INFORMATION FOR THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB)

Review for 2012 from The Department of Health
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EXECUTIVE SUMMARY

Introduction

1. The Chief Secretary to the Treasury wrote to the Pay Review Body Chairs on 26 June 2011 and explained, for workers in England paid above £21,000, as in the previous year, the Government would not submit evidence or seek recommendations on pay uplifts for 2012/13.

2. The Secretary of State for Health confirmed this in his letter of 22 August, but agreed to provide information about recruitment, retention and other aspects affecting the medical workforces as appropriate.

3. We are submitting this document to the Review Body to keep you advised of developments affecting your remit group.

Summary

4. The Coalition Government inherited one of the most challenging financial situations in the world and its proposals for this year's uplift must be seen in that light. The Government's top priority is and must continue to be the reduction of an unsustainable structural deficit. This strategy necessarily involves tight control of public spending, including pay, which represents around 50 per cent departmental resource budgets in England.

5. The Government therefore announced a two-year pay freeze across the public sector for 2011/12 and 2012/13 for those earning basic salaries of more than £21,000 a year. However, the Government also made a commitment to protect those on low incomes, and announced that those earning basic salaries £21,000 or less should receive uplifts of a minimum of £250 a year.

6. All doctors and dentists have full-time equivalent earnings of more than £21,000 and are therefore subject to the pay freeze.

Affordability

7. Although NHS has received a better spending review settlement than many other parts of the public sector, including a guarantee of real terms increases in NHS funding in each year of this parliament, NHS resources will be under considerable pressure. In particular, the Department of Health estimates that the NHS will need to deliver annual quality and productivity (QIPP) savings of up to £20 billion by 2014-15 to cope with demographic increases in demand, fund the increased cost of non-pay inputs such as drugs, and meet the cost of introducing new medical technologies and procedures.

8. The Government is determined to deliver these savings and has said that any funds released will be reinvested in front line services. However, delivering these savings will be extremely challenging and any unnecessary increase in pay would make this more difficult, could undermine this ambition and may put at risk our ability to meet growing public expectations.

Staff satisfaction and motivation remain healthy

9. The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2010 NHS staff survey is the 8th annual survey of its kind. The score for job satisfaction for NHS staff has remained consistently high and has increased again this year, from 3.53 to 3.54 in the 2010 survey

(on a scale of 1-5, where 1 is low and 5 high). This is now the highest it has been in the last five years.

Recruitment and retention remain healthy

10. The recruitment and retention position remains very healthy across the NHS. The latest annual census figures for England confirm that the NHS workforce has increased in 2010 to the highest ever recorded. Medical numbers continued to grow. The Foundation Programme was also over subscribed in 2011 and for the first time had a reserve list – although ultimately, all eligible applicants were placed on the Programme. This shows that Recruitment and Retention is healthy in the current economic climate, and with the current reward package we would expect the positive recruitment and retention situation to continue.

Total Reward in the NHS remains attractive

11. According to independent research by the Institute for Fiscal Studies (IFS) published in its Green Budget in February 2011, pay in the public sector remains greater than that in the private sector once appropriate adjustment has been made for relevant skills and experience. The IFS research also supported Lord Hutton’s conclusion that public sector pensions remain significantly more generous than those in the private sector and provided significantly better access to defined benefit schemes.

12. Lord Hutton's recent independent review of public sector pensions also highlighted that there was a case for increasing employee pension contributions to rebalance the relative contributions paid by the employer and the employee, and recognised that the employer had absorbed a disproportionate burden in respect of the recent forecast increases in longevity.

13. The Government has proposed changes in public sector pensions in response to Lord Hutton's report. These are being discussed with trade unions at the moment. The Government’s proposals to increase contributions from 2012/13 are also subject to a public consultation launched in July 2011. In the meantime, the Government has made it clear that future public sector pensions will remain among the best available. The Government is clear that any changes in pensions, including the proposed increase in contributions from 2012/13, do not justify upward pressure on pay.

Conclusion

14. The Coalition Government has guaranteed that health spending will increase in real terms in every year of this Parliament. However, with that protection comes the same obligation for the NHS to cut waste and transform productivity as applies to other parts of the public sector.

15. NHS pay must also been seen within the wider context of the current economic situation and cannot be immune from the serious economic challenges we face. Britain’s deficit in 2009-10 was the largest in its peacetime history. The Government is committed to a fiscal mandate which will achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast horizon. It is in this context that the June 2010 Budget announced a two year pay freeze from 2011-12 for public sector workforces, except for those earning a full-time equivalent salary of £21,000 or less, where the Government will seek increases of at least £250 per year. This policy will help to protect jobs and the quality of public services during the consolidation period.

CHAPTER 1: NHS STRATEGY

1.1 The Department of Health revised Business Plan, published on 19 July 2011, is a core part of the Department's commitment to the Governments' transparency agenda - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128494. It sets out the vision and priorities for the Department. The Structural Reform section of the Plan includes key commitments involved in delivering our reform programme up to 2015. The Transparency section of the Plan sets out the key indicators that are most useful in understanding the costs and outcomes of health and social care services. A key part of this is sustained control of the NHS pay bill.

1.2 The Emergency Budget in June 2010 announced a two-year pay freeze from 2011/12 for public sector workforces, except those earning a full-time equivalent of £21,000 or less. This is the second year of the Government's two-year pay freeze. All doctors and dentists have full-time equivalent earnings of more than £21,000 and are therefore subject to the pay freeze.

1.3 The Chief Secretary to the Treasury's letter of 26 June 2011 to Pay Review Body Chairs, made it clear that for workers in England paid above £21,000, as in the previous year, the Government would not submit evidence or seek recommendations on pay uplifts for 2012/13, but would provide Review Bodies with information about recruitment, retention and other aspects of the affected workforces as appropriate.

White Paper, '*Equity and Excellence: Liberating the NHS*'

1.4 The NHS White Paper, '*Equity and excellence: Liberating the NHS*', published 12 July 2010, sets out the Government's long-term vision for the future of the NHS in England. The vision builds on the core values and principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. The White Paper outlined a challenging and far-reaching set of reforms designed to:

- put patients at the heart of everything the NHS does;
- focus on continuously improving patient outcomes; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

1.5 Consultations on the implementation of the proposals in the White Paper closed on 11 October 2010. Detailed responses to the consultations were published during mid-December 2010.

Health and Social Care Bill 2011

1.6 The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

1.7 The Bill takes forward the areas of Equity and Excellence: Liberating the NHS (July 2010) and the subsequent Government response Liberating the NHS: legislative

framework and next steps (December 2010), which require primary legislation. It also includes provision to strengthen public health services and reform the Department's arm's length bodies. The Bill contains provisions covering five themes:

- strengthening commissioning of NHS services;
- increasing democratic accountability and public voice;
- liberating provision of NHS services;
- strengthening public health services; and
- reforming health and care arm's-length bodies.

1.8 The NHS Future Forum was launched on 6 April 2011 as an independent group in order to 'pause, listen and reflect' on the content of the Health and Social Care Bill. It published its recommendations on the future for NHS modernisation. The Government published its response on 20 June, setting out the changes it intends to make in response to the recommendations.

1.9 A further description of the context of the amendments to the Bill and of the other changes to the mordernisation plans is provided by the response.

Quality, Innovation, Productivity and Prevention (QIPP)

1.10 The current and forecast economic climate demands **more** efficient use of resources **across the public sector**. The NHS has understood for some time the need to make challenging improvements in productivity and efficiency **whilst maintaining or improving the quality of care**. To meet increasing demand, stemming partly from **changing demographics**, and to absorb increasing costs **of new technology and drugs**, the NHS needs to concentrate on improving productivity and eliminating waste while focusing relentlessly on clinical quality.

1.11 Work has already begun on releasing up to £20 billion of efficiency savings needed by the end of the Spending Review period **(2014/15).** These savings will be reinvested in front-line services to meet the current financial challenge and the future costs of demographic and technological change, ensuring that the NHS continues to deliver year on year quality improvements. Achieving this ambition will be extremely challenging.

1.12 Work is underway at a national, regional and local level to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service.

Assessing the Future Health Workforce Needs in England

1.13 The White Paper also set out the Government's vision of a provider-led workforce planning, education and training system, in which the professions have the leading roles in commissioning education and training, and work with employers to ensure a multi-disciplinary approach.

1.14 A public consultation on these proposed changes "Liberating the NHS: Developing the Healthcare Workforce" was published on 20 December 2010. It sets out proposals for a new framework for workforce planning, education and training. The consultation

closed on the 31 March 2011 and a summary of the consultation responses was published on 18 August 2011.

1.15 The new framework proposed in the consultation would see healthcare providers – with their local clinical leadership – taking a lead role in planning and developing their workforce, with responsibility for many of the workforce functions currently led by the Strategic Health Authorities (SHAs). A new statutory body, Health Education England (HEE), would be established to provide oversight and national leadership for education and training.

1.16 The new system will:

- Provide **security of supply**, ensuring sufficient numbers of appropriately trained professionals to meet future health needs and achieve health outcomes that are among the best in the world.
- Be **responsive to patient needs and changing service models**, such that the capacity and skills of current and future staff reflect the needs of patients and local health economies.
- Deliver **continuous improvement in the quality of education & training**, aspiring for excellence and innovation in all education and development activity, to build confident and competent healthcare staff able to deliver safe and high quality care.
- Ensure **value for money**, with transparent funding flows to support a level playing field across providers.

1.17 **Widen participation**, supporting diversity and equitable access to services, education, training and development opportunities and a system where talent flourishes free from discrimination with everyone having fair opportunities to progress.

1.18 It is clear that effective workforce planning is key to delivering the right workforce to deliver the Government's vision. The Centre for Workforce Intelligence (CfWI) information and analysis will support NHS organisations in their workforce planning, assisting them in taking a long-range approach to improving skills and resources. This will enable the Department and NHS bodies at all levels to understand workforce demand and supply in greater depth, and thereby to improve their workforce planning strategies.

Conclusion

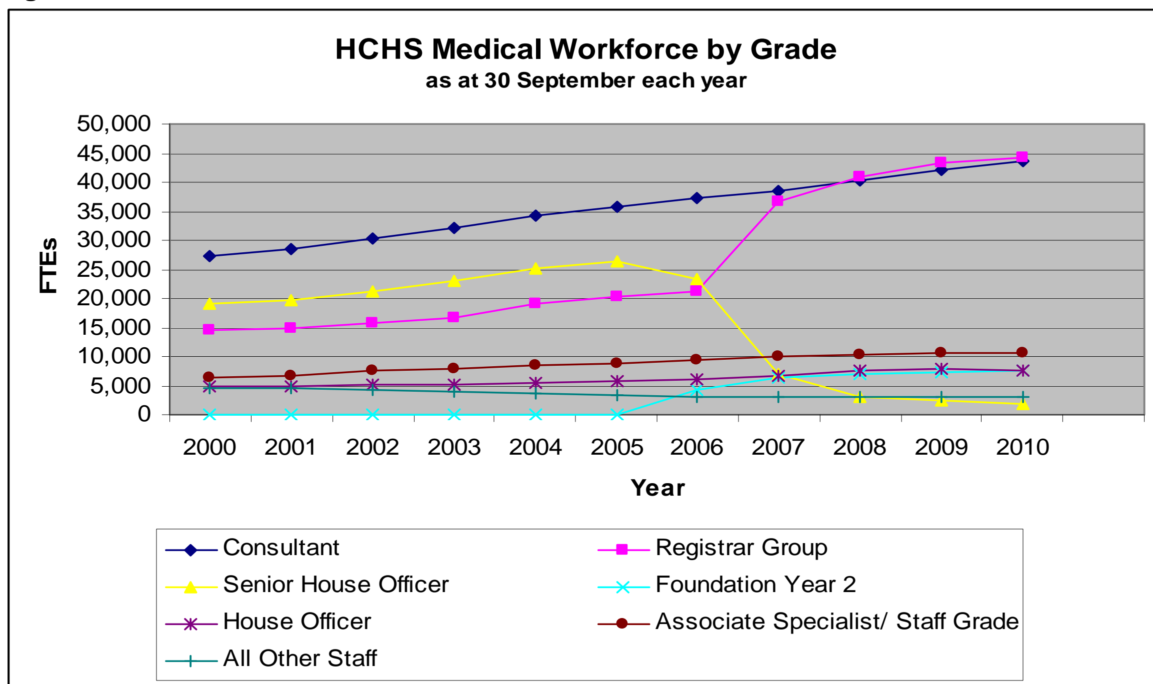
1.19 The Government has embarked on a major programme of reform to deliver better outcomes for patients from an empowered front line workforce. These changes are set out in the White Paper and the Health and Social Care Bill. Department has recently completed a number of consultations, including the listening exercise undertaken by the NHS Future Forum and will be taking forward its responses to those.

CHAPTER 2: MEDICAL WORKFORCE PLANNING CONTEXT

Workforce Numbers: Headline Figures

2.1 There are now more than 140,000 hospital and community health services (HCHS) doctors and GPs. Figure 2.1 shows the growth in the HCHS medical workforce since 2000. New healthcare methodology for 2010 data is not fully comparable with previous years due to improvements that make it a more stringent count of absolute staff numbers.

Figure 2.1

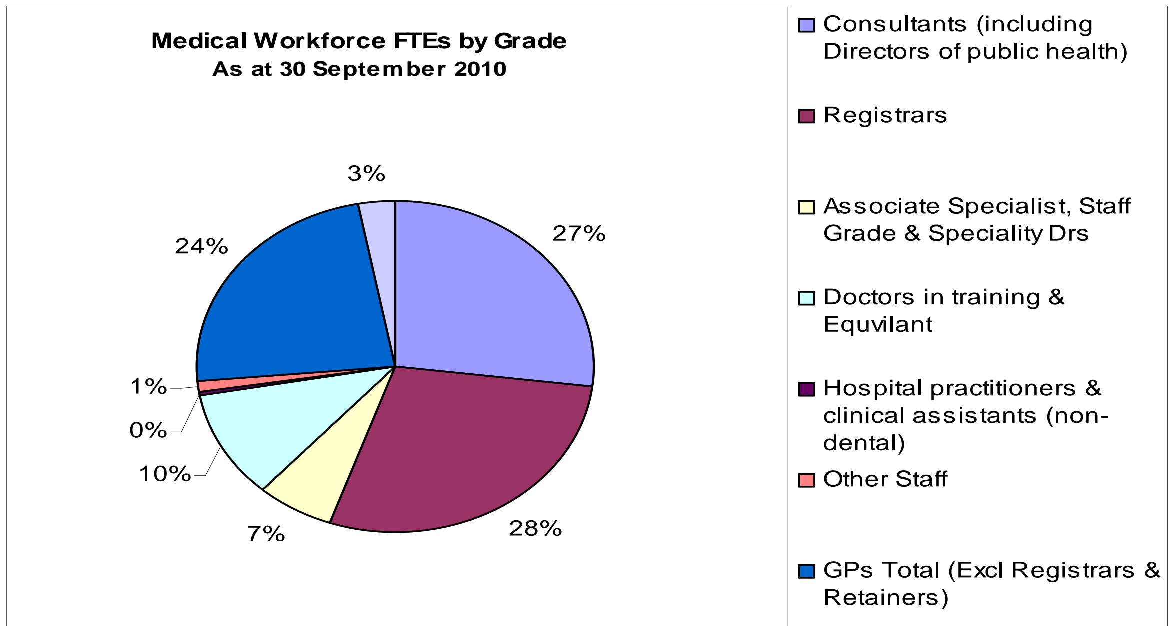


2.2 The latest annual census figures for England confirm that the NHS workforce has increased in 2010 to the highest ever recorded. Medical numbers continued to grow during the year to 30 September 2010, in particular:

- the numbers of hospital, public health medicine and community health service medical and dental staff (excluding retainers) increased by 2,041 (headcount) or 2% and 1,038 (full time equivalents (FTE)) or 1.1%;
- consultant numbers increased by 1,734 (headcount) or 4.8% and 1,127 (FTE) or 3.3%;
- the number of specialty doctors, staff grades and associate specialists increased by 182 (headcount) or 1.8% but decreased by 23 (FTE) or 0.3%;
- numbers of doctors in training and equivalents increased by 645 (headcount) or 1.3% and 181 (FTE) or 0.4%;
- GP numbers – excluding GP retainers and GP registrars – increased by 176 (headcount) or 0.5%, but decreased by 755 (FTE) or -2.4%; and
- GP registrars increased by 100 (headcount) or 2.6% and 59 (FTE) or 1.6%.

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

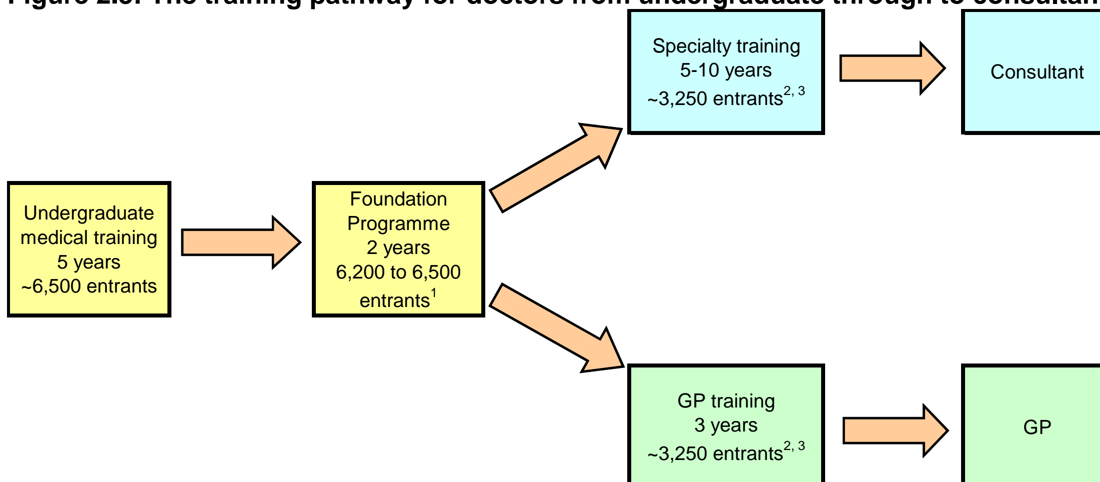
Figure 2.2



Workforce Planning

2.4 The training pathway for doctors is shown in Figure 2.3, indicating the number of trainees at each stage of the training pathway, and the timescales over which doctors are likely to progress through each stage.

Figure 2.3: The training pathway for doctors from undergraduate through to consultant /GP



Notes: 1) Foundation Programme entrant numbers are generally bolstered by a small number of non-UK graduates. Numbers in the 2nd year of the Foundation Programme are also likely to be bolstered by international recruitment.
2) Figures represent the DH ambition to move towards an aggregate specialty training intake of 6,500, split 50:50 between specialists and GPs.
3) Specialty and GP training numbers are also likely to be bolstered by non-UK graduates across all levels of training.

2.5 The timelines for medical training are long, the time lag between entry to undergraduate training and becoming a consultant is around 15 years (around 10 years for GPs). Therefore, the method used to determine appropriate training

numbers is to analyse the long-term demand for trained doctors (typically for the next 20 years). This produces estimates of medium-term demand for doctors in postgraduate training, which then drives the shorter-term demand for new trainees at undergraduate level.

Centre for Workforce Intelligence

2.6 Established in July 2010 the Centre for Workforce Intelligence (CfWI) supports long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis and will look to build strong leadership and capability in workforce planning.

2.7 The Centre focuses on three key, strategic areas:

- Provide **leadership** within the system, helping senior leaders to drive workforce planning, strengthening the influence of workforce planners, and connecting different parts of the system.
- Provide workforce **intelligence** to the health and social care system to enable it to make better decisions.
- Provide the support, resources and best practice to improve the effectiveness of workforce **planning** at local, regional and national levels.

2.8 To better understand the future demand for medical staff and to develop supply strategies to meet this demand the CfWI published its second report on the medical workforce in August 2011[1], this includes a series of factsheets. These factsheets will provide baseline data for each medical specialty, including recommendations on education commissioning numbers and a 3-5 year horizon scanning element.

2.9 This report contains its recommendations on training numbers for medical specialties, the report also makes medium term recommendations by specialty and geography. The report aims to inform and stimulate discussions on key areas of workforce planning. The Government will draw on the CfWIs work in future evidence to the Doctors & Dentists Review Body.

Entry to Training (Undergraduate)

2.10 There continues to be evidence of good recruitment into medicine. We are acting to ensure that supply meets demand, we are taking steps to manage the numbers entering medical school. It would be inefficient and wasteful to train doctors for which there will be no demand in future and who would be unable to secure posts.

2.11 The DH and the Higher Education Funding Council of England have recently commissioned the Health and Educational National Strategic Exchange to review the total number of undergraduate medical and dental students intake in England.

2.12 Data on entry to UK medical schools is at Statistical Tables 1-4. Medicine and dentistry remain very attractive careers and continue to attract high quality candidates

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[1] http://www.cfwi.org.uk/intelligence/projects/shape-of-the-medical-workforce-informing-medical-training-numbers

with average tariff points considerably higher than the average for all subjects. For 2010 entry, the average UCAS tariff points held by home domiciled accepted applicants to UK medical and dental schools were 443 and 408 respectively, compared to 423 and 400 in 2009. In 2010, there was an average of 2.4 & 2.8 applicants for every successful applicant to medicine and dentistry respectively. Of this 55% (for medicine) and 59% (for dentistry) were female applicants. The percentage of female applicants has remained the same for medicine but has risen by 1% for dentistry when compared with 2009.

2.13 We have noted the concern expressed by the DDRB that as women account for 55% of accepted applicants to medical schools, we need to consider this as part of any future workforce planning, especially for specialities that attract more female candidates. DH is advised on workforce planning by the Joint Working Group. The Joint Working Group (JWG) is a multi stakeholder group with strong Royal College, Employers, SHA and BMA representation.

2.14 The role of the JWG in relation to postgraduate medical specialty training numbers, is to consider the implications for investment in postgraduate medical specialty training numbers each year. This is achieved by providing guidance to SHAs on priorities, planning expectations and assessing proposals from SHAs to ensure account has been taken of strategic requirements and that they reflect the long term as well as short term planning needs. The Centre for Workforce Intelligence assists with a wide range of factors in developing these recommendations including the increasing feminisation of the medical workforce.

Current Workforce Pressures

2.15 The NHS Vacancy Survey, published by The NHS Information Centre (The NHS IC), collects information on vacancies that have been open and actively recruited to for three months or more at the end of March each year. This gives a measure of the vacancies which employers are finding hard to fill, rather than normal staff turnover.

2.16 The NHS vacancy collection and publication have been suspended for 2011. This collection is being reviewed as part of the national Fundamental Review of NHS data collections, which went out for consultation on 30th August with a closing date of 22nd November.

2.17 The NHS IC has also undertaken an internal review of all areas of work. In light of the review and resource constraints, the NHS IC has decided to suspend the NHS Vacancy collection and publication for 2011, to ensure that they can devote sufficient resources to other areas of workforce information, such as information on workforce numbers and turnover, which are of a greater strategic value and greater relevance in the present recruitment climate. Following the outcome of the Fundamental Review, they will then consider the future of the vacancy collections in 2012 and beyond. More information is available from here: http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-and-gp-vacancies, and http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_129725

2.18 Therefore the figures provided in statistical tables 6 and 7 relate to 2010 figures. The 2010 Survey shows that long-term vacancy levels remain at historically low levels for most staff groups.

2.19 In the Spending Review, the Government protected the NHS budget with real terms growth in each year. However, the funding available to the NHS is fixed and extremely tight compared with the recent past. In such circumstances, increases in pay will reduce the funds available for service developments and activity growth and reduce the derived demand for staff.

2.20 Although the DH plans unprecedented savings in non-pay costs through QIPP, the level of non-discretionary demand led pressures such as drugs bill, European Economic Area medical costs and litigation means the continuation of pay drift and pay proposals for Agenda for Change bands 1-4 might impact adversely on staffing levels. The Department also has ambitious plans to reduce the number of managers and administration staff, primarily in Strategic Health Authorities and Primary Care Trusts to protect front-line services, but reductions in clinical posts cannot be ruled out.

2.21 The Department believes that there is a prudent balance to be struck between the public's aspirations for continuing NHS service improvements on the one hand, and pay levels necessary to deliver a workforce of the required size, skill, motivation and morale on the other.

2.22 The total remuneration remains attractive to recruit, motivate and retain sufficient workforce as demonstrated by historically low vacancy rates.

CHAPTER 3: HOSPITAL DOCTORS AND DENTISTS IN TRAINING

Overview

3.1 There are no specific recruitment and retention problems among doctors in training:

- the number of doctors in training in England has increased by 690 in the year to September 2010;
- the fill rate for specialty training programmes in 2011 has been very high with a majority of specialties and geographies reporting 100% fill rates;
- in terms of average earnings for new graduates, medicine continues to stand up well in comparison with other graduate careers – including law and investment banking; and
- the NHS Staff Survey scores for job satisfaction and intention to leave jobs have improved for doctors and dentists in training since last year.

General Position

3.2 The current junior doctors' contract, introduced in 2000, uses a pay banding system to reward doctors in training grades for the frequency and duration of their out-of-hours work. They receive banding supplements, paid in addition to basic salary, the bandings reflects: whether the post is compliant with the New Deal hours limits and rest requirements; whether the doctor works up to 40, 48 or 56 hours per week; the type of working pattern; the intensity of work; whether the doctor receives appropriate rest and the unsocial nature of the working arrangements. For posts which comply with the New Deal, the banding supplements are: Band 1C – 20%; Band 1B - 40%; Bands 1A and 2B – 50%; Band 2A – 80%. Doctors in non-compliant posts are paid a Band 3 supplement of 100%. From 1 April 2010, foundation house officer 1 doctors in unbanded posts receive a supplement of 5%.

3.3 Since March 2005, at least 98% of doctors have been fully compliant with the New Deal (99% in March 2010) compared with 88% in March 2004 and 71% in March 2001. The latest monitoring returns show that 95% of junior doctors earn in excess of basic salary through the banding multipliers although there is some variation between grades. The average banding supplement in March 2010 for compliant posts was 43%.

3.4 In March 2010, the New Deal Monitoring data collection was discontinued. This break in the time-series of historical data makes it difficult to conclusively monitor any trends in changes to the payment of banding supplements. Whilst not directly comparable, analysis of Electronic Staff Records (ESR) data suggests that average banding supplement between April 2010 and March 2011 remains stable at approximately 42%, which is within 1% of that reported in the March 2010 New Deal Monitoring.

The European Working Time Directive

3.5 The Review Body will recall that the European Working Time Directive (EWTD) has been applied to the majority of staff since 1998, but its implementation for doctors in training grades has been phased in over a number of years from 2004. The NHS has

been reducing doctors' working hours gradually since then, moving to a 48-hour average working week in August 2009 and by January 2010 nearly 99% of rotas were compliant with the Directive.

3.6 In September 2009, the European Commission announced its commitment to reviewing the Working Time Directive, following the collapse of the previous round of negotiations in April 2009. The review process began with a two-stage consultation of EU Social Partners, which closed in March 2011. EU Social Partners now need to decide whether to enter into negotiations between themselves on amending the Directive. If Social Partners do not choose to negotiate, or in the event that Social Partner negotiations are unsuccessful, it will fall to the Commission to draft a proposal to change the Directive. Negotiations would then start in Council and in the European Parliament.

3.7 The Coalition Government is committed to limiting the application of the Working Time Directive in the UK, including maintaining the flexibility provided by the right of individuals to opt out of the maximum 48-hour working week. DH and Department for Business Innovation and Skills are working very closely together on the application of the Working Time Directive to the UK healthcare sector. The Government will engage positively and constructively with any further negotiations on Working Time with the aim of securing additional flexibility, for example regarding the treatment of on-call time and compensatory rest, while ensuring the retention of opt-out.

3.8 In response to the Temple recommendations that the New Deal contract be reappraised to ensure it supports training within the 48-hour working week, Secretary of State asked Medical Education England (MEE) to advise NHS Employers during their negotiations with the BMA on ways to realign the New Deal working arrangements. NHS Employers have outlined the options for negotiating new contract arrangements. The UK Health Departments will be considering the options for reforming the New Deal contract so it can be reappraised to ensure it supports training within the Working Time Directive. However, it is unlikely that these will be in place before 2013-14.

3.9 In addition, MEE has been asked by the Secretary of State to implement the recommendations from Temple and have developed a programme called *Better Training Better Care,* which is designed to:

- improve the quality of medical education and training and consequently the quality of patient care and safety; and
- address issues of providing high quality training within the limitations of the Working Time Directive; and specifically addressing the issues surrounding lack of appropriate supervision and trainees working beyond their competence.

An update on this is attached at **Annex B.**

Developments in Postgraduate Medical Education and Training

Liberating the NHS

3.10 The consultation document *"Liberating the NHS: Developing the Healthcare Workforce"* was published on 20 December 2010 and sets out proposals for a new framework for workforce planning, education and training. Consultation closed on 31 March with 544 responses received. A summary of consultation responses was published on 18 August.

3.11 The new framework proposed in the consultation would see healthcare providers – with their local clinical leadership – taking a lead role in planning and developing their workforce, with responsibility for many of the workforce functions currently led by the Strategic Health Authorities. A new statutory body, Health Education England (HEE), would be established to provide oversight and national leadership for education and training.

3.12 The consultation was followed by a Listening Exercise led by the NHS Future Forum with the report from the Future Forum and the Government's response published in June 2011.

3.13 As announced on 18 August 2011, the Future Forum will again consider education in it's next phase of work with a particular emphasis on quality, the balance of responsibilities and accountabilities, public and patient engagement, and partnerships with the education and research sector.

3.14 The Government's response to the NHS Future Forum signalled further engagement with stakeholders on the education and training proposals over the Summer with further proposals to be published in the Autumn.

3.15 Work is underway to shape the next phase of the work programme, develop an effective stakeholder engagement strategy and identify priority publications for the Autumn.

Medical Education England

3.16 Until HEE is established there will be a continuing role for Medical Education England (MEE). MEE is an Independent Advisory Non-Departmental Public Body with a remit for medicine, dentistry, pharmacy and healthcare science. MEE brings a coherent professional voice on education and training matters as they relate to these four professional groups and advises the Department of Health on policy.

3.17 The Medical Programme Board (MPB) is one of four professional advisory groups that are sub-committees of MEE. High level responsibilities for the MPB include accountability for identifying the medical policies and practices that should be recommended to the MEE Board and providing professional and service leadership.

3.18 Specifically, the MPB is responsible for ensuring that:

- training posts are filled by high quality and appointable candidates;
- the principle of curriculum-based training is supported and delivered;
- training is supported by capacity in the service to deliver training to a high standard;
- the needs of academic medicine are recognised in order to promote the excellence of medical care;

- progress is monitored and risks to delivery are reviewed regularly and managed within acceptable levels; and
- any other duties as delegated by the MEE Board are undertaken.

3.19 The MEE Board has developed its vision, strategic priorities and work programme (available at www.mee.nhs.uk). Major initiatives for the coming year will be:

- completion of a review on the future shape of postgraduate medical training; and
- the Better Training, Better Care initiative (see para 3.9 above) that aims to improve both the quality of training and hence the quality of learning and, consequently, the quality of patient care by enabling the delivery of the key recommendations from two important recent reports: Professor Sir John Temple's independent report Time for Training – the impact of the European Working Time Directive on the quality of training and Professor John Collins' evaluation of the Foundation Programme Foundation for Excellence.

Recruitment to medical training

3.20 In general recruitment to postgraduate and dental education has progressed well with high fill rates achieved. The Foundation Programme was over subscribed in 2011 and for the first time had a reserve list – although, ultimately, all eligible applicants were placed on the Programme. Specialty training achieved high fill rates with only one specialty, psychiatry achieving less than 94% fill rate with four specialties achieving 100% and five 99% fill rate for August 2011. In total there are approximately 9000 core and specialty training posts at all levels with 18000 applicants. In England there were over 6500 Foundation Programme places, with over 7500 applicants.

3.21 Changes have been made for the management of recruitment process to maximise applicant opportunity and improve fill rates. These improvements will continue in 2012.

3.22 For the future, the *Better Training, Better Care* and a range of other developments such as the board based curriculum, shape of training etc should have a positive benefit for junior doctors as well as improving recruitment and retention.

3.23 However, it is worth noting that we do not envisage a shortage of junior doctors and there is evidence of over supply in certain specialties when compared to future demand.

3.24 The postgraduate deans and Strategic Health Authority staff involved in planning and developing the workforce play a vital role in commissioning and quality assuring education and training. The NHS Future Forum's report reflected concerns about how their role will continue following abolition of the Strategic Health Authorities. The Government's response recognised that we have not made our plans clear enough.

3.25 Securing continuity for the work of the Strategic Health Authorities and deaneries into the new arrangements will be a key part of safe transition. We will work with the service, deaneries, the proposed HEE and professional bodies to ensure that

recruitment to postgraduate medical and dental programmes in 2012 and onwards is managed effectively.

3.26 Changing the system for planning and developing the whole healthcare workforce will take time and following further engagement with stakeholders on the education and training proposals over the Summer, further proposals will be published in the Autumn.

Workforce Numbers

3.27 At the September 2010 census, the number of doctors in training in England was 52,192 - an increase of 843 (1.6%) on the September 2009 position and 20,270 (63%) more than ten years ago. The FTE figure increased by 0.4% in the year to 2010 (from 51,216 to 51,397).

3.28 As discussed in paras 2.9 & 2.10, the demand for postgraduate medical trainees is driven by the demand for trained doctors in future years. The August 2011 CfWI report published its recommendations on training numbers for medical specialties, the report makes medium term recommendations by specialty and geography. We will continue to monitor the situation and the Government will draw on the CfWIs work in future evidence to the Doctors & Dentists Review Body.

3.29 There is evidence of junior doctors turning down offers of posts because they do not want to move location, but this has been a current theme for the past few years. Nevertheless high fill rates have been achieved.

3.30 There is evidence of doctors leaving programmes to gain more experience, take a career break, undertake research, go abroad or take up a service post. This appears to be common practice with Foundation Programme doctors with approximately 10% choosing to do this rather than apply for specialty training vacancies.

3.31 Competition for higher specialty training posts, ie ST3 and above, is very strong with junior doctors applying from within training system facing competition from experienced doctors outside the training system. Examples of specialties with high competition ratios are Plastic Surgery (8:1), Paediatric Surgery (10:1) and Trauma and Orthopaedics (6:1). Overall, for Core Surgical Training posts, there were over 1770 applicants for 325 higher specialty training posts.

3.32 Although filling locum and non-service posts remains difficult, there has been a reduction in reported difficulties with employers, more tightly, managing the demand for locums. This probably reflects the need to manage costs locally and the recognition that locums are a high cost. Fill rates in 2011 have been exceptionally high, which have reduced the need for locums or service doctors to fill rota gaps. The actions being taken forward to implement the Temple Report's recommendations, including reorganisation of rotas and multi-disciplinary team working, will help to address this position.

3.33 The Home Office reviewed the work routes (Tiers 1, 2) and the student route (Tier 4) of the Points Based System as part of the Government's aim to reduce net migration and increase cohesion. Tiers 1 and 2 were shaped to increase selectivity and skills

requirements. Furthermore, the Home Office also implemented a permanent limit on non-EU economic migration to the UK and announced changes to the student route. The Department worked closely with the Home Office to mitigate the effect of these changes on the recruitment of doctors, dentists and pharmacists and the potential significant negative impact this could have had on the delivery of medical, dental and pharmacy services in the NHS.

Graduate Starting Salary Comparisons with Other Professions

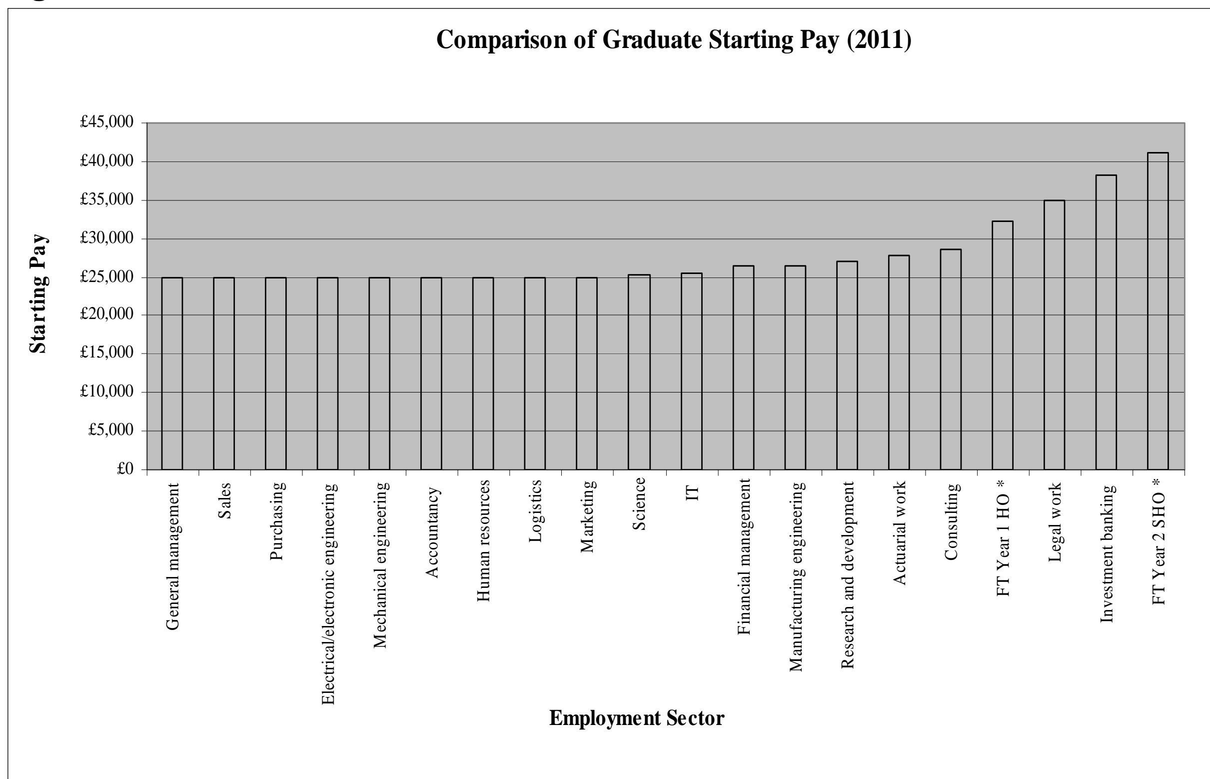
3.34 For medical graduates entering their first post, total earnings remain very competitive, particularly once account is taken of the availability of posts. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in the high proportion of graduates that are immediately able to enter their chosen career.

3.35 A recent survey by the Association of Graduate Recruiters[2] (AGR) reported that the survey shows that graduate vacancies are predicted to increase by 2.6% this year. This follows an increase of 8.9% in 2010, and signals sustained recovery of the graduate recruitment market. The average starting salary has also increased slightly (by 2%) to £25,500, the first increase since 2008. However, the number of applications for each graduate job has increased considerably to 83 on average in comparison, to 69 in 2010 and 49 in 2009 and 2008, Graduates face record level of competition for jobs. This is in contrast to the recruitment round of 2011, though for the first time it was oversubscribed, all eligible graduates of UK medical schools were successful in securing a place on the Foundation Programme.

3.36 Using the latest banding figures available from March 2011 and data taken from the AGR survey, Figure 3.3 shows a comparison between the pay of junior doctors in their first post and the pay of graduates entering other professions. The columns in red show the means total earnings - calculated as mean basic pay, but for all earnings for first year and second year Foundation Trainees. This includes basic pay, plus hours related pay, overtime, occupation payments & location payments. This continues to stand up well against the starting salaries in other professions including investment banking, construction / consultancy and the legal profession, where there were respectively 232, 130 and 65 applications for each graduate vacancy.

[2] Recruitment Survey 2011, Association of Graduate Recruiters

Figure 3.3



Junior Doctors' Contract

3.37 The Health Departments commissioned NHS Employers to undertake scoping work on any case for restructuring junior doctors' pay including renegotiation of the contract and setting out the principles on which new arrangements should be based. In England, this work has needed to take account of the Government's response to the recommendations of the Temple Report.

3.38 NHS Employers took views from a wide range of NHS employers across the UK, including the British Medical Association. This was to ensure that the study will be thorough and comprehensive and consider in some detail how any changes will help deliver on our vision for better patient care.

3.39 DH has now received NHS Employers scoping report, DH is giving it careful consideration with the devolved administrations and will write to Secretary of State on next steps.

3.40 All four UK Health Departments have agreed that, following SofS feedback, the study will first be shared with the Public Sector Pay Committee, then simultaneously with Medical Education England (and equivalent professional bodies in the Devolved Administrations) and the Doctors and Dentists Review Body (DDRB) for any comment.

3.41 UK officials will write to their respective Ministers setting out recommendations for future negotiations and how such negotiations will be handled across all four countries. A final date for publishing the scoping report is not yet confirmed but is

likely to be in the Autumn. UK officials are mindful that the Government's response to Lord Hutton's review of public service pension schemes will also be published in the Autumn, as will the DDRB's report on Clinical Excellence Awards. We are unlikely to get agreement on a UK-wide negotiating remit much before late 2011. Any new arrangements will not be ready for introduction before 2013-14.

3.42 DH remains strongly committed to ensuring that the contract is fit for purpose and supports its ambition for high quality education and training of junior doctors. DH hope that the report will provide a basis for agreeing an appropriate way forward with the BMA, the Royal Colleges and other key stakeholders.

NHS Staff Survey

Morale and motivation

3.43 The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2010 NHS staff survey is the 8th annual survey of its kind. Almost 306,000 NHS staff were invited to take part in the survey and approximately 165,000 employees responded – a 54% response rate (similar to 2009). The key score for job satisfaction in the NHS staff survey is regarded as one of the key indicators of staff motivation and morale.

3.44 The score for job satisfaction for NHS staff has remained consistently high and has increased again this year, from 3.53 to 3.54 in the 2010 survey (on a scale of 1-5, where 1 is low and 5 high). It is now the highest it has been in the last five years. The job satisfaction score for doctors and dentists in training is above the NHS average, as is the level of improvement in the score, increasing from 3.56 to 3.62.

3.45 The tables at **Annex A** show how some of the Survey results for the three groups of medical/dental staff surveyed (training grades, consultants and other) compare with last year's figures and the averages for all NHS staff.

3.46 Negating the improvement in job satisfaction scores is the key score for staff intention to leave jobs. The figure for doctors and dentists in training has increased slightly, from 2.49 in 2009 to 2.52 in 2010, although this is still well below the national average for all NHS staff. It is however, still higher than the average for medical and dental staff groups as a whole.

Workload

3.47 Items from the NHS staff survey in England that can give an insight into staff perceptions of workload are included in this section. These cover staff working additional hours (paid and unpaid), support to achieve work/home life balance and view on time to carry out jobs. The tables show the selected survey scores. In summary:

- The percentage of doctors and dentists in training working no additional paid hours is comparable to last year at 65% but is lower than the figure for all NHS staff, where 68% of staff report working no additional paid hours.

- The percentage of doctors and dentists in training working no additional unpaid hours has increased slightly to 32% from 31% in 2009. This is also lower than all NHS staff, where 46% report working no additional unpaid hours.

- The percentage of doctors and dentists in training who do not disagree (i.e. they agree, or neither agree nor disagree) that their trust is committed to helping staff balance their work and home life has increased in 2010 to 79% from 74% in 2009. This is slightly higher than average for medical and dental staff groups as a whole. They have a positive view of their immediate manager's help in finding work and home life balance, where the score remains high at 82%, which is slightly higher than the average of 79% for medical and dental staff groups as a whole.

- The proportion of doctors and dentists in training who do not disagree (i.e. they agree, or neither agree nor disagree) that they do not have the time to carry out all their work has decreased significantly from 65% in 2009 to 61% in 2010. This score is lower than the average for medical and dental staff groups as a whole (72%) and NHS staff as a whole (72%).

3.48 The 2011 NHS staff survey will be the ninth of its kind, providing the most reliable source of national and local data on how staff feel about working in the NHS and what staff experience in their day-to-day lives. It will run between September and December 2011. Trusts will receive local level aggregated data by February 2012 and nationally aggregated data will be available in late March 2012.

3.49 The 2011 survey will be the first survey undertaken since the beginnings of the pay freeze and results will be closely analysed to assess the impact of the pay freeze for all groups.

3.50 With the continued focus on the NHS Constitution and the pledges made to staff, the survey maintains its expanded role of providing information to NHS organisations that will contribute to their assessment in progressing the pledges to staff and in identifying specific areas for improvement that matter to staff.

CHAPTER 4: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

Overview

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

- in the year to September 2010, the numbers of associate specialists increased by 274, or 7.7% (headcount); there was a small decrease in staff grade and specialty doctors of 92 or -1.4% (headcount); and

- according to the NHS Staff Survey, job satisfaction for this staff group decreased slightly this year from 3.54 to 3.51, over the last year.

General Position

4.2 Between 2009 and 2010, associate specialist, staff grade and specialty doctor numbers employed by the NHS increased by 182 (headcount) and decreased slightly by 23 (FTE).

4.3 As Statistical Table 7 illustrates, the three-month vacancy rates for this group of HCHS doctors was 2.6% in 2010 compared to 3.0% in 2009. As mentioned in para 2.16 above the vacancy collection has been suspended for 2011.

Uptake of new contracts

4.4 We reported last year on the uptake of the new contracts. Based on data extracted from the Electronic Staff Record (ESR), it is estimated that as at June 2011**:**

- Around 65% of eligible Doctors were on the new Specialty Doctor or Associate Specialist contract.

- Of those doctors who had not transferred to the new contract:
  - 17% were Associate Specialists on the old contract;
  - 18% were Staff Grade Doctors;
  - 65% were Hospital Practitioners, Clinical Assistants, Clinical Medical Officers or Senior Clinical Medical Officers.

4.5 It should be noted that staff belonging to each type of post have been identified by recorded ‘grade code’ in ESR. This analysis is dependent on those grade codes being administered correctly. It is also important to note that there are doctors working on multiple assignments, which are recorded over more than one type of post i.e. Associate Specialist and Staff Grade, these doctors have been assigned to the most appropriate type of post in these instances.

4.6 Due to our improved understanding of the ESR data and its’ caveats, this year's evidence uses ESR data that has gone through data cleaning filters developed over the past year. These are similar to those used by the Information Centre for the data they use in publications such as the Quarterly Earnings Survey. The implication of

this is that the ESR dataset we use is a sample, but it is a reliable sample that we can have greater confidence in and use in greater detail.

4.7 We are pleased with the progress made. As expected the numbers have flattened off as we have almost exhausted the pool of eligible staff wishing to transfer. Figures from the ESR suggest that only around 20% of Associate Specialists remain on the old contracts as at June 2011. As the transfer is optional, we feel that these may have elected to remain on their old contracts. As new appointments are made, new entrants will continue to go onto the new Specialty Doctor contract as a matter of course.

Costs of the new contractual arrangements

4.8 As a condition of agreeing new contracts for Associate Specialists and the former Staff Grade doctors, we monitored and reported on the additional costs of the new contracts to the DDRB last year. The costing was based on those eligible Doctors that had transferred to the new contract by August 2009. The additional costs were estimated to be just over 9% of total earnings for these Doctors. We do not believe that there has been a significant change to the sample of doctors that this costing was based on to alter this result significantly, and we have therefore not provided a further update on costs this year.

Enhancing Opportunities for SAS Doctors

Funding

4.9 As we reported last year:

- recurrent funding of £12 million, uprated each year for inflation, has been provided since April 2008 for specialty doctor career support, training and CPD. This is reflected in Learning and Development Agreements (LDAs) between SHAs and NHS Trusts and other organisations in receipt of Multi-Professional Education and Training (MPET) funding; and

- to accompany this funding, the Department and NHS Employers jointly published *Employing and Supporting Specialty Doctors: A Guide to Good Practice* in April 2008.

Credentialing

4.10 The General Medical Council (GMC) is taking forward work to consider the concept of credentialing within medical education and careers.

4.11 The GMC also holds data on the number of applications for certificates of eligibility for specialist registration.

Certificates of Eligibility for Specialist Registration

4.12 GMC (and formerly Post Graduate Medical Education and Training Board (PMETB)) data show 61% of applications for Certificates of Eligibility for Specialist Registration (CESR) and Certificates of Eligibility for GP Registration (CEGPR) between 2005 and

2010 were successful. However, the data do not distinguish between applicants from overseas and from the SAS grades in the UK. Each application is, of course, assessed individually and decisions based on merit.

4.13 Information on the subsequent progress of CESR/CEGPR holders is available in the PMETB publication *Post-certification research 2008 - A comparison of employment outcomes by specialty and certificate type*. This concluded "the type of certificate held does not seem to impact on the likelihood of applicants taking up a substantive GP or consultant post".

4.14 However, as requested by the DDRB, we have noted the concern there may be discrimination against doctors that have pursued the Certificate of Eligibility for Specialist Registration (CESR) route. We have not seen evidence to support this concern, but the DH is contributing to the current GMC Review of the Equivalence Routes to GP and Specialist Registration, theme 3 of which is:

"To assess current perceptions of the equivalence routes, the evidence of the extent to which they are accorded equal status to CCTs and the nature of any impediments to their equivalence. In the light of this, to identify what steps the GMC might take, or encourage others to take, to support better recognition of a robust equivalence route."

4.15 The GMC is expected to report in September 2011 and undertake a public consultation on any proposals arising in the Autumn of 2011.

NHS Staff Survey

4.16 The results of the 2010 NHS Staff Survey show job satisfaction within the Speciality Grade and for Associate Specialists is high and has decreased slightly this year from 3.54 to 3.51 (scale 1 to 5), which is just above the high levels reported of all NHS staff (3.54).

4.17 Intention to leave jobs has slightly increased among Specialty Grade and Associate Specialist doctors and dentists, with survey scores rising from 2.42 to 2.48 (scale 1 to 5). But this remains below the average for all NHS staff which stands at 2.62.

CHAPTER 5: CONSULTANTS

Overview

5.1 There continues to be evidence of healthy recruitment, retention and morale among consultant doctors in England:

- in the 2010 NHS Staff Survey, the job satisfaction score for consultants was well above the NHS average and was the highest of the medical and dental staff groups;

- the latest annual census figures confirm that the NHS workforce has increased in 2010 to the highest ever recorded. Medical numbers continued to grow.

5.2 The Consultants on the new contract (97% of all consultants) saw basic pay rise by 0.1% over the last quarter from £89,400 to £89,500. The September 2011 NHS Staff Earnings Estimates published by the NHS Information Centre shows that consultants' mean NHS earnings per full time equivalent under the old contract are £101,600 and under the new contract are £117,900 a fall of £2,500 (2.1%) in the last year. However, Consultants remain among the better paid public sector groups, with basic salaries for those under the 2003 contract in the range £74,504 to £100,446.

General Position

5.3 In the year to September 2010, the number of consultants (including Directors of Public Health) working in the NHS in England increased by 802 (2.2%) to 37,752 (35,781 FTE).

5.4 The NHS and GP vacancy collections and publications have been suspended for 2011. Both of these collections are being reviewed as part of the national Fundamental Review of NHS data collections which is expected to be issued for consultation in mid to late August. Therefore, the NHS Information Centre's vacancy survey results shown below relate to March 2010. The three-month vacancy rates for consultants since 2002 shows that consultant vacancies continue to remain low. The break in collection of this data makes it difficult to accurately access the trend in vacancy rates. However, based on data over the last 4 years, it suggests that vacancy rates have remained low at approximately 1.0%.

Year	Three-month vacancy rate for HCHS consultants
2002	3.8%
2003	4.7%
2004	4.4%
2005	3.3%
2006	1.9%
2007	1.2%
2008	0.9%
2009	1.1%
2010	1.0%

5.5 The September 2010 workforce census indicated that 38% of the consultant headcount of 37,752 working in the NHS in England were aged 50 or over, and 8% were aged 60 or over. These proportions are around the same as those as at September 2009. The latest information on consultant retirements is at **Annex C**.

5.6 The overwhelming majority of consultants (96%) are now on the 2003 consultant contract, which applies to all new consultants and has eight pay thresholds ranging from £74,504 to £100,446. The remaining 4% of consultants are on the old pre-reform contract (a five point incremental scale rising to £80,186).

5.7 As we explained to the Review Body last year, the NHS Employers and the British Medical Association have worked together to produce *A guide to consultant job planning*. The challenges facing the NHS highlight the importance of consultant job planning as a means of organising resources effectively and efficiently. This guide emphasises the need for consultants and managers to work closely together to meet their shared responsibility of providing the best possible patient care within the resources available to them. The consultant job plan, is a key mechanism through which this shared responsibility can be agreed, monitored and delivered. This guide was published on 4 July 2011.

2010 NHS Staff Survey

Morale and motivation

5.8 The job satisfaction score (regarded as one of the key indicators of staff motivation and morale) for doctors and dentists (consultants) is well above the NHS average and is the highest of the medical and dental staff groups. The score has improved slightly since the last survey from 3.60 to 3.63 (on a scale of 1-5, where 1 is low and 5 high).

5.9 The high level of the job satisfaction score for doctors and dentists (consultants) is reflected in the key score for staff intention to leave jobs. The score for this occupational group remains significantly below the NHS average and the lowest of all the medical and dental staff groups, but has risen slightly from 2.28 in 2009 to 2.32 in 2010 (on a scale of 1-5, where 1 is low and 5 high).

Workload

5.10 Items from the NHS staff survey in England that can give an insight into staff perceptions of workload cover staff working additional hours (paid and unpaid), support to achieve work/home life balance and view on time to carry out jobs. The tables show the selected survey scores. In summary:

- Doctors and dentists (consultants) work the most paid and unpaid additional hours of all the medical and dental staff groups and significantly more than NHS staff as a whole. Only 59% of doctors and dentists (consultants) work no additional paid hours and 22% work no additional unpaid hours compared to 68% and 46% respectively for NHS staff as a whole.

- The percentage of doctors and dentists (consultants) who do not disagree (i.e. they agree, or neither agree nor disagree) that their trust is committed to helping

staff balance their work and home life has declined since 2009 from 76% to 75% in 2010. This is just below the average for medical and dental staff groups as a whole (78%). They have a positive view of their immediate manager's help in finding work and home life balance with a score of 76%, although this is lower than all medical and dental staff groups (average 79%) and lower than the NHS average (81%).

- The proportion of consultants who do not disagree (i.e. they agree, or neither agree nor disagree) that they do not have the time to carry out all their work has stayed the same at 78% in 2010. However, this score remains higher than that of all medical and dental staff groups (average 72%) and higher that the NHS average (72%).

Review of Compensation Levels and Incentives for NHS Consultants.

5.11 The DDRB sent its report on the review of clinical excellence and distinction awards to UK Health Ministers in July 2011. The Department is grateful for the very thorough way in which the DDRB has carried out this task. The recommendations in the report are far reaching and are currently being considered by the Department and Health Ministers in the devolved administrations. An announcement will be made in due course.

CHAPTER 6: GENERAL MEDICAL PRACTITIONERS

Introduction

6.1 This chapter relates to general medical practitioners (GMPs) providing NHS primary care services and also to salaried GMPs directly employed by NHS organisations in England.

6.2 As you know, the chapter on GMPs will be delayed as the GMS contract negotiations had not been concluded in time to report the outcome in this document, furthermore, because the latest GP Earnings & Expenses Report is not due to be published until 9th November 2011. As a result, we envisage providing you with the GMP chapter by 30th November at the latest.

CHAPTER 7: DENTISTS

Introduction

7.1 This chapter relates to general dental practitioners (GDPs) providing NHS primary care services and to those salaried GDPs directly employed by NHS organisations in England.

7.2 This is the second year of the Government's two-year public sector pay freeze for all staff who earn over £21,000. There is, therefore, no need for the Review Body to make recommendations on the remuneration of GDPs in England for 2012/13.

7.3 The Department of Health will make decisions on the contract uplift, if any, that will be applied to achieve a pay freeze, following discussion with the BDA. In reaching a decision for 2012/13 the Department will take into account the formula used for expenses, which DDRB developed and published alongside its recommendations, together with assumptions on the efficiency gains that it is reasonable to expect GDP practices to achieve.

7.4 The material in this chapter is, therefore, for information only and to provide an update on the settlement for 2011/12 and the continuing background to developments in general dental practice.

Background

7.5 It is clear that there continue to be problems with the new dental contracting arrangements introduced in 2006 and we are considering what contractual changes might be required to introduce a new system of remuneration for NHS dental services. We are now testing the underlying principles in 70 dental pilots which commenced in August 2011. Our initial view is that there has been too large an emphasis on process driven targets and measuring activity. We intend to move towards a system based on registration, capitation and quality, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions.

7.6 Dentists have consistently said, and we agree, that the current contract leaves dentists on an activity treadmill with no specific rewards for high quality care or for delivering prevention.

7.7 The profession has welcomed our commitment to bring in a new contract based on capitation and quality. This will allow them to focus on the treatment patients need and avoid unnecessary treatments, and therefore freeing up time for more patients to be seen and - by ensuring the right treatments are delivered - to improve oral health. The aim of the new contract is to improve the quality of patient care and increase access to NHS dental services, with an additional focus on improving the oral health of children. Three different pilot models are being piloted in 70 locations around the country. The new contract will encourage dentists to deliver the care patients need and may also help free up appointments for additional patients.

7.8 All pilots will be trialling the new oral health assessment and clinical pathway designed to support dentists in delivering the best care for patients. The new focus on quality is

intended to support dentists in improving the oral health of their patients, while the focus on registration will give patients the security of continuing care. It is planned that learning from the pilots will feed into the broader work currently underway to design a new contract. Any major changes will be discussed with the profession and with patient organisations. We hope that the proposed new contract will address many of the concerns of the profession and will drive further improvements in dental health in England.

7.9 Although it is clear that changes to the current system will be necessary, we are pleased to note that the current position on NHS dentistry continues to improve and there has been a further increase in the number of dentists working in the NHS in 2010/11. We intend to do more to increase access. For the first time last year, questions about access to NHS dental services were included in the GP Patient Survey. This shows that 94% of people who tried to get an appointment with an NHS dentist in the past two years were successful. For those seeking an appointment in the last six months, the success rate is 96%.

The table below gives the SHA success rates for 6 and 24 months:

	Success rate in last 24 months: % who succeeded - not including "Can't remembers"	Success rate in last 6 months: % who succeeded - not including "Can't remembers"
England	**94**	**96**
North East	96	97
North West	93	95
Yorkshire & the Humber	93	95
East Midlands	94	97
West Midlands	95	97
East of England	95	97
London	92	94
South East Coast	92	95
South Central	93	96
South West	94	96

7.10 In the last year:

- Access to NHS dental services has risen. 29.2 million patients were seen by an NHS dentist in the 24 month period ending June 2011, 56.3% of the population. The number is 651,000 higher than twelve months earlier, and 2.2 million higher than the low point reached in June 2008.
- NHS dental activity has risen, up from 85.5 million units of dental activity (UDAs) in 2009/10 to 87.5 million UDAs in 2010/11. PCTs commissioning plans at June 2011 for the following twelve months are 1.1 million UDAs higher than a year ago.
- the number of dentists providing NHS services rose by almost 800 to 22,800 dentists in 2010/11.
- the proportion of dentists' time spent on NHS work is rising. It rose from 72.2% in 2008/09 to 73.1% in 2009/10. By region, the NHS proportion ranges from 59.5% in the South Central SHA area to 82.9% in the North East.

- the number of new dental graduates has risen to 900 in 2011 (taken from Dental School estimates), a 34% increase since 2004; this will help to sustain the healthy workforce position.
- there was a corresponding increase in Vocational Trainee places in 20010/11 and an increase in practices wishing to participate in the scheme.

2011/12 settlement

7.11 As already noted, as part of the wider Government policy on public spending the Secretary of State indicated that the Doctors and Dentists Review Body would not be asked to make recommendations on dentists' pay for the financial years 2011/12 and 2012/2013. As part of this process, officials from DH discussed these issues with representatives of the profession adopting the formula approach to expenses that had previously been used by the Review Body. The Secretary of State also indicated that he expected the primary care sector to deliver the same 4% improvement in efficiency and productivity that was required from the rest of the NHS.

7.12 After a series of discussions and meetings with the British Dental Association we made two specific changes: Existing contract values were increased by 0.5% backdated to 1 April 2011. In addition dentists are now be expected to offer **all** patients best practice, preventive advice and treatment as set out in the Delivering Better Oral Health evidence toolkit and indicate on the FP17 form, or its equivalent electronic version, that they have done this. The toolkit has been distributed to all practices with an NHS contract over the last 2-3 years and can be accessed on line at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102331.

7.13 We believe that this is a good strategic approach to improving efficiency as it reflects evidence-based best practice, and will advance the important cause of improving children's oral health, which is both a key concern of dentists, and a commitment of the coalition government. The Department is keen that whilst we are moving towards the implementation of a new dental contract, following piloting and evaluation, development of the existing contract should encourage a move away from a focus on treatment, and more towards prevention and maintenance of good oral health.

7.14 We are already seeing improvements in practice including an increase in fluoride varnishes applied to children as evidenced by a 10% year on increase in supplies in both 2009 and 2010 recorded by the British Dental Trade Association, and emerging NHS IC data shows a further increase.

General Dental Practitioners: Earnings and Expenses

Net Earnings

7.15 The data from the NHS Information Centre this year continues to be hard to compare with previous years' data because of changes in the way dentists pay themselves, especially the move towards personal and practice incorporation, which continues to take profits out of the self employed tax system for the individual dentist and moves them into company accounts. This is a serious issue, which has a serious impact on

our ability to access the data on key decisions including the relative level of expenses and earnings and we wish to find a way to address it. But, despite these changes, it is clear that dentists continue to receive a good income. Although the average identifiable net profit after expenses for dentists in 2009/10 fell to £84,600 compared with £89,600 in the previous year this remains a well remunerated profession. For dentists holding a contract earnings were considerably higher at an average of £128,000, down 2.3% from the previous year's £131,000. The data also show many dentists earning considerably more; some earned over £300,000. Dentists working for others still had an average net profit of £65,600, down 3.1% from the £67,800 of the previous year.

7.16 As noted, there are data limitations which make this year's earnings report hard to interpret. A direct comparison of dentists' average net profit in 2009/10 with 2008/09 is difficult for a number of reasons. In 2009/10 a number of dentists changed their business arrangements to become companies (corporations), thereby either no longer being self-employed, or only part of their work being self-employed. As only self-employed earnings are covered in this publication, this change means that comparing to the previous year is not comparing like for like. We do not have exact figures on how many dentists changed their business arrangements in this way, but we do know the changes in the number of self-employed dentists overall in 2009/10. Compared to 2008/9 there were 7.5% fewer dental contract holders and 9.1% more "dentists who work for others". Dental contract holders have a substantially larger average net profit than "dentists who work for others" (£128,000 compared to £65,600), so the decrease in average net profit across both groups (5.2%) was larger than at dental group level. In fact, of the two groups of dentists, only "dentists who work for others" had a statistically significant drop in average net profit, which was 3.1%. Due to limitations on the data available, it is not possible to know the precise cause of this, but as there were 9.1% more dentists in this category compared to the previous year, it may be that the new joiners' salaries were considerably less than the 2008/9 average income for the group, thus bringing down the 2009/10 average for that group.

7.17 Overall, the data showed that just over half (54.1%) of gross payments to dentists was to meet their expenses. The NHS Information Centre report shows that dentists' earnings depend little on their NHS commitment. The most committed NHS dentists – those spending 75% or more of their time on NHS work – earn similar amounts on average (£89,200) to dentists who are mainly private (ie where NHS work is 25% or less of their time) (£95,700). Dentists doing a mixed amount of NHS and private work had an average net income of £97,600 in 2009/10.

Table 7.1: Gross income and net profit of primary care dentists 2004/05 to 2009/10

	Population	Average gross income	Expenses	Net profit	Expenses ratio
2004/05 GDS only	13,309	£193,215	£113,187	£80,032	58.6
2005/06	18,796	£205,368	£115,450	£89,919	56.2
2006/07	19,547	£206,255	£110,120	£96,135	53.4
2007/08	19,598	£193,436	£104,373	£89,062	54.0
2008/09	19,636	£194,700	£105,100	£89,600	54.0
2009/10	20,300	£184,900	£100,000	£84,900	54.1

Note: some double counting of expenses inflates both gross income and expenses but does not affect reported net profit.

7.18 Information on dentists' income compiled by the National Association of Specialist Dental Accountants (NASDAL), which represents more than 20% of self-employed dentists, reported a decrease in net profit for NHS practices in 2009/10 of 8.4%, to an average profit of £147,800. Net profit on NHS practices of £147,800 exceeds average net profit of private practices of £126,400, a reversal of the situation before 2005/06.

Table 7.2: Net profit for the practice

Type of practice	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
NHS	£90,400	£104,000	£118,000	£142,400	£149,500	£148,000	£161,300	£147,800
Mixed	£87,200	£98,800	£100,400	£129,600	£147,100	£140,700	£138,600	£143,800
Private	£100,100	£113,000	£124,700	£131,400	£130,900	£136,500	£130,600	£126,400

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

7.19 NASDAL report that average net profit for associate dentists (those dentists with no share of ownership) reduced to £71,100 in 2009/10 from £73,000 in 2008/09; however, they also reported that practices with associates continue to be more profitable than those without. The average net profit per principal for a practice with associates' being £148,400 compared to a practice without associates', with £119,000.

Expenses

7.20 The NHS IC earnings report this year notes the increasing difficulty in separating out expenses between performers and providers and the possible double counting of expenses. They note:

NHS IC Report on dental earnings and expenses 2008/09, paras 1.18 to 1.22:

1.18. The results presented in this report are estimates which accurately reflect earnings and expenses as recorded by dentists on their self assessment tax returns. However, it should be noted that flows of money between dentists (for example, between a Providing-Performer and a Performer Only working in the former's practice) mean that gross earnings and expenses can be double counted across the tax returns of the dental population. This will cause estimates of gross earnings and expenses for the dental population as a whole (i.e. all self-employed primary care dentists) to be artificially inflated.

1.19. The extent of this double counting is difficult to quantify, but may have increased since the introduction of the new dental contractual arrangements on 1 April 2006. Under the new system, payments for NHS dentistry are made to the Providing-Performer dentist (or in some cases to a corporate body) who holds the contract under which the dentistry is performed; if the Providing-Performer has sub-contracted this work, then some of the payment will be passed on to a Performer Only dentist. A single sum of money can be declared as gross earnings by both the Providing-Performer and Performer Only dentist, and also as an expense by the Providing-Performer. Estimates of average taxable income are not affected.

1.20. This report only considers those primary care dentists who are self-employed (i.e. they have earnings from self-employment). Traditionally, the employment status of a vast majority of primary care dentists (both Providing-Performer and Performer Only) has been self-employment. As such, these dentists complete self assessment tax returns which, subject to

certain exclusion criteria[3] have been used to inform the analyses presented in the dental earnings reports.

1.21. Since the introduction of the Dentists Act 1984 (Amendment) Order 2005 (SI 2005/2011), it has been possible for dentists to incorporate their business(es) and become a director and/or an employee of a limited company (Dental Body Corporate), with the potential to operate in a highly tax-efficient manner. Both Providing-Performer and Performer Only dentists are able to incorporate their businesses (for Providing-Performer dentists, the business tends to be a dental practice; for Performer Only dentists, the business is the service they provide as a sub-contractor).

1.22. It is currently not known how many dentists have incorporated their business(es) and what the precise consequences of incorporation may be for the results presented in this report. The NHS IC and DWG are working towards gaining greater understanding of this issue with a view to including further information in each subsequent edition of the report. Some potential arrangements and their likely effects are discussed in Dental Earnings and Expenses, England and Wales: Methodology[4].

7.21 In looking at expenses we need to take account of the fact that average earnings and expenses figures, being an average, are affected by the composition of the population which they cover. There are significant changes going on in the composition of the dentists covered in the earnings and expenses figures, mainly a large shift from Providing-Performer dentists to Performer only dentists.

7.22 It is worth noting that how dentists choose to work can alter the balance between gross and net pay without such a major effect on earnings. Changes in earnings and expenses reflect more than just changes in pay rates and price changes. For example, if dentists work longer hours they have higher gross income but also may have higher expenses (and higher net income). The figures are affected by changes in the type of work being done. For example, the relatively high reported growth in Band 3 treatments should lead to additional laboratory cost payments (a rise in expenses) but if this is substituting for lower band work then for the same number of contract UDAs dentists have some freed up time which they can spend on other things. The net income figure is less affected than either gross income or expenses by changes in the type of work of work being done.

7.23 The averages cover dentists doing any NHS work in the year. A significant number of dentists come and go within year. With 20,500 covered by GDS or PDS contracts in 2009/10, we have 1,000 leavers and 1,800 joiners in a year ie 2,800 or 14% working for only part of the year.

7.24 The numbers of dentists for the years 2006/07 to 2010/11 are set out below (Table 7e from 'Dental Statistics 2010/11').

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[3] See *Dental Earnings and Expenses, England and Wales: Methodology*, shown the in 'Other Publications' section of this report.

[4] See 'Other Publications' at the end of this report.

Table 7e: Number and percentage of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2010/11

Number and per cent

	Number					Per cent				
	2006/07	2007/08	2008/09	2009/10	2010/11	2006/07	2007/08	2008/09	2009/10	2010/11
Total	**20,160**	**20,815**	**21,343**	**22,003**	**22,799**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Providing performer	7,585	7,286	6,778	6,279	5,858	37.6	35.0	31.8	28.5	25.7
Performer only	12,575	13,529	14,565	15,724	16,941	62.4	65.0	68.2	71.5	74.3

Notes:

1. Dentists are defined as performers with NHS activity recorded by FP17 forms.
2. Data consists of performers in General Dental Services (GDS), Personal Dental Services (PDS) & Trust-led Dental Services (TDS).

7.25 As already noted, the changes from year to year are affected by contract holder dentists changing their business arrangements into companies. This is tax efficient. Some profit is retained in the company, which in turn makes a self-employment payment to the dentist. The profits retained in the company are no longer covered in these self-employed earnings figures. There is also evidence that individual performer dentists have moved to limited company status - further confusing the self-employed earnings report.

7.26 The issue of double counted expenses is also important. For example, a dental performer pays the laboratory bills associated with treatment out of their gross income. The performer pays the contract holder who in turn pays the laboratory. Both the contract holder and the dental performer show the cost as an expense with the contract holder showing the payment from the performer as an income. The IC paper (above) indicates that the extent of double counting may have increased since 2006. This is because gross payments are no longer paid directly to individual dentists.

7.27 Extracts from the NASDA results are in the table below. They show, for three categories of expenses that expenses as a percentage of gross income increased for both mainly NHS and mainly private dentists in 2009/10. A slight reduction was seen in the 'other non-staffing costs' category, in both mainly NHS and mainly Private.

	2005/06	2006/07	2007/08	2008/09	2009/10
Non-clinical staff wages (NASDA)					
NHS practices	18.2%	17.3%	17.9%	17.7%	18.8%
Private Practices	17.2%	17.4%	17.8%	17.6%	18.1%
Laboratory costs (NASDA)					
NHS practices	6.4%	5.6%	6.1%	6.0%	6.5%
Private Practices	8.9%	7.8%	7.6%	7.1%	7.9%
Materials costs (NASDA)					
NHS practices	5.6%	5.0%	5.6%	5.4%	5.6%
Private Practices	6.7%	7.0%	7.5%	7.1%	7.5%
Other Non-Staffing Costs (Morris & Co)					
NHS practices	16.4%	16.8%	15.7%	15.6%	15.1%
Private Practices	23.0%	23.2%	23.6%	21.4%	21.2%

Note: 2006/07 figures for NHS practices are affected by temporary increase in income from transition to the new contract. 2005/06 NHS figures include PDS.

General Dental Practitioners: Recruitment, Retention and Motivation

Supply of dentists

7.28 The numbers of dentists providing NHS services is a relatively weak indicator of supply: it is the number of NHS patients and the amount of NHS service they receive that is more important and these continue to rise. It is nonetheless encouraging that numbers of dentists are also continuing to rise, up by 3.6% last year. Overall, the number of dentists providing NHS services rose by almost 800 to 22,800 dentists in 2010/11

7.29 It is notable that dentists continue to bid for and undertake NHS contracts, especially in areas where dentists had previously chosen not to set up or provide NHS services. This is evidence that levels of NHS income are not acting as a bar to recruitment and retention or to growth in NHS services.

Future workforce supply

7.30 In the short to medium term, the position on workforce supply will be further enhanced by the 25% increase in undergraduate training begun in October 2005 and the fourfold increase in training places for dental therapists now in place. As a result, some 900 dentists qualified in summer 2011 – 34% more than the 2004 baseline - with the number of new graduates expected to rise to 933 in 2013.

7.31 The Department's current estimates of future workforce supply strongly suggest that the supply of dentists will be able to meet demand for new services, even taking account of the dental procurements in train. The Dental Programme Board of Medical Education England plans to update the dental workforce review published in 2004, taking account of the reduction in the complexity of treatment and gradual implementation of NICE guidelines for longer recall intervals and growth in skill mix. These changes are gradually allowing greater value for money (quality and productivity) to be obtained from existing investment in dental services and from the existing dental workforce, rather than having to rely mainly on new procurements to increase capacity. The workforce review, which will be completed by next summer will, in turn, lead to a review of the number of training places for dental undergraduates in English dental schools with effect from Autumn 2013

Motivation

7.32 Dentists have achieved a reduction in working hours, with evidence from the NHS Information Centre dental working hours survey published in August 2010 showing that dentists are working an average of 37.2 hours per week in 2009/10 compared to 39.4 hours in 2000. (Source: Dental Working Hours England and Wales 2008/09 and 2009/10 published by The NHS Information Centre.)

7.33 There are, however, still a number of key issues with the way dentistry is delivered and managed which we intend to work with the profession to address. As noted earlier, the Government has commenced piloting of aspects of a new dental contract based on registration, capitation and quality, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions.

Vocational trainees and trainers

7.34 The increase in dental graduates referred to at paragraph 7.28 will create a need for a corresponding increase in places for vocational trainees. (Newly qualified dentists may not work in the NHS until they have completed one year's vocational training.) The Department works with Postgraduate Dental Deans to identify the areas in which the additional training places should be provided. Although the numbers are challenging, the Department does not anticipate major difficulties because of increased interest from dental practices in applying to take vocational trainees.

7.35 The Department has not identified any increases in trainer workload but will be discussing the content of VT with the BDA in the context of a review of the curriculum for VT/Dental Foundation Training first published in 2006. Trainer workload will be included in these discussions.

General Dental Practitioners: Conclusion

7.36 The net pay award for dentists in 2012/13 will be zero. The gross award will again be determined by the Department after taking account of the data on expenses inflation and after applying efficiency. In making our determination we intend to build on the formula used by DDRB for expenses, and the evidence on non-staff expenses. This determination will be made after any necessary discussions with the BDA

Other Dental Staff Groups

Salaried Primary Dental Care Dentists

7.37 There are around 1,400 salaried dentists (headcount: NHS IC data) working in salaried primary dental care services in England, delivering a range of dental public health programmes and providing dental patient care, including specialised care, for a range of priority and at-risk patient groups. They also provide the staffing of Dental Access Centres. As part of implementation of the Department's Transforming Community Health Services initiative these dentists are moving from employment by the provider arm of PCTs to a range of different organisations include Social Enterprise, Community Trusts and acute NHS Trusts. These dentists remain an important and valued part of the overall dental workforce, whose services will, subject to enactment of the Health and Social Care Bill currently before Parliament, be commissioned by the NHS Commissioning Board. During transition we will be supporting the NHS in better defining the role of salaried dentists to ensure that full account is taken of their service contribution as part of local work to transform the quality and productivity of community health services.

7.38 The NHS vacancies survey published by NHS Information Centre reports only three vacancies of three months or more at 31 March 2010; this is equivalent to 0.1% of the workforce. The NHS IC also reported that the total number of vacancies were only 36, 1.2% of the workforce; 12 of these vacancies are in Special Health Authorities & Other Statutory Bodies.

7.39 Following the decision of the General Dental Council to recognise a new speciality of Special Care Dentistry, a small number of consultant posts and specialist training

posts are being created, typically based within the salaried primary dental care service but with close links with other branches of dentistry. Appointments to those posts are being made on the relevant generic doctors and dentists Terms and Conditions of Service. Consultant and training grade staff in special care dentistry will therefore automatically receive the same uplift to pay and allowances as other medical and dental staff in those grades. For this year, as with other staff groups at this salary point, there will be a pay freeze.

Dental Public Health Staff

7.40 Consultants in dental public health and trainees are employed on the generic terms and conditions of service for hospital and public health doctors and dentists. The review of capacity and capability in dental public health was published in March under the title *Improving oral health and dental outcomes: Developing the dental public health workforce in England.* The review shows how dental public health staff can improve oral health, reduce oral health inequalities, ensure patient safety and improve quality in dentistry. The Health and Social Care Bill proposes that these staff transfer to Public Health England where there will need to be a further review of functions and numbers of posts. For this year, as with other staff groups at this salary point, there will be a pay freeze for consultants and trainees.

CHAPTER 8: OPHTHALMIC MEDICAL PRACTITIONERS

Summary

8.1 We remain firmly of the view that there should be a common sight test fee for optometrists and OMPs, which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out over 99% of NHS sight tests. Discussions are to take place in the Autumn with representatives of the professions on the implementation of government pay policy.

Background

8.2 Between 31 December 2009 and 31 December 2010, the number of OMPs who were authorised by Primary Care Trusts in England and the number in Local Health Boards in Wales to carry out NHS sight tests decreased from 365 to 346, and the number of optometrists increased from 10,369 to 10,819 an increase of 4.3%. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

8.3 In 2010/11, 12.68 million sight tests were paid for by PCTs in England and Local Health Boards (LHB) in Wales. This was 1.1% more than in 2009/10. Within these figures, the proportion of sight tests carried out by OMPs was 0.3% in 2009/10.

8.4 The surveys, which we have conducted into the working patterns of optometrists and OMPs, show that the majority of OMPs practise part-time. Half of the sight tests carried out by OMPs are part of a hospital appointment. (Source: Sight tests volume and workforce survey 2005/06).

8.5 The Health and Social Care Bill, which is currently before Parliament, has proposed that commissioning of the NHS sight testing service in England should in future be, following the abolition of Primary Care Trusts, the responsibility of the NHS Commissioning Board.

CHAPTER 9: NHS PENSIONS AND TOTAL REWARD

The Current NHS Pension Scheme

9.1 NHS staff enjoy a competitive reward package and this is not limited to pay alone. The current NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary. Benefits for most staff in the 1995 Section of the NHSPS are based on 1/80ths of pay for each year of service, (career average with 1.4% accrual rate in the case of self employed practitioners), includes a separate lump sum, life assurance, ill health, partner and dependent benefits. Unreduced pensions are payable at the normal pension age of 60, based on the best of the last three years service. Since April 2008, most staff can increase their separate lump sum payment by commuting (or giving up) some of their pension.

9.2 Regulations came into effect from 1 October 2009 to allow all contributing members of the 1995 Section of the Scheme a choice to either remain in the 1995 Section or to transfer their accrued service to the 2008 Section of the Scheme (described as the NHS Pension Choice Exercise). The 2008 Section, open to new entrants since April 2008, has a normal pension age of 65, a 1/60th pension (1.87% accrual for self employed practitioners) no automatic lump sum, but members are able to commute part of their pension in order to secure a lump sum payment. Pensions in the 2008 Section are based on an average of the best three consecutive years in the last 10 years.

9.3 As part of the Pension Choice Exercise, eligible members of the 1995 Section receive a personalised pension statement, which compares benefits in the 1995 and 2008 Sections of the NHSPS, as well as an explanatory guide and a DVD to help inform their decision. The Pension Choice Exercise is due to end on 31 March 2012. There are two stages of Choice activity within each Strategic Health Authority with staff aged 50 and over offered Choice during 2010/2011 and staff aged 49 and younger during 2011/2012. The first stage (for those over 50) has now been successfully completed and approximately 28,000 of staff have elected to transfer to the 2008 Section of the NHSPS. However, in total there are now around 400,000 staff on the 2008 arrangements – which includes those making the decision through Choice and new staff.

Self-employed Access to the Current Scheme

9.4 Uniquely among self-employed people, General Medical and Dental Practitioners have access to a defined benefit pension scheme effectively guaranteed by the Exchequer.

Emergency Budget in June 2010

9.5 The Government announced in the Emergency Budget in June 2010 that benefits, the state second pension and public service pensions would be uprated by the Consumer Prices Index (CPI) from April 2011. CPI is already in use by the Bank of England and is a more appropriate measure to reflect the inflation experiences of benefit and pension recipients. The change to CPI is also a key element of the Government's deficit reduction programme. While the CPI is generally, but not always, lower than

RPI, the NHS Pensions continue to be protected against price increases and uprated in line with state second pensions.

9.6 This change does not just impact on members of the NHS Pension Scheme, but on all members of occupational pension schemes and recipients of the state retirement pension. It also applies to Government benefits and tax credits.

9.7 The Government provides generous tax relief to save for a pension, to encourage individuals to take responsibility for retirement planning and to recognise that pensions are less flexible than other forms of saving. However, the annual cost of tax relief net of income tax paid on pensions in payment doubled to around £19.7 billion over the decade to 2009-10.

9.8 To ensure that pensions tax relief remains fair and affordable, the Government confirmed in the June 2010 Budget that it would proceed with the previous Government's goal to reduce the cost of pensions tax relief by about £4 billion a year as a necessary part of deficit reduction. It also announced that an alternative approach to restricting relief would be considered involving reform of existing allowances. The Government believed that compared with the approach it inherited, such a system would be fairer, preserve incentives to save and would lessen the impact on the ability of UK businesses to attract and retain talent. This view was confirmed by the response to the informal consultation held over the summer of 2010.

Changes to the annual and lifetime allowances

9.9 Consequently, on 14 October 2010, the Government announced that the annual allowance for tax-free saving for retirement will be reduced from £255,000 to £50,000 from the 2011-12 tax year, and that the lifetime allowance will be reduced from £1.8 million to £1.5 million from April 2012. This approach restricts the amount of tax relief given to those who make the highest pension contributions, while ensuring generous incentives and flexibility for the vast majority of pension savers. The precise impact will depend on each individual's pension contribution and tax circumstances and applies to all pension savers not just to NHS staff.

9.10 Specific features are included to address the scope for moderate earners in generous defined benefit pensions to be affected by one-off spikes in pension accruals. In addition to setting a higher annual allowance than expected, the regime allows unused allowances to be carried forward over 3 years. These tax changes will largely impact on high earners – over 80% of the 100,000 individuals affected by the reduced annual allowance will have incomes of £100,000 or more. Of all the public service pension schemes, the NHS has the most members likely to be affected, in the region of 10,000 who will be for the greater part consultants and GPs

Review of Public Service Pension Schemes

9.11 On 20 June 2010, the Government announced the establishment of an Independent Public Service Pensions Commission (IPSPC), led by Lord Hutton of Furness.

9.12 The Commission published an interim report on 7 October and the final report was published on 10 March 2011. The final report made 27 recommendations to

Government for changes to public sector pensions, including the NHS Pension Scheme. The Government has accepted these recommendations and is currently in discussion with Trade Unions and other Departments on the changes.

9.13 The report highlights the importance of providing good quality pensions to public servants, rejects a race to the bottom in pension provision, but concludes that there is a clear rationale for public servants to make a greater contribution if their pensions are to remain fair to taxpayers and employees, and affordable for the country. At Budget 2011, the Government accepted Lord Hutton's recommendations as the basis for consultation with Trades Unions and others.

9.14 The Government also announced plans, based on the Hutton interim report, to increase pension contribution rates for scheme members by an average of around 3.2 percentage points for all public sector schemes including the NHS. This is in recognition of the fact that the taxpayer has largely paid for the increased cost of pensions due to increased life expectancy and that it is right that the balance should be shifted towards the employee. We are currently consulting on year one of these arrangements for implementation from April 2012.

9.15 The Government is currently discussing with Trade Unions the planned increases in employee contribution rates for years two and three and future pension arrangements and there will be a further announcement in due course.

9.16 Independent research by the IFS in February this year suggested that, overall, there remains a public sector pay premium over the private sector, adjusting for the relevant skills and experience - and Lord Hutton concluded that these remain significantly more generous than private sector pensions, on average. Given this evidence, the Government is clear that any changes to pensions, including the proposed increase in contributions from 2012-13, do not justify upwards pressure on pay.

9.17 As the new public service pension arrangements become clearer, properly communicating the value of the NHSPS as part of the overall reward package will become increasingly important for employers and staff. Exploratory work continues, with the aim of ensuring that the value of pensions and the total reward package are fully communicated to staff. This is likely to include:

- the development and delivery of Annual Benefit Statements (ABS) for all staff, which shows the value of personal and family benefits;
- the opportunity to expand ABS to include details of the overall total reward package through a Total Reward Statement (TRS) which would include things like annual leave, redundancy benefits etc; and
- the development of flexible benefits (for example, the ability to "sell" annual leave).

Total Reward

9.18 The Department strongly believes that the general NHS total reward package for hospital doctors is very competitive, including the pension element, and it is a valuable retention and recruitment tool at postgraduate training, career grade and consultant

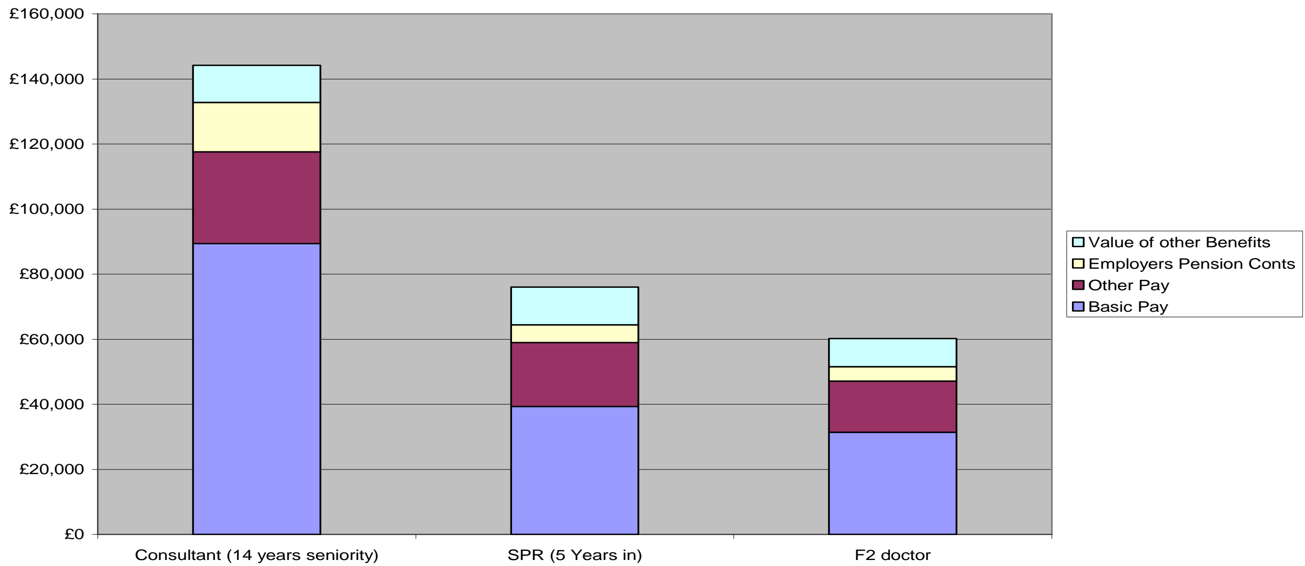
levels. A medical career in the NHS remains highly attractive in terms of financial reward, wider reward packages and job satisfaction.

9.19 This benefit package currently includes:

- the retention of a good quality defined benefit pension with protection of the normal pension age of 60 for existing staff;
- high annual leave allowances: 35 days rising to 41 compared with 28 days statutory entitlement;
- excellent sick pay entitlement: six months full pay and six months half pay after 5 years;
- 30 days study leave available to doctors in training;
- 39 weeks of paid maternity leave (eight weeks at full pay, 18 weeks at half pay and 13 weeks at statutory levels);
- opportunities for flexible working; and
- extremely high levels of security of employment for doctors in the NHS - there have been very few redundancies. Doctors, along with other NHS staff, also have the protection of redundancy arrangements that compare with the best private sector arrangements.

9.20 The chart below monetarises the value of the total employment package for Doctors. As well as base pay, it includes a representative value of other pay allowances and employer pension contributions at the actual rate paid. It includes the value of the additional holiday allowances over statutory provision and the value of sick pay provision above the statutory requirements based on average sickness absence levels. This understates the overall value of the package as it does not attempt to monetarise other important elements such as flexible working, childcare and maternity leave. It also understates the true value of pension contributions for most doctors as they tend to have higher than average benefits relative to the contributions that are paid on their behalf over the course of a career. The NHS Pension Scheme continues to offer excellent value to staff. The Government Actuary's Department estimate that for each £1 of contributions, members can expect to receive pension benefits of between £3 and £6 - an excellent rate of return. This figure is conservative and **Annex D** provides the GAD justification for these figures.

9.21 The chart shows that for doctors in training the value of employers' current pension contributions, in addition to annual, study and sick leave provisions above statutory requirements add over 20% to the value of the reward package. They are worth around £13,000 to a doctor in the second year of training, and around £17,000 to a doctor five years into training.



9.22 For consultants, the value of these benefits over statutory provision along with employer pensions contributions is over £26,000 and represent nearly 20% of the value of the reward package. This work shows base pay as a proportion of total reward to be just over 60% for a consultant with 14 years seniority, and just over 50% for a doctor in training.

9.23 In summary, the Government believes that the NHS continues to offer a comprehensive reward package and even during these difficult economic circumstances this reward package continues to be highly attractive.

ANNEX - A

NHS STAFF SURVEY 2010

The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2010 NHS staff survey is the 8th annual survey of its kind. Almost 306,000 NHS staff were invited to take part in the survey and approximately 165,000 employees responded – a 54% response rate (similar to 2009). The key score for job satisfaction in the NHS staff survey is regarded as one of the key indicators of staff motivation and morale.

Table A	**Staff Job Satisfaction**			**diff 2009/2010**
	2008	**2009**	**2010**	
All NHS Staff (inc. medics)	3.51	3.53	3.54	0.01
Medical / Dental staff in all trusts	3.55	3.57	3.59	0.02
Medical / dental (in training) in all trusts	3.52	3.56	3.62	0.06
Medical / dental (consultants) in all trusts	3.59	3.60	3.63	0.03
Medical / dental (other) in all trusts	3.51	3.54	3.51	-0.03

Table B	**Staff Intention to Leave**			**diff 2009/2010**
	2008	**2009**	**2010**	
All NHS Staff (inc. medics)	2.59	2.54	2.62	0.08
Medical / Dental staff in all trusts	2.38	2.34	2.41	0.07
Medical / dental (in training) in all trusts	2.66	2.49	2.52	0.03
Medical / dental (consultants) in all trusts	2.26	2.28	2.32	0.04
Medical / dental (other) in all trusts	2.46	2.42	2.48	0.06

Table C	**Percent of staff working no additional PAID hours.**			**Change (since 2009)**
	2008	**2009**	**2010**	
All NHS Staff (inc. medics)	**70**	**73**	**68**	**-5**
Medical / Dental staff in all trusts	64	64	65	1
medical / dental (in training) in all trusts	63	71	68	-3
medical / dental (consultants) in all trusts	58	57	59	2
medical / dental (other) in all trusts	72	70	72	2

Table D	**Percent of staff working no additional UNPAID hours.**			**Change (since 2009)**
	2008	**2009**	**2010**	
All NHS Staff (inc. medics)	**47**	**47**	**46**	**-1**
Medical / Dental staff in all trusts	34	33	31	-2
medical / dental (in training) in all trusts	32	31	32	1
medical / dental (consultants) in all trusts	25	22	22	0
medical / dental (other) in all trusts	46	48	44	-4

Table E	**Percent of staff who do not disagree that their trust is committed to helping staff balance their work and home life.**			**Change (since 2009)**
	2008	**2009**	**2010**	
All NHS Staff (inc. medics)	**80**	**81**	**75**	**-6**
Medical / Dental staff in all trusts	79	78	78	0
medical / dental (in training) in all trusts	76	74	79	5
medical / dental (consultants) in all trusts	78	76	75	-1
medical / dental (other) in all trusts	83	83	80	-3

Table F	Percent of staff who do not disagree that their immediate manager helps them find a good work-life balance.			Change (since 2009)
	2008	2009	2010	
All NHS Staff (inc. medics)	**83**	**84**	**81**	**-3**
Medical / Dental staff in all trusts	78	78	79	1
medical / dental (in training) in all trusts	79	79	82	3
medical / dental (consultants) in all trusts	75	74	76	2
medical / dental (other) in all trusts	83	82	82	0

Table G	Percent of staff who do not disagree that they do not have time to carry out all their work.			Change (since 2009)
	2008	2009	2010	
All NHS Staff (inc. medics)	**73**	**72**	**72**	**0**
Medical / Dental staff in all trusts	70	70	72	2
medical / dental (in training) in all trusts	60	65	61	-4
medical / dental (consultants) in all trusts	78	76	78	2
medical / dental (other) in all trusts	62	61	62	1

Source: NHS Staff Surveys 2008, 2009 and 2010.

Annex B

UPDATE ON BETTER TRAINING, BETTER CARE FOR MEDICAL EDUCATION UK REFERENCE GROUP

INTRODUCTION

1. Better Training Better Care aims to improve both the quality of training and hence the quality of learning and, consequently, the quality of patient care by enabling the delivery of the key recommendations from *Time for Training*[5], *Foundation for Excellence*[6] and other related reports. DH Ministers commissioned both *Time for Training* and *Foundation for Excellence,* and Medical Education England (MEE) is taking forward the work.

2. Sir John Temple's *Time for Training*, concluded that high quality training can be delivered in reduced EWTR compliant hours, however this is precluded when trainees have a major role in out of hours service, are poorly supervised and access to relevant learning opportunities is limited. He emphasised that high quality training leads to professionals who deliver high standards of safe patient care but recommended that the traditional experiential model of learning had to change and that consultants needed to be more directly responsible for the delivery of care. He called for better use of the expanded consultant workforce, not only to ensure improved training for junior doctors but also in terms both of efficiency savings for the service, as well as of enhanced safety and higher quality care for patients.

3. Professor John Collins' *Foundation for Excellence*, echoed and built upon several of these themes, particularly highlighting concerns that some of the most junior trainees are asked to practise beyond their level of competence and without appropriate or adequate supervision.

4. Although highlighted in *'Time for Training'* and *'Foundation for Excellence'*, these are not new issues. There were similar findings in the 2009 Wilson report to the MMC Programme Board[7], the 2009 PMETB survey of Foundation doctors, in evidence collected by Lord Patel[8], in QAFP reports based on visits to Deaneries and Foundation Schools and in the recent PMETB/GMC training surveys. Similar concerns, in part, led to the development and implementation of the Calman reforms and Modernising Medical Careers (MMC).

PROGRAMME OUTLINE

5. The work programme for Better Training Better Care includes two overlapping components:

   a. the identification, piloting, evaluation and dissemination of good education and training practice; and

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[5] Professor Sir John Temple: *Time for training - A Review of the impact of the European Working Time Directive on the quality of training, 2010*
[6] Professor John Collins*: Foundation for Excellence - An Evaluation of the Foundation Programme, 2010*
[7] Dr I Wilson: *Maintaining Quality of Training in a Reduced Training Opportunity Environment, 2009*
[8] *Lord Naren Patel: Recommendations and Options for the Future Regulation of Education and Training, 2010*

b. improvements to curricula and the underpinning education and training frameworks to ensure training is fit for the purpose of providing safe, effective and improving patient care.

6. A series of workstreams and activities are outlined in Annex A emphasising the need for both local and national activity. Outputs will inform the development of HEE commissioning decisions and work around the development of reliable and valid quality metrics. The whole programme will be underpinned by a communications and stakeholder engagement strategy.

IMPLEMENTATION

7. The Secretary of State for Health has asked that MEE take forward this programme as a priority. MEE agreed to remit responsibility to its Medical Programme Board (MPB) and a dedicated Taskforce reporting to MPB has been established.

8. Delivery will follow a phased approach; from identifying examples of good practice and identifying potential barriers to improvement, to implementing a strategy to spread that widely to ensure extensive implementation nationally.

9. Primary responsibility for delivering the recommendations will rest with local education providers (LEPs) supported by deaneries, Higher Education Institutions and medical Royal Colleges and Faculties. In addition to proposing changes to curricula, BTBC will provide evidence-based examples of good practice and refine the quality metrics that will be used for commissioning medical education and training by Health Education England. The recommendations also require action at national level. This will entail joint working with groups such as the GMC, Academy of Medical Royal Colleges, NHS Employers and BMA among others.

10. All of the leading national partner organisations have agreed to join the Better Training Better Care Taskforce to lead and co-ordinate the comprehensive plan of action required for implementation. There is already a great deal of interest from the service in this work and a number of NHS Trusts have expressed an interest in taking part.

July 2011

ANNEX C

CONSULTANT RETIREMENTS: DATA FROM THE NHS BUSINESS SERVICES AGENCY PENSIONS DIVISION

Data from the NHS Business Services Agency Pensions Division

1. Table 1 below shows data from the NHS Pensions Division, part of the Business Services Agency[9]. The table shows the number of consultants who received a pension award, from the NHS pension scheme between 1997 to 2011 by category of retirement. The figures include all retirements on grounds of age, ill health, premature retirements following redundancy or interests of efficiency and voluntary early retirement before age 60 (introduced from 6 March 1995). Where possible data is shown separately for each category. As with previous years' evidence, the figures relate to England and Wales as it has not been possible to dis-aggregate Welsh data for this exercise.

2. The total number of pension awards has increased over the period as the size of the workforce has increased. The number of age retirements is higher now than it was in the late 1990s, but this reflects the age profile of the current workforce rather than any change in retirement rates.

3. The NHS Pensions data recording system manages over 1.3 million active records most of which are subject to regular updates year on year. Retirement data will therefore represent a "snapshot" at a given period, which will be subject to change over time.

4. In addition to the above consideration, the Business Services Agency introduced a pension processing system in October 2005. The retirement data provided since September 2006, to assist in supporting evidence/guidance for DDRB, represented the extract from this new pension processing system. This new system is designed to assist in the daily processing of pension calculations and will in the future support scheme valuation, however development to utilise the system for valuation has yet to be fully defined and validated. The latest information has been amended to reflect the latest extract over retrospective years, but comparisons across the yearly reports is not possible.

[9] NHS Business Services website: http://www.nhsbsa.nhs.uk/index.htm

Table 1: Consultant Retirements and Reasons for Retirement

Year end 31 March	Age	Ill-health	Deferred Pension Benefits	Redundancy	Agreed Voluntary Early Retirement (AVER)	Voluntary Early Retirement (VER)	Unknown	Total Pension Awards
1997	249	57	49	27	*	*	31	**413**
1998	285	51	49	19	*	*	35	**439**
1999	266	57	32	19	*	*	37	**411**
2000	287	54	41	11	*	*	29	**422**
2001	316	66	52	11	*	*	31	**476**
2002	337	67	44	7	*	*	31	**486**
2003	306	60	42	7	*	*	37	**452**
2004	348	56	44	16	*	*	44	**508**
2005	339	48	44	9	*	*	42	**482**
2006	449	52	51	7	4	44	52	**659**
2007	551	59	41	6	3	77	43	**780**
2008	600	59	28	9	6	90	40	**832**
2009	611	41	16	6		80	48	**802**
2010	740	7	13	1		98	78	**937**
2011	954	5	4	4		169	75	**1211**
TOTAL	**6776**	**740**	**550**	**159**	**13**	**584**	**656**	**9478**

*** AVER and VER Data for 1997 – 2005 is not separately captured in this extract.**

MCRG Analysis of Wastage Rates

5. The Medical Careers Research Group (MCRG) figures on wastage rates provided to DDRB in previous years were based solely on **respondents** from their surveys. They were therefore vulnerable to non-responder bias. Non-responders are more likely to be abroad, or working outside the NHS or outside medicine, and consequently are less likely to have been easy to contact and to have replied to their surveys. This results in an under-estimate of the numbers not in UK medicine.

6. MCRG worked with DH, and used data from the DH employment record to augment the data from their surveys. By the use of a statistical method known as capture-recapture analysis, they have calculated the number and percentage of doctors in each year of qualification which they have studied, who were not working in the NHS five years after qualification. The result is a more reliable measure of non-participation. It is also specifically related to **non-participation in the NHS** rather than non-participation in UK medicine, or in medicine as a whole. This is a measure more applicable to DDRB's purposes than the previous measure related to UK medicine as a whole.

Annex D

NHSPS – benefits received per £1 contributions

The minimum and maximum contribution rates proposed in the consultation document to apply from 2012-13 onwards are 5% (for those earning under £15,000 a year) and 10.9% (for those earning over about £110,000).

At the 2004 actuarial valuation it was assumed that members will live for on average around 24 years after retirement (men) or 27 years (women). These averages are conservative estimates of life expectancy for most members, because longevity has continued to improve since 2004 and we are now assuming considerably greater longevity for current work such as the "cost ceiling" calculations.

Some simple arithmetic can illustrate the benefits that would ultimately be received for members on either the 1995 or the 2008 section benefit scales, using the life expectancies above, as follows:

1995 section:
Annual pension earned in 1 year = salary / 80

Total post-retirement benefits earned in 1 year
= Annual pension earned in 1 year x (life expectancy after retirement+ 3)

2008 section:
Annual pension earned in 1 year = salary / 60

Total post-retirement benefits earned in 1 year
= Annual pension earned in 1 year x life expectancy after retirement

The benefits earned per £1 contributions can then be determined as follows:
Total post-retirement benefits earned in 1 year / contributions paid in 1 year
= Total post-retirement benefits earned in 1 year / (salary x contribution rate)

Applying the arithmetic above to the different combinations of sex, contribution rate and scheme section produce the following ratios of benefits to contributions:

Benefits per £1 contributions	Male 5% contributions	Female 5% contributions	Male 10.9% contributions	Female 10.9% contributions
1995 section	6.8	7.5	3.1	3.4
2008 section	8.0	9.0	3.7	4.1

The range £3 to £6 reflects the numbers in this table. (In fact £6 is conservative and a figure of £9 could be justified on the basis of the arithmetic above.)

David Johnston
8 September 2011

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Table 6 3 month vacancy rates for all HCHS doctors (excluding training grades) and consultants by specialty group by SHA at March 2010.

Table 7 3 month vacancy rate for all HCHS doctors (excluding training grades) and consultants by specialty group 2002 to 2010.

TABLE 1

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

Academic Year	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Applicants Accepted through UCAS	7,955	7,821	8,011	7,837	8,013	7,977	7947
Home Domiciled Applicants Accepted through UCAS	7,262	7,106	7,176	7,017	7,144	7,063	7031
Total number of "A Level" Home Domiciled Applicants Accepted through UCAS	5,245	5,046	5,068	4,861	4,918	4,827	4869
Total Band Distribution for "A-Level" home domiciled accepted applicants							
Tariff Scores	**%**	**%**	**%**	**%**	**%**	**%**	**%**
>=540	8.26	8.27	9.83	10.39	11.18	11.15	19.61
>=480 <=539	19.05	20.74	22.75	24.54	25.01	26.02	21.77
>=420 <=479	18.40	19.69	18.33	17.59	17.43	16.32	16.31
>=360 <=419	28.17	29.20	29.34	28.68	29.54	31.26	30.77
>=300 <=359	23.31	19.29	15.11	13.78	12.63	11.52	8.67
>=240 <=299	1.72	1.53	1.52	1.77	1.63	1.28	1.11
>=180 <=239	0.82	0.91	0.69	0.72	0.71	0.33	0.21
>=120 <=179	0.21	0.34	1.46	1.63	1.18	1.37	0.84
>=080 <=119	0.06	0.04	0.75	0.76	0.61	0.66	0.70
>=001 to <=079	0.00	0.00	0.22	0.14	0.08	0.08	0.02
Grand Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Average A Level Tariff Score of "A Level" Home Domiciled Applicants Accepted through UCAS.	**409**	**413**	414	**417**	**422**	**423**	**446**

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

Notes:

(1) 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.

(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 a higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

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

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

(5) GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A* - 140 A - 120, B - 100, C - 80, D - 60, E - 40. The A* grade was introduced as an achievable grade in 2010.

TABLE 2

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

Academic Year	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Applicants Accepted through UCAS	989	1,187	1114	1,199	1,209	1,215	1,278
Home Domiciled Applicants Accepted through UCAS	917	1,114	1042	1,135	1,141	1,150	1,190
Total number of "A Level" Home Domiciled Applicants Accepted through UCAS	718	854	820	769	759	773	800
Total Band Distribution for "A-Level" home domiciled accepted applicants							
Tariff Scores	**%**	**%**	**%**	**%**	**%**	**%**	**%**
greater than 539	1.80	2.80	3.78	4.55	4.35	4.92	8.00
480 to 539	8.10	8.10	11.10	12.61	17.00	15.91	14.63
420 to 479	18.00	20.00	18.05	21.85	19.50	20.31	17.50
360 to 419	30.10	33.60	37.32	36.93	39.13	41.14	44.13
300 to 359	39.80	33.50	25.98	19.90	17.65	15.39	13.25
240 to 299	1.30	1.10	1.83	0.91	0.92	0.39	0.63
180 to 239	0.60	0.70	0.61	0.78	0.40	0.13	0.13
less than 180	0.30	0.20	1.34	2.47	1.05	1.81	1.75
Grand Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Average A Level Tariff Score of "A level" Home Domiciled Applicants Accepted through UCAS.	**375**	**381**	**385**	**391**	**399**	**400**	**408**

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

Notes:

(1) 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.

(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 a higher tariff points than those GCE A Level qualifications held. No account is taken of the number of AS levels held.

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

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

(5) GCE A levels are included within the qualifying tariff qualifications; Tariff points associated to A level Grades are as follows:- A* - 140 A - 120, B - 100, C - 80, D - 60, E - 40. The A* grade was introduced as an achievable grade in 2010.

TABLE 3

UK Medical Schools - UK APPLICANTS AND ACCEPTED APPLICANTS FOR MEDICINE BY GENDER

Year of Entry	Applicants			Accepted Applicants			Ratio of Applicants to Accepted Applicants		
	Total	Female	Male	**Total**	Female	Male	**Total**	Female	Male
1994	**10,416**	5,334	5,082	**4,363**	2,275	2,088	**2.4**	2.3	2.4
1995	**10,031**	5,074	4,957	**4,235**	2,126	2,109	**2.4**	2.4	2.4
1996	**10,016**	5,143	4,873	**4,471**	2,425	2,046	**2.2**	2.1	2.4
1997	**9,946**	5,198	4,748	**4,577**	2,482	2,095	**2.2**	2.1	2.3
1998	**9,742**	5,123	4,619	**4,683**	2,605	2,078	**2.1**	2.0	2.2
1999	**8,996**	4,942	4,054	**4,871**	2,767	2,104	**1.8**	1.8	1.9
2000	**8,506**	4,842	3,664	**5,229**	3,043	2,186	**1.6**	1.6	1.7
2001	**8,563**	5,014	3,549	**5,675**	3,355	2,320	**1.5**	1.5	1.5
2002	**10,071**	6,012	4,059	**6,287**	3,846	2,441	**1.6**	1.6	1.7
2003	**12,728**	7,556	5,172	**6,953**	4,286	2,667	**1.8**	1.8	1.9
2004	**15,172**	8,719	6,453	**7,262**	4,347	2,915	**2.1**	2.0	2.2
2005	**16,783**	9,411	7,372	**7,106**	4,138	2,968	**2.4**	2.3	2.5
2006	**16,458**	9,178	7,280	**7,176**	4,218	2,958	**2.3**	2.2	2.5
2007	**16,058**	9,037	7,021	**7,017**	3,940	3,077	**2.3**	2.3	2.3
2008	**15,539**	8,684	6,855	**7,144**	4,001	3,143	**2.2**	2.2	2.2
2009	**15,624**	8,657	6,967	**7,073**	3,887	3,176	**2.2**	2.2	2.2
2010	**17,203**	9,372	7,831	**7,031**	3,860	3,171	**2.4**	2.4	2.5

Source: UCAS Statistics

Notes: (1) These figures include those graduates who have applied to undergraduate medical degrees through UCAS. These figures do not include students who have applied directly to medical school.
(2). Applicants naming medicine at least once on an application form
(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 medicine remained at 5. In 2000 medicine was reduced to 4. In 2008 the number of applications was reduced to 5, whilst medicine remained at 4.

TABLE 4

UK Dental Schools - Number of Home Applicants and Accepted Applicants for Dentistry (1)

Year of Entry	Number of Applicants (2) (3)	Number of Accepted Applicants	Ratio of Applicants to Accepted Applicants
1989	1,636	802	2.0
1990	1,578	795	2.0
1991	1,525	762	2.0
1992	1,595	798	2.0
1993	1,696	776	2.2
1994	2,458	838	2.9
1995	2,765	810	3.4
1996	2,659	871	3.1
1997	2,358	779	3.0
1998	2,011	773	2.6
1999	1,695	805	2.1
2000	1,688	811	2.1
2001	1,560	848	1.8
2002	1,677	872	1.9
2003	1,865	871	2.1
2004	2,147	917	2.3
2005	2,690	1,114	2.4
2006	2,577	1,042	2.5
2007	2,817	1,135	2.5
2008	2,738	1,141	2.4
2009	2,978	1,150	2.6
2010	3,299	1,190	2.4

Source: UCAS 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. In 2001 dentistry was reduced to 4. In 2008 the number of applications was reduced to 5, whilst dentistry remained at 4.

TABLE 4

UK applicants and accepted applicants for dentistry by gender 2006 to 2009

Year of Entry	Applicants			Accepted Applicants			Ratio of Applicants to Accepted Applicants		
	Total	Female	Male	**Total**	Female	Male	**Total**	Female	Male
2006	**2,661**	1,416	1,245	**1,042**	591	451	**2.6**	2.4	2.8
2007	**2,817**	1,541	1,276	**1,135**	649	486	**2.5**	2.4	2.6
2008	**2,738**	1,460	1,278	**1,141**	657	484	**2.4**	2.2	2.6
2009	**2,978**	1,628	1,350	**1,150**	668	482	**2.6**	2.4	2.8
2010	**3,299**	1,796	1,503	**1,190**	701	489	**2.8**	2.6	3.1

Source: UCAS Statistics

TABLE 5

Hospital and Community Health Services medical and dental staff. United Kingdom at 30 September

	2001		2002		2003		2004		2005		2006		2007		2008		2009		2010	
	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE	Head count	FTE
All UK [1] - Total	90,988	79,031	95,177	84,232	99,345	88,705	106,466	95,841	110,513	100,446	114,123	104,903	116,248	107,513	121,067	112,101	125,461	117,106	126,667	118,365
Consultant	31,559	28,404	33,058	30,302	34,909	32,044	37,106	34,111	38,714	35,855	39,879	37,223	41,019	38,361	42,890	40,163	45,045	42,221	46,055	43,604
Registrar Group [2]	15,654	14,947	16,559	15,718	17,429	16,693	19,930	19,093	21,193	20,391	22,053	21,313	37,243	36,653	41,950	41,043	44,055	43,469	45,121	44,302
Senior House Officer	19,899	19,664	21,426	21,168	23,312	22,994	25,412	25,060	26,575	26,226	23,713	23,440	7,096	6,978	3,040	2,958	2,341	2,315	1,763	1,715
Foundation Year 2 [3]	.	.	.	.	.	.	.	.	.	.	4,284	4,280	6,248	6,233	6,950	6,925	7,360	7,376	7,576	7,544
House Officer [4]	4,832	4,822	5,238	5,217	5,259	5,249	5,545	5,530	5,921	5,901	6,204	6,188	6,574	6,532	7,510	7,481	7,911	8,012	7,795	7,681
Associate Specialist/ Staff Grade	8,057	6,786	8,512	7,657	8,745	7,906	9,408	8,396	9,830	8,714	10,698	9,460	11,175	9,861	11,834	10,373	12,307	10,631	12,478	10,511
All Other Staff [5, 6, 7,8]	11,061	4,407	10,456	4,171	9,764	3,819	9,128	3,652	8,333	3,357	7,337	2,999	6,942	2,895	6,998	3,160	6,558	3,082	6,420	3,008
England [9] - Total	73,846	64,055	77,031	68,260	80,851	72,260	86,996	78,462	90,630	82,568	93,320	85,975	94,638	87,533	98,703	91,586	102,961	96,598	103,912	97,636
Consultant [10]	25,782	23,064	27,070	24,756	28,750	26,341	30,650	28,141	31,993	29,613	32,874	30,619	33,674	31,430	34,910	32,679	36,950	34,654	37,752	35,781
Registrar Group [2]	13,220	12,629	13,770	13,031	14,619	13,989	16,823	16,112	18,006	17,313	18,808	18,180	30,759	30,175	35,042	34,272	37,108	36,700	38,158	37,527
Senior House Officer	15,830	15,642	17,135	16,912	18,698	18,419	20,601	20,283	21,642	21,337	18,863	18,662	5,954	5,849	2,577	2,504	2,015	1,994	1,566	1,520
Foundation Year 2 [3]	.	.	.	.	.	.	.	.	.	.	3,693	3,690	4,830	4,823	5,509	5,497	6,015	6,055	6,101	6,080
House Officer [4, 11]	3,742	3,733	4,010	3,989	4,003	3,994	4,273	4,259	4,663	4,645	4,905	4,890	5,240	5,203	6,050	6,025	6,364	6,467	6,379	6270
Associate Specialist/ Staff Grade [12]	6,595	5,513	7,035	6,377	7,256	6,608	7,761	6,977	8,081	7,226	8,767	7,820	9,103	8,089	9,586	8,456	10,058	8,741	10,166	8718
All Other Staff [5]	8,677	3,474	8,011	3,194	7,525	2,909	6,888	2,689	6,245	2,435	5,410	2,114	5,078	1,964	5,029	2,153	4,451	1,987	4,236	1740
N I [13, 14] - Total	2,875	2,602	3,033	2,738	3,225	2,944	3,375	3,096	3,508	3,230	3,706	3,427	3,837	3,540	3,881	3,589	3,900	3,624	3,912	3,634
Consultant [15]	943	889	999	930	1,050	987	1,086	1,021	1,135	1,077	1,224	1,163	1,280	1,211	1,316	1,240	1,362	1,289	1,397	1,317
Registrar Group [2]	482	467	524	513	559	548	601	591	626	616	676	665	1,268	1,254	1,315	1,301	1,324	1,305	1,311	1,288
Senior House Officer	735	725	743	737	827	823	881	878	903	898	913	908	195	192	55	52	35	34	27	26
Foundation Year 2 [3]	.	.	.	.	.	.	.	.	.	.	.	.	137	137	242	242	243	243	251	251
House Officer [4]	189	189	215	215	224	224	223	223	234	234	220	220	232	232	235	235	241	241	246	246
Associate Specialist/ Staff Grade	192	167	202	174	226	193	256	221	323	264	360	305	402	337	405	344	395	337	400	339
All Other Staff [6]	334	165	350	170	339	169	328	161	287	142	313	165	323	178	313	174	300	176	280	167

Scotland [16, 17] - Total	9,646	8,465	10,256	9,072	10,409	9,293	10,660	9,568	10,876	9,787	11,201	10,161	11,823	10,920	12,534	11,356	12,608	11,322	12,757	11,440
Consultant [10]	3,306	3,091	3,411	3,195	3,513	3,285	3,593	3,358	3,724	3,494	3,847	3,625	4,035	3,802	4,581	4,249	4,610	4,250	4,670	4,375
Registrar Group [2]	1,321	1,240	1,532	1,441	1,544	1,461	1,666	1,587	1,695	1,623	1,646	1,582	3,840	3,875	3,807	3,720	3,800	3,681	3,792	3,666
Senior House Officer	2,335	2,304	2,528	2,499	2,685	2,650	2,729	2,704	2,761	2,732	2,508	2,479	97	92	..	..	..	..	..	..
Foundation Year 2 [3]	.	.	.	.	.	.	.	.	.	.	485	483	1,033	1,025	926	914	852	828	872	862
House Officer [4]	716	716	803	803	798	797	802	802	767	766	793	793	781	777	903	899	964	963	828	825
Associate Specialist/ Staff Grade	684	573	690	578	691	579	718	589	760	627	779	638	892	732	1,076	879	1,007	814	1,041	729
All Other Staff [7]	1,358	543	1,364	556	1,251	521	1,215	529	1,222	546	1,188	562	1,194	617	1,346	696	1,491	786	1,649	985
Wales - Total	4,621	3,908	4,857	4,163	4,860	4,208	5,435	4,715	5,499	4,859	5,896	5,339	5,950	5,520	5,949	5,571	5,992	5,562	6,086	5,654
Consultant [10]	1,528	1,361	1,578	1,421	1,596	1,432	1,777	1,591	1,862	1,673	1,934	1,816	2,030	1,919	2,083	1,996	2,123	2,029	2,236	2,131
Registrar Group [2, 16]	631	611	733	733	707	696	840	803	866	839	923	886	1,376	1,349	1,786	1,750	1,823	1,783	1,860	1,821
Senior House Officer	999	993	1,020	1,020	1,102	1,102	1,201	1,194	1,269	1,260	1,429	1,392	850	846	408	402	291	287	170	170
Foundation Year 2 [3]	.	.	.	.	.	.	.	.	.	.	106	106	248	247	273	272	250	250	352	351
House Officer [4]	185	185	210	210	234	234	247	246	257	257	286	285	321	320	322	321	342	341	342	341
Associate Specialist/ Staff Grade [12]	586	533	585	528	572	526	673	608	666	596	792	697	778	704	767	694	847	739	871	725
All Other Staff [8, 18]	692	225	731	250	649	220	697	273	579	235	426	158	347	136	310	136	316	133	255	115

Source: England: The Information Centre, Medical and Dental Workforce Census. All rights reserved.

Northern Ireland: Human Resource Management System

Scotland: NHS National Services Scotland, Information Services Division

Wales: Welsh Assembly Government, Medical and Dental Workforce Census

Notes: [1] Some staff work in more than one location, in more than one nation. Therefore, the United Kingdom figure may have an element of double counting.

[2] From August 2007 there was a new specialty registrar grade introduced which also included staff previously graded as senior house officer. Therefore note that these staff have been included in the registrar group and this is the reason that the 2007 figures have almost doubled from the previous year.

[3] Foundation Programme Doctors in their second year (F2).

[4] Includes Foundation Programme Doctors in their first year (F1).

[5] The English 'Other' includes Hospital Practitioner, Clinical Assistant, Senior Dental Officer, Dental Officer, Community Dental Officer, Clinical Medical Officer, Senior Clinical Medical Officer, Dental Clinical Director, Dental Ass Clinical Director, Other (Med Practs doing part-time work) and Other (Salaried Dental Practitioner)

[6] In Northern Ireland the Other category includes Hospital Practitioners, General Medical Practitioners, Dental Practitioners, Medical Officer, Dental Officer, Medical Advisors, Clinical Assistants and Medical Research Fellows.

[7] Includes Senior clinical medical officer, Clinical medical officer, Clinical assistant (para 94 appt. - medical), Clinical assistant (para 107 appt. - dental), Hospital practitioner, Limited specialist, Clinical director, Assistant clinical director, Chief / Assistant chief administrative dental officer, Senior dental officer, Dental officer, Dental adviser, Medical Adviser, Assistant prescribing adviser, Other.

[8] The Welsh 'Other' includes Hospital Practitioner, Clinical Assistant, Senior Dental Officer, Dental Officer, Clinical Medical Officer, Senior Clinical Medical Officer, Assistant Clinical Director of Community Dental Service, Dental Assistant and Other. From 2009 Welsh other also includes the grades, Registrar and all other staff in community/Public Health Medicine.

9 England has a new headcount methodology for 2010 data. 2010 data is not fully comparable with previous years data due to improvements that make it a more stringent count of absolute staff numbers. Further information on the headcount methodology is available in the Census publication. Headcount totals are unlikely to equal the sum of components.

[10] In England, Scotland and Wales, Consultant also includes Directors of Public Health.

[11] The English 'House Officer' includes Foundation Programme Doctors in their first year (F1) and Other doctors in training which refers to those doctors with an unknown grade or payscale but with a recognised occupation code indicating they are a doctor in training.

[12] Includes Specialty Doctors from 2008 for England and Wales. Negotiations between NHS Employers and The BMA's Staff and Associate Specialist Committee resulted in a new contract for the associate specialist grade and the creation of the new specialty doctor grade from 1 April 2008.

[13] All Northern Ireland data have been amended and they now exclude staff on career breaks.

[14] Northern Ireland data excludes full-time equivalents of less than or equal to 0.03 and staff on career breaks.

[15] In Northern Ireland the consultant category does not include the grade Director of Public Health

[16] Scottish employees can work in more than one grade and are presented under each group but only counted once in the total. This issue must be considered when using Headcount figures, FTE figures are unaffected.

[17] Scotland data for 2003 and 2004 have been revised.

[18] Welsh Data for Registrar group in 2009 only includes the grade of Specialist Registrar. Any grades of Registrar are counted within All Other Staff.

' . ' denotes not applicable

' - ' denotes zero

'..' denotes not available

TABLE 6

Three Month Vacancy Rate for All HCHS Doctors (excluding doctors in training and equivalents) and Consultants by specialty group by SHA

Three month vacancy rates: March 2010 — vacancy rates (%)

		All Consultants	Consultants by specialty group												Other HCHS Doctors & Dentists
			A & E	Anaesthetics	Clinical Oncology	Dental group	General medical group	Obs & gynae	Paediatric group	Pathology group	PHM & CHS group	Psychiatry group	Radiology group	Surgical group	
England	**1.4%**	**1.0%**	**3.3%**	**0.7%**	**0.2%**	**0.8%**	**0.9%**	**0.5%**	**0.8%**	**1.1%**	**0.9%**	**1.5%**	**1.4%**	**0.8%**	**2.6%**
North East	1.3%	1.0%	0.0%	0.6%	0.0%	0.0%	1.3%	3.0%	0.0%	0.7%	0.0%	0.4%	1.8%	1.3%	2.7%
North West	1.9%	1.2%	3.8%	0.3%	0.0%	0.0%	1.1%	0.5%	0.3%	2.4%	2.0%	3.3%	2.3%	0.6%	3.7%
Yorks and the Humber	1.6%	1.1%	5.9%	0.6%	0.0%	2.2%	0.9%	0.0%	0.8%	0.7%	0.3%	0.6%	1.6%	1.6%	3.1%
East Midlands	1.0%	1.2%	5.3%	1.8%	0.0%	2.6%	0.5%	0.0%	0.6%	0.0%	0.0%	0.3%	1.0%	2.4%	0.4%
West Midlands	0.9%	1.0%	5.6%	0.0%	0.0%	0.0%	2.3%	0.0%	0.9%	1.2%	4.1%	0.3%	0.0%	0.3%	0.8%
East Of England	1.3%	1.1%	1.2%	0.6%	1.5%	0.0%	1.4%	1.3%	1.0%	2.2%	0.0%	0.0%	2.9%	0.8%	1.9%
London	1.9%	1.2%	2.5%	1.6%	0.0%	0.6%	0.4%	0.5%	1.7%	0.4%	0.0%	3.5%	1.3%	0.5%	4.6%
South East Coast	1.7%	0.6%	0.0%	0.3%	0.0%	0.0%	0.2%	0.0%	0.0%	1.9%	1.8%	1.1%	1.9%	0.4%	4.4%
South Central	1.0%	0.8%	5.5%	0.3%	0.0%	2.5%	0.8%	1.0%	0.6%	0.6%	1.9%	0.7%	0.0%	1.1%	1.7%
South West	0.6%	0.6%	3.0%	0.7%	0.0%	1.1%	0.7%	0.0%	0.5%	0.7%	0.0%	0.8%	0.8%	0.0%	0.6%
SHAs & Other Statutory Bodies	0.7%	0.8%	-	-	-	-	-	-	-	2.0%	0.0%	-	-	-	0.0%

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Notes: 1. The vacancy census excludes staff within training grades and their equivalents
2. SHA figures are based on Trusts and do not necessarily reflect the geographical provision of healthcare.
3. Three month vacancy rates are three month vacancies expressed as a percentage of three month vacancies plus staff in post (staff in post figures as at 30 September 2009).
4. Three month vacancies are vacancies as at 31 March 2010 which Trusts are actively trying to fill which had lasted for three months or more (full time equivalents).
5. ' * ' figures where staff in post and number of vacancies are less than 10.
6. ' - ' figures where staff in post and vacancies are both nil.
7. Percentages are calculated on unrounded figures and rounded to one decimal place.

TABLE 7

Three Month Vacancy Rate for All HCHS Doctors (excluding doctors in training and equivalents) and Consultants by specialty Group as at 31 March

England	2002	2003	2004	2005	2006	2007	2008	2009	2010
All medical and dental staff	4.0%	4.7%	4.3%	3.1%	1.8%	1.1%	0.9%	1.5%	1.4%
Consultants - *of which*	3.8%	4.7%	4.4%	3.3%	1.9%	1.2%	0.9%	1.1%	1.0%
• **Accident & emergency**	7.2%	8.2%	8.2%	9.0%	4.0%	3.2%	2.7%	4.5%	3.3%
• **Anaesthetics**	2.3%	3.5%	3.0%	2.0%	0.9%	0.3%	0.4%	0.6%	0.7%
• **Clinical oncology**	6.4%	8.7%	3.2%	1.3%	1.6%	0.0%	0.4%	0.2%	0.2%
• **Dental group**	4.5%	3.4%	4.1%	2.8%	2.0%	1.9%	2.3%	1.2%	0.8%
• **General medicine group**	2.7%	3.7%	3.6%	2.8%	1.7%	1.1%	0.7%	0.8%	0.9%
• **Obs & gynaecology**	1.7%	1.4%	1.4%	1.8%	0.7%	0.7%	0.7%	0.5%	0.5%
• **Paediatric group**	1.9%	2.8%	3.1%	2.2%	1.7%	1.3%	0.8%	1.0%	0.8%
• **Pathology group**	4.8%	5.5%	5.4%	3.5%	3.2%	2.0%	1.2%	1.1%	1.1%
• **PHM & CHS group**	4.7%	4.8%	5.8%	5.0%	0.9%	1.1%	0.6%	1.6%	0.9%
• **Psychiatry group**	8.5%	11.3%	9.6%	7.7%	4.0%	2.6%	1.6%	2.0%	1.5%
• **Radiology group**	8.0%	7.6%	7.5%	5.1%	2.6%	1.2%	0.8%	1.1%	1.4%
• **Surgical group**	1.9%	2.3%	1.9%	1.1%	1.0%	0.6%	0.7%	0.7%	0.8%
Other medical and dental staff	4.4%	4.4%	4.1%	2.6%	1.7%	0.7%	1.0%	3.0%	2.6%

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Notes: 1. The vacancy census excludes staff within training grades and their equivalents

2. Vacancy rates based on vacancy numbers and consultant staff in post figures as at 31 March each year and other staff in post figures as at 30 September the previous year.

3. Three month vacancies are vacancies as at 31 March each year which Trusts are actively trying to fill which had lasted for three months or more (full time equivalents).

4. Three month vacancy rates are three month vacancies expressed as a percentage of three month vacancies plus staff in post (staff in post figures as at 30 September the previous year).

5. Percentages are calculated on unrounded figures and rounded to one decimal place.