Department of Health

Review Body on Doctors' and Dentists' Remuneration

Review for **2005**

Written Evidence from the Health Departments for Great Britain

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October 2004

SCOTTISH EXECUTIVE

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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EXECUTIVE SUMMARY

1. In previous years' evidence we reported on the Government's priorities for the NHS as set out in the NHS Plan and the equivalent strategies for Scotland and Wales, and on the publication of the *HR in the NHS Plan*, a five-year strategy for growing and developing the NHS workforce to meet the challenges in the NHS Plan. *Delivering the HR in the NHS Plan 2004*, our second progress report, shows how we have continued to move forward on this agenda in the last year.

2. Chapter 4 of our evidence this year reports on the action we are taking to recruit, retain and attract back doctors and dentists and shows how our strategies in these areas fit within the overarching *HR in the NHS Plan* and *The NHS Improvement Plan: Putting People at the Heart of Public Services* published in June 2004. It shows that the recruitment position has continued to improve with further increases in GP, hospital doctor and dentist numbers in 2003, with faster growth than in any previous years in respect of the latter two groups. Over the past five years total numbers of hospital, public health medicine and community medical and dental staff in Great Britain have increased by 15,920 (wte) or 21.4%. Consultants represent 36% (wte) of the medical and dental workforce in hospitals and public health and an increasingly higher proportion of patient care is now being delivered by fully trained doctors. We are recruiting increasing numbers of medical students and doctors in training. The number of UK applicants to UK medical schools is now at its highest level ever.

3. We recognise the Review Body's concern about the morale of the remit groups. Chapter 4 includes details of ongoing work to improve the working lives of doctors and dentists with the aim of making the NHS the employer of choice. It also sets out the work to reform postgraduate medical education and introduce more flexible career pathways through the *Modernising Medical Careers* initiative.

4. The Pay Review Bodies have been asked to have regard to regional/local variations in labour markets and their impact on recruitment and retention. Chapter 5 includes our evidence setting out the current available information on the distribution of medical and dental staff across England and on comparative vacancy rates for consultants. We acknowledge that there is a need to investigate these issues more closely and we have allocated staffing resource to take forward work in this area. We invite the Review Body to endorse this programme of work. We are seeking the Review Body's agreement that there should be no increase in the cash value of London weighting for the financial year 2005/06.

5. Affordable pay settlements are an essential part of delivering the agenda for improvements for patients and staff set out in the NHS Plan. We continue to believe that improvements in pay must be linked to pay modernisation and targeted action rather than excessive general pay increases.

Recommendations for 2005/06

6. Following the introduction of the new General Medical Services (GMS) contract the Review Body is not required to make recommendations on remuneration for independent contractor GMPs for 2005/06.

7. Last year the Review Body endorsed the 3.225% pay uplift for 2005/06 for consultants on the new contract to give effect to year three of the agreed 10% three-year pay deal. We propose that the value of clinical excellence awards, distinction

awards and consultants' discretionary points should be increased by 3.225% in line with this general uplift.

8. We agreed with the BDA a 10% three-year pay deal for salaried primary care dentists of which 2005/06 is the third and final year. We ask the Review Body to endorse the 3.225% pay uplift for salaried dentists.

9. For all other groups within the DDRB's remit, we are seeking pay uplifts for 2005/06 in line with anticipated inflation. The Review Body is asked to consider the low and stable inflation as measured by the Consumer Price Index (CPI) and RPIX, the Government's inflation target for the CPI of 2% and other relevant factors such as the recruitment and retention situation. The Review Body is reminded that, a pay uplift in line with inflation would equate to an above-inflation increase in earnings for doctors who are not yet at the top of their pay scale. For example, without any pay uplift, the pay of a specialist registrar increases by between 4.6% and 5.3% per annum (depending on the point they are on in the pay scale); the average incremental increase is around 4.9%. This means that, for a specialist registrar, the effect of a 2% pay uplift would be an increase in earnings of around 6.9%. Further illustrations of the impact on earnings growth of different pay recommendations will be provided at the supplementary evidence stage if the Review Body would find this useful.

10. With regard to the pay of the non-consultant career grades, we now have a clear way forward and have made significant progress through the NHS Confederation. The NHS Confederation's report is expected to be submitted to Ministers before the end of October and we will be in a position to provide further details of our position in supplementary or oral evidence.

11. Chapter 6 presents our evidence on primary care dentistry. In July 2004 the Government announced a major programme of investment to rebuild NHS dentistry and tackle workforce issues. The new arrangements are planned to be introduced from October 2005. To ensure stability in the run-up to October 2005 we are seeking an increase in gross fees in line with inflation.

12. At Chapter 7, the Review Body is asked to note that the sight test fee for 2005/06 is covered by a three-year agreement with ophthalmic medical practitioners and optometrists.

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

WRITTEN AND STATISTICAL EVIDENCE
FROM THE HEALTH DEPARTMENTS

CONTENTS

CHAPTER 1: GOVERNMENT EVIDENCE ON THE GENERAL CONTEXT

A. INTRODUCTION

1.1 The recently concluded Spending Review (SR04) has set out government targets and expenditure plans for the next three years for the whole public sector, including the sectors covered by the Pay Review Bodies (PRBs). In essence, the role of the PRBs is to make recommendations about the appropriate resource allocation to pay in the context of the government objectives and the recruitment, retention and motivation situation for their sectors taking into account the constraints of SR04.

1.2 The Budget and Spending Review 2004 (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. 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.

1.3 Departments' plans for the longer-term workforce re-engineering of their sectors are set in their pay and workforce strategies. The Department of Health's strategy for the NHS workforce, *HR in the NHS Plan,* published in July 2002, is available at www.doh.gov.uk/hrinthenhsplan. These changes to the health workforce provide important context for the DDRB to be aware of when making recommendations.

1.4 The Department of Health has been set a target to deliver efficiency savings worth £6.5 billion by 2007/08 (equivalent to 2.7% per year) as part of SR04. These savings will be made in the following areas:

- Procurement
- Adult Social Care
- Productive Time (freeing up the time of front-line staff)
- Corporate Services (eg finance, HR and IT)
- Public Policy, Funding & Regulation

1.5 Around half of these savings are expected to come from the Productive Time workstream (from the new pay contracts, service redesign and the National Programme for IT) and around 10% of the total savings will be from the procurement of adult social care.

1.6 Within tight affordability constraints, the government is maintaining close control on the civil service pay-bill and is ensuring that resources needed for service improvement are not absorbed by pay. Against this background, the government considers it important that pay rises in the rest of the public sector are also set at sustainable rates and are justified by productivity. The government is looking to PRBs to take a firm and fair approach to public sector pay, facilitating the recruitment and retention of suitable staff, increasing their motivation and supporting diversity and equal pay within the boundaries of affordability determined by the recently concluded Spending Review.

1.7 Details of the pay-bill constraints on the health sector following the SR04 spending review are given in Chapter 2. But even 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, or where significant reform is to be achieved.

1.8 Local pay arrangements can be an effective way of addressing local recruitment and retention pressures, and more information is provided on this at Chapters 4 and 5. 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.

B. ECONOMIC CONTEXT

1.9 The macro-economy is in a strong position. The UK is currently benefiting from its longest period of sustained low and stable inflation since the 1960s. Similarly, long-term interest rates are around their lowest levels since the 1960s. The ten year interest rate is currently just above 4 ½ %, the lowest average annual rate in over 40 years. Economic growth is expected to remain strong with the Budget forecasting GDP growth between 3 and 3.5% for this year and next. As regards the labour market, unemployment levels are close to their lowest levels since the 1970s. 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.

Earnings growth and pay-bill growth

1.10 It is critical to consider the earnings growth, pay-bill growth and pay bill per head impact of a pay decision as well as the actual settlement. The pay-bill growth reflects the cost to the employer and the earnings growth reflects the impact of the decision on individual's pay packets and on the labour market.

1.11 The earnings growth is a measure of how much the average earnings of existing employees who remain in the same grade increase over the year. Earnings growth is calculated using a bottom-up approach identifying all the elements of increases, including progression increases, bonuses, allowances, overtime and any other elements of take-home pay. (This is different from the headline award – this is simply the average headline increase in base pay and excludes these other elements of take-home pay).

1.12 The growth in pay-bill per head (PPH) includes the net effect on pay-bill of all these increases and also reflects the effects of changes in workforce composition.

1.13 For the civil service, the pay remits process is focusing attention on the earnings growth impact of department's pay proposals as this reflects the effect in terms of money received in people's pockets. The average earnings growth of pay remits newly agreed in 2003-04 was 3.61%. In the same way, PRBs are encouraged to focus on the earnings growth impact of their pay recommendations.

1.14 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, in the short term, 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.

1.15 Based on the business needs of civil service organisations and the labour market environment in 2003-04, levels of 3.6% earnings growth were considered appropriate. We estimate similar average earnings growth for the civil service in 2004-05. In general, we have not observed recruitment and retention difficulties across the civil service as a whole (although particular departments may have problem for specific types of occupations in specific areas). Chapter 4 gives more detail on the current recruitment and retention position.

Inflation

1.16 While close attention should be paid to the earnings growth impact of any pay recommendations, cost of living is a factor that pay review bodies may also wish to take into account. The Chancellor wrote to the Chairs of the Pay Review Bodies to inform them of the change in the inflation target for the Bank of England (2% for the CPI, changed from 2.5% for RPIX) when he made his pre-budget report in November 2003.

1.17 The new 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. The comments of Mervyn King, Governor of the Bank of England are instructive:

"… Of course, the new target will make clearer how much of an increase in money earnings represents a real rise in living standards - a pay increase of 2½% that was described as a "cost of living" rise under RPIX will now be shown by the CPI as a ½% increase in real pay, even though no individual price has changed."

However, the RPIX series will remain available and can be taken into account in pay negotiations in the private sector and elsewhere. PRBs should consider the new target along with RPIX, regional price indices and all other relevant factors, such as developments in the local market, recruitment, retention, motivation and reform, in determining their public sector pay recommendations.

1.18 The data in **Annex A** shows that CPI and RPIX inflation has been controlled at low levels over the last 12 months. Looking forward, Budget 2004 forecasts were for CPI inflation to average 1.75% in 2004-5 and thereafter to rise and remain at the target of 2% from 2005-6 to 2008-9. RPIX inflation was forecast at 3% for 2004-5 and then projected to fall to 2.75% in 2005-6 and remain at that level to 2008-9.

C. LOCAL PAY FLEXIBILITY

1.19 The Government changed the remits of the Pay Review Bodies last year to give greater prominence to this issue and to give them a clear locus to investigate the role that local pay can play in addressing specific recruitment and retention pressures. The Government is looking for further evolutionary but definite change building on current structures.

1.20 But local pay additions in certain areas are not normally a justification for higher average pay awards. Instead, PRBs should consider ways of introducing local pay by differential awards within the same overall pay-bill envelope. In general, the Government would expect higher targeted pay for areas with significant and persistent recruitment/retention issues and lower targeted pay for those areas with little or no recruitment/retention difficulties. More specific information on this agenda is contained in Chapter 5.

CHAPTER 2: THE GOVERNMENT'S PLANS FOR PUBLIC SPENDING LIMITS

SUMMARY

2.1 This chapter sets out the Departmental Expenditure Limits (DELs) for 2003/04 until 2007/08 as announced in the Chancellor's 2004 Budget Statement and the other pressures, apart from pay uplift, that there will be on these additional funds.

2.2 The key points are:

- In the 2004 spending review the Chancellor confirmed the sustained high levels of investment that were set in the five year NHS settlement announced in the 2002 Budget. This means that, for the period 2003/04 to 2007/08, expenditure on the NHS in England will increase on average by 7.2% a year over and above inflation.

- The increase in demand for NHS services and the delivery of the targets set out in the NHS Plan needs to be considered in the use of the DEL, together with pay for NHS staff. The more resources that are used to fund pay bills, the less Primary Care Trusts (PCTs) are able to take on initiatives such as National Service Frameworks (NSFs).

THE HEALTH DEPARTMENTS' AND THE GOVERNMENT'S PLANS FOR SPENDING LIMITS

(NB: The figures quoted here are for England only, see Chapters 8 and 9 for Wales and Scotland respectively)

2.3 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.

2.4 There is no money within the Department that is specifically earmarked for spend on pay. 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 nearly 80% of the total DEL (78.6% in 2004/5). Any large increases in pay will inevitably have an affect on the amount available for PCTs to spend on commissioning new services. Pay is an integral part of the total cost of any patient service and PCTs routinely need to make decisions on what services to commission based upon patient need.

2.5 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.

2.6 The areas of business PCTs would be likely to look towards in the light of increased costs would include among other things:

- Delivery of the policy commitments and targets set out in the NHS Plan and National Service Frameworks;
- The increasing demand for services supplied by GPs, dentists and opticians;
- The year-on-year rises in demand for hospital services shown by the increases in emergency admissions and attendances at A&E departments;
- The cost and demand for drugs, with drugs bill pressures up typically over 11% per year;
- 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.
- The pressures arising from the implementation of the European Working Time Directive for doctors in training;
- The resources to meet demand in terms of capital investment for new hospitals and equipment, the IT infrastructure; and training and development for the growing NHS workforce.

2.7 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	63,667	-	-	-	-
2004/05	69,369	5,702	9.0%	2.31%	6.5%
2005/06	76,384	7,015	10.1%	2.52%	7.4%
2006/07	83,818	7,434	9.7%	2.68%	6.9%
2007/08	92,143	8,325	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 30 June 2004.

2.8 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 7.2% 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 and the impact of underlying demand pressures.

2.9 With the announcement of the additional resources for the five years from 2003/04 to 2007/08, we have secured the highest sustained increase in funding in the history of the NHS. The increase in NHS resources for the next five years 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.

FAMILY HEALTH SERVICES

2.10 The constraints on affordability apply similarly to non-discretionary (ie demand-led) Family Health Services provided by independent contractors under the terms of their national contracts. Funding of the remuneration for almost all of these services is currently managed nationally, without cash limits at local level. But the more NHS resources are committed to meet contractors' pay, the less there is available for service developments or to meet the pay costs of employed NHS staff. In fact from 2004/05 most of the funding for GMS will be allocated as part of the overall PCT allocations.

CONCLUSION

2.11 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.

2.12 In conclusion:

- 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 3: DELIVERY OF SERVICES AND OUTPUT TARGETS

3.1 The Department is continuing to move the emphasis towards outputs rather than process measures. Within the last year, we have seen a review of the number of national targets set within a focused set of national priorities. This has resulted in fewer national targets and Local Delivery Plans set by Primary Care Trusts (PCTs) focussing more on the delivery of each of the priority areas and the local contribution to national targets.

Progress Reports

3.2 An analysis of progress against the Department's Public Service Agreement (PSA) targets is contained in the fourteenth annual *Departmental Report*[1] published in April 2004. Further information on progress in service improvement is set out in the May 2004 *Chief Executive's Report to the NHS*[2].

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

3.3 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.

3.4 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 next three years;
- Includes a framework for local target setting. Fewer national targets will 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.

3.5 Local Delivery Plans (LDPs) will be set by PCTs in response to the national Planning Framework by the beginning of the next financial year and will cover a three-year period. The LDPs will address each of the priority areas set out in the Planning Framework and will show quantified plans for local contributions to the national targets. These plans define the agreement between the service and the Department of Health which is the basis for monitoring local progress. Progress against the PSA targets will continue to be published through the Departmental Report and the Autumn Performance Report.

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

Links Between Pay and Output Targets

3.6 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, 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.

3.7 The link between pay and output targets is multi-faceted:

- Pay is a factor, but not the only factor, in ensuring the NHS can recruit and retain the staff it needs to deliver its output targets. Our evidence shows that, generally, recruitment is healthy and sets out the wide range of other measures we are taking to maintain and improve this still further;

- Affordability, and the other cost pressures outlined in Chapter 2, 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;

- We are committed to investing in improved pay for doctors and dentists, and other NHS staff, but have argued consistently in our evidence that improvements in pay must be linked to pay modernisation and targeted action rather than excessive general pay increases. It is through such an approach that the necessary flexibilities and incentives will be put in place to deliver the service improvements required to meet the Government's output targets.

CHAPTER 4: HCHS/GMPS RECRUITMENT, RETENTION AND MOTIVATION

A. SUMMARY

4.1 This chapter sets out the latest position on recruitment, retention and motivation for Hospital and Community Health Service (HCHS) medical and dental staff, salaried General Practitioners (GPs) employed by a primary care organisation and GP Registrars. Following the acceptance by GPs of the new GMS contract the Review Body is not required to make recommendations on independent contractor GMP remuneration for 2005/06.

4.2 Additionally it sets out the action we are taking to recruit new staff, retain current staff and attract back former staff, and shows how our strategies in these areas fit within the overarching *HR in the NHS Plan* strategy for England www.doh.gov.uk/hrinthenhsplan published in July 2002 and *The NHS Improvement Plan: Putting People at the Heart of Public Services* published in June 2004 and available at www.dh.gov.uk/publications.

4.3 It also details ongoing work to:

- reform postgraduate medical education and introduce more flexible career pathways through the *Modernising Medical Careers* initiative; and
- to improve the working lives of all staff - including medical and dental - with the aim of making the NHS the employer of choice.

4.4 It shows:

- further increases in GP, hospital doctor and dentist numbers in 2003 with faster growth than in any previous years in respect of the latter two groups
- that the number of UK applicants to UK medical schools has continued to rise and is now at its highest level ever.
- a range of measures to free up the training system and to increase consultant supply, running in parallel to a range of central recruitment, retention and return initiatives to increase the supply of GPs
- how the NHS is offering a flexible and supportive working environment for all staff, including doctors and dentists.
- evidence of more focused targeting of action on specific problem areas, and addressing health inequalities

B. RECRUITMENT

Workforce Numbers: headline figures

4.5 There were further increases in the numbers of doctors and dentists and GPMS doctors in Great Britain in 2003:

- Total numbers of hospital, public health medicine and community health service medical and dental staff increased by 4,340 (wte) or 5.3%;
- Consultant numbers increased by 1,690 (wte) or 5.8%;

- Associate specialist and staff grade numbers increased by 199 (wte) or 2.7%;
- Numbers in the registrar group (mainly specialist registrars) increased by 1,070 (wte) or 7.1%;
- Senior house officer numbers increased by 1,700 (wte) or 8.3%;
- Pre–registration house officer numbers increased by 19 (wte) or 0.4%;
- GP numbers - excluding GP retainers and GP registrars - increased by 838 (wte) or 2.6%;
- GP registrars increased by 225 (wte) or 9.8%.

Entry to the medical workforce

4.6 Medicine and dentistry continue to remain very attractive careers and to attract high quality candidates. For 2003 entry, the average UCAS tariff points for accepted applicants to medicine and dentistry were 403.5 and 373.1 compared with 406.7 and 375.3 for autumn 2002 entry respectively. This is considerably higher than the average tariff points for all subjects of 278.3 in 2003 and 275.8 in 2002.

4.7 The number of UK applicants to study medicine at UK universities has increased again over last year. There are 18.7% more UK applicants to medical schools for 2004 entry (as at 24 March 2004) than applied for entry in 2003 and 77.5% more UK applicants than applied for entry in 2000. This indicates that the number of UK applicants is rising more rapidly than the number of available places.

4.8 The female proportion of UK applicants has increased from 51.2% for 1994 entry to 59.4% for 2003 entry and of UK accepted applicants from 52.1% for 1994 entry to 61.6% for 2003 entry. The female proportion of UK applicants for 2004 entry has fallen to 57.4%, although the actual number of UK female applicants is more than 1,100 higher than last year.

4.9 The provisional UK medical school intake figure in autumn 2003 was 7,559. This is 2,497 more than in autumn 1997, an increase of 49.3% and 807 more than in autumn 2003, an increase of 12%. Over autumn 2004 and 2005, six medical schools are due to create at least 200 further new places between them.

4.10 We are keen to reinforce the upward trend in applications and to increase the diversity of applicants to medical school. The NHS Careers service goes from strength to strength (www.nhs.uk/careers - 0845 6060655). NHS Careers is often the first point of contact for those interested in healthcare careers, including medicine and dentistry. It offers an interactive service providing information and advice on all NHS careers to young and mature people and their advisers, as well as current and former NHS staff who may wish to return. It is supported by a Recruitment, Retention and Return lead in each Strategic Health Authority (SHA). Most recent results show that from 1 October 2003 to mid August 2004 NHS Careers responded to 2068 contacts interested in medical and dental careers. In addition, there were nearly 265,000 hits to the doctors' home page on NHS Careers website, over 33,000 user sessions and the average length of stay was an encouraging 4 minutes and 40 seconds. For dentistry, a dedicated recruitment campaign launched at the end of June has generated to date (15 September) 270 calls from dentists wanting to return or start a career in NHS dentistry.

4.11 We said in supplementary evidence last year that we would consider, in consultation with the Department for Education and Skills, measures necessary to safeguard the supply, retention, diversity and quality of students on health professional training courses, once the full implications of the new arrangements for tuition fees could be assessed. On 10 August 2004, the Department of Health announced that it would meet the full cost of variable tuition fees for medical and dental students in years five and six of the standard undergraduate courses, and years two, three and four of fast-track courses from their introduction in September 2006.

4.12 Aimhigher

The Department of Health is also taking action to widen the diversity of students in the healthcare professions through the Aimhigher healthcare strand. This is a joint initiative between the Department of Health, the Higher Education Funding Council for England, the Department for Education and Skills, and the Learning and Skills Council's "Aimhigher" national outreach programme to address the Government's targets to widen and increase participation in higher education. The healthcare strand will provide £9 million over five years for nine schemes around England which will look at ways of encouraging a wider range of young people to train in the healthcare professions.

Reform of Postgraduate Medical Training

Modernising Medical Careers

4.13 The NHS needs doctors in training to move through the system as smoothly as possible to deliver the medical workforce required to meet service and patient needs. As a result, the *Modernising Medical Careers* (MMC) initiative was launched in February 2003 which takes a radical look at the way we train doctors, the speed and quality with which we do it and the end product of that process. This involves examining the opportunities for streamlining medical training and increasing flexibility in medical careers.

4.14 MMC means:

- all stages of training will be delivered through structured programmes;
- two-year Foundation Programmes will replace the existing PRHO year and first year of SHO training;
- each specialty is now looking at opportunities for developing run-through, integrated training (i.e. to remove the inefficient hurdle between the current SHO and SpR grades that follow on from the Foundation Programme);
- a move to competency-based training and assessment; and
- parallel reform of the non-consultant career grades (NCCGs).

4.15 These proposals are being tested and evaluated through pilot schemes in a variety of practical settings in the NHS. The process of reform will begin with the introduction of Foundation Programmes for all new medical graduates in August 2005.

4.16 The benefits from this will be better focused, structured and streamlined training with greater opportunities for developing flexible career pathways for doctors. This will contribute to the quality of patient care delivered and will boost the drive to increase consultant numbers as well as the flexibility of the medical workforce.

Postgraduate Medical Education and Training Board (PMETB)

4.17 The PMETB was established in October 2003 and will replace the Specialist Training Authority of the Medical Royal Colleges (STA) and Joint Committee on Postgraduate Training for General Practice (JCPTGP) as the competent authority for postgraduate medical training in the UK. As a new organisation, it is in the process of establishing its structure and processes with a view to assuming its full responsibilities in 2005. Until then the STA is continuing to fulfil its current functions.

4.18 The goal of the PMETB is to reform the regulation of training. It will help open up better career pathways and facilitate international recruitment. The PMETB will become responsible for evaluating applications for entry onto the Specialist Register. Whilst the majority of applicants for inclusion on the Specialist Register have completed a UK training programme leading to the award of a Certificate of Completion of Specialist Training (CCST) there have always been alternative routes, for example for doctors who hold a specialist qualification awarded outside the UK. A change in legislation means that PMETB will now be able to consider experience, formal training and qualifications in deciding whether such applicants have reached the standard for inclusion on the Specialist Register.

4.19 Both these reforms will increase opportunities for doctors in the Non Consultant Career Grades. Further explanation of the implications is provided at **Annex C**, and is important in supporting the Department's arguments on pay reform for the NCCGs.

Increasing Numbers: The Recruitment and Retention Context

2004 Vacancy Survey – national position

4.20 The 2004 NHS staff vacancy survey for England shows that the three-month vacancy rate for consultants was 4.4% in March 2004, compared with 4.7% in March 2003. The vacancy rates for each SHA and for the main specialty groups are given in Table 19 and our evidence on the regional and local dimensions is at Chapter 5.

4.21 It is important that our measure of vacancies reflects posts where there is a genuine intention to recruit, rather than a notional view of establishment. The intention of the vacancy survey is to identify areas where there are current recruitment pressures. It would not be possible to define a rigorous statistical survey to capture details of notional establishment counts which change as services are reconfigured to meet demand.

4.22 The HCHS vacancy survey captures details of vacancies that have been unfilled for three months or more. A survey that did not have this condition would show large increases in vacancies when, for example, we were recruiting large numbers of additional staff, even if there was no difficulty filling the posts. It is not possible to expand the workforce without advertising vacancies. The three month condition gives a useful working measure of posts that are notionally 'hard to fill'.

The Impact of Part-time Working

4.23 The effects of part-time working are taken into account in the Department's workforce models. In general, this is done by assessing the current ratio of WTE to headcount and using analysis of historical data and judgement about future trends to determine how this ratio will change over time. (For example, within a particular specialty we might find that each headcount currently provides 0.8 WTE, and we might assume that this will change gradually over time until each headcount provides only 0.7 WTE).

4.24 Our current short-term workforce projections for consultants and junior doctors assume that we hold the 2002 ratio for the next six years. This assumption is based on evidence that the ratio has been stable in recent years. As the table below shows, for consultants this assumption has held firm in the 21 months between September 2002 and June 2004 and there is no evidence of a substantial shift. Across the whole of the HCHS sector in England, the ratio was unchanged between September 2002 and September 2003 at 0.89. (Quarterly figures cover consultants only).

WTE to headcount ratio for Consultants in England

YEAR	Headcount	WTE	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
Mar-03	28,024	25,675	0.92
Jun-03	28,345	25,971	0.92
Sep-03	28,750	26,341	0.92
Dec-03	29,217	26,671	0.91
Mar-04	30,176	27,564	0.91
Jun-04	30,171	27,640	0.92

Source: Department of Health Medical and Dental Workforce Census

4.25 More generally, the Department's 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.

4.26 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. The development of Flexible Career Schemes is an example of a tailored response to this trend aimed at encouraging access to and demonstrating the potential of more flexible working arrangements as a means of recruiting and retaining people who chose not to work full-time.

Local variations in recruitment and retention

4.27 The Department's main source of data on recruitment variations is the annual NHS vacancy survey. As well as collecting data on a range of non-medical categories this survey also provides results for consultants and for other non-training grade doctors. The survey counts the number of vacancies that NHS employers are actively trying to fill, and which have been vacant for three months or more.

4.28 This count provides the most appropriate measure of vacancies. The intention of the condition that employers are actively trying to fill posts is to ensure that the survey focuses only on posts that are part of the active establishment of the organisation. It excludes posts where alternative means of providing the service have been found or where the funding for a notional establishment post does not exist. The three-month condition ensures that results are not masked by routine filling of posts where there is no recruitment difficulty.

4.29 Variations do occur, and our strategy to improve the working lives of all NHS staff is designed to address these issues, alongside the ongoing increases in workforce numbers.

4.30 As a general rule, initiatives have a national focus but can be used flexibly to target local issues. An example is expert work in progress to address the problems of a cohort of 30 PCTs in difficult to recruit areas. This is being delivered via some one-to-one input to help them find tailored solutions, make the best use of schemes available and learn from good practice elsewhere.

4.31 One example aimed specifically at GPs is the ongoing Golden Hello Scheme. Work is in hand with the Employers' Organisation and the GPC to follow through the intention flagged in the new GMS contract to review the Golden Hello Scheme and make changes with effect from 1 April 2005. The scheme's universal application in England will end from that date to be replaced with more local discretion to tailor it to local circumstances to improve primary care, taking account of the needs of PCTs experiencing the greatest difficulties.

4.32 This shift from a universal to a more targeted approach reflects the reality of local variation and the need to be able to respond flexibly in way which makes the most effective use of resources.

Staff Survey

4.33 The Healthcare Commission's national NHS Staff Survey 2003 - believed to be the largest workforce survey in the world - sought to identify which factors had the greatest impact on staff attitudes and their intention to leave an organisation. The survey had many positive findings, including that staff feel they have support to achieve a good balance between their work and private lives. Furthermore, a high proportion of staff have received training and development.

4.34 In relation to doctors, the survey highlighted room for improvement in terms of support from supervisors. We believe this is being addressed through the NHS Leadership Centre. By April 2005, over 1,000 senior doctors (largely medical and clinical directors, PCT Professional Executive Committee Chairs and Directors of Public Health) will have accessed one or more of over 15 different leadership programmes offered by the NHS Leadership Centre. From April 2004, senior medical leaders in trusts, PCTs and SHAs have had full access to a comprehensive range of leadership development opportunities which form the NHS Leadership Centre Directors Portfolio.

4.35 There are no plans to introduce a programme of systematic exit interviews. This is because mechanisms already exist to gauge staff opinion about working in the NHS, including national staff surveys and the IWL assessment process. The staff survey covers issues of overall staff satisfaction with their job. The results from 2003 show that staff satisfaction in the NHS is higher than in other sectors. When we receive the results from the 2004 survey we will be in a better position to gauge if this is changing

over time. The 2004 survey will go further by asking staff that expect to leave the NHS in 2004 to provide their reasons for leaving.

4.36 There is no reason why exit interviews should not be used locally and there is some anecdotal evidence of this occurring.

Pre-Registration House Officers (PRHOs)

4.37 As a result of increases in medical school intakes, there will be 203 extra funded PRHO posts in 2004-05. A Foundation Years Steering Group is currently considering the appropriate number of PRHO/F1 and F2 posts that need to be created in the future and how they will be distributed around England.

Senior House Officers (SHOs)

4.38 The Department has acknowledged that the number of doctors taking the Professional and Linguistic Assessment Board (PLAB) Test exceeds the number of SHO vacancies and steps are being taken to address this issue. Entry into SHO posts is extremely competitive. There is a great deal of information available to doctors on obtaining their first post in the NHS and the information available does highlight the issue of competition and recommends that thorough research is undertaken before applying. The Department is developing a web-based source of information for doctors to refer to before deciding whether to come to the UK, whilst also considering the impact on international doctors of the implementation of *Modernising Medical Careers*.

4.39 At present doctors who have gained PLAB can only gain limited registration. The Department is working closely with the GMC to introduce legislation which will abolish limited registration. Subject to consultation and Parliamentary approval, we will abolish limited registration by the end of 2005. In future doctors will gain full registration once their PLAB test has been successfully completed.

Specialist Registrars (SpRs)

4.40 As *Modernising Medical Careers* is implemented, SpR numbers will be increasingly driven by inputs into the training system, as outlined above. The additional SpR opportunities that have been made available support this move. The latest census data show that by September 2003 we had already exceeded the NHS Plan target in England of 1,000 more SpRs by March 2004 over the October 1999 baseline, increasing SpR numbers by 1,939 since September 1999.

4.41 Central funding has been made available for 119 additional SpR posts in 2004/05 and a further 40 posts in 2005/06. The main specialties to benefit from these allocations will be clinical radiology, histopathology and chemical pathology.

4.42 NHS Trusts have also been given the opportunity to locally fund additional posts and since 2003/04, around 470 posts have been implemented through these means with a further 850 in the pipeline.

4.43 In 2004/05, SHAs have been given freedom to agree as many additional SpR training opportunities as are necessary to achieve Working Time Directive (WTD) compliance, subject to obtaining educational approval and local funding. To date, NHS Trusts have expressed an interest in taking up 1,258 specialist registrar posts. The Workforce Review Team is planning to conduct a survey in October 2004 to find out how many of these posts have been implemented.

~~4.44~~ Information on length of time in grade at SHO and SpR levels is at **Annex E**. The measures outlined above to increase SpR posts will allow more doctors to progress to higher specialist training, as will the introduction of *Modernising Medical Careers*.

GPs and GP Registrars

4.45 In England, there has been an increase of 857 GPs (excluding GP retainers and GP registrars and locums) between September 2003 and June 2004; this can be compared to an increase of 1156 during the 12 months to September 2003.

4.46 The NHS Plan target in England of 2,000 extra GPs (excluding registrars, retainers and locums) by March 2004 over the October 1999 baseline has now been exceeded by 748 GPs.

4.47 Numbers of GP Registrars in England have risen steadily in recent years and are now 1,068 (80%) more than in 1997, at 2,411 in June 2004. This is the most ever recorded, and the Department expects further growth this year and beyond. The NHS Plan target in England of 550 more GP Registrars by March 2004 over the October 1999 baseline has now been exceeded by 341 GPRs.

4.48 Holding on to these gains is critical and the Department has a number of initiatives in place aimed at their maintenance, including the Flexible Career and Golden Hello Schemes flagged below.

4.49 The recent BMA Cohort study found that "there has been an increase in the number of doctors planning to enter general practice, with a contrasting decline in the proportion of the cohort planning to enter hospital specialties such as general medicine and surgery. An important factor underlying this shift is the perceived greater flexibility of general practice".
Although there is evidence of this in the figures collected for the Department showing take up of the Flexible Careers Scheme by GPs, we believe there is a shift in culture and the scheme is equally attractive to doctors in the hospital settings.

Non-Consultant Career Grades

4.50 Non-consultant career grade numbers have risen an average of 9.8% a year since 1997 and increased by 2.7% between 2002 and 2003. There is no evidence of any general recruitment and retention problems in these grades.

4.51 The implementation of *Modernising Medical Careers* will offer these doctors more opportunities to undertake further training and progress their careers. The Government has accepted in full the recommendations of the 2003 consultation paper *Choice and opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors* . Implementation is linked with the proposed reform of pay for these doctors – on which further information is set out in Chapter 5.

Consultants

4.52 Whilst it is disappointing that the formal NHS Plan target in England to recruit 7,500 more consultants over the October 1999 baseline has not yet been met, there are offsetting issues to consider. These include the trend for roles historically carried out in the acute sector to be undertaken by staff such as nurse or therapy consultants and also to shift such work to primary care where it is carried out by GPs with a special interest. The <u>total</u> targets for consultants and GPs add up to 9,500 and the NHS has delivered aggregate growth of 9,598 by June 2004.

4.53 There will however be no let up in the drive to increase consultant numbers and bring new consultants into the workforce as quickly as possible. We expect that the NHS will deliver the target of 10,000 extra doctors (consultants and GPs) in England by 2005.

4.54 With the increasing feminisation of the medical workforce – up from 31.2% in 1993 to 37.1% in 2003, and with female UK medical school intake up from 51% in 1993 to over 60.5% in 2003, access to childcare provision is fundamental to retention. The Government has committed a further £100m for 2004/05 to extend the NHS Childcare Strategy to ensure that the childcare needs of all staff are met and special consideration for the needs of doctors are built into local childcare strategies. This includes recognising the need for emergency places and to provide solutions for the problems caused by doctors working across organisations and on rotation.

4.55 New interim data interim results from a survey expected to be published later this year from the Medical Careers Research Group (MCRG) suggest that the number of consultants intending to retire early may be reducing, although there is no evidence yet of this being reflected in actual retirements. On balance, and reflecting the available analytical evidence, our view is that there are no large shifts in retirement patterns and the number of retirements are consistently moderate, manageable and within planning parameters.

4.56 In last year's evidence, we reported on early stages of developing support measures for doctors making the transition into their first consultant post. This was a follow-up to findings of a survey of doctors on the Specialist Register who were not in consultant posts. The measures, for example the **'Becoming a Consultant Pack'**, provide practical advice and information in helping to make the transition from SpR and non consultant career grade to early days as a positive experience. The resource material includes advice on preparing CVs, interview skills, and how to prepare a successful business case for additional resources.

4.57 Early this year, we introduced a new scheme for doctors looking for their first consultant appointment. Aimed at SpRs with their Certificate of Completion of Specialist Training and non-consultant career grades on the Specialist Register, the **New Consultant Entry Scheme** provides a six month placement in a consultant post. The doctors on the scheme are given structured Personal Development Plan, support from a mentor/coach and up to two programmed activities a week for continuing professional development. At the end of the six month placement, the doctor is better equipped to compete for a substantive consultant position.

Dental public health staff

4.58 Dental public health staff represent an increasingly important resource for PCTs and SHAs as they prepare for the introduction of local commissioning of the totality of dentistry in 2005, and for the opportunity to shape a more preventatively-oriented dental service. They will also be an important factor in enabling PCTs to deliver their dental public health responsibilities flowing from the 2003 Health and Social Care Act, which we will be setting out in Regulations.

4.59 We have concerns about the adequacy of the current size of that workforce for the task in hand. Through the normal workforce planning processes we have already increased the number of training places available in the specialty in England. The Chief Dental Officer has commissioned a review of dental public health capacity and capability in the NHS in the light of these new roles and responsibilities. We will be considering the

outcome of this review in early 2005 and will draw any relevant matters to the attention of the Review Body in the next round.

4.60 Meanwhile, we consider it appropriate to maintain the principle of exact parity for dental public health staff with their public health medicine and hospital medical and dental staff colleagues and ask the DDRB to recommend the same uplifts for dental public health staff as for other consultants and training grades.

Flexible Careers Scheme

4.61 The Flexible Careers Scheme (FCS) for hospital doctors and GPs enables flexible working; supported return to the NHS after a career break and offers flexible retirement options. It is a key part of our recruitment and retention strategy and also feeds the Improving Working Lives standard that promotes work life balance. A breakdown by strategic health authority, specialty and grade suggests that the scheme is well embedded across all trusts. By the end of 2003, the number of doctors and GPs on the scheme had exceeded the April 2004 target of 1,000 doctors. By end August 2004 the number of doctors accessing the FCS had grown significantly, with 259 doctors having been through it, 1426 currently on the scheme and a further 839 preparing to join over the next few months.

4.62 Significant numbers of FCS doctors are in the shortage specialties. There are, for example, 37 FCS doctors in anaesthetics including 14 consultants, 45 in general psychiatry (13 of whom are consultants), 50 in paediatrics of whom 17 are consultants and 14 in radiology (12 as consultants).

Flexible Retirement

4.63 There is now more scope for doctors to draw back from full-time work without giving up their skills and experience altogether. In conjunction with NHS Pensions, flexible retirement options for doctors were first publicised during 2003. The Flexible Retirement Campaign has helped 55 hospital doctors and 64 GPs to take the option of a **flexible retirement.** Within the Department's guidance on flexible retirement options, we have set up a **dedicated Flexible Retirement Helpline** to help doctors make the right choice about their working lives.

4.64 Now all GP pension enquirers are given information about flexible retirement options that are available. From April 2004 the GP Delayed Retirement Scheme was subsumed into the new improved seniority arrangements for GPs which were negotiated as part of the new GMS contract.

4.65 In addition to the specific schemes detailed above there is also action in hand to recruit internationally as well as wider initiatives to promote a healthy work/life balance and maintain a healthy workforce. The use of E- recruitment is increasing to provide an efficient and more cost effective means of advertising NHS employment opportunities, and NHS Professionals runs a range of bespoke schemes to aid the supply of temporary medical staff.

International recruitment

4.66 The Department's international recruitment campaigns are aimed specifically at consultants and GPs. So far 284 consultants and 203 GPs have been supported to take up posts in the NHS.

4.67 The Department is currently piloting a new approach to consultant international recruitment which aims to offer additional support to trusts who choose to recruit from abroad. The pilot will be completed by the end of November 2004 and will be offered across England following a full evaluation. This is the first step towards ensuring that international recruitment is an integral part of the NHS recruitment strategy and that activity is mainstreamed through the **electronic recruitment service**.

4.68 The Department is also supporting a project to recruit international doctors to Fixed Term Training Appointments which will assist trusts with European Working Time Directive compliance. The project is targeting doctors from EEA countries who wish to receive further experience in their chosen specialty.

The E-recruitment service

4.69 The E-recruitment service is designed to support NHS employers in recruiting the workforce required to meet NHS Plan targets and modernise services to patients. It will widen access to NHS employment and provide a more efficient, cost effective means of advertising jobs. It will enable NHS employers to re-allocate much of their current advertising spend to the provision of direct patient care and enable HR Departments to modernise and improve recruitment practice, providing services which meet expectations of the NHS as a modern employer of choice. It will provide real time workforce information locally and nationally. The service was launched on 1 December 2003. By 31 August 2004, 220 NHS employers were using the service, with a further 230 committed to join by 31st March 2005.

Healthy Work/life Balance

4.70 A number of research findings suggest that recruitment, morale and motivation of doctors is now less influenced by levels of remuneration and more by a feeling of being valued, flexible working arrangements and a healthy balance between work and home life. All of which is embraced within the **Improving Working Lives** programme.

4.71 All organisations have been assessed against the Improving Working Lives Standard for Practice Status, signalling their delivery of modern Human Resources practices for staff working in the NHS. Almost all NHS Trusts have achieved practice level of IWL implementation and are currently working towards the final level, Practice Plus which requires them to demonstrate that they are delivering modern HR practices to all staff groups, including doctors.

4.72 The Department of Health has appointed a **national Improving Working Lives Champion** for Doctors to work closely with Royal Colleges and NHS Trusts to foster the IWL ethos within the medical profession. This initiative is mirrored in some organisations by 'appointments' of **Trust IWL Champions**. These Champions are in addition to existing IWL Leads within workforce development confederations/strategic health authorities driving the basic **IWL principles which include a specific category in respect of doctors.**

4.73 Evidence is emerging to demonstrate the positive impact of champions on NHS organisations as they work towards IWL Practice Plus.

NHS Professionals – temporary staffing

4.74 NHS Professionals was established as a Special Health Authority in April 2004 to provide a national service to manage the supply of temporary staff for the NHS in England. In relation to temporary medical staff it provides a register of locum activity

and support with appraisal and revalidation. In addition, the SHA manages a number of bespoke schemes including the Managed Placements for Overseas Consultants, the New Consultant Entry Scheme for doctors wanting to sample working in consultant posts for six months. Other support services for doctors include international doctors' induction and an on-line induction tool.

Healthy Workforce

4.75 Maintaining a healthy medical workforce is vital to delivering the best results for patients, and maintaining workforce numbers. We do not have figures specifically for doctors in relation to sickness absence or accidents because Trusts do not generally collect data by staff type. New initiatives to protect the health and welfare of all staff are seeing early results in relation to both short and long term sick absence. A comparison of figures for sickness absence over the last four years shows that the statistics for the NHS have remained relatively steady at 4.7% in 2003.

4.76 With specific regard to doctors, the Department currently has a small task force under the chairmanship of Louis Appleby, National Director of Mental Health, looking at mental health of doctors and is due to report at the end of the year.

4.77 The Department is underpinning good occupational health practice through the continued expansion of *Occupational Health Smart Cards* for hospital doctors and dentists. As well as carrying clinical information to provide health clearance for dealing safely with patients the cards contain the doctor's personal and contractual data and act as a quality assurance tool for Trusts. By August 2004 there were software installations across 221 NHS Trusts, with over 2,200 staff trained as system operators. The central database now contains records for more than 35,000 doctors. Doctors in training posts, locum placements or some mobile career grade posts across the NHS in England participate by taking their cards with them as they move from one NHS Trust to another. This prevents time-consuming and wasteful duplication of effort, especially at induction, and allows the doctors themselves to benefit from the portability of the personal and health data carried on the card.

Productivity

4.78 We are developing some analysis to compare productivity of consultant activity at Trust and Specialty level. This relates the number of consultants to weighted activity output. Initial data shows up to a four fold variation in output levels. A number of factors are likely to contribute including the nature/complexity of activity but it is likely that working practices and delivery processes are also a factor. The data is being shared with Trusts for them to benchmark performance with peer organisations and identify where genuine productivity improvements are possible through local redesign.

D. WORKING TIME DIRECTIVE

4.79 The Government takes the Working Time Directive (WTD) very seriously. By making sure that no NHS employees work excessive hours, we will not only improve their working lives but also ensure that no patients are treated by tired staff.

4.80 The Department of Health has provided the NHS with the tools and support for local implementation, including details of best practice from the WTD pilot sites. For example, a compendium of solutions to implementing the WTD was produced by the Department of Health and endorsed by the BMA, the Academy of Medical Royal Colleges and the NHS Confederation. The document provides advice and assistance for organisations that are finding WTD compliance difficult.

4.81 The vast majority of NHS Trusts achieved compliance across all specialties by August but implementation of the WTD has resulted in a handful of Trusts experiencing teething problems in a small number of specialties. The Modernisation Agency WTD team continues to offer help to parts of the NHS which face difficulties through expert advice and sharing of good practice solutions. These difficulties are largely the result of the SiMAP and Jaeger European Court of Justice (ECJ) judgements.

4.82 These judgements have made this significantly more challenging for parts of the NHS by ruling that all the time spent resident on call is working time, and by changing the rest entitlements. The European Commission published proposals on 22 September 2004 to address the difficulties from the SiMAP and Jaeger cases. However, any changes to the WTD will not come into force before early 2006.

4.83 All NHS Trusts have locally agreed WTD action plans to ensure maximum compliance. The Department of Health, Modernisation Agency, BMA and the Academy of Medical Royal Colleges are continuing to work together to support the NHS.

Impact on junior doctors' morale

4.84 There are numerous types of working patterns that can be adopted in achieving WTD compliance, some concerning innovative ways of providing services involving a wide range of staff. If a working pattern is to be sustainable in the long term then it has to take account of the impact it has on staff. As outlined in 'Guidance on working patterns for junior doctors' (jointly signed by the BMA, DH and NHS Confederation and the National Assembly of Wales) the emphasis is on creating *good* working patterns. A working pattern is considered such if it "delivers training, meets service needs and WTD hours and rest requirements whilst allowing junior doctors a satisfactory quality of life".

4.85 Lessons learnt from the current set of WTD pilots show that there are some positive impacts on doctors in training from achieving compliance. These include the reduction in working hours, maintenance of training standards and the appropriate use of their skills. For example, the 'Hospital at Night' pilots have been shown to offer the best way of not just providing the best quality of care to patients but, also preserving, and even enhancing, doctors' training in the reduced hours available. Lessons from the pilot sites are being disseminated across the NHS through regular publications of the WTD magazine 'Calling Time…' and through web based tools and materials.

4.86 Although some pilot sites have already done so, most anticipate carrying out either formal or informal surveys/questionnaires to determine the views of doctors in training in respect of the new working patterns.

4.87 A substantial interim evaluation report on the WTD pilots is due from Manchester University in October 2004 which will include an executive summary to be publicly available. This document will also consider the impact of changes to working patterns on junior doctors.

4.88 Improving the working lives of doctors is also underpinned by the Improving Working Lives Standard which summarises the commitment the Department expects from NHS employers to create well-managed, flexible working environments that support staff, promote their welfare and development, and respect their need to manage a healthy and productive balance between work and life outside work. WTD solutions locally are taken forward within this wider context.

Implementation for consultants

4.89 Compliance with the WTD for doctors in training and senior doctors is the responsibility of NHS employers, as with other aspects of employment law.

4.90 Employers and consultants should work together locally to assess working hours to ensure that they are compliant with the regulations. It should be remembered that career grade doctors could choose to agree to work more than 48 hours a week over a 26 week reference period. We hope that more effective job planning under the new consultant contract, based on a partnership approach, will enable consultants and employers to better prioritise work and reduce any excessive consultant workload and therefore long hours.

E. CONCLUSION

4.91 The recruitment position has continued to improve over the past year. The medical workforce has grown by 9,542 WTE (10.3%) between September 2001 and 2003 with further increases planned. It is clear that the recruitment, retention and return policies are working. But, as we reported last year, there is no room for complacency. We will continue to deliver a wide range of HR policies to help secure more doctors, working differently.

CHAPTER 5: HCHS AND GMS PAY AND CONDITIONS OF SERVICE

A. SUMMARY

5.1 This chapter sets out our evidence on pay and conditions of service for Hospital Doctors and Dentists, salaried General Medical Practitioners (GMPs) employed by a primary care organisation and GMP Registrars. It also includes an update on progress on the new GMS contract although the Review Body is not required to make recommendations on independent contractor GMP remuneration for 2005/06.

B. REGIONAL AND LOCAL DIMENSIONS

5.2 The Review Body has been asked to have regard to regional and local labour markets and their effects on recruitment and retention. Chapter 1 sets out the Government's overall approach to improving the local and regional responsiveness of public sector pay systems.

5.3 Historically the only nationally agreed provision for regional variation in doctors' and dentists' pay has been the system of London Weighting that is paid to all HCHS doctors and dentists, GMP Registrars and salaried GMPs. The principal allowance in the London Zone for 2004/05 is £2,098 for non-resident staff and £584 for resident staff (although some residual rates remain in terms and conditions).

5.4 The new consultant contract includes provision for NHS employing organisations to pay a recruitment and retention premium of up to 30% of starting salary. This can be paid either as a single sum or on a recurrent basis for a period typically not exceeding four years. Under the old consultant contract there was provision for employers to re-advertise hard to fill posts at the top of the consultant scale.

Assessing the case for greater local differentiation in pay

5.5 Statistical Tables 18 and 19 update the information provided last year on the distribution of medical and dental consultants (i.e. variations in the number of consultants per 10,000 population by SHA area, with population adjusted for age, need and cross-boundary flows) and on the geographical and specialty variations in medical and dental vacancies.

5.6 Table 19 shows the March 2004 mean three-month vacancy rate for medical and dental consultants was 4.4%. This compares with last year's figure of 4.7%. Although two of the five London SHAs had three-month vacancy rates above the mean (South East London (5.6%) and North East London (4.8%)), the lowest three-month vacancy rates in England were also in London SHAs (South West London (1.2%) and North Central London (1.4%). As last year, the evidence suggests comparatively greater problems of recruitment and retention in of parts of the north and midlands, namely County Durham and Tees Valley (8.5%), Greater Manchester (6.8%), West Yorkshire and West Midlands South (5.8%), Cheshire and Merseyside (5.5%). The differences in vacancy rates generally become more pronounced for particular specialties such as psychiatry, radiology and accident and emergency medicine. In addition, there is likely to be substantial variation in vacancies between Trusts within each SHA.

5.7 The areas with the highest vacancies also have in most cases lower than average numbers of staff per 10,000 population (Table 18). The main exception to this is South East London, which has the second highest number of staff per head of population in England (8.5 per 10,000).

5.8 There are a number of possible factors that are likely to explain these variations, including the location of medical schools, opportunities for teaching and research, opportunities for additional work outside the NHS (e.g. in private practice) and consultants' preferences about where they wish to live. In the medium term, as consultant supply expands and with the creation of new medical schools, we would expect to see a reduction in the degree of variation between localities.

5.9 There is already an opportunity to use the recruitment and retention premium of up to 30% of starting pay for consultants employed on the new 2003 consultant contract as a means of varying levels of pay within local areas. There is nonetheless a clear need to investigate more closely the reasons for current variations and to assess whether greater differentiation in pay would contribute in a cost-efficient way to reducing comparative recruitment and retention pressures.

5.10 The Department of Health recognises the importance of regional and local dimensions of pay for this group of staff. We have identified specific staff resources to take forward work in this area. A project has been established to enable a detailed assessment to be made of the likely effectiveness and cost-effectiveness of greater pay differentiation in addressing comparative recruitment and retention difficulties.

5.11 Within the project, work is progressing to identify evidence and develop proposals to meet the following issues:

- Reasons for variations in staffing and vacancy levels between different localities, including analysis by speciality;
- Extent to which NHS employers are using pay/non pay measures to address recruitment and retention problems;
- Effectiveness of such measures and their impact on distribution of consultants.

5.12 We are exploring the economic factors that may be affected by local variations. This includes drawing on experiences from the private sector as well as any learning from other public sector areas. Once we have collected this information, the intention is to determine an appropriate response commensurate with the needs of the NHS. The expectation is that recommendations on the likely effectiveness of greater local pay differentiation and the ways in which this could be implemented will be available for consideration by DDRB next year.

5.13 We invite the Review Body to endorse this programme of work.

London Weighting

5.14 As at September 2003, there was an England average of 5.8 consultants per 10,000 population compared to 5.5 consultants for the same population group in the previous year. Table 18 shows that in four of the five London SHAs consultant numbers are above the mean and are the four highest in England. Table 19 shows that three of the five London SHAs have three-month vacancy rates below the mean, South West London and North Central London SHAs having the lowest three-month vacancy rates in England. The current evidence strongly suggests that NHS Trusts in London find it easier to attract doctors than most other parts of the country and we can see no case for an increase in London weighting. As part of the NHS Pay Reward Strategy project, we will investigate factors affecting recruitment of consultants in London. At this stage our view is that there should be no change to the current arrangements for London

weighting and we are seeking the Review Body's agreement that for the financial year 2005/06, it should remain at its existing value in cash terms.

5.15 In last year's evidence to the Review Body, the BMA drew attention to the market forces factor (MFF) element of the resource allocation formula and suggested that the MFF could be regarded as a proxy for the excess costs met by London doctors. The purpose of the MFF is to equalise the commissioning power of PCTs by adjusting for unavoidable variations in NHS Trust costs directly related to location. It seeks to capture a range of extra costs associated with commissioning NHS services in different locations. It is certainly not intended to read across directly to levels of pay. Pay levels in London or elsewhere should take into account, not living costs per se, but the ability to attract doctors and dentists to work in those areas. The data shows that, regardless of cost inequalities, other areas of Great Britain are less well doctored than London and the south east. Further information on the MFF is at **Annex F**.

5.16 The Review Body's last report asked why some of the remit groups do not receive London weighting. The new GMS contract remunerates GPs through a practice-based contract, instead of an individual practitioner contract. Resources are calculated against an allocation formula, used to calculate practice entitlement, taking into account six key determinants of practice workload and circumstances. One of these is unavoidable higher costs of living through a Market Forces Factor applied to all practice staff. This will compensate for those additional costs involved in delivering services in areas such as the south-east of England (obviously including London). Therefore the practice will receive within its Global Contract Sum an element for employing practice staff which already includes an element for high cost areas.

5.17 To ensure a smooth transition to local commissioning, the Department of Health is developing a new General Dental Services (GDS) contract for all general dental practitioners to use from October 2005 if they had not already agreed alternative local arrangements under Personal Dental Services (PDS). The base contract value will represent the dentists' most recent gross earnings including the expenses element. During the three year transitional period, the DH would expect PCTs to agree with their dentists any adjustment to reflect local factors such as any higher costs in the South East. The introduction of London weighting at this time would seriously disrupt and distort that process without benefitting either dentists or patients.

C. HOSPITAL CAREER GRADES

CONSULTANTS

5.18 The Review Body has already endorsed the 3.225% pay uplift for 2005/06 for consultants on the new contract to give effect to year three of the agreed 10% three-year pay deal.

5.19 The new consultant contract was accepted in a BMA ballot in October 2003 - in England, 61% of consultants and 55% of SpRs supported the contract.

5.20 Since the ballot NHS employing organisations and consultants have been working together on a partnership basis to deliver the intended benefits of the new contract for NHS patient services and for consultants' working lives. This has involved a huge amount of work for both NHS employing organisations and consultants alike. Throughout the process SHAs and the NHS Modernisation Agency have been working closely with NHS Trusts to help ensure that there is clear information locally about the new contract.

5.21 All existing consultants were given the opportunity to indicate by 31 October 2003 whether they wished to give a commitment to the new contract. Where a consultant gave a formal commitment to the new contract by 31 October 2003, pay increases under the new contract were backdated to 1 April 2003. Where a consultant gave a formal commitment to the new contract between 1 November 2003 and 31 March 2004, pay increases were backdated by three months from the date on which the commitment was given. In each case, backdating was conditional upon a job plan being agreed within three months, except where this deadline was not met for reasons beyond the consultant's control. For existing consultants, the timetable assumed that, once a commitment had been given, Trusts and consultants should seek to agree new job plans typically within three months. The timetable recognised that in some cases Trusts might need longer than this to complete the process for all their consultants and, in practice, this timetable has been considerably extended.

5.22 Around 85% of consultants gave a formal commitment to the new contract by 31 October 2003. The latest information we have shows that by 27 August 2004, 95% of consultants, who gave a formal commitment to the contract by 31 October 2003, had received final job plan offers, including 68% who have signed-up to the contract and 5% who have rejected it. It is, of course, too early to assess how the new contract is operating in practice but we plan to issue a formal survey instrument to employing organisations to provide detailed information on job plans and to provide baseline information to facilitate a longer-term study of the impact of the contract. The results will be shared with the Review Body when available.

5.23 One of the key aims of the new consultant contract was to help address the desire for flexible working patterns. For example, the job planning process provides a stronger, unambiguous framework of contractual obligations for consultants. There is also greater opportunity for phased careers to recognise the changing focus of the consultant role over an individual's working life.

5.24 The new contract was intended to help better prioritise NHS work and better manage consultant workload, via the job planning process. Early evidence of the effect on consultant workload will be obtained from the survey of employing organisations. We would expect the contract to have a positive impact on the retention of consultants, although information on this will not filter through in the short-term.

5.25 Information on the total number of consultants on the new contract and the numbers remaining on the old contract will be available from the survey of employing organisations. This will show information by geographical spread and specialty profile.

5.26 As we reported last year, the new consultant contract is a 'something for something' deal and we worked hard with the BMA to pitch the benefits for consultants – compared with the current contract – at a level that can be justified by the benefits for patient care. For consultants remaining on the old contract, we can see no justification for a pay uplift of more than the anticipated rate of inflation.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

5.27 The clinical excellence award scheme was launched last year with the first awards payable for the 2004/05 financial year. The new scheme replaced the previous consultant reward schemes – distinction awards and discretionary points. However, distinction awards and discretionary points will remain in payment until award holders retire or are awarded a clinical excellence award. For 2005/06, we propose that the

value of clinical excellence awards, distinction awards and discretionary points should be uplifted by 3.225% in line with the pay uplift for consultants on the new contract.

NON-CONSULTANT CAREER GRADE STAFF

NHS Confederation scoping study

5.28 In May 2004 the Secretary of State for Health announced that the recommendations of the '*Choice and Opportunity*' report about modernisation of the non-consultant career grades have now been accepted in full by the Government. As a first step in taking the recommendations forward, the Department of Health commissioned the NHS Confederation to scope the need for a detailed review of NCCG pay and terms and conditions of service, so that we can best recognise, value and reward these doctors. As part of its work, the NHS Confederation has considered the appropriateness of the current arrangements for NCCGs in respect of discretionary points, job planning and appraisal and payment for hours worked beyond the standard contracted week. The scoping work includes a review of the arrangements for the employment of clinical assistants and hospital practitioners.

5.29 The NHS Confederation's remit is to scope out issues and make recommendations for further consideration; formal negotiations are subject to the outcome of the NHS Confederation's report. The widespread support for the recommendations of '*Choice and Opportunity'* has given us a clear mandate to explore linking pay to competence. The NHS Confederation has been asked to consider appropriate links between competence and pay in their report that is expected to be submitted to Ministers in October 2004.

5.30 As part of the process for taking forward this work the NHS Confederation have engaged with NHS representatives to determine what are the key issues with the current contract from an employer's perspective and to determine their needs in respect of any new arrangements. It is important that the views of employers and those responsible for commissioning services are considered in determining new pay arrangements. If any new pay arrangements were not to reflect the needs of employers, there could be potential consequences for the recruitment and retention of doctors in the non-consultant career grade.

5.31 Further development work is to be agreed in order to develop systems for measuring individuals' competence and job weighting. In addition, we need to determine where any reformed medical grades would "fit" in the medical career structure, in relation to other grades of doctor. The pay for non-consultant career grade doctors must be appropriately pitched between the pay scales for doctors in training and consultants taking account of the impact of '*Modernising Medical Careers*' and structural reform of the training grades.

5.32 The NHS Confederation have made significant progress in this work and have already held several meetings with the BMA which have identified the key issues that need to be addressed by any review. The NHS Confederation have reported that they have met with the Staff and Associate Specialists Committee of the BMA on a number of occasions and a workshop to engage with a wider range of stakeholders from both the NHS and the BMA was held on 8 September. The NHS Confederation are committed to taking work forward in partnership with the BMA.

Timeframe

5.33 The NHS Confederation is expected to report to Ministers on the outcome of its scoping work in October 2004. The report will include a recommendation on the proposed way forward including an assessment of the possibility of successful resolution through continued negotiation by the BMA and the new NHS Employers' Organisation. This is slightly after the end September deadline that was originally set to enable the NHS Confederation to take full account of the outcome of the 8 September workshop.

5.34 Following the NHS Confederation's report, the negotiations would be handled by the proposed new NHS Employers Organisation subject to an agreed set of parameters and funding envelope. Given the amount of work to be undertaken, it is unlikely that a final agreement could be reached by April 2005. However, the underpinning work is necessary if we are to justify a case for increased public investment in the pay of non-consultant career grade doctors and a sustainable pay solution.

5.35 Details of the NHS Confederation's report will be shared with the Review Body in November when their report has been received and Ministers' views are known. We would expect the report to comment on the following points:

- NCCG pay currently ranges from £29,845 to 72,882. The lower end of this range equates to mid SHO/low SpR whilst the higher end overlaps with the post 2003 consultant contract. NCCG numbers have recently grown less than other medical groups but we have no evidence of national issues of recruitment and retention in these grades.

- Although the broad structure of the NCCG pay band is appropriate, there are wide variations in the way it is applied which may account for any dissatisfaction within these grades. For example, there is no standard contract and employers have considerable flexibility over starting salaries, especially for staff grades. The NHS Confederation is therefore expected to propose consideration of a standard national contract – along the lines of the new consultant contract – that would rationalise and enhance NCCG's terms and conditions of service, thus reducing the wide variation in terms that currently exists.

- The introduction of a new contract would offer increased opportunity to ensure support for the personal development of NCCGs. When linked to PMETB Article 14, this would enable them for the first time to work towards the grade of consultant, thus significantly improving their pay and career prospects.

Potential way forward

5.36 As previously stated, the Government has fully accepted the recommendations of *Choice and Opportunity*, including the need for a competence-based pay structure for this group of doctors. Subject to the recommendations to be made to Ministers by the NHS Confederation, the Department of Health is keen to move towards such a system within an overall framework of reform and modernisation.

5.37 Under a competence-based system, pay would be linked to a system of job evaluation and/or job planning and ensure comparatively appropriate rates of pay between one individual and another in the grade. This in turn would provide a remuneration system that could be effectively linked to a modernised career structure with opportunities for individual development. Much of the knowledge necessary to implement such a

system is already available in the NHS and the Royal Colleges. However, such a system cannot be introduced overnight.

5.38 In summary, there is some underpinning work that needs to be undertaken before a new pay deal can be agreed. However, the process we have embarked upon amounts to a fundamental review of the grade, from the educational requirements, to the job role, through to the pay arrangements. We believe that considering pay issues in isolation to wider reforms of the grade would be entirely inappropriate. The key issues that need to be addressed relate to the career structure for these doctors and facilitating career progression. While a simple pay solution might alleviate a problem in the short-term, it would not provide for a long-term solution.

UK Dimension

5.39 We understand that the Health Departments in the Devolved Administrations are broadly content with the approach taken in England. However, decisions about taking work forward are a matter for the responsible Ministers.

Recommendations for April 2005

5.40 We do not believe that it would either be prudent, or justifiable to simply increase the pay of doctors in the non-consultant career grades above the anticipated rate of inflation for 2005/06.

5.41 As previously stated, following the publication of the NHS Confederation's report in October 2004, proper consideration will be given to the appropriateness of developing pay reform within a wider review of this grade of doctors. Any reform will be taken forward with regard to the Government's key principle for public sector pay reform – namely, investment in return for modernisation.

5.42 As a general principle, when considering the pay of one group of medical staff compared with another group, we need to consider the comparative value of the duties and responsibilities of the two groups of staff, in generic terms. As a first step in applying the principles of equal value to the work of medical staff, the Department of Health and the NHS Confederation will consider how the pay and terms and conditions of service for non-consultant career grade fit within the overall medical pay arrangements when compared to consultants and doctors in training.

5.43 Adjusting the associate specialist payscale upwards will further increase the overlap with the 2003 Consultant pay scale and increase the disparity in earnings between some associate specialists and consultants on the pre-2003 consultant contract. Any new pay arrangements for NCCG doctors would need to be consistent with the principles of existing reforms, i.e. investment for modernisation. There will also need to be clear and identifiable benefits for NHS services and consequently for patients.

5.44 The NHS Confederation report into the scope for any new arrangements will provide further issues for us to consider. At the time of drafting this evidence, the NHS Confederation report had not been presented to Ministers. However, we expect to be in a position to discuss the report's findings further with the Review Body during oral evidence in December.

5.45 In summary therefore, we now have a clear way forward and have made significant progress through the NHS Confederation. In order to deliver any new pay reform for this group of doctors, we need to first take account of the NHS Confederation report.

As previously stated, we will be in a position to provide further details of our position at the oral evidence stage.

D. COLLABORATIVE FEES

5.46 For consultants on the new contract, regular work undertaken on behalf of a local authority or Government Department should generally be planned as part of NHS programmed activities, with no fee being payable to individual consultants unless they and the employing organisation agree that the work involves minimal disruption. For consultants who remain on the old contract and for any such work undertaken outside NHS programmed activities by consultants on the new contract, we are seeking a recommendation for a fee increase in line with inflation.

E. HOSPITAL DOCTORS AND DENTISTS IN TRAINING

5.47 The 2000 contract is now fully established. It has been successful in improving the working lives of doctors in training. The use of banding supplements has acted as a financial incentive to encourage NHS Trusts to reduce hours and develop less intense shift patterns while at the same time rewarding junior doctors for the hard work and dedication they show. Monitoring of compliance with the New Deal, currently carried out every six months, shows continuous improvement. The most recent monitoring round carried out in March 2004 revealed:

- 88% of all juniors fully compliant, up from 55.9% in March 2001;
- 94% of all juniors working less than 56 hours a week; and
- 43% of employers reporting all juniors in contractually compliant posts.

5.48 Establishing improvements to working patterns continues to prove difficult in places, partly because of a lack of recognition by some juniors of their contractual obligation to monitor their working patterns and to work with their employers to improve compliance, and partly because of a failure on the part of some trusts to implement monitoring properly. Action taken on the second point has resulted in a 43% drop in the number of posts not properly monitored by trusts; however anecdotal evidence from the monitoring rounds continues to suggest that a significant number of trainees are still failing to co-operate with their employers in monitoring working arrangements. This continues to be addressed at a national level by both the DH and the BMA.

Basic Salary

5.49 Following the above-inflation uplift and additional scale points recommended by the DDRB in their 33rd report which were accepted in full by the Department, we see no reason for increases over and above the cost-of-living for trainee salaries in 2005. At a time when we are seeking to increase the medical workforce and continue to attract the most able graduates into a medical career it is important to ensure that trainee salaries continue to remain attractive, therefore we do not believe it would be appropriate to recommend no increase for trainees.

5.50 As a result of the introduction of the Working Time Regulations this year, hours spent resident on-call are generally falling so that total duty hours will have fallen, for many doctors, from a maximum of 72 to 58 at most without a corresponding drop in salary.

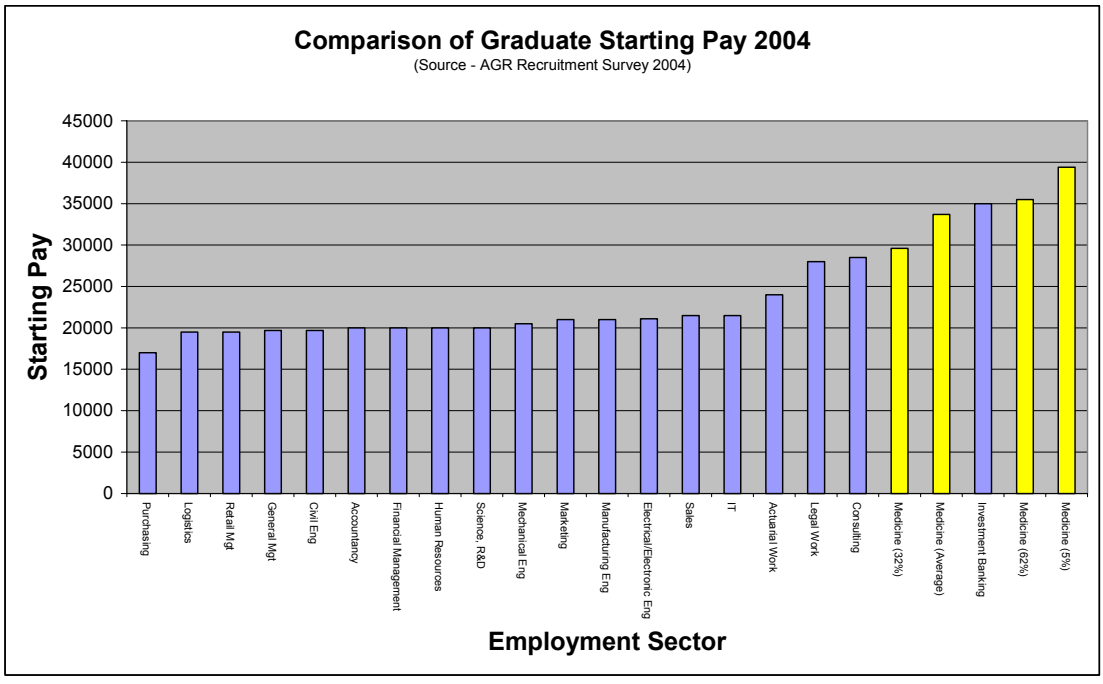
5.51 For graduates entering their first PRHO post, salaries are already very competitive. Almost two-thirds of the employers questioned in a recent survey[1] expected graduate starting salaries to increase in 2005 by no more than the cost-of-living, with a further quarter predicting that salaries would be frozen at 2004 levels. We continue to believe it is important to ensure a continued upward trend in the number of trainees in the NHS and that can be achieved with an inflation only uplift for 2005.

5.52 The same survey suggests that in 2005 salaries will remain stable, indicating that the days of escalating starting salaries for graduates appear to be over. It is significant that in the sectors usually compared with medicine, including law, consulting and investment banking, rates have been frozen and median salaries in these areas have remained unchanged for the last three years, while the typical starting pay in medicine has risen by some 28% over the same period.

Date	Basic Salary	Typical Pay (2A)	Increase on 2002
March 2002	£18,585	£27,736 (78%)	-
December 2002	£18,585	£33,453 (76%)	21%
March 2003	£19,185	£34,533 (73%)	25%
March 2004	£19,703	£35,466 (61%)	28%

(figures in parentheses indicate the proportion of trainees then in that pay band)

Typical PRHO Salaries – 2002 to 2004



5.53 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 last year's evidence, show the range of actual starting pay for PRHOs. The chart shows the percentage of doctors on each of the three main pay points in addition to the average, which for PRHOs in 2004 was £33,494, with 67% earning £35,435 or more. This compares very well with other professions, exceeding even the starting salary for investment banking.

[1] AGR Recruitment Survey 2004, Association of Graduate Recruiters

5.54 In addition to pay, there is a further factor to take into account that works to the advantage of medical students. Competition between graduates for posts is intense, particularly in those organisations where starting pay is at the upper end of the range, with an average of 37.6 applicants for each post in all the organisation types in the AGR survey. Competition for public sector posts is even harder, with 46.3 applications for each vacancy. Medical School graduates, on the other hand, have been assured of a position on some of the highest pay available to any new graduate.

5.55 However, we do recognise that doctors remain in training for between 10 to 12 years post qualification, far longer than most other professions. The starting pay comparisons help to indicate the first year or so of post-qualification working but there needs to be consideration made for the remaining time spent in training. While we do not believe it necessary to award an above inflation uplift, we would caution against considering anything less than inflation as this would in effect be a real terms reduction for a large number of medical staff.

Student Debt

5.56 When the value of the free accommodation provided in the first year of training is taken into consideration, the position of medical graduates is rather better than graduates in other professions. Even after taking into account the longer university course and the consequent potential for higher levels of student debt, the savings on accommodation and travel to work (because most PRHOs are housed in or close to their base hospital), combined with the guarantee of a post and a salary at the top end of the graduate spectrum, still leaves medicine as a most attractive career choice.

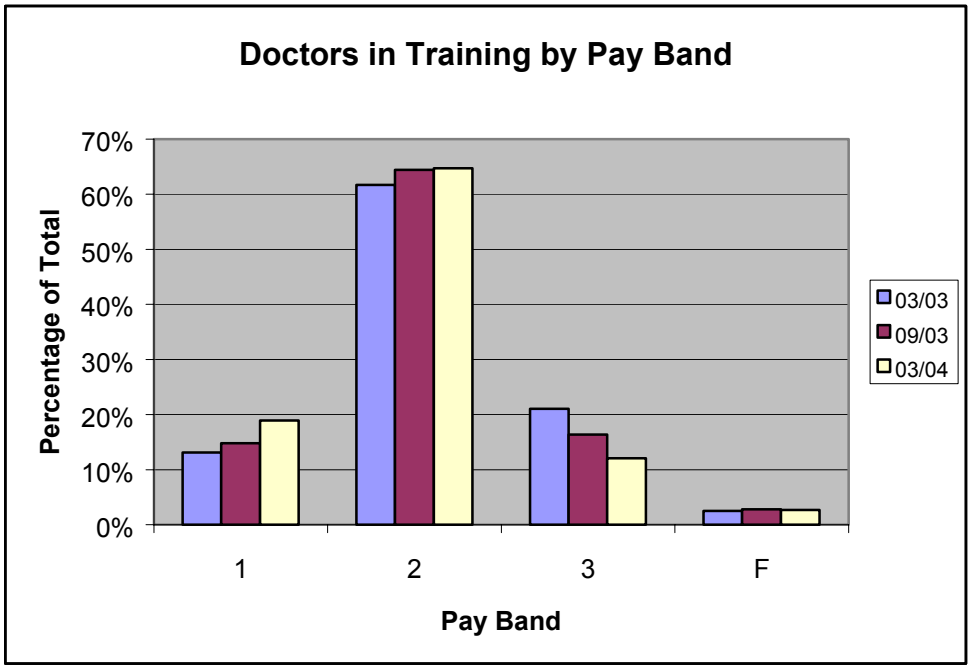
Banding Multipliers

5.57 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.

New Deal Compliant Posts

5.58 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 that they provide an appropriate financial incentive for Trusts and trainees to manage the workload of doctors in training.

5.59 It has been suggested that, with the changes to working practices implemented in preparation for, and following, the introduction of the Working Time Regulations to junior doctors' working arrangements, it might be necessary to revise the banding multipliers as moves to lower bands as a result of reduced hours could reduce overall earnings. Monitoring carried out in March 2004 showed no evidence of a significant change in average bandings from the previous year (see chart below), and while it might be true that some doctors could earn less as hours reduce, this is to be expected as a natural consequence of the current contract that has as its basis a relationship between hours worked and pay. We consider that to revise banding multipliers to address overall pay when the agreed purpose of the multipliers was to properly reflect hours and intensity would be to distort the principles behind the contract, and we would firmly oppose such an approach. If overall pay were to fall as a result of reducing hours and if it were to be seen as appropriate to address this in some way, a more fundamental review would be necessary.



5.60 If there were to be a review of the pay system, we believe that the focus for any fresh consideration of pay for doctors in training should be the impact of *Modernising Medical Careers.* This would enable the parties to take a fresh view on the appropriate levels of pay for a pathway from trainee to trained doctor in an environment where hours have been significantly reduced. Where hours reduce, the presumption must however be that – in line with the banding system agreed in 2000 – higher levels of pay are no longer justified (subject to the agreed safeguards for individuals). To do otherwise would undermine the principle of matching levels of pay to relative work intensity and out-of-hours commitments. It would also prevent resources being re-deployed to secure in other ways the extra capacity that will be needed as hours are reduced for doctors in training.

Non-Compliant Posts

5.61 Doctors in non-compliant posts are paid an enhanced supplement, with the stated intent of penalising the employer to encourage them to make posts compliant. The BMA have argued in the past that the level of the non-compliant banding multiplier should be raised to give trusts a greater incentive to comply. We would suggest that the evidence for the use of a punitive rate for non- compliant posts is that it was helpful in the early stages of the contract in encouraging Trusts to reduce hours. However, once the early benefits were gained, the higher rates became an attraction for juniors rather than a disincentive for Trusts. We are also aware from conversations with trainees that the availability of Band 3 payments for SpRs at or near the top of their pay scale has caused an undesirable overlap with the bottom of the consultant scale, and has required some to take an unwelcome pay cut on promotion.

5.62 Non-compliance is now down to 12% overall. There will inevitably be some trusts, particularly in the early stages of implementation of the Working Time Regulations, who will find it challenging to make all posts compliant despite the best efforts of all parties. We suggest that this will be some 5% of the total. It would be singularly inappropriate to impose further penalties on these trusts in order to penalise an equally small number of employers who may not be compliant for other reasons. We see no reason to increase the Band 3 multiplier as an incentive towards compliance.

5.63 Increasing the multiplier would risk providing a perverse incentive for doctors to maintain non-compliant working. At the extreme we are aware of some instances of falsification of returns and of disciplinary action that has been taken, only occurring because of the perverse financial incentives created by enhanced pay for doctors in non-compliant posts. As we argued again last year, there is a very real risk that if the non-compliant multiplier was further increased it would merely create a greater financial incentive for juniors to maintain non-compliant working practices.

5.64 Using pay to penalise an employer in this way is no longer necessary as there are now additional contractual and legislative penalties. As a result of the contractual changes in August 2003, pressure on employers to comply with the New Deal is increasing, and those employing doctors in non-compliant posts now face the possibility of an industrial tribunal. From August 2004, as the Working Time Regulations now apply to doctors in training, employers are accountable to the Health and Safety Executive for breaches of the hours limits. We expect Band 3 payments to wither further over the next year.

5.65 Again, we firmly oppose any suggestion that multipliers for either compliant or non-compliant posts should be raised. Rather, for the reasons above, we think that if change is considered necessary the whole system should be reviewed to prevent further distortion of pay differentials between doctors in training and other medical grades. We would support maintaining the current value of the multipliers in percentage terms for this year, alongside consideration of the interaction of the new foundation programme with the existing PRHO and SHO scales (see paragraph 5.77 below) to take account of the impact of '*Modernising Medical Careers*'. We would welcome the Review Body's support for this approach.

Flexible Trainees

5.66 Last year we reported to the Review Body that flexible trainees (ie those doctors training on a part-time basis) continued to experience difficulties in obtaining posts, and that this served to show up problems experienced by employers in changing working practices to accommodate flexible trainees.

5.67 We remain convinced that the contract is flawed in respect of flexible trainees, with employers still resisting the concept of paying a part-time trainee a salary based on a full salary plus a supplement. We believe that this approach has significantly damaged the employment opportunities of junior doctors, and that a contract that could be seen by employers to be founded on a pro-rata basis would ease the problem greatly.

5.68 The Department is very conscious of the strong feelings held by some stakeholders about the availability of flexible training, and assertions that the current apparent shortage of available places for doctors wanting to train on a part-time basis is simply down to a lack of funding. The situation is, in reality, rather more complex.

5.69 The basis for flexible (part-time) working and its availability differs fundamentally for doctors in training from other health workers. Whereas workers in other staff groups can ask to work reduced hours and can reasonably expect to be allowed to do so, doctors wishing to train flexibly are required by European legislation (93-16-EC) to have individual personal reasons that actually prevent them from training on a full-time basis. There is significant lobbying from the medical profession to widen the availability of part-time training to those who, for example, wish to make a lifestyle choice, regardless of legislation, but we believe that most doctors who need to train flexibly, for reasons of maternity, personal illness or care of elderly relatives for example, are currently able to do so.

5.70 Nevertheless, the current pay arrangements for flexible trainees continue to make their employment problematical. Firstly, on the notional basis of hourly rates, a flexible trainee earns more than a full-time trainee working at a similar intensity. Secondly,

because flexible pay is based on the concept of a full salary plus a supplement for part-time work, employers resist them, seeing full pay for part-time work as an unacceptable concept while hour-for-hour they are more expensive to employ than full-time trainees. In essence, the 'new' contract has priced flexible trainees out of the market.

5.71 The legislation applicable to part-time medical training, Council Directive 93-16-EC, requires such trainees to participate in the full range of activities of the department in which they are working.

ANNEX I (European Directive 93-16-EC)

Characteristics of the full-time and part-time training of specialists as referred to in Articles 24 (1) (c) and 25.

1. Full-time training of specialists

Such training shall be carried out in specific posts recognized by the competent authority.

It shall involve participation in all the medical activities of the department where the training is carried out, including on-call duties, so that the trainee specialist devotes to this practical and theoretical training all his professional activity throughout the duration of the standard working week and throughout the year according to provisions agreed by the competent authorities. Accordingly these posts shall be subject to appropriate remuneration.

Training may be interrupted for reasons such as military service, secondment, pregnancy or sickness. The total duration of the training shall not be reduced by reason of any interruption.

2. Part-time training of specialists

This training shall meet the same requirements as full-time training, from which it shall differ only in the possibility of limiting participation in medical activities to a period at least half of that provided for in the second paragraph of point 1.

The competent authorities shall ensure that the total duration and quality of part-time training of specialists are not less than those of full-time trainees.

Appropriate remuneration shall consequently be attached to such part-time training.

5.72 As part-time trainees are required to undertake at least half of all the duties of a full time trainee and as most contract for 0.6 of the training of a full-timer it would seem reasonable to base pay on a system which reflects the actual amount of work undertaken. We believe that this would remove most of the barriers to the acceptance of flexible trainees by employers.

5.73 The Department of Health is currently in discussion with the BMA over ways in which the contract might be amended to make the pay system more fair and transparent, and with deaneries, through CoPMED, to develop guidance for the service to ensure that, in conjunction with changes to the pay system, those doctors who need to train flexibly are enabled to do so. Allied to these two strands we agree with the BMA that demand for, and supply of, flexible training opportunities requires further monitoring.

Pay implications of Modernising Medical Careers

5.74 In their last report, DDRB asked the Department to take note of the potentially demoralising effect of the drop of earnings for SpRs on promotion to consultant, and to ensure that its plans to remove career bottlenecks were taken forward.

5.75 We are aware of the possibility that a small number of SpRs who are at the top of the pay scale and working in the most intensive bands could earn more in total in the SpR post than they would receive as a newly appointed consultant. However, the introduction of the new consultant contract has already reduced the number of SpRs whose total pay might fall in the short term on promotion, by raising the starting salary of a new consultant. We believe that the longer-term benefits such as immediately increased pension provision, access to a considerably extended pay system, greater

autonomy of practice and control over working time far outweigh the perceived short-term cash disadvantage, particularly as remaining for an extended period in the SpR grade after completion of CCST is not a practical option.

5.76 We would agree with the suggestion that the current pay structure can accommodate a reduction in the number of years spent in training, as envisaged under *Modernising Medical Careers*. Were the period of training to be shortened, it would reduce the number of trainees on the higher pay points, remove any remaining overlap between SpR and Consultant pay, and reverse the trend of adding additional points to the top of the scales as trainees should no longer spend an extended time in the grade.

Introduction of Foundation Programmes

5.77 As all new graduates will embark on Foundation programmes from September 2005 we suggest that a new scale is introduced to run alongside (and eventually replace) the existing PRHO scale. There have been some concerns about the pay arrangements for trainees in the second year (F2) of the new Foundation programme, and to avoid financially disadvantaging trainees entering F2 in comparison with colleagues who have followed the traditional PRHO/SHO route they are paid a salary equivalent to the first point of the SHO scale. A new scale would clarify the arrangements without affecting pay. We would ask the Review Body to consider the following proposal:

F1 (=PRHO 0)	**F2** (=SHO 0)	**F3** (=SHO 1)
Starting point for all new graduates	Subject to achieving Full Registration	In the event of a delay in completing F2

Proposed pay structure for MMC Foundation Trainees

F. GENERAL MEDICAL PRACTITIONER SERVICES

Salaried GMPs employed by PCOs

5.78 The salary range for salaried GMPs employed by PCOs is currently £47,710 to £72,478 with starting pay, progression and review determined locally. For 2005/06, we would ask the Review Body to uprate the salary range in line with the Government's inflation target. The model terms and conditions of service for salaried GMPs employed by either a GP practice or by a PCT are intended to be the minimum, with employers free to offer more favourable terms as they see fit. We believe that such a framework is flexible enough to enable local employees to amend it to reflect local needs and circumstances.

GMP Registrars

5.79 The supplement for practitioners entering GPR training is currently set at a level calculated to facilitate movement between hospital and general practice training, and to provide incentives, as necessary, to recruitment. This is clearly having an effect, with GPR numbers up by over 15% in the twelve months to March 2004. The current supplement, 65% of basic salary, could be considered somewhat high by comparison with that of hospital trainees who average some 60%, but it will be a matter for careful consideration whether it is appropriate to reduce the GPR supplement to retain trainees in the hospital service whilst continuing to maintain some expansion in GP numbers.

5.80 Among issues relating to GPRs that require resolution, in the Review Body's last Report the question was raised of an uplift to the motor vehicle allowance for GPRs, and we are pleased to report that discussions on this are now in progress.

The new GMS contract

5.81 The new GMS contract aims to resource and reward GPs on the basis of how well they care for patients rather than simply the number of patients they treat; allocate resources more fairly according to patient need; provide new recruitment and retention possibilities to tackle GP shortages; ensure patients have more choice and access to a wider range of high-quality services, with more treatment in the community rather than the hospital and overhaul and modernise GP premises and their IM&T systems.

5.82 As at March 2004, 61% of GPs were working within new GMS practice-based contracts. By 1 April 2004, 4910 (99.9%) of the new GMS contracts had been signed by practices and PCTs. The remaining five were unsigned for a variety of reasons that have been addressed by PCTs. This was an excellent result and exceeded our expectations at the centre. It was a tribute to the hard work and partnership working of PCTs and practices, and support from SHAs.

5.83 Getting contracts signed was the first major milestone in implementation and, whilst very important, was of course just the first big step. The service still faced big operational and strategic challenges: around ensuring all practices get paid by the end of April; agreeing actual practice budgets; managing the quality framework; and finalising new out-of-hours arrangements. The Department has and continues to work closely with the service on delivery and we have met those challenges to date and remain on track to deliver those that remain.

5.84 The new GMS contract is based on the principles of new money for new work. The new work includes quality-based incentive schemes – a Quality and Outcomes Framework based on the best clinical practice which will deliver the best outcomes for patients. It also includes enhanced service payments that will be paid to practices and other providers delivering specialist services in a primary care setting. Every practice will be computerised, with a modern clinical system attached to a national analytical tool. The Government is investing unprecedented extra money and resources in primary care. Over the next three years, funding in primary care across the UK will increase by 33%, from £6.1 billion in 2002/03 to £8 billion in 2005/06. In England, resources are expected to rise from £5 billion in 2002/03 to £6.8 billion in 2005/06.

5.85 The Government has made a commitment that these total resources will be delivered through a Gross Investment Guarantee (GIG), agreed as part of discussions on the new GMS contract. We have also given practices permanent protection on aspects of historical spend through a minimum practice income guarantee (MPIG) so that no practice loses out under the new formula.

Quality payments

5.86 The new GMS contract introduced a Quality and Outcomes Framework (QOF) in order to redress the emphasis in the old contract on high volume rather than quality of primary care.

5.87 The framework represents the first time any large health system will systematically reward practices for the quality of care delivered to patients. It is in line with professional opinion and reflects the ethos that higher quality care is most likely to be achieved through the use of incentives.

5.88 Funding is allocated based on performance in a number of clinical and organisational domains. All quality points are weighted according to the practice's registered list. Further, all ten clinical domains are also weighted according to disease prevalence, using relative practice-recorded prevalence data collated from practice disease registers introduced through the QOF in 2004/05.

5.89 A total of 1,000 points are available, with 50 additional points for those meeting the 24/48 hour access targets.

5.90 Achievement against the QOF will be assessed by PCTs using the QOF annual review visit. The visit will strike a balance between monitoring and demonstrating that standards have been achieved in line with the high trust principle of the contract.

5.91 Practices will indicate to the PCT the number of quality points it intends to deliver in the following year, and it will receive one-third of the value of these points (rising to two-thirds next year) at the start of the year to help them to realise their aspiration. The remainder of the payment will be made early in the next financial year and will depend upon the level of points achieved by the practice in the previous year.

5.92 The value of the quality points will be £75 each in 2004/05 and £120 in 2005/06, for an average practice. All rewards are weighted for registered list size, with a further weighting for disease prevalence under clinical domains and for target populations for additional services.

5.93 It is up to practices to decide for themselves how much of the QOF they wish to take on, in which domains, and the number of points to which they aspire. However, if practices are able to achieve standards in at least eight of the clinical areas they are entitled to a "holistic payment" and if they perform across the other three domains they are entitled to a 'quality practice payment'.

5.94 The Review Body's last report requested further evidence on the operation of the quality framework as the Review Body expected the quality framework to deliver remuneration equitably to GMPs who are meeting the same standards, whether they are working in GMS or PMS. All practices using the national QOF will be paid the same amount of money for the same amount of work - we have developed a national IMT system (called QMAS) to ensure that this occurs, and that the process is transparent and seen to be equitable.

5.95 PMS practices will have 174 points deducted from their QOF achievement, to ensure that these practices are not paid twice for some aspects of quality. This is necessary because PMS practices had money for certain aspects of quality included in their baselines at the time they changed to PMS.

5.96 The QOF is voluntary for all GPs, whether working under a PMS or nGMS contract. PMS GPs also have the option to develop a local QOF, in negotiation with their PCT. Any local QOFs must be signed off by a senior clinician in the PCT (usually the Director of Public Health) as being comparable in terms of workload and difficulty of achievement with the national QOF.

Enhanced Services

5.97 Following agreement with the General Practitioners Committee of the BMA and the NHS Confederation, we allocated £394 million in 2002 for enhanced services as part of the three-year allocation for primary care. In February 2004, we allocated a further

£108 million for GMS and we have nationally identified a further £99 million in PMS discretionary allocations. From 2004/05, each PCT will be set a floor for enhanced services spend, which it must meet and may exceed. PCT planned spend must be signed off by the PCT's Professional Executive Committee and discussed with the Local Medical Committee. Nationally, the Technical Steering Committee will monitor spend to ensure that the enhanced services floor is met.

5.98 The new contract includes an element of local negotiation and there have been some disputes between PCTs and LMCs over the content of the Enhanced Services floor. However, we believe most practices and PCTs are resolving these issues locally. We are currently monitoring the situation via SHAs.

Review of the new GMS contract

5.99 During the negotiations of the new GMS Contract, the NHS Confederation, GPC and Department of Health agreed that, following the implementation of the contract, a formal review of the GMS allocation formula would commence in October 2004. The joint GPC/NHS Confederation letter of 30 May 2003 explained that a revised formula could not be implemented before 1 April 2006 in order to ensure a full and comprehensive review of all factors, appropriate modelling at practice level, and to tie into the timing of future financial settlements for primary care.

5.100 Commitments in *Investing in General Practice: New GMS Contract 2003* and *Delivering Investment in General Practice: Implementing the new GMS contract* were also made to review the Quality and Outcomes Framework, recognising it will need to be updated in light of changes to the evidence base, advances in healthcare, changes in legislation or regulation and the need for further clarity or so as to include new areas. Again, the process of review is to be in place before the end of 2004 and no changes are to be made before April 2006.

5.101 Negotiations with the BMA's General Practitioners' Committee on the review of the new GMS contract are on track to begin this autumn. Prior to that, papers have now been sent to the GPC outlining terms of reference for the Quality and Outcomes Framework review and for the review of the allocations formula.

G. CONCLUSION

5.102 Through our pay modernisation agenda we want to ensure that doctors and dentists are fairly rewarded for their effort, hard work and commitment. The new consultant contract was a 'something for something' deal. For consultants choosing to remain on the old contract, we believe that a pay uplift in line with the Government's inflation target is appropriate. We are committed to a fundamental review of the career structure and pay and terms and conditions of service of the non-consultant career grades and we will provide further details in supplementary or oral evidence following the NHS Confederation's report to Ministers. In advance of the outcome of the review, we are seeking an uplift in line with the Government's inflation target for doctors in these grades. Similarly, we believe that an inflation-based increase for salaried GMPs is appropriate. Given the continuing needs to grow the medical workforce, we also believe it is necessary to provide for an increase of no more than anticipated inflation for doctors in training.

CHAPTER 6: PRIMARY CARE DENTISTRY

A. SUMMARY

6.1 Our evidence is submitted this year against a background of solid progress on reform and a major programme of investment announced by the Government in July 2004 to rebuild NHS dentistry and tackle workforce issues.

6.2 As part of its commitment to reform and to work with the profession, the Government has consulted the profession's representative bodies on the proposals and in response to the comments they have made, Government has allowed a longer time period for the introduction of the new arrangements which are now planned to be introduced from October 2005. The Government has also made available £9 million for general dental practitioners and £400,000 for salaried dental staff to support change.

6.3 We have been developing a simple base contract with the British Dental Association and our submission highlights the progress made and the issues that remain to be resolved. The new arrangements will take dentists off the so-called treadmill and freed-up capacity under the new arrangements will benefit both dentists and the NHS. We will continue to support dentists who wish to move to the new arrangements earlier than October 2005 to do so under Personal Dental Services arrangements.

6.4 Our evidence highlights the significant investment Government has earmarked to support improvements in access to dentistry and support an expanded workforce. The Government has made clear that the NHS will fund increased capacity from existing dentists where they are willing to increase and sustain their commitment to the NHS in the transition to the new arrangements.

6.5 Against this background, the Government considers that an increase in gross fees in line with the Government's inflation target represents a fair deal for dentists and ensures that available resources are used to best effect to benefit patients.

B. INTRODUCTION

6.6 The past year has laid the foundation for major developments in NHS dentistry. In January, the Chief Dental Officer wrote to every dentist in England to set out the underpinning principles for the new arrangements. In February 2004, the Department published for consultation *Framework proposals for primary dental services in England from 2005*. Consultation on the framework ended 30 April 2004. This was followed by a landmark Government statement on 16 July 2004 reaffirming Government's commitment to NHS dentistry. Underpinning this is the Government's vision for NHS dental services which:

- offer access to high quality treatment for patients
- focus on prevention and improved oral health
- give a fair deal and improved working lives to dentists and their teams.

6.7 The statement set out a significant programme for NHS dentistry, including the investment of unprecedented new resources in support of reform, workforce expansion and improved access.

6.8 The statement also announced that, in the light of the responses to the consultation on the *Framework proposals for primary dental services,* that time was very tight for a 1 April 2005 start, the Government had decided to give more time to the NHS and dentists to prepare for the change, and that the new arrangements would be introduced from 1 October 2005.

6.9 It is against this background that we present our evidence which reports on progress we have made towards implementing new arrangements for NHS dentistry in line with the proposals in the 2003 Health and Social care (Community Health and Standards) Act. We also report here on the arrangements which are now in place to move dentists off the GDS item of service treadmill in advance of the new arrangements. Alongside this work aimed at improving working lives of dentists and their staff and expanding services for patients, we have also put in place arrangements to support PCTs in preparing for change and in improving access to NHS dentistry.

6.10 A new Statement of Dental Remuneration was introduced from 1 May 2004 to implement the increase of 2.9% in item of service fees, capitation payments and commitment payments recommended by the Review Body in its Thirty-Third Report, published in March 2004. The increases were backdated to 1 April 2004. The Government also accepted the Review Body's recommendation that additional funding should be made available and should be targeted locally as part of a structured change management programme to prepare dentists and their staff for the change. It announced on 16 July that it was making available £9 million for this and we are currently considering development of centrally commissioned training material to further support this.

Guarantees to dentists

6.11 As reported in our evidence last year, we have been working with the BDA to develop for those who have not already moved to PDS, a base contract to underpin the move to local commissioning of dentistry to provide certainty and security to dentists. An early priority was to provide important guarantees to dentists with regard to gross earnings, entitlement to the base contract and workload. In January 2004, the Chief Dental Officer wrote to dentists to set out the Underpinning Principles of the new contractual arrangements. The underpinning principles provide important guarantees 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 (2005-2008) in return for a similar level of NHS commitment;
- the ability for dentists to manage their own workload, and to offer a more preventative approach to patient care and to be able to move off the so called item of service treadmill;
- out-of-hours services ceasing to be the dentist's responsibility and instead becoming the responsibility of PCTs.

6.12 The Underpinning Principles also offer

- protections about goodwill and practice income by PCTs offering contract value to practice owners in the first instance if self-employed associates move on;

- the commitment to minimising bureaucracy;

- the commitment that practices will not bear any financial risk as a result of any changes that may flow from the review of patients' charges.

Consulting the profession

6.13 Following work with the BDA to develop these Underpinning Principles, the Department published for consultation with representative organisations in February 2004, *Framework proposals for primary dental services in England from 2005* to provide more detail about the proposed arrangements including:

- the implications of local commissioning, the new contracting arrangements and the opportunities that will exist to build on and shape contracts in the future

- an outline of the principles that will underpin the new contracts and the new system

- the steps taken to protect dentists' livelihoods and ensure stability during this period of change, whilst ensuring the NHS and patients get a fair return for the investment.

6.14 The BDA, the General Dental Practitioners' Association, British Orthodontic Society, British Association for the Study of Community Dentistry and the Faculty of General Dental Practitioners were consulted on the framework proposals document.

6.15 The Department is grateful for the responses which were submitted. There was unanimous support for the direction of travel and the proposal to move away from item of service remuneration system. There was concern, however, that time was short for a 1 April 2005 start and that PCTs might not have the capacity to manage this. The BDA also proposed that any dentist in England who wished to continue on existing terms and conditions after April 2005 should be allowed to do so until such time as the new contract had been shown to have clear benefits for patients, the profession and the government, over current arrangements. There was no indication from the BDA of when or how it might be judged that that point had been reached.

6.16 There was also concern that additional investment was needed to support local commissioning, and that dentists needed clarity about how their workload and commitment would be measured in the new world.

Government Response

6.17 In addressing the BDA Conference on 6 May 2004, the Minister of State, Rosie Winterton MP, reaffirmed Government's commitment to reform to give a better deal to both patients and dentists, including taking dentists off the so called treadmill of item of service fees. She acknowledged the profession's concerns and gave an undertaking that Government would take these into account in formulating its response.

6.18 The Government response was announced on 16 July 2004 as part of the Government's strategy for delivering change on NHS dentistry in England. In a statement to Parliament on 16 July, the Secretary of State for Health announced:

- that the new arrangements, which are based on five-years experience of PDS, would come in from October 2005, allowing six more months to prepare for the change in response to the representations received during consultation;

- the equivalent of an additional 1000 whole time dentists by October 2005 through:

  - securing extra NHS capacity from existing dentists
  - attracting dentists back from career breaks and through flexible working
  - international recruitment
  - 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.

- 170 extra undergraduate training places in England from October 2005 – 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;

- additional new investment of £250 million by 2005-06 compared to 2003-04, an increase of 19.3% (after allowing for the impact of additional superannuation costs for which a further £50 million has been provided). This will take Government investment in dentistry up from £1.3 billion in 2003-04 to £1.6 billion in 2005-06;

- the financial resources for dentistry will be devolved to PCTs from October 2005 and that PCTs would be consulted on indicative allocations for 2004-05 (which is to be a preparatory year) and 2005-06;

- issuing of proposed 2005 contract values for dentists based on their most recent gross earnings.

6.19 The statement also made clear that arrangements for moving into PDS were being streamlined to support dentists who wished to move into the new arrangements in advance of October 2005 to do so speedily with a turnaround time of 12 weeks from application to approval.

Recruitment and Retention

6.20 As we have acknowledged in our evidence to the Review Body in previous years, although the number of dentists in the General Dental Services has been growing each year, there has continued to be a drop in their overall NHS commitment. Under current arrangements, dentists can switch from NHS to private work with relative ease and with very little notice to the NHS. As we have explained in our evidence in previous years, private practice, which is relatively less regulated, has been an attractive option for dentists and one with which the NHS has found it difficult to compete.

6.21 We have reported in earlier years on a number of initiatives taken by Government to try to address this. While many have shown some return, it has been clear – as all authoritative bodies including the DDRB have stated - that the current nationally determined remuneration system has been a major factor in the decline in dentists' NHS commitment. A shortage of dentists and lack of explicit commitment to fund growth in dentistry have also been cited by the profession as contributing to dentists reducing their commitment to the NHS.

6.22 The Government statement of 16 July addresses all these issues and provides an unprecedented increase in earmarked funding for dentistry that, under the local commissioning arrangements, PCTs will be required to dedicate to primary dental services for the initial three-year transition period. With the planned change to local commissioning and abolition of the item of service fees, Government has acted to address all of the concerns raised about NHS dentistry by the profession and expert bodies, including the Review Body, and to make the NHS an attractive option for dentists.

Workforce

6.23 The Government statement of 16 July 2004 included a substantial programme of action to increase dental workforce capacity alongside the move to local commissioning. The proposals were informed by the work undertaken as part of the 2002 Dental Workforce Review to which a wide range of stakeholders contributed. The Review report was published on 23 July 2004.

6.24 The review sought to identify the dental workforce (dentists and professionals complementary to dentistry) required to deliver modern future services within both the NHS and in the private sector. It took account of the balance between the NHS and private sector work, skill mix and the impact on recruitment and retention of remuneration systems. The review concluded that there was an undersupply of 1,850 dentists (covering both NHS and private work) that, if no action were taken, would increase to between 3,000 and 5,000 by 2011.

6.25 Work on the review pre-dated the development of the Government's plans for the delegation of the commissioning of general dental services to PCTs. In particular, it could not take account of the abolition the item for service remuneration system that has been cited as a major reason for dentists reducing commitment to the NHS. As the introduction to the report indicates, the implications for workforce planning of these changes are considerable and complex. For example, the changes are intended to make NHS dentistry more attractive to dentists, but it is not yet clear to what extent there will be a change in the balance of primary care dentistry carried out in the private sector and the NHS.

6.26 Although time has moved on since the modelling for the dental workforce review was done, the report contains important contextual information. It was taken into account in drawing up plans, announced by the Secretary of State for Health on 16 July 2004 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 represents a substantial increase in dental workforce. It takes into account the general thrust of the workforce review while recognising that the planned reforms represent a significant change. The Department plans to review the position on dental workforce in 2005-06 to check if the assumptions on which the recruitment plans are based need revisiting.

Investing in Access, Quality and Choice

6.27 We reported in our evidence last year that an NHS Support Team had been set up to work with the hardest pressed PCTs to improve access. The Team was backed by £9 million over the two years 2003-04 and 2004-05. Additionally, £35 million capital over the same two years was being allocated to PCTs to support improved access, choice and quality. This was increased by a further £15 million revenue allocated to PCTs for 2004-05.

6.28 The NHS Dentistry Support Team was established in September 2003 to work with a group of PCTs that were under the greatest pressure in sustaining and developing NHS dental services during the transition to local commissioning of NHS dentistry. To date the Team has worked intensively with 16 PCTs to agree robust dental action plans that address their dental access problems. As well as supporting PCTs on access, the Support Team has been assisting PCTs to gear up to understand and commission NHS dentistry and to establish effective communications with their local dentists. The Team is now starting to work with a second tranche of 15-16 PCTs.

6.29 Examples of development the Team has supported:

- West Gloucestershire PCT: Cinderford Dental Practice. The PCT's primary objective was to keep a dental practice open in Cinderford and improve access to NHS dental services for local people. Cinderford had one NHS dental practice that had gradually reduced the level of service it was providing, going from a three-dentist practice down to a 0.5 dentist practice. The PCT has purchased the surgery premises and it is being modernised and refurbished to provide NHS dental care for up to 7,500 patients by 2005 (an increase of 5,000 over the current level). The surgery will be operated by a dental body corporate and it is hoped to commence the service this autumn. The frontage of the building will be significantly improved and the new building will comprise:

  - 4 surgeries
  - An X-Ray facility
  - A refurbished waiting area and reception
  - Staff room
  - Patient and staff toilets

- Blackburn with Darwen PCT: Larkhill Health Centre. The PCT is developing a three dentist salaried dental service at two Health Centres in the PCT area, Larkhill and Montague. They are extending the existing CDS facility at Larkhill Health Centre by one surgery and using the conversion of privately owned accommodation (an annexe to a pharmacy) adjacent to Montague Health Centre (which also houses a CDS facility), to create two surgeries. This will be completed by the end of 2004/05 and will provide services for and additional 6,000 to 7,000 patients.

- Morecambe Bay PCT: Rural NHS Dental Service. Improving access to health care for people living in economically deprived and/or isolated rural areas is a priority for Morecambe Bay PCT. They are developing dental facilities, a minimum of 2-3 surgeries, in rural areas and in multi-agency developments to increase access and offer opportunities for newly qualified and other dentists to lease premises to provide NHS services. The service will be linked to the PCT's dental access system. Development of the service will be ongoing over next two

years. This development is expected to support some 6,000 additional treatments each year.

6.30 All PCTs have benefited from the additional funding of £35 million capital and £15 million revenue to support access, quality and choice. The allocations have been made through SHAs.

Personal Dental Services

6.31 The interest in PDS has grown significantly since January 2004. At the end of August 2004 there were 156 practices working under PDS contracts. Interest in working under the new arrangements is continuing to grow and we are currently in discussion with more than 800 practices that are in discussion with their local PCTs about PDS arrangements. PDS arrangements are proving popular with all types of practices including single-handed, multi partner, corporate bodies and some specialist practices. Some PCTS have already worked with local dentists to move most or all practices into PDS. This is particularly the case in the North West where areas such as Birkenhead, Bebington, Runcorn and Warrington have made rapid steps to implement local commissioning. Additionally, as at 1 October 2004, 215 practices taking part in the *Options for Change* programme were also working under PDS arrangements.

6.32 The Department issued *Personal Dental Services – a step-by-step guide* during August 2004. The guidance sets out clearly the process, contractual framework and a draft contract template for PDS. This guide will be updated regularly as PDS is rolled out more widely across the country and the arrangements associated with the base contract are formalised. The guidance can be found at:
http://www.dentalandeyecare.nhs.uk/Dental/PDS.aspx

6.33 The Department of Health has responded to PCTs' requests for support through the PDS contracting process and as a result a series of 20 two-day training programmes have been set up commencing in mid September 2004. By December 2004, every PCT in England and more than 500 local commissioning leads will have had an opportunity to participate in the two-day event. The training will be provided at venues co-ordinated by SHAs and the central PDS team will attend every event to deliver the programme for commissioning and finance leads aimed at:

- ❖ Building local confidence in negotiating PDS contracts
- ❖ Clarifying the process and steps to signing off a PDS scheme.

Options for Change

6.34 Following the publication of *Options for Change*, the NHS Modernisation Agency was tasked with establishing Field Sites to test different ways of working. The *Options for Change* programme is now working with 48 Field Sites in around 243 practices across England, covering 72 PCT's. Topics covered include The Patient Experience, IT, Extended Use of the Dental Team and Commissioning and Remuneration. In the area of Commissioning and Remuneration, 215 practices are working under PDS arrangements looking at the effect on working patterns, patient care and the overall dental experience. Learning from the Field Sites has informed the development of the base contract arrangements.

6.35 Whilst learning from the remuneration field sites is still at an early stage, common outcomes across sites show:

- An increase in the time spent with patients
- Improved working lives

- A decrease in laboratory work
- More ability to plan financially
- Potential for providing 'open access' sessions

Support for PCTs

6.36 The new arrangements for dentistry represent a major change for PCT's responsibilities in this area and together with NatPaCT we have organised a series of workshops and training events on local commissioning for all PCTs, including a series of events specifically aimed at PDS contracting. Additionally, officials have attended numerous conferences and meetings organised by individual PCTs, LDCs and dental groupings to provide information and support on the new arrangements. The Department has also issued commissioning guidance to PCTs at key points in the process, the latest of which accompanies indicative allocations for PCTs for the years 2004-05 and 2005-06 to assist their commissioning plans.

6.37 We will continue to work with the NHS to provide guidance and support in the run-up to October 2005. Furthermore, the planned implementation date of October 2005 allows for preparation for both dentists and PCTs as well as a three year transition period to full local commissioning. Additionally, the base contract provides a simple default contract which can be implemented easily. This is to enable a smooth transition to the new arrangements for both parties and to enable them to move to full local commissioning as they build relationships over the next three years. But as the Department has made clear, we will continue to support those dentists and PCTs who wish to move faster to local commissioning to do so.

Base Contract and the New arrangements

6.38 For dentists who have not already moved to alternative local contractual arrangements, the base contract (based on the PDS model) will be introduced for all practices on 1 October 2005. It will be based on the *Base Contract – Underpinning Principles* which set out important guarantees to dentists and which was sent to all dentists under cover of a letter from the Chief Dental Officer and circulated under guidance in January 2004. This guidance can be found at (http://.www.dpb.nhs.uk/mod_dentistry/documents/pctguidancejan04.pdf)

6.39 It is intended that the contract currency, ie what is measured under the contract, will be courses of treatment weighted to reflect the complexity of treatment provided. Based on PDS experience, the total number of courses of treatment will be fewer than under general dental services arrangements, freeing up capacity in the practice. Discussions are on-going between the Department and BDA on how this additional capacity can be shared fairly between dentists and the NHS so that dentists can spend more time with their patients and better manage their clinical work. Remaining issues under discussion with the BDA include weighting of the contract currency and performance monitoring arrangements. As soon as these issues are resolved, the base contract details will be published.

6.40 The DDRB has raised with us the issue of movement in expenses and how expenses might be affected under the new arrangements. As the DDRB will be aware, we had offered, as part of a three-year deal covering the years 2003-4 to 2005-06, to develop with the BDA, a mechanism for assessing movements in expenses in order to predict any significant changes. Additionally, the Department had offered to negotiate with the NHS Purchasing & Supplies Agency national contracts which would be available to GDPs to access as they wished without further negotiation for both practice

consumables and laboratory materials. Given that we are now only a year away from a major change in the way dentists are remunerated, and that new clinical patterns and less emphasis on the volume of treatments may alter treatment-related costs, we believe that what is needed now is time to allow the changes to settle so that the effect on expenses can be properly assessed.

6.41 A key feature of the new arrangements is that relating to PCT assistance and support for providers of primary care dental services. The Health and Social Care Act 2003 inserts new section 28R in the 1977 Act. This new section gives PCTs a power to assist and support providers and prospective providers of primary dental services and primary medical services. Support and assistance includes 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.

6.42 A PCT will be able to charge for the support given, but not necessarily at commercial rates. It is expected that a charge might be made where PCT staff provide clerical functions for the practice or where a PCT dentist covered a vacancy within a practice. This is because in both these examples the practice will have received funding for those staff through the practice contract. It is not expected that a charge will be made where an additional dentist is provided on a temporary basis to help out in a crisis that might otherwise lead to a contract variation.

6.43 Similarly, once the PCT holds the total financial resources there will be a greater degree of flexibility to deal with expenses. 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. Indeed the PCT, or the NHS more widely, could use its purchasing power to provide directly services such as special waste removal or bulk purchase of procedure gloves or other commonly used dental materials in agreement with its independent providers. Additionally, the PCT could agree a range of dental laboratory services with accredited laboratories for the provision of NHS appliances at more competitive rates. Should the provider chose to use these services, the PCT could directly reimburse the provider.

C. CONCLUSION

6.44 The past year has seen significant developments on NHS dentistry. The Government has announced an unprecedented level of new investment in dentistry and set out a comprehensive strategy to rebuild NHS dentistry through reform of the remuneration system on the move to local commissioning from October 2005 and plans to address the workforce shortfall. The planned changes will remove dentists off the so-called treadmill and will ensure that dentists as well as the NHS benefit from freed-up capacity under the new arrangements. Against this background, we consider that an increase in gross fees is the best way to ensure stability in the run-up to October 2005 and that the increase should be set at a level which is in line with the Government's inflation target to maintain comparability with similar groups.

D. SALARIED PRIMARY DENTAL CARE SERVICES

6.45 In the autumn of 2002 we agreed with the BDA a three-year pay deal for all salaried primary care dentists of 10%, comprising an uplift on salaries across all grades of 3.225% each year over the three years 2003-4, 2004-5 and 2005-06. We also agreed with the BDA a mechanism for re-considering the percentage uplift if inflation fell outside defined limits. Inflation has remained within the specified tolerances in both

the last year and current financial year and, in each of those years, the DDRB has confirmed via its recommendation the agreed uplift of 3.225%.

6.46 2005-06 represents the third and last year of the agreement. Inflation remains within the agreed parameters. DDRB is therefore asked to recommend an uplift across all pay-bands and allowances for the salaried primary dental care services, including salaried general dental practitioners employed by PCTs under GDS Regulations, of 3.225% for the coming year.

6.47 As part of the pay agreement the Department made available a capital sum of £5 million for use by PCTs in supporting the modernisation of salaried primary dental care services in preparation for the 2005 model of primary dental care. Following discussions with the BDA about its use and distribution, we apportioned the funds on a weighted capitation basis to SHAs, with the latter then required to target the funds particularly to those PCTs and services which had not previously received central capital modernisation support through the salaried PDS pilot process. Guidance to the NHS concerning these funds was issued in early 2004 but, in agreement with the BDA, release of the funds was delayed into the current financial year to permit SHAs and PCTs to properly plan its use. The funds were issued to the NHS during September 2004.

6.48 The Department has also been undertaking a major review of the salaried primary dental care services, led by the Chief Dental Officer, and we have previously reported to DDRB on the Terms of Reference and process for the review. A key element of the review has been the involvement, via two stakeholder groups, of the BDA, of grass-roots clinicians from primary care, of senior NHS managers, and a patient representative. The work of the two stakeholder groups was completed in late June.

6.49 The review commenced with a visioning of the likely shape of primary dental care in about ten years time, which was validated with wider NHS management input, and which concluded that PCTs would continue to want to be able to directly employ salaried dentists in order to fulfil their responsibilities to provide or secure dentistry for their local populations. It went on to consider the role of salaried dentists in that environment, and the education and training and career pathways necessary to enable salaried dentists to fulfil their roles. It then considered what kind of pay principles would need to underpin those career pathways and roles. In doing so, it considered the needs both of generalist primary care dentists and those with a recognised specialism. Also considered were issues of service leadership and service size.

6.50 Following the valuable work of the stakeholder groups, the Department now intends to publish the high-level proposals developed in the review, for wider input from patients, the profession and the NHS over a three-month period during the autumn of 2004. We hope to provide the report to DDRB in supplementary evidence. Following that communication period, the principles of the changes required will be finalised and detail developed in each of the various areas addressed by the review. We anticipate that we will be making a major submission on the review to the DDRB in the next round.

6.51 We have also commissioned qualitative research about the factors which make salaried employment attractive, to identify with greater clarity what factors make for a rewarding career in the SPDCS, whether in the CDS, salaried PDS, DACs or as a salaried GDP. With the assistance of the BDA, all salaried dentists will be surveyed this autumn seeking views about their experience of working in the SPDCS. The results of this anonymous survey will help to inform the final review principles.

6.52 As part of the review process we undertook to consider for possible early implementation any affordable actions which would help to support the direction of the review. A number of ideas were generated and proposed, many of which failed the test of adequately supporting the desired direction of travel. However, it was recognised that there is a need for organisational development work to support the transition of salaried dentists and services into the world of PCT commissioning of dentistry and therefore into the right contextual position for implementing review outcomes. We have therefore made £400,000 available nationally during 2004/05 to fund an organisational development programme aimed specifically at SPDCS clinicians and are currently in discussions with the BDA about the content of that programme. We will provide an update in supplementary evidence.

CHAPTER 7: OPHTHALMIC MEDICAL PRACTITIONERS

A. SUMMARY

7.1 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 and optometrists.

7.2 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.

B. INTRODUCTION

7.3 We reported in our evidence last year that it was our intention to offer the three year 10% offer to Ophthalmic Medical Practitioners as we had to optometrists to cover the years 2003-04, 2004-05 and 2005-06. The offer was accepted and sight-test fees of £17.26p, £17.82p and £18.39p have been agreed for the years 2003-04, 2004-05 and 2005-06 together with corresponding increases in domiciliary sight-test fees. The agreement includes making a payment towards loss of earnings while undertaking mandatory continuing education and training. The payment has been agreed at £270 for 2004-5 and £425 for 2005-6. In respect of Ophthalmic Medical Practitioners, it has been agreed that the payment will only apply to practitioners who have no other medical appointment. Future payments will be considered as part of normal negotiations between the Department and the professions.

C. BACKGROUND

7.4 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.

7.5 Demand for NHS sight tests has increased by 2% in the last year – 11.4 million sight tests were paid for by primary care trusts in England, local health boards in Wales and health boards in Scotland in 2003/04 compared with 11.2 million in 2002/03. Within these figures, the proportion of sight tests carried out by OMPs is around 3%.

7.6 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).

7.7 The first report of the Eye Care Services Steering Group was launched in May 2004. The group continues to meet and consider proposals to improve ophthalmic services.

CHAPTER 8: EVIDENCE FROM THE NATIONAL ASSEMBLY FOR WALES

A. SUMMARY

This Chapter has been prepared by the Health and Social Care Department (NHS Wales) to complement the evidence from the other Health Departments and highlights the main differences in the NHS in Wales.

B. THE WANLESS REPORT

8.1 The Wanless Health and Social Care Review, published in June 2003, highlighted the need in Wales for a change in the balance between preventing and treating problems and between acute and other forms of care. It emphasised the importance of individuals taking greater responsibility for their own health and called for radical redesign of services, all supported through far greater use of information and information technology.

8.2 A high level Implementation Plan was developed in November 2003 alongside the establishment of comprehensive and inclusive programme management arrangements to deliver the required changes. Implementation of the recommendations in the Review was aligned to four themes:

- Prevention: A major shift towards prevention, early intervention and supporting people to take more responsibility for their own health, through initiatives such as Health Challenge Wales.

- Optimising Service Delivery: The need to remodel services to deliver safe, high quality services to local people supported by a well-trained, motivated workforce.

- Involving People: Effective engagement with individuals, communities, professionals, staff and partners.

- Performance and Accountability: Strengthening a broad range of measures that underpin services, such as finance, and information communications technology.

8.3 Restructuring services to meet the Wanless objectives and deliver improvements in the priority areas will require a huge investment of time and resources across the NHS, local government and other parts of the health and social care sector.

8.4 Local Health Boards and Local Authorities are establishing excellent joint commissioning arrangements and every locality has preparing a draft Health, Social Care and Wellbeing Strategy as the basis for health improvement and service development over the next 3 years. In acting on these commissioners must form a clear view of the pattern of services to meet local needs and expectations and work with providers to create these.

8.5 Through their Local Action Plans, local partners have begun the process of considering how to address these issues. Each Local Action Plan demonstrates how progress is to be made in three essential areas:

- keeping people out of hospital who could best be treated in the community;

- getting people out of hospital, once treatment has been completed; and

- reconfiguring services to provide long term sustainability.

The plans represent a step-change in joint working between the NHS, Local Authorities and their partners.

8.6 Health Challenge Wales is a concept behind which the whole nation can work together to improve health in Wales – a means of building further the momentum for better health and for delivering changes across the whole of society.

8.7 Targets for better health and reduced disparities in health have been set for coronary heart disease, cancer, mental health, children and older people. In addition, through Health Challenge Wales, the Welsh Assembly Government is looking for a stronger role for prevention to tackle the big five areas – smoking, obesity, accidents and injuries, alcohol and other substance misuse.

C. THE NATIONAL LEADERSHIP AND INNOVATION AGENCY FOR HEALTHCARE

8.8 As part of the review of the Health and Social Care Department and deriving from considerations about leadership and renewal in the Wanless report, a strategic requirement has been identified to establish a new organisation, to bring together the Centre for Health Leadership, the Innovations in Care Team and a strategic workforce planning resource to support innovation and renewal, strategic workforce remodelling, leadership and organisational development and evidence based change and evaluation.

8.9 This new agency will enable Wales to envisage and begin to shape its future workforce and to support organisations in changing job roles, structures and technology to improve services.

8.10 The requirement will be to have by 2007 a clear considered statement of the future workforce that illustrates the projected requirements for new and enhanced roles as well as more conventional roles, addresses the demand and supply implications of these requirements and is subject to iterative review and remodelling as modernisation progresses.

D. WORKFORCE STRATEGY

8.11 Workforce planning is integral to the strategic and business planning processes within Trusts and Local Health Boards. A patient-centred approach to the whole planning process is essential to enable workforce planners to define required skills and knowledge and develop this into a picture of future workforce requirements.

8.12 For NHS Wales targets of 700 additional consultants and GPs, 6000 more nurses and 2000 more Allied Health professionals and others have been set for achievement by 2010 compared with 2002. These additional staff are to come through increases in pre-registration training places, overseas recruitment and co-ordinated recruitment and retention initiatives under the all-Wales strategy.

8.13 The number of medical students in training has been increased by 52% over the last few years and this increase will feed into additional numbers of SHOs and specialist registrars, eventually supporting the recruitment of more consultants and GPs.

8.14 In relation to the NHS workforce, major changes will help shape service reconfiguration, including the European Working Time Directive (EWTD), new primary care contracts, the revised consultant contract and Agenda for Change. The workforce must be adapted to match the changing needs of the people of Wales within the changing pattern of service. This will require changes and innovation in employment practices, working practices, skills, job definitions and staff location.

8.15 Five Local Health Boards in Wales have been identified to model workforce modernisation which will form part of the second stage of the Wanless workforce project that is being taken forward as part of the optimising service delivery group.

8.16 The NHS must deal effectively with the different elements of pay restructuring and use implementation as an opportunity to improve services. The revised hospital consultant contract must be implemented quickly by all NHS Trusts, maximising the benefit to service provision of revised job planning. This together with NHS pay modernisation and the EWTD provide a unique opportunity to review and modernise working and employment practices across the whole of the NHS Wales workforce, realigned to today's agenda.

E. MEDICAL WORKFORCE

8.17 The Assembly is committed to increasing the number of qualified doctors. As a result of increases in medical school intakes, pre-registration house officer numbers increased by 11.4% in 2003. Senior house officer numbers also went up by 5.9%. Since April 2001 a total of 80 extra specialist registrar posts have been approved with central funding while a further 39 have been funded by NHS Trusts.

8.18 In line with feminisation of the medical workforce and a greater demand for work/life balance, the demand for flexible training places is increasing year on year. In September 2004 the number of doctors on this scheme had increased to 97 compared with 80 the previous year.

8.19 The Assembly has also funded a project to facilitate the integration of refugees and asylum seekers who are professionally trained as doctors into the NHS in Wales.

8.20 Consultant numbers increased from 1377 to 1417 over the last 12 months and have increased by 33% since 1997. This increase is in line with achieving the target of 525 extra consultants by 2010. As a result of the recent consultant recruitment campaign 70 new consultant appointments have been made since December 2003 and some of them will have filled long-term vacant posts.

WTE to headcount ratio for Consultants in Wales

Year	Headcount	WTE	Ratio
September 1999	1,378	1,220.7	0.89
September 2000	1,441	1,250.5	0.87
September 2001	1,471	1,312.1	0.89
September 2002	1,526	1,376.9	0.90
September 2003	1,567	1,416.9	0.90

International and E-Recruitment

8.21 The Department's international recruitment campaigns are aimed mainly at consultants and GPs, although employers are flexible in their offers of employment where appropriate, on negotiation with overseas applicants, e.g. Clinical Fellow, Staff Grade Posts.

8.22 Wales subscribes to the Department of Health's Global Recruitment Scheme and has access to all eligible doctors listed on the scheme. An international medical recruitment jobs fair hosted in Cardiff in March resulted in the successful appointment of 6 consultants with further applications ongoing.

8.23 All NHS Wales employers are encouraged to use the HOWIS website to advertise vacancies and provide direct links to employing organisations. In addition, an on-line application form is being piloted in 4 NHS Wales organisations. (18 on-line applications were received in July; 38 in August).

GPs

8.24 There has been a small increase of 14 GPs (0.7%) (excluding GP retainers and GP registrars and locums) during the 12 months to September 2003. Future recruitment and retention initiatives will be focusing on GPs to ensure the additional 175 GPs target made in 2002 is achieved by 2010.

8.25 The Golden Hello Scheme will also be reviewed with the benefit being targeted to the areas where there is greatest need. This will be confirmed once the outcome of a number of research projects that are examining the effectiveness of existing recruitment and retention initiatives are known.

F. HUMAN RESOURCES STRATEGY

8.26 The most recent HR Strategy for NHS Wales, *Delivering for Patients,* was published in 2000. The agenda for NHS Wales has moved on since then and the supporting HR Strategy needs revitalising. Developments include the Wanless Review, structural change within the service, changing patterns of the workforce and the continuing development of partnership working and the increasing impact of devolution.

8.27 The health service is in a constant state of change and development. The dynamic state is a reflection of a variety of influences both internal and external to the service with the paramount driver being the need to constantly improve the experience of the patient. The new HR Strategy will, therefore, be designed around the service delivered to patients and as such must be owned and delivered by all staff working in NHS Wales.

8.28 The draft framework encompasses the following key principles:

- the needs of the patient are central
- open and transparent communications
- recognising and valuing diversity
- valuing individual contributions

The strategic areas for inclusion will be:

- modernising the workforce
- organisational development
- education, development and training
- recruitment and retention
- employment policies and practice
- equality and diversity
- partnership working and staff involvement
- workplace health

- performance development

It will be published after consultation with all interested parties in April 2005.

G. PAY AND CONDITIONS OF SERVICE

Consultant Vacancies

8.29 The following tables show how the three-month vacancy rate for medical and dental consultants has changed over the last 3 years.

The number of vacant consultant posts has fallen from 153.1 (8.3%) to 135.1 (8.8%) between March 2003 and March 2004. The breakdown by specialty is as follows:-

	31/3/2002	**31/3/2003**	**31/3/2004**
A&E	6	11	8
Anaesthetics	19	13	9
Clinical oncology	4	2	
Dental Group		1.9	1
General Surgery	9	8	4
ENT	1	0.1	
T&O	7	3	3
Ophthalmology	4	1	2
Urology	2	1	1
Cardio-thoracic surgery	1		
Pathology	2	1	
Haematology	3.5		5
Histopathology	2	2	6
Medical Microbiology		1	1
Paediatrics	6	5.6	5.5
General Medicine	34.5	33	34
Obstetrics & Gynaecology	7	2	1
Community Health		1	
Psychiatry	32.1	47	41
Radiology	18	19.5	13.6
	158.1	153.1	135.1

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

	31/3/2002	**31/3/2003**	**31/3/2004**
Bro Morgannwg	16	8	16
Cardiff and Vale	3	7	12
Carmarthenshire	25	29.6	10
Ceredigion & Mid Wales	14	4	3.6
Conwy & Denbighshire	16	12	9
Gwent Healthcare	7	16	16
North East Wales	12	16.5	25.5
North Glamorgan	5	12.5	16
North West Wales	21	19	-
Pembrokeshire & Derwen	10	16.5	14.4
Pontypridd & Rhondda	10	16.5	14.4
Powys LHB	1	1	1.6
Swansea	20	8	4
Velindre	2	-	1
	158.1	153.1	135.1

8.30 It is probably unwise to draw any significant conclusions from the above figures but we will be carrying out further research into the reasons for the vacancy variations in North East Wales and North Glamorgan where the respective rates increased to 22.3% and 24.4%. In Wales, there is still provision for employers to re-advertise hard to fill posts at the top of the consultant scale but this is not currently being used to any great extent by the two Trusts in question.

8.31 It is anticipated that the availability of the new contract in Wales will lead to further reductions in the current vacancy levels.

Consultant Contract

8.32 A revised consultant contract has been negotiated for Wales which differs from that in other parts of the UK. The contract is based on consultants delivering a 37.5 hour week comprising ten sessions. Typically, seven sessions will be devoted to direct clinical care and three to 'supporting professional activities'. The new contract received a high level of backing from consultants with over 94% voting to accept it. However, there are major concerns that its implementation will have significant financial implications, particularly in the short term, for the NHS in Wales as a result of having to fund additional sessions, over and above the contracted ten per week, in order to maintain current levels of activity.

8.33 The implementation of the contract was piloted at North West Wales and Bro Morgannwg NHS Trusts. Pilot exercises showed that these Trusts would need to fund an average of 1.4 and 1.2 extra sessions per consultant respectively. This was, however, simply based on the hours consultants reported they were currently working, and did not (in the time the pilots had available) include any assessment of the appropriateness of the activities, or to what extent there were variations between consultants in the time taken to undertake similar activities.

8.34 The negotiations with the BMA were concluded with the agreement that declared job plans would be subject to independent audit prior to agreement to fund the sessions indicated. Consequently, the Assembly has asked the Audit Commission in Wales to undertake a substantive review of the implementation of the consultant contract in Wales, focusing on the job planning process and its projected impact in terms of additional sessions that need funding. This is likely to be completed by January 2005.

8.35 Successful implementation of the consultant contract is vital to the future sustainability of the NHS in Wales. For it to be successful the new contract must be consistently implemented across Wales, robustly managed by Trusts and it must be affordable. Currently there is uncertainty as to how much it will cost to implement the contract. The Assembly has set aside £19million, although an allocation of additional funds is expected to be required following job planning exercises by Trusts across Wales.

8.36 The starting point in achieving successful implementation of the contract is the need to obtain a clear idea of the current level of consultant activity, i.e. what is currently done where, and by whom. This activity then has to be reviewed before the need to fund additional sessions is identified. Where additionally funded sessions are indicated they must be seen to provide value for money to the service and in the context of how Trusts plan over time to reduce and eliminate the need for consultants to continue to work long hours.

8.37 Many consultants have long argued that they deliver over and above their contracted requirements. If the job planning processes confirm this there are financial implications for maintaining current activity, at least in the short to medium term. Conversely, a

review of job plans may identify scope for some consultants to deliver more NHS work, providing an opportunity to better manage demand and to start to tackle waiting list problems. The consultant contract therefore becomes an important lever in tackling some of the key issues raised by the Wanless Review.

Non-Consultant Career Grades

8.38 In the last 2 years the number of consultant career grades have remained stable due mainly to our policy of converting non consultant career grades to training posts.

8.39 The Assembly has established a Reference Group which provides a discussion forum with representatives of BMA Wales to:

- encourage best practice and where appropriate make changes in the working conditions of the staff and associate specialist group of practitioners; and

- share ideas about the development of new terms and conditions of service for this group and to feed these into the main negotiating arena.

8.40 The Group has met three times and is considering the concept of a Welsh Staff and Associate Specialist Charter to improve the working conditions and career prospects, job planning, to recognise time for supporting professional activities, on-call and out of hours commitments and the need for further guidance on appraisal.

H. DOCTORS IN TRAINING

8.41 NHS Trusts in Wales have made significant progress in achieving New Deal compliance with the overall rate currently standing at 80% which is broken down as follows (100% PRHO, 84% SHOs and 65% SpRs). Emphasis during the past year switched to the need for NHS Trusts to be compliant with the first stage of the Working Time Directive effective from 1 August.

8.42 It had been evident for some time that meeting the Directive by maintaining existing service configuration whilst modifying the current staffing establishment was not an option because of the inability to recruit or train sufficient junior doctors to meet the relevant work pattern. It would also escalate the cost of the provision of secondary care across Wales. As a result it became imperative for other ways to be explored to meet the Directive whilst maintaining standards of care and training.

8.43 NHS Trusts in Wales were advised to continue to plan acute residential service provision around 13 hour shift systems. This allowed Trusts to be certain of meeting the WTD without the need for compensatory rest while also meeting the New Deal.

8.44 Trusts were therefore asked to consider the requirements for traditional out of hours on-call arrangements according to the weight of emergencies anticipated and to plan for either cross cover with another suitable specialty or to reorganise the normal working day so that only minimal emergency procedures were undertaken out of hours.

8.45 Changing service reconfiguration was seen in the context of delivering services in a different yet effective and clinically safe way and to be considered alongside other factors such as the developments in modernisation, Agenda for Change, the Consultant and GP Contracts and the financial resources available.

8.46 Some Trusts were encouraged to make urgent changes to very intensive working patterns. Emphasis was placed on rotas that were outside the WTD and could pose a

'health and safety' risk to both doctors and patients. In these cases short-term measures were advocated such as employing locum or trust grade doctors pending a more satisfactory long-term solution. Currently 71% of all training grade doctors comply fully with the requirements of the WTD (73% - PRHOs, 72% SHOs and 62% SpRs). All flexible trainees (84) are both New Deal and WTD compliant.

8.47 The Assembly is supporting the phased implementation of the Hospital at Night concept by funding the Welsh 'Hospital at Night' Team which is based at Ysbyty Glan Clwyd Hospital in North Wales. This team will establish a framework to disseminate information across Wales regarding the important and innovative methods of out-of-hours care.

8.48 The resources for pay modernisation were considered as a whole in resolving the funding issues for implementing the WTD.

I. GMPs

8.49 By 1 April 2004, 495 practices had signed the new GMS contract whilst 13 practices were being managed by the Local Health Boards. The Quality and Outcomes Framework will be monitored and achievement calculated using Merck Sharp Dohmi Informatics Contract Manager software.

8.50 In Wales £16.4m was allocated in 2003/04 for enhanced services. This was made up of £9.3m for six services that were funded through the Statement of Fees and Allowances and an additional £7.1m of new money. For 2004/05 the enhanced services expenditure floor has been set at £21.9m, which represents an increase of £5.5m over the previous year.

8.51 A national framework of principles to assist local negotiations for GPs working in community hospitals has been issued to Trusts. It sets out a series of criteria against which future services in community hospitals are to be provided and remunerated.

J. DENTISTS

8.52 In May the Minister announced proposals for a major reform of dental services and the introduction of new contractual arrangements for dentists providing NHS care. This aims to provide a new service framework for primary care dentistry which will improve access and help dentists by ending the item of service treadmill.

8.53 The announcement included £5.3m over the next 3 years to improve access to NHS dentistry and support implementation of the new contract and associated reforms. It was agreed that we would follow the same timetable for implementation of the new contract and programme of reform as in England.

8.54 In August it was decided that the implementation date for the base contract for dentists not already in local contracts would be October 2005. Dentists and Local Health Boards who wished to move to local contracts ahead of this date would consider doing so immediately using PDS schemes.

8.55 Since then there has been significant interest from individual dentists, practices and LHBs wishing to take advantage of the new arrangements ahead of the formal implementation date. Assembly officials and those from the Dental Practice Board are in the process of talking to interested parties.

8.56 The announcement also included a 17% increase in dental training places in Wales and details of how the first £1.5m tranche of the £5.3 m would be allocated - £550k for dentists, which is equivalent to £1k per dental practice, to assist them manage the change and the new ways of working; £510k between the 6LHBs where access to NHS primary care dentistry is most difficult and £440k to LHBs to support them with the dental change agenda through supporting their dental advisory committees or developing dental leadership skills.

8.57 The Welsh Dental Initiative, designed to attract NHS dentists to areas where there is a shortage, continues to be a success. In 2003/04, £1.77m was allocated in support of this scheme, the fissure sealant programme and additional access sessions. Part of the £5.3 m will also be used to improve access prior to implementation of the new contract.

8.58 Set in the context of the recent structural reforms of NHS Wales, Routes to Reform and the implications for dentistry of the Health and Social Care (Community Health and Standards) Act 2003, the Assembly has commissioned a review of Community Dental Services in Wales which is expected to be finalised in late Autumn.

K. RESOURCE ASSUMPTIONS

8.59 Most of what the NHS and its partners will achieve over the next 3 years will not come from additional resources but from targeting differently the existing financial allocations made to LHBs and the staff and resources available to NHS Trusts. To make the necessary progress in meeting national and local objectives, the NHS and its partners must:

- reconfigure services to use resources effectively
- improve efficiency and increase flexibility
- use the workforce better.

8.60 The NHS in Wales will enter the next three years with a level of resources that will challenge commissioners and providers in their efforts to run services at the current level and make changes. Financial discipline is essential. Existing deficits must be contained and reduced, and eliminated by March 2006.

L. WELSH ASSEMBLY GOVERNMENT SPENDING PLANS

Summary

8.61 This section sets out the Welsh Assembly Government's Departmental Expenditure Limits for Health. Figures for 2005/06 are from the Assembly's draft Budget tables, published on 12 October 2004 and must be taken as provisional until the Assembly votes its final Budget for 2005/06 in December.

8.62 The key points are:

- the Assembly sets its budget annually and, unlike England, there has not been a five-year settlement for health;
- there is a significant increase in funding for health but this is lower than in England;
- the Assembly has a higher level of expenditure on NHS manpower than England – some 6.6% of England's compared with a population share of some 5.9%;
- the Assembly is committed to introducing pay modernisation for all groups of NHS staff (including the contractor professions) alongside the new contractual arrangements being introduced in the other countries. It also has its own targets for growth in NHS staff;

- Wales faces the same underlying demand pressures as England and has relatively greater health needs;
- Because of the factors listed above, the Assembly has relatively less funding available as growth on revenue than England. Accordingly the NHS in Wales finds it more difficult to fund pay awards than England.

	Health DEL £m	**Cash Growth £m**	**Cash Growth**	**GDP Deflater**	**Real Terms Growth**
2003/04	3982	402	11.2%	2.69	8.3
2004/05	4279	297	7.5%	2.59	4.7
2005/06	4616	303	7.0%	2.52	4.4

M. CONCLUSION

8.63 Last year the Review Body endorsed the 3.225% pay uplift for the amended consultant contract in Wales which represented year three of the agreed 10% three-year pay deal. The Assembly supports the recommendations contained in the Executive Summary in relation to the uplift for clinical excellence awards, distinction awards and consultant commitment awards in Wales and the suggested pay increase in line with anticipated inflation for all other groups within the DDRB's remit.

CHAPTER 9: EVIDENCE FROM THE SCOTTISH EXECUTIVE HEALTH DEPARTMENT (SEHD)

SUMMARY

9.1 This chapter has been prepared by the Scottish Executive Health Department (SEHD) to complement evidence from the Department of Health in England and the Welsh Assembly. 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.

9.2 The evidence sets out:

- A. The Scottish context;
- B. The position in relation to recruitment, retention and motivation of medical and dental staff across NHSScotland;
- C. The position in relation to education, training and career development for doctors;
- D. Specific information about individual staff groups;
- E. The current position on regional pay; and
- F. Affordability and the competing demands for investment.

A. SCOTTISH CONTEXT

9.3 *A Partnership for a Better Scotland: Partnership Agreement* (http://www.scotland.gov.uk/library5/government/pfbs-00.asp) produced in May 2003 following the Scottish Parliamentary elections, sets out the Scottish Executive's policy priorities and commitments to delivering improvements to NHSScotland through the empowerment of the workforce. This year's evidence is set in the context of this challenging agenda at a time when NHSScotland is bedding in new structures following the dissolution of Trusts and the creation of unified NHS Boards in April 2004.

9.4 A priority for SEHD this year has been the implementation of the new contract for consultants and the new General Medical Services (GMS) contract as well as work to prepare for the proposed implementation of *Agenda for Change* and delivery of a National Workforce Strategy for Scotland. Another major impetus has been the work required to prepare for *Modernising Medical Careers* as well as continuing actions to take forward workforce development strategies, policies on educating and training, the Staff Governance Standard and partnership working, and work to facilitate the effective implementation of the New Deal for junior doctors and the European Working Time Directive.

National Workforce Strategy

9.5 Development and dissemination of the new National Workforce Strategy (NWS) has been a key priority in the last year. The strategy sets out, in one place, a clear vision about what action will be taken to secure an efficient, effective, well motivated health workforce, on whom the future provision of health services in Scotland depends. It covers all staff engaged in providing health services in Scotland, including independent contractors, and encompasses three broad themes:

- culture and behaviour;
- supply and demand;
- mobilisation and change.

9.6 The strategy aims to:

- make explicit the key workforce objectives for health and health-related services in Scotland;
- link these objectives to the service and business objectives for the health sector;
- generate energy, direction and focus on delivery of these objectives;
- give a clear context for work at all levels of NHSScotland;
- provide clarity for partnership working with other sectors;
- set out a distinctive Scottish strategy in a UK and international context.

9.7 The National Workforce Strategy is being led by the National Workforce Committee (NWC), chaired by SEHD's Director of Human Resources. The NWC has initiated a number of work strands to take forward work to support the NWS. These include:

- Model of Supply and Demand
- Workforce Planning and the National Workforce Plan
- Commissioning Plan for Education
- Workforce Design and Workload
- Careers, Recruitment and Retention
- Workforce Performance and Effectiveness
- Occupational, Professional and Regulatory Standards
- The Workforce Observatory

Current Workforce Issues

9.8 Current workforce issues are clearly a major contributory factor to NHS Boards' priorities in planning for sustainable services for the future. Three major new pay systems are likely to be delivered this year. NHS systems are also aiming to deliver significant re-design, in many cases arising from existing workforce dynamics, and to implement a new postgraduate training programme for doctors, all of which will stretch the capacity of NHSScotland.

9.9 The European Working Time Directive presents a major challenge for the NHS and pay modernisation provides a key mechanism for accommodating the working time limits through the introduction of new contracts for junior doctors, consultants and GP practices. This naturally reduces capacity in the NHS and becomes a driver for extensive recruitment of more staff working in new working patterns. SEHD is supporting this process through promotion of a regional approach to service and workforce planning, through the development of the National Framework for Service Change (which will outline a vision of future service provision and how to achieve it) being taken forward by Professor David Kerr, through the work of the SEHD Pay Modernisation Team supporting the delivery of pay modernisation, and through dissemination of best practice such as the "Hospital at Night" initiative to address the reduction in junior doctor capacity.

9.10 Junior doctor capacity is also affected by the New Deal Contract for Junior Doctors, which limits the length of the working week for doctors in training, and by Modernising Medical Careers (MMC), the new postgraduate training programme for doctors, which will introduce more structured programme-based training for doctors in training and further reduce their direct service input. SEHD has established an MMC Delivery Group chaired by Professor Stuart McPherson (post-graduate dean for South East Scotland) to ensure effective delivery and risk management of this initiative. With regard to the New Deal contract, much work has been done by Boards, with help from the New Deal Implementation Support Group established by SEHD, to redesign junior doctor rotas and delivery of services in order to

comply with the limits applied by the contract, such that over 90% of doctors in training are now compliant with the 56-hour-a-week limit.

9.11 Better workforce planning is a key response to these pressures, ensuring that workforce supply is aligned with the changing needs created by these dynamics. As described below, arrangements are now in place to build more strategic workforce planning capacity across NHSScotland. Work to develop more corporate NHSScotland leadership under the National Workforce Strategy is being taken forward through the establishment of "Team HR" (which brings together key senior HR officers within the NHS and SEHD to articulate joint strategic responses to the priorities currently facing the workforce), and the HR Forum, which with groups such as the Scottish Pay Reference Implementation Group (SPRIG) provides a partnership-based mechanism for addressing specific workforce issues and initiatives on an all-Scotland basis.

9.12 The Learning, Development and Careers Division within SEHD is carrying forward work, with partners such as NHS Education for Scotland (NES), to ensure that policy on training and education supports and underpins changes to the workforce. This is supported by a focus that the NWC and pay modernisation are bringing to the development of new roles in support of multi-disciplinary team working and changes in skill mix. The re-provision of GP Out of Hours services, being overseen by the Pay Modernisation Team, is a good example of this, and the NWC is sponsoring a strand of work on new roles being led by the Centre for Change and Innovation.

Workforce Development in Scotland

9.13 *Working for Health,* SEHD's action plan for workforce development, was published in August 2002. It links workforce development to service planning and redesign, to the future shape of services, to employment markets and to changing patterns of supply and demand. This was summarised in the evidence provided by SEHD for the DDRB's 2003 report which outlined the regional infrastructure (covering 3 regions: North, West and South-East) that has been created to establish and embed workforce development across NHSScotland.

9.14 Within each region there is a Regional Workforce Co-ordinator role, accountable to the National Workforce Committee. Currently two out of these three regional posts have been recruited to and the final post is in the process of being filled.

9.15 In April 2004 the Scottish Executive Health Department published a *Scottish Health Workforce Plan 2004 Baseline*. This is the first in an annual series which will make assessments of Scotland's future workforce needs; bring together current knowledge of the health workforce; and support effective workforce planning and decision-making.

9.16 Each year's national workforce plan will guide local, regional and national work on workforce development and be underpinned by a new statutory duty on NHS employers in Scotland to have regional workforce planning arrangements in place. Preparation for the 2005 Workforce Plan, to be published next April, is now underway, with detailed modelling of staff needs being taken forward by SEHD's National Workforce Unit. This work is being led by the Workforce Numbers Group (WoNuG), (the Scottish equivalent of WNAB (Workforce Numbers Advisory Board) in England), which was established in June 2004 and has agreed a work programme to December 2005. This includes projections for medical, dental and GP staffing.

9.17 In terms of skill mix changes, a key group that can impact on the role of the medical and dental group are qualified nursing and midwifery staff and Allied Health Professionals, with an increasingly greater emphasis being placed on the role of the clinical team rather than the

individual, maximising the scope for other clinical staff to extend their practice and skill base, thereby relieving pressures on doctors' capacity.

9.18 As part of SEHD's efforts to increase the capacity of the workforce a short life working group on retention issues has been established on a partnership basis and this will make recommendations by December on short, medium and long term initiatives that could assist with retention. The group will be particularly mindful of the needs of the Consultant 600 project (see below) in this respect. A "branded" internet site, with full interactive functionality, including an on-line job application facility, is currently under development. The website will also provide comprehensive careers information, and further links for accessing training and development opportunities.

National Framework for Service Change

9.19 The White Paper *Partnership for Care* acknowledged various drivers for change in the way health services are delivered. These include demographic pressures, the changing expectations of patients, improvements in healthcare technology, and workforce legislation and constraints. The extent of the change that is evidently required has highlighted the need for further work to provide a clear national policy context for the detailed planning and service re-design being developed at regional and local levels.

9.20 In response to these issues a project to develop a national Framework for Service Change has been initiated. The objectives of the Framework are:

- to explore and advise on strategies to secure a sustainable configuration of health services in Scotland;
- to recommend how sustainability might be supported and enhanced through improved integration of care;
- to identify those services that need to be delivered at the national, regional and local levels, in a way that will help ensure that patients get the treatment they require when and where they need it, delivered to nationally agreed standards in an equitable and cost effective manner in Scotland.

9.21 The Advisory Group overseeing the development of the Framework is chaired by David Kerr, Rhodes Professor of Cancer Therapeutics and Clinical Pharmacology at Oxford University. It will develop a Framework in line with the aims of the White Paper *Partnership for Care* to develop sustainable specialist services along with more local services delivered in community settings.

Staff Governance Standard

9.22 Staff Governance is about how staff are managed and feel they are managed. In Scotland this has been recognised as a key policy area and NHSScotland employers are now legally accountable under the NHS Reform (Scotland) Act for staff governance in the same way as they are already responsible under law for the quality of clinical care and appropriate financial management. 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. NHS Boards produce Staff Governance Standard action plans as part of the process. These are audited by Audit Scotland to provide independent assurance that the self assessment process is robust, the action plan is agreed and credible, and that action plan is being delivered year on year. The Standard specifies that staff are entitled to be:

- well informed;

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

Partnership Information Network (PIN) Board

9.23 PIN guidelines, produced in partnership, outline best employment practice which NHSScotland employers are required to meet. Eleven PIN guidelines have been published and work is now underway to review the first six to reflect new legislation and good practice development since 2001, when they were originally introduced. Consultation on the revisions should begin over the next few months. The PIN Board has recently completed consultation on two new PIN guidelines, *Recruitment* and *Fixed Term Selection Contracts,* and will be reviewing the remaining guidelines over the next couple of years.

***Healthy Working Lives*: Being an Exemplar Employer**

9.24 The Scottish Executive recently published *Healthy Working Lives*: *A Plan for Action* http://www.scotland.gov.uk/library5/health/hwls-00.asp which identifies the workplace as an area for focused action to promote public health and inequalities, improve the health of working-age people, and maximise their employment opportunities. This policy development fits with NHSScotland's commitment to become an exemplar employer and be better able to recruit and retain staff. This initiative focuses on providing staff with a safer working environment and places a priority on employers to promote staff health and ensure staff are not made ill as a consequence of their work. SEHD will shortly be developing a *Healthy Working Lives* strategy to take forward this key area of work.

Improving safety, improving patient care

9.25 SEHD is working with staff and NHS 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. SEHD has spent over £1m 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. SEHD has organised a successful violence and aggression conference and is in the process of developing a Strategy for action to tackle violence and aggression towards staff. This will be backed by £400,000 of additional funding. SEHD is also working with other Scottish Executive Departments to promote a culture shift in behaviour and attitudes to make clear that abusive behaviour towards public sector staff is unacceptable through the "*Bang out of Order*" television and poster campaign. 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 (such as ambulance staff and other NHS staff working in an emergency situation).

9.26 Many other initiatives are being developed to make NHSScotland a safer and more attractive place to work, including for example, a latex hand and glove policy and a "Fast Track" policy for early access to physiotherapy, as well as counselling services aimed at improving staff health and reducing sickness absence.

Working Time Regulations

9.27 Working Time Regulations (WTR) started to apply to Doctors in training from 1August 2004. Meeting the requirements of the WTR for doctors in training is an integral part of modernising and improving services. A recent SEHD survey shows an overall compliance

rate of 85.5% based on the number of junior doctors assessed as being compliant by 1 August 2004. The overall rate represents a significant achievement for NHSScotland, and is a strong platform from which to tackle the remaining 14.5%. SEHD is working with other UK Health Departments to develop solutions for small and isolated sites where it is more difficult to achieve compliance.

B. RECRUITMENT AND RETENTION

9.28 The total number of doctors and dentists employed in the Hospital and Community Health Service (HCHS) in Scotland increased by 195 (WTE) or 2.2% in 2003. For individual staff groups this represents changes as follows:

- Consultant numbers increased by 89.9 (WTE) or 2.8%;
- Associate Specialist and staff grades increased by 1.3 (WTE) or 0.2%;
- Registrars increased by 19.4 (WTE) or 1.3%;
- Senior House Officers increased by 150.3 (WTE) or 6.0%;
- Pre-Registration House Officer numbers decreased by 5.8 (WTE) or 0.7%; and
- GP numbers (Principals and Other) increased by 44.9 (WTE) or 1.2%.

9.29 As Scotland's largest employer NHSScotland is heavily influenced by developments in the labour market. A key shift is the increasing feminisation of the workforce in areas which have traditionally been male-dominated. Some 60% of the medical student intakes in Scotland are now female, and this has major implications for medical workforce numbers, given the greater tendency for women to seek flexible working patterns and to pursue part-time working.

9.30 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. Pay modernisation provides financial incentives to join and stay in the NHS and also creates a platform for a number of non-financial incentives such as flexible working conditions; the opportunity for self-development through quality training and learning; and a high calibre professional environment.

9.31 There are particular challenges in recruiting and retaining staff to work in rural and remote 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 at UK level, where Scotland is competing with proactive recruitment from England of nurses and doctors across the UK.

9.32 With its strong medical school/teaching hospital base Scotland generates a healthy supply of doctors in training. However many 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 some shortage specialities. Work is ongoing, to improve retention rates in this area, in support of a Partnership Agreement commitment to recruit an extra 600 consultants.

Vacancies

9.33 The most recent vacancy figures (at 30 September 2003) showed that there were 245 medical and dental consultant vacancies, an increase of 43 from 202 in September 2002. The 6 month vacancy rate increased to 3.4% from 1.9% in 2002.

9.34 The flow of staff within each of the medical grades both within and outwith NHSScotland, and associated observations, can be seen in the table at **Annex G**. (This shows the latest available data as at 2001-02).

Future Workforce Increases

9.35 *A Partnership for a Better Scotland: Partnership Agreement May 2003* contains a number of targets that relate to the medical and dental workforce, as follows:

- We will introduce further measures to attract and retain GPs.
- We will aim to increase the number of consultants in the NHS by 600 by 2006 and continue to build on that increase thereafter.
- We will further pursue mechanisms which encourage preventive 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 of 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 of 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.

9.36 Further assessments of required increases in the medical and dental workforce will be informed by workforce planning being taken forward under the aegis of the National Workforce Committee (see paragraphs 9.13-9.18).

'Consultant 600'

9.37 *A Partnership for a Better Scotland: Partnership Agreement May 2003* established a target of aiming to increase the number of consultants in the NHS by 600 and continuing to build on that increase thereafter.

9.38 There are a number of significant drivers which will impact on the number of consultants required over the next two years 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)

9.39 In recent years consultant numbers have seen an average annual growth of 3%. This level of growth will need to increase to enable NHS Scotland to respond to the many pressures outlined above, whilst continuing to deliver a high quality clinical service.

9.40 This situation is exacerbated by problems currently experienced in the recruitment and retention of some consultants. Boards are reporting reduced numbers of applicants for advertised posts and there are a number of acute shortage specialities, such as radiology and cardiology. Some of these shortages also exist at an international level, which makes attracting these skills particularly challenging.

9.41 A number of strategies are being developed to address these issues. These strategies seek to build on the healthy supply of training grade doctors in Scotland by focusing on improving the retention of consultants within NHS Scotland, as well as encouraging consultants from elsewhere in the UK and overseas to work in Scotland.

C. EDUCATION, TRAINING AND CAREER DEVELOPMENT FOR DOCTORS

Modernising Medical Careers

9.42 In February 2003 the four UK Health Ministers launched *Modernising Medical Careers (MMC)* which set out proposals for the fundamental reform of postgraduate medical education. These proposals were further developed by the publication of *Modernising Medical Careers: The Next Steps,* in April 2004. Implementation of *Modernising Medical Careers* in Scotland is overseen by a Scottish Modernising Medical Careers Delivery Group, responsible for establishing new Foundation Programmes for medical graduates followed by progressive specialist and general practice training programmes, as well as advising the Executive on strategies for the effective transition between current and new training arrangements, taking account of service and training implications.

9.43 This work is being taken forward in Scotland in line with the agreed UK strategic framework for MMC, and is informed by two reports published in June 2004 which have reviewed aspects of medical education and careers in Scotland. The first report by Professor Sir John Temple, covers medical career structures in Scotland; the second is by Sir Kenneth Calman and covers basic medical education in Scotland.

9.44 The Scottish Modernising Medical Careers Delivery Group is in the process of establishing a number of sub-groups to take forward detailed aspects of implementation and to inform its work programme in specific areas. These will include sub-groups to assess MMC policy in respect of:

- NHSScotland Service Impact;
- Communication Issues;
- Human Resource Issues;
- Student and Trainee matters; and
- Non-Consultant Career Grades.

Review of Medical Career Structures in Scotland

9.45 A short-life working group under Professor Sir John Temple was commissioned in Autumn 2002 by the Minister for Health and Community Care to review, as an integral part of the wider healthcare workforce, career structures for all doctors in Scotland from PRHO to consultant or principal in general practice. The Group's findings were published in June 2004 and endorsed by the Scottish Executive Health Department.

9.46 Key recommendations were made in the areas of:

- What kind of service we will need to staff in the future;
- What kinds of doctor we will need to staff such services;
- How we will provide for education, training and career development; and
- How we will secure the workforce.

9.47 Key messages include:

- The need for more doctors, working in new ways in a re-designed, multi-professional workforce;
- A move towards a trained-doctor based service;
- The need for effective workforce planning; and
- The need to engage with the public in matters of service re-design.

9.48 Much of what has been recommended will be taken forward by the Scottish Modernising Medical Careers Delivery Group and by its sub-groups. Other recommendations will be taken forward through the developing workforce planning and development arrangements and through other initiatives such as the National Framework for Service Change.

Review of Basic Medical Education in Scotland

9.49 As reported in SEHD's evidence last year, in the light of specific recommendations on undergraduate and medical education, contained in the summer 2002 report, *Future Practice,* the Minister for Health and Community Care commissioned a review of basic medical education in Scotland led by Professor Sir Kenneth Calman. The review published its findings in June 2004.

9.50 Key recommendations were made in the areas of:

- Additional medical student numbers;
- Admission to the Scottish medical schools; and
- Collaboration between the Scottish medical schools.

9.51 The Scottish Executive is currently considering Sir Kenneth's Report and will publish its response later in 2004.

D. STAFF GROUPS

Hospital Consultants

9.52 A new consultant contract for Scotland was accepted by a BMA Scotland ballot in October 2003.

9.53 Since the ballot the Consultant Contract Pay Modernisation Team has been working in partnership with NHSScotland management representatives, university representatives and BMAScotland to deliver the arrangements for transfer to and implementation of the contract and to realise benefits for NHS patient services and for consultants' working lives. The contract was implemented in Scotland from 1 April 2004.

9.54 In Scotland all existing consultants were given the opportunity to indicate by 31 December 2003 whether they wished to give a commitment to the new contract. A consultant in Scotland appointed prior to 1 April 2003 who, by 31 December 2003, gave a written expression of intent to transfer to the new contract, and who by 31 March 2004 was in the process of agreeing a job plan under the terms set out in the new contract (circulated to NHSScotland under cover of NHS Circular PCS(DD)2004/2) was entitled to receive pay increases backdated to 1 April 2003. Backdating was conditional upon a job plan being agreed except where this was not agreed due to reasons outwith the consultant's control.

9.55 Around 98% of consultants in Scotland gave a formal commitment to the new contract by 31 December 2003. Information shows that by September 2004, 95% of consultants who gave a formal commitment to the contract by 31 December 2003 had received final job plan offers. The total number on the new contract as at September 2004 is 2,895. Currently 486 consultants remain on the old contract while their job plan offer is agreed. 65 consultants have elected to remain on the old contract and have decided not to transfer.

9.56 Specific detail on the consultants choosing to remain on the old contract is not yet available as the job planning process is still continuing. Evidence received so far from NHS Boards

suggests that consultants choosing not to move to the new contract are either those near the end of their career who have elected not to transfer for pensions related reasons or those whose earning potential through private practice under the old contract cannot be matched by the new contract. Once the job planning process has been completed a more detailed assessment of this group of consultants will be undertaken.

9.57 A detailed financial assessment is scheduled to be undertaken across Scotland once the job planning process is complete, as the final financial impact of the contract is dependent on the outcome of individually agreed job plans. This is anticipated to take place during November.

9.58 Morale is reportedly high among consultants but some NHS Boards have reported that the new contract has given rise to reduced flexibility in some working practices, for example with regard to covering absent colleagues. SEHD is clear that while the contract rightly recognises the commitment provided by consultants through more transparent and systematic job planning, consultants' professional ethos should not be undermined by taking an extreme time sensitive "minute by minute" approach to job planning, and that a reasonable flexibility should be preserved in these matters.

9.59 It is too early to identify if the new contract has made an impact on recruitment and retention. No recruitment and retention premia have been adopted in Scotland and their use is currently subject to approval by a Pan-Scotland NHS Employers Reference Group for the contract. No applications have been approved to date.

9.60 NHS Boards in Scotland have found that implementing the new contract has assisted them in clarifying what gaps exist in service provision and, through the awarding of extra programmed activities, where additional workload is undertaken. NHS Boards report that the job planning process has helped to prioritise the workload and activities undertaken by consultants. This has reportedly given a clearer direction to Boards about which clinical areas require service re-design and has generally acted as a catalyst for change.

9.61 Since the introduction of the new contract NHS Boards have been working to ensure that, as a minimum, they manage to retain existing clinical activity undertaken under the old contract. Boards have found it necessary to pay consultants extra programmed activities in most specialties in order to do this. Achieving this in addition to ensuring compliance with the European Working Time Directive has been a significant challenge for most NHS Boards in Scotland. Boards are seeking to develop service and workforce re-design to help reduce the level of extra programmed activities or to enable an increase in workload.

9.62 SEHD has set up a National Partnership Steering Group (NPSG) comprising departmental representatives, BMA representatives, University representatives and NHSScotland managers under the chairmanship of the Pay Modernisation Director for the Consultant Contract to oversee the smooth implementation of the contract across Scotland. The Group has responded to issues as they have been raised and has issued guidance on issues such as job planning, backdated pay and offsetting, handling of fees and external duties.

Review of Distinction Awards and Discretionary Points

9.63 SEHD is committed to a review of the distinction awards and discretionary points schemes applied to consultants. In December 2003 SEHD met with key stakeholders for a "blue skies" session ahead of this review. It is intended that talks will begin in later this year and be completed next year.

Doctors in Training

9.64 There has been significant progress in achieving compliance with the New Deal for Junior Doctors and the recent July 2004 figures show an increase in New Deal compliance from 82% to 85%. SEHD is urging NHSScotland to continue its efforts to achieve full compliance. The Executive has also been in discussion with the BMA and NHSScotland to agree a national approach to managing non-compliant rotas for SHOs and SpRs.

9.65 The New Deal Implementation Support Group (ISG), run in partnership with BMA Scotland and Service representatives to help Boards achieve New Deal compliance, is continuing to work with Boards throughout Scotland to provide advice and guidance on producing compliant rotas. As a result of a review of ISG carried out last year SEHD is working with NHSScotland and the BMA to determine how support for NHSScotland on the New Deal contract should be best delivered in the future.

Non-Consultant Career Grades

9.66 SEHD welcomes the UK review of Non-Consultant Career Grade (NCCG) doctors, to be undertaken by the NHS Employers Organisation, and has confirmed that it will participate in that exercise. SEHD also notes that the make-up and operation of the NCCG grade in Scotland is different to that in England for the following reasons:

- Scotland has relatively few "trust doctors" and retains a formal policy that such appointments should not be made (although it is accepted, in the light of MMC, that this situation requires to be reviewed).
- Most of Scotland's NCCGs are female (65%), while we understand there is a male predominance in England.
- Most of Scotland's NCCG grade doctors are UK graduates (65%) compared to only 33% in England;
- Scotland's terms and conditions of service currently vary from those applicable elsewhere in the UK. For example, in Scotland promotion to Associate Specialist is by personal regrading.
- Scotland has tighter workforce controls on these grades than in England.

9.67 SEHD will be participating in the UK review on the basis that this will produce a contractual framework flexible enough to respond to differences which exist across the UK. The Department has already set in train discussions with the Scottish Staff and Associate Specialists Committee (SSASC) of BMAScotland in readiness for taking forward work alongside and following the outcome of the UK review.

9.68 In the meantime SEHD has become aware of concerns in relation to the application of current terms and conditions of service for NCCG doctors and has issued two letters to NHS Boards (on 18 February and 4 August 2004) reminding employers that the discretionary points schemes for NCCGs are being operated effectively and to ensure that NHS employers are carrying out their responsibilities to conduct effective job planning and appraisal for NCCGs.

New General Medical Services Contract

9.69 The new GMS contract aims to resource and reward GPs on the basis of how well they care for patients rather than simply the number of patients they treat; allocate resources more fairly

according to patient need; provide new recruitment and retention possibilities to tackle GP shortages; ensure patients have more choice and access to a wider range of high-quality services, with more treatment in the community rather than the hospital; and overhaul and modernise GP premises and their I M & T systems.

9.70 All GMS practices in Scotland have signed a new GMS contract with their Health Board. This result is tribute to the hard work and partnership working of Health Boards and practices.

9.71 Having signed contracts, the Service in Scotland has faced major operational and strategic challenges to ensure all practices were paid by the end of April; to agree practice budgets; to manage the Quality and Outcomes Framework; and to finalise new out-of-hours arrangements. The Department continues to work closely with the Service on delivering these and other aspects of the contract. All these challenges have been met to date and NHSScotland remains on track to deliver those that remain to be completed.

Implementation Arrangements

9.72 Each NHS Board area has established an implementation team to develop a local framework for delivering the new contract in a way that is best suited to local circumstances. Each team has produced a detailed implementation project plan and is in the process of delivering against that plan. Funding has been allocated (2003-04 and 2005-06) to support this activity as part of an integrated approach to pay modernisation across NHSScotland.

9.73 A Pay Modernisation Director for the new GMS contract in Scotland has been appointed to lead activity at national level and a National Reference Group comprising key stakeholders, including from NHSScotland, the relevant professions and SEHD, has been created to support this work. The Reference Group has identified the need for national Working Groups to generate guidance and model templates for the Service and to share best practice on key issues arising from the contract. The working groups are addressing significant issues around the following major themes:

- Out of Hours service delivery
- Quality and Outcomes Framework
- Organisational Development
- Service Redesign
- Finance
- Information Management and Technology (IM & T)
- Premises

Enhanced Services

9.74 Following agreement between the Health Departments, the General Practitioners Committee of the BMA and the NHS Confederation, SEHD allocated £12 million in 2003 for enhanced services as part of the 3-year funding allocation for general medical services. In 2004 a further £34.9 million was allocated for enhanced services. Health Board-planned spend must be discussed with the GP Sub-Committee of the Board's Area Medical Committee. At UK level, the Technical Steering Committee will monitor spend on enhanced services.

Out of Hours Service Delivery

9.75 NHS Boards across Scotland are developing their plans for out-of-hours service re-provision. Where required, new arrangements must be in place by 31 December 2004. Given the structural and geographical diversity of Scotland, from densely populated urban centres to

sparsely populated rural areas, there is no single appropriate model of out-of-hours service provision. Each Board will put arrangements in place in accordance with local circumstances, but these must meet common, mandatory accreditation standards which will ensure a safe, quality service for patients.

9.76 These standards, entitled "*The Provision of Safe and Effective Primary Medical Services Out-of-Hours"*(www.nhshealthquality.org) have been developed by NHS Quality Improvement Standard (NHS QIS) with the support of healthcare professionals and members of the public. By November 2004 all out-of-hours providers must register with NHS QIS and from 1 January 2005 all providers will have a statutory requirement to meet the standards.

9.77 Re-provision of out-of-hours services is a key priority for NHS Boards across Scotland. To assist the Service a national Out-of-Hours Working Group has been established involving key representatives from NHS Boards, the public, GPs, the Scottish Ambulance Service and NHS24. In addition, three national Out-of-Hours co-ordinators have been appointed to the NHS Scotland Pay Modernisation Team to lead this planning activity.

9.78 As at 1 October 2004, five Board areas had already introduced their new out-of-hours arrangements: NHS Ayrshire and Arran, NHS Fife, NHS Glasgow, NHS Lothian and NHS Forth Valley. To date, no significant adverse issues have been reported in these areas and implementation appears to be bedding in with no more than expected "teething troubles".

Inducement Practitioners

9.79 The inducement payment scheme for rural and remote GPs was abolished in Scotland upon introduction of the new GMS contract on 1 April 2004. There were previously some 125 inducement practitioners (IPs). IPs' contractual arrangements have been brought into line with their mainstream colleagues. Under the terms of the new contract IPs have several employment options:

- Independent contractor status under the new GMS contract, on the assumption that there is adequate income for the practice through the standard GMS arrangements applied across the UK (global sum, MPIG, quality payments, enhanced services payments, seniority payments and additional out-of-hours payments);

- Independent contractor status under a 'Section 17C' (formerly personal medical services) contract;

- A salaried option based on the national pay range for salaried GPs under the new GMS contract but subject to local job evaluation.

9.80 An approach to calculating the Global Sum Equivalent for all Inducement Practices has been agreed with the Scottish General Practitioners Committee (SGPC) and signed off by the UK plenary negotiating body for the new GMS contract.

Associate GPs

9.81 Like the inducement payment scheme, the associate scheme for rural and remote GPs was abolished upon introduction of the new GMS contract. Following negotiation and agreement with SGPC, and sign off at the UK plenary negotiating body, associates are able to choose one of the following options as their new contractual arrangement:

- A salaried contract based on the model for a salaried GP employed by a Primary Care Organisation as set out in the Supplementary Documents to the new GMS Contract 2003

publications and using the DDRB recommended salary. NHS Boards should also take account of any relevant related expenses to which the current Associate GP is entitled.

- A level of funding equivalent to that in option a) plus the relevant related expenses of the current Associate GP, to be made available to the appropriate practice to enable it to offer a salaried contract based on the model for a salaried GP employed by a GMS practice as set out in the Supplementary Documents to the new GMS Contract 2003 publications.

- A level of funding equivalent to that in option b) to be made available to the appropriate practice to enable it to offer partnership status to the current Associate GP. NHS Boards have the discretion to offer an enhanced package to recognise the increased responsibility of partnership status and to improve this option should they deem this to be required. The offer of any premium over the funding available for the salaried option is a matter for local determination by the NHS Board. Any premium which the Board may decide to offer should be agreed between the Board, the current associate GP and the practice concerned.

9.82 Choice of the most appropriate new option in each case is a matter for local determination and agreement between current Associate GPs, practices and NHS Boards.

Recruitment and Retention of GPs

9.83 The total numbers of General Practitioners in Scotland increased by 78 (WTE) or 1.9% in 2003. We believe that introduction of the new General Medical Services (GMS) contract will help attract and retain GPs in future years.

9.84 The new contract contains several measures aimed at improving the recruitment and retention of GPs as follows:

- GPs will have the option to transfer responsibility for providing out-of-hours care. The out-of-hours commitment was perhaps the single most important disincentive to working in general practice, particularly in remote and rural areas.

- New and most returning GPs will receive the £5,000 "Golden Hello" payment. They can also receive a further payment of between £2,500 and £7,500 if the practice they join is in a remote and rural area or one of the most deprived areas of Scotland.

- There is an improved seniority scheme to reward GPs the longer they stay in the service.

9.85 The Scottish Allocation Formula for allocating funds under the contract gives additional weighting to reflect the extra costs incurred in providing GMS in remote and rural areas.

9.86 Health Boards have the flexibility to employ salaried GPs and deploy them as necessary. This new flexibility will help Boards manage particular difficulties which may arise.

Community Hospitals

9.87 *A Partnership for a Better Scotland* carried a commitment that "we will develop the important role of community hospitals and develop a strategy for sustaining small, rural and community hospitals where they are safe and effective, including the provision of minor surgery and to act as a resource for GPs".

9.88 To deliver on this commitment a national review of the role of community hospitals is underway. A small Community Hospitals Strategy Core Group has been established. This

group is currently gathering information about current provision and aspirations for future provision. A broader based Reference Group has also been established to further support and inform the strategy development.

9.89 New contractual arrangements for GPs working in Community Hospitals were not included in the new GMS contract negotiations. Discussions between SEHD and SGPC are now underway on this issue, with support and input from the Service and the Scottish Association of Community Hospitals. These discussions aim to develop a national framework for contractual arrangements for GPs working in Community Hospitals. This should be sufficiently flexible to recognise local variations but would focus on key principles on the use of Community Hospitals, readily identifiable activity measures, and quality and outcomes standards. The framework would recognise the contribution of all members of the clinical team. The draft quality standards from NHS Quality Improvement Scotland would also be an important element in any arrangements. The aim is to produce an initial framework by April 2005. Any short term arrangements should accord with the emerging findings of the strategic review of Community Hospitals.

Dental Services

***Modernising NHS Dental Services in Scotland* Consultation**

9.90 The consultation on *Modernising NHS Dental Services in Scotland,* announced on 20 November 2003, closed on 2 April 2004. Over 200 written responses were received and an analysis is now complete. The full analysis report can be found on the internet at http://www.scotland.gov.uk/library5/health/srmdscr-00.asp. and a summary Research Findings paper can be found at http://www.scotland.gov.uk/cru/resfinds/ocr5-00.asp. We expect an Executive response to put forward policy proposals in the Autumn.

Allowances for General Dental Practitioners

9.91 New and enhanced grants and allowances for general dental practitioners as detailed in our previous contribution came into effect on 1 April 2004 – see **Annex H**. Details of these have been sent to all general dental practitioners, dental undergraduate and postgraduate students. Information about uptake of allowances for vocational trainees is not yet available. However, SEHD intend to provide DDRB with a report in due course which will compare this year's and last year's uptake of the other allowances.

Free Dental Examinations

9.92 *A Partnership for a Better Scotland: Partnership Agreement* published in May 2003 made a commitment to systematically introduce free dental (and eye) checks by 2007. Discussions are on-going with the Dental Profession in Scotland to consider how this might be taken forward.

E. REGIONAL PAY

9.93 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 recruitment and retention and what impact these will have on any requirement for pay differentials in addressing local recruitment and retention pressures. There is scope within the new consultant contract for Scotland to apply recruitment and retention premia in specific cases but NHS employers have determined that this should be avoided in order to retain a "level playing field" in the consultant labour market across Scotland – perceived as a clear benefit of the new contract.

9.94 Clearly in the initial contract implementation period differentials will exist in consultants' pay depending on how many programmed activities they agree in their job plans. In the medium term future this variation makes it difficult to identify what impact additional recruitment and retention measures would have. SEHD will monitor the situation with a view to reporting in next year's evidence on whether additional action is required to address vacancy variations.

F. AFFORDABILITY

9.95 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. However, 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
- Inflation.

9.96 The Scottish Executive Health Department's provision for 2004-05 to 2007-08 are set out in the following table:

	2004-05	2005-06	2006-07	2007-08
Total (£m)	8062	8803	9537	10286
Cash Growth (£m)	745	741	734	749
Cash Growth (%)	10.2%	9.2%	8.34%	7.85%
GDP Deflator	2.31%	2.52%	2.68%	2.70%
Real Terms Growth	7.7%	6.51%	5.51%	5.01%

9.97 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 on-going commitment to 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, which will account for some £60 million per year;
- Reducing waiting times for outpatient, inpatient or day case treatment;
- Delivery of visible improvements in care for patients in the clinical priority areas of cancer, coronary heart disease 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.

9.98 NHS Boards have been allocated revenue allocations for 2004-05 comprising a minimum increase of 6.75% with an average increase of 7.25% and a maximum increase of 8.66%. NHSBoards have been notified of indicative increases of an average increase of 7.25% for 2005-06.

9.99 The Scottish Executive is committed to improving health and revitalising the NHS and community 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.

9.100 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 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.**

- There are proportionately more NHS staff in Scotland than in England so the cost of implementing any given level of pay award is correspondingly higher.

- The Department's ongoing commitment to the modernisation of NHSScotland.

- Affordability and the competing demands for investment

- The Government's inflation target.

- The significant extra investment already provided in the delivery of new contracts for doctors this year.

9.101 Details of Scotland's paybill budget for this sector is at **Annex I**.

CONCLUSION

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

- The totality of funding available to SEHD;

- Specific consideration of the position in Scotland in relation to the new consultant contract and the GMS contract;

- 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; and

- Inflation.

9.103 Last year the Review Body endorsed the 3.225% pay uplift for hospital consultants transferring to the new consultant contract in Scotland, to give effect to Year 2 of the agreed 10% 3-year pay deal. The Scottish Executive Health Department supports the recommendations contained in the Executive Summary in relation to the uplift of 3.225% for consultants on the new consultant contract, for salaried dentists and for distinction awards and discretionary points and that for all other groups within the DDRB's remit pay uplifts for 2005-06 should be in line with inflation. SEHD also strongly supports the recommendation on consultants' collaborative fees made in paragraph 5.46 of the Department of Health's evidence.

ANNEX A

KEY ECONOMIC DATA

Data on average earnings and inflation
Average earnings

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 for National Statistics (ONS). The AEI covers both full-time and part-time workers and includes basic pay, shift payments, bonuses and profit-related pay. Earnings growth for the public, private and whole economy sectors, among others, is measured using the AEI, published monthly by the ONS. ONS measure of the year-on-year % growth in earnings is calculated as the average rate of pay-bill per head (PPH) increase over all employers in the relevant sector. The difference between earnings growth and PPH growth is that the former includes only pay increases to employees in-grade, whilst PPH growth includes the net effect on pay-bill of all these increases, including changes to the workforce composition. Despite this**,** earnings growth for an organisation can be usefully compared to AEI growth on the basis that over the whole economy (or a broad sector of the economy) in the short to medium term, there is likely to be little net change in the compositional mix of the workforce. This is similar to a situation where everyone remains in the 'same' job. Because earnings growth considers only individuals who remain in post, and AEI growth is measured over broad sectors in which there is little compositional change to the workforce, AEI and earnings growth are conceptually equivalent measures, so can be compared.

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.

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

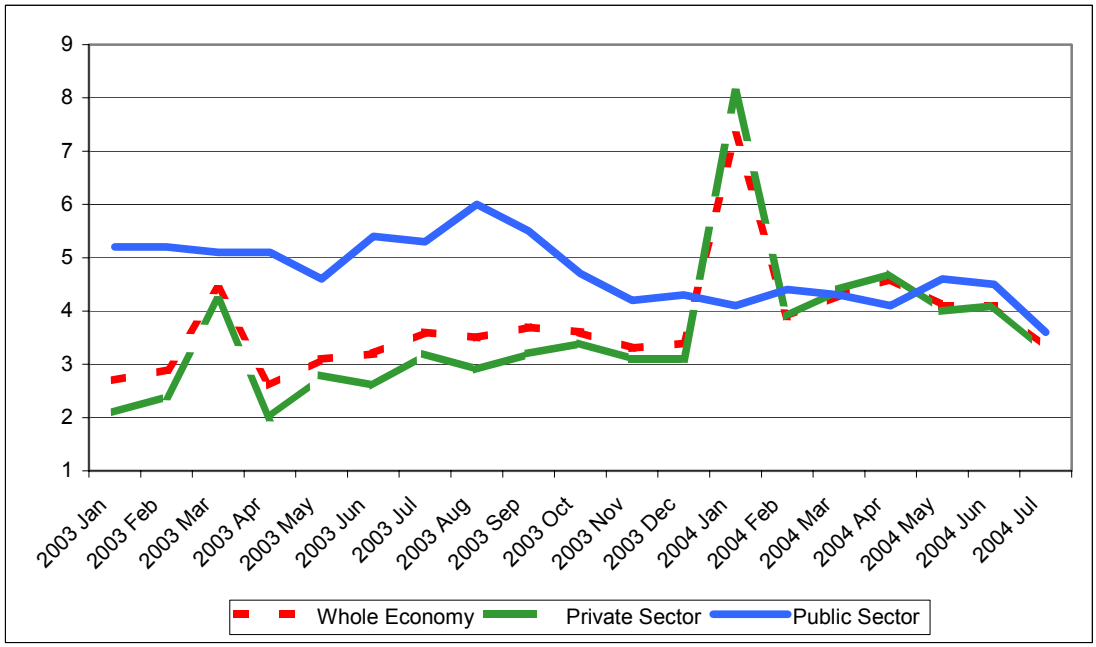
The AEI measures earnings growth in two ways:

- 12-month increase in the level of the index
- Average of the last three months' 12-month increases. This averaging process smoothes out aberrations of the index from month to month, giving a better view of underlying earnings growth.

Table 1. Recent seasonally adjusted Average Earnings Index (AEI) figures

	Whole Economy		**Private Sector**		**Public sector**	
	Average Earnings Index (%) inc bonuses					
	3mth increase	12mth increase	3mth increase	12mth increase	3mth increase	12mth increase
Jun 2004	**4.3**	**4.1**	**4.3**	**4.1**	**4.4**	**4.5**
Jul 2004	**3.8**	**3.3**	**3.8**	**3.2**	**4.2**	**3.6**

Chart 1. 12-month Average Earnings Index including bonuses

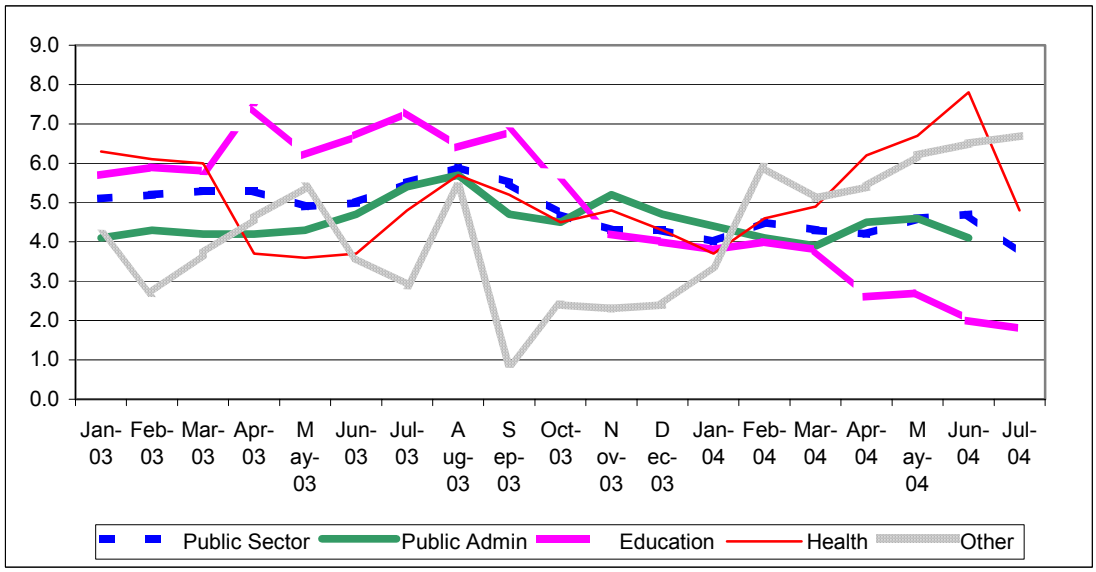


The table below shows the last 2 months' data on increases to the average earnings index excluding bonuses and arrears for public sector and for (i) public administration, (ii) education, (iii) health and social work, and (iv) other public sector over the past year. The chart shows how these indices of average earnings have changed over the past year.

Table 2. Public Sector AEI breakdown

	12 Month Public Sector Average Earning Index*				
	Percentage change (Excl bonuses and arrears)				
	Public Sector	Public Admin	Education	Health	Other
June 04	**4.7%**	**4.6%**	**2.0%**	**7.8%**	**6.5%**
July 04	**3.7%**	**4.1%**	**1.8%**	**4.8%**	**6.7%**

*Note the breakdown of the public sector AEI is not seasonally adjusted each month and so the Public Sector growth rate differs slightly to that in Table 1.



Inflation Data

Inflation is the rise to the price level over time which results in a general fall in the purchasing power of money. The ONS calculates inflation using several measures:

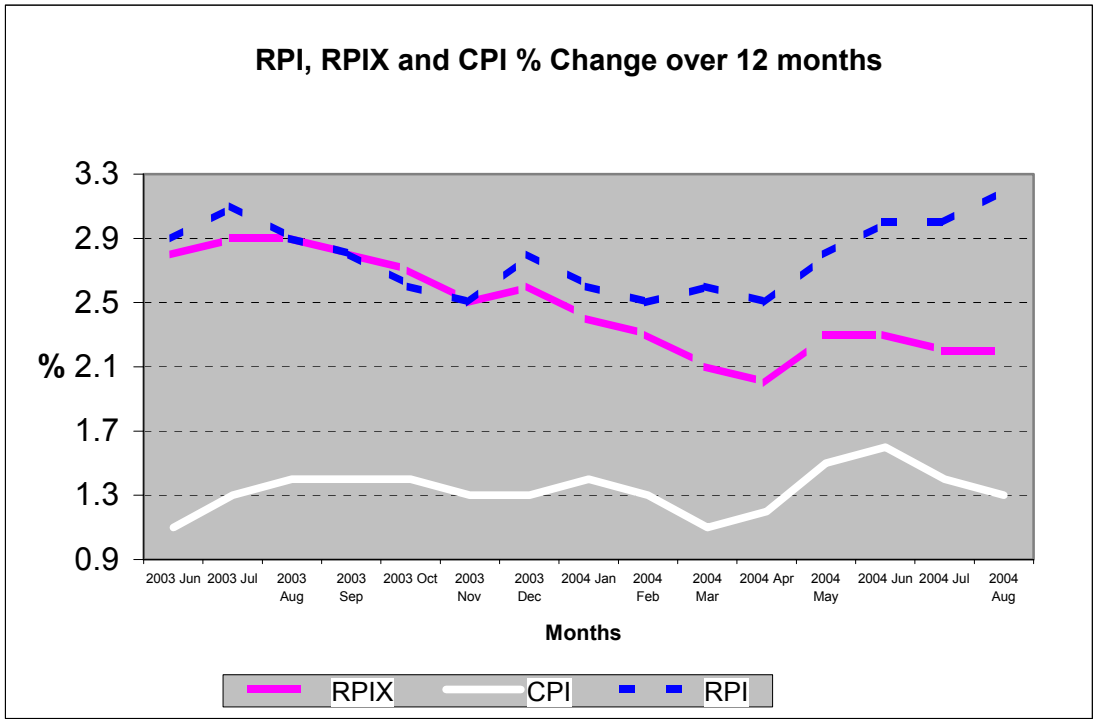
- The Retail Prices Index (RPI) is calculated as the weighted average of changes to the prices of a 'basket' of goods that represent the expenditure of UK households.
- RPIX is similar to the RPI but excludes mortgage interest payments. This makes the index less volatile to changes in the interest rate.
- Like the RPI, the Consumer Price Index (CPI) measures the average change from month to month in the prices of consumer goods and services. However it differs in the particular households it represents, the range of goods and services included, and the way the index is constructed.

Information on these and other ONS measures of inflation can be found on ONS' website.

The table below presents the latest two months' data on RPI, RPIX and CPI. The chart shows the fluctuation over the past year.

Table 3. Recent inflation trends

	CPI (%)	RPI (%)	RPIX (%)
July 04	**1.4**	**3.0**	**2.2**
Aug 04	**1.3**	**3.2**	**2.2**



ANNEX B

SPENDING REVIEW 2004 PUBLIC SERVICE AGREEMENT

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

The objectives of the SR2004 Public Service Agreement are:

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

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

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

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

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

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

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

Objective III: Improve access to services

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

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

Objective IV: Improve the patient and user experience

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

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

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

ANNEX C

POSTGRADUATE MEDICAL TRAINING REFORM AND NEW OPPORTUNITIES FOR DOCTORS IN THE NON-CONSULTANT CAREER GRADES (NCCGs)

Although doctors in these grades provide a valuable service for the NHS, many feel undervalued and that there are insufficient opportunities for them to develop their careers. There is clearly scope to improve arrangements to help them develop their skills further and fulfil their potential. This must benefit the doctors themselves, the NHS and patients.

Obstacles currently faced by NCCG doctors can be divided into two main issues:

Legislative

There is a pool of doctors in the NHS with potential to become consultants but unable to do so because of the restrictions inherent in the existing regulatory framework:

- In order to be appointed to a consultant post in the NHS, a doctor has to have his or her name included on the Specialist Register. This register lists the names of those doctors who hold the UK Certificate of Completion of Specialist Training (CCST) or, for doctors trained overseas, enter the UK already possessing *qualifications* considered by the Specialist Training Authority (STA) to be equivalent to a CCST. There is no provision, in law, to upgrade those not on the Specialist Register to consultant posts.

- Similarly, there are doctors with skills at a level close to that of the CCST who could reach the appropriate level with "top-up" training. However, current UK legislation does not allow such training to be undertaken in the UK – doctors either need to have a CCST-equivalent qualification from overseas or need to complete a full programme of specialist training in the UK leading to the award of a CCST.

Perception and lack of support

NCCGs have been regarded as a professional cul de sac. Although their creation, at different times, was in response to legitimate service requirements and their contribution to the National Health Service is undoubted, they are seen by some as lacking in status and recognition. Often achieving consultant status is seen as the only proper pathway for a career in hospital medicine. Even senior colleagues may be unaware of the variety of reasons why NCCGs are in these posts and of the qualifications they hold.

There is no consistent framework for progress through the grades and no form of external review to quality assure the work of NCCGs and so make sure they get proper career development. Ad hoc local arrangements compound the lack of clarity. Added to this, there is little or no access to formal, skilled career counselling and frequently a lack of a perspective on career options. Many NCCG doctors would like to move back into the training system and to complete training, but find limited opportunities to do so.

Action

Opportunities for NCCG doctors will increase as a result of two initiatives:

- the establishment of the Postgraduate Medical Education and Training Board (PMETB); and

- reforms proposed in the recommendations of the document *Choice and Opportunity: Modernising Medical Careers for Non-Consultant Career Grade doctors*.

PMETB

Once the PMETB goes live it will be able to assess the training, qualifications and experience of doctors wherever obtained to establish if they have skills equivalent to the level of the CCST, or if not, to prescribe the training required to reach that level. In other words this will remove the legislative obstacles described above and should significantly increase opportunities for doctors "stuck" in the NCCGs.

Choice and Opportunity

This document was published for consultation in July 2003 as part of the *Modernising Medical Careers* initiative. It aimed to ensure that NCCG doctors were not left behind by the reforms of medical training. It set out the problems and identified the key principles for reform of the NCCGs: proper entry to, progress through and exit from a new career structure linked with opportunities for development and the chance to return to training and supported by good career advice. The Secretary of State announced on 5 May that the Government had accepted all the recommendations.

Why NCCG reform cannot be introduced immediately

The proposed NCCG reforms are linked to implementation of the *Modernising Medical Careers* proposals. In particular:

- Both assume the introduction of competency-based assessment. This should be applied to NCCG doctors as in the same way as doctors in training so that doctors with comparable competencies can be recognised as able to provide the same service whether in the training grades or the NCCGs and aid movement between the two structures - and in due course blur unhelpful distinctions.

- Such assessment will also allow doctors to establish the competencies required for their progress so that they can seek appropriate opportunities for development. A new system will need to be developed to make sure that "top-up" training opportunities are available in a fair and organised way which offers NCCG aspirants a reasonable chance of progressing further.

- More work is required on scoping numbers in order to understand the scale of the changes required. Unfortunately, producing an accurate picture of the NCCG population - including those employed on local contracts - is not straightforward and depends on interpreted data. The published data show around 12,500 doctors (headcount) in this category. Separate analysis shows that there are around 5,000 doctors on local contracts, for whom the equivalent national grade is unclear.

The link to pay reform

It is acknowledged both that:

- pay reform for NCCGs is desirable and that their representatives are calling for progress to be made; and

- it would be difficult to address developmental and career issues without making a link with pay reform (indeed, one of the recommendations of *Choice and Opportunity* is

"a new career structure and competencies will need new pay and terms and conditions of service which are appropriate for it")

However, the Department's argument is that any new pay arrangements will need to take account of the revised structure to ensure that it can:

- meet the needs of the new system, reflecting the new structure and providing appropriate rewards linked to the level of competency of the doctor and weighting of posts;

- enable rather than hinder movement into training;

- include effective and fair transitional arrangements which would see existing NCCGs move into new structures.

Whilst this means a delay in the eyes of NCCG representatives, if offers the longer term prospect of a much improved, fairer and more transparent structure for NCCG doctors both in terms of career development and financial reward.

Next Steps

As a first step, the Department of Health has commissioned the NHS Confederation to begin scoping how pay reform and NCCG reform can be taken forward and to report back in September. Implementation of the *Choice and Opportunity* recommendations will be taken forward in the light of that report.

Conclusion

The Department recommends that pay reform should reflect structural reform and that the detail of any reformed pay system will have to be agreed in the light of emerging proposals for structural reform. We will not be in a position to agree the detail of any new pay system by April 2005.

ANNEX D

RETENTION AND RETIREMENTS

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

2. We remain of the view that, whilst there are some indications of a small shift towards early retirement, the numbers involved are small and would have only a marginal impact on total numbers overall. The Department has put in place a range of measures to encourage higher rates of retention.

How does the Department model retirement rates?

3. In its modelling, the Department examines recent leaving rates for consultants at different ages. These figures are then adjusted to reflect the available evidence on changes in retirement rates over time. Typically, models assume a shift of around half a year in the average retirement age for each 10-year period. These adjusted leaving rates are then combined with information about the current age profile of the workforce, to model numbers of future leavers.

4. The starting point for this analysis is to examine the Department's own workforce census data and to identify, for example, how many 53 year old consultants are in service one year but not the next. This produces a series of age-specific leaving rates. It is important that these figures are checked against evidence from other sources and the impact of any variations noted and taken on board. In our analysis, figures are adjusted to reflect evidence from MCRG surveys and data from the NHS Pensions agency.

5. When modelling Consultant numbers, our assumptions about numbers of retirements are informed by separate evidence from the Medical Royal Colleges. The projected leavers from these calculations are in line with figures from the Department's own analysis.

New data on early retirement intentions

6. The Medical Careers Research Group (MCRG) has provided results from a new study into the retirement intentions of doctors approaching the age when some of them might to start to consider early retirement. The MCRG have sought views from those doctors who qualified in 1977, most of whom are now in their late 40s. This study follows the format of a previous MRCG study, relating to the 1974 cohort and provides a view on emerging trends in retirement intentions.

7. These interim results show that 17% of the 1977 cohort have a definite intention to retire early. This compares to 25% of the 1974 cohort at a similar stage in their careers. Initially, these figures seem quite high, although the results of the 1977 survey do show an improvement. A total of 35% of the 1977 respondents said they would definitely not or probably not stay on to retirement age. Again this compares favourably with the survey of the 1974 cohort in which over half were of this opinion.

8. These results need to be viewed with caution. They do suggest a reduction in the level of intentions to retire early. However, the key point to bear in mind is that early retirement intentions are not the same thing as actual retirements. It is common in many professions for early retirement intentions to be overstated. The survey of the

1974 cohort suggested very high rates of early retirement, but the reality is that this has not produced any significant shift in actual retirements so far.

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

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

Data from the NHS Pensions Agency

11. The table below updates the evidence provided last year by the NHS Pensions agency. It shows the number of consultants who received a pension award, from the NHS pension scheme, in each of the financial years 1997 to 2003, by category of retirement:

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

Year	Age	Ill-health	Deferred Pension Benefits	Redundancy	Agreed Voluntary Early Retirement	Voluntary Early Retirement	Unknown	Total Consultant Pension Awards
1997/98	257	51	8	32	0	31	42	**421**
1998/99	290	57	13	27	0	28	37	**452**
1999/00	268	51	8	28	2	18	32	**407**
2000/01	282	49	8	17	0	31	31	**418**
2001/02	332	66	15	10	0	62	17	**502**
2002/03	328	65	14	8	0		74*	**489**
2003/04	328	57	8	8	0		73*	**474**

*data for voluntary early retirement in 2002 and 2003 are not currently available.

12. The figures relate to England and Wales, because it is not possible to separate Welsh doctor data for this calculation. Also, retirement data held by the NHS Pensions agency is used primarily to record membership of the scheme. The information is updated continuously so can change.

13. The updated table shows that there is no clear trend, and that total number of retirements has actually fallen in the last two years. The number of age retirements is higher now than it was in the late 1990s, but this reflects the age profile of the current workforce rather than any change in retirement rates. Unfortunately there is no new data on voluntary early retirements because those cases are still included in the unknown category, but if we look at unknowns and early retirements together the figures suggest no systematic increase over the last two years.

14. These data need to be considered alongside existing evidence on retirement trends. In previous years' evidence we have quoted findings from the 1979-1984 actuarial

investigation of the NHS Pension Scheme by the Government Actuary's Department. This projected an average age of retirement for male hospital doctors of 63.9. The corresponding figure in their latest valuation (for 1989 to 1994, completed in October 1998) is 63.3 indicating a small change over a ten-year period. It is this change that we reflect in the age-specific leaving rates used in departmental workforce models.

15. Retirement is not the only source of leavers from the workforce, but general retention rates do not show any unwelcome trends and our workforce planning models already factor in non-retirement leavers. For this year's evidence we have updated the usual analysis from the Medical Careers Research Group (MCRG) on overall wastage rates 5 years after qualifying. Table 2 below shows the MCRG's estimates of numbers of doctors not practising medicine, and numbers not practising medicine in the UK, five years after qualification. The figures are minimum estimates, because they exclude non-respondents who are registered as doctors in the UK.

Table 2: Patterns of Retention – Five Years After Qualification

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

16. The percentage of graduates not practising medicine after five years has remained quite low for all cohorts, with no clear trends over time. The percentage of 1996 graduates not practising medicine in 2001 was 4.7%, compared with 5.2% for the 1993 graduates at the same stage of their career (1998). The percentage not practising medicine in the UK was 7.9%, compared to 8.8% for the 1993 cohort. There is no clear trend, but in both cases the proportions not working in UK medicine are smaller than for previous cohorts.

New Analysis of HCHS Census Data

17. To ensure that we are assembling as complete and up to date a picture as possible of any emerging trends in retention patterns, we have also updated the analyses of our won HCHS census data in the usual way. The latest available figures show retirement patterns in the year to September 2003. As in previous years, we have analysed the data in two different ways, firstly looking at latest trends and then looking at likely future trends based on the current age profile of the workforce

18. The first analysis provides details of consultants who have left the NHS between 2002 and 2003, but without taking into account the small numbers that flow to other sectors, such as GMS, so the wastage rates may be slightly overstated. Overall, the wastage rate for hospital medical consultants has remained almost unchanged since 1995, with gross wastage at between 5% and 6%. In the last 4 or 5 years there has been a slight upward trend in the number of consultants appointed from outside the NHS (including rejoiners) and as a result the net wastage rate has fallen from a 2% loss to a 1.1% gain.

19. As expected, there is a variation by age. The gross number of leavers in the 55 to 59 age group is typically about 250 to 300 each year – about 8% or 9% of staff in that

group. However, when taking into account the number of staff in this age group newly appointed from outside the NHS, the net wastage in this age group currently stands at 4%.

20. As well as assessing retirement rates, we also need to take into account the age profile of the current workforce. Doctors recruited during the expansion of medical school places in the late 1960s are now nearing retirement age, and an increase in the numbers retiring is only to be expected. It leads to only a marginal increase in the projected numbers of retirements, not enough to have a significant impact on our workforce projections, but this factor is always assessed as part of our workforce planning mechanisms and is a factor that we will continue to monitor.

ANNEX E

ESTIMATED PERCENTAGE OF SHOs AND SPRs IN EACH YEAR OF GRADE

1. The Review Body requested evidence on the length of time in grade at SHO and SpR level. This information is not collected by the Department, but it is possible to estimate the distribution. Table 1 below shows the estimated distribution for the SHO grade in England. It is important to note that years 1 and 2 will include a number of staff who will later join the VTS scheme for General Practice, hence the sharp fall after year 2.

Table 1: Estimated percentage of SHOs in each year of grade
Source: Medical and dental workforce census

Year	Percentage of grade
1st year	42%
2nd year	31%
3rd year(1)	17%
4th year (1)	7%
5th year (and over) (1)	4%

(1): Excludes staff who will join the VTS scheme for General Practice

2. For SpRs, there are some data available on date of entry to grade. This information is collected from the Postgraduate Deans in England and Wales. Table 2 below gives the breakdown for those records that have this field completed. The table shows a fairly even spread across years 1 to 4, allowing for moderate non-retention in the SpR grade (typically around 1.6% per year).

Table 2: Estimated percentage of SpRs in each year of grade
Source: Postgraduate Deans Planning Extract Returns

Year	Percentage of grade
1st year	19%
2nd year	20%
3rd year	17%
4th year	14%
5th year	12%
6th year	8%
6th year +	9%

ANNEX F

MARKET FORCES FACTOR

- Funding is allocated to PCTs on the basis of the relative needs of their populations. A weighted capitation formula is used to determine each PCT's target share of available resources, to enable them to commission similar levels of health services for populations in similar need.

- In order to be equitable, the weighted capitation formula takes account of the fact that the cost of providing healthcare is not the same everywhere. The need for a market forces factor (MFF) was identified by the Resource Allocation Working Party, who recognised that the costs of care may vary from place to place depending on local variations in market forces. The purpose of the MFF is to equalise the commissioning power of PCTs by adjusting for unavoidable variations in NHS Trust costs directly related to location.

- The aim of the staff MFF is to reflect the geographical variation in staff costs that NHS employers incur. This is necessary in spite of national pay arrangements because the geographical variation in the labour market results in some NHS trusts facing higher "hidden" staff costs due to recruitment and retention difficulties, grade drift, the use of agency staff etc.

- The staff MFF is based on the three latest years of the New Earnings Survey Panel Data Set (NESPD). For 2003/04 to 2005/06 allocations, these were based on 1999, 2000 and 2001. The analysis uses individual earnings of full-time employees aged 16-70 in the private sector whose pay is not affected by absence, all others are stripped out. The annual sample used is around 75,000.

- The data are aggregated into 117 NES zones, based on London boroughs, shire counties and the former metropolitan counties. Each year's data are used in a regression analysis which isolates the effect of geography on staff costs in each zone by accounting for the effect of other factors, such as age, sex, industry and occupation.

- The current methodology was adopted following the 2001 review of the staff MFF by the Institute for Employment Research (IER) at the University of Warwick. The results of the review were reported in Spatial Variations in Labour Costs: 2001 Review of the Staff Market Forces Factor.

ANNEX G

ADDITIONAL STATISTICS NHS SCOTLAND

All HCHS Doctors and Dentists: Scotland

Table 1: HCHS Medical and Dental Staff by staff group and region

	East	West	North	Other
Population [1]	**1,516,490**	**2,352,110**	**1,186,200**	**-**
All staff	**2,815**	**4,843**	**2,643**	**106**
Consultant [2]	964	1,639	858	54
Associate specialist & Staff grades	200	310	170	11
Registrar group [3]	492	610	435	8
Senior house officer	661	1,431	589	6
House officer	225	350	223	-
Other	280	523	374	27

Source: ISD Scotland

1 Registrar General for Scotland Population Estimates as at mid June 2002.
2 Consultant includes Director of Public Health
3 Registrar group includes Specialist Registrars, Senior Registrars and Registrars

Consultants: Scotland

Table 2: Current average age of Consultants per medical and dental specialty

	Average Age as at 30th September		
	2001	**2002**	**2003**
All Specialties	**46.6**	**46.8**	**46.9**
All Medical Specialties	**46.6**	**46.7**	**46.6**
Hospital Medical Specialties	**46.5**	**46.7**	**46.5**
Accident & Emergency Medicine	43.9	43.3	43.9
Anaesthetics	44.8	45.1	44.8
Clinical Laboratory Specialties	**47.3**	**47.6**	**47.3**
Blood transfusion	47.8	48.8	47.8
Chemical pathology	47.9	48.1	47.9
Clinical genetics	44.7	45.3	44.7
Haematology	46.7	47.0	46.7
Histopathology	47.2	47.4	47.2
Immunology	45.5	49.5	45.5
Medical microbiology & Virology	48.4	48.9	48.4
Medical Specialties	**46.9**	**47.0**	**46.9**
Audiological medicine	49.0	50.0	49.0
Dermatology	48.0	49.0	48.0
General medicine (group)	**47.2**	**47.3**	**47.2**
Cardiology	46.1	46.8	46.1
Clinical pharmacology & therapeutics	44.3	44.7	44.3
Infectious diseases	48.1	49.1	48.1
Endocrinology & diabetes	43.3	44.4	43.3
Gastroenterology	45.5	45.3	45.5
General medicine	48.6	48.5	48.6
Renal medicine	45.0	45.9	45.0
Respiratory medicine	48.5	47.3	48.5
Rheumatology	45.2	45.9	45.2
Genito - urinary medicine	47.1	48.0	47.1
Geriatrics	45.7	46.1	45.7
Homoeopathy	43.5	44.5	43.5
Intensive Care Medicine	33.0	34.0	33.0
Medical oncology	45.2	45.9	45.2
Medical ophthalmology	37.0	-	37.0
Neurology	46.9	46.0	46.9
Paediatrics	47.5	47.0	47.5
Palliative medicine	46.3	46.1	46.3
Clinical oncology	46.4	46.6	46.4
Rehabilitation medicine	45.9	47.3	45.9
Clinical Neuro-Physiology	50.0	51.0	50.0
Obstetrics & Gynaecology	48.0	48.2	48.0
Occupational Medicine	46.9	47.4	46.9
Psychiatric Specialties	**45.5**	**45.3**	**45.5**
Child & adolescent psychiatry	46.1	45.6	46.1
Forensic psychiatry	44.7	45.3	44.7
General psychiatry	45.6	45.4	45.6

Psychiatry of learning disability	46.9	46.9	46.9
Old age psychiatry	43.8	43.1	43.8
Psychotherapy	48.1	48.5	48.1
Radiology	**45.3**	**45.5**	**45.3**
Clinical radiology	45.3	45.6	45.3
Nuclear medicine	40.7	42.2	40.7
Surgical Specialties	**47.8**	**48.1**	**47.8**
Cardiothoracic surgery	48.8	49.1	48.8
ENT surgery	46.5	47.6	46.5
General surgery	49.2	49.2	49.2
Neurosurgery	46.2	48.0	46.2
Ophthalmology	47.1	46.7	47.1
Trauma & Orthopaedic surgery	47.5	47.8	47.5
Paediatric surgery	47.8	48.8	47.8
Plastic surgery	47.4	47.8	47.4
Urology	46.8	46.6	46.8
Public Health Medicine	**47.3**	**47.5**	**47.3**
Community Medical Specialties	**47.0**	**46.8**	**47.0**
Breast screening service	48.5	44.1	48.5
Community child health	49.1	48.8	49.1
Community psychiatry	41.9	43.3	41.9
Family planning	46.8	48.1	46.8
Well woman service	33.0	34.0	33.0
General Practice	47.5	43.5	47.5
All Dental Specialties	**47.8**	**48.3**	**47.8**
Hospital Dental Specialties	**47.8**	**48.4**	**47.8**
Oral medicine	43.8	44.9	43.8
Oral surgery	49.8	50.7	49.8
Orthodontics	48.4	48.1	48.4
Paediatric dentistry	42.1	43.5	42.1
Restorative dentistry	47.8	48.8	47.8
Dental & Maxillofacial Radiology	49.0	50.0	49.0
Oral Microbiology	44.0	45.0	44.0
Oral Pathology	58.5	59.5	58.5
Fixed & Removable Prosthodontics	-	-	-
Oral & Maxillofacial Surgery	45.8	49.5	45.8
Surgical Dentistry	-	-	-
Community Dental Specialties	**47.3**	**48.3**	**47.3**
Community Dentistry	-	-	-
Dental Public Health	47.3	48.3	47.3

Source: ISD Scotland

Doctors in Training and Career Doctors: Scotland

The tables below identify the proportion of staff who are female and the proportion who are working part-time, per grade, in the Medical & Dental workforce over the past 10 years.

Table 3: Female headcount as percentage of total staff in post, at 30th September

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All staff	**35.0%**	**36.1%**	**36.6%**	**37.7%**	**38.3%**	**39.0%**	**39.3%**	**40.2%**	**40.9%**	**41.3%**	**41.7%**
Consultant [1]	17.4%	18.2%	18.9%	19.6%	20.5%	21.3%	22.0%	23.0%	23.9%	25.1%	26.5%
Associate specialist & Staff grades	50.0%	48.3%	51.4%	56.4%	56.7%	57.5%	57.6%	57.8%	58.5%	59.1%	59.1%
Registrar group [2]	29.0%	33.3%	35.0%	37.3%	38.1%	39.7%	41.4%	41.7%	39.9%	41.6%	41.2%
Senior house officer	42.2%	42.6%	42.8%	44.9%	45.5%	46.5%	46.0%	48.6%	50.1%	48.7%	48.6%
House officer	46.0%	49.2%	48.2%	49.8%	53.6%	52.0%	54.5%	51.4%	53.8%	53.2%	55.9%
Other	51.5%	51.4%	52.3%	50.9%	50.3%	50.7%	50.3%	51.2%	52.0%	51.7%	52.0%

Source: ISD Scotland

1 Consultant includes Director of Public Health
2 Registrar group includes Specialist Registrars, Senior Registrars and Registrars

Table 4: Part-time headcount as percentage of total staff in post, at 30th September

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All staff [1, 2]	**24.6%**	**24.5%**	**24.5%**	**23.1%**	**22.4%**	**22.6%**	**22.9%**	**23.1%**	**22.4%**	**21.3%**	**20.2%**
Consultant [3]	17.0%	17.6%	17.8%	17.5%	17.5%	17.7%	18.3%	18.3%	17.9%	17.8%	17.9%
Associate specialist & Staff grades	28.2%	24.9%	26.0%	29.2%	31.0%	33.1%	33.9%	34.6%	34.4%	33.0%	33.3%
Registrar group [4]	16.8%	17.5%	18.2%	16.3%	16.3%	15.6%	16.5%	17.2%	14.6%	14.2%	13.5%
Senior house officer	4.7%	4.1%	4.7%	3.2%	1.3%	2.0%	1.8%	2.2%	2.5%	2.4%	2.9%
House officer	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%	0.3%	0.1%	0.1%	0.0%	0.1%
Other	77.4%	77.9%	77.4%	79.2%	78.9%	80.0%	81.5%	81.8%	81.5%	80.8%	80.3%

Source: ISD Scotland

1 Includes honorary appointments which are included under part time.
2 Maximum part-time staff are included as full time
3 Consultant includes Director of Public Health
4 Registrar group includes Specialist Registrars, Senior Registrars and Registrars

Currently, the national distribution of SHO and SpR grades by incremental point as at 31 March 2004 is as follows:

Table 5: Senior House Officers and Specialist Registrars by Increment – Headcount at 30 September 2003

	SHO [2]	SpR [1,2]
Incremental Point		
Total	**2685**	**1544**
Unknown	17	89
0	790	18
1	535	49
2	453	89
3	349	134
4	231	201
5	115	288
6	195	257
7	0	185

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

1 The SpR data includes data on Registrars and Senior Registrar who have been given under the appropriate points on the Specialist Registrar scale
2 Data are collected from the Scottish Standard Payroll System. It excludes Dumfries and Galloway Primary Care NHS Operating Division which use a different system .

Table 6 - Summary of Workforce Flows across Medical Grades: NHS Scotland 2001 - 2002

Grades	Census a) 30/09/01 b) 30/09/02	Vacancies	Intake				Output			Comment
			Total	Directly from NHS Scotland	New to NHS Scotland	Rejoiners	Total	Other NHS Scotland	Outside NHS Scotland	
PRHO	716 (a) 803 (b)	Unknown	795 (100%)	735 (92%)	60 (8%)	N/A	708 (100%)	454 (64%)	254 (36%)	Output - Just over one third PRHOs leave NHS Scotland.
SHO	2,270 (a) 2,458 (b)	Unknown	1189 (100%)	454 (38%)	580 (49%)	155 (13%)	1001 (100%)	391 (39%)	610 (61%)	Intake - Scottish PRHOs from just over one-third with Overseas/EEA doctors slightly less. Output - Only just over one third of SHOs stay in Scotland
SpR	1,280 (a) 1,494 (b)	Unknown	497 (100%)	175 (35%)	188 (38%)	134 (27%)	284 (100%)	103 (33%)	181 (64%)	Intake - Direct entry from Scottish SHOs form only one-third, but rejoiners a further third. Output - One third become consultants in NHS Scotland within the year.
Consultant	3,201 (a) 3,303 (b)	194 (b) 6%	249 (100%)	95 (38%)	52 (21%)	102 (41%)	147 (100%)	N/A	147 (100%)	Input - Just over one-third come directly from SpR output in Scotland. A similar number return to the workforce having worked in Scotland previously.
GP Registrar	283 (a) 284 (b)	nil	254 (100%)	177 (70%)	51 (20%)	26 (10%)	253 (100%)	65 (26%)	188 (74%)	Intake - Direct entry from Scottish SHOs form over two-thirds. Output - Only 15% were in a GP post in Scotland within the year.
GPs	3,867 (a) 3,882 (b)	74 (b) 2%	227 (100%)	37 (16%)	45 (20%)	145 (64%)	212 (100%)	22 (10%)	190 (90%)	Intake - Mainly from rejoiners.
NCCGs	807 (a) 790 (b)	Unknown	105 (100%)	45 (43%)	27 (26%)	33 (31%)	122 (100%)	34 (28%)	88 (72%)	Intake - ¾ worked in Scotland before. Output - almost leave.

Notes

1. 'Lateral moves' within NHS Scotland have been excluded, e.g. when moving within Scotland to a new substantive post at the same grade
2. Rejoiners are those who have worked in NHS Scotland in the last 10 years (HCHS)or in the last 5 years (GMS), excluding those who worked in Scotland only as PRHOs, but have not proceeded directly from the 'previous' grade in Scotland. This will include those who have taken career breaks, have worked as locums and/or have worked elsewhere and then returned to Scotland. It will also include those who have 'joined' from other grades in NHS Scotland, e.g. from GP Registrar to SHO/SPR, etc.
3. GP vacancies are established principal posts that have been vacated and not filled.
4. The definition for joining and leaving in this chart is based on occupancy of substantive posts in NHS Scotland at the two census points shown. The location upon Output for those who leave a substantive post and are working as a locum at the latter census point will therefore be shown as Outside Scotland.
5. GP data as at 1st October.

Source: Annex D, *Securing Future Practice - Shaping the New Medical Workforce for Scotland (June 2004)*

ANNEX H

GRANTS AND ALLOWANCES FOR GENERAL DENTAL PRACTITIONERS IN SCOTLAND

These grants and allowances have been introduced by the Scottish Executive in consultation with the Scottish Dental Practice Committee.

NEW AND RETURNING PRACTITIONERS

- A "Golden Hello" allowance of £10,000 over two years for dentists who join the dental list of an NHS Board (NHSB) within three months of completing their training. If this is in a designated area* the allowance is doubled to £20,000 over two years (Determination XIII).
- 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).
- A Vocational Trainee allowance of £3,000 for newly qualified dentists taking up vocational training. If this is in a designated area* the allowance is doubled to £6,000 (Determination XIII).
- An allowance of £5,000 over two years for dentists joining the dental list of an NHSB in Scotland for the first time or on re-entry to a dental list in Scotland after a break of five years. If this is in a designated area* the allowance is doubled to £10,000 over two years (Determination XIII).
- 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 (Determination II).
- The Return to Work scheme offers grants under the Scottish Dental Access Initiative (see below), an increase in the NHS earnings potential for the first year back in practice, reimbursement of indemnity insurance costs and free (in most cases) training courses from NHS Education for Scotland (NES). Practice owners who take on a returner also receive a payment to offset the slower workrate of a returner in their first year back (NHS: 2003 PCA(D)2).

*As of 1 August 2002 designated areas include: Orkney, Shetland, Western Isles, Highland, Borders, Dumfries & Galloway, Grampian and, within Argyll & Clyde, Campbeltown, Dunoon, Lochgilphead, Lochgoilhead, Oban, Rothesay, Tarbert and the Isles of Mull, Iona, Colonsay, Tiree, Islay and Jura.

ESTABLISHED PRACTITIONERS

- Commitment payments have been extended to cover assistants from 1 April 2003 (Determination IX) (Contact: Practitioner Services).

CAPITAL GRANTS

- Vocational Training Practice – grants of up to £10,000 (subject to NHS commitment) to ensure that appropriate NES standards are met by dentists wishing to establish a new Vocational Training practice or to improve an existing one (Determination X).
- Scottish Dental Access Initiative – grants of up to £100,000 to dentists proposing to establish new NHS practices or grants of up to £50,000 to dentists proposing to expand existing NHS practices in areas of unmet patient demand or high oral health need.

QUALITY INITIATIVES

- General Dental Practice Allowance – calculated with reference to NHS earnings up to a maximum of £4,500 per dentist. This is to address increasing requirements in relation to

the provision of high quality premises, information, health and safety, clinical standards and practice staff training (Determination XIV).

- Sedation Practice Allowance – calculated with reference to NHS earnings up to a maximum of £2,000 per practice. This is for practices offering such services to agreed standards and conditions (sedation practice inspection) which will be developed with the profession (Determination XIV).
- Practice Improvement Funding – enables dentists to upgrade their practices, particularly in respect of the Disability Discrimination Act; to improve patient safety and access or to introduce new environmental measures (Determination X).
- Clinical Audit Allowance – Since 1 April 2002 it has been mandatory that all dentists in Scotland who provide general dental services take part in at least 15 hours of clinical audit during each 3 year period. This allowance, payable for undertaking approved projects in the relevant period is calculated at an hourly rate of £57.35 (Determination XI).
- Continuing Professional Development Allowance – The standard Continuing Professional Development Allowance is £100.36 for education sessions of 1-2 hours and £200.72 for education sessions of 2-3.5 hours. Remote dentists can claim an additional £100.36 or £200.72 for the same sessions in recognition of the longer journey that they must make to their nearest postgraduate centre (Determination VII) (Contact: NES or Practitioner Services).

B. **PREVENTION**

- Caries Prevention Scheme – provides dentists with an enhanced monthly fee (according to the Deprivation Category of the practice postcode) for preventative treatment, including fissure sealing, performed on 6 and 7 year olds in Scotland (Item 41(d) of Determination I).

REMOTE PRACTITIONERS

- Remote Areas Allowance – a payment of £6,000 per year to encourage dentists servicing some of the remotest communities to continue practising in these areas (Determination XII).

VOCATIONAL TRAINERS

- Trainers Allowance – Vocational trainers receive a grant of £953 per month (£11,436 per annum). In addition, vocational trainers receive a Vocational Training Practice Allowance of £1,500 per annum (Determinations IV and XIV) (Contact: NES for trainer's allowance and Practitioner Services for Practice Allowance).

SENIOR PRACTITIONERS

- Seniority Payments – senior dentists can earn a potential £13,500 per annum through seniority payments (Determination III).

ANNEX I

PAYBILL ANALYSIS NHS SCOTLAND

Paybill Analysis for directly employed hospital and community medical and dental staff

NHS Scotland, Financial Year Ending 31 March 2004

	Total cost (£)
Consultant	320,573,948
Associate specialist	15,300,930
Staff grade	28,845,428
Registrar group	98,951,279
Senior house officer	148,884,335
House officer	31,310,118
Other	36,889,699
Total	**680,755,738**

Notes:

Information provided by ISD Scotland.

Total costs data are taken from ERBOD (Earnings Related Base of Data) ERBOD data are extracted from the Scottish Standard Payroll System (SSPCS) and provide cumulative pay details for the financial year ending in March.

Definition of Terms:

1. Total cost: gross salary (basic salary plus overtime, enhancements and allowances etc) plus employers' national insurance and superannuation.

2. Data covers directly employed substantive medical and dental staff only, and as such does not include locums, and may not include all honorary medical and dental staff.

STATISTICAL

TABLES

LIST OF STATISTICAL TABLES

Entry to the Professions

HCHS and Public Health Medical and Dental Staff

Hospital Medical Staff

Hospital Dental Staff

Doctors and Dentists in Public Health Medicine and Community Health

Table 16	Public Health Medicine and Community Health Service Medical Staff by Grade, Nature of Contract and Sex Great Britain at 30 September 2003
Table 17	Community Health Service and Public Health Medicine Dental Staff by Grade, Nature of Contract and Sex Great Britain at 30 September 2003

Regional/Local Variations

Table 18 & Chart 2	Consultant numbers and numbers per 10,000 population - analysis by SHA at 30 September 2003
Table 19	3 month vacancy rates for medical and dental staff (excluding training grades) - analysis by SHA and main specialty group at March 2004

General Dental Service

Table 20	Patients registered at 30 April 1992 to 2004 Great Britain
Table 21	Adult by volume indicator treatments Great Britain: 1995/96 to 2003/04
Table 22	Bank base rates from 5 October 1989
Table 23	Number of dentists by status Great Britain
Table 24	Number of dentists by age Great Britain
Table 25	Number of dentists and population to dentist ratio by health region Great Britain
Table 26	Number of courses of treatment provided for adults by country 1987/88 to 2003/04

TABLE 1

UK Medical Schools - Admissions, First qualifications and UCAS A Level Tariff Scores (1) of Accepted Applicants

Academic Year	2001/02	2002/03	2003/04
Actual intake of pre clinical students	*6,115*	6,752	7,559
Applicants Accepted through UCAS	6,240	6,959	7,667
Number obtaining first qualification	*4,450*	4,641	N/A
Home Domiciled Applicants Accepted through UCAS	5,675	6,287	6,953
Total number of "A Level" Home Domiciled Applicants Accepted through UCAS (2)	4,434	4,686	4,990
A Level Tariff Score Distribution for " A Level" Home Domiciled Applicants Accepted through UCAS (3)			
>=540	10.22%	8.77%	7.64%
>=480 <=539	16.42%	17.43%	16.31%
>=420 <=479	23.73%	19.10%	19.58%
>=360 <=419	25.58%	25.99%	27.82%
>=300 <=359	22.08%	25.84%	25.65%
>=240 <=299	1.69%	1.84%	2.12%
>=180 <=239	0.23%	0.83%	0.68%
>=120 <=179	0.05%	0.17%	0.18%
>=080 <=119	0.02%	0.02%	0.02%
Grand Total	100.00%	100.00%	100.00%
Average A Level Tariff Score of "A Level" Home Domiciled Applicants Accepted through UCAS.	416.12	406.73	403.51

Source: Higher Education Funding Council for England Universities and Colleges Admissions Service.

Notes:

(1) UCAS Tariff did not exist for 2001/2; for comparison purposes that **part** of a Total Tariff score that would have been attributed to exclusively to GCE A Levels held has been retrospectively calculated for 2001/2 and compared with the corresponding tariff component for 2002/3.

(2) "A Level" applicants are those who were known by UCAS to have held 2 or more GCE A Level passes but **excluding** those who were known to also hold a Degree, Partial Degree Credits, BTEC HNC/HND, SQA HNC/HND or other SQA qualifications that yielded higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

(3) Tariff Scores reported are those that were (or for 2001/2 would have been) allocated exclusively to GCE A level passes. Any other tariff points for those qualification(s) that may have contributed to the applicant's Total Tariff Score are **excluded** from this analysis. In many instances the presence of other qualifications (e.g. AS levels, Scottish Highers, Key Skills) would have meant that an applicant would have recorded a higher Total Tariff score.

(5) UCAS Tariff includes a range of qualifications. There is no limit upon the number of qualifying qualifications that can contribute to an applicant's score. Details of the UCAS Tariff can be found at http://www.ucas.com/candq/tariff/index.html.

GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A - 120, B - 100, C - 80, D - 60, E - 40.

TABLE 2

UK Dental Schools - Admissions, First qualifications and UCAS A-Level Tariff Scores of Accepted Applicants

Academic Year	2001/02	2002/03	2003/04
Actual intake of pre clinical students	922	958	975
Successful candidates applying through UCAS	921	926	948
Number obtaining first qualification	800	749	-
Home domiciled applicants accepted through UCAS	848	872	864
Total number of "A-Level" home domiciled applicants accepted through UCAS	689	700	694
	Total Band Distribution for "A-Level" home domiciled accepted applicants		
Tariff Scores	%	%	%
greater than 539	3.0	2.7	2.3
480 to 539	4.9	7.7	6.2
420 to 479	19.3	16.9	16.1
360 to 419	29.8	30.6	33.1
300 to 359	38.5	39.6	40.5
240 to 299	4.2	1.9	1.0
180 to 239	0.3	0.6	0.6
less than180	0.0	0.1	0.1
Average Tariff Score	373	375	373

Source: Higher Education Funding Council for England, Universities and Colleges Admissions Service.

Notes:

2001/02 and 2002/03
UCAS Tariff did not exist for 2001/2; for comparison purposes that **part** of a Total Tariff score that would have been attributed to exclusively to GCE A Levels held has been retrospectively calculated for 2001/2 and compared with the corresponding tariff component 2002/3.

"A Level" applicants are those who were known by UCAS to have held 2 or more GCE A Level passes bu**t excluding** those who were known to also hold a Degree, Partial Degree Credits or SQA qualifications that yielded a higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

Tariff Scores reported are those that were (or for 2001/2 would have been) allocated exclusively to GCE A level passes. Any other tariff points for those qualification(s) that may have contributed to the applicant's Total Tariff Score are excluded from this analysis. In many instances the presence of other qualifications (e.g. AS levels, Scottish Highers, Key Skills) would have meant that an applicant would have recorded a higher Total Tariff score.

UCAS Tariff includes a range of qualifications. There is no limit upon the number of qualifying qualifications that can contribute to an applicant's score. Details of the UCAS Tariff can be found at http://www.ucas.com/candq/tariff/index.html.

GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A - 120, B - 100, C - 80, D - 60, E - 40.

TABLE 3

UK applicants and accepted applicants for medicine 1986 to 2004[1]

Year of Entry	Number of applicants	Number of accepted applicants	Ratio of applicants to accepted applicants
1986	8249	3841	2.1 : 1
1987	7955	3805	2.1 : 1
1988	7691	3823	2.0 : 1
1989	8051	3898	2.1 : 1
1990	7941	3960	2.0 : 1
1991	7960	3953	2.0 : 1
1992	8718	4080	2.1 : 1
1993	10072	4292	2.3 : 1
1994	10416	4363	2.4 : 1
1995	10031	4235	2.4 : 1
1996	10016	4471	2.2 : 1
1997	9946	4577	2.2 : 1
1998	9742	4683	2.1 : 1
1999	8996	4871	1.8 : 1
2000	8506	5229	1.6 : 1
2001	8563	5675	1.5 : 1
2002	10071	6287	1.6 : 1
2003	12728	6953	1.8 : 1
2004	15102[2]		

Notes

1 These figures include those graduates who have applied to undergraduate medical degrees through UCAS. These figures do not include students who have applied directly to medical school

2 As at 24th March 2004

UK applicants and accepted applicants for medicine by gender 1994 to 2004

	Applicants		Accepted applicants		Ratio of applicants to accepted applicants	
	Female	Male	Female	Male	Female	Male
1994	5334	5082	2275	2088	2.3	2.4
1995	5074	4957	2126	2109	2.4	2.4
1996	5143	4873	2425	2046	2.1	2.4
1997	5198	4748	2482	2095	2.1	2.3
1998	5123	4619	2605	2078	2.0	2.2
1999	4942	4054	2767	2104	1.8	1.9
2000	4842	3664	3043	2186	1.6	1.7
2001	5014	3549	3355	2320	1.5	1.5
2002	6012	4059	3846	2441	1.6	1.7
2003	7556	5172	4286	2667	1.8	1.9
2004	8673	6429				

Source: UCAS Department of Research and Statistics

TABLE 4

UK Dental Schools
Number of Home Applicants and Accepted Applicants for Dentistry [1]

Year of Entry	Number of Applicants [2] [3]	Number of Accepted Applicants	Ratio of Applicants to Accepted Applicants
1989	1,636	802	2.0
1990	1,578	795	2.0
1991	1,525	762	2.0
1992	1,595	798	2.0
1993	1,696	776	2.2
1994	2,458	838	2.9
1995	2,765	810	3.4
1996	2,659	871	3.1
1997	2,358	779	3.0
1998	2,011	773	2.6
1999	1,695	805	2.1
2000	1,688	811	2.1
2001	1,560	848	1.8
2002	1,504	872	1.7
2003	1,733	864	2.0
2004[4]	1,989	N/A	N/A

Source: UCAS Department of Research and Statistics.

Notes

1. These figures include those students from the UK who have applied to undergraduate dental degrees through UCAS. These figures do not include students who have applied directly to dental school.
2. Applicants naming dentistry at least once on an application form.
3. The number of applications submitted per applicant changed over the years. From 1989 to 1993, the maximum was 5 applications. In 1994 it rose to 8 applications and was reduced to 6 applications in 1996, although the recommended number for dentistry remained at 5.
4. At 15 October 2003.

TABLE 5

Hospital, community health service and public health service medical and dental staff
Great Britain at 30 September

		1998		1999		2000		2001		2002		2003		Percentage growth 1998 to 2003	
		Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE
Great Britain	Total	82,090	70,600	83,740	72,240	85,470	74,050	87,930	76,360	91,950	81,380	96,000	85,720	16.9	21.4
	Consultant	26,670	24,490	27,850	25,640	29,000	26,480	30,550	27,520	32,000	29,340	33,800	31,030	26.7	26.7
	Registrar Group	14,120	13,460	14,630	13,930	14,630	13,990	15,140	14,450	15,980	15,150	16,930	16,220	19.9	20.5
	Senior House Officer	18,510	18,310	18,450	18,060	18,700	18,480	19,140	18,920	20,700	20,450	22,460	22,140	21.3	20.9
	House Officer	4,350	4,350	4,490	4,430	4,590	4,580	4,630	4,620	5,020	5,000	5,030	5,020	15.6	15.6
	Assoc spec./ Staff Grade	5,700	5,120	6,380	5,640	7,240	6,260	7,850	6,610	8,310	7,490	8,500	7,690	49.0	50.2
	Other	12,730	4,870	11,940	4,540	11,320	4,250	10,620	4,230	9,950	3,940	9,280	3,610	-27.1	-25.8
England	Total	68,460	58,750	70,000	60,340	71,690	62,090	73,850	64,060	77,030	68,260	80,850	72,260	18.1	23.0
	Consultant	22,320	20,430	23,320	21,410	24,400	22,190	25,780	23,060	27,070	24,760	28,750	26,340	28.8	28.9
	Registrar Group	12,130	11,560	12,680	12,090	12,730	12,200	13,220	12,630	13,770	13,030	14,620	13,990	20.5	21.0
	Senior House Officer	15,220	15,040	15,240	14,870	15,500	15,320	15,830	15,640	17,140	16,910	18,700	18,420	22.8	22.5
	House Officer	3,500	3,490	3,610	3,550	3,690	3,680	3,740	3,730	4,010	3,990	4,000	3,990	14.5	14.4
	Assoc spec./ Staff Grade	4,670	4,220	5,280	4,680	6,070	5,240	6,600	5,510	7,040	6,380	7,260	6,610	55.5	56.7
	Other	10,620	4,000	9,870	3,750	9,300	3,470	8,680	3,470	8,010	3,190	7,520	2,910	-29.1	-27.4
Scotland	Total	9,080	7,960	9,270	8,130	9,330	8,160	9,650	8,470	10,260	9,070	10,380	9,270	14.3	16.4
	Consultant	3,010	2,820	3,140	2,940	3,200	2,980	3,310	3,090	3,410	3,190	3,510	3,280	16.8	16.5
	Registrar Group	1,340	1,240	1,330	1,230	1,290	1,190	1,320	1,240	1,530	1,440	1,540	1,460	15.6	17.3
	Senior House Officer	2,180	2,160	2,200	2,180	2,200	2,180	2,340	2,300	2,530	2,500	2,680	2,650	23.1	22.8
	House Officer	670	660	700	700	720	720	720	720	800	800	800	800	20.0	20.0
	Assoc spec./ Staff Grade	590	500	630	530	660	550	680	570	690	580	690	580	16.9	15.0
	Other	1,340	570	1,320	540	1,300	550	1,320	540	1,330	560	1,180	500	-11.2	-13.5
Wales	Total	4,400	3,680	4,500	3,780	4,650	3,900	4,620	3,910	4,860	4,160	4,860	4,210	10.4	14.4
	Consultant	1,390	1,210	1,430	1,270	1,500	1,300	1,530	1,360	1,580	1,420	1,600	1,430	15.0	18.7
	Registrar Group	590	570	620	610	660	650	630	610	730	730	710	700	20.6	22.3
	Senior House Officer	1,070	1,070	1,040	1,040	1,040	1,040	1,000	990	1,020	1,020	1,100	1,100	3.0	3.4
	House Officer	180	180	190	190	200	200	180	180	210	210	230	230	29.3	29.6
	Assoc spec./ Staff Grade	460	400	480	430	530	480	590	530	580	530	570	530	25.2	30.4
	Other	720	250	730	240	730	230	690	220	730	250	650	220	-9.7	-13.3

Source: Medical workforce census.

[1] Figures have been rounded to the nearest 10. Percentage changes are based on unrounded figures.
[2] Some staff work in more than one location, in more than one nation. The sum of figures for England, Scotland and Wales is therefore greater than figures for Great Britain.

TABLE 6

Hospital Medical Staff by Grade

Great Britain at 30 September

Whole-time equivalents and percentage change [1]

	1993	1998	2001	2002	2003	Percentage change 1993-2003	Percentage change 1998-2003	Percentage change 2001-2003	Percentage change 2002-2003
All staff	52,480	65,090	71,110	76,120	80,540	*53*	*24*	*13*	*6*
Consultant	18,250	23,140	26,110	27,950	29,570	*62*	*28*	*13*	*6*
Associate specialist	1,030	1,440	1,610	1,780	1,990	*93*	*38*	*24*	*12*
Staff Grade [2]	1,230	3,460	4,720	5,410	5,460	*344*	*58*	*16*	*1*
Registrar group [3]	11,230	12,860	13,830	14,530	15,580	*39*	*21*	*13*	*7*
Senior House Officer	14,590	17,760	18,380	19,850	21,530	*48*	*21*	*17*	*8*
House Officer	3,790	4,290	4,560	4,940	4,980	*31*	*16*	*9*	*1*
Hospital Practitioner	180	220	220	250	250	*35*	*13*	*11*	*0*
Clinical Assistant	2,160	1,910	1,680	1,410	1,180	*-45*	*-38*	*-30*	*-16*
Other staff	10	20	0	0	-	*-100*	*-100*	*-100*	*-100*

[1] Figures have been rounded to the nearest ten. Percentage changes are based on unrounded figures.

[2] New grade introduced in 1989.

[3] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R grades. Comparisons across years should therefore be interpreted with caution.

TABLE 7

Hospital Medical Staff by Grade and Nature of Contract

Great Britain at 30 September 2003

	Number					Whole Time Equivalent				
	All Staff	Full Time	Maximum Part Time	Part Time	Honorary	All Staff	Full Time	Maximum Part Time	Part Time	Honorary
All grades	96,000	69,540	6,780	16,140	3,540	85,720	69,540	6,780	7,470	1,940
Consultant	33,800	19,710	6,710	4,790	2,580	31,030	19,710	6,710	3,180	1,420
Associate Specialist	2,340	1,660	60	610	10	2,070	1,660	60	350	0
Staff Grade	6,160	4,890	-	1,240	20	5,620	4,890	-	720	10
Registrar group [1]	16,930	15,140	-	1,210	580	16,220	15,140	-	720	360
Senior House Officer	22,460	21,740	-	550	170	22,140	21,740	-	310	90
House Officer	5,030	5,000	-	20	10	5,020	5,000	-	10	10
Hospital Practitioner	1,230	-	-	1,230	0	270	-	-	270	0
Clinical Assistant	4,910	190	-	4,540	170	1,290	190	-	1,060	40
Other Staff	3,140	1,210	-	1,930	0	2,060	1,210	-	850	0

[1] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R grades

TABLE 8

Hospital Medical Staff by Grade and Sex

Great Britain at 30 September

Whole-time equivalents

	1993			1998			2003		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	52,480	37,490	14,980	65,090	44,070	21,010	80,540	52,530	28,000
Consultant	18,250	15,250	3,000	23,140	18,560	4,580	29,570	22,680	6,890
Associate Specialist	1,030	720	320	1,440	1,000	440	1,990	1,300	690
Staff Grade	1,230	880	350	3,460	2,350	1,110	5,460	3,530	1,930
Registrar group [1]	11,230	8,150	3,080	12,860	8,550	4,320	15,580	9,730	5,850
Senior House Officer	14,590	8,960	5,630	17,760	10,240	7,520	21,530	12,100	9,420
House Officer	3,790	2,020	1,770	4,290	2,050	2,240	4,980	2,330	2,650
Hospital Practitioners	180	160	20	220	180	40	250	190	60
Clinical Assistant	2,160	1,340	820	1,910	1,140	760	1,180	670	510
Other staff	10	10	0	20	10	10	-	-	-

Percentage

	1993			1998			2003		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	100	71	29	100	68	32	100	65	35
Consultant	100	84	16	100	80	20	100	77	23
Associate Specialist	100	69	31	100	70	30	100	65	35
Staff Grade	100	72	28	100	68	32	100	65	35
Registrar group [1]	100	73	27	100	66	34	100	62	38
Senior House Officer	100	61	39	100	58	42	100	56	44
House Officer	100	53	47	100	48	52	100	47	53
Hospital Practitioners	100	90	10	100	80	20	100	76	24
Clinical Assistant	100	62	38	100	60	40	100	57	43
Other staff	100	83	17	100	66	34	-	-	-

[1] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R g
Comparisons across years should therefore be interpreted with caution.
Figures have been rounded to the nearest ten.
"0" denotes less than 5 "-" denotes zero

TABLE 9

Junior Doctors' Hours: New Deal Compliance - Analysis by Grade
England at 31 March 2004

	FULL SHIFTS			PARTIAL SHIFTS			HYBRID CONTRACTS			ON-CALL			FLEXIBLE			OTHER			SUMMARY			
	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Total Posts	Total outside targets	% outside targets	Total in disputed bandings
PRHO	2867	107	0	210	9	0	232	28	0	440	58	0	24	0	0	26	0	0	4001	202	5%	0
SHO	9070	383	0	1552	324	0	749	138	0	2662	863	5	358	18	0	151	0	0	16255	1726	11%	5
SpR	3113	324	3	1180	369	0	706	128	0	4900	1280	18	866	44	2	631	0	2	13522	2145	16%	25
Totals	15050	814	3	2942	702	0	1687	294	0	8002	2201	23	1248	62	2	808	0	2	33778	4073	12%	30

Notes

All figures rounded to the nearest whole number, percentages worked out on un-rounded numbers

1 New deal contracted hours targets. Average weekly contracted hours must not exceed 56 for full shifts, 64 for partial shifts, 72 for on-call rotas.

2 For full compliance with the New Deal:

- actual hours of duty must not exceed contracted hours of duty for any work pattern.
- contracted hours must be within the New Deal targets as defined by the working pattern
- work intensity and rest periods must be within acceptable limits as defined by the working pattern and in line with definitions in HSC 1998/240 so that actual hours of work, in all working patterns, do not exceed 56 a week.

3 A hybrid working arrangement is a working pattern in which junior doctors' out-of-hours duty comprises work of substantially different levels of intensity due to different clinical responsibilities. As a result the post or placement comprises elements of two or more distinct working arrangements, usually combined with a time limit of one month or less.

4 These figures represent the latest data on compliance within the English regions only. Similar data is collected and validated within Scotland and Wales and their compliance figures will be referred to within the text of the written evidence and/or reported separately to the DDRB when validated.

TABLE 10

Junior Doctors' Hours: New Deal Compliance - Analysis by Specialty
England at 31 March 2004

	FULL SHIFTS			PARTIAL SHIFTS			HYBRID CONTRACTS			ON-CALL			FLEXIBLE			OTHER			SUMMARY			
	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Posts complying in full	Posts outside targets	Disputed bandings	Total Posts	Total outside targets	% outside targets	Total in disputed bandings
Medicine	4959	242	2	420	63	0	491	73	0	1710	490	6	239	11	1	56	0	1	8764	879	10%	10
Surgery	3070	255	0	642	114	0	320	77	0	2426	1128	5	63	12	0	3	0	0	8115	1586	20%	5
O&G	1266	59	0	324	126	0	93	15	0	136	90	0	99	0	0	0	0	0	2208	290	13%	0
Pathology	230	9	0	40	38	0	34	0	0	343	41	0	49	2	0	162	0	0	948	90	9%	0
Anaesthetics	1343	80	0	823	222	0	449	83	0	207	71	0	120	14	0	1	0	0	3413	470	14%	0
Paediatrics	1701	131	0	421	97	0	69	31	0	240	162	0	180	13	1	0	0	1	3047	434	14%	2
A&E	1800	29	0	16	2	0	32	9	0	106	6	0	56	0	0	1	0	0	2057	46	2%	0
Radiology	82	4	0	60	0	0	8	0	0	658	19	7	62	0	0	60	0	0	960	23	2%	7
Psychiatry	501	0	1	153	40	0	177	3	0	1824	88	0	272	10	0	0	0	0	3069	141	5%	1
Dentistry	96	5	0	43	0	0	14	3	0	241	106	5	8	0	0	1	0	0	522	114	22%	5
Public Health	2	0	0	0	0	0	0	0	0	111	0	0	38	0	0	1	0	0	152	0	0%	0
				0	0	0																
Total	15050	814	3	2942	702	0	1687	294	0	8002	2201	23	1186	62	2	808	0	2	33778	4073	12%	30

Notes:

All figures rounded to the nearest whole number, percentages worked out on un-rounded numbers

1 New Deal contracted hours targets. Average weekly contracted hours must not exceed 56 for full shifts, 64 for partial shifts, 72 for on-call rotas.

2 For full compliance with the New Deal

- actual hours of duty must not exceed contracted hours of duty for any work pattern.
- contracted hours must be within the New Deal targets as defined by the working pattern.
- work intensity and rest periods must be within acceptable limits as defined by the working pattern and in line with definitions in HSC 1998/240 so that actual hours of work, in all working patterns, do not exceed 56 a week.

3 A hybrid working arrangement is a working pattern in which junior doctors' out-of-hours duty comprises work of substantially different levels of intensity due to different clinical responsibilities. As a result the post or placement comprises elements of two or more distinct working arrangements, usually combined with a time limit of one month or less.

4 These figures represent the latest data on compliance within the English regions only. Similar data is collected and validated within Scotland and Wales and their compliance figures will be referred to within the text of the written evidence and/or reported separately to the DDRB when validated.

TABLE 11

Hospital Medical Consultants by Age Band

Great Britain at 30 September

numbers and percentages [1]

	1993	1998	2001	2002	2003
All ages: total	19,830	25,040	28,820	30,310	31,990
Percentage of all staff	*100*	*100*	*100*	*100*	*100*
Under 35	550	650	670	670	390
Percentage of all staff	*3*	*3*	*2*	*2*	1
35-39	3,530	4,540	5,230	5,500	4,890
Percentage of all staff	*18*	*18*	*18*	*18*	15
40-44	4,370	5,980	6,810	7,200	7,630
Percentage of all staff	*22*	*24*	*24*	*24*	24
45-49	4,240	5,000	5,970	6,380	6,960
Percentage of all staff	*21*	*20*	*21*	*21*	22
50-54	2,990	4,360	4,990	5,100	5,400
Percentage of all staff	*15*	*17*	*17*	*17*	17
55-59	2,630	2,770	3,390	3,710	4,360
Percentage of all staff	*13*	*11*	*12*	*12*	14
60 and over	1,510	1,730	1,760	1,740	2,380
Percentage of all staff	*8*	*7*	*6*	*6*	*7*

[1] Figures have been rounded to the nearest ten. Percentages are based on unrounded figures.

Table 12: Figure 1: Hospital medical staff by grade
Great Britain at 30 September 2003

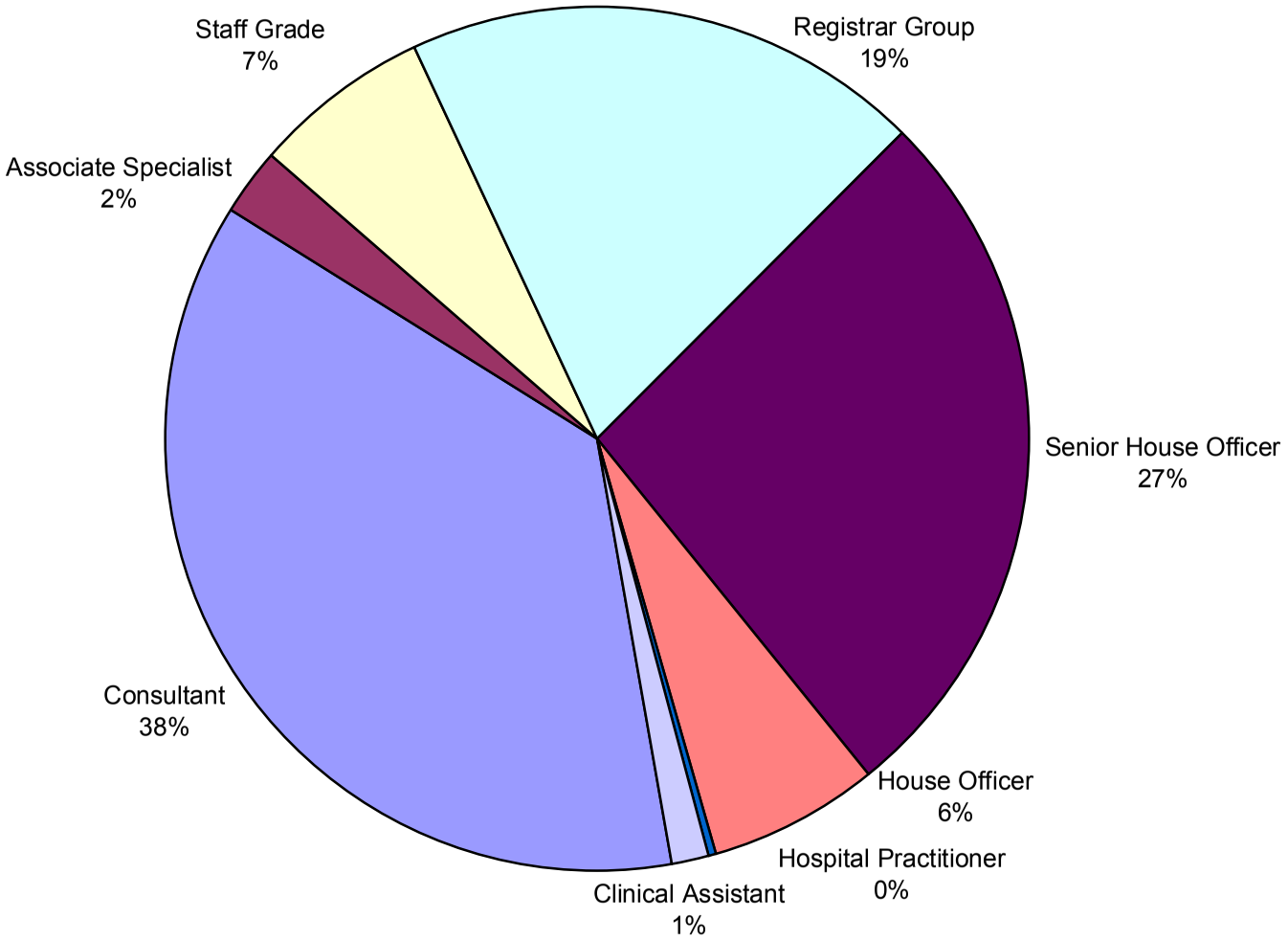


TABLE 13

Hospital Dental Staff by Grade

Great Britain at 30 September 2003

Whole-time equivalents and percentage change [1]

	1993	1998	2001	2002	2003	Percentage change 1993-2003	Percentage change 1998-2003	Percentage change 2001-2003	Percentage change 2002-2003
All staff	1,570	1,810	1,820	1,940	1,980	*26*	*10*	*9*	*2*
Consultant	520	570	580	610	660	*27*	*16*	*15*	*9*
Associate specialist	70	70	70	80	80	*15*	*16*	*8*	*5*
Staff Grade [2]	20	100	130	150	160	*575*	*60*	*17*	*3*
Registrar group [3]	320	310	310	340	330	*3*	*6*	*6*	*-3*
Senior House Officer	350	530	510	570	580	*65*	*10*	*14*	*2*
House Officer	130	60	60	60	40	*-70*	*-35*	*-38*	*-37*
Hospital Practitioner	20	20	20	20	20	*16*	*-4*	*10*	*-2*
Clinical Assistant	140	140	130	110	110	*-24*	*-25*	*-14*	*-3*
Other staff	0	10	-	0	-	*-100*	*-100*	*-*	*-100*

[1] Figures have been rounded to the nearest ten. Percentage changes are based on unrounded figures.

[2] New grade introduced in 1989

[3] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R grades Comparisons across years should therefore be interpreted with caution.

"0" denotes less than 5 "-" denotes zero

TABLE 14

Hospital Dental Staff by Grade and Nature of Contract

Great Britain at 30 September 2003

	Number					Whole-time equivalent				
	All staff	Full time	Maximum part-time	Part time	Honorary	All staff	Full time	Maximum part-time	Part time	Honorary
All Staff	2,750	1,400	130	970	260	1,980	1,400	130	310	150
Consultant	800	310	130	160	200	660	310	130	100	120
Associate Specialist	110	60	0	50	0	80	60	0	20	0
Staff Grade	210	120	-	90	10	160	120	-	40	10
Registrar group [1]	340	290	-	30	20	330	290	-	20	20
Senior House Officer	600	570	-	20	0	580	570	-	10	0
House Officer	40	40	-	-	-	40	40	-	-	-
Hospital Practitioner	90	-	-	90	0	20	-	-	20	0
Clinical Assistant	570	10	-	540	20	110	10	-	90	0
Other Staff	-	-	-	-	-	-	-	-	-	-

[1] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R grades Comparisons across years should therefore be interpreted with caution.

Figures have been rounded to the nearest ten. Percentage changes are based on unrounded figures.

"0" denotes less than 5. "-" denotes zero

TABLE 15

Hospital Dental Staff by Grade and Sex

Great Britain at 30 September

Whole-time equivalents [1]

	1993			1998			2003		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	1,570	1,150	420	1,810	1,240	560	1,980	1,280	700
Consultant	520	470	50	570	500	70	660	550	120
Associate Specialist	70	40	30	70	40	20	80	50	30
Staff Grade[2]	20	10	10	100	50	50	160	90	70
Registrar group[3]	320	220	100	310	210	100	330	200	130
Senior House Officer	350	210	140	530	310	220	580	290	290
House Officer	130	70	50	60	30	30	40	20	20
Hospital practitioners	20	10	0	20	10	10	20	10	10
Clinical Assistant	140	100	40	140	90	50	110	70	40
Other staff	0	0	0	10	0	0	-	-	-

Percentage [1]

	1993			1998			2003		
	All staff	Male	Female	All staff	Male	Female	All staff	Male	Female
All staff	100	73.1	26.9	100	68.9	31.1	100	64.7	35.3
Consultant	100	91.1	8.9	100	87.4	12.6	100	82.0	18.0
Associate Specialist	100	57.2	42.8	100	64.9	35.1	100	59.2	40.8
Staff Grade[2]	100	52.3	47.7	100	52.8	47.2	100	56.1	43.9
Registrar group [3]	100	69.8	30.2	100	66.6	33.4	100	61.4	38.6
Senior House Officer	100	60.3	39.7	100	57.9	42.1	100	49.7	50.3
House Officer	100	57.1	42.9	100	52.1	47.9	100	57.9	42.1
Hospital Practitioner	100	79.4	20.6	100	66.9	33.1	100	74.3	25.7
Clinical Assistant	100	71.2	28.8	100	62.4	37.6	100	66.2	33.8
Other staff	100	41.4	58.6	100	41.3	58.7	-	-	-

[1] Figures have been rounded to the nearest ten. Percentage changes are based on unrounded figures.

[2] New grade introduced in 1989

[3] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced formally on 1 April 1996 to gradually replace the SR/R grades Comparisons across years should therefore be interpreted with caution.

"0" denotes less than 5 "-" denotes zero

TABLE 16

Public Health Medicine and Community Health Service Medical Staff by Grade, Nature of Contract and Sex

Great Britain at 30 September 2003

numbers

	All staff				Male staff				Female staff			
	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary
All staff	2,580	1,220	1,310	40	990	630	320	40	1,590	600	990	10
Regional director of public health	0	0	-	-	0	0	-	-	0	0	-	-
District director of public health	260	210	50	-	150	140	10	-	120	80	40	-
Consultant in public health medicine	620	360	230	40	330	200	90	30	290	150	140	0
Consultant working in the Community	0	0	0	-	0	0	-	-	0	-	0	-
Special Salary Scale Staff	40	10	20	-	20	10	20	-	10	0	10	-
Registrar group [1]	310	240	60	10	120	110	10	0	190	130	60	0
Senior house officer	40	30	0	-	10	10	-	-	30	30	0	-
Senior clinical medical officer	590	250	350	-	200	130	70	-	390	120	280	-
Clinical medical officer	490	120	370	-	100	40	60	-	390	80	310	-
Other medical staff	220	-	220	-	60	-	60	-	160	-	160	-

whole-time equivalent

	All staff				Male staff				Female staff			
	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary
All staff	1,760	1,220	510	20	760	630	110	20	1,000	600	400	0
Regional director of public health	0	0	-	-	0	0	-	-	0	0	-	-
District director of public health	240	210	30	-	140	140	10	-	100	80	20	-
Consultant in public health medicine	490	360	110	20	250	200	30	20	230	150	80	0
Consultant working in the Community	0	0	0	-	0	0	-	-	0	-	0	-
Special Salary Scale Staff	20	10	10	-	10	10	10	-	10	0	0	-
Registrar group [1]	290	240	40	0	120	110	10	0	170	130	30	0
Senior house officer	40	30	0	-	10	10	-	-	30	30	0	-
Senior clinical medical officer	410	250	160	-	160	130	30	-	250	120	140	-
Clinical medical officer	230	120	110	-	50	40	20	-	180	80	90	-
Other medical staff	50	-	50	-	20	-	20	-	30	-	30	-

[1] Includes Specialist Registrar (SpR), Senior Registrar (SR) and Registrar (R). The SpR grade was introduced in public health medicine from 1 April 1997 to gradually replace the Sr/R grades Comparisons across years should therefore be interpreted with caution.

Figures have been rounded to the nearest ten. "0" denotes less than 5. "-" denotes zero

TABLE 17

Community Health Service and Public Health Medicine Dental Staff by Grade, Nature of Contract and Sex

Great Britain at 30 September 2003

numbers

	All Staff				Male Staff				Female Staff			
	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary
All Staff	1,940	900	1,030	0	730	440	290	0	1,210	470	740	0
Clinical Director	90	70	20	-	40	40	0	-	50	30	10	-
Assistant Clinical Director	60	40	10	-	30	30	0	-	30	20	10	-
Senior Dental Officer	540	260	280	-	220	130	90	-	320	130	190	-
Dental Officer/Community Dental Officer	1080	450	620	0	330	190	130	0	750	260	490	0
Consultant in Dental Public Health	70	30	30	0	40	20	20	0	20	10	10	0
Dental Surgeon acting as p/t Hosp. Cons.	0	-	0	-	-	-	-	-	0	-	0	-
Trainee in Public/Community Dental Health	20	20	0	-	0	0	-	-	20	10	0	-
Other Staff	80	20	60	-	60	10	40	-	20	0	20	-
District Director of Public Health	10	0	0	-	0	0	0	-	0	0	0	-
Specialist Registrar in PHM	0	0	0	-	-	-	-	-	0	0	0	-

whole-time equivalent

	All Staff				Male Staff				Female Staff			
	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary	All staff	Whole Time	Part Time	Honorary
All Staff	1,450	900	540	0	570	440	130	0	880	470	410	0
Clinical Director	80	70	10	-	40	40	0	-	40	30	10	-
Assistant Clinical Director	50	40	10	-	30	30	0	-	20	20	10	-
Senior Dental Officer	430	260	170	-	190	130	60	-	240	130	110	-
Dental Officer/Community Dental Officer	780	450	320	0	260	190	60	0	520	260	260	0
Consultant in Dental Public Health	50	30	10	0	30	20	10	0	20	10	10	0
Dental Surgeon acting as p/t Hosp. Cons.	0	-	0	-	-	-	-	-	0	-	0	-
Trainee in Public/Community Dental Health	20	20	0	-	0	0	-	-	10	10	0	-
Other Staff	30	20	10	-	20	10	10	-	10	0	10	-
District Director of Public Health	10	0	0	-	0	0	0	-	0	0	0	-
Specialist Registrar in PHM	0	0	0	-	-	-	-	-	0	0	0	-

Notes:

Figures have been rounded to the nearest ten.

"0" denotes less than 5. "-" Denotes zero

TABLE 18

Hospital, Public Health Medicine and Community Health Services (HCHS):
medical and dental consultants by Strategic Health Authority

As at 30 September 2003 — numbers (headcount) and numbers per 10,000 population

		Consultant	Staff per 10,000 population
England		28,750	5.8
Q01	Norfolk, Suffolk & Cambridgeshire	1,336	6.1
Q02	Bedfordshire & Hertfordshire	601	6.0
Q03	Essex	600	4.6
Q04	North West London	1,423	7.2
Q05	North Central London	1,423	8.9
Q06	North East London	909	5.3
Q07	South East London	1,368	8.5
Q08	South West London	849	7.6
Q09	Northumberland, Tyne & Wear	1,096	6.3
Q10	County Durham & Tees Valley	643	5.2
Q11	North and East Yorkshire and Northern Lincolnshire	685	4.7
Q12	West Yorkshire	1,279	5.5
Q13	Cumbria & Lancashire	836	4.5
Q14	Greater Manchester	1,658	5.3
Q15	Cheshire & Merseyside	1,498	5.5
Q16	Thames Valley	1,189	7.1
Q17	Hampshire & Isle of Wight	943	6.7
Q18	Kent & Medway	636	4.7
Q19	Surrey & Sussex	1,277	6.1
Q20	Avon, Gloucestershire & Wiltshire	1,251	5.9
Q21	South West Peninsula	825	5.0
Q22	Dorset & Somerset	535	5.1
Q23	South Yorkshire	941	6.1
Q24	Trent	1,237	5.2
Q25	Leicestershire, Northamptonshire & Rutland	728	5.5
Q26	Shropshire & Staffordshire	660	5.0
Q27	Birmingham & The Black Country	1,492	5.2
Q28	Coventry, Warwickshire, Herefordshire & Worcestershire	727	5.3
T1290	National Blood authority	43	..
T1310	Health Protection Agency	62	..

Source: Department fo Health medical and dental workforce census
Populations from EOR Resource allocation models, weighted for age, need and cross boundary flows.

Notes:
' **..** ' denotes not available, as there are no population statistics for these organisations

Chart 2 - Consultant numbers (headcount) and Numbers per 10,000 population

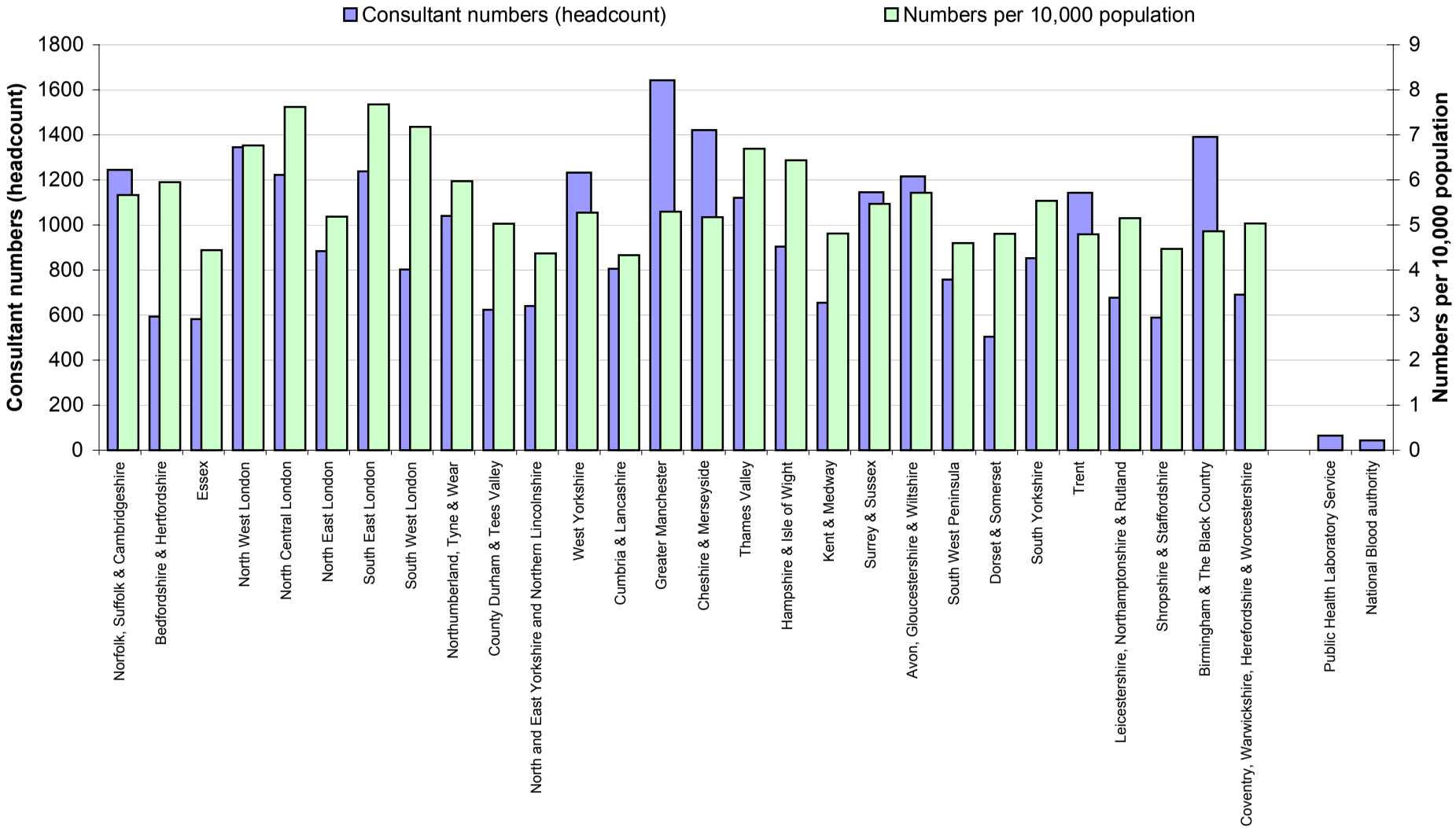


TABLE 19

Department of Health Vacancies Survey, March 2004
Vacancies in NHS Trusts by Strategic Health Authority areas[1], medical and dental staff (excluding training grades) and consultant specialty groups
3 month vacancy rates[2]

		All medical and dental staff	All consultants	Accident & emergency medicine	Clinical oncology	Dental Group	Surgical group	Pathology group	Paediatric Group	Anaesthetics	General medicine group	Obstetrics and Gynaecology	PHM & CHS group	Psychiatry group	Radiology group
England		**4.3%**	**4.4%**	**8.2%**	**3.2%**	**4.1%**	**1.9%**	**5.4%**	**3.1%**	**3.0%**	**3.7%**	**1.4%**	**5.6%**	**9.6%**	**7.5%**
Q01	Norfolk, Suffolk & Cambridgeshire SHA	3.7%	3.9%	4.0%	4.5%	6.1%	1.9%	3.6%	4.8%	3.9%	4.2%	3.7%	2.9%	7.3%	4.0%
Q02	Bedfordshire and Hertfordshire SHA	6.8%	5.0%	18.3%	0.0%	*	4.5%	8.6%	5.9%	7.9%	4.9%	3.4%	*	0.0%	4.9%
Q03	Essex SHA	5.8%	5.4%	9.1%	8.2%	14.3%	3.5%	6.0%	0.0%	2.1%	1.6%	0.0%	5.8%	16.1%	10.2%
Q04	North West London SHA	5.2%	3.8%	0.0%	*	0.0%	2.5%	3.0%	1.9%	4.2%	0.9%	1.6%	0.0%	9.3%	9.3%
Q05	North Central London SHA	1.9%	1.4%	0.0%	0.0%	0.0%	0.0%	4.5%	3.3%	2.1%	0.8%	0.0%	0.0%	1.4%	1.4%
Q06	North East London SHA	6.3%	4.8%	12.6%	0.0%	3.6%	2.0%	7.5%	0.9%	6.5%	4.7%	0.0%	0.0%	9.9%	1.8%
Q07	South East London SHA	6.7%	5.6%	4.8%	*	2.3%	1.1%	5.0%	0.0%	5.4%	2.2%	0.0%	0.0%	15.4%	13.9%
Q08	South West London SHA	1.1%	1.2%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.6%	0.0%	0.0%	4.7%	3.0%
Q09	Northumberland, Tyne & Wear SHA	3.4%	3.8%	0.0%	0.0%	4.1%	4.2%	5.9%	2.8%	3.9%	5.5%	0.0%	0.0%	0.7%	6.7%
Q10	County Durham & Tees Valley SHA	7.4%	8.5%	10.0%	*	*	5.8%	10.5%	2.1%	5.1%	9.1%	2.3%	22.2%	15.1%	11.1%
Q11	North & East Yorks&Northern Lincse SHA	4.8%	4.0%	5.6%	*	18.3%	0.7%	2.9%	2.5%	6.8%	3.7%	2.9%	0.0%	5.2%	8.6%
Q12	West Yorkshire SHA	4.8%	5.8%	11.3%	0.0%	8.6%	2.0%	8.5%	1.2%	3.3%	5.3%	1.8%	0.0%	14.6%	14.9%
Q13	Cumbria & Lancashire SHA	3.5%	4.7%	9.4%	*	0.0%	1.1%	9.7%	2.1%	2.2%	6.0%	0.0%	3.6%	9.7%	10.8%
Q14	Greater Manchester SHA	5.8%	6.8%	14.6%	0.0%	5.3%	2.8%	9.1%	2.7%	3.3%	6.5%	6.3%	13.5%	14.9%	13.1%
Q15	Cheshire & Merseyside SHA	4.7%	5.5%	7.7%	0.0%	0.0%	1.1%	6.4%	2.8%	2.7%	3.2%	0.0%	0.0%	20.4%	14.6%
Q16	Thames Valley SHA	2.7%	2.8%	0.0%	0.0%	6.8%	1.4%	2.0%	1.6%	0.0%	1.8%	0.0%	9.4%	8.4%	5.5%
Q17	Hampshire & Isle Of Wight SHA	2.4%	1.9%	0.0%	0.0%	0.0%	0.5%	1.5%	8.2%	0.7%	0.5%	0.0%	9.8%	5.7%	0.0%
Q18	Kent & Medway SHA	4.7%	4.8%	8.7%	*	*	2.5%	8.3%	0.0%	3.3%	5.4%	2.2%	14.4%	7.5%	8.3%
Q19	Surrey & Sussex SHA	4.1%	4.1%	7.6%	0.0%	0.0%	0.0%	5.3%	2.9%	1.1%	4.3%	0.0%	10.9%	13.1%	4.7%
Q20	Avon, Gloucestershire & Wiltshire SHA	3.1%	3.8%	6.6%	0.0%	0.0%	0.8%	2.2%	2.4%	2.4%	3.9%	0.0%	0.0%	15.3%	1.2%
Q21	South West Peninsula SHA	2.4%	2.4%	5.5%	13.2%	5.3%	0.6%	0.0%	4.8%	0.0%	4.9%	0.0%	0.0%	2.4%	4.7%
Q22	Dorset and Somerset SHA	2.8%	2.1%	9.3%	*	0.0%	0.9%	0.0%	0.0%	1.5%	2.1%	0.0%	0.0%	8.4%	0.0%
Q23	South Yorkshire SHA	3.2%	3.6%	9.8%	0.0%	6.5%	1.6%	5.6%	1.9%	2.7%	2.2%	0.0%	11.4%	8.6%	6.0%
Q24	Trent SHA	3.9%	4.2%	0.0%	5.8%	9.4%	2.5%	4.8%	5.9%	6.8%	2.1%	1.9%	0.0%	3.0%	12.4%
Q25	Leics, Northants & Rutland SHA	5.1%	5.3%	20.0%	0.0%	15.7%	2.9%	9.9%	9.3%	0.0%	6.7%	8.1%	4.9%	5.5%	2.1%
Q26	Shropshire & Staffordshire SHA	5.2%	4.6%	33.3%	*	0.0%	0.7%	4.7%	4.0%	2.0%	5.1%	0.0%	0.0%	7.6%	11.5%
Q27	Birmingham & The Black Country SHA	3.4%	4.3%	7.3%	18.6%	0.0%	4.6%	6.8%	3.6%	3.9%	2.3%	0.0%	0.0%	7.1%	5.9%
Q28	West Midlands South SHA	5.8%	5.8%	16.6%	*	0.0%	1.2%	9.8%	11.5%	0.0%	7.1%	2.6%	0.0%	14.0%	6.1%
Y13	Special Health Authorities	8.2%	12.5%	-	-	-	-	1.7%	-	-	-	-	25.8%	-	-

Source: Department of Health Vacancies Survey 2004
Notes:
1. SHA figures are based on Trusts, and do not necessarily reflect the geographical provision of healthcare
2. Three month vacancies are vacancies as at 31 March 2004 which trusts are actively trying to fill, which had lasted for three months or more (whole time equivalents)
3 * = figures where staff in post and number of vacancies are less then 10
4 - = figures where staff in post and number of vacancies are both nil

TABLE 20

General Dental Service
Patients Registered at 30 April 1992 to April 2004
Great Britain

millions

Month	Adults	Children
April 1992	22.7	7.5
April 1993	24.4	7.9
April 1994	24.6	8.0
April 1995	23.6	7.8
April 1996	22.9	7.9
April 1997	22.6	7.9
April 1998	20.8	7.9
April 1999	19.7	8.0
April 2000	19.9	8.1
April 2001	19.9	8.0
April 2002	19.9[2]	7.9
April 2003	19.8	7.9
April 2004	19.3	7.7

Source: Dental Practice Boards.

Note:
1.The figures are affected by several factors. Adminstration changes have reduced the number of duplicate registrations by around 1 million. The shortening of the registration period caused the numbers to drop between April 1997 and April 1999.

2. Scottish registrations from April 2002 are on a new basis and are updated as claims are received. April 2002 figure for GB adults has been revised from 19.8 million.

TABLE 21

General Dental Service: Adult Key Volume Indicator Treatments[1,2] for year ending 31st March

Great Britain

millions

Sample Treatments	1995/96	1996/97[3]	1997/98[3]	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Exam and Report (1A)	19.6	19.2	19.7	20.3	20.0	20.2	20.1	20.1	20.3
Simple scaling (10A)	14.2	14.1	14.7	15.2	15.1	15.2	15.0	14.9	15.0
MO/DO filling (14A3)	5.2	4.9	4.9	4.8	4.5	4.4	4.2	4.1	4.0
Bonded FJC gold crown (17D1)	1.5	1.4	1.0	1.0	1.0	0.8	0.8	0.8	0.8
Bridge:bonded jc gold (18A4)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Extractions - 1 tooth (21A1)	1.4	1.4	1.4	1.4	1.3	1.3	1.4	1.5	1.4
Total of the above	42.2	41.2	41.9	42.8	42.0	42.1	41.6	41.7	41.6
All Incidences	85.8	84.4	86.1	87.8	85.9	87.9	91.8	91.2	91.2

Source: Dental Practice Boards

Notes:

1. The figures relate to items included in completed courses of treatments processed by the Dental Practice Boards.
2. Sample treatments have been selected to illustrate trends in that category of treatment. The item number in the Statement of Dental Remuneration is quoted in brackets.
3. In Scotland, data from 200,000 forms received during 1996/97 were not processed until 1997/98.

TABLE 22

Bank Base Rates from 5 October 1989

Date of Change	Interest Rate %
05-Oct-89	15
08-Oct-90	14
12-Jul-91	11
22-Sep-92	9
26-Jan-93	6
08-Feb-94	5.25
03-Feb-95	6.75
06-Jun-96	5.75
07-Aug-97	7
04-Jun-98	7.5
10-Jun-99	5
10-Feb-00	6
10-May-01	5.25
02-Aug-01	5
18-Sep-01	4.75
04-Oct-01	4.5
08-Nov-01	4
07-Feb-03	3.75
10-Jul-03	3.5
06-Nov-03	3.75
05-Feb-04	4
06-May-04	4.25
10-Jun-04	4.5
05-Aug-04	4.75

Source : Bank of England

TABLE 23

General Dental Service : Number of Dentists by Status

Great Britain

Year		All Dentists	Number of principals	Number of Assistants & Vocational Dental Practitioners (1)
Great Britain - 30 September				
1987		17,083	16,969	114
1988		17,440	17,144	296
1989		17,830	17,436	394
1990	(2)	18,011	17,539	472
1991	(2)	18,037	17,440	597
1992	(2)	18,019	17,384	635
1993	(2)	18,467	17,699	768
1994	(2)	18,600	17,642	958
1995	(2)	18,736	17,670	1,066
1996	(2)	19,139	17,897	1,242
1997	(2)	19,598	18,174	1,424
1998		20,216	18,557	1,659
1999		20,750	18,895	1,855
2000		21,124	19,117	2,007
2001		21,462	19,320	2,142
2002		21,538	19,336	2,202
2003		21,701	19,555	2,146
Great Britain - 31 March				
1995	(2)	18,472	17,856	616
1996	(2)	18,728	17,647	1,081
1997	(2)	19,209	17,920	1,289
1998		19,711	18,223	1,488
1999		20,296	18,575	1,721
2000		20,842	18,910	1,932
2001		21,148	19,085	2,063
2002		21,356	19,239	2,117
2003		21,455	19,273	2,182
2004	(3)	21,425	19,329	2,096

Source: Dental Practice Boards

Notes:

(1) Where a dentist is both an assistant and a principal the dentist has been counted as a principal only.

(2) The compulsory retirement of principals aged 72 and over was introduced on 1 April 1990.
The age limit was lowered by one year each year until it reached 65 at 1 April 1997.

(3) Age limit for principles increased to age 20 from April 2003

TABLE 24

General Dental Service : Number of Dentists by Age at 30 September
Great Britain

Number of dentists and percentage of all ages

Age group	1995		1996		1997		1998		1999		2000		2001		2002		2003	
All ages:	18,736	100%	19,139	100%	19,598	100%	20,216	100%	20,750	100%	21,124	100%	21,462	100%	21,538	100%	21,701	100%
Under 30	3,529	18.8	3,483	18.2	3,560	18.2	3,721	18.4	3,887	18.7	3,964	18.8	3,884	18.1	3,761	17.5	3,764	17.3
30-34	3,441	18.4	3,425	17.9	3,406	17.4	3,383	16.7	3,303	15.9	3,241	15.3	3,182	14.8	3,197	14.8	3,157	14.5
35-39	3,207	17.1	3,327	17.4	3,370	17.2	3,503	17.3	3,482	16.8	3,548	16.8	3,580	16.7	3,515	16.3	3,426	15.8
40-44	2,681	14.3	2,819	14.7	2,948	15	3,066	15.2	3,246	15.6	3,281	15.5	3,394	15.8	3,398	15.8	3,445	15.9
45-49	2,464	13.2	2,494	13	2,437	12.4	2,459	12.2	2,572	12.4	2,678	12.7	2,789	13.0	2,905	13.5	2,965	13.7
50-54	1,695	9.0	1,846	9.6	2,026	10.3	2,117	10.5	2,160	10.4	2,264	10.7	2,310	10.8	2,267	10.5	2,278	10.5
55-59	1,056	5.6	1,076	5.6	1,160	5.9	1,247	6.2	1,325	6.4	1,360	6.4	1,493	7.0	1,627	7.6	1,727	8.0
60-64	471	2.5	501	2.6	520	2.7	528	2.6	574	2.8	575	2.7	607	2.8	631	2.9	656	3.0
65 & over	192	1.0	168	0.9	171	0.9	192	0.9	201	1.0	213	1.0	223	1.0	237	1.1	16	0.1

Source: Dental Practice Boards

TABLE 25

General Dental Service: Number of Dentists (1) and Population (2) to Dentist Ratio by Health Region

Great Britain

Region	30 September 2001 Population Per dentist	30 September 2002 Number of dentists	30 September 2002 Population Per dentist		30 September 2003 Number of dentists	30 September 2003 Population Per dentist
Great Britain	2,663	21,528	2,655	**Great Britain**	21,701	2633
England and Wales	2,690	19,415	2,683	**England and Wales**	19,555	2653
England	2,680	18,400	2,673	**England**	18,537	2642
Northern & Yorkshire	2,870	2,190	2,840	**London**	3,195	2246
Trent	3,177	1,639	3,105	**East and Midlands**	5,055	2908
West Midlands	3,158	1,698	3,102	**North**	5,017	2834
North West	2,813	2,294	2,812	**South**	5,270	2443
Eastern	2,661	2,021	2,669			
London	2,253	3,146	2,285			
South East	2,515	3,457	2,499			
South & West	2,502	1,955	2,524			
Wales	2,872	1,015	2,860	**Wales**	1,018	2867
Scotland	2,415	2,123	2,385	Scotland	2,146	2401

Source: Dental Practice Boards and Office for National Statistics

Notes:
(1) A dentist practising in more than one Health Authority has been included under the Health Authority area in which they carried out the major part of their work.
(2) Population estimates are mid year estimates based on 2001 census. For 2002, mid-2001 estimates are used.

TABLE 26

General Dental Service: Number of Courses of Treatment Provided for Adults by Country
Great Britain

millions

Year	Great Britain	England	Wales	Scotland
1987/88	25.6	22.4	1.2	2.0
1988/89	27.4	24.0	1.3	2.1
1989/90	26.1	22.8	1.2	2.1
1990/91	25.8	22.6	1.2	2.1
1991/92	27.9	24.3	1.3	2.3
1992/93	28.9	25.1	1.4	2.4
1993/94	28.7	24.8	1.4	2.4
1994/95	28.8	24.9	1.4	2.5
1995/96	28.6	24.8	1.4	2.5
1996/97	28.4	24.6	1.4	2.4
1997/98	29.5	25.3	1.4	2.8
1998/99	30.5	26.2	1.5	2.8
1999/00	30.3	25.9	1.5	2.8
2000/01	30.7	26.4	1.6	2.8
2001/02	30.7	26.3	1.6	2.8
2002/03	30.8	26.3	1.6	2.9
2003/04	30.9	26.5	1.6	2.8

Source: Dental Practice Boards

Notes:
(1) Scottish data includes all those forms processed and paid in the monthly schedules.
However due to operational procedures, unpaid forms will appear in later monthly schedules.
(2) Figures are for completed courses of treatment processed for payment.