLIC SERVICE AGREEMENT

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

The objectives of the SR2004 Public Service Agreement are:

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

1. Substantially reduce mortality rates by 2010:
 - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
 - from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
 - from suicide and undetermined injury by at least 20%.
2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.
3. Tackle the underlying determinants of health and health inequalities by:
 - reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
 - halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport; and
 - reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. Joint target with the Department for Education and Skills.

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

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

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

Objective III: Improve access to services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

Objective IV: Improve the patient and user experience

7. Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.
8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:
 - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
 - increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

ECONOMIC CONTEXT: LATEST DATA**Inflation**

The tables below present the percentage changes in the RPI, RPIX and CPI, both on the year and over the month. As stated in Chapter 6, however, too much emphasis should not be placed on a single month's inflation figure, instead the Review Body should focus on underlying trends.

	CPI (%)	RPI (%)	RPIX (%)
2004	+1.3	+3.0	+2.2

	March 2005	April 2005	May 2005	June 2005	July 2005
CPI	+1.9	+1.9	+1.9	+2.0	+2.3%
RPI	+3.2	+3.2	+2.9	+2.9	+2.9%
RPIX	+2.4	+2.3	+2.1	+2.2	+2.4%

Future Inflation Expectations

The Government expects CPI inflation to return to target by mid 2006. The forecast for RPI (in September) is for inflation to fall in 2005-06 and 2006-07, before rising again 2007-08 and remaining constant at 2¾% thereafter.

	<i>Projections % Change on a year earlier</i>				
	2005-06	2006-07	2007-08	2008-09	2009-10
CPI	+1.75	+2	+2	+2	+2
RPI (Sept)	+2.75	+2.5	+2.75	+2.75	+2.75

Average earnings Index¹

The main source of the data on average growth in individuals' earnings in the UK is the Average Earnings Index (AEI), collected by the Office of National Statistics (ONS). ONS measure of the year-on-year percentage growth in earnings is calculated as the average rate of PPH increase over all employers in whole economy, private and public sectors (as well as broad industrial sectors). The AEI covers both full-time and part-time workers and includes basic pay, shift payments, bonuses and profit-related pay.

The table below provides the headline AEI three-month average figures, which measure the change in the index for the last three months compared with the same period a year earlier. For completeness, the single month rate, comparing the change in the index to that individual month a year earlier, is also provided. However, as this is a particularly volatile series it should be used with caution in recommendations for future pay.

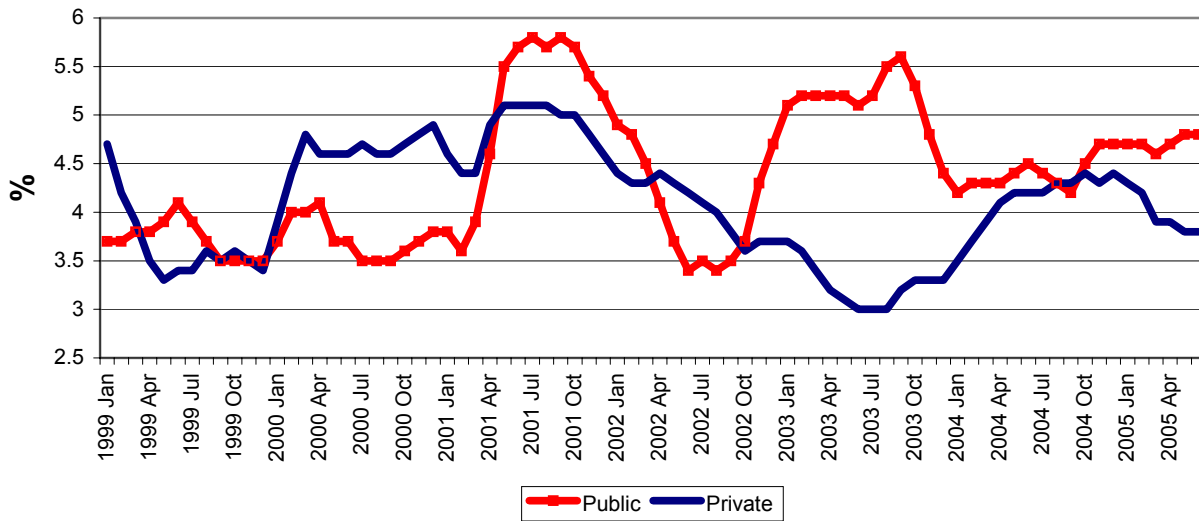
¹ Further technical details and monthly AEI updates can be found at <http://www.statistics.gov.uk/CCI/nugget.asp?ID=304&Pos=2&ColRank=2&Rank=640>

	Whole Economy		Private Sector		Public sector	
	Average Earnings Index (%) (Excl bonuses)					
	3mth average	Single month	3mth average	Single month	3mth average	Single month
July 2004	4.2	4.2	4.1	4.3	4.4	3.8
Aug 2004	4.3	4.4	4.3	4.5	4.3	4.3
Sept 2004	4.3	4.3	4.3	4.2	4.2	4.5
Oct 2004	4.4	4.5	4.4	4.4	4.5	4.9
Nov 2004	4.4	4.4	4.3	4.3	4.7	4.7
Dec 2004	4.4	4.4	4.4	4.5	4.7	4.5
Jan 2005	4.4	4.2	4.3	4.0	4.7	4.8
Feb 2005	4.3	4.1	4.2	4.0	4.6	4.7
March 2005	4.1	3.9	3.9	3.8	4.6	4.4
April 2005r	4.1	4.1	3.9	3.9	4.7	4.9
May 2005r	4.0	3.9	3.8	3.6	4.8	5.1
June 2005p	4.0	4.0	3.8	3.8	4.8	4.5
	Average Earnings Index (%) (Incl bonuses)					
	3mth average	Single month	3mth average	Single month	3mth average	Single month
July 2004	3.8	3.3	3.7	3.2	4.2	3.7
Aug 2004	3.8	4.1	3.7	4	4.2	4.5
Sept 2004	3.8	3.9	3.7	3.8	4.2	4.4
Oct 2004	4.1	4.2	4	4.1	4.6	4.8
Nov 2004	4.2	4.6	4.1	4.6	4.7	4.7
Dec 2004	4.4	4.3	4.3	4.3	4.7	4.4
Jan 2005	4.3	4.0	4.2	3.9	4.6	4.7
Feb 2005	4.7	5.7	4.7	5.9	4.6	4.6
March 2005	4.5	3.9	4.6	3.9	4.6	4.3
April 2005 r	4.6	4.3	4.6	4.1	4.6	5.0
May 2005 r	4.1	4.1	3.8	3.3	5.6	7.6
June 2005p	4.2	4.1	3.8	4.1	5.6	4.3

(p) = Provisional figures

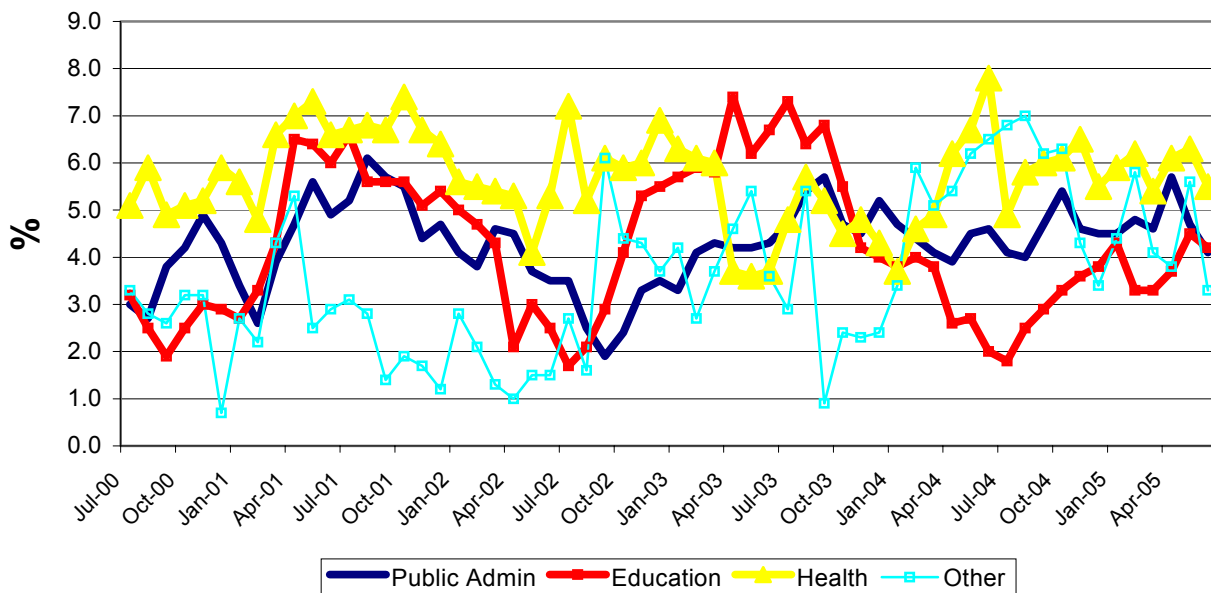
12 month increases in Whole Economy, Private and Public Sectors AEI

Public v Private Sector AEI Exc Bonuses



The graph below breaks down the overall headline AEI growth in the public sector (excluding bonuses) into the broad classification of public sector, public administration, education, health and other.

Public Sector AEI Breakdown



Over the 12 month period, the health sector has witnessed amongst the strongest growth in the AEI, with an annualised figure of 6%. Pay increases in the NHS have been in return for contract and workforce reform, which is now being driven through the NHS.

The remaining annualised figures are shown below.

Average Earnings Index (%) excl bonuses					
	Public Sector	Public Admin	Education	Health*	Other
12 month average	4.5	4.5	3.0	6.1	5.5

* The AEI 'health' category covers more than the NHS just in England. It is based on standard industrial classification category health and social work with any private sector activities stripped out

Based on the current and expected trends in productivity, the government considers that in the medium term (over the economic cycle), AEI growth for the whole economy around 4.5% to 4.75% is consistent with achievement of the Bank of England's CPI inflation target of 2%¹.

We believe that, in the medium term, public sector pay growth should be broadly in line with the sustainable level of earnings growth for the economy as a whole. However, this may not be an appropriate level for all sectors. It may be appropriate for earnings growth to be above or below these levels, depending on the evidence of recruitment and retention needs of the sector and the labour market conditions prevailing at that time.

¹ The switch from RPI to CPI as the inflation measure for monetary policy purposes does not itself materially change our view of the medium term sustainable rate of whole economy earnings growth.

ANNEX D

ADDITIONAL STAFFING INFORMATION NHS SCOTLAND

All HCHS Doctors and Dentists

HCHS Medical and Dental Staff by staff group and region

Hospital, Community and Public Health Medical and Dental Staff Headcount at 30 Sept 04	REGION				
	Scotland ⁸	East ⁴	North ⁵	West ⁶	Other ⁷
All Staff	10,608	2,469	2,703	5,355	105
Consultant ¹	3,593	859	874	1,821	52
Registrar group ²	1,666	464	492	704	8
Senior house officer	2,729	583	595	1,542	9
House officer	802	183	227	392	-
Associate specialist and Staff Grades ³	802	195	198	396	13
Other	1,079	192	331	535	23

Source: ISD Scotland

¹ Consultants includes Directors of Public Health

² Registrar group includes Senior Registrars, Registrars and Specialist Registrars

³ Associate Specialist and Staff grade group includes Senior Clinical Medical Officers and Clinical Medical Officers

⁴ East Region includes Borders, Fife and Lothian.

⁵ North Region includes Grampian, Highland, Orkney, Shetland, Tayside and Western Isles.

⁶ West Region includes Ayrshire & Arran, Argyll & Clyde, Forth Valley, Greater Glasgow, Lanarkshire and Dumfries & Galloway.

⁷ Other includes National Bodies and Special Health Boards includes State Hospital, Golden Jubilee, Scottish Ambulance Service, NHS24, NHS National Services Scotland (formerly CSA), NHS Education for Scotland, NHS Health Scotland and NHS Quality Improvement Scotland

⁸ Note sum across the regions /grade may not equal the Scotland total as some individuals work in more than one region /grade

NHSScotland Workforce Statistics
Average age of Consultants by specialty

	Average Age as at 30th September			
	2001	2002	2003	2004
All Specialties	46.5	46.7	46.9	47.2
All Medical Specialties	46.5	46.7	46.8	47.1
Hospital Medical Specialties	46.5	46.6	46.8	47.1
Accident & Emergency Medicine	43.9	43.3	43.9	44.4
Anaesthetics	44.7	45.1	45.4	45.8
Clinical Laboratory Specialties	47.3	47.9	47.8	48.3
Blood transfusion	48.1	49.1	49.8	51.1
Chemical pathology	48.4	49.0	47.9	48.2
Clinical genetics	44.9	45.5	45.7	46.3
Haematology	46.8	47.1	47.1	47.6
Histopathology	47.0	47.5	47.6	48.3
Immunology	45.5	49.5	47.6	48.6
Medical microbiology & Virology	48.4	49.0	48.9	48.8
Medical Specialties	46.9	47.0	47.2	47.5
Audiological medicine	49.0	50.0	51.0	52.0
Dermatology	47.6	48.6	48.5	48.2
General medicine (group)	47.2	47.3	47.2	47.5
Cardiology	46.1	46.7	46.3	47.1
Clinical pharmacology & therapeutics	44.3	44.7	46.5	47.5
Infectious diseases	48.1	49.1	49.1	50.1
Endocrinology & diabetes	43.1	44.3	44.4	43.8
Gastroenterology	45.5	45.3	44.8	46.1
General medicine	48.6	48.6	48.6	48.6
Renal medicine	45.0	45.9	44.8	45.3
Respiratory medicine	48.3	47.1	47.8	47.2
Rheumatology	45.5	46.2	46.0	47.6
Genito - urinary medicine	46.6	47.2	45.6	45.7
Geriatrics	45.8	46.4	46.8	47.0
Homoeopathy	43.5	44.5	45.5	46.5
Intensive Care Medicine	33.0	34.0	35.0	36.0
Medical oncology	45.2	46.0	46.8	47.0
Medical ophthalmology	37.0	-	-	-
Neurology	45.9	44.9	45.6	45.9
Paediatrics	47.5	47.0	47.4	47.8
Palliative medicine	46.4	46.1	47.6	48.6
Clinical oncology	46.6	46.9	47.7	48.3
Rehabilitation medicine	45.9	47.3	46.8	47.8
Clinical Neuro-Physiology	50.0	51.0	49.0	50.0
Obstetrics & Gynaecology	47.9	48.2	48.0	47.9
Occupational Medicine	46.9	47.4	48.9	50.0
Psychiatric Specialties	45.5	45.3	45.4	45.6
Child & adolescent psychiatry	46.1	45.6	45.0	45.5
Forensic psychiatry	44.7	45.3	44.5	45.4
General psychiatry	45.5	45.4	45.6	45.7
Psychiatry of learning disability	46.7	46.6	46.9	47.4
Old age psychiatry	43.7	43.1	44.1	44.2
Psychotherapy	48.1	48.9	48.9	48.1
Radiology	45.3	45.5	45.9	46.1
Clinical radiology	45.4	45.6	45.9	46.1
Nuclear medicine	40.7	42.2	43.8	44.8
Surgical Specialties	47.7	48.0	48.0	48.2
Cardiothoracic surgery	48.3	48.7	48.0	48.4
ENT surgery	46.7	47.6	48.1	48.8
General surgery	49.2	49.2	49.2	49.0
Neurosurgery	46.1	48.0	48.1	47.4
Ophthalmology	46.9	46.4	46.4	46.8
Trauma & Orthopaedic surgery	47.4	47.7	47.7	47.8
Paediatric surgery	47.6	48.6	48.7	50.0
Plastic surgery	46.6	46.8	45.9	46.0
Urology	46.5	46.5	47.5	48.3

Doctors in Training and Career Doctors

NHSScotland Workforce Statistics

Proportion of HCHS medical and dental staff who are female, by staff group

	Female headcount as percentage of total staff in post, at 30th September					
	1999	2000	2001	2002	2003	2004
All staff	39.2%	40.1%	40.8%	41.2%	41.6%	41.7%
Consultant ¹	22.0%	23.0%	23.9%	25.1%	26.5%	27.5%
Associate specialist & Staff grades ²	64.8%	64.5%	65.2%	64.7%	64.1%	63.3%
Registrar group ³	41.4%	41.7%	39.9%	41.6%	41.2%	43.0%
Senior house officer	46.0%	48.6%	50.1%	48.7%	48.6%	48.0%
House officer	54.5%	51.4%	53.8%	53.2%	55.9%	52.5%
Other	44.7%	45.6%	46.4%	47.0%	47.3%	48.0%

Source: ISD Scotland

1 Consultant includes Director of Public Health

2 Associate specialist & Staff grades group includes Clinical Medical Officers and Senior Clinical Medical Officers

3 Registrar group includes Specialist Registrars, Senior Registrars and Registrars

Part-time headcount as percentage of total staff in post, at 30th September

NHSScotland Workforce Statistics

Proportion of HCHS medical and dental staff who are employed part-time, by staff group

	Part-time headcount as percentage of total staff in post, at 30th Sept					
	1999	2000	2001	2002	2003	2004
All staff¹	27.6%	27.5%	26.4%	25.2%	23.3%	22.4%
Consultant ²	18.0%	17.9%	17.5%	17.3%	17.5%	17.6%
Associate specialist & Staff grades ³	42.7%	42.7%	42.1%	40.1%	41.6%	40.4%
Registrar group ⁴	16.5%	17.2%	14.5%	14.0%	13.3%	11.3%
Senior house officer	1.8%	2.2%	2.5%	2.4%	2.8%	2.5%
House officer	0.3%	0.1%	0.1%	0.0%	0.1%	0.0%
Other	83.5%	83.5%	83.4%	82.1%	81.2%	81.5%

Source: ISD Scotland

1 Maximum part-time staff are included as full time

2 Consultant includes Director of Public Health

3 Associate specialist & Staff grades group includes Clinical Medical Officers and Senior Clinical Medical Officers

4 Registrar group includes Specialist Registrars, Senior Registrars and Registrars

NHSScotland Workforce Statistics
Senior House Officers and Specialist Registrars by Increment

Headcount at 31st Sept 2004

		Senior House Officer	Specialist Registrar ¹
Incremental Point			
	Total	2,729	1,666
Unknown		85	359
	0	795	27
	1	550	28
	2	410	75
	3	316	132
	4	235	142
	5	132	210
	6	206	280
	7	-	165
	8	-	172
	9	-	76

¹ The Specialist Registrar data includes data on Registrars and Senior Registrar who have been given under the appropriate points on the Specilaist Registrar scale

Source: Earnings Related Base of Data (ERBOD)
ISD Scotland

GRANTS AND ALLOWANCES FOR SALARIED GENERAL DENTAL PRACTITIONERS

These grants and allowances have been introduced by the Scottish Executive in consultation with the Scottish Joint Negotiating Forum.

NEW AND RETURNING PRACTITIONERS

- A “Golden Hello” allowance of £10,000 over two years for salaried dentists being employed by an NHSB within three months of completion of training. If this is in a designated area* the allowance is doubled to £20,000 over two years (Determination II).
- An allowance of £5,000 over two years for dentists being employed an NHSB for the first time as a salaried dentist. If this is in a designated area* the allowance is doubled to £10,000 over two years (Part IV of Determination II).

REMOTE PRACTITIONERS

- Remote Areas Allowance – a payment of £4,500 per year payable on the date of commencement of employment as a remote salaried dentist on or after 1 April 2005 increasing to £9,000 per year after the dentist has been so employed for a continuous period of 3 years. Remote salaried dentists employed before 1 April 2005 will have their previous service taken into account when determining the level of allowance payable. This allowance shall be paid by NHSBs monthly in arrears in 12 equal instalments (Part VI of Determination II).

VOCATIONAL TRAINERS

- Trainers Allowance – An allowance of £3,500 per year payable to salaried dentists who are trainers. The amount of allowance to be paid where a salaried dentist acts as a trainer otherwise than full time shall be a pro-rata sum calculated on the basis of a whole time week of 37 hours. The allowance shall be paid by NHSBs monthly in arrears in 12 equal instalments (Part VII of Determination II).

OUT OF HOURS

- Out of Hours Allowance - An allowance payable per year where a salaried dentist provides out of hours emergency cover, to the extent required by the NHSB. The amount of the allowance is determined by the number of dentists who provide the out of hours cover. Those salaried dentists who provide out of hours emergency treatment single-handed will receive a higher allowance than those who take part in out of hours rotas.

- £4,600 as a single handed practitioner

where a salaried dentist takes part in a rota:

Band	No. of dentists in rota	Allowance
High	2 – 4	£3,600
Medium	5 – 10	£2,600
Low	> 10	£1,600

The allowance will be paid by an NHSB monthly in arrears in 12 equal instalments (Part V of Determination II)

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