THE REVIEW BODY ON DOCTORS' & DENTISTS' REMUNERATION (DDRB)

REVIEW FOR 2013

Written Evidence from the Health Department for England

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EXECUTIVE SUMMARY

Returning the UK to sustainable, balanced growth is the Government's overriding priority. The Government has taken decisive action to set out a clear strategy for fiscal consolidation and there is evidence that these fiscal plans are continuing to contribute to the UK being seen as a safe haven, with interest rates near record lows, benefiting businesses and families.

Official statistics have estimated a contraction in the UK economy of -0.4 per cent in the second quarter of 2012. This is a disappointing figure, but the UK is dealing with some deep-rooted problems at home, including recovering from the biggest debt and financial crisis of our lifetimes, as well as a very serious debt crisis abroad.

The financial crisis of 2008 and 2009 exposed an unstable and unbalanced model of economic growth in the UK based on ever increasing levels of public and private sector debt. In 2010 and 2011, the UK economy was hit by a series of further shocks: commodity price driven inflation; the euro area debt crisis damaging confidence; and the ongoing structural impact of the financial crisis.

Despite the difficult current conditions, inflation has more than halved since its peak in September 2011 - and in the third quarter of 2012 it was 2.4 per cent, below the Office for Budget Responsibility's (OBR) forecast of 2.6 per cent. The Bank of England's August *Inflation Report* forecasts inflation to be below the 2 per cent target for a large part of the period to 2015. Headline labour market indicators have been more positive in the beginning of 2012 than many had expected, with employment in the three months to August rising by 212,000 on the quarter and up 510,000 on the year. The unemployment rate fell from its most recent peak of 8.4 per cent in the final quarter of 2011 to 7.9 per cent in the three months to August 2012. However, labour market conditions remain weaker than prior to the recession, with recent employment growth supported by increases in part-time and self-employment.

The Government remains committed to fiscal consolidation. The June 2010 Budget announced the Government's forward-looking fiscal mandate to achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast period. In their March 2012 forecast, the OBR concluded that the Government remained on course to meet the fiscal mandate. However there remains substantial uncertainty over the medium term, particularly in relation to market sentiment towards high-deficit countries and the UK therefore faces significant risks until fiscal sustainability is restored.

In light of all of these factors, the Government believes that there remains a strong case for continued pay restraint in the public sector. Therefore, at the 2011 Autumn Statement, the Chancellor announced that public sector pay awards will average at 1% in each of the two years following the pay freeze (**Annex A)** – and the Pay Review Bodies (PRBs) have been asked to consider how best this should be divided between their remit group. The Chief Secretary to the Treasury (CST) followed this up on 16 July (**Annex B**) setting out how the Government proposes that DDRB approaches the 2013/14 pay round.

NHS Pay has to be viewed in the context of wider public sector pay and fiscal policy. Although there has been a 2 year pay freeze and the prospect of average pay increases of up to one per cent per annum over the next 2 years, many medical and dental staff receive regular incremental rises of between 3% - 8% and recruitment, retention, morale and motivation remain strong. This reinforces the Government's view that pay increases should only be implemented if there is any evidence that there are recruitment, retention, morale or motivation issues that require this.

In addition, the recent expansion of undergraduate numbers is beginning to feed through into postgraduate training such that we are now forecasting a growing surplus. So the risk is now shifting towards having more doctors than we can afford, especially if pay increases significantly.

Turning to the content of our evidence, this year marks a change in the responsibilities between the DH and NHS Employers (NHSE). Unlike previous years when the DH gave comprehensive evidence on recruitment, retention and motivation of staff, the role of DH is changing and it will no longer include day- to- day management of the NHS. In future therefore, as set out in Secretary of State's letter to the DDRB of 3 July 2012 (**Annex C**):

- DH will provide high level evidence for the DDRB focussing on the economic and financial (NHS) funding context and strategic policy;

- NHSE will provide separate detailed evidence about the recruitment, retention and morale of employed doctors and dentists. The DH will not comment in detail on these issues.

The subsequent chapters of this evidence therefore set out:

- in Chapter 1, the importance of an affordable NHS pay and reward strategy in supporting the Health and Social Care Act 2012 to deliver DH priorities to address rising demand and treatment costs and deliver NHS improvements;

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- in Chapter 2, the general economic outlook for the UK economy which, as described above, demonstrates that the situation is still very challenging and the Government's overriding priority is to return the UK back to growth through fiscal consolidation. While the Government's consolidation plans are contributing to the UK being seen as a safe haven, risks remain and there is a strong case for continued pay restraint;

- in Chapter 3, that, even though the NHS has received a better Spending Review (SR) settlement than most other government departments with guaranteed real terms growth each year, the NHS budget will be under considerable pressure to cope with demographic changes; an ageing population and inflation on non-pay expenditure such as drugs. In 2013/14 there are only £2.7bn of extra resources available compared to an average of £7bn per year over the past three SRs. The NHS will therefore need to deliver productivity savings of £1.2bn if it is to fund baseline pressures, activity increases, service developments, pay increases of 1%; and pay drift at the long-run historical average of 1.6%. This is a much higher level of productivity than has

previously been achieved and any pay increase adds directly to this already considerable challenge;

- in Chapter 4, progress with the Quality, Innovation, Productivity and Prevention (QIPP) programme to deliver unprecedented savings of up to £20 bn for reinvestment in services; demonstrating how £5.8bn has been achieved so far while meeting key quality and access ambitions but that the scale of the remaining challenge is considerable;

- in Chapter 5, arrangements for the future for medical workforce planning which will pass from DH to Health Education England (HEE) and Local Education and Training Boards (LETBs) from April 2013 and how the Centre for Workforce Intelligence (CfWI) will support these arrangements. We also summarise:

    - the impact of tuition fees on workforce planning with a long term future to be agreed in due course;

    - the important role clinicians will play in ensuring quality and safety;

    - projects led by DH to develop the future Workforce Information Architecture;

    - ongoing challenges including policy work to consider solutions to A&E shortages (which will not be resolved by additional pay) and General Medical Practitioner (GMP) training.

- in Chapter 6, high level updates on relevant policy developments including:

    - for doctors and dentists in training, the implementation of "*Better Training, Better Care*", review of the European Working Time Directive (EWTD) and next steps with the Temple Report "*Time for Training*";

    - for consultants: that national and local clinical excellence awards were sanctioned for 2012 before publication (expected shortly) of the review of compensation levels and incentives, and that we are awaiting publication of the National Audit Office report on the effectiveness of the 2003 consultants contract;

    - for Specialty Doctors and Associate Specialists: the General Medical Council review of applications for Certificates for Eligibility for Specialist Registration, and progress with monitoring the costs of implementing the new contract;

- in Chapter 7, the Government provides an update on salaried primary care dentists and dental public health staff for information;

- in Chapter 8, the Government reaffirms its view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fees;

- in Chapter 9, progress with NHS pensions reform and our continued work to introduce the concept of total reward to the NHS so staff can better understand the value of their pay and benefits package.

In conclusion, the Government has provided sufficient funding for the NHS to support an average annual headline pay increase of up to one per cent for NHS staff in 2013/14 and invites the DDRB to make recommendations on how this might best be distributed taking account of the fact that recruitment, retention and motivation of NHS doctors and dentists remains strong. Many employed doctors and dentists receive regular increments of between 3% and 8% and any element of these funds that is not used for pay will be retained in the NHS and may be better employed on other issues such as increasing staff numbers or improving patient services. The DH, therefore, invites the DDRB to consider this and make recommendations for the distribution of the available funds of up to one per cent, balancing 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.

1 - NHS STRATEGY & INTRODUCTION

1.1 The DH Business Plan for 2012-15[1] sets out the work that is planned to take place over the next three years to support the Government's ambitious programme for the delivery of high quality health and care services. It also contains information on our structure and budget, and the way we measure our performance.

1.2 This year's Business Plan[2] is an update of the one published in July 2011 and includes the full list of actions and indicators in the 2011 plan, with details of any changes made to that version.

1.3 The DH's priorities are to:

- **integrate health and care systems around the needs of patients and users**: strengthen patients' and users' ability to exercise extended choice, to manage their care and to have their voice heard. This includes a range of workstreams, for example creating HealthWatch[3], a new body to act as the voice for patients and the public by April 2013, and making a step change in data transparency for the benefit of patients and the public, which is due to be completed by April 2015;

- **promote better healthcare outcomes**: shift focus and resources from bureaucratic process targets to better healthcare outcomes, and reduced inequalities, including national health outcome measures, patient reported outcome measures and patient experience measures. This includes, for example, scrapping process targets and introducing national health outcome measures to prioritise the health results that really matter by April 2013, and introducing a value-based pricing system to align treatments with outcomes by January 2014;

- **revolutionise NHS accountability**: create a long term, sustainable framework of institutions, with greater autonomy for doctors and nurses, and greater accountability to patients and the public. Examples of the work to deliver this priority include:

    - improving the effectiveness of commissioning through establishment of the NHS Commissioning Board (NHSCB) and clinical commissioning groups (CCGs) from April 2013;

    - reducing bureaucracy through the abolition of primary care trusts (PCTs) by April 2013 and abolishing Arms Length Bodies (ALBs), transferring their functions to new organisations or stopping them by April 2015;

- **promote public health**: create a public health service which rebalances our approach to health and health inequalities, drawing together national leadership with local delivery, and a new sense of community and social responsibility. This includes establishing Public Health England (PHE), including relevant health protection functions,

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_121393
[2] http://www.number10.gov.uk/wp-content/uploads/2012/15/DH-2012-Business-Plan.pdf
[3] http://www.healthwatch.co.uk

and incorporating the nutrition functions of the Food Standards Agency (FSA) into DH and recruiting an extra 4,200 Sure Start health visitors by March 2015;

- **reform Care and Support**: enable people needing care to be treated with dignity and respect, and reform the system of care and support to provide much more control to individuals and their carers, improve quality, and ease the burden of care costs that they and their families face. This will be achieved through reforming the funding of the Care and Support system as set out in the Social Care White Paper published in June 2012 and extending the roll-out of health and social care personal budgets to give people and their carers more control and purchasing power.

The Health and Social Care Act 2012

1.4 These priorities reflect the Health and Social Care Act 2012 which received Royal Assent on 27 March 2012. The Act's main aim is to modernise the NHS, putting clinicians at the centre of commissioning, freeing up providers to innovate, empowering patients and giving a new focus to public health.

1.5 The Act is based on a compelling case for change. In particular, the Government is committed to the founding principles of the NHS but there has been broad consensus that NHS modernisation is essential for three main reasons:

- **rising demand and treatment costs**. Similar to other health systems, pressures on the NHS are increasing. As the population ages and long-term conditions become more common, more sophisticated and expensive treatment options are becoming available. The cost of medicines is growing by over £600m per year;

- **need for improvement**. At its best, the NHS is world-leading, but there are important areas where the NHS falls behind other major European countries eg we would save 5,000 lives per year if we had cancer survival rates at the average in Europe;

- **the state of the public finances**. Whilst the Government has protected the NHS budget, this is still among the tightest funding settlements the NHS has ever faced so doing things in the same way will no longer be affordable in future.

1.6 The Act is designed to meet these challenges, by making the NHS more responsive, efficient and accountable drawing on evidence and experience of 20 years of NHS reform. The Act therefore introduces:

- **clinically led commissioning**. The Act puts clinicians in charge of shaping services, enabling NHS funding to be spent more effectively. Supported by the NHSCB, new CCGs will now directly commission services for their populations. The NHSCB, which was set up as a Special Health Authority (SpHA) in April 2012, is currently going through the process of authorising CCGs;

- **provider regulation to support innovative services** .The Act enshrines a fair-playing field in legislation for the first time. This will enable patients to be able to choose services which best meet their needs, including services provided by the charity or independent sectors, as long as they can be delivered within NHS prices. Providers,

including NHS foundation trusts, will be free to innovate to deliver quality services. Monitor will be established as a specialist regulator to protect patients' interests;

- **greater voice for patients**. The Act establishes new Healthwatch patient organisations locally and nationally to drive patient involvement across the NHS;

- **new focus for public health**. The Act provides the underpinnings for PHE, a new body to drive improvements in the public's health. PHE, which will be an ALB of the DH, will be established from April 2013;

- **greater accountability locally and nationally**. The Act sets out clear roles and responsibilities, whilst retaining Ministers' ultimate responsibility for the NHS. It limits political micro-management and gives local authorities a new role to join up local services;

- **streamlined ALBs which will help release resources to the frontline**. It also places the National Institute for Health and Clinical Excellence (NICE) and the NHS Information Centre (NHSIC) in primary legislation.

NHS pay strategy

1.7 The DH's aim is to develop a total reward strategy for the NHS, covering pay, conditions of service and pensions policy, that is affordable, provides value for money for the taxpayer and enables the NHS to recruit, retain and motivate sufficient high calibre staff to deliver Government policy. The pay strategy must also comply with the Government's wider public sector pay strategy and be aligned to support the DH's agenda to improve Quality, Innovation, Productivity and Prevention (QIPP).

1.8 The DH's general approach to pay was set out in the 2010 White Paper "*Equity and Excellence: Liberating the NHS*". The key points of this were that:

- the Government does not believe that it should be responsible for setting the pay of staff in every NHS organisation;

- individual employers should be free, as Foundation Trusts are now, to set their own pay, terms and conditions to recruit, retain and motivate their staff;

- financial control will be maintained through the running cost limits on commissioners and the tariff for service providers;

- employers will be free to continue to use national contracts as the basis for local terms and conditions. Many will wish to do so provided national contracts remain fit for purpose and affordable;

- some guidance may be necessary where normal market arrangements do not exist. The Government will therefore retain the authority to issue guidance on pay policy for its ALBs and the NHSCB will be given the authority to issue guidance on pay policy for CCGs.

1.9 The maintenance of national contracts for pay, terms and conditions for those employers that wish to use them is therefore an important part of the NHS pay strategy. The NHS trades unions and NHSE have a role in ensuring that these remain fit for purpose. The PRBs have an equally important role in recommending the annual uplift for these contracts. This is not about maintaining or increasing the real purchasing power of NHS staff based on any particular price index; nor is it about maintaining parity with the pay of any other particular group of workers. It is more complex than that and requires careful judgement. It is about ensuring that national terms and conditions are fit for purpose to recruit, retain and motivate staff while remaining affordable and making the best use of the available resources.

2. Economic context and outlook for the economy

Growth

2.1 The UK was amongst the hardest hit by the financial crisis of 2008 and 2009. Between the first quarter of 2008 and the second quarter of 2009, Gross Domestic Product (GDP) fell by 6.3 per cent. The crisis also reduced the UK's growth potential relative to the pre-crisis trend. The OBR estimate that by 2016, the economy will be 11 per cent smaller than it would have been had the pre-crisis trend continued.

2.2 The OBR judge that the recovery of the UK economy has been hit by subsequent repeated shocks. Higher inflation driven by global commodity prices have reduced real incomes, increased business costs and weighted-on global growth.

2.3 The Government has taken decisive action to protect the economy in this period of global uncertainty, and has set out a comprehensive strategy to achieve strong, sustainable and balanced growth, based on: fiscal consolidation to return the public finances to a sustainable position; monetary activism to support the recovery; financial sector reform; tax reform to make Britain one of the most competitive places to do business; and microeconomic reforms to strengthen the economy in the medium term.

2.4 The OBR expect GDP growth to build gradually in 2012 and 2013 but the recovery will only gather pace in 2014 as tensions in the financial markets ease and the banking sector returns to strength. The OBR forecast business investment to pick up and make an increasingly strong contribution to growth in each year of the forecast and net trade to make a positive contribution in each year of the forecast.

2.5 Measures taken to support growth include the National Loan Guarantee Scheme, through which over 19,000 loans worth over £2.6 billion (bn) have been offered to businesses. In addition the Government has announced a major housing and planning package to boost jobs and growth, including: conditionally removing affordable housing restrictions to help unlock 75,000 homes; guarantees for up to £10bn of new homes; temporarily cutting red tape so it's easier for businesses and families to improve their properties; a £280m extension of the NewBuy Scheme to help 16,500 more first time buyers; and up to 15,000 more affordable homes, and 5,000 more private rental properties.

2.6 However, the UK's open economy and large financial sector means it is not immune to global risks from deteriorating global confidence and nervous financial markets. Conditions remain challenging given that Europe remains the UK's major trading partner, accounting for half of all UK exports. The ongoing intensity of the euro area crisis has created uncertainty, undermined confidence and fed through to tighter credit conditions for households and firms. The greatest threat to the UK recovery stems from the risk that an effective policy response is not promptly implemented in the euro area. The IMF forecast the euro area economy to contract by -0.4 per cent in 2012.

2.7 The UK has experienced three consecutive quarters of negative growth, re-entering recession in the second quarter of 2012. The Office for National Statistics (ONS)

estimate UK output to have fallen by 0.4 per cent in the second quarter of 2012. While one off factors, including the extra Jubilee bank holiday may have distorted the second quarter estimate, the economic recovery following a financial crisis was always expected to be uneven.

2.8 GDP growth forecasts have fallen over recent months and diverged from the OBR's March forecast. In October, the average independent forecasts were -0.3 per cent for 2012 and 1.1 per cent for 2013. These are below the OBR's March forecast of 0.8 per cent for 2012 and 2.0 per cent for 2013. Table 2.1 summarises the OBR, Bank of England and independent forecasts for GDP growth over 2012 and 2014.

Table 2.1: Forecasts for GDP growth 2012 to 2014

1	Forecasts for GDP growth (per cent)	2	2012	3	2013	4	2014
5	**OBR (March 2012 Budget)**	**6**	**0.8**	**7**	**2.0**	**8**	**2.7**
9	**Bank of England mode projection (August 2012)**	**10**	**0.0**	**11**	**1.8**	**12**	**2.1**
13	**Avg. of independent forecasters (October 2012)[4]**	**14**	**-0.3**	**15**	**1.1**	**16**	**1.9[1]**

Inflation

2.9 Despite the difficult current conditions, inflation has more than halved since its peak in September 2011. CPI inflation peaked at 5.2 per cent in September 2011 but has since fallen back sharply in 2012 as past rises in commodity and energy prices and VAT dropped out of the twelve month comparison. In the third quarter of 2012 falling energy prices and broader-based weakness in price pressures caused inflation to fall faster than the OBR forecast in March. CPI inflation in the third quarter of 2012 was 2.4 per cent, 0.2 percentage points below the OBR forecast of 2.6 per cent.

2.10 The Bank of England's August *Inflation Report* forecasts inflation to be below the 2.0 per cent target for a large part of the period to 2015 as the impact of external price pressure eases further and domestic cost pressures remain constrained due to the continued labour market slack. Table 2.2 sets out the latest forecasts for inflation from the OBR, Bank of England and the average of independent forecasters.

[4] *Forecasts for the UK economy: A comparison of independent forecasts*, August 2012, HM Treasury.

Table 2.2: Forecasts for CPI Inflation 2012 to 2014

17 Forecasts for CPI Inflation (per cent change on a year earlier)	18 Q4 2012	19 Q4 2013	20 Q4 2014
OBR (March 2012)	21 2.3	22 1.9	23 2.0
Bank of England mode projection (August 2012)	24 2.2	25 1.9	26 1.7
Avg. of independent forecasters (October 2012)[4]	27 2.3	28 2.1	29 1.9[5]

Affordability

2.11 The Government remains committed to fiscal consolidation. Implementing the deficit reduction plan is vital to the economic, fiscal and financial prospects of the UK, as it will help restore private-sector confidence and underpin sustainable economic growth. But in a period of global instability there is a high degree of uncertainty, particularly relating to market sentiment towards high-deficit countries.

2.12 As announced in the June Budget 2010, the Government has set a clear and measurable forward-looking fiscal mandate to achieve cyclically-adjusted current balance by the end of the rolling five-year forecast period (currently 2016-17). At a time of rapidly rising debt, the June Budget also announced that the fiscal mandate would be supplemented by a target for public sector net debt as a percentage of GDP to be falling at a fixed date of 2015-16, ensuring that the public finances are restored to a sustainable path in the medium term.

2.13 Budget 2012 confirmed that the implementation of the Government's fiscal consolidation plan is well underway. By the end of 2011-12, almost 40 percent of the annual fiscal consolidation planned at the Spending Review (SR) 2010 was achieved, with almost 30 per cent of the spending and two-thirds of the tax consolidation in place. In their Budget 2012 forecast, the OBR concluded that the Government remained on course to meet the fiscal mandate and the supplementary target. Reflecting the Government's consolidation plan, the deficit was forecast to fall from 5.8 per cent of GDP this year to 2.8 per cent in 2015-16.

2.14 Illustrating the implications of the consolidation for departmental spending levels, Table 2.3 shows the resource DEL Budgets for each department, as set at SR 2010. An estimated £171 bn in 2011-12 was spent on public sector pay, representing around 50 per cent departmental resource spending.[6]

[5] Inflation figures relate to the calendar year

[6] Source: PESA July 2011 Table 5.3 on pay and PESA 2009/10, HM Government, http://www.hm-treasury.gov.uk/d/pesa_july_2011_chapter5.xlsx. Public sector pay outturn: £168 bn. Public sector Total Managed Expenditure, £691.7bn, RDEL: £346 bn

Table 2.3: Resource DEL Budgets for each Department (Excluding Depreciation)[7]

	£ billion			
	Estimate	Plans		
	2011–12	2012–13	2013–14	2014–15
Departmental Programme and Administration Budgets (Resource DEL excluding depreciation[1])				
Education	51.2	52.5	53.1	54.2
NHS (Health)	101.1	104.3	106.9	109.8
Transport	4.8	5.1	4.9	4.5
CLG Communities	1.8	1.8	2.0	1.4
CLG Local Government	26.6	23.9	23.8	22.2
Business, Innovation and Skills	16.3	15.9	14.9	13.9
Home Office	8.7	8.6	8.0	7.7
Justice	8.5	7.7	7.3	7.0
Law Officers' Departments	0.6	0.6	0.6	0.5
Defence[2]	28.6	27.6	24.7	24.5
Foreign and Commonwealth Office	2.1	1.8	1.4	1.2
International Development	6.2	6.8	9.1	8.9
Energy and Climate Change	1.1	1.4	1.4	1.0
Environment, Food and Rural Affairs	2.0	2.0	1.9	1.8
Culture, Media and Sport[3]	1.5	2.0	1.2	1.1
Work and Pensions	7.4	7.8	7.7	7.8
Scotland	24.9	25.2	25.4	25.5
Wales	13.2	13.4	13.5	13.5
Northern Ireland	9.5	9.5	9.5	9.6
Chancellor's Departments	3.6	3.7	3.6	3.4
Cabinet Office	2.1	2.1	2.0	2.2
Small and Independent Bodies	1.7	1.5	1.4	1.3
Reserve[4]	0.0	1.9	2.3	2.4
Special Reserve[5]	0.0	0.6	2.5	1.8
Green Investment Bank	0.0	0.0	1.0	0.0
Adjustment for Budget Exchange[6]	0.0	-0.6	0.0	0.0
OBR allowance for shortfall	-1.0	0.0	0.0	0.0
Total Resource DEL excluding depreciation[1]	**322.5**	**327.2**	**330.2**	**327.0**

[1] Resource DEL excluding ring-fenced depreciation is the Treasury's primary control within resource budgets and the basis on which Spending Review 2010 settlements were agreed.

[2] The Defence budget for 2012–13 reflects the likely initial allocation of funding from the Special Reserve for the net additional cost of military operations. No such allocation has yet been made for 2013–14 onwards; the funding remains within the Special Reserve for these years.

[3] Includes the Olympics budget which falls to £0 billion after 2012–13.

[4] The Reserve has been reduced by £0.2 billion per annum to offset the costs of bringing the Royal Mail Pension Plan into the public sector.

[5] The Special Reserve has been reduced by £2.4 billion over the spending review period to reflect the reduction in the net additional costs of military operations in Afghanistan.

[6] Departmental budgets in 2012–13 include £0.6 billion RDEL excluding depreciation and £0.2 billion capital DEL carried forward from 2011–12 through the system of Budget Exchange, which will be voted at Main Estimates. These increases will be offset at Supplementary Estimates and so are excluded from spending totals.

2.15 There is evidence that the Government's fiscal plans are continuing to contribute to the UK being seen as a safe haven. Chart 2.1 below shows the path of the spread between German bonds and bonds issued by the UK and other high-deficit countries. Until the June Budget, UK bond yields moved broadly in line with those of Italy and Spain. After the announcement of the deficit reduction plan, gilt yields diverged and moved onto a consistently lower path, reflecting in large part the scale and credibility of the consolidation on course to be delivered in the UK. Low market interest rates provide a direct benefit to the economy and help keep interest payments lower for families, businesses and the taxpayer.

[7] Budget 2012, HM Treasury, March 2012

Chart 2.1: UK bond yields in international context (spread to German Bunds)

2.16 On 18 July 2012, the Chancellor announced a new UK Guarantees scheme to accelerate major infrastructure investment and provide support to UK exporters. Up to £40 bn worth of projects that may have stalled because of adverse credit conditions could qualify for support. This scheme is only possible because of the Government's hard-won fiscal credibility.

2.17 But there remains substantial uncertainty over the medium term. Public sector net borrowing for September 2012 showed £ 700 m less borrowing compared with a the same period last year. PSNB for September 2011 was £13.5 bn and for September 2012 was £12.8bn. The experience of countries in the Eurozone shows that market confidence can be lost rapidly and unexpectedly and, once lost, is difficult to restore. A sharp rise in market interest rates would be damaging to an economy with the UK's levels of public and private sector debt. Therefore the UK must remain focused on restoring fiscal sustainability.

Labour market

2.18 Having worsened in the second half of 2011, headline labour market indicators have been more positive since the beginning of 2012. The level of employment increased in the first half of 2012 and, having reached 8.4 per cent in the final quarter of 2011, International Labour Organisation (ILO) unemployment fell to 7.9 per cent in the three months to August 2012.

2.19 While, in the three months to August, the overall level of Labour Force Survey (LFS) employment was 18,000 above its pre-recession peak in the three months to May 2008, the employment rate is 1.7 percentage points lower than its pre-recession peak. There has been a large shift towards part-time employment, up 635,000 over the same period. Many labour market indicators have a long way to go to recover to their pre-recession conditions and some indicators (such as the level of vacancies and subdued average earnings growth) suggest that underlying labour demand remains tentative. There is still some uncertainty surrounding the labour market outlook which is likely to be impacted by the outlook for growth.

Employment and unemployment

2.20 A rise in private sector employment in the second quarter of 2012, (up 275,000) more than offset the decline in public sector employment (down 39,000) for the third consecutive quarter. Between the first quarter of 2010 and the second quarter of 2012, public sector employment declined by 485,000 and private sector employment increased by over 1.1 million over the same period.

2.21 Having declined in the third quarter of 2011, the employment rate (proportion of the population aged 16 to 64 in employment) partially recovered towards the end of 2011 and first half of 2012. In the three months to August 2012, the employment rate was 71.3 per cent – up over the year but around 1.7 percentage points below its peak at the start of 2008.

2.22 Around 62 per cent of the increase in employment that has occurred in the latter part of 2011 and first half of 2012 has been accounted for by an increase in part-time employment. Involuntary part-time work remains widespread among those in employment; in the three months to August, around 17.8per cent of part-time workers (about 1.4m people) were working part-time because they could not find a full-time job.

2.23 The ILO unemployment rate, which rose from a trough at 5.2 per cent in the first quarter of 2008 and peaked at 8.4 per cent (2.66m people) in the final quarter of 2011, has subsequently fallen to 7.9 per cent in the three months to August 2012.

2.24 Youth unemployment (unemployment among those aged 16 to 24) has reached its highest level since comparable records began, peaking at 1.044 m in the three months to November 2011 or 22.3 per cent of all active young people. In the three months to August 2012, youth unemployment remains high at 957,000 (20.5 per cent). However, this includes around 300,000 young people in full-time education. Excluding people in full-time education, there were 658,000 unemployed 16 to 24 year olds in the three months to July.

2.25 Long-term unemployment (unemployment spells of 12 months and over) has more than doubled since the start of 2008, but the incidence of long-term unemployment remains below the peaks experienced following previous recessions. Over a third (35.5 per cent) of all unemployed people (897,000 people) had been unemployed for more than 12 months in the three months to August 2012.

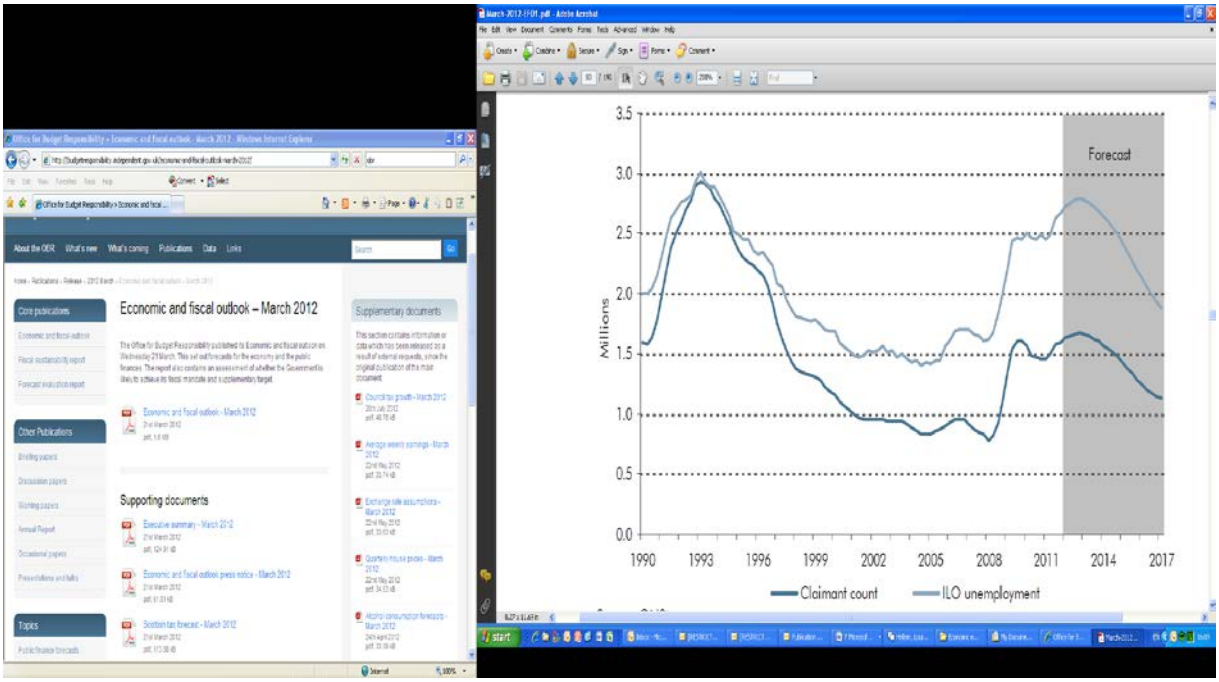
2.26 The claimant count (number of people claiming Jobseeker's Allowance) rose consistently from the end of 2010 to the beginning of this year. Since November 2011 it has remained around 1.6 m, standing at 1.6 m in the three months to June 2012 – around 820,000 above its level in February 2008. In September 2012, the number of claimants fell for third consecutive month (down 4,000). Table 2.4 summarises these statistics:

Table 2.4: Labour market statistics summary (Levels in 1,000's, rates in %)

	2008	2009	2010	2011	Latest[8]
Employment level (All aged 16 and over)	29,440	28,960	29,035	29,176	29,590
Employment rate (All aged 16-64)	72.6	70.9	70.5	70.5	71.3
Unemployment level (All aged 16 and over)	1,783	2,394	2,479	2,560	2,528
Unemployment rate (All aged 16 and over)	5.7	7.7	7.8	8.1	7.9
Youth unemployment level (All aged 16-24)	742	920	934	981	957
Youth unemployment rate (All aged 16-24)	15.1	19.3	19.8	21.0	20.5
Claimant Count	906	1,528	1,496	1,534	1,567.3

[8] Latest data: three months to August 2012, September 2012 for Claimant Count

Chart 2.2: Unemployment levels (From March 2012 OBR forecast)



Recruitment and retention

2.27 Recruitment potential has remained strong in the economy as a whole, reducing some of the upward pressure on pay. Having hit a low of 430,000 in mid 2009, vacancy levels published by the ONS have recovered marginally, and were at 476,000 in the three months to September 2012, although the number of vacancies remains well below its long-run average prior to the recession of around 620,000. The number of unemployed for each vacancy has remained above five since the first half of 2009, more than twice the pre-recession average, standing at 5.3 in the three months to August 2012.

2.28 Chartered Institute of Personnel and Development (CIPD) data shows that turnover rates increased or remained flat in most sectors, although public sector voluntary turnover rates have fallen over the past few years[9]. For voluntary leavers, the median leaving rate is lower in the public sector than all sectors surveyed, although sample sizes are small (Table 2.5). This has continued to fall despite the public sector pay freeze announced in 2010.

[9] *Resourcing and Talent Planning* : CIPD annual survey report 2012. Bracketed is ppt change from previous year

Table 2.5: Median Turnover Rates by Industry (%) [11]

	All Leavers			Voluntary Leavers		
	2012	**2011**	**2010**	**2012**	**2011**	**2010**
Private Sector Services	16.1 (+2.3)	13.8 (-0.8)	14.6 (-2.2)	8.9 (+0.2)	8.7 (+1.3)	7.4 (-3.0)
Public Services	10.1 (+1.6)	8.5 (-0.1)	8.6 (-4)	1.9 (-1.5)	3.4 (-2.4)	5.8 (-1.8)
Manufacturing and production	9.5 (0.0)	9.5 (-2.9)	12.4 (-2.9)	4.5 (+0.8)	3.7 (+1.0)	2.7 (-5)
Voluntary, Community and not-for profit	13 (-0.1)	13.1 (-2.8)	15.9 (-0.5)	7.6 (+0.6)	7 (-3.2)	10.2 (-0.8)

2.29 All sectors reported a pickup in recruitment difficulties compared with last year. Part of this increase can be explained by an increase in difficulties filling vacancies for senior managers/directors where reported recruitment difficulties have doubled compared to last year (10% to 19%). Retention challenges increased for the public sector (38% had no difficulties in 2012 compared with 49% in 2011). This was particularly true for managers and professionals, although as mentioned earlier this is also an issue in the private sector. Recruitment in the public sector is likely to remain subdued over the coming years as Departments continue to come under pressure to reduce their staffing numbers and costs.

Public and private sector earnings

2.30 Pay in the public sector continues to be, on average, above that of the private sector. A 2012 study by the Institute of Fiscal Studies estimated that the average difference between public and private sector pay in 2011 was 8.3%, controlling for the type and characteristic of employees[10].

Changes in average earnings

2.31 Regular pay (which is total pay excluding bonuses) growth for the whole economy fell from above 4 per cent in the years preceding the recession, to 1 per cent at the end of 2009.

2.32 Average private sector regular pay grew by 1.4 per cent in 2010 and although it has gained some strength in 2011 and at the beginning of 2012, with growth of around 2 per cent for the past year, it remains below its pre-recession average. In the public sector (excluding financial services) average regular pay growth was 2.3 percent in 2010 and 1.8 per cent in 2011.[11] The percentage of all employees reporting a pay freeze, as recorded in settlements data by IDS, has fallen from over 20 per cent of all employees in 2010 to 14 per cent in 2011. However, this remains high compared to a pre-recession average of around 1 per cent.[12]

2.33 The sharp drop in bonuses seen in 2009 put more downward pressure on total pay (pay including bonuses), with pay growth in the whole economy turning negative through the start of 2009. Growth in bonuses has been weak across broadly all private sector industries over the past few months (although construction and manufacturing have experienced stronger growth in the last quarter). Total private sector pay has recovered somewhat but remains weak, growing by just 2 per cent in 2010 and 2.5 per cent in 2011, compared to above 4 per cent prior to the recession. Public sector total pay grew by 2.1 per cent in 2010 but fell to 1.5 per cent in 2011.

2.34 Total public sector pay growth has been weaker since 2011, although it was higher before 2011. Table 2.6 sets out the differences in regular and total pay growth across years in the public and private sector.

[10] The IFS Green Budget, February 2012, http://www.ifs.org.uk/budgets/gb2012/gb2012.pdf
[11] Office for National Statistics, Average Weekly Earnings
[12] Income Data Services, Online pay settlements database.

Table 2.6: Regular pay (excluding Bonuses) and Total pay growth[13]

	Total Pay, annual growth			Regular pay, annual growth		
	All	**Private**	**Public[14]**	**All**	**Private**	**Public[14]**
2009	-0.1%	-1.0%	2.8%	1.7%	1.2%	3.0%
2010	2.3%	2.0%	2.1%	1.9%	1.4%	2.3%
2011	2.5%	2.5%	1.5%	2.0%	2.0%	1.8%
Three months to August 2012	1.7%	1.9%	2.4%	2.0%	2.1%	2.3%

2.35 Despite the pay freeze, average earnings in the public sector (as measured by the ONS) still display positive growth for a number of reasons: the provision of £250 to those earning £21,000 or less, upwards pay drift due to constrained recruitment, and the fact that some three year pay deals only ended in September 2011.

[13] Source: ONS, AWE; HMT calculations
[14] Public Sector excluding financial services

Public sector pensions

2.36 When considering changes to remuneration, it is important to consider the overall value of the public sector reward package. As set out above, pay in the public sector continues to be above that of the private sector on average. However, there are many reasons aside from pay that may drive an individual's decision as to whether they will work in the public or private sector.

2.37 One major factor in the overall reward package is pension provision. In the last few decades pension provision in the public and private sectors has diverged, in response to pressures around longevity, changes in the business environment and investment risk. This has led to a sharp decrease in the provision of defined benefit schemes. Around 85% of public sector employees are members of employer sponsored pension schemes, compared to only 35% in the private sector.

2.38 The interim report of the Independent Public Service Pensions Commission, chaired by Lord Hutton, was published on 7 October 2010. It said that there was a clear rationale for increasing member pension contributions to ensure a fairer distribution of costs between taxpayers and members. In response, SR 2010 set out an average 3.2 percentage point increase in contributions to be phased in progressively over three years from April 2012. However, the Government made clear that lower earners will be protected, proposing that there should be no increase in member contributions for those earning under £15,000, and no more than a 1.5 percentage point increase in total (before tax relief) for those earning up to £21,000. In April 2012, contributions increased by an average of 1.3 percentage points, and the Government will review the impact of the 2012-13 contribution increases, including the number of people opting out of pension schemes, before taking final decisions on how further increases will be delivered.

2.39 The Commission's final report was published on 10 March 2011. The Government accepted its recommendations as a basis for consultation, and on 2 November 2011 published '*Public Service Pensions: Good pensions that last'* that set out its preferred pension scheme design as the framework for further discussion with trades unions and member representatives. Agreements on all of the major public service schemes were reached in spring and summer 2012, and will be legislated for in the Autumn Public Service Pensions Bill. The new schemes will be introduced in 2015, and will remain amongst the very best available in the UK.

2.40 Putting together the evidence on pension provision and pay levels – and recognising that there will be significant variation between and within individual workforces – the overall remuneration of public sector employees is above that of the market. The Government is therefore clear that any changes to public service pensions, including the progressive increase in contributions from 2012-13, do not justify upward pressure on pay.

3 – NHS FINANCES

3.1 This chapter sets out the financial position for the NHS in 2013/14.

Funding growth

3.2 The NHS saw large increases in funding between 2000/01 and 2010/11, with an average real terms growth in revenue expenditure of 5.3% per year. Table 3.1 shows

- the NHS revenue figures from 2000/01 to 2010/11;
- forecasted revenue outturn for 2011/12; and
- the Revenue Departmental Expenditure Limits (RDEL)as agreed in the 2010 SR for the years 2012/13 to 2014/15 (SR 2010):

Table 3.1: NHS Revenue Since 2000/01

NHS Revenue Expenditure (£bn)	Cash Growth	NHS Revenue Expenditure (£bn)	Cash growth	Real growth
2000/01	Outturn	42.7		
2001/02	Outturn	47.3	10.8%	8.7%
2002/03	Outturn	51.9	9.8%	7.1%
2002/03	Outturn (rebased)	55.4		
2003/04	Outturn	61.9	11.7%	8.8%
2004/05	Outturn	66.9	8.1%	5.0%
2005/06	Outturn	74.2	10.9%	8.4%
2006/07	Outturn	78.5	5.8%	3.0%
2007/08	Outturn	86.4	10.1%	7.4%
2008/09	Outturn	90.7	5.0%	2.3%
2009/10	Outturn	97.8	7.8%	6.2%
2009/10	Outturn (aligned)	95.6		
2010/11	Outturn	98.9	3.4%	0.6%
2011/12	Estimated Outturn	101.5	2.7%	0.3%
2012/13	RDEL	105.5[4]	3.9%	1.1%
2013/14	RDEL	108.2	2.5%	0.0%
2014/15	RDEL	111.1	2.7%	0.2%

(1) Expenditure figures from 2000/01 to 2002/03 are on a Stage 1 resource budgeting basis.
(2) Expenditure figures from 2003/04 to 2008/09 are on a Stage 2 resource budgeting basis, this means cost of capital and cost of new provisions are included in the RDEL.
(3) Expenditure figures from 2010/11 are on an aligned basis. Aligned means that cost of capital is no longer included in RDEL and new provisions are included in Annually Managed Expenditure rather than RDEL.
(4) This includes the budget exchange that moved £250m of the SR settlement from 2011/12 to 2012/13.

Share of resource going to pay

3.3 Table 3.2 below shows the proportion of these funds that has been required or is available for pay. In particular, it shows the cash increases in the NHS revenue expenditure over the last eight years, and the proportion of the revenue expenditure increases consumed by paybill. This proportion is then analysed separately into:

- the proportion that went on price increases (that is, on wage increases); and

- the proportion that went on volume increases (that is, on employing extra staff).

Table 3.2: Increase In Revenue Expenditure And Proportion Consumed By Paybill

	Revenue increase (cash) (£bn)	Paybill increase (cash) (£bn)	% of revenue increase on paybill	% of revenue increase on paybill prices	% of revenue increase on paybill volume
2001/02	4.6	2.4	51.4%	31.6%	19.8%
2002/03	4.6	2.4	51.1%	25.1%	26.0%
2003/04	6.5	2.6	40.9%	20.7%	20.1%
2004/05	5.0	4.5	90.6%	65.1%	25.4%
2005/06	7.3	2.5	34.4%	20.4%	14.1%
2006/07	4.3	1.3	30.2%	42.1%	-11.9%
2007/08	7.9	1.3	16.3%	18.5%	-2.1%
2008/09	4.4	2.5	57.3%	38.3%	19.0%
2009/10	7.1	2.8	39.5%	14.7%	24.8%
2010/11	3.3	1.5	45.4%	32.9%	12.5%
2011/12	2.7(1)	-0.2	-6.7%	18.3%	-24.9%
Average	5.5	2.4	45.7%	29.8%	11.1%

(1): Provisional out-turn.

The NHS paybill

3.4 Between 2000/01 and 2011/12, increases in paybill prices have on average accounted for 29.8% of the cash increases in NHS revenue expenditure. In 2011/12, despite the pay freeze and a reduction in paybill volume increases of 24.9% due primarily to reductions in non clinical staff numbers, increases in paybill prices still accounted for a revenue increase of 18.3%.

3.5 Pay is the most significant cost pressure, accounting for more than 40% of NHS revenue expenditure and from 2001/02 to 2011/12 accounted for 45% of the increases in revenue. As pay represents such a large proportion of the NHS budget, managing the paybill is key to ensuring that the NHS is able to cope with the future slow-down in funding growth.

Pressures on NHS funding growth

3.6 Different priorities compete for shares of the DH's cash limited funding. These spending pressures are normally analysed in three broad areas:

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

3.7 Baseline pressures cover the costs of meeting existing commitments that are essential for the NHS: they do not cover additional and new activity. Baseline pressures are the first call on NHS resources. The Hospital and Community Health Services (HCHS) paybill (including pay settlement) forms a significant part of these baseline pressures, along with prescribing (in primary care and hospitals) and primary care services.

3.8 Underlying demand is pressure due to general growth in activity levels. For example, demand has grown on average by 2.7% p.a. over the last 10 years.

3.9 Service development covers the cost of policy and manifesto commitments to improve quality. Service developments over the current SR period include:

- the cancer drugs fund (£600m total over the course of the SR);
- the commitment to commission an additional 4,200 sure start health visitors (£577m total over the course of the SR and £172m annual recurrent cost after the SR period);
- expanding access to talking therapies (£433m total cost over the course of the SR and £141m annual recurrent cost post SR).

Allocation of resources in past SRs

3.10 Table 2.3 shows how increases in revenue (RDEL) in past SRs have been deployed across these different components. Approximately 35% has been deployed to higher pay (rows 4 & 10) and 48% to activity growth and service developments (rows 2, 3 & 12). In the past, non-pay baseline pressures have consumed less than 20% of available resources.

3.11 However, despite the fact that the NHS has received a better SR settlement than many other parts of the public sector, including a guarantee of real terms increases in health spending for each year of the current parliament, NHS resources will be under considerable pressure in 2013/14. Table 3.3 also shows (row 1) that the increase in cash resources available in 2013/14 is 60% less than in years covered by previous SRs. In the last 3 SRs there were annual increases in resource of £6-8bn, in 2013/14 there is only an extra £3bn of resources available.

3.12 The final column in Table 3.3 illustrates what this is likely to mean in practice. In particular, it shows how the SR2010 settlement for 2013/14 might be distributed under a “do nothing” scenario if we assume that:

- pay drift is 1.6% p.a. (the historic average); and
- there is an average 1% pay settlement.

Table 3.3: Disposition or Revenue Increase Across Expenditure Components

Row	Component of Expenditure	SR2002 £bn	SR2004 £bn	CSR2007 £bn	Indicative disposition in 13-14 £bn
1	Average annual increase in revenue (£bn)[1]	7.9	7.2	5.7	2.7
2	Activity Growth[2]	0.8	2.9	1.1	0.8
3	Productivity[3]	0.7	-0.3	-0.3	-1.1
4	Service Developments	1.5	1.6	1.7	0.03
5	Hospital and Community Services Pay (Price only Component)	2.3	1.7	2.0	1.3
6	Secondary Care Drugs	0.3	0.3	0.4	0.6
7	EEA Medical Costs, Welfare Food & NHS Litigation	0.2	0.3	0.1	0.1
8	Primary Care Drugs	0.4	0.3	0.3	0.4
9	General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.2	0
10	Prices	0.1	0.1	0.1	0.1
11	General Medical Services	1.3	0.1	0.2	0.3
12	Funding for Social Care[3]				0.2

(1) Average growth over each SR period in 2013/14 prices.

(2) In the past activity growth and service development has driven workforce growth. Under do nothing scenario , presented here it assumes the discretionary spend grows at a much lower rate and much larger levels of productivity will be required

(3) The productivity figures represent the money that was saved/spent as a result of changes in productivity ie a negative figure represents an increase in productivity.

(4) The NHS will make funding available to be spent on measures to support social care which also benefit health. This funding is £137m in 2013/14 including reablement, designed to help people stay independent as long as possible

3.13 The indicative disposition for 2013/14 shows the difficulties that arise with lower levels of resources available in 2013/14. The forecast growth in non-discretionary, baseline pressures at rows 5, 6, 7, 8 & 9 and increased support to social care consume the majority of extra resources available. This leaves just £1bn (37%) of the extra resources available for pay increases, activity growth and service developments.

3.14 Even with 1% settlement and1.6 percentage drift[16] (the long run historic average), pay increases consume approximately £1.1bn of extra resources. So to deliver even moderate increases in activity of £0.7bn (compared to a previous average of £1bn) and £0.5bn spend on service development (compared to a previous average of £1.6bn) the NHS would need to deliver £1.2bn of productivity savings (much higher than that delivered in the recent SRs).

3.15 Any extra increases in pay over the 1% level would increase this already considerable productivity challenge. A 1% increase for all NHS HCHS staff itself represents a cost pressure of around £430m.

3.16 The DH has introduced the QIPP agenda to deliver higher productivity, procure savings and reduce management costs to release resources for activity growth and service improvements. However, the higher the level of pay growth the more difficult the balance between staff numbers, productivity and service delivery becomes. In a nutshell, the higher the levels of pay the fewer staff will be employed and more productivity improvement is required to meet patient demand.

Conclusion

3.17 The funding available to the NHS is fixed and extremely tight compared with the recent past (as shown above in Table 2.1). In such circumstances, increases in pay will reduce the funds available for service developments and activity growth and reduce the derived demand for staff.

3.18 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 (EEA) medical costs and litigation means the continuation of pay drift and pay growth of 1% is likely to put considerable pressure on staffing levels. The DH has delivered ambitious reductions in the number of managers and administration staff, primarily in SHAs and PCTs to protect front-line services but reductions in clinical posts cannot be ruled out.

4 - QIPP (Quality, Innovation, Productivity & Prevention)

The quality and productivity challenge

4.1 The Government has protected the NHS in the SR settlement, with cash funding growth of £12.5 bn by 2014–15. However, the NHS needs to make up to £20bn of recurrent efficiency savings by 2014–15 to meet additional demands on services from an ageing population and to be able to continue to invest in new technologies and new drugs.

4.2 Of the £20bn, the 10 SHA Integrated Plans have identified £17.4bn of efficiency savings. DH will also contribute £1.5bn of savings from central DH and ALBs' budgets bringing the total savings identified across the health system to £18.9bn. This total is based on assumptions about costs pressures and will continue to be refined and updated between now and 2015.

4.3 These challenges are unlikely to come to an end in 2015. Budget 2012 plans show that reductions in overall departmental spending will continue in 2015/16 and 2016/17. Although detailed plans for departmental spending including DH's budget have not yet been set, this suggests that QIPP is no longer just a strategy for managing the NHS up to 2015. It may be fundamental to the way we manage the service for the foreseeable future.

The response to the challenge

4.4 The local NHS is best placed to identify the scale of the financial challenge they face over the next four years and the opportunities for making savings whilst driving up or maintaining quality. Each local health economy is currently working towards their own vision of how they can transform their local health system by 2015, so they can meet the efficiency savings targets while continuing to provide quality care to their populations.

Progress to date:

4.5 In the first full year of delivery, the NHS has delivered strongly, with efficiency savings of £5.8bn reported in 2011/12.[15]

4.6 At the same time, key quality and access ambitions have been maintained or improved:

- infection rates at their lowest since mandatory surveillance was introduced;
- lowest ever level of patients waiting more than 18 weeks for their treatment and both standards met each month;
- all ambulance trusts meeting their category A8 performance measure for the first time since Call Connect was introduced;
- performance measures on A&E, cancer care, dentistry, waiting times – all met.

[15] Department of Health (2012) *The Year: NHS Chief Executive Annual Report 2011/12 at http://www.dh.gov.uk/health/files/2012/06/the-year-and-quarter-4-210612-gw-17802-PDF-2.33MB.pdf*

Maintaining performance

4.7 The NHS's strong performance in 2011/12 provides firm foundations for sustained delivery over the next three years, as the NHS continues to face ongoing challenges from rising demands in a funding-constrained environment.

Next Steps:

The need for transformational change

4.8 Delivering transformational change through clinical service redesign will play a significant role in helping the NHS to deliver a high quality sustainable service.

4.9 In 2011/12, QIPP savings were weighted towards central actions, including pay and administrative cost reductions and local efficiency programmes. In 2012/13, the NHS needs to build on the progress made in delivering efficient organisations and, through reinvestment of efficiencies made in 2011/12, to start to deliver transformational change whilst maintaining the gains already made.

4.10 The Government has been clear that savings from transformational change will be weighted towards the later years of the SR to ensure that appropriate clinical leadership and local engagement takes place.

4.11 **Annex D** provides an overview of the QIPP lifecycle and key steps that the NHS will take up until 2014-15.

5 – Medical Workforce Policy Context

Workforce development

5.1 The Government values the important role played by all NHS staff in delivering high quality services and has committed through NHS Constitution pledges to ensure that they have access to appropriate training and development. In particular, the pledges said that staff should have:

- "….clear roles and responsibilities and rewarding jobs…that make a difference to patients, their families and carers and communities;
- "…personal development, access to appropriate training for their jobs and line management support to succeed.

5.2 To support this, the Government is committed to ensuring a world class healthcare education and training system underpinned by robust workforce planning led by employers who are responsible for the provision of NHS commissioned services.

5.3 It therefore published a policy framework for a new approach to education and training on 10 January 2012 – "*Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*[16]". This followed extensive consultation through 2011, including two reviews led by the NHS Future Forum.

5.4 The aim is to empower healthcare employers and national and local clinical leaders to take the leading role in planning the workforce and commissioning education and training.

Education and training reforms

5.5 Changes to the structure of DH and the NHS, outlined in '*Equity and Excellence: Liberating the NHS*' and the subsequent Health and Social Care Bill, can only be fully realised if healthcare providers employ staff with the skills required to deliver a high quality service to patients in every circumstance.

5.6 The approach to achieving this requirement is defined in "*Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*". This sets out a vision for a new framework where healthcare providers take a lead role in the planning and development of their workforce. Under the framework healthcare providers will work collaboratively, forming LETBs overseen by HEE. The realisation of this new framework is the overall objective of the Education and Training Reform Programme.

5.7 The vision for the programme, as confirmed by the Secretary of State for Health on 14 November 2011, is provision of a health education and training system that:

- ensures greater accountability for providers to plan and develop their workforce, whilst being professionally informed and underpinned by strong academic links;
- supports NHS values and behaviours to provide person-centred care;

[16] http://www.dh.gsi.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076

- supports the development of the whole workforce, within a multi-professional and UK-wide context;
- supports innovation, research and quality improvement;
- provides greater transparency, fairness and efficiency to the investment made in education and training; and
- reflects the explicit duty of the Secretary of State to secure an effective system for education and training.

5.8 This needs to be achieved in the context of wider healthcare reform. The overall objective of the programme is to achieve the above vision and to deliver a system for health education and training that meets the requirements of "*Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*".

National Leadership – Health Education England

5.9 HEE is the new national leadership body for education, training and the development of the health workforce. HEE was established from June 2012 and became a shadow SpHA in October 2012; it will take on full responsibility from April 2013. HEE will:

- place providers of NHS services firmly in the driving seat to plan and develop the workforce, within a coherent national framework and to consistent standards;
- ensure that staff are available with the right skills and knowledge, at the right time, and that the shape and structure of the workforce evolves to meet changing needs;
- provide a clear focus on the entire healthcare education and training system, and ensure greater accountability against service improvements;
- ensure that investments made in education and training are transparent, fair and efficient, and achieve good value for money.

5.10 HEE took on the roles and responsibilities of Medical Education England (MEE) from 30 September at which point MEE ceased to exist.

5.11 HEE's Chair, Chief Executive and Non-Executive Directors have been appointed. 'Introducing HEE' has been published[17] to explain its role.

5.12 In 2012/13 HEE will focus on securing a safe transition to the new system and start to take forward the key education and training priorities set out in *From Design to Delivery*. The high level objectives for HEE in this transitional year are:

- building organisational capacity and capability, including strong governance and financial control;

[17] (http://www.hee.nhs.uk/2012/06/22/introduction/

- establishing the education and training landscape;
- developing excellent relationships and partnerships; and
- setting the strategic education outcomes and priorities for 2013/14.

Local workforce planning – LETBs

5.13 HEE will work closely with employers through newly established Local Education and Training Boards (LETBs) who will be responsible for commissioning and funding the education and training required by local health economies. The purpose of LETBs is to:

- identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services;
- plan and commission education and training on behalf of local health communities in the interests of sustainable, high quality service provision and health improvement;
- be a forum for developing the whole health and public health workforce.

5.14 LETB operating principles have been published[18] committing the NHS to greater local autonomy. Arrangements to support LETBs through the authorisation process, which starts from October 2012, have been published[19].

5.15 One of the first priorities for LETBs will be the development of workforce planning models, over a minimum 5 year period in the first instance, that create a clear picture of service demand for different healthcare groups, including the primary care workforce and GMPs. It is anticipated that LETBs will begin to make projections on the basis of patterns of workforce retention and retirement and also the likely future service needs of the population they serve. This work has already begun in some LETB areas and others will follow shortly.

5.16 This is a major change from past attempts at medical workforce planning which have largely been nationally and supply side driven. It is clear that this has to be the direction of travel if we are to ensure that, locally and nationally, there is an adequate workforce to ensure comprehensive patient services in future. This is especially the case in general practice where the majority of GMP trainees commence employment in an established practice a relatively short distance from where they trained.

The Centre for Workforce Intelligence

5.17 The Centre for Workforce Intelligence (CfWI) is the national authority on workforce planning and development, providing advice and information on the NHS and social care system.

5.18 CfWI aims to provide an accessible route to NHS and social care planners, clinicians and commissioners seeking workforce planning and development expertise to improve NHS and social care services. It supports long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis.

[18] (http://www.uclpartners.com/lotus/wp-content/uploads/2012/06/NCEL1240-LETB-Guidance-to-the-Operating-Principles)
[19] http://www.hee.nhs.uk/category/publications/letb-guidance/

5.19 CfWI focuses on three key, strategic areas, by providing:

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

Assuring the safety and quality of changes in the size and shape of the workforce

5.20 Local healthcare organisations, with their knowledge of the patients that they serve, are best placed to plan and deliver a workforce appropriate to the needs of their patients, based on clinical need and sound evidence.

5.21 Consequently, there will always be local and regional variations. The main variations are likely to involve skill mix, service re-design and moving services into the community. Each region has a slightly different timescale for these changes, as they need to happen when it is right for the local community.

5.22 Where changes are planned to the size and shape of the workforce, local healthcare organisations must provide assurance that the safety and quality of patient care is maintained or improved.

5.23 A new safety and quality assurance process has, therefore, been developed to ensure that any significant change proposed in the clinical workforce has involved clinicians at all levels, maximising on their engagement, leadership and sign off.

5.24 The Government also expects the NHS to protect front line services. Where there are reductions in the clinical workforce, this should be achieved mainly through natural turnover. Every effort should be made to secure suitable alternative employment for staff affected by such changes and to consider compulsory redundancy only as a last resort. We also expect the NHS to ensure that good progress is made in areas that can relieve the pressure on the pay bill, such as reducing sickness absence and agency spend.

Workforce information

5.25 Workforce planning in a more diverse NHS will require continued access to Workforce Information to enable HEE, LETBs and CfWI to fulfil their roles. To ensure the necessary information is available we have established a workstream to set out the future Workforce Information Architecture (WIA).

5.26 The WIA workstream is part of the DH's Education and Training transition programme and is made up of three projects:

- project 1 :– 'Information' (Minimum Data Set) aims to identify what workforce information is needed, and by whom;

- project 2: – 'Systems and Processes' aims to develop the processes by which this information is collected and flows around the new system;

- project 3: - Defining the future role of the CfWI.

5.27 The benefit of the completed projects will be a fit for purpose WIA that will enable effective workforce planning and education commissioning at national, sub-national and locally in line with '*Liberating the NHS'*.

The impact of tuition fees on workforce planning

5.28 The Government is committed to ensuring the future supply of the medical and dental workforce.

5.29 From 2012, universities will be able to charge students up to £9,000 in tuition fees and this could particularly impact on medical and dental students because of the length of their training and the split responsibility for funding between DH and the Department of Business, Innovation and Skills (BIS).

5.30 Both departments are committed to agreeing a suitable long-term solution to the funding of medical and dental tuitions fees.

5.31 We have agreed interim arrangements to support medical and dental students with their tuition fees in the later years of their courses to provide clarity to prospective students. These arrangements are set out below:

- undergraduates on the five/six year medical and dental programme :

    - in years 1 to 4, eligible students will receive a loan from the Student Loans Company to cover the full cost of tuition fees;
    - from the fifth year of study, the NHS Bursary will pay eligible students' tuition fees up to £9,000.

- graduates on the four year accelerated programme:

    - In their first year of study, graduate students will have to fund the first £3,465 of tuition fees themselves. Eligible students will have access to a Student Finance England loan of up to £5,535 to cover the remainder tuition fees;

    - from their second year of study, the NHS Bursary will cover the first £3,465 of tuition fees. Eligible students will have access to a loan of up to £5,535 from Student Finance England for their remaining tuition fees.

5.32 In 2014/15, the level of tuition cost met by the student in the first year and by the NHS Bursary from year two may have to increase to cover any (inflationary) rise in tuition fees.

Challenges

A&E Shortages

5.33 There is a recurring issue in the recruitment and retention of doctors in Emergency Medicine at ST4. The Emergency Medicine Taskforce was established in January 2011 to work collaboratively with the service and education establishments to provide recommendations on appropriate multi-professional staffing of departments and offer solutions to Emergency Medicine (EM) trainee recruitment, progression and retention challenges. The Taskforce is currently considering a number of important recommendations designed to improve the working conditions and staff experience in accident and emergency departments (A&Es) which should improve the attractiveness of the specialty, thereby improving recruitment and retention of EM staff. LETBs will in the future operationalise the recommendations from the Taskforce.

5.34 In addition, there is ongoing work to use more GMPs in A&Es to manage minor injuries and illness, which enables emergency medicine practitioners to attend to cases needing their more specific skills. We are also developing enhanced non-medical roles. Enhanced nursing roles in particular have major potential as they allow a greater proportion of patients to be seen by skilled practitioners with non-medical backgrounds.

5.35 All of these measures must sit alongside the development of emergency services networks so that medical staff adequately provide cover for A&Es without duplicating services that can be more appropriately delivered elsewhere.

GMP training

5.36 DH is committed to continuing to move towards a 50:50 split between GMP and hospital specialty training. This will require an increase in numbers of GMP trainees and a reduction in some hospital specialties. The change is being informed by the work of CfWI and will take place over a number of years.

Improving data on vacancies

5.37 The DH has led the Fundamental Review of Data Returns and is due to publish its response later this year to the public consultation which took place between 30 August and 22 November 2011. The NHSIC responded to the feedback from the Fundamental Review consultation and proposed, in collaboration with DH, that existing vacancy surveys should be stopped given concerns about their reliability. The broad conclusions of the DH and NHSIC are that the vacancy surveys only offer a proxy for the national picture, can be of poor quality due to low response rates and only reflect one point in time. As an interim, DH and NHSIC have considered alternative data sources for vacancy data, however on reflection it was decided that none of these would provide robust data on vacancies.

5.38 Subject to the outcome of the Fundamental Review, it is expected that vacancy surveys will end and the Fundamental Review will offer a steer about how vacancy data can be improved to offer better support to workforce planning by providing a better balance of information at national and local level. In particular the NHSIC continues to investigate using the new NHS Jobs website to provide some substitute figures on vacancies, and will

aim to source the NHS vacancy information from this new administrative system which is due to be implemented in December 2012, with vacancy information available shortly afterwards. This is expected to allow NHS vacancy figures to be collected for 2013.

5.39 The new NHS Jobs service is able to provide data covering adverts for posts within the NHS at any point although the available data is a proxy for vacancies because, for example, not all employers use NHS Jobs. It must be noted that this information should not be compared directly with earlier vacancy survey information and represents only those posts that have been advertised. Advertisements may be placed for multiple posts (and would therefore only count as one advert), they may be placed for roles not previously considered vacancies or vacant posts may not be advertised.

6 – EMPLOYED DOCTORS AND DENTISTS

6.1 In this Chapter, we update DDRB on policy developments aimed at ensuring the appropriate recruitment and retention of employed doctors and dentists.

Context

6.2 Since this Government came to office, the overall number of doctors providing NHS care increased by 1.4% from 132,879 (2010) to 134,713 (2011) including:

- an increase of 3.3% (the highest of any group) in the number of consultants from 35,781 (2010) to 36,965 (2011);
- an increase of 1.2% in the number of doctors in training (registrars and others in training and equivalents) from 51,396 (2010) to 51,994 (2011).

6.3 Whilst we have experienced difficulties recruiting in some specialties (accident and emergency, obstetrics and gynaecology, anaesthetics, paediatrics and psychology) we had no general difficulty expanding the medical workforce from 2006 to 2010.

6.4 Since the current Government took office in 2010, post-graduate medical and dental training places have remained broadly stable with 6,800 posts in 2010 and 6,700 in both 2011 and 2012. Our main focus has been concentrated on rebalancing the number of doctors working in the hospital and community services towards an annual 50:50 split at entry to general practice or hospital specialty training.

6.5 The DH and the Higher Education Funding Council for England (HEFCE) has commissioned a review of medical and dental student intakes in England that is being informed by a comprehensive project undertaken by CfWI. The CfWI work has involved considerable stakeholder engagement to "horizon scan" and develop possible future scenarios. These have then been modelled to illustrate the workforce implications. The results of the review will be available to inform recruitment to medical school courses commencing in 2013.

6.6 The following provides updates on key policy developments.

Doctors And Dentists In Training

Entry to training

6.7 There continues to be evidence of good recruitment into medicine. We are acting to ensure that supply meets demand, 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.

6.8 DH and HEFCE have commissioned the Health and Education National Strategic Exchange to review the total number of undergraduate medical and dental students intake in England. Recommendations will be made so that decisions can be taken to determine the intake to medical and dental schools in England in 2013/14 and beyond.

Recommendations of the review have been received and are being considered by the Government.

Recruitment to postgraduate medical and dental training

6.9 In general recruitment to postgraduate medical and dental training 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 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% for August 2011. In total there are approximately 9000 core and specialty training posts at all levels with 18,000 applicants. In England there were over 6500 Foundation Programme places, with over 7500 applicants.

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

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

6.12 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.

6.13 The role and functions of the Postgraduate Deaneries will continue to be a key component in the effective planning and provision of high quality medical education.

6.14 From April 2013, responsibility for postgraduate medical and dental training will lie with HEE and LETBs whose roles and functions were described in the previous chapter.

Better Training Better Care

6.15 Medical Education England (MEE) was asked by the Secretary of State to implement the recommendations from Sir John Temple's Review entitled "*Time for Training*"[20] and developed a programme called *Better Training Better Care*[21] 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 EWTD; and specifically addressing the issues surrounding lack of appropriate supervision and trainees working beyond their competence.

6.16 An update on this is attached at **Annex E.**

[20] (http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web20Version.pdf

[21] (http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care.aspx),

The European Working Time Directive

6.17 The DDRB will recall that the 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 EWTD.

6.18 In September 2009, the European Commission announced its commitment to reviewing the EWTD, 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. Following the consultation, the EU Social Partners wrote to the European Commission in November 2011 confirming they are exercising their right under the EU treaties to open negotiations to amend the EWTD. Negotiations commenced in December 2011 and, from that point, the social partners were given nine months (until September 2012) in which to reach an agreement and to put forward proposed changes to the EWTD. (The EU Social Partners may apply for an extension of the deadline until December 2012 which the European Council may be inclined to grant). If social partners reach an agreement, it would be submitted to the European Council for approval.

6.19 However, if the social partner negotiations prove unsuccessful, any proposals to change the EWTD would revert to the Commission. Negotiations would then start in Council and in the European Parliament.

6.20 The Government is committed to limiting the application of the EWTD 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 BIS are working together on the application of the EWTD to the UK healthcare sector. However, the EU Social Partner process is autonomous, and operates independently of the Commission and Council. Therefore, the Government has no formal role in any EU Social Partner negotiations. The Government will continue to keep in close contact with the UK representatives to the EU Social Partners with the aim of retaining the opt-out and securing additional flexibilities with regard to the treatment of on-call time and compensatory rest.

Consultants

Review Of compensation levels and incentives for NHS consultants

6.21 UK Health Ministers have been considering carefully the DDRB's review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants, and expect to publish the report shortly.

6.22 In the meantime, Ministers gave the go-ahead for new award rounds at National and Local Level in 2012. There will be 300 new national awards and results are expected to be announced in March 2013, with awards back dated to 1 April 2012. For local awards the recommended investment criterion is unchanged at 0.20 per eligible consultant. The decision to have new awards in 2012 underlines the Government's commitment to rewarding the most excellent consultants for their achievements for the NHS. A decision about awards in 2013 will be made in due course.

Consultant contract

6.23 The National Audit Office (NAO) is undertaking work to examine the effectiveness of the 2003 Consultant Contract and whether it is delivering the intended benefits. We understand that the NAO's report is likely to be published in December.

Specialty Doctors And Associate Specialists (SAS Doctors)

Credentialing

6.24 Credentialing is a way of formally recognising capabilities at defined points of the medical career. Currently the only recognition is the completion of training to be registered as a fully qualified consultant or GMP. The General Medical Council (GMC) is taking forward work to consider the concept of credentialing within medical education and careers.

Certificates of eligibility for specialist registration

6.25 The GMC (and formerly the Post Graduate Medical Education and Training Board (PMETB)) data show 61% (3437 out of 5498) 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 assessed individually and decisions based on merit.

6.26 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 GMP or consultant post".

6.27 As requested by the DDRB, DH noted the concern that there may be discrimination against doctors that have pursued the CESR route. DH has not seen evidence to support this concern, but contributed to the GMC Review of the Equivalence Routes to GMP and Specialist Registration, theme 3 of which was:

> "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."

6.28 The GMC completed its review in January 2012 and produced a report[22] which they published for consultation between March and June 2012. The outcomes from the consultation were considered by the GMC at its meeting in September and all the recommendations were accepted. These were that:

[22] http://www.gmc-uk.org/07___Report_on_the_Consultation_on_the_Routes_to_GP.pdf_49969059.pdf

- prospective applicants for the equivalence routes must have practised in the UK as a licensed doctor for at least 12 months in the three years prior to the application;

- tests of specialist knowledge should be a mandatory element of the new model for evaluating equivalence applications;

- individuals of high international renown and proven expertise in their field should not be required to undergo acclimatisation or evaluation of their performance in practice as a pre-requisite to specialist registration and should instead be assessed on the basis of documentary evidence of their credentials (paragraphs 19-24).

New contractual arrangements

6.29 A condition of the Government agreeing new contracts, with associated funding, for SAS Doctors, was that DH would monitor the costs against the investment.

6.30 Funding to meet the costs of the new contract was invested over 2008/09 and 2009/10, becoming recurrent thereafter, and was 10% of the pay bill for SAS staff. By August 2009, 65% of eligible doctors had transferred and we undertook detailed work, which suggested that the additional costs for these doctors were 9.8% of basic earnings, 9.36% of total earnings.

6.31 The Government was satisfied that this analysis suggested that the cost modelling that underpinned the contract proposals was robust and that the contracts were being implemented as intended.

6.32 It is not our intention to undertake further analysis. Moving to the new contracts was optional; and, in our evidence last year, we reported that there had not been a significant change to the number of doctors who had transferred. We would not expect to see any significant difference in the costs if any of the remainder of eligible doctors chose to transfer. No party has raised any concerns regarding implementation or costs.

7 – DENTISTS

Salaried primary dental care dentists

7.1 There are over 1,100 salaried dentists (latest headcount: NHSIC 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 may also work in Dental Access Centres. As part of implementation of the Department's Transforming Community Health Services initiative, these dentists are now employed by a range of different organisations include Social Enterprises, Community Trusts and acute NHS Trusts. These dentists are an important and valued part of the overall dental workforce, whose services will be commissioned by the NHSCB.

7.2 Following the decision of the GDC 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.

Dental public health staff

7.3 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 2012 under the title *Improving oral health and dental outcomes: Developing the dental public health workforce in England*[23]. The review shows how dental public health staff can improve oral health, reduce oral health inequalities, ensure patient safety and improve quality in dentistry. These staff will transfer to PHE where there will need to be a further review of functions and numbers of posts.

[23] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance?DH_114488

8 - OPHTHALMIC MEDICAL PRACTITIONERS

Summary

8.1 The Government remains firmly of the view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out over 99.8% of NHS sight tests. Discussions are to take place with representatives of the professions on the implementation of government pay policy.

Background

8.2 Between 31 December 2010 and 31 December 2011, the number of OMPs who were authorised by PCTs in England and the number in Local Health Boards (LHBs) in Wales to carry out NHS sight tests decreased from 346 to 336, and the number of optometrists increased from 10,819 to 11,238 an increase of 3.9%. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

8.3 In 2011/12, 13.07m sight tests were paid for by PCTs in England and LHBs in Wales. This was 3.1% more than in 2010/11. Within these figures, the proportion of sight tests carried out by OMPs was 0.2% in 2011/12.

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 Act 2012 has proposed that commissioning of the NHS sight testing service in England should in future, following the abolition of PCTs, be the responsibility of the NHSCB.

9 – NHS PENSIONS AND TOTAL REWARD

Introduction

9.1 This updates the DDRB on progress with pensions reform since the information we provided last year.

9.2 As a result of improving life expectancy, the cost of pensions has increased by a third over the last 50 years. For example, a 60 year old doctor retiring today can now expect to enjoy 29 years of retirement. This is in contrast to a doctor retiring at 60 in 1984 who could only expect to live for 20 years in retirement with these additional costs mainly falling to the taxpayer.

9.3 The Government's reforms will ensure public sector pensions are more sustainable, affordable and fairer to both public sector workers and other taxpayers.

9.4 The new pension arrangements will continue to provide a generous pension to doctors and dentists and remain some of the best available anywhere, for example, an inflation-proof pension of £68,000 a year would require a pension of pot of nearly £2 million in the private sector.

The NHS Pension Choice Exercise

9.5 The Pension Choice exercise ended on the 31 March 2012. In total there are now around 400,000 staff on the 2008 arrangements – which includes all new starters and 4% of staff who made the decision through Choice to move from the 1995 scheme.

Increases in pension contributions

9.6 In 2011, the Government announced its plans to increase contribution rates for the scheme members by an average of around 3.2% by April 2015 for all public sector schemes including the NHS Pension Scheme (NHSPS). These increases will be staged over 3 years. These changes reflect the fact that the taxpayer has largely paid for the increased cost of pensions due to increased life expectancy. The Government believes it is right that there should be a fairer distribution of costs between employees and employers. A consultation in relation to year 1 changes took place and concluded in early 2012 following which the changes were effective from April 2012.

9.7 These increases in contributions followed the HMT principles that included:

- protecting the lower paid;
- recognising that higher earners should pay higher contribution rates given the higher level of benefits they receive in final salary arrangements;
- protection for those staff earning less than £15,000 a year;

- those in post on 1 April 2012 and with 10 years or less to go until their Normal Retirement Age (NPA) will not have to move onto the new scheme;

- transitional arrangements for those in post on 1 April 2012 with more than 10 and up to 14.5 years until their NPA.

9.8 Discussions on contribution rates for years 2 and 3 are continuing with the NHSPS Governance Group based on the available opt-out data. These will be subject to formal consultation in due course. However a proposal for years 2 and 3 was included as part of the consultation on the Hutton reform proposals and is attached at **Annex F** for information.

Review of the Public Service Pension Schemes

9.9 In last year's update, we referred to the Government's establishment of an Independent Public Services Pensions Commission (IPSPC), led by Lord Hutton of Furness which made 27 recommendations. These are outlined at **Annex G.**

9.10 Key areas of importance to NHS staff are changes relating to the move to a career average scheme as oppose to final salary and the shift linking Normal Pension Age (NPA) and State Pension Age (SPA). In other respects, the new scheme looks very similar to the 2008 scheme with ill health retirement benefits, partner, spouses and dependent children's pensions on the death of the member and death in service benefits remaining unchanged. There will also be retirement flexibilities enabling staff to take their pension and continue working and being members of the scheme allowing, for a flexible approach to mixing work and other commitments in the run up to retirement

Progress toward implementation of Hutton Reforms

9.11 In March 2012, NHS trade unions shared a proposed final agreement. On 4 July 2012, the CST confirmed to the House of Commons that the Government will take forward legislation to implement NHSPS reforms. The reforms will be based on the proposed final agreement reached with the NHS Trades Unions on the design for a new NHSPS, effective from 2015. The publication of the proposed final agreement[24] followed extensive discussions with NHS Trades Unions. The main parameters of the proposed new NHSPS are set out in **Annex H.**

9.12 The proposed 2015 NHSPS is still one of the best available – a table which compares it with the 1995 and 2008 schemes is at **Annex I.**

9.13 In 4 July 2012, the CST confirmed to the House of Commons that the Government will be taking forward legislation to implement reform to the NHSPS. The reforms will be based on the proposed final agreement reached with the NHS Trades Unions on the design for the NHSPS from 2015. The publication of the proposed final agreement followed extensive discussions that took place with the NHS Trades Unions for over a year. Full details are available on the DH website at www.dh.gov.uk/pensions.

[24] http://www.dh.gsi.gov.uk/pensions

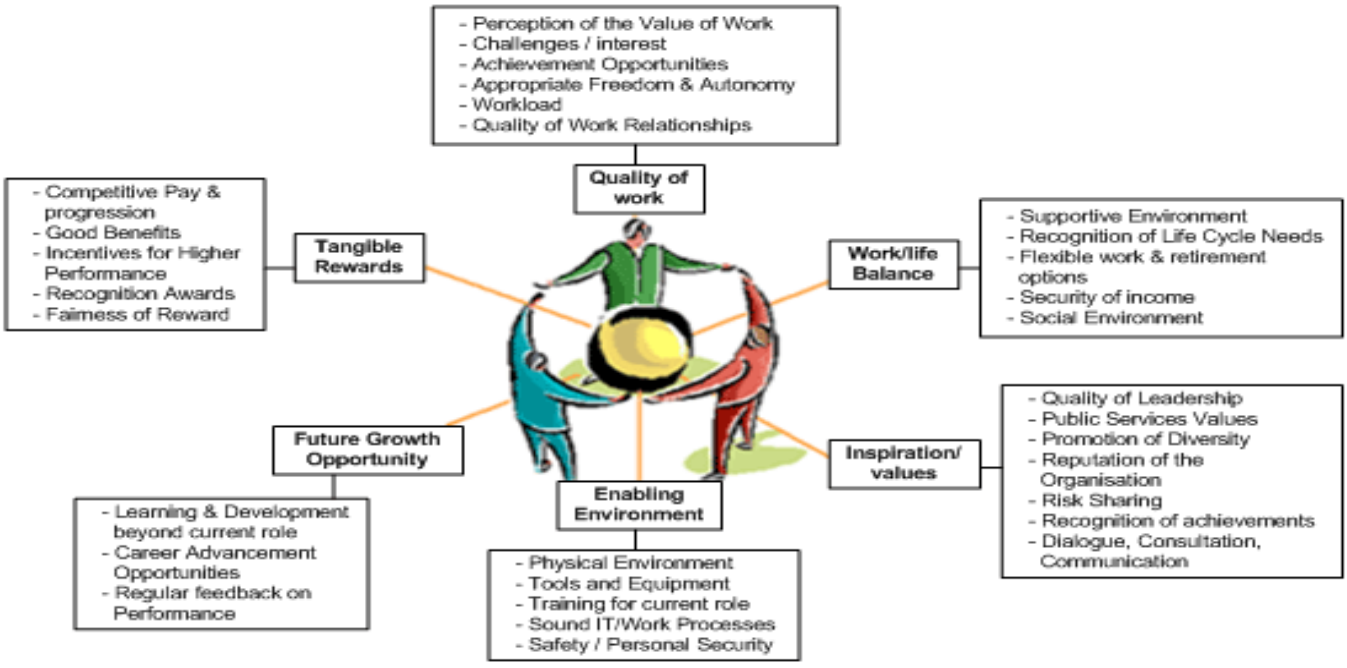
Review into working longer

9.14 The NHSPS Proposed Final Agreement includes the provision that for pension accruals post 2015, the NPA should be set equal to the SPA. The tripartite "Working Longer" review between the DH, NHSE and the trade unions will seek to address the impact of working longer in the NHS, with particular reference to staff working on the frontline and those working in physically demanding roles, including the emergency services. The first meeting of the review group took place in September 2012.

Total Reward

9.15 Total Reward is both the tangible and intangible benefits that an employer offers an employee: the financial benefits e.g. pay, pension, life assurance, and the non-financial benefits e.g. training, career development opportunities, culture and working environment. As NHSE said in their recent briefing for staff[25], it is a means of explaining to employees the total value of their employment packages.

9.16 The DH has used the following model which was developed by the Hay Group for the Cabinet Office (IES Report, 2011[26]) as the basis for developing our approach to total reward in the NHS:



9.17 The DH's vision for Total Reward within the context of continued pay restraint and fiscal consolidation is one in which NHS organisations have the appropriate capability and capacity to:

- fully utilise the NHS employment package in order to recruit and retain the staff they need;

[25] http://www.nhsemployers.org/Aboutus/Publications/Documents/Total_reward_101111.pdf
[26] http://www.cipd.co.uk/NR/rdonlyres/03655B02-FDB6-4D18-ADFD-7D5A4399C72C/O/TotalReward-HayGroup.pdf

- implement local reward strategies that are aligned with their organisational objectives and meet the needs of their workforce;

- ensure employees understand the full value of their total reward package (the tangible and intangible benefits) and the flexibilities within it.

9.18 Examples of NHS organisations which are beginning to develop holistic approaches to reward include York Teaching Hospital NHS Foundation Trust and Sherwood Forest Hospital Foundation Trust. They offer benefits such as buying/selling annual leave, salary sacrifice schemes, on-site nursery and exercise classes, access to local discounts as well embedding health and wellbeing and learning and development into their reward strategies.

9.19 The Government has committed to reduce administration costs by 33% over this Parliament which will have some impact on HR capacity. However, we believe that with appropriate support NHS managers would be able to use this total reward approach to help recruit, retain and motivate staff by making more effective, flexible use of existing pay and benefits.

9.20 The DH is working closely with NHSE to develop proposals on how we might support the service to improve the capability and capacity of the HR community to take a total reward approach to the employment offer. We are in the very early stages of preparing a scoping study, which will draw on and be informed by the ongoing project to deliver Total Reward Statements (TRSs) (paragraph 9.21) and will report on our progress for the 2014/2015 pay round.

9.21 The DH is working with NHS Business Services Authority, ESR and NHSE to deliver TRSs for all NHS employees. TRS will set out for employees what their range of benefits are that make up their pay and reward package. The process for introducing TRS will, initially, take the form of two pilots, the first commencing in September 2012 with TRS being rolled out more widely from April 2013.

9.22 For employed doctors and dentists, it includes:

- for consultants: annual incremental progression of about 3% per annum up to their 5th year and about 6% every 5 years after then. Overall, there are seven thresholds taking them from £74,504 to £100,446 ;

- for specialty doctors, incremental rises taking them from £36,807 to £68,638;

- for associate specialists, incremental rises from £51,606 to £84,948;

- for juniors, incremental rises throughout all the training grades. Increases when moving from one training grade to another - around 24% when moving from Foundation year 1 to Foundation year 2 (£22,412 to £27,798, minima of scales), around 7% on entry to specialty registrar training and incremental progression through that grade from £29,705 (minimum of scale) to £46,708;

- a generous defined benefit pension scheme with a 14% employer contribution and flexible early retirement options from 55 years old,

- immediate life assurance of twice an employee's annual pay and generous death benefits for widows/widowers and dependants/children;

- up to 41 days holiday per annum compared with the 28 days statutory entitlement;

- sick pay of six months at full pay and six months at half pay compared with statutory sick pay of £85.85 per week for up to 28 weeks;

- redundancy pay of up to two years salary with a maximum of 24 years reckonable service compared with the statutory 0.5 - 1.5 weeks pay for each full year of service depending on age;

- maternity pay of eight weeks full pay, 18 weeks half of full pay, 13 weeks Statutory Maternity Pay (SMP) and an optional extra 13 weeks unpaid leave compared with the statutory of six weeks at 90 per cent of average gross weekly earnings and 33 weeks at either £135.45, or 90 per cent of your average gross weekly earnings;

- paternity leave of 2 weeks starting twenty weeks after the child is born as well as an additional 2 to 26 weeks if the mother has returned to work. Fathers are also entitled to receive additional paternity pay if the mother has not exhausted her SMP when she returns to work;

- the nationally recognised values, diversity and reputation of the NHS including, for example, excellent opportunities for flexible working, career breaks etc.

9.23 DH is committed to achieving its total reward vision for the NHS for the benefit of both employers and employees. For example:

- a consultant with 14 years service on a basic salary of £89,369 can, when including, for example, 11 sessions per week, 5% on-call allowance, 5 CEAs as well as sick leave entitlement, holiday entitlement, employers' pension contributions, have a total reward package estimated to be worth £144,213, adding about 61% to basic pay;

- a specialist registrar (5 years in) on a basic salary of £33,724 can, when including, for example, on call payments, employer pension contributions, sick leave entitlement, holiday entitlement and study leave, have a total reward package estimated to be worth £65,196, adding about 93% to basic pay.

Annex A

Chancellor's Letter Setting out General Context to Pay

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

7 December 2011

Ron Amy OBE
Chair
Pay Review Body - Doctors and Dentists
Office of Manpower Economics
6th Floor
Victoria House
Southampton Row
London WC1B 4AD

Dear Mr Amy,

Following my recent announcements at the Autumn Statement, I am writing to set out the Government's view on the critical role of the Doctors and Dentists Review Body in the years ahead.

The Government continues to value the independent and expert view that the Review Bodies provide. You will be aware that, at the Autumn Statement, I announced that the public sector pay freeze will end after 2012-13 – but that in order to support fiscal consolidation, for each of the following two years the Government will seek public sector pay awards that average at 1 per cent. The Secretary of State will write to you in advance of the 2013-14 pay round, in line with normal process.

However, when it comes to setting pay policy after the freeze, the Government is concerned not only with the appropriate annual uplift, but also ensuring that overall public sector pay systems are the most appropriate for the modern labour market.

I am therefore today writing to the chairs of the NHS Pay Review Body, School Teachers Review Body, Prison Service Pay Review Body and Senior Salaries Review Body – requesting that they make recommendations on how pay can be made more market-facing in local areas, to submit initial findings by July 2012. Doctors and dentists have currently been excluded from this work – but I look forward to continuing to receive your recommendations on other issues in the future.

I am copying this letter to the Chief Secretary to the Treasury and the Secretary of State for Health.

Best wishes.

GEORGE OSBORNE

Annex B

DDRB Remit Letter from CST

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Ron Amy OBE, Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
6th Floor
Victoria House
Southampton Row
London
WC1B 4AD

16 July 2012

Dear Ron,

PUBLIC SECTOR PAY 2013-14

The Government greatly values the contribution of the Doctors' and Dentists' Review Body in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced that public sector pay awards will average 1% for the two years following the pay freeze. The Government has also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups- who will be reporting from July 2012. I am now writing to set out how the Government proposes that the Doctors' and Dentists' Review Body approach the 2013-14 round.

2. The Government believes that the case for continued pay restraint across the public sector remains strong. Detailed evidence will be set out in the round, but at the highest level, reasons for this include:

- Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market

position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

- Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

3. The Government recognises the Review Bodies role in providing independent advice on pay uplifts. In 2013-14, the Government will limit uplifts to an average of 1% in each workforce. The Review Body should therefore focus on considering how the 1% will be divided within their remit group. When considering their recommendations, Review Bodies may additionally want to consider the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff.

4. The 1% average uplift should be applied to the basic salary based on the normal interpretation of basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

5. I would like to express my gratitude to the Doctors' and Dentists' Review Body once again and look forward to continued dialogue with you in the future.

DANNY ALEXANDER

Changes to Evidence Submission

Annex C

From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

POC1_717161

Ron Amy OBE
Chair – Review Body on Doctors' and Dentists' Remuneration
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

Dear Ron,

REVIEW BODY ON DOCTORS' AND DENTISTS REMUNERATION – CHANGES TO EVIDENCE SUBMISSION

As you are aware, for many years now, the Department has been responsible for providing detailed evidence on the recruitment, retention and morale of NHS staff and why the pay uplift recommended by Government is sufficient to recruit and retain the staff it needs.

However, in July 2010, our White Paper – "Equity and Excellence: Liberating the NHS" set out the high level vision, including for the future determination of NHS pay, stating:

"Pay decisions should be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff. However, it is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions."

Following on from this, my officials have had extensive discussions with NHS Employers, the secretariat of the NHSPRB & DDRB and HM Treasury officials and agreed that from the 2013/14 pay round onwards:

- DH will produce separate high level evidence for the NHSPRB and the DDRB, focusing on the economic and financial (NHS funding) context and strategic policy.

- NHS Employers will provide separate and more detailed evidence about the recruitment, retention and morale of staff subject to the Agenda for Change (AfC) pay system and employed doctors and dentists and the NHS Commissioning Board (NHSCB) will assume responsibility for self employed doctors and dentists.

- The Department will however retain overall accountability for the evidence provided by NHS Employers and will ensure that it meets the quality expectation of the PRBs.

- DH will retain responsibility for providing evidence to the SSRB. The remit includes SHAs and PCTs (which will cease to exist from April 2013) and Ambulance Trusts (which will become Foundation Trusts and outside of the government's pay remit). Evidence for SSRB will therefore be limited to the remaining remit group of VSMs in Arms-Length Bodies.

I would like to confirm that my officials will ensure that the evidence provided by NHS Employers will contain the same level of detail previously provided by DH. Both parties, as now, will answer any supplementary questions about their own evidence.

You may wish to note that NHS Employers will not give evidence on behalf of the government, but as the voice of healthcare employers. Their evidence will be cleared by their own Policy Board and shared with DH and HMT for comment/ information.

The final version of DH evidence will continue to be cleared by SofS, HMT and the Cabinet Office Public Sector Pay Committee (PSPC) before it is submitted to the PRBs.

For a transitional year, my officials have agreed to work very closely with NHS Employers to ensure that all the evidence submitted meets the needs of the Review Bodies and HMT. In addition, they are also having discussions with policy leads for the new NHS national organisations, e.g. the NHS Commissioning Board, Health Education England, Information Centre etc, to explore whether the PRBs will require these organisations to submit evidence directly to them on issues that affect their workforce.

I am aware that the DDRB receives evidence from all the Devolved Administrations, but this step change is for England alone. My officials

Department of Health

have been closely in touch with their counterparts in the other countries and kept them informed of these proposed changes to evidence submission.

I hope this letter and attachment give you confidence that my officials will continue to do everything possible to ensure that the evidence submitted will meet the needs of the Review Bodies.

I will write to you again in due course with the remit for the 2013/14 pay round.

I am copying this letter to Nicola Sturgeon, Edwin Poots, Lesley Griffiths and NHS Employers.

Yours ever,

ANDREW LANSLEY CBE

Annex D

QIPP Lifecycle – Key Features of each year

Key features of each year:

FY11/12 QIPP Year 1	FY12/13 QIPP Year 2	FY13/14 QIPP Year 3	FY14/15 QIPP Year 4
Building an Efficient Organisation	**Building Transformation**	**Releasing the Old, Embedding the New**	**Ending Transformation, Back to Transactional**
Efficiency transactional changes create headroom to enable transformational changes in coming years	Re-investment of efficiency savings to support creation of transformation	Re-investment of efficiency savings to embed transformation.	The new system and care settings fully implemented and delivering patient centred outcomes with care closer to home
Focus on whole system working to reduce activity through better care pathway management and transformation work begins. If important planned activity reductions do not occur at scale and pace QIPP is pushed into future years.	A leaner, more efficient and cost effective system creates recurrent savings and is starting to run alongside the old. New transformational care settings are forming	Embedding the new systems and the new care settings to further reduce acute activity to the identified "tipping points" to achieve efficiency savings through releasing old systems	New reform structures are fully operational and QIPP transformational changes and efficiency savings are fully realised.

3

Annex E

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*[27], *Foundation for Excellence*[28] 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[29], the 2009 PMETB survey of Foundation doctors, in evidence collected by Lord Patel[30], 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:

[27] Professor Sir John Temple: *Time for training - A Review of the impact of the European Working Time Directive on the quality of training, 2010*

[28] Professor John Collins*: Foundation for Excellence - An Evaluation of the Foundation Programme, 2010*

[29] Dr I Wilson: *Maintaining Quality of Training in a Reduced Training Opportunity Environment, 2009*

[30] *Lord Naren Patel: Recommendations and Options for the Future Regulation of Education and Training, 2010*

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

- 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 have been developed which emphasise 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 HEE. The recommendations also require action at national level. This will entail joint working with groups such as the GMC, Academy of Medical Royal Colleges, NHSE 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.

Annex F

Indicative Contribution Rate Structure after Implementation of 3.2% Increase in Contributions

Full-time equivalent pensionable pay	% of pensionable pay in the band	Est. no. of members in band '000	Contribution rate (before tax relief) 2011/12	2012/13		2013/14		2014/15		Contribution rate increase by 2014/15
				Contribution rate (before tax relief)	Contribution rate increase	Contribution rate	Contribution rate increase	Contribution rate	Contribution rate increase	
Up to £15,000	3%	100	5.0%	5.0%	0.0%	5.0%	0.0%	5.0%	0.0%	0.0%
£15,001 to £21,175	13%	330	5.0%	5.0%	0.0%	5.3%	0.3%	5.6%	0.3%	0.6%
£21,176 to £26,557	11%	200	6.5%	6.5%	0.0%	6.8%	0.3%	7.1%	0.3%	0.6%
£26,558 to £48,982	43%	540	6.5%	8.0%	1.5%	9.0%	1.0%	9.3%	0.3%	2.8%
£48,983 to £69,931	7%	55	6.5%	8.9%	2.4%	11.3%	2.4%	12.5%	1.2%	6.0%
£69,932 to £110,273	13%	60	7.5%	9.9%	2.4%	12.3%	2.4%	13.5%	1.2%	6.0%
Over £110,273	11%	35	8.5%	10.9%	2.4%	13.3%	2.4%	14.5%	1.2%	6.0%
Contributions as % payroll:			6.6%	8.0%		9.2%		9.8%		3.2%
OBR Nov 2011 estimated payroll £bn:				38.36		39.03		39.47		
Additional yield £bn:				0.530		1.023		1.260		

Full-time 2010/11 pay	2011/12	2012/13			2013/14			2014/15		
	Contribution rate net of tax relief	Contribution rate net of tax relief	Increase in contribution rate net of tax relief	Additional cost (£ per month)	Contribution rate net of tax relief	Increase in contribution rate net of tax relief	Additional cost (£ per month)	Contribution rate net of tax relief	Increase in contribution rate net of tax relief	Additional cost (£ per month)
£15,000	4.00%	4.00%	0.00%	0	4.00%	0.00%	0	4.00%	0.00%	0
£20,000	4.00%	4.00%	0.00%	0	4.24%	0.24%	4	4.48%	0.24%	4
£25,000	5.20%	5.20%	0.00%	0	5.44%	0.24%	5	5.68%	0.24%	5
£30,000	5.20%	6.40%	1.20%	30	7.20%	0.80%	20	7.44%	0.24%	6
£40,000	5.20%	6.40%	1.20%	40	7.20%	0.80%	27	7.44%	0.24%	8
£60,000	3.90%	5.34%	1.44%	72	6.78%	1.44%	72	7.50%	0.72%	36
£80,000	4.50%	5.94%	1.44%	96	7.38%	1.44%	96	8.10%	0.72%	48
£130,000	5.10%	6.54%	1.44%	156	7.98%	1.44%	156	8.70%	0.72%	78

Annex G

HUTTON RECOMMENDATIONS

RECOMMENDATION	POSITION AS SET OUT IN PRINCIPLES PAPER
Recommendation 1: The Government should make clear its assessment of the role of public service pension schemes. Based on its framework of principles, the Commission believes that the primary purpose is to ensure adequate levels of retirement income for public service pensioners.	Public service pensions are an important and valued part of the remuneration package offered to public servants. They are intended to ensure dignity in retirement, and represent a significant investment by public service workers and other taxpayers.
Recommendation 2: Pensions will continue to be an important element of remuneration. The Commission recommends that public service employers take greater account of public service pensions when constructing remuneration packages and designing workforce strategies. The Government should make clear in its remits for pay review bodies that they should consider how public service pensions affect total reward when making pay recommendations.	Public service pensions are an important and valued part of the remuneration package offered to public servants.
Recommendation 3: The Government should ensure that public service schemes, along with a full state pension, deliver at least adequate levels of income (as defined by the Turner Commission benchmark replacement rates) for scheme members who work full careers in public service. Employers should seek to maximise participation in the schemes where this is appropriate. Adequate incomes and good participation rates are particularly important below median income levels	The pension that individuals receive at retirement will be broadly as generous for low and middle earners as it is now. The cost ceiling and scheme designs will be set to ensure that this commitment will be met. Modelling suggests this likely to require an accrual rate of the order of 1/65^{ths} to 1/75^{ths}.
Recommendation 4: The Government must honour in full the pension promises that have been accrued by scheme members: their accrued rights. In doing so, the Commission recommends maintaining the final salary link for past service for current members.	Pension rights that members have already built up will be honoured. For deferred and pensioner members, all rights to future benefits including those potentially payable on death will be deemed to be accrued rights,

	including the NPA. For current active members, in addition to protection of accrued rights earned up to the date of change, the final salary link for past service will be maintained.
Recommendation 5: As soon as practical, members of the current defined benefit public service pension schemes should be moved to the new schemes for future service, but the Government should continue to provide a form of defined benefit pension as the core design.	Existing schemes would be closed to future accrual. All members of the current schemes would be moved to new, defined benefit schemes for future accrual. The Government strongly supports the CARE model.
Recommendation 6: All public service pension schemes should regularly publish data which, as far as possible, is produced to common standards and methodologies and is then collated centrally. This information should be of a quality that allows simple comparisons to be made across Government, between schemes and between individual Local Government Pension Scheme (LGPS) Funds.	Not commented upon
Recommendation 7: A new career average revalued earnings (CARE) scheme should be adopted for general use in the public service schemes.	The Government strongly supports the CARE model (with indexation by average earnings for active members and CPI for deferred).
Recommendation 8: Pension benefits should be uprated in line with average earnings during the accrual phase for active scheme members. Post-retirement, pensions in payment should be indexed in line with prices to maintain their purchasing power and adequacy during retirement.	Indexation by average earnings for active members and CPI for deferred members.
Recommendation 9: A single benefit design should apply across the whole income range. The differing characteristics of higher and lower earners should be addressed through tiered contribution rates. The Government should consider the trade off between affordability and the impact of opt outs on adequacy when setting member contribution levels.	Not commented upon
Recommendation 10: Members should have greater choice over when to start drawing their pension benefits, so they can choose to retire earlier or later than their	Schemes should have appropriate flexibilities available to individuals in choosing the date of their retirement, with the pension in the new schemes

Normal Pension Age and their pension would be adjusted accordingly on an actuarially fair basis. Flexible retirement should be encouraged and abatement of pensions in its current form for those who return to work after drawing their pensions should be eliminated. In addition, caps on pension accrual should be removed or significantly lifted.	adjusted accordingly on an actuarial basis.
Recommendation 11: The Government should increase the member's Normal Pension Age in the new schemes so that it is in line with their State Pension Age. The link between the State Pension Age and Normal Pension Age should be regularly reviewed, to make sure it is still appropriate, with a preference for keeping the two pension ages linked.	The Government is committed to seeing the NPA rise, in line with the rising SPA, initially to 66 by 2020.
Recommendation 12: The Government, on behalf of the taxpayer, should set out a fixed cost ceiling: the proportion of pensionable pay that they will contribute, on average, to employees' pensions over the long term. If this is exceeded then there should be a consultation process to bring costs back within the ceiling, with an automatic default change if agreement cannot be reached.	There should be a cost ceiling mechanism to ensure that public service pensions remain affordable and sustainable. This builds on and replaces the principle of cost capping agreed under 'cap and share' in 2005. Scheme level proposals must not exceed the cost ceiling. Cost ceilings will be set as maximum employer contribution rates. Cost ceilings will be established by HMT, with advice from GAD by September 2011.
Recommendation 13: The Commission is not proposing a single public service pension scheme, but over time public service pensions should move towards a common framework for scheme design as set out in this report. However, in some cases, for example, the uniformed services, there may need to be limited adaptations to this framework.	Lord Hutton's report provided a common framework for scheme design, however there is a need to be flexible enough to take into account the differing characteristics of workforces and how schemes are funded.
Recommendation 14: The key design features contained in this report should apply to all public service pension schemes. The exception is in the case of the uniformed services where the Normal Pension Age should be set to reflect the unique characteristics of the work involved. The Government should therefore consider	Police, firefighters and armed forces will have a normal pension aged of 60 for active members

setting a new Normal Pension Age of 60 across the uniformed services, where the Normal Pension Age is currently below this level in these schemes, and keep this under regular review.	
Recommendation 15: The common design features laid out in this report should also apply to the LGPS. However, it remains appropriate for the Government to maintain the different financing arrangements for the LGPS in future, so the LGPS remains funded and the other major schemes remain unfunded.	N/A
Recommendation 16: It is in principle undesirable for future non-public service workers to have access to public service pension schemes, given the increased long-term risk this places on the Government and taxpayers.	The Government is considering representations received through the Fair Deal consultation. Final decisions on Fair Deal and access to the reformed schemes will therefore be taken after scheme designs have been finalised.
Recommendation 17: Every public service pension scheme (and individual LGPS Fund) should have a properly constituted, trained and competent Pension Board, with member nominees, responsible for meeting good standards of governance including effective and efficient administration. There should also be a pension policy group for each scheme at national level for considering major changes to scheme rules.	Not commented upon
Recommendation 18: All public service pension schemes should issue regular benefit statements to active scheme members, at least annually and without being requested and promote the use of information technology for providing information to members and employers.	Not commented upon
Recommendation 19: Governance and the availability and transparency of information would be improved by government establishing a framework that ensures independent oversight of the governance, administration and data transparency of public service pension schemes. Government should consider which body or bodies, including, for example, The Pensions Regulator, is most suitable to undertake this role.	The Government and the TUC are committed to further discussions to develop shared principles on best practice in scheme governance and administration. In response to the IPSPC recommendations, we will work to achieve greater member representation in the governance of schemes and set transparency standards and consistency objectives across all areas of scheme costings and

	administration.
Recommendation 20: When assessing the long term sustainability of the public finances, the Office for Budget Responsibility should provide a regular published analysis of the long term fiscal impact of the main public service pension schemes (including the funded LGPS).	Not commented upon
Recommendation 21: Centrally collated comprehensive data, covering all LGPS Funds should be published including Fund comparisons, which, for example, clarify and compare key assumptions about investment growth and differences in deficit recovery plans.	N/A
Recommendation 22: Government should set what good standards of administration should consist of in the public service pension schemes based on independent expert advice. The Pensions Regulator might have a role, building on its objective to promote good administration. A benchmarking exercise should then be conducted across all the schemes to assist in the raising of standards where appropriate.	The Government and the TUC are committed to further discussions to develop shared principles on best practice in scheme governance and administration. In response to the IPSPC recommendations, we will work to achieve greater member representation in the governance of schemes and set transparency standards and consistency objectives across all areas of scheme costings and administration.
Recommendation 23: Central and local government should closely monitor the benefits associated with the current co-operative projects within the LGPS, with a view to encouraging the extension of this approach, if appropriate, across all local authorities. Government should also examine closely the potential for the unfunded public service schemes to realise greater efficiencies in the administration of pensions by sharing contracts and combining support services, including considering outsourcing.	Not commented upon

Recommendation 24: The Government should introduce primary legislation to adopt a new common UK legal framework for public service schemes.	Not commented upon
Recommendation 25: The consultation process itself should be centrally co-ordinated: to set the cost ceilings and timetables for consultation and overall implementation. However, the consultation on details should be conducted scheme by scheme involving employees and their representatives.	The central process will continue alongside scheme-specific discussions as required. Once cost ceilings have been set, scheme discussions should take place within the parameters set out in this agreement.
Recommendation 26: The Commission's view is that even allowing for the necessary processes it should be possible to introduce the new schemes before the end of this Parliament and we would encourage the Government to aim for implementation within this timeframe.	New schemes will come into operation from 2015.
Recommendation 27: Best practice governance arrangements should be followed for both business as usual and the transformation process, for each scheme. And there will also need to be the right resource, on top of business as usual, to drive the reforms; particularly given the challenging timescale and scope of the reforms.	Not commented upon

Annex H

Main Parameters of proposed new NHS pensions scheme

A. A pension scheme design based on career average;
B. An accrual rate of 1/54th of pensionable earnings each year with no limit to pensionable service;
C. Revaluation of active members' benefits in line with CPI plus 1.5% per annum;
D. a Normal Pension Age equal to the State Pension Age, which applies both to active members and deferred members (new scheme service only). If a member's SPA rises, then NPA will do so too for all post 2015 service (see annex A). Those within ten years of current NPA are excluded and accrued rights in pre-2015 schemes will also be related to current NPA;
E. pensions in payment to increase in line with inflation (currently CPI);
F. benefits to increase in any period of deferment in line with inflation (currently CPI);
G. Member contributions on a tiered basis to produce a total yield of 9.8% of total pensionable pay in the Scheme'. (subject to the detailed arrangements for determining future contribution structures set out in annex A);
H. Optional lump sum commutation at a rate of £12 of lump sum for every £1 per annum of pension foregone up to the maximum limit on lump sums permitted by HMRC;
I. the current flexibilities in the 2008 section: early/late retirement factors on an actuarially neutral basis, draw down of pension on partial retirement and being able to retire and return to the pension scheme will be included in the 2015 scheme;
J. Ill-health retirement pensions to be based on the current ill-health retirement arrangements but with enhancement for higher tier awards to be at the rate of 50% of prospective service to normal pension age;
K. Spouse and partner pensions to continue to be based on an accrual rate of 1/160th. For deaths in retirement, spouse and partner pensions will remain based on pre-commuted pension;
L. The current arrangements for abatement (for service accrued prior to and post 2015) will be retained;
M. Lump-sum on death in service will remain at two times actual pensionable pay;
N. For members who in the new scheme have a Normal Pension Age higher than 65 there will be an option in the new scheme to pay additional contributions to reduce or, in some cases, remove any early retirement reduction that would apply if they retire before their Normal Pension Age. Only reductions that would apply in respect of years after age 65 can be bought out and the maximum reduction that can be bought out is for 3 years (that would apply to a member with a Normal Pension Age of 68 or higher);
O. Added Years contracts in the 1995 section will continue on compulsory transfer to the 2015 scheme;
P. Additional pension arrangements will continue;
Q. The Public Sector Transfer Club will continue and further consideration will be given to the best way of operating it in the reformed schemes;
R. An employer contribution cap.

Annex I

Summary of benefits & comparison with 2015 scheme

Feature or Benefit	1995		2008		2015
Staff group	Officers	Practitioners	Officers	Practitioners	All staff
Method	Final Salary	CARE	Final Salary	CARE	CARE
Accrual rate	1/80th	1.4% of uprated earnings per year	1/60th	1.87% of uprated earnings per year	1/54th
Retirement Lump Sum	3 x pension plus optional further commutation up to HMRC limit	3 x pension plus optional further commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit
Normal Pension Age	60 (or 55 for special classes)	60	65	65	SPA
In-service earnings revaluation	N/A	Pensions Increase + 1.5%	N/A	Pensions Increase + 1.5%	CPI + 1.5%
Deferred benefits revaluation	N/A	Pensions Increase	N/A	Pensions Increase	CPI
Member Contributions	5% - 10.9% depending upon level of pensionable pay or earnings		5% - 10.9% depending upon level of pensionable pay or earnings		TBC but graduated tiers between 5% - 14.5% expected

Death in service	2 x pensionable pay or average annual earnings	2 x reckonable pay or average annual earnings	Same as 2008 section
Survivor benefits	Spouse & partner pension based on accrual of 1/160th	Spouse & partner pension based on accrual of 1/160th	Same as 2008 section
Retirement flexibilities	None. Full retirement from NHS service required before pension can be paid. Unable to re-join the scheme once benefits have been taken.	Early/late retirement factors on an actuarially neutral basis, draw down of pension on partial retirement and ability to retire and return to the scheme	Same as 2008 section
Ill-health retirement	Basic ill-health retirement = no actuarial reduction for early pension payment. Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.	Basic ill-health retirement award = no actuarial reduction for early pension payment. Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.	Basic ill-health retirement award same as 2008 section Higher tier ill-health retirement award = enhance pension by 50% of prospective service to NPA.

Rationale for differences between 2008 & 2015 benefits

CARE methodology and NPA-SPA link is a core design feature across all reformed public service pension schemes. Beyond this, the 2015 scheme differs from the current open 2008 section in two further aspects:

Accrual rate & revaluation

When exploring variations to the reference scheme based on the priorities put forward by unions, the Department undertook extensive modelling to assess the impact of various combinations of accrual rate and indexation.

The modelling considered a range of NHS workers of different ages and at different stages of their careers. Projected pension figures were calculated using typical career paths. Specifically, the modelling looked at projected pension payments at retirement.

The resulting scheme design of a revaluation factor of CPI + 1.5% and an accrual rate of 1/54th was considered to provide the fairest balance for the majority of the membership across age ranges within the limitations of the cost ceiling.

Ill-health retirement

Members of the 2008 scheme retiring on ill-health grounds and who qualify for higher tier awards (with there being no change in the qualifying conditions), receive an enhancement to their pension of 2/3^{rds} of prospective service to NPA. The 2015 scheme will reduce this enhancement to 50%. The change is being made in light of the increase in normal pension age from 65 to SPA, which in turn increases the underlying service on which the enhancement is based.

The basic ill-health retirement award mirrors the 2008 section - which provides an unreduced pension based on service accrued without enhancement.

Further mitigations in recognition of working longer

The proposed final agreement committed to a "Working Longer Review" in partnership with NHS employers and trade unions. The purpose of this is to identify and seek mitigation for potential impacts of a later normal pension age.

The retention of substantial ill-health retirement benefits serve a valuable function in mitigating any negative impacts arising from the increase in NPA for those members who may not benefit from the statistical trends of increasing longevity and improved health into later life.

In addition, for members who in the new scheme have a NPA higher than 65 there will be an option in the new scheme to pay additional contributions to reduce or, in some cases, remove any early retirement reduction that would apply if they retire before their NPA. Only reductions that would apply in respect of years after age 65 can be bought out and the maximum reduction that can be bought out is for 3 years (i.e. for those with an NPA of 68 or higher).

Transitional protection

Full protection

All members who are within 10 years of their NPA (including special class NPA of 55) as at 1 April 2012 will remain in their current section. Around 25% of the total scheme membership will benefit from full protection.

Partial protection

All members who are within 13.5 years of their NPA as at 1 April 2012, but not within 10 years, will have tapered protection. For every month of age that they are beyond 10 years of their normal pension age, they lose 2 months of protection. At the end of the protected period, they will be transferred to the 2015 scheme for future service. Around 10% of members will qualify for this partial protection.

Option for protected 2008 section members

2008 Scheme members with full or tapered protection will be offered a one-off opportunity to opt into the new scheme in 2015 if they prefer. This is because already have a normal pension age of 65 and by being old enough to benefit from protection will therefore have an SPA of 65 or 66. Modelling suggests that the better accrual rate available in the 2015 scheme means that these members may be better off transferring to the new arrangements in 2015 rather than taking advantage of the protection.

Protection for accrued rights

All staff transferring to the 2015 scheme, either in 2015 or at the expiry of tapered protection, will have their pension rights accrued under their former arrangments fully protected. For benefit calculation purposes, the final salary will be based on pensionable pay at the point of leaving service rather than the point of entering the 2015 scheme.