



Department
of Health

The Review Body on Doctors' & Dentists' Remuneration (DDRB) Review for 2014

Written evidence from the Health Department
for England – September 2013

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The Review Body on Doctors' and Dentists' Remuneration

Written evidence from the Health Department for England – September 2013

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Executive summary

The financial challenge facing the NHS is the biggest in its history. Despite real terms growth in its budget in successive years, it needs to continue to secure improved value from the taxpayers' investment, if it is to meet the growing pressures it faces in the years to come both from an ageing and growing population and the need to improve the quality of care provided. The Francis report on the very poor care provided at Mid Staffordshire NHS Foundation Trust has brought this into full relief.

Pay restraint has been, and will continue to need to be, a key part of delivering this. Although the NHS is forecasting significant savings from non-pay elements of expenditure, national pay frameworks and the occupational pension scheme represent about two-thirds of a Trust's total expenditure at local level. Employers are therefore facing the consequences of a stark choice for staff on national pay contracts. This is to either pay staff more, accepting that this may do little to improve the quality of care for patients and is likely to restrict the number of staff employers can afford to employ, or, to reform contracts to enable employers to use their pay bill, as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity.

NHS employers say they want 'something for something'. They want to make better use of their pay bill in return for better performance and productivity. The challenge for the NHS is to continue to improve the quality and responsiveness of services, whilst addressing the challenges set out in the Francis report to deliver safe, effective and compassionate care.

The need for reform

NHS staff are our greatest asset. We know that high-performing staff improve the outcome for patients. We also know that delivering better patient care is not simply about paying staff more, it is about engaging and empowering the entire workforce so we secure a fundamental and permanent shift in culture. We want a workforce that is rewarded fairly for the important life-saving work they do and which supports the very important principle that staff and managers must make the care and safety of patients their priority.

However, employers cannot pay staff more, improve quality and productivity and protect jobs. Careful and prudent management of the NHS pay bill is critical if we are to maintain the right number of front-line staff with the right skills. We believe more affordable employment contracts can help deliver better care and improve job security.

Currently, national medical pay frameworks provide for annual pay progression, which means employers face a two per cent (about £200m pa) pressure on the pay bill each year even during a pay freeze. Last year, for example, employed doctors and dentists received a one per cent basic pay rise, coupled with, for many, increments of up to eight per cent. This is out of step with our wider policy on public sector pay and the ambitions the Chancellor set out in the Spending Round 2013, where he made clear that:

“...the biggest reform we make on pay is to automatic progression pay. This is the practice whereby many employees not only get a pay rise every year, but also automatically move up a pay grade every single year – regardless of performance. Some public sector employees see annual pay rises of seven per cent. Progression pay can at best be described as antiquated; at worst, it’s deeply unfair to other parts of the public sector who don’t get it and to the private sector who have to pay for it. So we will end automatic progression pay in the Civil Service by 2015-16. And we are working to remove automatic pay rises simply for time served in our schools, NHS, prisons and police. The armed forces will be excluded from these reforms.”

The one per cent that the Government has made available for pay in the Spending Round, would, in our view, be best deployed in supporting the modernisation of national pay frameworks. In particular, that the reform of medical contracts should seek to improve the quality of patient care and therefore outcomes by ensuring there is a better balance between pay, performance, and productivity rather than time served. Substantial reforms to progression pay will be taken forward or are already underway across the public sector.

The priority for this pay round therefore, should be support for continued reform of national contracts so that they deliver improvements in performance and productivity, are affordable and fit for purpose. Putting patients at the heart of everything the NHS does means ensuring services are available seven days a week and that staff are rewarded for what they do for patients, not time served. They must also reward appropriate behaviours – compassionate patient-centred care.

The recruitment and retention picture for the NHS remains strong and measures of staff engagement in the staff survey remain good. During 2012/2013 recruitment, retention, morale and motivation remained strong with, for example, an improved engagement score for all staff in the 2012 NHS Staff Survey, rising from 3.61/5 to 3.68/5. The Government’s view, therefore, remains that basic pay increases should only be implemented if there is strong evidence that recruitment, retention, morale or motivation issues require this.

The public want and need a health service which is able to respond effectively to their needs whether in hospital or at home. A pay system which is designed around a

Monday to Friday working week, with, for example, premium rates for care at the weekends, cannot easily facilitate the delivery of seven day services. In particular, the need to have consultants available at evenings and weekends. National pay systems must of course be fair to staff, but they should also balance the needs of patients and the cost to the tax payer.

To help ensure national pay contracts are affordable and fit for purpose, we are continuing with our extensive programme of national contract reform. Heads of Terms have been agreed between NHS Employers and the BMA about negotiations for changes to:

- the consultant contract, based on your excellent “Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants” and we have commissioned NHS Employers to begin negotiations with the BMA
- the contract for doctors in training, based on NHS Employers’ constructive “Scoping report on the contract for doctors in training”, and we have commissioned NHS Employers to begin negotiations

Our ask of the pay review body

Employers want to secure a better balance between pay, performance and productivity. To deliver our aspirations for the prevention of ill health and the delivery of seven day care, national pay frameworks must be fit for purpose, fair to staff and offer the taxpayer the very best value for money. The NHS will be in a stronger position to maintain or increase staffing levels, and therefore protect jobs, if employers are able to make better use of their pay bill.

The DDRB is, therefore, invited to:

- consider and make observations on the Heads of Terms about negotiations for consultants and doctors in training, with particular emphasis on the current structure for pay progression, and whether it can help improve performance (so staff are paid for what they do for patients) and productivity
- consider and make observations on whether any pay awards should be made to staff whose performance does not meet local standards
- make recommendations on how any pay award, if the DDRB consider one is justified, might be made dependent on the partners reaching agreement on contract reform. We propose that any such recommendation is tied to progress on contract reform, with the parties invited to report on progress in their evidence to the DDRB next year, effectively deferring any award
- consider and make observations on whether the arrangements for working ‘out of hours’ supports the Department’s ambition for seven day

services (particularly relevant to Sir Bruce Keogh's Mortality Review). In particular, the need to have consultants available at evenings and weekends. For, example, consultants are able to opt out of non-emergency care at evenings and weekends

- make recommendations on appropriate uplifts for General Medical Services (GMS) contracts and general dental service contracts, in the context of public sector pay policy for 2014/15
- make recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay, in line with other sectors of the NHS workforce. The Government and NHS England will make final decisions on the overall gross uplift for GMS and dental contracts in the light of DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations

The content of our evidence this year reflects the new NHS architecture. As set out in the Parliamentary Under Secretary of State for Health's remit letter, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy with separate evidence provided by:

- NHS Employers – on recruitment, retention, motivation and morale for doctors and dentists on the national conditions of service
- NHS England – on independent primary care contractors
- Health Education England - on education, training and workforce capacity

The subsequent chapters of the Department's evidence, therefore, set out:

- in Chapter 1, how our pay strategy, based on fit for purpose, affordable national pay contracts, supports delivery of the Department of Health priorities from 2013/14 to improve productivity, value for money, delivery and performance
- in Chapter 2, the general economic outlook for the UK economy which, as described above, shows that, while recovery is underway, it remains uncertain and that public sector pay restraint remains a key component of fiscal consolidation plans
- in Chapter 3, that, despite the NHS benefitting from real terms growth from the spending round, the financial challenge remains the biggest in NHS history with transformational change required to reduce long term cost pressures requiring unprecedented productivity improvements and decreased demand on the NHS
- in Chapter 4, the medical workforce planning policy context and new arrangements

- in Chapters 5, 6 and 7, details of the discussions with the profession about changes to the national contracts and other reward arrangements for consultants and doctors and dentists in training and the read-across to other hospital doctors
- in Chapter 8, developments in general practice and information on salaried GPs and the GP trainers' grant
- in Chapter 9, confirmation that the Department is content with the methodology change that DDRB put forward for the uplift formula for general dental practitioners
- in Chapter 10, information on salaried primary care dental services
- in Chapter 11, the Government view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners
- in Chapter 12, information on our progress with NHS Pensions and Total Reward Strategy

Chapter 1: NHS Strategy and Introduction

NHS Strategy and Introduction

- 1.1 No exposition of the overall strategy for the NHS could be complete without a prominent role for the recommendations of the Francis Inquiry¹ into the events at the Mid Staffordshire NHS Foundation Trust. The implications of the report (see Annex C) are a humbling reminder that while NHS staff deserve to be rewarded fairly for their work, care and compassion need to be at the heart of all that the NHS does.
- 1.2 The Department of Health Business Plan for 2013-2015², updated in June 2013, sets out the Government's priorities for the NHS:
- to enable better health and wellbeing for all helping people live healthier lives by improving our public health system; protecting people's health by ensuring we have the capabilities and policies in place to address threats to public health; promoting health and wellbeing to deliver better health outcomes and tackle health inequalities across all ages
 - to enable better care for all helping people get better and ensuring people are treated with dignity and respect and supporting a patient-led NHS, reforming social care; working with the NHS and care sector to strengthen people's ability to make meaningful choices about their care and support the integration of services around the individual; getting the basics right on safety in health and care; a greater focus on health outcomes
 - to enable better value for all providing better quality care by improving productivity and ensuring value for money for the taxpayer; reducing bureaucracy; supporting the NHS to save up to £20 billion to reinvest in frontline services; simplifying regulation of the development and adoption of new medicines and treatments
 - to deliver successful change delivering the transition to a more autonomous and accountable system by making sure the new partnership organisations, clinical commissioning groups and health and wellbeing boards are ready to take on their new responsibilities; continuing our own transformation into a smaller, more purposeful organisation, with a clear sense of its role in health and care
 - to work with our partners achieving strategic clarity, building a common sense of purpose by developing strong relationships with our external

¹ <http://www.midstaffspublicinquiry.com/report>

stakeholders and establishing effective ways of working with the new organisations in the health and care system; playing our full role in delivering the government's priorities led by other departments

- to support UK growth by reducing direct costs to taxpayers caused by ill health, championing UK strengths in technology and life sciences, maintaining the UK as a world-class location for clinical research and developing the life sciences sector, reducing NHS barriers to innovation and growth and trading on UK health-related expertise

1.3 In addition, the Department of Health has the following priorities for 2013-14²:

- preventing people from dying prematurely by improving mortality rates for the big killer diseases to be the best in Europe, through improving prevention, diagnosis and treatment
- improving the standard of care throughout the system so that quality of care is considered as important as quality of treatment, through more accountability, better training, tougher inspections and more attention paid to what patients say
- improving treatment and care of people with dementia to be among the best in Europe through early diagnosis, better research and better support; and
 - bringing the technology revolution to the NHS to help people, especially those with long term conditions, manage their health and care
 - improving productivity and ensuring value for money for the taxpayer
 - focusing on improved delivery and performance
 - leading transition to the future system and working together to build a sense of common purpose
 - contributing to economic growth

1.4 2013/14 was a landmark year for the health and care system. On 1 April 2013, NHS England, Public Health England, the NHS Trust Development Authority and Health Education England took up their responsibilities in full. 211 clinical commissioning groups became formally established with GPs and other health professionals assuming leadership and responsibility for commissioning services for their local communities. All these bodies have vital roles in delivering the Government's priorities for the NHS. NHS England, in particular, is responsible for ensuring that the money spent on NHS services delivers the best possible care for patients.

² <https://www.gov.uk/government/publications/department-of-health-corporate-plan-2013-14/department-of-health-2013-14-corporate-plan>

NHS Mandate

1.5 The first Mandate from the Government to NHS England³ which, together with the NHS Outcomes Framework⁴ set out the strategic framework within which NHS England will discharge its responsibilities from April 2013 to March 2015, was published in December 2012. The mandate is structured around 5 key areas where the Government expects NHS England to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm

1.6 The Secretary of State's foreword to the Mandate summed up the challenge facing the NHS as follows:

“Never in its history has the NHS had to face such a profound shift in our needs and expectations. An ageing population, rising costs of treatments and huge increase in the numbers of us with long-term, often multiple conditions are rewriting our relationship with health and care, all at a time of acute pressure on public finances. These challenges go to the heart of the objectives I am setting the NHS Commissioning Board [now NHS England].”

1.7 The NHS Outcomes Framework set out the outcomes and corresponding indicators used to hold NHS England to account for improving health outcomes using the same key areas set out in the Mandate as described above.

1.8 These priorities place a new emphasis on prevention and care to go alongside the focus on treatment. Overall, this should result in greater integration between health and care and more care being provided in the community.

³ <http://mandate.dh.gov.uk/>

⁴ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014>

Putting Patients at the heart of the NHS

1.9 The NHS Constitution⁵ says:

“The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most”.

1.10 Robert Francis, QC, speaking in Stafford about his report on Mid Staffordshire NHS Foundation Trust, the presentation of his report was concluded with a message for all concerned with the management of NHS hospital services:

“People must always come before numbers. Individual patients and their treatments are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS.”

1.11 The 2013 Spending Round settlement means that the NHS is protected and will continue to grow in real terms in 2015/16. This means we can focus on our priorities e.g. mortality, care for older people, dementia and other long term conditions, and dignity and respect in care. The Settlement demonstrates our biggest ever commitments to integrated care and will enable the Department and NHS leaders to deliver solutions which are as efficient as possible.

Pay Strategy

1.12 The NHS is changing, as is the role of the medical and non-medical workforce to meet the challenges of a modern NHS. Our starting point must be based on putting the patient at the heart of what we do and to sustain and improve quality. The NHS should be responsive to patient needs. Patients need the NHS every day, not just Monday to Friday and not just in hospitals; but increasingly in an integrated way in the community.

1.13 One of the most significant principles of the reform of the NHS is decentralisation. As a result, the main incentives for provider financial management and efficiency is derived from tariff setting and a transparent

⁵ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

regulatory framework, not from central government controls on providers' pay and internal processes. This is a challenging environment where employers seek to deliver efficiency challenges, maintain quality and generate more value from every pound invested in the NHS.

- 1.14 Therefore, the overarching policy aim is to develop an affordable reward strategy for the NHS, covering pay, conditions of service and pensions. The strategy must provide the employment package that supports the maintenance of a skilled, motivated and caring workforce that can fulfill government ambitions for the delivery of high quality patient services. Within this strategy, employers must be able to recruit and retain high calibre staff with the right skills and experience to meet the challenging demands created by an ageing population and advances in technology.
- 1.15 Our pay strategy is aimed at ensuring the national pay, terms and conditions of service remain affordable and fit for purpose and, therefore, are able to support employers across the NHS in delivering service priorities. Pay accounts for £45bn of the total NHS budget and pay and pensions accounts for around two-thirds of running costs for typical NHS employers. It is essential that a time of unprecedented financial challenge, the best possible value for money is obtained from this investment. Pay arrangements in the NHS should enable employers to attract, retain and motivate high quality staff to deliver a first class public service.

Staff Engagement

- 1.16 Our pay strategy also includes improving staff engagement. There is a complex relationship between overall pay and levels of staff engagement, morale and motivation. Other factors have a much greater impact on levels of engagement in the short term, for example, overall organisational culture, interaction with line managers, employee voice and the handling of organisational change. The scores in the 2012 NHS Staff Survey⁶ suggest some progress is being made, despite the pressures on NHS staff, rising from 3.61/5 to 3.68/5. There was variation across the service so there is still plenty of scope for improvement.
- 1.17 From 2010 the Department highlighted the importance of staff engagement in the NHS through its publications and by supporting events with NHS Employers to raise the profile of the issue in the service including support for the Government's "Engaging for Success Taskforce". The Department also

⁶ <http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/>

introduced a new measure of staff engagement, building on measures of staff motivation and satisfaction.

- 1.18 Since 2010, the Department has commissioned NHS Employers to support the NHS in developing, sustaining and improving staff engagement which has been done by measuring staff engagement and setting national objectives including:
- in 2011 and 2012, a national target for improving staff engagement in the Operating Framework
 - in 2011, Staff Pledge 3 in the NHS Constitution which refers to the need to "engage staff in decisions which affect them"
 - in 2013 passing responsibility for the Staff Survey which measures staff engagement, to NHS England
- 1.19 The Review Body's 2011 Report cited research commissioned by the Department from Professor Michael West of Aston University which demonstrated correlations between levels of staff engagement and HR outcomes such as absence levels, organisational performance and quality measures such as patient satisfaction and mortality.
- 1.20 During 2012 specific attention was paid to the "advocacy" dimension of staff engagement within the NHS Staff Survey and organisations are ranked on this on the staff survey website. This concept is being developed further via the "Friends and Family" test for staff alongside that for patients. NHS England intend to link results of organisations on the advocacy question within the staff survey to payment stream for NHS organisations.
- 1.21 There has been a particular focus, post Francis, on the cultural challenges to engagement, development of local values and issues of employee advocacy. The report highlighted the potential negative impact on patients of staff disengagement. It emphasised the need for leaders to create a culture that supports engagement. Staff engagement has been woven into work on the relevant areas as part of work on the nursing strategy known as the 6C's⁷ especially around engaging staff in the delivery of compassionate care. Work is on-going on the delivery of this strategy including areas such as appraisal.
- 1.22 CQC's regulatory regime is also seeking to make use of measures of staff engagement as part of the Chief Inspector's assessment of the organisational health of providers. Consultation⁸ is underway on changes to the way CQC

⁷ <http://www.england.nhs.uk/tag/6cs>

⁸ http://www.cqc.org.uk/sites/default/files/media/documents/cqc_consultation_2013_tagged_0.pdf

regulates, inspects and monitors care. This includes a vision of a ‘well-led’ service, with effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people’s views and experiences to make improvements. Inspections would encompass an assessment of aspects of governance, leadership and culture to assess whether a service is ‘well-led’.

- 1.23 The importance of staff engagement is also being promoted by the NHS Leadership Academy in their recently published, refreshed version of *the Health NHS Board*⁹. This sets out what boards need to put in place to help them develop a responsive, insightful approach to issues in their organisations, including advice on effective staff engagement. The Academy is also developing and implementing a leadership development offer that places a strong emphasis on shaping positive cultures and engaging staff.
- 1.24 The NHS Leadership Academy was established in 2012 as a national hub for leadership development and talent management. Through leadership development, it aims to improve leadership behaviours and skills and ultimately lead to better patient care, experience and outcomes. Starting in September 2013, the Academy has launched a suite of five leadership development programmes that together represent the first national approach to leadership development in the NHS, designed to develop outstanding leaders for every tier across the healthcare system ‘from ward to board’.
- 1.25 Building on evidence (West et al) that found a significant reduction in patient standardised mortality rates in organisations with high staff engagement (in turn associated with high levels of effective and engaging leadership), all of the Academy’s leadership development programmes will contain components on the values and behaviours required in a new integrated health care system focussed around the needs of patients, carers and service users and in ways which liberate, engage and motivate staff to provide a compassionate and personal health care experience. These behaviours are congruent with NHS values and uphold the NHS Constitution, which itself states:

“Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported”.

⁹ <http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf>

1.26 Staff Engagement is critical if employers in the NHS are to carry staff with them as they seek to meet their efficiency targets, maintain quality and deliver the best outcomes for patients. In 2010 the Department commissioned NHS Employers to research, promote and support employers to embed staff engagement within their organisations. Based on data from the 2012 NHS Staff Survey, it appears that staff engagement and job satisfaction (78 per cent) has held up well. Overall staff satisfaction with pay has remained positive although less than in 2011. Staff willingness to recommend the NHS as an employer has improved from 51 per cent to 55 per cent, suggesting there is an understanding of the overall and relative value of the NHS total reward package.

Chapter 2: General Economic Context¹⁰

Summary

- 2.1 The Government's economic strategy set out in the June Budget 2010 is designed to protect the economy through this recent period of global uncertainty and provide the foundations for recovery. This strategy is restoring the public finances to a sustainable path and the deficit has been reduced by a third in the three years from 2009-10. The UK is seen as a relative safe haven, with low market interest rates helping keep interest payments lower for households, businesses and the taxpayer. This strategy has helped the Government equip the UK to compete in the global race.
- 2.2 The UK economy grew by 0.2 per cent over the course of 2012 and the Office for Budget Responsibility (OBR) forecast the UK to grow by 0.6 per cent in 2013. The UK economy is recovering from the biggest financial crisis in generations, of the developed economies, only Japan experienced a deeper recession and a decade of growth built on unsustainable levels of debt.
- 2.3 Three key factors first set out in the OBR's November 2011 *Economic and fiscal outlook* have resulted in a more subdued and uneven recovery than expected. The impact of the financial crisis on GDP and underlying productivity has been greater than expected. The euro area sovereign debt crisis and global uncertainty have damaged confidence and reduced external demand. Commodity price driven inflation since 2011 has reduced real incomes and raised business costs.
- 2.4 The OBR forecast inflation of 2.8 per cent in 2013 and 2.4 per cent in 2014 and forecast it to return to target by early 2016. The Bank of England's latest inflation forecast, published in the August *Inflation Report* is little changed compared to the May report. The Monetary Policy Committee (MPC) expect inflation to be above the two per cent target for much of the next two years
- 2.5 Labour market figures strengthened in the second quarter of 2013 after a weak start to the year. The OBR expects employment to continue to rise over the forecast period although with slower growth than that seen over 2012. The unemployment rate remained flat over the quarter, in line with market expectations, but is down on the year and down from the peak of 8.4 per cent in the final quarter of 2011. Wage growth remains weak although total pay increased above two per cent in the three months to June for the first time since late 2011 driven by unusually strong bonus payments made in April 2013.

¹⁰ HMT Chapter accurate as of 16/8/2013

- 2.6 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. Implementation of the fiscal consolidation plans is well underway. By the end of 2012-13, around 70 per cent of the annual fiscal consolidation planned for the Spending Review 2010 period will have been achieved, with around 65 per cent of the spending and around 90 per cent of the tax consolidation in place.
- 2.7 The OBR's March 2013 *Economic and fiscal outlook* concluded that the Government remains on course to meet the fiscal mandate to achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast period. The OBR also forecast that public sector net debt as a percentage of GDP will be falling in 2017-18, two years later than set out in the supplementary debt target. The Government's judgment is that significant changes to the path of consolidation in the short term would constrain the operation of the automatic stabilisers, limiting their ability to support the economy.
- 2.8 Public sector pay restraint has been a key part of the fiscal consolidation so far. Budget 2013 announced that public sector pay awards in 2015/16 will be limited to an average of up to one per cent.

Economic context and outlook for the economy

Growth

- 2.9 The Government inherited the largest deficit since the Second World War and of the major economies only Japan experienced a deeper recession. Across the world, recovery over the past four years has been slower than forecast.
- 2.10 The OBR's October 2012 *Forecast evaluation report* showed that the shortfall in growth compared to its June Budget 2010 forecast could largely be explained by private consumption, investment and net trade, in roughly equal measure, reflecting shocks from commodity prices, financial conditions and confidence.
- 2.11 The Government's strategy is designed to protect the economy through this period of global uncertainty, to maintain market confidence in the UK and to lay the foundations for a stronger more balanced economy in the future. The Government is taking decisive action through: monetary activism and credit easing, stimulating demand, maintaining price stability and supporting the flow of credit in the economy; deficit reduction; reform of the financial system; and a comprehensive package of structural reforms.
- 2.12 Compared with Autumn Statement 2012, the OBR's March 2013 *Economic and fiscal outlook* revised down its forecast for GDP growth in 2013 to 0.6 per cent

from 1.2 per cent and GDP growth in 2014 to 1.8 per cent from 2.0 per cent reflecting smaller contributions to growth from net trade and consumption.

- 2.13 Risks to UK growth have become more balanced. Global risks have started to ease. As the Funding for Lending Scheme begins to gain traction, UK credit conditions have improved. There are signs of increasing momentum. The Bank of England revised up its forecast for growth and maintained its forecast for inflation in August's quarterly *Inflation Report*. The Bank of England believe "a recovery appears to be taking hold."
- 2.14 The Government is delivering ambitious structural reforms to enable the UK to compete in a rapidly changing global economy. These reforms are a key part of the Government's economic strategy, alongside fiscal consolidation, monetary activism, and reform of the financial system.
- 2.15 Since November 2010, the Government has set out a programme of structural reforms to remove barriers to growth for businesses and equip the UK to compete in the global race. These reforms span a range of policies, including improving the UK's infrastructure, cutting red tape, root and branch reform of the planning system and boosting trade and inward investment.
- 2.16 Budget 2013 announced a further reduction in corporation tax to 20 per cent by 2015, £18 billion of additional capital investment over the next Parliament, and a major housing package worth £5.4 billion to support home ownership, new development and affordable housing.
- 2.17 The UK is not immune to what happens elsewhere. As our biggest trading partner the euro area represents more than 40 per cent of UK exports. The successful implementation of a comprehensive resolution to this crisis remains a key priority for the global economy.

Table 1: Forecasts for GDP growth 2013 to 2015

Forecasts for GDP growth (per cent)	2013	2014	2015
OBR (March Budget 2013)	0.6	1.8	2.1
IMF WEO Update (July 2013)	0.9	1.5	-
Avg. of independent forecasters (July)	1.0	1.7	2.1

Inflation

- 2.18 Despite the difficult current conditions, inflation has fallen significantly since its peak in September 2011. CPI inflation peaked at 5.2 per cent in September 2011 but fell back in 2012 as past rises in commodity and energy prices and VAT dropped out of the twelve month comparison. Inflation over the second quarter of 2013 was 2.7 per cent.
- 2.19 Compared to the May *Inflation Report*, the outlook for inflation in the August report is similar, as the stronger demand outlook is assumed to be largely matched by an expansion in effective supply capacity. CPI inflation is likely to remain close to three per cent in the near term, reflecting the impact of past increases in import prices and the persistent contribution of administered and regulated prices. Inflation is forecast to fall back towards target in the latter part of the forecast period as external price pressures fade.

Table 2: Forecasts for CPI Inflation 2013 to 2015

Forecasts for CPI Inflation (per cent change on a year earlier)	2013	2014	2015
OBR (March Budget 2013)	2.8	2.4	2.1
IMF WEO April 2013)	2.7	2.5	2.2
Avg. of independent forecasters (July 2013)	2.5	2.4	2.2

Affordability

- 2.20 The Government inherited the largest deficit in post-war history due to the financial crisis and unsustainable pre-crisis increases in public spending. The historically high level of borrowing risked undermining fairness, growth and economic stability in the UK. In 2010 the Government set out clear, credible and specific medium-term fiscal consolidation plans to return the public finances to a sustainable path.
- 2.21 The Government's fiscal strategy has been effective in providing protection against a challenging backdrop of global uncertainty and fiscal vulnerabilities. This has restored fiscal credibility, allowing activist monetary policy and the automatic stabilisers to support the economy, and is consistent with the approach recommended by international organisations.
- 2.22 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. By the end of 2012-13, around 70 per cent of the

annual fiscal consolidation planned for the Spending Review 2010 period will have been achieved, with around 65 per cent of the spending reductions predicted by 2014-15 and around 90 per cent of the tax consolidation in place. 80 per cent of the total consolidation in 2015-16 will be delivered by lower spending with current spending reduced by a further £11.5 billion.

- 2.23 As a result, the Government has made significant progress in reversing the unprecedented rise in borrowing between 2007-08 and 2009-10. The deficit has been reduced by a third as a percentage of GDP in the three years from 2009-10.
- 2.24 The UK's fiscal vulnerabilities argue strongly in favour of maintaining a credible path of deficit reduction. Despite significant progress since 2010, the UK is forecast to have the largest structural deficit in the EU in 2013. Among the G7, only the US and Japan are forecast to have larger structural deficits in 2013. Clear and credible consolidation plans remain essential for reducing the risk of a costly loss of market confidence in the UK.
- 2.25 In February Moody's downgraded the UK sovereign credit rating from Aaa to Aa1 with stable outlook. Among the G7, only Canada and Germany are now rated AAA by all three major credit rating agencies; Canada and Germany had the lowest pre-crisis structural deficits in 2007.
- 2.26 The credit rating is one of many important benchmarks, but near historic low gilt yields continues to reflect the market-tested credibility earned by the Government's economic strategy.
- 2.27 The implication of fiscal consolidation for departmental spending levels can be seen in the table below, which shows resource DEL budgets for each department from the Public Expenditure Statistical Analyses 2013. An estimated £166 billion in 2011-12 was spent on public sector pay, around 50 per cent of departmental resource spending.

Table 1.5 Resource DEL excluding depreciation, 2008-09 to 2015-16

	National Statistics							
	2008-09 outturn	2009-10 outturn	2010-11 outturn	2011-12 outturn	2012-13 outturn	2013-14 plans	2014-15 plans	2015-16 ⁽¹⁾ plans
£ million								
Resource DEL excluding depreciation by departmental group								
Education	46,637	49,385	50,568	50,265	50,239	52,442	53,181	53,168
NHS (Health)	86,671	93,237	96,260	99,070	101,416	105,519	108,340	110,372
Personal Social Services (Health) ⁽²⁾	1,261	1,362	1,471	-	-	-	-	-
Transport	5,436	5,652	5,176	4,679	4,315	3,986	3,621	3,198
CLG Communities	4,084	4,299	3,649	1,745	1,309	2,561	2,085	1,134
CLG Local Government ⁽³⁾	29,487	30,798	28,735	29,764	27,576	16,242	13,330	11,820
Business, Innovation and Skills	16,329	17,321	17,029	16,231	15,467	14,871	13,776	13,000
Home Office	9,009	9,268	12,288	11,904	11,199	10,977	10,359	9,901
Justice	8,633	8,529	8,614	8,453	8,067	7,216	6,793	6,235
Law Officers' Departments	712	697	658	611	591	597	532	519
Defence	25,410	27,587	28,090	28,142	26,415	26,470	24,386	23,896
Foreign and Commonwealth Office	1,946	2,022	2,091	2,052	1,987	1,920	1,158	1,102
International Development	4,742	5,234	5,909	6,167	6,105	8,556	8,273	8,499
Energy and Climate Change	288	1,216	1,146	1,144	1,117	1,375	1,078	952
Environment, Food and Rural Affairs	2,219	2,261	2,175	1,981	1,887	1,932	1,695	1,559
Culture, Media and Sport	1,502	1,457	1,471	1,473	2,059	1,239	1,134	1,098
Work and Pensions	7,689	8,549	8,685	7,286	7,117	7,612	7,412	5,988
Scotland	23,901	24,852	25,587	25,189	25,341	25,672	25,691	25,655
Wales	12,610	13,289	13,615	13,475	13,265	13,705	13,690	13,635
Northern Ireland	8,894	9,293	9,597	9,437	9,461	9,617	9,633	9,622
Chancellor's Departments	4,132	4,048	3,758	3,642	3,262	3,635	3,456	3,265
Cabinet Office	1,772	1,962	2,025	2,045	2,074	2,136	2,279	1,995
Small and Independent Bodies	1,649	1,587	1,552	1,624	1,394	1,468	1,434	1,295
Spending commitments not yet in budgets ⁽¹⁾	-	-	-	-	-	-	-	1,100
Reserve	-	-	-	-	-	2,200	2,800	2,800
Special Reserve	-	-	-	-	-	400	1,800	1,000
Green Investment Bank	-	-	-	-	-	1,000	-	-
OBR allowance for shortfall	-	-	-	-	-	-1,200	-1,000	-
Adjustment for Budget Exchange ⁽⁴⁾	-	-	-	-	-	-1,700	-1,200	-
Total resource DEL excluding depreciation	305,012	323,905	330,149	326,380	321,663	320,700	315,700	312,900

⁽¹⁾ Figures are consistent with Table 1 of the Spending Round 2013 document (Cm8639) published on 26 June 2013.

⁽²⁾ Personal Social Services (Health) are grants previously paid by the Department of Health that are now included in CLG Local Government's budget.

⁽³⁾ Figures from 2013-14 onwards reflect adjustment to departmental plans for changes to local government funding for business rates retention and council tax localisation.

⁽⁴⁾ Departmental budgets in 2013-14 and 2014-15 include amounts carried forward from 2012-13 through Budget Exchange. These increases will be offset by any deposits at Supplementary Estimates in future years so are excluded from spending totals.

Labour market

2.28 Headline labour market figures strengthened in the second quarter of 2013 after a weak start to the year. Employment increased on the quarter to its highest recorded level, driven predominantly by an increase in the number of employees. Employment increased by 69,000 on the quarter and is up 301,000 over the year. The OBR expects employment to continue to rise over the forecast period, but at a slower pace than the increase over 2012. Unemployment decreased slightly over the quarter (-4,000) and is down 49,000 over the year. The unemployment rate remained unchanged, in-line with market expectations but is down 0.2 percentage points compared to the same period last year and down from the peak of 8.4 per cent in the final quarter of 2011. The OBR expect the unemployment rate to increase over 2013 reaching 8.05 per cent by the end of 2014.

- 2.29 In the second quarter of 2013, the overall LFS employment level was 205,000 above its pre-recession peak in the three months to May 2008, but the employment rate at 71.5 per cent was 1.5 percentage points lower than its pre-recession peak. The recovery of the level of employment over this period was driven by strong increases in part-time employment (up 572,000) and self-employment (up 346,000) while full-time employment and the number of employees have fallen by 367,000 and 183,000 respectively.
- 2.30 The performance of other labour market indicators are providing mixed signals on the recovery in labour demand. Average earnings growth remains weak, with regular pay growth (excluding bonuses) at 1.1 per cent. However, the number of vacancies increased by 58,000 over the year to 533,000 in the three months to June 2013, the highest level since late 2008.

Employment and unemployment

- 2.31 The increase in the level of employment of 301,000 over the year to the second quarter of 2013 continues to give indications of a positive change in the composition of employment, with the number of employees increasing by 299,000 while self-employment is down by 20,000. The increase saw those working full-time increase by 306,000 while those working part-time fell by 4,000. It is also notable that the increase of employment has been driven by women, which increased by 225,000 over the period.
- 2.32 The ILO unemployment rate, which rose from a low of 5.2 per cent in the first quarter of 2008 to peak at 8.4 per cent (2.66m people) in the final quarter of 2011, has subsequently fallen to 7.8 per cent in the second quarter of 2013.
- 2.33 Long term unemployment (unemployment of 12 months or more) increased by 28,000 over the year up to the second quarter of 2013 to stand at 909,000.
- 2.34 Working age inactivity (16-64) was down by 105,000 over the year at 22.3 per cent. This has been driven entirely by the fall in female inactivity, which has fallen by 148,000 over the year while male inactivity has increased by 43,000.
- 2.35 Youth unemployment (16-24) increased by 15,000 in the second quarter of 2013 to 973,000 (21.4 per cent). Excluding those that are in full-time education, the level is 676,000 (or 19.8 per cent).
- 2.36 The claimant count (the number of people claiming Jobseeker's Allowance) continues to fall, declining by 29,200 in July 2013. July was the ninth consecutive month the claimant count has fallen. Table 4 summarises these statistics:

Table 4: Labour market statistics summary (Levels in 1,000's, rates in %)

	2009	2010	2011	2012	2013 Q2
Employment level (All aged 16 and over)	28,960	29,019	29,166	29,519	29,777
Employment rate (All aged 16-64)	70.9	70.5	70.5	71.1	71.5
Unemployment level (All aged 16 and over)	2,390	2,476	2,564	2,548	2,514
Unemployment rate (All aged 16 and over)	7.7	7.8	8.1	7.9	7.8
Youth unemployment level (All aged 16-24)	912	932	986	992	973
Youth unemployment rate (All aged 16-24)	19.1	19.8	21.1	21.2	21.4
Claimant Count	1,528	1,496	1,534	1,585	1,496

2.37 The latest public and private sector employment figures available are for the first quarter of 2013. These show that private sector employment rose by 46,000 on the quarter and was up by 544,000 over the year. This more than offset the fall in public sector employment which decreased by 22,000 on the quarter and by 112,000 over the year. This takes into account reclassifications of education corporations in the second quarter of 2012¹¹.

Public and Private Sector Earnings

¹¹ (<http://www.ons.gov.uk/ons/rel/pse/public-sector-employment/q1-2013/stb-pse-2013q1.html>)

- 2.38 Average total pay growth (including bonuses) increased by 2.1 per cent in the three months to June, the first time the rate has been above two per cent since late 2011. However, this is likely to be due to unusually strong bonus payments made in April with some businesses reporting that they paid bonuses in March 2012 but in April in 2013. Regular pay growth (excluding bonuses) rose by 1.1 per cent over the same period. Between June 2012 and June 2013 the Consumer Price Index increased by 2.9 per cent, meaning that real pay growth continued to be negative over this period.
- 2.39 Average total private sector pay has recovered somewhat from its large decline in 2009 but remains mostly weak, growing by just two per cent in 2010 and 2.5 per cent in 2011, compared to above four per cent prior to the recession. Private sector pay growth weakened in 2012 and into the first quarter of 2013. Total private sector pay strengthened in the second quarter of 2013 to grow by 2.6 per cent in the three months to June on the year; however, this is likely to be due to the unusually high bonus payments in this period. Average private sector regular pay grew by 1.4 per cent in 2010 and gained some strength in 2011 and at the beginning of 2012. However, it weakened in the latter half of 2012 and into 2013, growing by just 0.8 and 1.2 per cent in the first and second quarters of this year.
- 2.40 Public sector (excluding financial services) average regular pay was 2.3 per cent in 2010 and 1.8 per cent in 2011. While this recovered slightly in the middle of 2012, growing by 2.4 per cent in the three months to September 2012, it weakened towards the end of the year and grew by 1.4 per cent and 1.2 per cent in the first and second quarters of 2013 respectively.
- 2.41 The sharp drop in bonuses seen in 2009 put more downward pressure on total pay (pay including bonuses), while there were some tentative increases in the levels during 2010 and 2011, it has remained mostly subdued. Bonus pay in the private sector continued to be weak throughout 2012, falling on average by 1.6 per cent compared to average growth of 10.6 per cent in 2011. Bonus pay has seen large fluctuations during 2013 with a fall of 8.1 per cent in March 2013 but an extremely large single month increase in April 2013 of 62.3 per cent likely due to the timing of annual bonus payments.

Table 5 sets out the differences in regular and total pay growth across years in the public and private sector.

Table 5: Total pay and Regular pay (excluding Bonuses) growth¹²

	Total Pay, annual growth			Regular pay, annual growth		
	All	Private	Public ¹³	All	Private	Public
2009	-0.1%	-1.0%	2.8%	1.8%	1.2%	3.0%
2010	2.4%	2.0%	2.2%	1.9%	1.5%	2.3%
2011	2.4%	2.5%	1.5%	2.0%	2.0%	1.8%
2012	1.4%	1.4%	1.7%	1.7%	1.8%	1.6%
<i>Three months to June 2013</i>	2.1%	2.6%	1.2%	1.1%	1.2%	1.2%

2.42 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.

Public Sector Pensions

2.43 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.

¹² Source: ONS, AWE; HMT calculations annual percentage change for quarter one.

¹³Public Sector excluding financial services

- 2.44 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 in the private sector. Around 85% of public sector employees are members of employer sponsored pension schemes, compared to only 35% in the private sector.
- 2.45 Following a fundamental review of public service pension provision by the Independent Public Service Pensions Commission, the Government is introducing key changes to the pension element of the remuneration package. New public service pension schemes will be introduced in April 2015, which will:
- calculate pension entitlement using the average earnings of a member over their career, rather than their salary at or near to retirement
 - calculate pension benefits based on Normal Pension Age linked to the member's State Pension Age
 - Include an employer cost cap mechanism, where unforeseen changes in scheme costs are shared by members and employers (based on two per cent of the scheme's total pensionable pay bill)
- 2.46 The changes being introduced through the Public Service Pensions Act 2013 will save an estimated £65 billion by 2061-62.
- 2.47 Wider changes to public service pension provision have also taken place. Progressive increases in the amount that members contribute towards their public service pension began in April 2012. Members will contribute an average of 3.2 percentage points more, phased in over three years (increases will be finalised in April 2014). This will deliver £2.8 billion of savings a year by 2014-15.
- 2.48 Protections from the impact of the contribution changes have been put in place for the lowest paid. Those earning less than £15,000 will see no increases; and those earning up to £21,000 (£26,000 for Teachers) will not see increases of more than 1.5 percentage points by 2014-15.
- 2.49 Public service pensions will remain among the best available and will continue to offer members guaranteed, index linked benefits in retirement that are protected against inflation. Private sector workers buying benefits in the market would have to contribute over a third of their salary each year to buy an equivalent pension.
- 2.50 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.

Chapter 3: NHS Finances

Funding Growth

- 3.1 This chapter sets out the financial position for the NHS in 2014/15.
- 3.2 Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.5 per cent in real terms. The first two years of the current spending review period (2011/12 and 2012/13) have shown subdued growth, averaging 0.7 per cent per year in real terms.
- 3.3 Table 3.1 shows:
- Outturn NHS revenue expenditure figures from 1999/00 to 2012/13
 - Revenue Departmental Expenditure Limits (RDEL), as agreed in the 2010 and 2013 Spending Reviews, for 2013/14 to 2015/16.

Table 3.1 - NHS Revenue Expenditure since 1999/00

Year		Revenue Net NHS Expenditure (5)(7) £bn	% increase	% real terms increase (6)
RB Stage 1⁽¹⁾				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	7.9
2001/02	Outturn	47.3	10.8	7.9
2002/03	Outturn	51.9	9.8	7.3
RB Stage 2⁽²⁾⁽⁴⁾				
2003/04	Outturn	61.9	-	-
2004/05	Outturn	66.9	8.1	5.2
2005/06	Outturn	74.2	10.9	8.9
2006/07	Outturn	78.5	5.8	2.8
2007/08	Outturn	86.4	10.1	7.4
2008/09	Outturn	90.8	5.0	2.2
2009/10	Outturn	97.8	7.8	4.9
Resource Budgeting - Aligned⁽³⁾				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	0.6
2011/12	Outturn	100.3	2.9	0.6
2012/13	Outturn	102.6	2.3	0.8
2013/14	Plan	106.7	4.1	1.7
2014/15	Plan	109.6	2.7	0.8
2015/16	Plan	111.9	2.1	0.2

1. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting basis.

2. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis.

3. Expenditure figures from 2009-10 to 2010-11 are on an aligned basis.

4. Figures from 2003/04 include a technical adjustment for trust depreciation

5. Expenditure excludes NHS (AME)

6. GDP as @ 27/06/2013

7. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings the Department of Health in line with HMT presentation of the statistics.

Share of resource going to pay

3.4 Table 3.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time.

Table 3.2 – Increases in Revenue Expenditure and the proportion consumed by Paybill

Year	Increase in Revenue Expenditure (£bn)	Increase in HCHS Paybill (£bn)	Proportion of revenue increase on paybill (%)	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
				(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4
2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1
2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	3.1	1.1	1.2	0.4
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.0*	0.4*	0.5*	0.2*
Average	5.0	2.0	39	4.2	1.2	2.8	0.8

*. Provisional

1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations

2. Excludes ALB and Department of Health core staff expenditure

3. Excludes GPs

4. Pay (price element) methodology changed from last year's evidence to maintain consistency of series.

5. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR

6. Figures may not sum due to rounding.

3.5 On average, between 2001/02 and 2012/13, increases to the HCHS paybill have consumed 39 per cent of the increases in revenue expenditure. Of this 39 per cent, pay effects have consumed around 23 per cent and volume effects around 16 per cent.

3.6 HCHS pay is the largest cost pressure, accounting for 45 per cent of revenue expenditure in 2012/13. On average it has also accounted for around 39 per cent of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next 3 years.

Pressures on NHS funding growth

3.7 Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories:

- baseline pressures
- underlying demand
- service developments

3.8 Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand, or increased levels of activity, which may arise due to demographic pressures or medical advance. Service developments are new areas of activity which arise due to new policies or ministerial commitments.

3.9 HCHS pay bill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Allocation of resources

3.10 Table 3.3 shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

Table 3.3 – Disposition of Revenue Increase Across Expenditure Components

	Outturn			Plan	
	SR2004 £bn	CSR2007 £bn	First 2 years of SR10 £bn	2013/14 £bn	2014/15 £bn
Activity Growth	2.9	1.1	0.8	2.2	1.8
Service Development	1.6	1.7	0.3	0.5	0.5
HCHS Pay (Price only Component)	1.7	2.0	0.2	0.9	0.7
Secondary Care Drugs	0.3	0.4	0.3	0.4	0.0
Other (including central budgets)	0.3	0.1	-0.1	0.6	-0.5
Primary Care Drugs	0.3	0.3	-0.2	0.4	0.2
General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.2	0.1	0.1
Procurement	0.1	0.1	0.9	0.3	0.1
General Medical Services	0.1	0.2	0.1	0.1	0.2
Funding for Social Care			0.5	0.2	0.2
Productivity	-0.3	-0.3	-0.4	-1.2	-1.3
Average annual increase in revenue	7.2	5.7	3.7	4.2	2.5

Note:

SR2004 and CSR2007 activity growth numbers exclude purchases of healthcare from non NHS bodies, whereas they are included in the SR10 figures.

3.11 There are £2.5bn of increased revenue resources available in 2014/15 for the NHS to meet in-year pressures. This is lower than the previous three spending review periods, lower than the first two years of this spending review and lower than the planned disposition of resources for 2013/14.

- 3.12 The difficulty of allocating resources is therefore more acute than it has been in the previous ten years. Of the £2.5bn available, demand pressures consume £1.8bn, even after an assumption that demand growth will be lower than in recent years due to the transformational activities being undertaken as part of the NHS Quality, Innovation, Productivity and Prevention (QIPP) challenge. The remaining £0.7bn is assumed to be available for pay, with other cost pressures being absorbed by improved productivity (more than four times the rate of the previous two Spending Reviews).
- 3.13 A £0.7bn pay pressure is equivalent to an increase in pay costs of 1.5 per cent.
- 3.14 Any increases in pay costs above this level would therefore have to be afforded by further increases in productivity and fewer staff employed. It is unclear how much further the NHS can go in reducing the number of non-clinical staff given the large reductions over the past three years and there is a real risk that underlying pay pressures in the system, even before any pay rise, will have an adverse impact on the affordable clinical workforce.

Productivity

- 3.15 Improvements in workforce productivity are key to helping deliver the efficiency savings in this, and the next, Spending Round period. So far, workforce productivity gains have contributed 12 per cent of the total savings made in 2011/12 and 2012/13, compared to 23 per cent which has come from pay restraint. The workforce productivity share of total savings is expected to grow to 26 per cent in 2013/14 and 2014/15.
- 3.16 Despite improved productivity performance in the last two years, there still exists wide labour productivity variation at Trust level.¹⁴ Levelling up performance as well as shifting the average Trust performance upwards will help achieve the workforce productivity gains that are required. The level of resource assumed available for pay is predicated on this increased level of productivity in 2014/15.

Conclusion

- 3.17 The NHS has received a better Spending Round settlement than almost all other parts of the public sector, including a guarantee of real terms increases in funding in 2014/15. However, although generous compared to other departments, this represents the biggest financial challenge in the history of the NHS.

¹⁴ <http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity>

- 3.18 The NHS is delivering on this challenge and has so far met its savings targets in 2011/12 and 2012/13. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services.
- 3.19 Pay competes for fewer available resources. To restrict pay cost growth to 1.5 per cent in 2014/15, workforce productivity must increase faster than at any time over the last three Spending Review periods. Alongside this, reductions in the growth rate of demand are required to retain financial balance. Any increase in pay costs above 1.5 per cent risks significant reductions in clinical staff to balance the financial position, which in turn may harm the ability to maintain access to and quality of NHS services to the public.

Chapter 4: Medical Workforce Policy Context

High level strategy and policy context for workforce planning

- 4.1 The Government remains committed to supporting a world class healthcare education and training system underpinned by robust workforce planning with providers of NHS commissioned services taking the leading role.
- 4.2 The Department of Health published a policy framework for a new approach to education and training on 10 January 2012, *Liberating the NHS: Developing the Healthcare Workforce*¹⁵. It set out the government's vision for the new education and training system. Its aim is to empower healthcare employers and national and local clinical leaders to drive forward both the planning of the workforce and the commissioning of education and training.
- 4.3 The Department and Health Education England (HEE) share a vision of planning for future workforce needs and securing funding for education and training that is underpinned by accurate, comprehensive, complete and timely workforce information, to ensure the workforce truly reflects the needs of local service users. This will meet the needs of patients, providers, and commissioners of healthcare.

New arrangements

- 4.4 The Department of Health will ensure, through its sponsorship role, effective collaborative working between the elements of the system. However, the reformed system for workforce development offers a major opportunity for providers of NHS-funded care to be influential in determining the investment priorities for education and training. As well as engaging and working with their local education and training boards (LETBs), providers will need to be more actively involved in planning their future workforce needs and in sharing the results of their plans with the rest of the system.
- 4.5 HEE took on its full range of functions and responsibilities on 1 April 2013, including the responsibility for delivery of the Secretary of State's duty to ensure an effective system is in place for education and training, as set out in the Health and Social Care Act 2012. It is accountable for the investment of education and training resources, which in 2013/14 total around £4.9 billion. HEE's primary focus is on professionally qualified healthcare and public

¹⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216421/dh_132087.pdf

health staff whose education and training is funded through the multi-professional education and training budget for which HEE is responsible for.

Health Education England

4.6 HEE was issued with a mandate by the Secretary of State for Health on 28 May 2013. *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values: a mandate from the Government to HEE*¹⁶ sets out the key priorities for HEE from April 2013 to March 2015. It is centred around the five domains of the education outcomes framework:

- excellent education
- competent and capable staff
- flexible workforce, receptive to research and information
- NHS values and behaviours
- widening participation

4.7 The mandate provides details of the strategic objectives of the Government in the areas of workforce planning, health education, training and development for which HEE and the LETBs have responsibility. It aligns with the mandate for NHS England and the Francis Report, as well as the requirements of the NHS, Public Health and Social Care Outcomes Frameworks^{17&18}. It also reflects the increasing importance of public health matters and will require HEE to take into account the development of the Public Health England (PHE) strategy and the Secretary of State's four priorities:

- Preventable mortality
- Long-term conditions
- 'being caring' and
- Dementia

4.8 HEE will provide its own evidence and in doing so will address the priorities set out in the mandate.

Education Outcomes Framework

4.9 The Education Outcomes Framework¹⁹ (EOF) sets out the expected strategic outcomes that HEE and other partners in the system will need to achieve to

¹⁶ http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/05/29257_2900971_Delivering_Accessible.pdf

¹⁷ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

¹⁸ <https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

¹⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175546/Education_outcomes_framework.pdf

deliver system wide improvements in education and training. The outcomes are set in terms of the impact for patients, users of services and carers.

- 4.10 The framework was published on 28 March 2013 and will be used to measure improvements in education, training and workforce development and the impact on the quality and safety of services for patients. The EOF is a 'living document' which will evolve during the life of the HEE mandate. While HEE is responsible for a number of areas within the EOF, in other areas progress is dependent on the entire health and care system working effectively.

Local Education and Training Boards

- 4.11 On 1 April 2013, thirteen local education and training boards (LETBs) were also established by HEE across England. Each LETB has taken on responsibility for managing workforce planning, education commissioning and education provision across England, on behalf of the healthcare providers in their geographical area.
- 4.12 The LETBs include senior provider leadership and reflect the important partnerships needed on education and training, with representation from the education sector, research and innovation sector, commissioning organisations and local government. HEE is managing its relationship with each LETB through an annual accountability agreement. These set out the agreed priorities and deliverables for each LETB, and reflect any areas for development against the LETB authorisation framework.

The Centre for Workforce Intelligence

- 4.13 The Centre for Workforce Intelligence (CfWI) is an independent body providing advice, information and tools to support workforce planning and development to the NHS, social care and public health system. CfWI will provide national and strategic intelligence and consider international implications.
- 4.14 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.
- 4.15 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
- supporting HEE in their role as leaders of the workforce planning and education and training system
- the support, resources and best practice to improve the effectiveness of workforce planning at local, regional and national levels

Workforce planning and education and training commissioning

4.16 The *Health and Social Care Act 2012* placed a duty on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. It does this through the duty placed on:

- the Secretary of State to put in place an effective education and training system
- providers of NHS-funded care to co-operate within the new education and training system and
- service commissioners, via NHS England and clinical commissioning groups (CCGs), to ensure service providers with whom they contract have regard to education and training when carrying out their functions

4.17 The majority of the workforce is employed in delivering healthcare that has been commissioned by service commissioners. The responsibility for planning the future workforce extends to service commissioners, who need to be able to articulate their strategic intentions clearly, so that providers can translate these into service delivery proposals. Furthermore, service commissioners need to have regard for the workforce implications of their commissioning intentions and consider the viability and achievability of their commissioning plans.

4.18 Fundamental to the operation of the reformed system for the planning, commissioning and delivery of education and training will be the process of securing, analysing and managing information, both about the current workforce and about future workforce needs. Workforce planning in this more diverse NHS requires continued access to high quality, comprehensive and complete workforce information to enable HEE, LETBs and CfWI to fulfil their roles. The Workforce Information Architecture (WIA) work stream was established by the Department as part of the reforms to education and training in order to review, improve and test the arrangements for handling workforce data and intelligence that will be necessary for the reformed system to

operate effectively. The WIA report²⁰ sets out findings and recommended actions which includes a requirement for all providers of NHS-funded care to participate in the new education and training system and provide information on their current workforce and future workforce requirements. A Workforce Minimum Data Set has been developed to ensure consistent information on the current workforce, with details available on the Health and Social Care Information Centre website at www.hscic.gov.uk/wMDS. HEE will take forward the implementation of the recommended actions set out in this report, making available further details during 2013-14.

Structure of medical education and training

4.19 The HEE mandate sets HEE the objective that it must ensure that medical trainees who are competent and able to complete training programmes successfully are supported to secure full GMC registration. The Department of Health and HEE will work with partners, including the other UK health departments, the GMC, medical schools, employers and trainees to set out a reformed approach by Autumn 2013 with a view to introduction in Autumn 2014. This objective will be updated to reflect progress when the mandate is refreshed in Autumn 2013.

Postgraduate tariffs for secondary care

- 4.20 The Department has confirmed that it will move to a tariff-based system for funding clinical education and training. The aim of the tariffs is to provide a more transparent, fair and consistent basis for the funding of clinical placements. The tariffs will be applicable at a national level and based on activity rather than local funding agreements.
- 4.21 Tariffs for post graduate training in secondary care will be introduced from 1 April 2014. The tariffs will standardise the price of clinical education and training and introduce a number of benefits, including payments that reflect service contributions (through collection of actual costs data to underpin tariffs).
- 4.22 To reduce the financial instability due to the introduction of a tariff, there will be a phased movement to operating under full tariff. The tariff for 2014-15 (and a number of subsequent years) will therefore be transitional and calculated to 'cushion' the losers towards the tariff prices and correspondingly to limit gainers to what can be afforded during the transition period.

²⁰ Published by DH at www.gov.uk/government/publications/health-workforce-information-review

Workforce issues in emergency medicine

- 4.23 In order to tackle historical shortages in doctors working in emergency medicine, the HEE mandate sets an objective to ensure that the medical taskforce working group is maintained. HEE are also expected to encourage more doctors into emergency medicine. The taskforce will urgently review the workforce issues in emergency medicine, produce recommendations in summer 2013 and develop and execute an implementation plan with relevant partners to address workforce shortages for both the short and long term. We will update the DDRB at supplementary evidence stage following publication of the taskforce recommendations.

Extension to GP training

- 4.24 The Government has asked HEE to ensure that General Practitioner (GP) training produces GPs with the required competencies to practise in the new NHS. Medical Education England (MEE) accepted the educational case to extend GP training to four years. This extension is supported by the Department of Health in principle, subject to confirmation of the economic case and affordability. We expect HEE to work with the General Medical Council (GMC), the four UK Health Departments and the Royal College of General Practitioners to agree an approach for implementing the revised training programme. We have agreed with HEE that this objective will be updated in Autumn 2013 to reflect progress and the outcome of the Shape of Training review that is being led by Professor David Greenaway.

International dimension: reducing the reliance on international migration of skilled occupations in shortage occupations

- 4.25 In the past, the NHS has relied on immigration to bolster domestic workforce supply. The UK has been moving towards self-sufficiency for a number of years and there has been significant investment in training to increase UK supply of health professionals.
- 4.26 Following a consultation in 2012 the Migration Advisory Committee (MAC) recommended an overall reduction of 11 medical health roles listed on the National Shortage Occupation List (NSOL) as shown in table 4.1.

Table 4.1 – National Shortage Occupation List

NSOL from 14 Nov 2011 (medical posts)	NSOL from 06 Apr 2013 (medical posts)
18 posts	7 posts
<i>Consultants in the following specialties:</i>	
clinical neurophysiology emergency medicine genito-urinary medicine haematology neurology occupational medicine	emergency medicine haematology old age psychiatry
<i>Consultants in the following specialties of psychiatry:</i>	
forensic psychiatry general psychiatry learning disabilities psychiatry old age psychiatry	
<i>Non-consultant, non-training, medical staff posts in the following specialties:</i>	
anaesthetics general medicine specialities delivering acute care services (intensive care medicine, general internal medicine (acute)) paediatrics emergency medicine general surgery obstetrics and gynaecology trauma and orthopaedic surgery	anaesthetics general medicine specialities delivering acute care services (intensive care medicine, general internal medicine (acute), emergency medicine (including specialist doctors working in accident and emergency)) rehabilitation medicine psychiatry
ST4 level trainees in paediatrics	

4.27 This recommendation suggests that the increased investment and focus by the Department over recent times has gone some way to remedying the structural skill shortages that exist within the sector.

4.28 The Department will continue to monitor the position of these shortage staff groups as part of its responsibility to ensure strategic supply for the NHS in England; additionally HEE has been specifically tasked to reduce the number of health roles on the shortage occupation list by March 2015.

Information sources

NHS Electronic Staff Record (ESR)

4.29 The Electronic Staff Record (ESR) is the integrated human resource, payroll and learning management system for all hospitals in England and Wales

(apart from two), and for those social enterprises which use it as their HR and Payroll system. It enables the capture of up to date workforce information, securely and confidentially, in a timely and consistent format.

- 4.30 The Department of Health, HEE, LETBs, the Health & Social Care Information Centre (HSCIC) and a limited number of other bodies, including NHS Employers, access summary data from its warehouse for a range of purposes, such as understanding the size and shape of the current workforce, planning the future workforce, pay bill modelling and sickness absence. This model of centrally sourced workforce information significantly reduces the submission burden on local NHS service providers in relation to the annual workforce census and monthly workforce publication, and supports the drive to improve back office efficiency.
- 4.31 The contract for the provision of ESR will be re-procured to ensure continuity of service and by engaging users in developing future requirements we anticipate its continued widespread use. It is currently available for all NHS employers including successor bodies providing NHS-funded services, such as social enterprises. It is not used by general practitioners and other primary care providers.

Fundamental Data Review

- 4.32 The Government made a commitment in the White Paper, *Equity and Excellence: Liberating the NHS* to

“...initiate a fundamental review of data returns, with the aim of culling returns of limited value, to ensure that the NHS information revolution is fuelled by data that are meaningful to patients and clinicians when making decisions about care, rather than by what has been collected historically”.

- 4.33 The Fundamental Review covered all national data returns requested by the Department of Health in England and its Arm’s Length Bodies (ALBs) from NHS organisations and recommended that 76 (25 per cent) of the returns be discontinued and estimated that this would reduce the burden on the NHS by approximately £10m per annum. Following consultation, a number of central returns were discontinued, including the Annual NHS Vacancy Collection and the General Practitioners Practice Vacancy Survey.
- 4.34 The Department is working with NHS England, HEE and the HSCIC on the design of the workforce information architecture for the new education and training system, which includes some vacancy data as part of the Workforce Minimum Data Set.

- 4.35 NHS Jobs, an electronic jobs board for the NHS, may provide some useful data in the form of adverts opened and closed to be used as a proxy for data on vacancies²¹. The system holds data on (the number of) advertisements. However, the data available from NHS Jobs will not be able to identify when posts are filled or where posts have been vacant for three months directly, but the dates associated with the adverts should provide a useful proxy measure.

Published workforce statistics

Annual workforce statistics

- 4.36 The HSCIC publishes annually the NHS Workforce Census. The Census covers both Hospital and Community Health Services (HCHS) and primary care staff, and records the numbers of NHS staff employed in England within the main occupational groups on 30 September each year.
- 4.37 The annual Census provides the best means of viewing medium and long-term trends in workforce numbers. Full Time Equivalent (FTE) figures are the best measure of real changes in the NHS as they reflect service capacity rather than the number of people.
- 4.38 A summary of the data on the medical workforce from the latest annual workforce census, published in March 2013 is shown in table 4.2.

²¹ There are a number of factors that should be taken into account: not all adverts are vacancies (as some trusts recruit into pools so that they may appoint immediately as a post becomes available); some adverts are standing adverts and are not linked to a specific vacancy; jobs may be re-advertised as new vacancies; and some adverts are for multiple posts. Furthermore, if an advert did directly correlate to one post, there is no guarantee that the appointment will be recorded on NHS Jobs.

Table 4.2 – NHS Hospital & Community Health Service (HCHS) and General Practice Workforce as at 30 September each specified year

Table 1b: NHS Hospital & Community Health Service (HCHS) and General Practice workforce as at 30 September each specified year

England		full time equivalent & percentages		
	2011	2012	Change 2011-2012	% change 2011- 2012
Total HCHS medical and dental staff	99,394	100,899	1,505	1.5%
Total GPs	35,319	35,871	552	1.6%
Professionally qualified clinical staff	605,452	607,149	1,697	0.3%
All doctors	134,713	136,770	2,057	1.5%
Consultants (including Directors of public health)	36,965	38,197	1,232	3.3%
Registrars	38,134	38,489	355	0.9%
Other doctors in training and equivalents	13,860	13,773	-86	-0.6%
<i>Hospital practitioners and clinical assistants (non-dental specialties)</i>	402	350	-52	-13.0%
Other medical and dental staff	10,034	10,091	57	0.6%
GPs total	35,319	35,871	552	1.6%
GP Providers	24,415	24,095	-320	-1.3%
Other GPs	6,976	7,483	507	7.3%
GP registrars	3,784	4,138	354	9.3%
GP retainers	143	155	12	8.1%

Source: 2013 Health and Social Care Information Centre.

Monthly workforce statistics

4.39 The HSCIC also continues to publish monthly workforce data. This covers NHS (HCHS) staff working in NHS organisations in England who use ESR (excludes primary care staff), and those social enterprises that use ESR. Data is taken from the annual census for the two Foundation Trusts who do not use ESR and included in the data published monthly.

4.40 The data includes some staff, for example, those working as locums, who did not appear on the Census; while other staff who do appear on the Census, including primary care staff, are not recorded on ESR.

NHS reforms

4.41 The structural changes in the NHS from April 2013 are impacting on how the HSCIC report the data. The HSCIC is consulting stakeholders on which new bodies should be included in the annual workforce Census publication. Some NDPBs, for example, Monitor and CQC have always been and will continue to be excluded from NHS workforce publications.

Recent reviews

Francis Inquiry

- 4.42 Robert Francis QC published his report into the care provided by Mid Staffordshire NHS Foundation Trust in February 2013²². The Francis Inquiry examined the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire and considered why the serious problems at the Trust were not identified and acted on sooner.
- 4.43 The Inquiry report discussed the issue of staffing levels and suggested the use of tools to ensure that staffing levels are correct rather than mandating either a system or specific level. Recommendations included evidence based benchmarks and guidance and input from clinicians, professional bodies and patient and public representatives. The Department of Health agrees with Robert Francis that there is a need for evidence-based guidance and tools to inform appropriate staffing levels.

Keogh Mortality Review

- 4.44 Sir Bruce Keogh (NHS Medical Director) conducted reviews into the quality of care and treatment provided by 14 hospital Trusts, and the Keogh Mortality Review report was published on 16 July 2013²³.
- 4.45 The reviews set out to identify any sustained failings in the quality of care and treatment being provided to patients at these Trusts. From the reviews, Sir Bruce has identified eight national ambitions for improvements aimed to tackle underlying causes of poor care as well as individual recommendations for each of the 14 Trusts. All will be inspected again within the next 12 months by the new Chief Inspector of Hospitals, Professor Sir Mike Richards.
- 4.46 The new Chief Inspector of Hospitals will have a clear remit to inspect staffing levels and report if they are appropriate and the Department of Health will work with NICE, CQC and NHS England to review the use of evidence based guidance and tools to inform staffing decisions locally.

Professor Don Berwick Review

- 4.47 Professor Don Berwick, a renowned international expert in patient safety, was asked by the Prime Minister to carry out a review following publication of the Francis Report. Professor Berwick's report²⁴ follows five months of intensive

²² <http://www.midstaffspublicinquiry.com/report>

²³ <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

²⁴ <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

work to examine the lessons for NHS patient safety from healthcare and other industrial systems throughout the world. It echoes the Keogh Mortality Review in saying that staffing levels cannot be dictated from the centre, but that boards and local leaders should take responsibility for ensuring that clinical areas are adequately staffed.

Chapter 5: Consultants

The Consultant Contract 2003

5.1 In December 2012, the Government published the Review Body's report on rewards and incentives for consultants²⁵, which made recommendations about clinical excellence awards and observations on the consultant contract. Ministers welcomed the key principles underlying the report, in particular that:

- there should be a new approach to national and local awards
- the contract should recognise different stages in the consultant career
- progression should be linked to performance rather than time served and
- reward should reflect current, not past performance, and be informed by patient feedback

5.2 Reports by the National Audit Office²⁶ and the Public Accounts Committee²⁷ also made observations on the contract and clinical excellence awards. The Government has accepted²⁸ recommendations that changes to the contract should:

- aim to drive efficiency savings across the hospital sector
- be flexible enough to support seven day services and set a maximum limit on payments for additional work
- strengthen the link between job plan review and appraisal and the award of pay progression
- and that changes to clinical excellence awards must ensure that awards truly reflect performance above the norm, with more routine reviews of awards already made

5.3 The Government believes that there is a compelling case for changes to the consultant contract to ensure that terms and conditions are fit for purpose (including pay scales that are equality proof) and to support the affordable continued expansion of the consultant workforce and the policy aims of a

²⁵ DDRB: [Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants](http://www.ome.uk.com/DDRB_Reports.aspx), December 2012. http://www.ome.uk.com/DDRB_Reports.aspx

²⁶ National Audit Office: *Managing NHS hospital consultants*, 6 February 2013. <http://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf>

²⁷ Committee of Public Accounts: *Department of Health: managing NHS hospital consultants*, 12 June 2013. <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpublic/358/35802.htm>

²⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/239115/32914_Cm_8697_v0.2.pdf

consultant-led service and seven day services, which are essential to quality patient care.

- 5.4 Whilst the Review Body's report made recommendations about future clinical excellence awards being non-pensionable, Ministers are prepared, given the move to a career-average pension scheme, to consider the continued, affordable pensionability of awards, subject to agreement on a package of changes as recommended in the report.
- 5.5 The Department asked NHS Employers to enter into discussions with the British Medical Association (BMA) on changes to the contract. The BMA agreed to discussions for England and Northern Ireland only. These resulted in a draft Heads of Terms Agreement for Consultant Contract Reform, published on 31 July 2013²⁹. On 18 September the BMA agreed to enter into formal negotiations with NHS Employers.
- 5.6 Should the Review Body consider that any award is needed, we recommend that this be tied to securing agreement on changes to the contract, with the parties invited to report on progress in their evidence to the Review Body next year.

Clinical Excellence Awards (CEAs)

- 5.7 Discussions about the future shape of CEAs at both national and local level are also taking place in the context of discussions on the Consultant Contract.
- 5.8 In the meantime:
- Nearly 300 new 2012 National awards were announced in March 2013
 - A 2013 awards round was launched on 22 July 2013. The results of that round are expected to be announced by March 2014
 - There was a successful outcome to the stakeholder engagement by the Department and the Welsh Government about the proposed discontinuation of two anomalous features of the current schemes. The Review Body was among those who sent helpful comments. A post consultation document has been issued to the organisations who sent comments. In summary, no one will receive pay protection after 30 September 2014 if their Award has been previously or is subsequently withdrawn. The possibility of applying for reinstatement of a Distinction Award upon return to work after retirement is being phased out. No one will hold a reinstated Award after 31 March 2015

²⁹ http://www.nhsemployers.org/SiteCollectionDocuments/HoT_final_for_website_ap290713.pdf

5.9 In its last report the Review Body asked for an update on monitoring of diversity issues arising from the distribution of consultants' awards, action to address inequalities and any concerns regarding compliance with equality legislation. We understand that the Advisory Committee on Clinical Excellence Awards (ACCEA) will cover these matters in its evidence.

Appraisal

5.10 Effective annual appraisal is one of the foundations of medical revalidation and is essential for the responsible officer to be assured that each doctor is up to date and fit to practise.

5.11 As referenced in the executive summary of the Francis report, appraisal systems are a key tool to monitor and enforce standards and to reinforce a caring culture. The GMC have introduced common minimum standards for appraisal and support with which doctors are obliged to comply. As a part of this mandatory annual performance appraisal, each doctor is required to demonstrate their ongoing commitment, compassion and caring shown towards patients, evidenced by feedback of the appraisee from patients and families, as well as from colleagues and co-workers.

5.12 For many organisations, the raised expectations of appraisal means upgrading of their appraisal system. The responsible officer is accountable for the quality assurance of the appraisal and clinical governance systems in their organisation. Improving these systems will support doctors in developing their practice more effectively, which will add to the safety and quality of health care in the UK. It will also enable the early identification of those doctors whose practice needs attention, allowing for more effective intervention.

5.13 Final results from the latest annual Organisational Readiness Self-Assessment (ORSA) exercise are expected to be published in the Autumn. Interim progress reports indicate that over the past three years, there has been a steady rise in the number of doctor appraisals being completed. We will provide further details to the DDRB at supplementary evidence stage, following publication of the ORSA report.

5.14 The ORSA exercise is designed to help NHS bodies ensure their systems and processes are ready to support doctors with revalidation.

Chapter 6: Doctors and Dentists in Hospital Training (Juniors)

- 6.1 For several years, the Review Body has urged the parties to consider restructuring the contract for juniors to shift the balance away from banding supplements towards basic pay. In December 2012, the Government published, and welcomed, NHS Employers' scoping study report which set out a compelling case for changing the existing contract³⁰. The report identified that the contract, having served its purpose of reducing hours in line with the Working Time Regulations, now works against the interests of doctors and patients. It is in the interest of quality services and training, and the morale and motivation of junior doctors, that new contractual arrangements be agreed.
- 6.2 NHS Employers' report highlighted the need for:
- more flexible working patterns and better training. In 2010, the Temple Review found that the contract does not support the best training for junior doctors, as the set working patterns in the contract (and consultants' way of working) make it difficult for juniors to take full advantage of training opportunities
 - a single contract for trainees so that all trainees have the same fair conditions, regardless of whether they are training as a hospital doctor, GP specialty trainee or dental trainee
 - more support for doctors' work/life balance, including recommending that changes are made so that junior doctors are given more notice before they need to move cities or areas for their training rotations
- 6.3 The Government commissioned NHS Employers to enter into discussions with the BMA. Discussions were UK-wide, and resulted in a draft Heads of Terms³¹ being published on 22 June 2013. On 22 July, the Junior Doctors Committee of the BMA accepted the Heads of Terms as a basis for negotiations.
- 6.4 The Review Body has asked whether the levels of the banding supplements require adjustment. The Government's view is that there should be no adjustment to the levels of banding supplements for hospital trainees or for

³⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213214/FINAL-PDF-revised-for-DH.pdf

³¹ <http://www.nhsemployers.org/SiteCollectionDocuments/HoT%20final%20draft%20with%20explanatory%20notes.pdf>

GP registrars, pending the conclusion of negotiations on new contractual arrangements. It is an aim of negotiations to deliver more predictable earnings for juniors and a more predictable pay bill for employers. The Government would be content with proposals for increased basic pay and the removal of banding supplements. Whilst it is an overarching requirement that changes to the contract should not, of themselves, increase the pay bill, the Government is content that any pressure on employer contributions that results from moving earnings out of non-pensionable banding supplements into basic pensionable pay be funded from outside the pay bill for juniors.

- 6.5 Should the Review Body consider that any award is needed, we recommend that this be tied to progress on making changes to the contract, with the parties invited to report on progress in their evidence to the Review Body next year.

Chapter 7: Staff Grade and Associate Specialists

- 7.1 There are no specific issues with the contractual arrangements introduced in 2008. However, we would wish to consider, in due course and in the light of the reform of contracts for other staff groups, what changes might be desirable for this group of doctors, to ensure a continued fit with the arrangements for other employed doctors and consistency with wider public sector pay policies.
- 7.2 Should the Review Body consider that any award is needed, we recommend that this be tied to making changes to the contracts consistent with those under discussion for other employed doctors, on which the parties should be invited to report in their evidence to the Review Body next year.

Chapter 8: General Medical Practitioners

The material in this chapter is for information only and is intended to provide a background to ongoing developments in general practice. Detailed evidence on general practitioners and general dental practitioners will be provided separately by NHS England.

Primary care overview

- 8.1 In England, there are around 8,088 GP practices, which act as both the gateway to and co-ordinator of patient access throughout their care journey. They are usually the first point of contact for a patient seeking treatment or advice about their health.
- 8.2 General practice plays a key role throughout people's lives in helping people to stay well through prevention and support for self-management of conditions; diagnosing and managing the connection to specialist or multi-disciplinary care; and directly providing care and treatment. At its core is a registered list of patients which enables practices to provide continuity of care, coupled with an ability to look at physical, mental and social needs in the round, identifying and managing risk and ensuring that people can access the full range of services they need.
- 8.3 GPs and nurses in general practice see over 800,000 people a day – that is around 300 million contacts every year. Around 90 per cent of people's contact with the NHS is with general practice.
- 8.4 However, general practice, like the wider health system, faces rising demand from an ageing population, growing numbers of co-morbidities and increasing patient expectations. This is set against a backdrop of increasing pressure on NHS financial resources due to the global economic crisis. More than ever before, the role of primary and community care services in providing high quality, integrated out of hospital care is coming to the fore in order for people to stay well and independent for longer and to avoid unnecessary hospital admissions.
- 8.5 With demand on their skills and time intensifying, we need to ensure that we take advantage of the opportunity to innovate in primary care, to strive for continuous quality improvement, and to remove the barriers to change, for instance, by reducing the unnecessary burdens placed on their time.

- 8.6 Locally, there are many examples of innovation and excellence taking place to meet these new challenges. For instance, we are seeing many examples of general practices coming together in networks or federations in order to provide access to a wider range and higher quality of services to their patients through the pooling of knowledge, skills and resources.
- 8.7 At a national level, the Government has already made clear its intentions for general practice to continue to strive for improvement through the changes made to the GP Contract for 2013/14. These include a greater focus on reward based on delivering better care and early diagnosis for patients, reflecting expert advice from NICE on which areas should be included in the Quality and Outcomes Framework; progress to ensure fairer funding between practices; investment in two new vaccination programmes for rotavirus and shingles; and the inclusion of new Direct Enhanced Services for people with dementia, improving care management of the seriously ill, booking appointments and repeat prescriptions online, and remote monitoring for patients with long-term conditions.
- 8.8 The key role of general practice in understanding the healthcare needs of their local populations was given further teeth in the move to clinical commissioning groups, formally established from April 2013, as part of the Government's modernisation of the NHS. These groups allow the freedom for local clinicians, to plan, prioritise and commission health services for their local populations and to work with others in the local community, such as local authorities and patient groups, so that their combined actions improve the health and wellbeing of the local population.
- 8.9 Looking forward, we are currently in discussions with the public, patients, carers and professionals, as part of the work to refresh the Government's Mandate to NHS England, about how to strengthen the role that general practice can play in supporting vulnerable older people. For instance, through a named accountable clinician, responsible for ensuring that a person's care is co-ordinated and of the highest standard. The Department is also exploring how the system can stimulate new models of care to ensure that care is fully integrated around people's needs, and the key role that general practice can play within these models, both in their role as providers but also as commissioners of services. This work will culminate in the publication of a 'Vulnerable Older People's Plan' in the Autumn.

- 8.10 NHS England, as commissioner of primary care services, will build on this work to develop their strategy for the commissioning of general practice over the coming years, including how they can stimulate and support innovation and new models of care in general practice.

Salaried GPs

- 8.11 The model terms and conditions for salaried GPs are intended to be the minimum – employers are free to offer more favourable terms to reflect local needs and circumstances. The Department has no evidence that the current salary range is inappropriate.

GMP speciality registrar supplement

- 8.12 HEE has been set a short term deliverable to ensure progress should be made in each year of the mandate towards ensuring that 50 per cent of medical students become GMPs. A longer term objective for HEE is to ensure that 50 per cent of speciality trainees choose to enter GMP speciality training. As covered in Chapter 6, the Government has mandated NHS Employers to negotiate with the BMA on new contractual arrangements for doctors and dentists in training including GP registrars. The Department expects HEE will wish to inform considerations about what future pay arrangements are appropriate to ensure adequate recruitment to general practice training.

GMP Trainers Grant

- 8.13 The Department's review of the funding arrangements for education and training highlighted that the GMP trainers' grant was no longer treated at local level as an individual GMP's remuneration. Instead, it was generally treated as a practice income stream, for which the allocation was decided collectively by the practice. Furthermore, the review reflected that GMP trainers were operating as educational supervisors to GMP specialty trainees, when they were on their HCHS placements, and not just when they were in general practice placements.
- 8.14 The Department is currently in the process of moving to a tariff based system to fund education and training. Further work is being undertaken by the Department, in association with the BMA, the Royal College of General Practitioners (RCGP) and HEE to develop a similar tariff based approach for funding clinical placements in primary care for medical students and trainees in their undergraduate and postgraduate years. The outcomes of this work will provide recommendations regarding the GMP trainers' grant.

Chapter 9: General Dental Practitioners

General Dental Services

- 9.1 We are content with the methodology change the DDRB have put forward for the uplift formula and the evidence behind this change seems sound. The Department notes that it is a temporary 'fix' to try to reduce the effect of multiple counting, to be able to give more accurate results, until we have a means of actually identifying how much and which aspects of the expenses are duplicated.

Chapter 10: Salaried Primary Care Dental Services

Salaried Services - Dentists

- 10.1 Salaried dentists, or salaried dentists working in the community dental services as they would perhaps be more accurately called, provide an important service to patients across England. They have an important place within the new health and social care system and work in the services commissioned by NHS England.
- 10.2 The Department of Health understands from NHS England that they are reviewing how the Community Dental Services are commissioned as part of the move to a more standardised way of commissioning dental services across England. This is in line with their concept of a single operating model wherever possible.
- 10.3 The Department of Health believes that community dental services and the salaried dentists working in them are valued by NHS England and fill an important role in dental health service provision. NHS England has also established a work stream looking at vulnerable groups and how they access dentistry. Traditionally this group is one of the main users of community dental services. This should give further assurance that community dental services is a valued service.
- 10.4 The Department is extending the piloting activity that it is carrying out to test out aspects of a new dental contract to a small number of community dental services – the Department has always intended to ensure that they are taken account of in any redevelopment of the NHS dental contract.

Chapter 11: Ophthalmic Medical Practitioners

Summary

11.1 The Department of Health 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 per cent of NHS sight tests. Discussions are to take place with representatives of the professions on the implementation of government pay policy.

Background

11.2 Between 31 December 2011 and 31 December 2012, the number of OMPs who were authorised by Primary Care Trusts (PCTs) in England and the number in Local Health Boards in Wales to carry out NHS sight tests decreased from 336 to 318, and the number of optometrists increased from 11,238 to 11,624 an increase of 3.4 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

11.3 In 2012/13, 13.11 million sight tests were paid for by PCTs in England and LHBs in Wales. This was 0.3 per cent more than in 2011/12. Within these figures, the proportion of sight tests carried out by OMPs was 0.2 per cent in 2012/13.

11.4 The surveys, which the Department has 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 appointment³².

11.5 Under changes made by implementation of the Health and Social Care Act, commissioning of the NHS sight testing service in England is, following the abolition of PCTs, the responsibility of NHS England.

³² http://www.fodo.com/downloads/resources/Sight_Tests_Volume_And_Workforce_Report_2005-06.pdf

Chapter 12: NHS Pensions and Total Reward Strategy

Introduction

- 12.1 The Government is undertaking a range of changes to pensions for both public and private sector schemes. This includes changes such as single tier pensions, a review of the State Pension Age within the Department for Work & Pensions (DWP) Pension Bill 2013 and introduction of both auto-enrolment and the Public Services Pension Act 2013. This is a framework Act, building on the precedent of pensions legislation and based on the recommendations of the Independent Public Service Pensions Commission chaired by Lord Hutton. The Hutton report identified that people are living longer than ever before; today the average 60 year old can expect to live 10 years longer than in the 1970's, and therefore changes to public sector pensions had to be made. As a result of improving life expectancy, the cost of pensions has increased by a third over the last 50 years.
- 12.2 The Government's pension reforms aim to ensure public sector pensions are sustainable, affordable and fairer to both public sector workers and taxpayers. The proposals for the 2015 scheme ensure that the NHS Pension Scheme will continue to deliver a fair reward to staff and continue to support the retention and recruitment of staff. The Department continues to work closely with both employers, through the NHS Employers organisation, and the NHS Trades Unions to agree the detailed business rules that will apply so that changes can be implemented from April 2015. The changes, based on the Proposed Final Agreement, are outlined at Annex D and this also provides a comparator to benefits in both the 1995 scheme and the 2008 scheme.
- 12.3 The table in Annex D demonstrates that the new pension arrangements will continue to provide a generous pension to doctors and dentists and remain one of the best available given that a similar inflation-proof pension of £68,000 a year would require a pension pot of nearly £2 million in the private sector. Higher paid NHS staff continue to pay a reasonable amount for their pension, contributing a similar proportion of their salary as other NHS staff on lower incomes once tax relief is taken into account. They also receive a 14 per cent employer contribution to their pension in the form of deferred pay.

1995 and 2008 sections of the NHS Pension Scheme

- 12.4 The current NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary. Benefits for most staff in the 1995 Section of the NHSPS are based on 1/80ths of pay for each year of service, includes a separate lump sum, life assurance, ill health, partner and dependent benefits. Unreduced pensions are payable at the normal pension age of 60, based on the best of the last three years' pensionable pay. Since April 2008, most staff can increase their separate lump sum payment by commuting, or giving up, some of their pension.
- 12.5 Regulations came into effect from 1 October 2009 to allow all contributing members of the 1995 Section of the Scheme an opportunity (known as the *NHS Pension Choice Exercise*) to either remain in the 1995 Section, or transfer their accrued service to the 2008 Section of the Scheme. The 2008 Section, has been open to new entrants since April 2008, has a normal pension age of 65, a 1/60th pension but no automatic lump sum, but members are able to commute part of their pension in order to secure a lump sum payment. Pensions in the 2008 Section are based on an average of the best three consecutive years in the last 10 years.
- 12.6 As part of the Pension Choice Exercise, eligible members of the 1995 Section received a personalised pension statement, which compared benefits in the 1995 and 2008 Sections of the NHSPS, as well as an explanatory guide and a DVD to help members inform their decision. The Pension Choice exercise was completed on 31st March 2012 and resulted in 3.3 per cent of members (37,200) opting to move from the 1995 to 2008 section. Around two-thirds of staff are currently in the 1995 Section and a further third now in the 2008 Section.

2015 NHS Pension Scheme position

- 12.7 The main parameters of the new scheme are set out below:
- a pension scheme design based on career average
 - an accrual rate of 1/54th of pensionable earnings each year with no limit to pensionable service
 - revaluation of active members' benefits in line with the Consumer Price Index (CPI) plus 1.5 per cent per annum
 - a Normal Pension Age (NPA) equal to the State Pension Age (SPA), 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. Those within ten years of current NPA are excluded and accrued rights in pre-2015 schemes will also be related to current NPA

- pensions in payment to increase in line with inflation (currently CPI);
- benefits to increase in any period of deferment in line with inflation (currently CPI)
- member contributions on a tiered basis to produce a total yield of 9.8 per cent of total pensionable pay in the Scheme³³ (subject to the detailed arrangements for determining future contribution structures)
- 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
- 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
- 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 per cent of prospective service to normal pension age
- 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
- the current arrangements for abatement (for service accrued prior to and post 2015) will be retained
- lump-sum on death in service will remain at two times actual pensionable pay
- 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 three years (that would apply to a member with a NPA of 68 or higher)³⁴

³³ The Government has determined that the average member contributions will be increased from 6.6 per cent in 2011/12 in stages to 9.8 per cent in 2014/15. Member contribution rates in 2012/13 will increase by amounts between 0 per cent and 2.4 per cent. There will be no increase in 2012/13 for staff with WTE pensionable pay less than £26,558. Further increases in member contributions will be made in 2013/14 and 2014/15 to reach the required 9.8 per cent average contribution level, The Government will formally consult on the increases for those years in due course.

³⁴ This will be subject to a minimum normal retirement age of 65. Contributions will ordinarily be payable by members but individual employers will be able to choose to provide a contribution in certain circumstances, subject to the conclusions of the Working Longer Review. Where members make earlier retirement contributions, e.g. for retirement from age 65, but subsequently choose to retire, at a different date, their benefits will be actuarially reduced or enhanced to take full account of the extra years of earlier retirement they bought. The cost of earlier retirement will be actuarially neutral, and expressed as a percentage increase in the employee contribution rate, per year of earlier retirement. Periodically, the additional contribution rate will be reviewed, and may change during the period of purchase. The cost of purchase has yet to be calculated but

- added Years contracts in the 1995 section will continue on compulsory transfer to the 2015 scheme³⁵
- additional pension arrangements will continue³⁶
- the Public Sector Transfer Club will continue and further consideration will be given to the best way of operating it in the reformed schemes
- an employer contribution cap

Progress toward implementation of the 2015 scheme

12.8 Good progress has been made in partnership with the NHS Trades Unions, including BMA and the British Dental Association (BDA), and NHS Employers in developing the new arrangements and agreeing the detailed business rules based on the Proposed Final Agreement. Additionally HMT have a process across the public sector schemes to ensure, where appropriate, there is consistency. The Department of Health will use the business rules as a basis to develop the supporting regulations to implement reform to the NHS Pension Scheme. The regulations will follow a further consultation process. The 2015 reforms are based on the Proposed Final Agreement reached with the NHS Trades Unions and published in March 2012. Long-term contribution rates remain under discussion, and all parties are working together to reach a common set of principles upon which any new proposals can be based.

12.9 The Department of Health has commenced the Valuation process, based on the available 2012 data, using the methodology set out in the draft HMT Valuation Directions enacted through provisions in the Public Services Pension Act 2013. There remain uncertainties about employer contributions from 2015. The valuations need to be complete before the Department of Health can be clear as to the level of any pressure on the employer contribution from 2015. There will potentially be further pension pressures in 2016 onwards given the changes in National Insurance (NI) and contracting out, stemming from the single tier pension policy. These further changes will not take effect before the next Spending Review. HMT are carrying out a further consultation on a revised draft of the valuation directions running from the end of September to the end of October. We will provide further details on the outcome of the consultation to the DDRB at supplementary evidence stage.

indicative costings are that it would be in the region of 1.2 per cent to 1.5 per cent of salary from 2015 for each year taken early depending on the age of the member when they move into the new arrangements.

³⁵ Already "paid-up" contracts, lump sum contracts and ongoing extra percentage contribution contracts will be maintained within the 1995 section of a member's NHS Pension Scheme service until their chosen end age for the contract, which is 60 or 65, or 55 for members of the special classes. A member with service in the 1995 scheme could in future elect to receive the benefits accrued via their Added Years contracts at the contract end date rather than upon their retirement. The continuation of 'Half cost' and pre 1972 Added Years contracts (taken out by married men) is no longer appropriate and this facility will be removed from 2015 onwards, after a suitable period of notice and publicity for currently active members.

³⁶ Members with service in the 1995 schemes could in future elect to receive the benefits accrued via their additional pension contracts at the contract end date rather than upon their retirement.

Review into working longer

- 12.10 The NHS Pension Scheme Proposed Final Agreement included the provision that in the new scheme, for pension accruals post 2015, a member's NPA should be set equal to their State Pension Age (SPA). To support implementation, since September 2012 there has been an on-going tripartite review between the Department of Health, NHS Employers and the NHS Trades Unions to address the impact of working longer in the NHS, with particular reference to staff working on the frontline and those with physically demanding roles, including the emergency services.
- 12.11 The initial primary research, carried out by Bath University, identified a number of key findings that might feed into a final set of recommendations to the Department of Health. Further secondary research will provide evidence from NHS organisations, Trades Unions and NHS employees – the overall aim of this review is to identify and share examples of good practice that will enable staff to continue working to SPA. Partnership responses between unions and employers are being encouraged.

Review of scheme access

- 12.12 Within the recommendations of the Independent Public Service Pensions Commission there was provision to review the Fair Deal policy. After further consultation and discussions with the Trades Unions the Chief Secretary to the Treasury laid a Written Ministerial Statement in the House of Commons on the 4th July 2012 that stated;

“The Government has reviewed the Fair Deal policy and agreed to maintain the overall approach, but deliver this by offering access to public service pension schemes for transferring staff. When implemented, this means that all staff whose employment is compulsorily transferred from the public service under Transfer of Undertaking (protection of employment) Regulations (TUPE), including subsequent TUPE transfers, to independent providers of public services will retain membership of their current employer’s pension arrangements. These arrangements will replace the current broad comparability and bulk transfer approach under Fair Deal, which will then no longer apply.”

- 12.13 The changes to the ‘Fair Deal for Staff Pensions’ are HMT led and will apply to all members of the public service pension schemes that transfer out of the public sector under TUPE, and to staff that have previously transferred out of the public sector, and who have remained eligible for the current Fair Deal protection. There will continue to be protection where staff are subsequently transferred to a new employer.

12.14 The wider access review, included in the Proposed Final Agreement, is NHS specific and is being developed in partnership with the Department of Health, HMT, Trades Unions, Independent Sector and NHS Employers – building on the new Fair Deal provisions. It covers the terms of access for non-NHS organisations providing NHS Clinical Services (Independent Providers) ([IPs]), where they are delivering services under an Alternative PMS contract or an NHS Standard Contract – including services procured under ‘Any Qualified Provider’ and covers both clinical and non-clinical staff delivering the clinical service. The final approach is subject to ministerial agreement.

Changes in employee pension contributions

12.15 In addition to the new pension scheme from April 2015, in the Spending Review 2010 Government set forecasts for reducing net public expenditure on public service pensions through phased increases in members’ contributions on the current scheme. The target savings to be delivered across all schemes were over a three year period from 2012/13 to 2014/15³⁷. The forecast savings for the NHSPS in particular were originally set out in Annex E of the Proposed Final Agreement dated 9 March 2012 for 2012/13, 2013/14 and for 2014/15³⁸. These are attached at Annex E for ease of reference, based on an average 3.2 percentage point increase in member contribution rates being implemented by 2014-15.

12.16 Even with the increases in employee contribution rates, the NHS PS remains an excellent investment for retirement. The Government Actuary’s Department calculate that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.

12.17 It should also be borne in mind that if members choose to leave the scheme they will lose the current NHS employer contribution to their pension – currently 14 per cent. Members would also give up their death-in-service benefits which may mean needing to review their life insurance arrangements.

12.18 In determining the distribution of contribution increases, a key Government objective is to limit any commensurate increase in instances of members choosing to opt-out from the scheme. Consequently the Department has reviewed opt-out data from the scheme administrators to evaluate the impact of the first year of increases which were applied from 1 April 2012. Trades Unions and NHS employer representatives have also reviewed this data. The

³⁷ See table A.3 in

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203828/Spending_Review_2010_-_statistical_annex.pdf

³⁸ See Annex E in https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151957/dh_133003.pdf.pdf

evidence shows that there has been no significant change, and staff continue to value membership of the scheme. The auto-enrolment has also affected the opt-out position and it is difficult from the available data to disentangle the effect of the two policies. Overall, there has been an increase in scheme membership, in the region of 2.2 per cent – 2.4 per cent.

12.19 High earners are likely to benefit from higher rate tax relief on their pension contributions. This meant that before contributions were raised in April 2012, members with full-time earnings over £60,000 actually paid a contribution rate that was lower than colleagues who earned half that amount, once tax relief had been taken into account.

12.20 Net of tax relief, the proposed 2013-14 contribution rates mean that a doctor on a salary of £80,000 will only actually contribute 0.18 per cent more than a nurse earning £30,000. The Department does not consider this a disproportionate outcome for high earners.

Table 12.1 - 2013-14 contributions after tax relief (net)

Full-time pay	2012-13 contribution rate net of tax relief	2013-14 contribution rate net of tax relief	Net contribution rate increase (percentage points)	Additional cost (£ per month)
£10,000	4%	4%	0	0
£15,000	4%	4%	0	0
£20,000	4%	4.24%	0.24	4
£25,000	5.2%	5.44%	0.24	5
£30,000	6.4%	7.2%	0.8	20
£40,000	6.4%	7.2%	0.8	27
£60,000	5.34%	6.78%	1.44	72
£80,000	5.94%	7.38%	1.44	96
£130,000	6.54%	7.98%	1.44	156

12.21 Separately the tax changes relating to lifetime allowance are having some impact on very high earners in the NHSPS. However there is no hard evidence to suggest that this is affecting the recruitment and retention of key staff roles, in particular medics. From the available Electronic Staff Record (ESR) data the percentage of doctors in the NHSPS by headcount was 93 per cent in May 2013 as compared to 91 per cent in October 2011. However, it has been common in the NHS for medics who have chosen to retire, take their pension, and return to work in the service. Annex F provides the available comparative data on opt-outs over the period from October 2011 to May 2013 by different staff group.

Total Reward Statements

12.22 The Public Service Pension Act 2013 introduces a new legal requirement for public sector schemes to provide benefits information statements to members in pensionable service. For NHS staff employed in organisations using the ESR this will be enhanced to a Total Reward Statement (TRS). The TRS aims to ensure that staff are fully aware of the benefits they receive as a total remuneration package including pension, pay and leave, as evidence carried out both by HMT and NHS workshops, demonstrates that employees do not understand this fully, and many are not aware they receive 14 per cent employer contribution toward their pension package. For staff in organisations not using the ESR which is many GPs, dentists and locums, they will receive an annual benefit statement (ABS).

12.23 The core elements of the TRS project's infrastructure are now in place and two pilot exercises have been undertaken, involving the production of around 90,000 statements to 17 organisations. These exercises will inform the completion/refinement of the IT solution and the finalising of a national rollout strategy.

12.24 Feedback from the pilots has confirmed that:

- the concept appears to be understood by staff and well supported
- the quality of statements is regarded as good
- the technical environment appears generally fit for purpose though some usability refinements are required prior to national rollout
- the Cabinet Office led Government Gateway element of the solution would benefit from simplification if mass use is to be achieved across the NHS and support costs contained
- there is further work to be undertaken with NHS employers to support the local customisation of statements thus ensuring that the project's benefits are fully realised

12.25 In the one-to-one employee sessions, as part of the evaluation of the technical pilot of TRS, NHS Business Services Authority (BSA) took the opportunity to ask people who had accessed their statements:

- whether the statement had prompted them to start planning or change their financial plans for retirement: and
- whether the statement had made them think differently about their overall employment package – did they now feel it was a better or worse package than they had previously thought

In relation to financial planning, 47.5 per cent said that the statement had made them think or act about financial planning for retirement. Feedback from the in-depth one-to-one interviews supports this:

- *“the pensions tab made me think “when can I retire?” I am 58 and was already pretty much aware of what I will get – the statement made me feel good as it confirmed my expectations. I didn’t need to seek any further information”*
- *“I realise I can retire now – hadn’t really thought about retiring but can now”*
- *“made me feel more inclined to stay in the pension scheme – knowing what is there already ... It reminded me that financial planning is something I need to do”*
- *in relation to the perception of the value of their employment package, 47.5 per cent said that they now valued their overall package more than before. The remaining 52.5 per cent said that their perception was the same as before receiving the statement*

12.26 Following an evaluation of these pilot exercises, it has been determined that the national rollout should commence, once the technical solution has been further refined and we can ensure improved employer engagement. The statement content will be generated annually to achieve optimum impact on NHS employees, and the initial national rollout is anticipated to take place from September 2014.

Total Reward Strategy

12.27 Total Reward is both the tangible and intangible benefits that an employer offers an employee: the financial benefits for example, training, career development opportunities, culture and working environment. It is a means of explaining to employees the total value of their employment package.

12.28 The Department of Health 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 to attract, motivate and retain the staff they need
- implement local reward strategies that are aligned with their organisational objectives and the needs of their workforce
- ensure employers understand the full value of their total reward package (the tangible and intangible benefits) and the flexibilities within it

12.29 NHS Employers is delivering our total reward strategy to deliver the vision described above by:

- engaging with NHS employers and staff, for example, with those involved in the Total Reward Statement pilots
- ensuring the NHS has access to total reward expertise and is kept up to date with latest developments and leading edge practice supported by a range of products
- influencing a change in employer behaviour to embrace total reward and share learning
- ensuring that our total reward approach influences and is influenced by ongoing pay contractual changes and pensions modernisation

Components of the total reward package for doctors and dentists

12.30 Components of the total reward package for medical and dental staff employed directly by the NHS, updated where appropriate from last year, currently include:

- incremental progression of up to 8 per cent of basic salary³⁹
- a competitive starting pay for doctors in training
- a defined benefit pension scheme with a 14 per cent 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 spouses and dependent children
- between 40 and 42 days holiday compared with the 28 days statutory minimum
- sick pay of 6 months full pay and six months half pay compared with statutory sick pay of £86.70 per week for up to 28 weeks
- redundancy pay of up to two year's salary with a minimum of 24 years reckonable service compared with the statutory half to one and a half week's pay for each full year of service depending on age
- maternity pay of eight weeks full pay, 18 weeks half pay, 13 weeks statutory maternity pay (SMP) and an optional extra 13 weeks unpaid leave compared with the statutory entitlement of six weeks at 90 per cent of average gross weekly earnings and 33 weeks at the lower of either £136.78 or 90 per cent of average gross weekly earning
- paternity leave of two weeks starting twenty weeks after the child is born as well as an additional two to twenty six weeks if the mother has returned to work. Fathers are also entitled to receive additional

³⁹ A very small minority of doctors on the closed Associate Specialist scale may receive slightly more, but this situation is rare and is disappearing over time.

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, less than full time training, career breaks etc

12.31 Annex G provides a list of activities/products that have been suggested to support the vision for reward in the NHS.

Annex A: for the Economy

UNCLASSIFIED



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

Professor Paul Curran
Review Body of Doctor and Dentists' Remuneration
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

23 July 2013

Dear Paul,

PUBLIC SECTOR PAY 2014-15

I would like to thank you for your work on the 2013-14 pay round. The Government greatly values the contribution of the DDRB in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced its policy that public sector pay awards will average 1 per cent for the two years following the pay freeze. The Government also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups. The Government published these reports at the 2012 Autumn Statement and has accepted the key recommendations, including that there should be no new centrally determined local pay rates or zones but that there should be greater use of existing flexibilities.

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

- a. 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.
- b. 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.

4. The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher

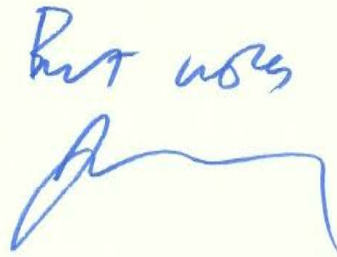
award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties.

5. Pay awards 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.

6. A number of Review Bodies will be considering additional elements of reward such as non-pay terms and conditions and specific allowances. These recommendations form an important part of managing the total reward package of public sector workers, and the Government welcomes the contribution of the Review Bodies in these areas.

7. Finally, in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group's progression structure and its distribution among staff in recommending annual pay awards.

I look forward to continued dialogue with you in the future.

A handwritten signature in blue ink, appearing to read 'Danny Alexander', with a stylized flourish at the end.

DANNY ALEXANDER

Annex B: DDRB Remit Letter



Department
of Health

From Dr Dan Poulter MP
Parliamentary Under Secretary of State for Health

POC5 805694

Richmond House
79 Whitehall
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SW1A 2NS

Paul Curran
Chair

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

Tel: 020 7210 4850

03 SEP 2013

Dear Paul,

DOCTORS AND DENTISTS PAY REVIEW BODY Review Body on Doctors' & Dentists' Remuneration – Remit 2014/15

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander, on 23 July 2013 confirming the Government's approach to the 2014/15 pay round.

Once again, I would like to thank you and your colleagues for the vital and independent expert work undertaken by the Doctors' and Dentists' Review Body (DDRB) in considering remuneration for doctors and dentists working for the NHS.

As always, while DDRB's remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay review round and to communicate this to you directly.

We continue to keep in close touch with our counterparts in the other countries and my officials will do all they can to support you in handling any consequences that may arise as a result of different approaches taken by each country.

This year, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy. Separate detailed evidence will be provided by:

- NHS Employers – on recruitment, retention, motivation and morale for employed doctors and dentists;
- NHS England – on independent primary care contractors; and
- Health Education England – on education, training and workforce capacity.

The Department will work closely with all these organisations and the DDRB secretariat to ensure that, overall, the evidence meets the needs of the DDRB.

You will be aware that in the 2013 Spending Round, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector.

The Government is clear that time served is no longer an appropriate rationale for pay progression for staff in the public sector. In his remit letter the CST states:

“.....in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group’s progression structure and its distribution among staff in recommending annual pay awards”.

You will be aware that discussions with the representatives of medical and dental staff are underway about changes to the national contractual arrangements for consultants and doctors and dentists in training. However, since any changes will take time to be agreed, implemented and take effect, I would ask that the Review Body consider the existing progression structure for employed doctors and dentists and its distribution among staff when considering and recommending the annual pay award.

NHS England has begun negotiations with the BMA General Practitioners Committee on potential improvements to the 2014/15 General Medical Services (GMS) contract, and will be seeking comparable improvements from the contractual framework for general

dental services. These negotiations will not cover the question of what gross uplift there should be in the value of GMS or dental contracts. DDRB is, therefore, invited to make recommendations on appropriate uplifts for these two contractor groups, in the context of public sector pay policy for 2014/15. We would also particularly welcome DDRB's recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay, in line with other sectors of the NHS workforce. The Government and NHS England will make final decisions on the overall gross uplift for GMS and dental contracts in the light of DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

As CST set out, the case for continued pay restraint across the public sector remains strong. The Government is clear that it is for each Pay Review Body to consider the evidence and affordability for each workforce. The Chief Secretary's letter also observes that:

"... 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".

"The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties".

For the NHS, affordability and the level of incremental pay staff will receive, alongside recruitment and retention pressures, will be a critical element as the Review Body determines whether any award is justified.

I should be grateful if you would make recommendations for the basic pay of doctors and dentists working in the NHS. In doing so, you should consider evidence in respect of:

- the level of incremental pay staff that have not reached the top of their pay band will receive;
- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the DH, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS; and
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

I look forward to receiving your report on 2014/15 pay for your remit group in due course.

Best wish,



DR DAN POULTER

Annex C: Francis Report

1. The Francis report challenges the NHS to move beyond championing consistent safe and compassionate care in partnership with patients to actually achieving it.
2. There are many professionals and organisations that already provide an exemplary service, but the Department of Health also knows that there are many organisations and individuals that could do better. While the case of Mid Staffordshire NHS Foundation Trust was an extreme one, there is evidence that some of the behavioural issues and examples of poor care that characterised some parts of Mid Staffordshire can also be found in other parts of the NHS. Addressing behaviour of this kind and driving up levels of compassion and safety are a critical part of the Government's strategy for the NHS.
3. In the initial response to the Francis report issued on behalf of the whole health and care system, *Patients First and Foremost*⁴⁰ the Government highlighted a number of issues of importance for the NHS to meet the challenge of Francis, including:
 - leadership at every level from board to ward
 - commitment to improving the safety and quality of care at all levels of the system
 - a culture built on partnership with patients
 - openness and transparency throughout care organisations including candour with patients and transparency about decisions at organisational level
4. The importance of these issues has been further reinforced by a number of reviews conducted to inform the further Government response to the Francis Report, including Sir Bruce Keogh's mortality review into the quality of care at 14 Trusts and Professor Don Berwick's patient safety review.
5. Support for staff (by both managers and their peers of both formal and informal kinds) is one of the key defences against the development of the kind of toxic culture seen at Mid Staffordshire. Measures which help to develop

⁴⁰ [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf]

mutual support are therefore an important part of the response to Francis, for example the Department's funding of Schwartz rounds.⁴¹

6. On leadership, the NHS Leadership Academy is developing and launching a number of programmes designed to ensure that there is leadership support at all levels of the NHS and that it is focused on achieving safe, compassionate care through the development of an open, learning-oriented culture.
7. On safety and quality of care, the Government has welcomed the publication of the Berwick Review⁴² and is committed to addressing the issues it highlights. This includes working with other organisations in the system to review the use of evidence-based guidance and tools for local decisions about staffing levels. The Department is putting in place a number of measures to ensure that patients are better informed and better able to provide feedback on the services they receive. A new Chief Inspector of Hospitals is now in post with a remit to assess the performance of every NHS hospital.
8. On developing a culture built on partnership with patients, since *Patients First and Foremost* we have seen many local initiatives to develop this culture, a number of which are captured through the pledges in NHS Change Day:⁴³
 - initial results from the 'Friends and Family Test' which asks patients to say whether they would be happy for their friends and family to be treated where they have been
 - a commitment from the Chief Inspector of Hospitals to using patients and carers as part of the new inspection teams for hospitals
 - the Government to commission a report from Ann Clywd MP and Professor Tricia Hart on complaints in the NHS

⁴¹ <https://www.gov.uk/government/news/expansion-of-groundbreaking-scheme-to-support-nhs-staff>

⁴² <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

⁴³ <http://www.changemodel.nhs.uk/pg/groups/33183/NHS+Change+Day/?community=NHS+Change+Day>

Annex D: Summary of Benefits & Comparison with 2015 Scheme

Summary of benefits & comparison with 2015 scheme

Feature or Benefit	1995		2008		2015
	Officers	Practitioners	Officers	Practitioners	All staff
Staff group	Officers	Practitioners	Officers	Practitioners	All staff
Method	Final Salary	CARE	Final Salary	CARE	CARE
Accrual rate	1/80 th	1.4% of uprated earnings per year	1/60 th	1.87% of uprated earning per year	1/54 th
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 1/160 th		Spouse & partner pension based on accrual of 1/160 th		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 per cent and an accrual rate of $1/54^{\text{th}}$ 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 $2/3^{\text{rds}}$ of prospective service to NPA. The 2015 scheme will reduce this enhancement to 50 per cent. 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 trades 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 three years (i.e. for those with an NPA of 68 or higher).

Transitional protection

Full protection

All members who are within ten years of their NPA (including special class NPA of 55) as at 1 April 2012 will remain in their current section. Around 25 per cent 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 ten years, will have tapered protection. For every month of age that they are beyond ten years of their normal pension age, they lose two months of protection. At the end of the protected period, they will be transferred to the 2015 scheme for future service. Around 10 per cent 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 they 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 arrangements 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.

Annex E: Increase in Employee Contributions

Based on PFA data										
Full-time equivalent pensionable pay	% of pensionable pay in the band	Est. no. of members in band '000	Contribution rate 2011/12	Contribution rate 2012/13	Contribution rate increase	Contribution rate 2013/14	Contribution rate increase	Contribution rate 2014/15	Contribution rate increase	Contribution rate increase by 2014/15
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 est. payroll £billion:				38.36		39.03		39.47		
Additional yield £bn:				0.530		1.023		1.260		

Annex E Continued: Increased Employee Contribution Rates Net of Tax Relief 2012/13 – 2014/15

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 F: Estimated Percentage of Staff with Pension: Headcount by Staff Group and AfC Band

Note: '-' indicates groups with fewer than 500 staff.

Note: numbers highlighted in grey background indicates groups with fewer than 5,000 staff.

	Headcount points increase between March 2013 and May 2013													Non AfC	Total
	1	2	3	4	5	6	7	8a	8b	8c	8d	9			
Doctor	-	-	-	-	-	-	-	-	-	-	-	-	-	1.5%	1.5%
Qualified nursing, midwifery & health visiti	-	-	-	-	3.0%	2.0%	1.3%	1.0%	0.8%	0.8%	-	-	-	1.3%	2.3%
Qualified Scientific, therapeutic and techn	-	2.2%	2.6%	2.9%	2.0%	1.4%	1.0%	0.5%	0.7%	0.1%	0.2%	-	-	0.6%	1.3%
Qualified Ambulance Staff	-	-	-	0.2%	0.1%	-0.1%	0.5%	-	-	-	-	-	-	-	0.1%
Support to Clinical Staff	5.4%	3.9%	2.8%	2.3%	2.3%	1.2%	1.5%	0.3%	-	-	-	-	-	0.5%	3.1%
Central Functions & Hotel, Property & Es	4.0%	3.8%	2.7%	2.2%	2.1%	1.8%	1.2%	1.1%	-0.5%	-	-	-	-	5.0%	2.7%
Managers	-	-	-	-	1.2%	0.7%	1.1%	0.5%	0.6%	0.4%	-0.1%	-0.2%	-1.1%	-	0.3%
All Non-Medical	4.2%	3.9%	2.8%	2.3%	2.6%	1.8%	1.2%	0.7%	0.5%	0.4%	0.1%	-0.0%	1.4%	2.4%	
All	4.2%	3.9%	2.8%	2.3%	2.6%	1.8%	1.2%	0.7%	0.5%	0.4%	0.2%	-0.5%	1.4%	2.3%	

March 2013 and May 2013			
AfC 1 - 5	AfC 6 - 9	Non AfC	Total
-	-	1.5%	1.5%
3.0%	1.7%	1.3%	2.3%
2.2%	1.0%	0.6%	1.3%
0.1%	-0.0%	-	0.1%
3.2%	1.2%	0.5%	3.1%
2.4%	1.4%	5.0%	2.7%
3.9%	1.4%	-1.1%	0.3%
3.0%	1.3%	1.4%	2.4%
3.0%	1.3%	1.4%	2.3%

	Headcount points increase between October 2011 and May 2013													Non AfC	Total
	1	2	3	4	5	6	7	8a	8b	8c	8d	9			
Doctor	-	-	-	-	-	-	-	-	-	-	-	-	-	1.5%	1.5%
Qualified nursing, midwifery & health visiti	-	-	-	-	3.2%	1.6%	0.9%	0.7%	0.4%	0.2%	-	-	-	7.1%	2.2%
Qualified Scientific, therapeutic and techn	-	1.0%	2.6%	3.7%	2.0%	1.1%	0.9%	0.3%	0.7%	1.2%	-1.1%	-	-	2.8%	1.2%
Qualified Ambulance Staff	-	-	-	-0.4%	-0.3%	-0.3%	1.1%	-	-	-	-	-	-	-	-0.2%
Support to Clinical Staff	7.3%	4.7%	3.3%	2.2%	2.3%	1.0%	0.2%	0.2%	-	-	-	-	-	2.7%	3.6%
Central Functions & Hotel, Property & Es	4.5%	3.7%	2.7%	2.2%	1.5%	1.5%	0.6%	-0.4%	-0.4%	-	-	-	-	4.7%	2.7%
Managers	-	-	-	-	-	0.1%	0.6%	-0.2%	-0.3%	-0.2%	-1.0%	-1.2%	-3.9%	-0.6%	
All Non-Medical	4.9%	4.5%	3.2%	2.2%	2.7%	1.4%	0.9%	0.3%	0.1%	0.3%	-0.8%	-0.9%	2.6%	2.5%	
All	4.9%	4.5%	3.2%	2.2%	2.7%	1.4%	0.9%	0.3%	0.1%	0.3%	-0.8%	-1.3%	1.5%	2.4%	

October 2011 and May 2013			
AfC 1 - 5	AfC 6 - 9	Non AfC	Total
-	-	1.5%	1.5%
3.2%	1.3%	7.1%	2.2%
2.4%	0.8%	2.8%	1.2%
-0.3%	-0.0%	-	-0.2%
3.7%	0.8%	2.7%	3.6%
2.7%	1.0%	4.7%	2.7%
3.5%	0.3%	-3.9%	-0.6%
3.3%	1.0%	2.6%	2.5%
3.3%	1.0%	1.5%	2.4%

Annex G: List of Activities/Products Suggested to Support the Vision for Reward in the NHS

Enablers	Description
Education and Training	
Training Programmes	Linking with leading training providers to develop an NHS specific training programme that can be offered nationally at a reduced rate to employers
Seminar sessions	Series of seminar sessions run across the country on a variety of reward topics Run by different benefit providers and reward consultants
Employer Reward Network	
Employer support network	Develop the existing NHS Employers Reward Engagement Group: <ul style="list-style-type: none"> • update communications • regional events • regular meetings with employers • online forums to discuss pay and reward
NHS Employers team working more collaboratively	

Enablers	Description
Proactively develop supportive/creative approaches to counteracting emerging issues	To ensure emerging issues are responded to proactively, providing employers with support to implement/develop new approaches to rewarding their staff
National Products and Tools	
Briefing Papers	Provide guidance, ideas and suggestions for how employers can maintain engagement with changes in how they reward staff
Reward Strategy Toolkit	<p>Develop online for employers to adapt locally including the following:</p> <ul style="list-style-type: none"> • business case for reward strategy • template documents • case studies <p>This would be supported by an implementation plan and plan to add to/update the products regularly</p> <p>Aon Hewitt consultancy to support the development of the content</p>
Online communication	<ul style="list-style-type: none"> • webinars • online forum • social media

Enablers	Description
<p>Guidance on voluntary benefits - 'top available products'</p>	<ul style="list-style-type: none"> • Guidance to advice employers on additional cost effective benefits that can be offered to staff
<p>Intelligence</p>	
<p>Networking with Reward Experts from other sectors</p>	<p>Discover reward practices in organisations outside of the health service to generate ideas for new ways of rewarding staff and learning that can be transferred to employers.</p> <p>Link with HPMA</p>
<p>Total Reward Statement Development</p>	<p>Assess impact of TRS in year 1 and develop recommendations for how this can be improved to incorporate:</p> <ul style="list-style-type: none"> • more flexibility for local arrangements • flexible benefits • improved access mechanisms
<p>Research into employee understanding of reward package in the NHS</p>	<p>Using feedback from the TRS pilot</p> <p>This will provide a basis on which to measure staff understanding and whether or not this improves with the introduction of TRS and other reward initiatives</p>

Enablers	Description
<p>Research into how flexible reward/benefits can work in the NHS</p>	<p>Research on this area which will inform national policy on the flexibility of the reward package</p> <p>This will also inform the future development of the TRS</p>

