# INFORMATION
# FOR THE

# REVIEW BODY ON
# DOCTORS' AND DENTISTS'
# REMUNERATION

# FROM THE DEPARTMENT OF HEALTH

**November 2010**

**INFORMATION FOR THE**
**REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION**
**FROM THE DEPARTMENT OF HEALTH**

## CONTENTS

## CHAPTER 1: INTRODUCTION

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

1.2 The Chief Secretary to the Treasury's letter of 26 July 2010 to Pay Review Body Chairs made clear that for workers in England paid above £21,000, the Government would not submit evidence or seek recommendations on pay uplifts for 2011/12 but would provide Review Bodies with information about recruitment, retention and other aspects of the affected workforces as appropriate. The Secretary of State for Health wrote to the Chair of the Review Body on Doctors' and Dentists' Remuneration (DDRB) on 19 August making clear that the Government was not seeking recommendations from DDRB on remuneration of doctors and dentists for 2011/12.

1.3 Although the DDRB is not required to report on the remuneration of doctors and dentists in England in 2011/12, this document is being submitted to the Review Body to keep them advised of developments affecting their remit group.

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

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

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

1.5 The Government also published more detailed documents seeking views on:

- NHS outcomes framework (published 19 July);
- Commissioning for patients (published 22 July);
- Increasing democratic legitimacy (published 22 July);
- Freeing providers and economic regulation (published 26 July)

1.6 Consultation on the implementation of the proposals in the White Paper and the detailed questions in the supporting consultation documents is now closed. The Government's response and the Health Bill will be introduced shortly.

1.7 Two further public consultations were launched on 18 October:

- *Liberating the NHS: An Information Revolution*: and
- *Liberating the NHS: Greater choice and control.*

1.8 A further consultation, on the move to a provider-led education and training system, will be launched shortly (see para 3.9).

Quality, Innovation, Productivity and Prevention (QIPP)

1.9 The current and forecast economic climate demands efficient use of resources. The NHS has understood for some time the need to make extremely challenging improvements in productivity and efficiency. To meet increasing demand, stemming partly from the fact that our population is ageing, and to absorb increasing costs, the NHS needs to concentrate on improving productivity and eliminating waste while focusing relentlessly on clinical quality. Work has already begun on releasing up to £20 billion of efficiency savings needed by the end of the Spending Review period. These savings will be reinvested in front-line services to meet the current financial challenge and the future costs of demographic and technological change ensuring that the NHS continues to deliver year on year quality improvements. Achieving this ambition will be extremely challenging.

1.10 To help achieve these savings, the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency.

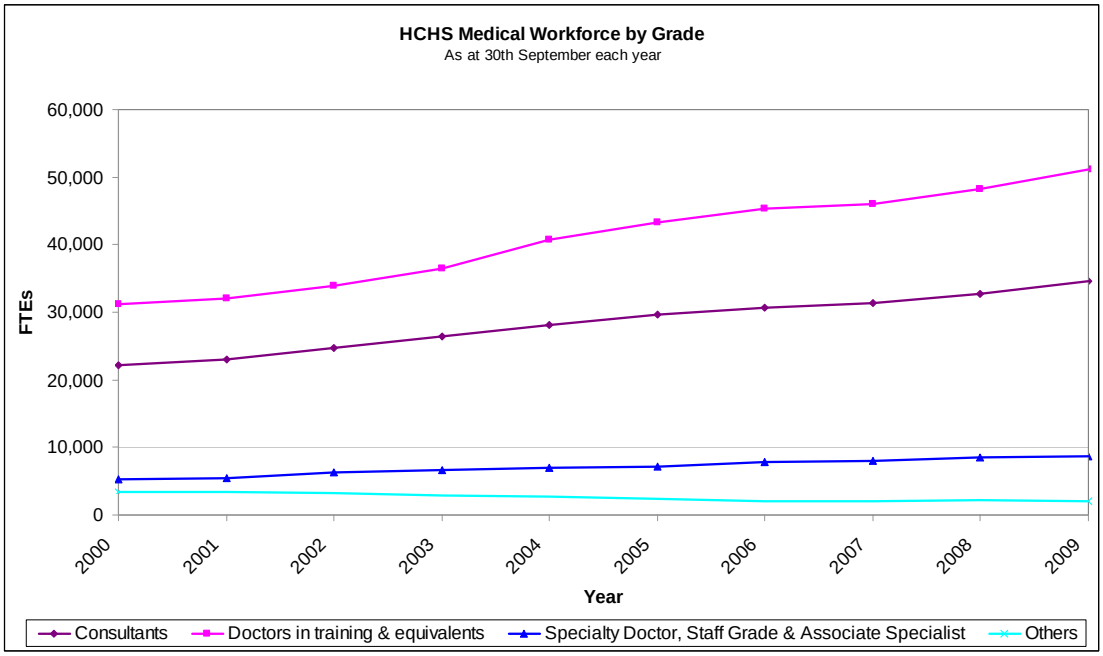
1.11 QIPP is working at a national, regional and local level to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service.

## CHAPTER 2: MEDICAL WORKFORCE PLANNING CONTEXT

### Workforce Numbers: Headline Figures

2.1 There are now more than 140,000 hospital and community health services (HCHS) doctors and GPs. Figure 2.1 shows the growth in the HCHS medical workforce since 2000.

**Figure 2.1**

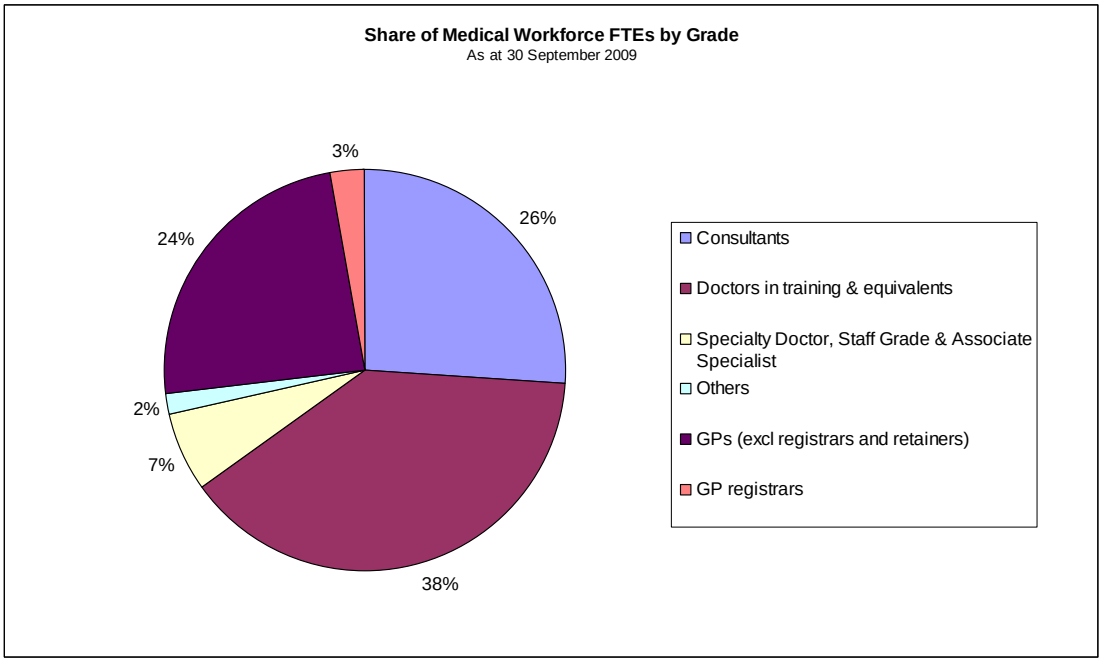



2.2 The latest annual census figures for England confirm that the NHS workforce has increased in 2009 to the highest ever recorded. Medical numbers continued to grow during the year to 30 September 2009, in particular:

- the numbers of hospital, public health medicine and community health service medical and dental staff (excluding retainers) increased by 7,271 (headcount) or 5.5% and 7,052 (full time equivalents (FTE)) or 5.6%;
- consultant numbers increased by 2,040 (headcount) or 5.8% and 1,975 (FTE) or 6.0%;
- the number of specialty doctors, staff grades and associate specialists increased by 472 (headcount) or 4.9% and 285 (FTE) or 3.4%;
- numbers of doctors in training and equivalents increased by 2,324 (headcount) or 4.7% and 2,918 (FTE) or 6.0%;
- GP numbers – excluding GP retainers and GP registrars – increased by 1,907 (headcount) or 5.6%, and1,436 (FTE) or – 4.7%; and
- GP registrars increased by 678 (headcount) or 21.2% and 604 (FTE) or 19.8%.

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

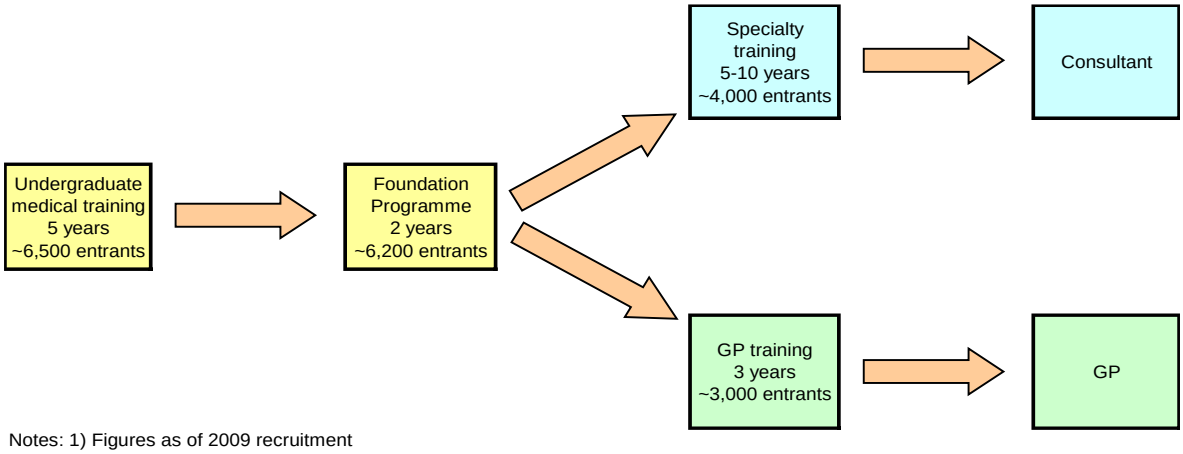
**Figure 2.2**




## Workforce Planning

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

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




Notes: 1) Figures as of 2009 recruitment
2) Foundation Programme entrant numbers were bolstered by ~150 non-UK graduates in 2009. Numbers in the 2nd year of the Foundation Programme are also likely to be bolstered by international recruitment
3) Specialty and GP training numbers were bolstered by ~2,500 non-UK graduates in 2009 across all levels of training

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

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

Centre for Workforce Intelligence

2.6 We reported last year on the plan to set up the Centre for Workforce Intelligence (CfWI) to provide expert analysis and intelligence on workforce planning. The CfWI was established on 1 July 2010.

2.7 CfWI will be an objective, trusted, credible source of workforce intelligence, analysis and evidence for the health and social care system. It will influence national and local decision-making and developments in workforce planning, policy and strategy.

2.8 The Centre will provide strategic oversight and leadership on the quality of workforce planning and development across the healthcare system including that which is delivered for the health system by social care. It will:

- align the whole system around a shared endeavour to improve and use high quality data, analysis and modelling;
- horizon-scan for innovation and future service, workforce and labour market issues that are likely to have an impact on care pathways and the health and social care workforce; and
- provide leadership for capability building by supporting national, regional and local organisations to build their effective use of workforce information as a core skill, promoting best practice in workforce planning, challenging the NHS and social care services to improve performance and setting standards for resources and tools.

2.9 The CfWI published their first report on the medical workforce on 16 August 2010[1]. They analysed the likely output from postgraduate medical training over the next five to ten years and compared these supply forecasts with estimated levels of demand.

2.10 The CfWI estimates of future trained doctor demand were based on drivers including:

- population growth and change;
- changes to morbidity;
- service level and design;
- the role of doctors.

2.11 The CfWI also considered supply side effects, including:

- the output of the core and higher specialty training pipelines;
- workforce participation;

1 http://www.cfwi.org.uk/documents/recommendation-for-medical-specialty-training-2011

- retirements and attrition;
- migration;
- European Working Time Directive (EWTD).

2.12 The CfWI report indicates that workforce demand and supply for trained doctors are broadly in balance in aggregate, so that a modest (less than 1%) overall reduction in postgraduate training numbers is required for supply and demand to balance. However, the CfWI report also highlighted regional and specialty level variations within the aggregate modest reduction; these are available via their full final report.

2.13 DH is working with SHAs, Postgraduate Deans and Employers to ensure that the recommendations from the CfWI report are realised in the 2011 intake to postgraduate medical training.

**Entry to Training (Undergraduate)**

2.14 There continues to be evidence of good recruitment into medicine. Data on entry to UK medical schools is at Statistical Tables 1-4. Medicine and dentistry remain very attractive careers and continue to attract high quality candidates with average tariff points considerable higher than the average for all subjects. For 2009 entry, the average UCAS tariff points held by home domiciled accepted applicants to UK medical and dental schools were 423 and 400 respectively, compared to 422 and 399 in 2008. In 2009, there was an average of 2.2 applicants for every successful applicant for medicine and 54% of UK accepted applicants were female compared with 56% in the previous two years.

**Current Workforce Pressures**

2.15 The NHS Vacancy Survey, published by the NHS Information Centre, collects information on vacancies that have been open and actively recruited to for three months or more at the end of March each year. This gives a measure of the vacancies which employers are finding hard to fill, rather than normal staff turnover. The 2010 Survey shows that long-term vacancy levels are still very much the exception in the NHS, and remain at historically low levels for most staff groups.

2.16 The long-term vacancy rate for hospital doctors and dentists has fallen since last year - from 1.5% to 1.4% (that is, from 674 to 644). Long-term vacancy rates among GPs increased slightly to an estimated 0.5% after remaining at a record low of 0.3% for two years.

2.17 Statistical Table 6 shows the latest three-month vacancy rates for HCHS doctors (excluding doctors in training) by SHA area and specialty group. Table 7 summarises the available vacancy data by specialty over the period 2002 to 2010.

2.18 The long term vacancy rate for consultants has fallen from 1.1% in 2009 to 1.0% in 2010 although the number shows a small increase (from 349 to 354). The numbers remain small compared to the peak year of 2005, when there were 970 long-term vacancies. The highest vacancy rates among consultants are in London, East Midlands and the North West at 1.2%.

2.19 Vacancy rates vary between specialties and, as the Review Body is aware, under the 2003 consultant contract there is provision for employers to pay a recruitment and retention premium of up to 30% of normal starting salary under certain circumstances.

2.20 In the Spending Review, the Government protected the NHS budget at above inflation growth in each year. Local healthcare organisations, with their knowledge of the healthcare needs of their local populations, are best placed to determine the workforce required to deliver safe patient care within their available resources.

## CHAPTER 3: HOSPITAL DOCTORS AND DENTISTS IN TRAINING

### Overview

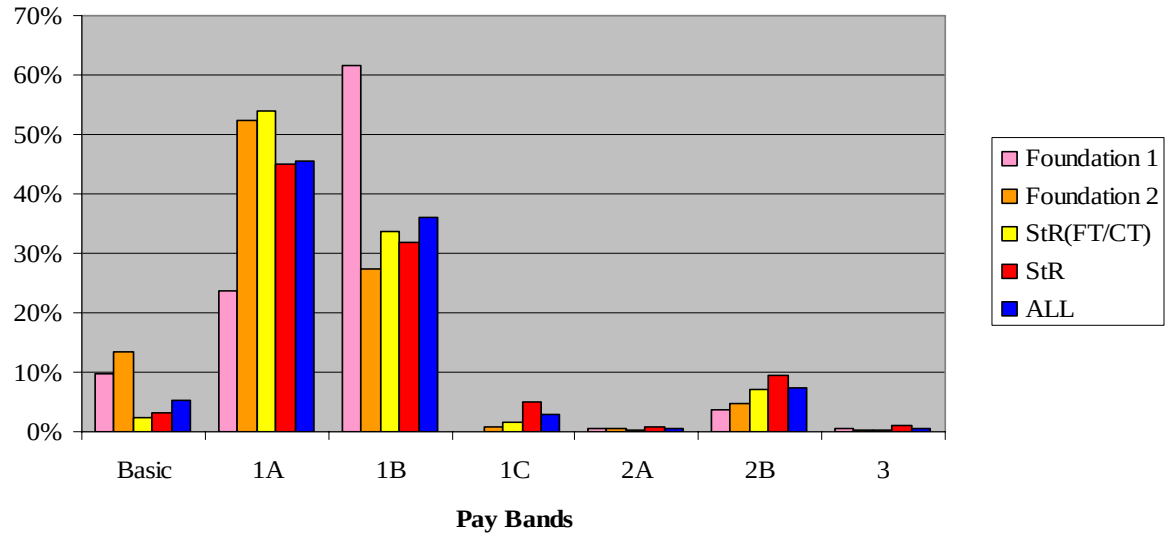
3.1 There are no specific recruitment and retention problems among doctors in training:

- the number of doctors in training in England has increased by 2,324 in the year to September 2009;
- the fill rate for specialty training programmes in 2010 has been high with a majority of specialties and geographies reporting 100% fill rates;
- in terms of average earnings for new graduates, medicine continues to stand up well in comparison with other graduate careers – including law and investment banking; and
- the NHS Staff Survey scores for job satisfaction and intention to leave jobs have improved for doctors and dentists in training since last year.

### General Position

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

**Figure 3.1** **Summary of proportions in pay bands by grade: March 2010**

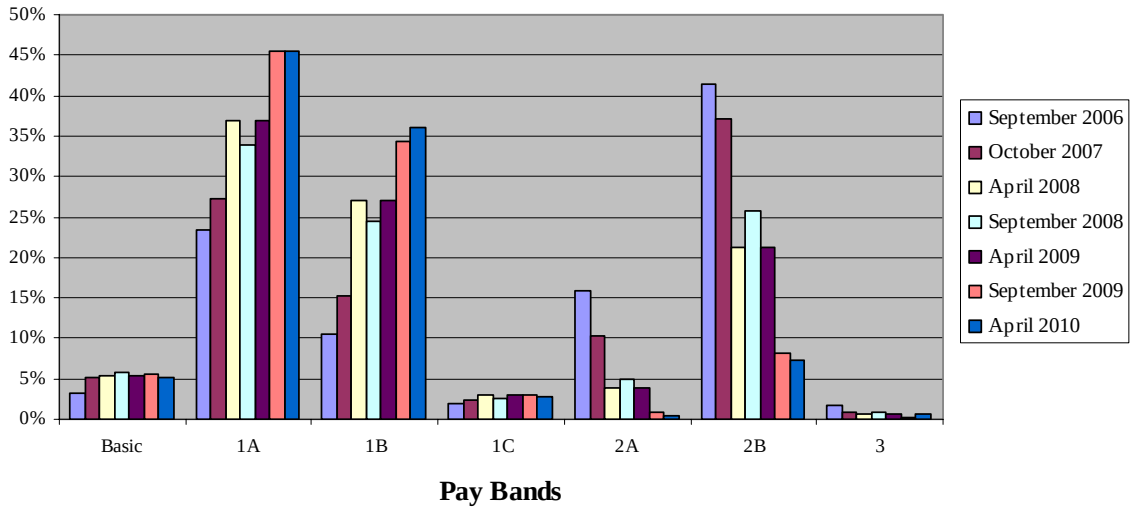


3.3 Since March 2005, at least 98% of doctors have been fully compliant with the New Deal (99% in March 2010) compared with 88% in March 2004 and 71% in March 2001. The latest monitoring returns show that 95% of junior doctors earn in excess of basic salary through the banding multipliers although there is some variation between grades. Figure 3.1 above shows the proportions of doctors in each pay band by grade as at March 2010. The average banding supplement in March 2010 for compliant posts is 43% and is unlikely to fall significantly beyond this level.

3.4 Figure 3.2 shows how the proportions of doctors in each pay band have changed since September 2006.

Figure 3.2

**Proportions by pay band since September 2006: All Grades**




**The European Working Time Directive**

3.5 The Review Body will recall that the European Working Time Directive (EWTD) has applied to the majority of staff since 1998 but its implementation for doctors in training grades has been phased in over a number of years. By August 2009, 6,370 of the 6,643 rotas (96%) were compliant. The remaining 273 rotas included services where additional support was needed to provide 24-hour immediate patient care, some supra-specialist services (services that are centred in one place but which serve several different areas), and some rural units in small and remote parts of the country. To support these services, the UK Governments took up the option of a limited derogation under Article 17(5) of the EWTD; 273 service rotas were included for derogation in "The Working Time (Doctors in Training) (Amendment) Regulations 2009" which became law on 1 August 2009. These rotas are allowed a possible 52-hour week between 2009 and 2011 (exceptionally until 2012). By January 2010, 194 of the derogated rotas were reported by Trusts to be compliant with a 48-hour week.

3.6 The new Government committed in the Coalition Agreement to limit the application of the EWTD in the UK. The Secretary of State for Health will support the Secretary of State for Business, Innovation and Skills in taking a robust approach to future

negotiations on the revision of the Directive to achieve greater flexibility. The European Commission has begun a two-stage consultation with Social Partners on the Directive. The consultation comes from the need for the Commission to resolve legal issues around on-call time and compensatory rest, which continue to cause problems for many member states following European Court of Justice Judgements. An initial solution to these problems could offer additional and welcome flexibility, and we are prepared to work with the Commission and other Member States to that end. However, we would not agree to any attempt to limit people's individual choice over working hours by removal of the opt-out.

3.7 At the same time, the Government has welcomed the publication of Professor Sir John Temple's independent report *Time for Training – the impact of the European Working Time Directive on the quality of training.* This made important recommendations about junior doctors' training and the way consultants work. Sir John concluded that high quality training can be delivered within a 48-hour week but traditional models of training and service delivery waste training opportunities and will need to change. It concluded that more consultant involvement is needed to safeguard patient safety and improve patient experience and that this will lead to better training and supervision. This could be done through stronger job planning with an emphasis on clinical service and the role of the consultant in the delivery of 24/7 patient care.

3.8 Consequently, the Secretary of State has asked Medical Education England (MEE) to consider with the profession, the service and medical Royal Colleges, how best to implement training practices that support the delivery of high quality training within the European Working Time Regulations. He has also asked MEE to advise NHS Employers on realigning EWTD and the New Deal contract for junior doctors (see para 3.26).

**Developments in Postgraduate Medical Education and Training**

White Paper – *Equity and Excellence: Liberating the NHS*

3.9 A public consultation on the future education and training system is planned for later this year. It will be based on the principle that the system should be driven by healthcare provider decisions underpinned by strong clinical leadership. It will be set within the context of delivering appropriate investment in workforce education and training, whilst ensuring better outcomes for patients and value for money. It will also need to ensure appropriate checks, balances and accountability. The arrangements for commissioning and delivery will be transparent and more efficient.

3.10 The systems for healthcare education require complex training and supervision programmes with rotations through different specialties and contexts. The professions will have a key role to play in commissioning the future system for education and training. We will be working closely with the professions as part of the consultation and the implementation that follows from this.

Medical Education England

3.11 We reported last year the establishment of Medical Education England (MEE). MEE is an Independant Advisory Non-Departmental Public Body with a remit for medicine, dentistry, pharmacy and healthcare science. The new body brings a coherent professional voice on education and training matters as they relate to these four professional groups and advises the Department of Health on policy.

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

3.13 Specifically, the MPB is responsible for ensuring that:

- training posts are filled by high quality and appointable candidates;
- the principle of curriculum-based training is supported and delivered;
- training is supported by capacity in the service to deliver training to a high standard;
- the needs of academic medicine are recognised in order to promote the excellence of medical care;
- progress is monitored and risks to delivery are reviewed regularly and managed within acceptable levels; and
- any other duties as delegated by the MEE Board are undertaken.

3.14 The MEE Board has developed its vision, strategic priorities and work programme (available at www.mee.nhs.uk). A major initiative for the coming year will be a review leading to recommendations for the future shape of postgraduate medical training.

3.15 This year, two important reports have been published:

- Professor Sir John Temple's independent report *Time for Training – the impact of the European Working Time Directive on the quality of training* – that acknowledged the Directive is creating some difficulties for trainees and the service but concluded that high quality training can be delivered in a 48-hour week with appropriate service and training re-design (see para 3.7 above); and

- Professor John Collins' evaluation of the Foundation Programme, published 4 November. Its key messages were:

    - a recommendation to continue the two-year Foundation Programme pending further review in 2015;

- to highlight concerns around appropriate supervision of trainees and trainees reporting they feel expected to perform tasks which are beyond the level of their competence; and
- recommendations for a more appropriate spread of placements within Foundation programmes, particularly to ensure greater experience in community settings.

**Workforce Numbers**

3.16 At the September 2009 census, the number of doctors in training in England was 51,502 - an increase of 2,324 (4.7%) on the September 2008 position and 19,975 (63%) more than ten years ago. The FTE figure increased by 6.0% in the year to 2009 (from 48,298 to 51,217).

3.17 As discussed in para 2.5, the demand for postgraduate medical trainees is driven by the demand for trained doctors in future years. The CfWI report on medical training numbers[2] indicates that the supply of trained doctors over the next five to ten years is broadly expected to meet forecast demand. We therefore believe that the current number of doctors in training is appropriate.

3.18 Entry to the Foundation Programme in 2010 has enabled places for all eligible applicants from UK medical schools.

3.19 The competition for specialty training places varies across specialties and locations. The fill rate for specialty training programmes in 2010 has been high with a majority of specialties and geographies reporting 100% fill rates. There were very few vacancies nationally as the service entered the August period. In total, there were 7,800 vacancies with a very small number of reported vacancies at the August period. Competition varies across specialties with some specialties having large numbers of doctors competing for posts.

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

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

3.22 Competition for higher specialty training posts, ie ST3 and above, is very strong with junior doctors applying from within training system facing competition from experienced doctors outside the training system. Examples of specialties with high competition ratios are Plastic Surgery (14:1), Paediatric Surgery (9:1) and Trauma and Orthopaedics (7:1). Overall, for Core Surgical Training posts, there were over 2,000 applicants for approximately 350 higher specialty training posts.

2 http://www.cfwi.org.uk/documents/recommendation-for-medical-specialty-training-2011

3.23 There continues to be reported difficulties in filling service or locum posts. There are reports from the service of difficulties filling non-training posts that arise due to short-term absence for vacancies that may occur. This reflects an overall shortage of service doctors in the system, although there are a large number of doctors in training. The actions being taken forward to implement the Temple Report's recommendations, including reorganisation of rotas and multi-disciplinary team working, will help to address this position. The introduction of an interim cap on immigration, via Tier 1 and Tier 2, by the UK Borders Agency has reduced the numbers of overseas doctors recruited. Issues have arisen, however the Department of Health and UKBA officials are working together to try to ensure that the NHS is able to make the best use of any flexibility in the interim immigration rules and to ensure that the Health (and Social Care) sector continues to use the flexibility provided by the use of appropriate immigration in any new system.

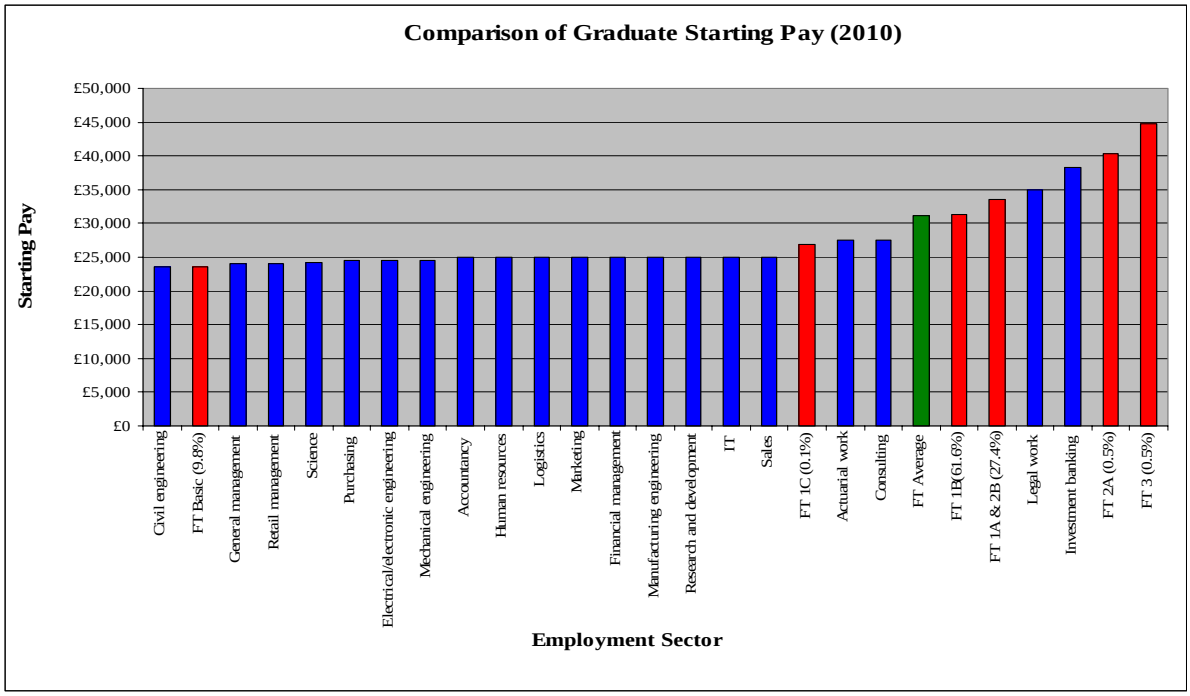
**Graduate Starting Salary Comparisons with Other Professions**

3.24 For medical graduates entering their first post, total earnings remain very competitive, particularly once account is taken of the availability of posts. Uniquely amongst undergraduates of any discipline, medical graduates are fortunate in the high proportion of graduates that are immediately able to enter their chosen career. A recent survey by the Association of Graduate Recruiters[3] (AGR) reported that the number of graduate vacancies has fallen by nearly 7% in the last year and for the first time in the history of the Graduate Recruitment Survey, median graduate starting salaries at AGR employers are expected to remain unchanged for two consecutive years. AGR members received 69 applications for every graduate vacancy advertised in 2010, up from 49 in 2009 and 31 in 2008. In contrast, in the 2010 recruitment round all graduates of UK medical schools were successful in securing a place on the Foundation Programme.

3.25 Using the latest banding figures available from March 2010 and data taken from the AGR survey, Figure 3.3 shows a comparison between the pay of junior doctors in their first post and the pay of graduates entering other professions. The columns in red show the range of actual starting pay for first year Foundation (F1) trainees. The average F1 salary (£31,153) is shown in green. The chart also shows the percentage of F1 doctors on each of the main pay bands with 90% earning £31,377 or more. This continues to stand up well against the starting salaries in other professions including investment banking and the legal profession, where there were respectively 84 and 35 applications for each graduate vacancy.

3 Recruitment Survey 2010, Association of Graduate Recruiters

**Figure 3.3**




## Junior doctors' contract

3.26 The Health Departments commissioned NHS Employers to undertake scoping work on the current contract for doctors in training in May 2009. In England, this work has needed to take account of the Government's response to the recommendations of the Temple Report mentioned above (para 3.7). In responding to that report in June, the Secretary of State for Health asked Medical Education England to advise NHS Employers on ways to realign and simplify the New Deal working arrangements.

3.27 NHS Employers intend to submit a final report to the UK Health Departments in November 2010 and we will forward a copy to the Review Body.

## NHS Staff Survey

3.28 The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2009 NHS staff survey is the 7th annual survey of its kind. Almost 290,000 NHS staff were invited to take part in the survey and approximately 160,000 employees responded – a 55% response rate (same as in 2008). The key score for job satisfaction in the NHS staff survey is regarded as one of the key indicators of staff motivation and morale. The score for job satisfaction for NHS staff has remained consistently high and has increased again this year, from 3.51 to 3.53 in the 2009 survey (on a scale of 1-5, where 1 is low and 5 high). It is now the highest it has been in the last five years. The tables at **Annex A** show how some of the Survey results for the three groups of medical/dental staff surveyed (training grades, consultants and other) compare with last year's figures and the averages for all NHS staff.

3.29 The job satisfaction score for doctors and dentists in training is above the NHS average, as is the level of improvement in the score, increasing from 3.52 to 3.56.

3.30 Reflecting the improvement in job satisfaction scores is the key score for staff intention to leave jobs. The figure for doctors and dentists in training has fallen significantly, from 2.66 in 2008 to 2.49 in 2009 and is now well below the national average for all NHS staff, though slightly higher than the average for medical and dental staff groups as a whole.

3.31 Doctors and dentists in training report greater satisfaction with their pay this year with the percentage of staff who are either satisfied, very satisfied or neither satisfied nor dissatisfied with their pay rising from 70% in 2008 to 73% in 2009. This is again significantly above the equivalent figure for NHS staff as a whole (64%).

## CHAPTER 4: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

### Overview

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

- in the year to September 2009, the numbers of associate specialists increased by 324, or 10.1% (headcount); and staff grade and specialty doctors by 148 or 2.3% (headcount);
- three-month vacancy rates for this group of HCHS doctors was 2.6% in 2010 down from 3.0% in 2009; and
- according to the NHS Staff Survey, job satisfaction for this staff group is high and has increased again from 3.51 to 3.54, over the last year.

4.2 By the end of July, 7,313 doctors out of a total of 10,149 (headcount) were on the new contracts.

### General Position

4.3 Between 2008 and 2009, associate specialist, staff grade and specialty doctor numbers employed by the NHS increased by 472 (headcount) and 285 (FTE).

4.4 As Statistical Table 7 illustrates, the three-month vacancy rates for this group of HCHS doctors was 2.6% in 2010 compared to 3.0% in 2009.

### Uptake of new contracts

4.5 The Electronic Staff Record (ESR) showed that, as at July 2010, there were:

- 4,742 doctors on the new Specialty Doctor contract; and
- 2,571 doctors on the new Associate Specialist contract

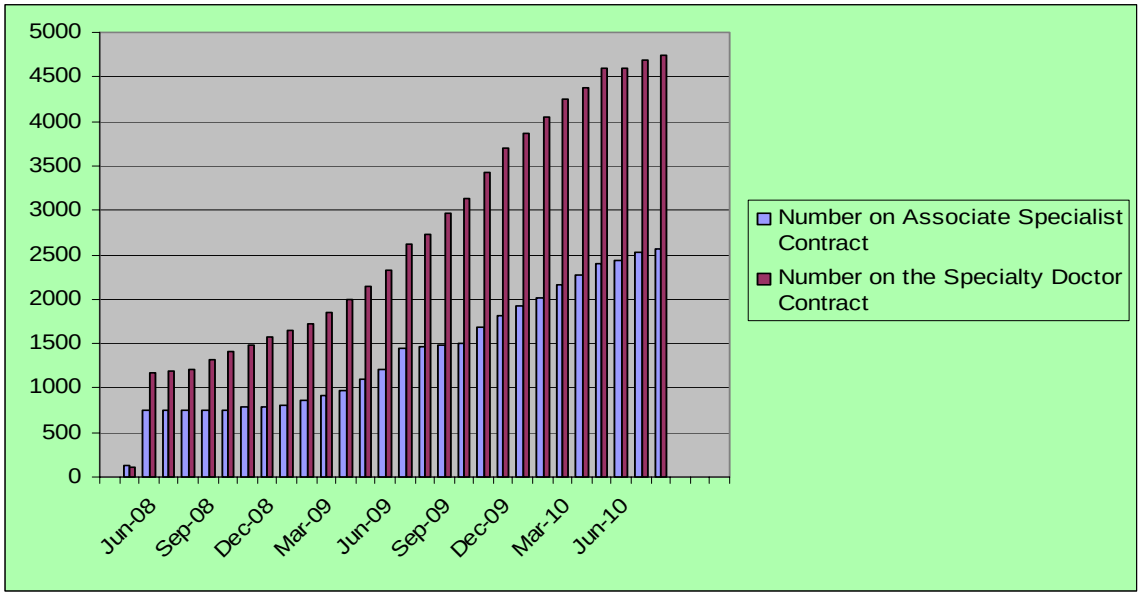
and, at the end of July 2010, there were:

- 1,560 doctors remaining on the Staff Grade contract; and
- 1,276 doctors remaining on the old Associate Specialist contract.

4.6 We are pleased at the progress being made. Figures from the ESR suggest that around 27% of Staff Grade doctors and 44% of Associate Specialists remained on the old contracts as at July 2010. Some doctors may still be in the final stages of transferring, subject to agreeing job plans. Transfer is optional and some may have elected to remain on their old contracts.

4.7 As well as doctors transferring from the Staff Grade and new joiners, the numbers on the new Specialty Doctor contract will also include some doctors from the following grades: non-GP clinical assistants and hospital practitioners; clinical medical officers; and senior clinical medical officers.

4.8 As well as doctors transferring from the old Associate Specialist contract, the numbers on the new Associate Specialist contract will include some personal regradings from eligible doctors in other grades. The Associate Specialist grade was closed to new entrants on 31 March 2008 (with the exception of eligible doctors regrading through the 'window of opportunity' by 31 March 2009).




4.9 We expect to see numbers flattening off as we exhaust the pool of eligible staff wishing to transfer. New numbers will continue to move onto the new Specialty Doctor contract as a matter of course, as new appointments are made, but not in the same numbers as we have seen as they no longer transfer from the old grades in the same numbers.

**Costs of the new contractual arrangements**

4.10 As a condition of agreeing new contracts for associate specialists and the former staff grade doctors in 2008, it was agreed that the costs of the contracts should be monitored and reported to DDRB.

4.11 The projection, based on modelling by NHS Employers and the BMA during negotiations, was that the new arrangements would result in additional costs of 10% over the existing pay bill. In England, funding was allocated to the NHS on this basis.

4.12 We have calculated that the additional costs of the new contracts in England (for those doctors who had transferred by August 2009) were 9.8% (of basic earnings, 9.36% of total earnings), suggesting that the cost modelling was robust and that the contracts are being implemented as intended.

4.13 The paper at **Annex B** explains our approach to calculating the costs.

**Enhancing Opportunities for SAS Doctors**

Funding

4.14 As we reported last year:

- recurrent funding of £12 million, uprated each year for inflation, has been provided since April 2008 for specialty doctor career support, training and CPD; and

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

Credentialing

4.15 Last year, we reminded the Review Body that recommendation 3 of *Choice and Opportunity* states:

> "*A system of limited accreditation of competences is required through which NCCGs with formally recognised skills can work independently at the appropriate level.*"

4.16 We reported that the *Next Stage Review* included a commitment to develop the concept of modular credentialing that will help take this forward:

> "*In partnership with the medical profession, in particular the Royal Colleges and the professional regulators, we will develop plans to introduce modular credentialing for the medical workforce over the coming decade*".

4.17 The Postgraduate Medical Education and Training Board (PMETB) lead further work to consider the options, ensuring the engagement of stakeholders through its Credentialing Steering Group (CSG) - on which the BMA was represented. The CSG's report, published in April 2010, recognised the potential benefits of credentialing, but also highlighted potential risks. To maintain momentum, the Department has asked Medical Education England to consider the CSG's report as it undertakes its review of the future shape of postgraduate medical education. The CSG report also identified the close link between credentialing and revalidation and has asked the GMC to align these initiatives as they progress the revalidation agenda.

Certificates of Eligibility for Specialist Registration

4.18 GMC (and formerly PMETB) data show 61% of applications for Certificates of Eligibility for Specialist Registration (CESR) and Certificates of Eligibility for GP Registration (CEGPR) between 2005 and 2010 were successful. However, the data do not distinguish between applicants from overseas and from the SAS grades in the UK. Each application is, of course, assessed individually and decisions based on merit.

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

**NHS Staff Survey**

4.20 The results of the 2009 NHS Staff Survey show job satisfaction within the Speciality Grade and for Associate Specialists is high and has increased again this year from 3.51 to 3.54 (scale 1 to 5), which is just above the high levels reported of all NHS staff (3.53).

4.21 The percentage of Specialty Grade and Associate Specialist doctors and dentists surveyed who reported that they are satisfied, very satisfied or neither satisfied nor dissatisfied with their pay has risen from 61% in 2008 to 66% in 2009.

4.22 Intention to leave jobs is again reduced among Specialty Grade and Associate Specialist doctors and dentists, with survey scores falling from 2.46 to 2.42 (scale 1 to 5). This remains higher than the average for all medical and dental staff (2.34) but below the average for all NHS staff (2.54).

## CHAPTER 5: CONSULTANTS

### Overview

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

- in the 2009 NHS Staff Survey, the job satisfaction score for consultants was well above the NHS average and was the highest of the medical and dental staff groups;

- the three-month vacancy rate remains very low at 1.0%, well below the peak of 4.7% in 2003.

5.2 Consultants are among the better paid public sector groups, with basic salaries for those under the 2003 contract in the range £74,504 to £100,446. The September 2010 NHS Staff Earnings Estimates published by the NHS Information Centre shows that consultants' mean NHS earnings per full time equivalent are £120,400.

### General Position

5.3 In the year to September 2009, the number of consultants (including Directors of Public Health) working in the NHS in England increased by 2,040 (5.8%) to 36,950 (34,654 FTE).

5.4 The NHS Information Centre's latest vacancy survey shows that consultant vacancies remain low. The March 2010 three-month vacancy rate for medical and dental consultants was 1.0%. The three-month vacancy rates for consultants since 2002 are shown below.

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

5.5 The Review Body asked for an update on the use of recruitment and retention premia (RRP). As last year, data extracted from the Electronic Staff Record confirm that recruitment and retention premia are not widely used for consultants. The proportion of consultants in receipt of general recruitment and retention premia in August 2010 averaged 0.4% in England and was highest in East Midlands (1.3%).

5.6 The September 2009 workforce census found that 38% of consultants working in the NHS in England were aged 50 or over, and 8% were aged 60 or over compared with 42% and 10% at September 2008. The latest information on consultant retirements is at **Annex C**.

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

5.8 Consultants on either contract with at least one year's service are eligible to apply for clinical excellence awards. Information to inform the DDRB's UK wide review of Clinical Excellence and Distinction Award Schemes will be provided in line with the separate timetable for this work.

5.9 As we explained to the Review Body last year, the NHS is still working to deliver the full benefits of the 2003 consultant contract. NHS Employers are preparing further guidance, jointly with the BMA, on job planning. This is more over-arching than the job planning toolkit (which remains relevant), and is about using organisational and team objectives to drive the job planning process, including supporting professional activities. We understand that the guidance will be published early in 2011.

**2009 NHS Staff Survey**

5.10 In the 2009 NHS Staff Survey, the job satisfaction score for consultants was well above the NHS average and was the highest of the medical and dental staff groups. The score has improved slightly since the last survey from 3.59 to 3.60 (on a scale of 1-5, where 1 is low and 5 high).

5.11 The high level of the job satisfaction score for consultants is reflected in the key score for staff intention to leave jobs. Whilst the score for consultants' intention to leave jobs has risen slightly from 2.26 in 2008 to 2.28 in 2009, it remains significantly below the NHS average and was the lowest of all the medical and dental staff groups.

5.12 The new key score on staff engagement reveals that consultants are also the most engaged with their jobs of all the medical and dental staff groups with a score of 3.99 (on a scale of 1-5, where 1 is low and 5 high), This score is well above the average for all NHS staff (3.86).

5.13 The proportion of consultants who reported that they were satisfied, very satisfied or neither satisfied nor dissatisfied with their pay increased slightly from 84% in 2008 to 86% in 2009. This score is again well over the average of all medical and dental staff (78%) and the NHS average (64%).

5.14 Consultants work the most paid and unpaid additional hours of all the medical and dental staff groups and significantly more than NHS staff as a whole. Only 57% of consultants work no additional paid hours and 22% work no additional unpaid hours compared to 73% and 47% respectively for NHS staff as a whole.

## CHAPTER 6: GENERAL MEDICAL PRACTITIONERS

### Introduction

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

6.2 The Government has announced a two-year public sector pay freeze for all staff who earn over £21,000. There is, therefore, no need for the Review Body to make recommendations on the remuneration of GMPs in England for 2011/12 and 2012/13.

6.3 The Department of Health will make decisions on the contract uplift, if any, that will be applied in these two years to achieve a pay freeze, following discussion with the BMA General Practitioners Committee. In reaching decisions, the Department will take into account the formula used for expenses, which DDRB developed and published alongside recent recommendations, together with assumptions on the efficiency gains that it is reasonable to expect GP practices to achieve.

6.4 The material in this chapter is, therefore, for information only and to provide a continuing background to developments in general practice.

### Background

6.5 Most of the doctors working in General Medical Services (GMS) are independent contractors: self-employed individuals or partnerships running their own practices as a small business. There are currently 8,228 GP practices in England, and around 58% of practices (52% of GMPs) operate under the national GMS contract.

6.6 Contractors with Personal Medical Services (PMS) arrangements operate within locally agreed contracts, and any uplifts in investment for PMS contracts are currently a matter for Primary Care Trusts to decide.

### *'Liberating the NHS'*

6.7 In July, the Secretary of State for Health laid a White Paper before Parliament, entitled "*Equity & Excellence: Liberating the NHS*" (Cm7881). This proposed a number of reforms to empower healthcare professionals and healthcare providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level.

6.8 The White Paper included proposals to devolve power and responsibility for commissioning most healthcare services to consortia of GP practices, working in collaboration with a range of other health and care professionals and with patients and the public.

6.9 The White Paper also indicated that the Department intended to seek over time to establish a single contractual and funding model for general practice to promote quality improvement, deliver fairness for all practices, support free patient choice,

and remove unnecessary barriers to new provision. Under this model, funding would follow the registered patient on a weighted capitation model, adjusted for quality, and provide stronger incentives to register patients from more deprived areas with greater health needs.

6.10 The deadline for responses to the public consultation on the proposed reforms was 11 October 2010. A response to the consultation will be made available on the DH website in due course, and it will help shape the Health Bill later in the year.

**Trends in the Earnings and Expenses of GMPs**

6.11 In 2009/10, the NHS in England spent £8.3 billion on primary medical services compared to £5 billion in 2002/03.

6.12 The following points set out the trends in GP earnings and expenses since 2002/03:

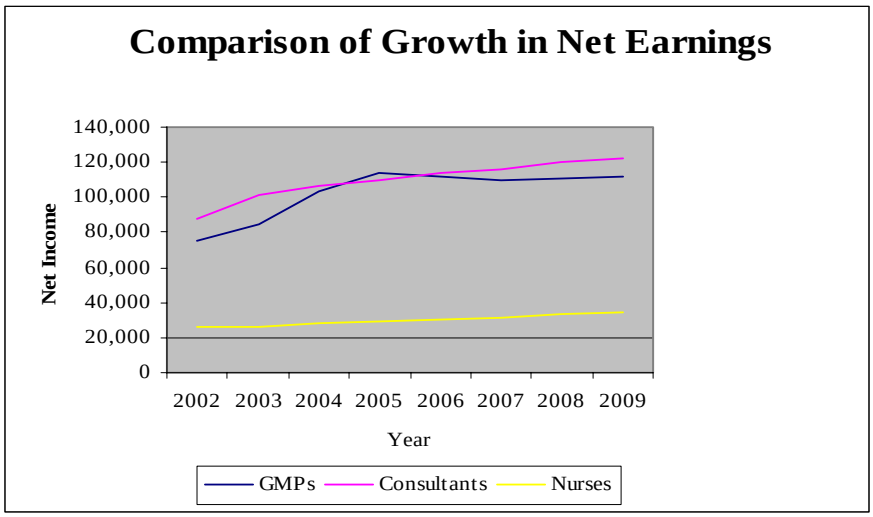
- GMP pay has increased in cash and real terms relative to other NHS staff groups. Figure 6.1 shows the comparison of pay growth between GMPs, nurses and consultants in England. On a cash basis, pay has increased by 46% over the period 2002/03 to 2008/09 (2008/09 being the latest year for which figures are available). This compares to a cash increase of 31% for consultants and 21% for nurses over the same period;

- in real terms pay has increased by more than 28% for England over the same period, compared to 15% for consultants and 6% for nurses, see Figure 6.1;

- taking account of the Department's forecasts of GMPs', consultants' and nurses' earnings for 2008/09 and 2009/10, GMP real terms pay has increased by 28% for England over the period 2002/08 to 2009/10, compared to 20% for consultants and 15% for nurses; and

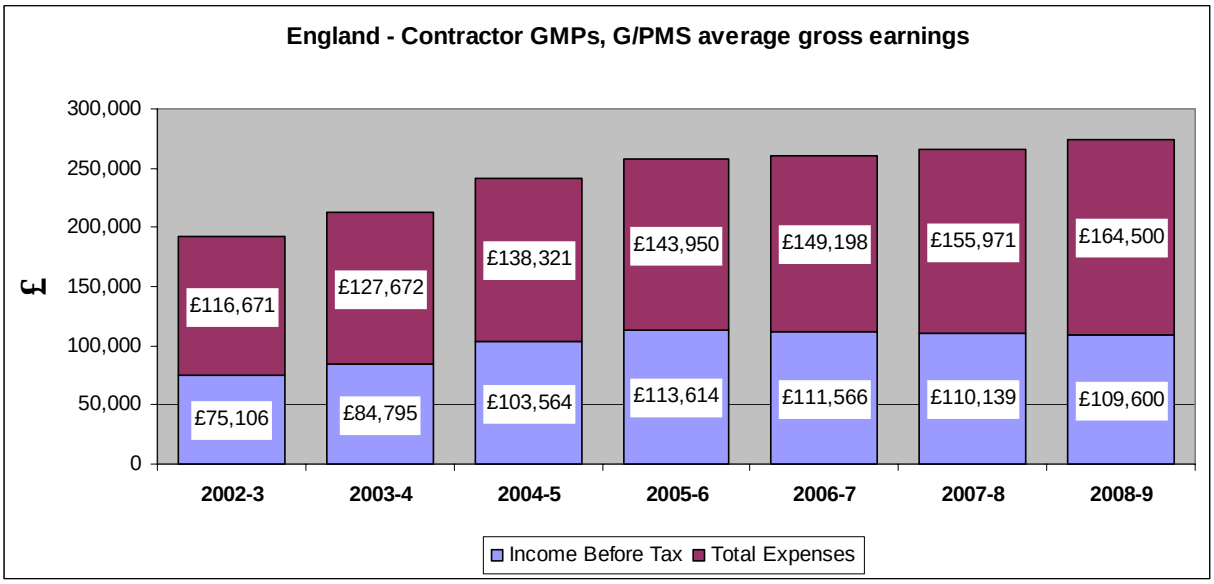
- this increase was concentrated in the three years from 2003/04 to 2005/06 following introduction of a new GMS contract. Since 2005/06, there have been small year-on-year falls in net income

**Figure 6.1**



6.13 Figure 6.2, which is based on data provided by Her Majesty's Revenue & Customs (HMRC), shows increases in gross earnings and net income for the average GMP in England during the period 2002/03 to 2008/09.

**Figure 6.2**




6.14 The figures in Table 6.1, below, represent the position for the average GMP and show the distribution of net income, or profit, received by groups of contractor GMPs on a UK basis (England figures are not available at this level of granularity).

**Table 6.1**

| Numbers of UK GPMS GPs in different net income brackets (before tax) | | | | | | |
|---|---|---|---|---|---|---|
| **Financial Year** | **Less than £50k** | **£50k - £100k** | **£100k - £150k** | **£150k - £200k** | **£200k - £250k** | **More than £250k** |
| 2002/03 | 7,842 | 20,493 | 3,875 | 221 | 0 | 0 |
| 2003/04 | 5,138 | 19,883 | 6,469 | 904 | 222 | 0 |
| 2004/05 | 3,060 | 15,442 | 12,264 | 2,492 | 475 | 154 |
| 2005/06 | 2,001 | 12,342 | 14,534 | 3,876 | 816 | 307 |
| 2006/07 | 2,048 | 13,387 | 13,832 | 3,623 | 739 | 258 |
| 2007/08 | 2,320 | 13,610 | 13,220 | 3,560 | 650 | 260 |
| 2008/09 | 2,310 | 14,020 | 12,820 | 3,280 | 700 | 250 |

6.15 Table 6.1 shows the significant movement of GMPs into higher income brackets following the introduction of the new GMS contract, followed by some year-on-year reductions in the number of very high earners (£150k+) since 2005/06.

6.16 Table 6.2 sets out the Department's current estimates for GMP earnings in 2009/10 and 2010/11. These estimates reflect DDRB's recommendations that net income for GMS contractors should increase by 1.5% in 2009/10 and 0.0% in 2010/11.

**Table 6.2**

| England GPMS GMPs | | | | |
|---|---|---|---|---|
| Year | Average Net Earnings £ | Year on Year Cash Change | Cumulative Cash Change | Cumulative Real Terms Change |
| 2002/03 | 75,106 | - | - | - |
| 2003/04 | 84,795 | 12.9% | 12.9% | 9.8% |
| 2004/05 | 103,564 | 22.1% | 37.9% | 30.5% |
| 2005/06 | 113,614 | 9.7% | 51.3% | 40.6% |
| 2006/07 | 111,566 | -1.8% | 48.5% | 33.6% |
| 2007/08 | 110,139 | -1.3% | 46.6% | 28.2% |
| 2008/09 | 109,600 | -0.5% | 45.9% | 24.1% |
| **Estimates:** | | | | |
| 2009/10 | 111,244 | 1.5% | 48.1% | 24.1% |
| 2010/11 | 111,244 | 0.0% | 48.1% | 20.4% |

6.17 Table 6.3 shows trends in the ratio of gross earnings to practice expenses:

**Table 6.3**

| England GPMS GMPs | | | |
|---|---|---|---|
| Financial year | Gross Earnings | Expenses | Expenses as a % of Earnings |
| | £ | £ | % |
| 2002/03 | 191,777 | 116,671 | 61% |
| 2003/04 | 212,467 | 127,672 | 60% |
| 2004/05 | 241,885 | 138,321 | 57% |
| 2005/06 | 257,564 | 143,950 | 56% |
| 2006/07 | 260,764 | 149,198 | 57% |
| 2007/08 | 266,110 | 155,971 | 59% |
| 2008/09 | 274,100 | 164,500 | 60% |

**Workload of GMPs**

6.18 The average number of patients per medical practitioner in England has fallen from 1,788 in 1999 to 1,520 in 2009 mainly as a result of the increased number of GMPs (increase of 26% or 7,450 to 35,917 since 1999).

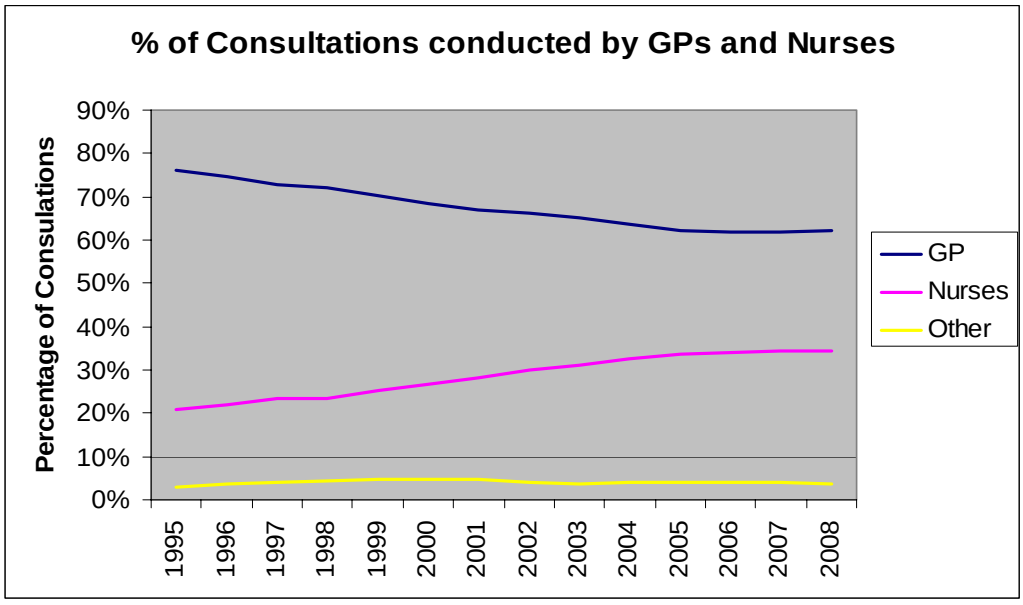
6.19 There has been a significant increase in the number of practice staff over the last decade. There are now 2,893 – or 27% - more practice nurses, and 3,275 – or 175% - more other staff than in 1999.

6.20 The number of patients per practice has risen from 5,634 in 1999 to 6,637 in 2009. The number of practices has decreased from 9,034 to 8,228 over the same period, reflecting a move towards larger practices employing more GPs. This trend is also evident in the decline of single-handed GPs from 2,721 in 1999 to 1,266 in 2009.

6.21 There were on average 3.9 consultations per patient in 1995, rising to 5.4 consultations per patient in 2008, a total of 300.4 million consultations annually.

6.22 As shown in Figure 6.3, the proportion of consultations undertaken by nurses and other clinicians rather than by GPs has risen from 24% in 1995 to 38% in 2008. The number of GP consultations taking place over the telephone has risen from 3% in 1995 to 12% in 2008.

**Figure 6.3**




6.23 The number of home visits (as a proportion of consultations) has fallen from 7.6% of consultations in 1995 to 3.5% in 2008.

**Recruitment, Retention and Motivation of GMPs**

6.24 As at September 2009, there were 35,917 GMPs in England (excluding retainers and registrars). This is the highest ever number and an increase of 5.6% on last year, with a further 1,907 practitioners joining the workforce. Of this increase, 1,260 are new GP providers or partners, and 647 are salaried GPs.

6.25 The estimated 3-month vacancy rate for GMPs has fallen from 2.4% in 2005 to 0.5% in 2010.

6.26 There are now 3,880 GMP registrars, compared with 1,520 in 1999.

6.27 There were around 6,000 applicants for 2,700 GP training places in 2009. The NHS has filled 100% of GP training places in 2010.

6.28 A work life survey conducted by the National Primary Care Research & Development Centre in February 2009, which gave 1,300 responses from 3,000 GMPs (in England) selected, showed:

- overall satisfaction on a seven-point scale had reduced from 5.2 in 2005 to 4.7 in 2008, but with both sets of results higher than in 2001;

- working hours were on average 3 hours per week lower than in 2004;

- 83% of GPs aged under 50 say they had either no intention or only a slight intention of leaving direct patient care over the next five years.

6.29 The NHS Pension Scheme forms a significant part of the overall GP reward package. The Scheme is particularly favourable towards GMPs both compared to other NHS staff groups and to other self-employed persons. GMP earnings can fluctuate widely from year to year, according to the work that the individual practitioners carry out and how much is taken as profit. To take account of these fluctuations in earnings, GPs have a Career Average Pension arrangement in which their pensionable earnings are revalued by an annual uprating factor. This process is known as "dynamisation". Since April 2008, the NHS Pension Scheme has revalued GP earnings for pension purposes by the Retail Prices Index plus 1.5%.

**Additional Earning Potential**

6.30 Unlike many other staff groups, GMP contractors have scope to increase their net income from sources other than the uplift to GMS contract payments. These are:

- additional income from a variety of professional activities outside their NHS work. In the Association of Independent Specialist Medical Accountants (AISMA) survey of 2007, on average 8% of total income was generated from sources outside NHS contracts. This represented an average income of £22k per annum for a full-time equivalent GP;

- additional investment in local enhanced services. Over the last two years, additional local investment in GP services has grown by 36% from £250 million in 2007/08 to £339 million in 2009/10. Assuming an earning to expenses ratio of 40:60, this is equivalent to a 1.1% average growth in pay; and

- additional income earned from other enhanced services, such as the Pandemic Flu vaccination scheme Directed Enhanced Service, which paid £28 million to, practices in England during 2009/10. Assuming an earning to expenses ratio of 40:60, this is equivalent to a 0.4% average growth in pay.

**Minimum Practice Income Guarantee (MPIG)**

6.31 As a result of the increase in global sum price per patient from £63.21 in 2009/10 to £64.59 in 2010/11, DH modelling suggests that the number of practices on MPIG has fallen from 68% in 2009/10 to 61% in 2010/11 with a reduction in the costs of MPIG from £131 million to £110 million.

**Update on Negotiations**

6.32 Negotiations are taking place between NHS Employers and the BMA General Practitioners Committee on the GMS contract arrangements for 2011/12. We hope to be able to provide information shortly on the outcome.

## CHAPTER 7: DENTISTS

### Introduction

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

7.2 The Government has announced a two-year public sector pay freeze for all staff who earn over £21,000. There is, therefore, no need for the Review Body to make recommendations on the remuneration of GDPs in England for 2011/12 and 2012/13.

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

7.4 The material in this chapter is, therefore, for information only and to provide a continuing background to developments in general dental practice.

### Background

7.5 It is clear that there continue to be problems with the new dental contracting arrangements introduced in 2006. We are considering what contractual changes might be required and intend to test these in pilots which will be announced in December. Our initial view is that there has been too large an emphasis on process driven targets and measuring activity. We intend to move towards a system based on registration, capitation and quality, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions. Any major changes will be discussed with the profession and with patient organisations and will be piloted. We hope that this will address many of the concerns of the profession and will drive further improvements in dental health in England.

7.6 Although it is clear that change will be necessary, we are pleased to note that the current position on NHS dentistry is improving and there has been a further increase in the number of dentists working in the NHS in 2009/10. We intend to do more to increase access, initially by a million additional NHS patients. For the first time, questions about access to NHS dental services were included in the GP Patient Survey in 2009/10. 92% of people who tried to get an appointment with an NHS dentist in the past two years were successful. For those seeking an appointment in the last six months, the success rate is 95%.

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

| | Success rate in last 24 months (% who succeeded, not including "Can't remembers") | Success rate in last 6 months (% who succeeded, not including "Can't remembers") |
|---|---|---|
| **England** | **92%** | **95%** |
| North East | 95% | 97% |
| North West | 91% | 95% |
| Yorks & the Humber | 91% | 94% |
| East Midlands | 92% | 95% |
| West Midlands | 94% | 96% |
| East of England | 93% | 96% |
| London | 91% | 94% |
| South East Coast | 91% | 95% |
| South Central | 90% | 94% |
| South West | 92% | 95% |

7.7 In the last year:

- access to NHS dental services has risen. 28.5 million patients were seen by an NHS dentist in the 24 month period ending June 2010, 55.4% of the population. The number is almost 870,000 higher than twelve months earlier, and 1.6 million higher than the low point reached in June 2008.

- NHS dental activity has risen, up from 81.4 million units of dental activity (UDAs) in 2008/09 to 85.5 million UDAs in 2009/10. PCTs commissioning plans at June 2010 for the following twelve months are 3.4 million UDAs higher than a year ago.

- the number of dentists providing NHS services rose by 660 to 22,003 dentists in 2009/10.

- the proportion of dentists' time spent on NHS work is rising. It rose from 72.2% in 2008/09 to 73.1% in 2009/10. By region, the NHS proportion ranges from 59.5% in the South Central SHA area to 82.9% in the North East.

- the number of new dental graduates has risen to 840 in 2010, a 25% increase since 2004; this will help to sustain the healthy workforce position.

- there was a further increase in Vocational Trainee places in 2009/10 and an increase in practices wishing to participate in the scheme.

## General Dental Practitioners: Earnings and Expenses

Net Earnings

7.8 The data from the NHS Information Centre this year continues to be hard to compare with previous years' data because of changes in the way dentists pay themselves, especially the move towards incorporation which takes profits out of the self employed tax system for the individual dentist and moves them into company accounts. This is a serious issue, which clouds the data on key decisions including the relative level of expenses and earnings. But, despite these changes, it is clear that dentists continue to receive a good income. In particular, the average identifiable net profit after expenses for dentists in 2008/09 was £89,600 compared with £89,100 in the previous year. For dentists holding a contract this was considerably higher at an average of £131,000, up 3.3% from the previous year's £126,800. The data also show many dentists earning considerably more; some earned over £300,000. Dentists working for others still had an average net profit of £67,800, up 3.1% over the £65,700 of the previous year.

7.9 The data showed that just over half (54%) of gross payments to dentists was to meet their expenses. The NHS Information Centre report shows that dentists' earnings depend little on their NHS commitment. The most committed NHS dentists – those spending 75% or more of their time on NHS work – earn similar amounts on average (£94,100) to dentists who are mainly private (ie where NHS work is 25% or less of their time) (£99,200). Dentists doing a mixed amount of NHS and private work had an average net income of £99,900 in 2008/09.

**Table 7.1: Gross income and net profit of primary care dentists 2004/05 to 2008/09**

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

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

7.10 Information on dentists' income compiled by the National Association of Specialist Dental Accountants (NASDA), which represents more than 20% of self-employed dentists, reported an increase in net profit for NHS practices in 2008/09 of 8.97% which would raise average profit to £161,300 Net profit is 37% higher than four years earlier, in 2004/05. Net profit on NHS practices of £161,300 exceeds average net profit of private practices of £130,600, a reversal of the situation before 2005/06.

**Table 7.2: Net profit for the practice**

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

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

7.11 NASDA report that average net profit for associate dentists (those dentists with no share of ownership) increased from £70,299 in 2007/08 to £72,988 in 2008/09, bringing net profit back above the average in 2005/06 of £70,695. The increase occurred for associate dentists working in NHS or in mixed NHS and private practices

Expenses

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

*NHS IC Report on dental earnings and expenses 2008/09, paras 1.18 to 1.20. and para 1.21*

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

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

*1.20 Since the introduction of the Dentists Act 1984 (Amendment) Order 2005 (SI 2005/2011), it has been possible for dentists to incorporate their practices and operate as a limited company. It is currently not known how many dentists have incorporated, and the precise effects this may have on the results presented in the report. The NHS IC and DWG are working towards gaining further understanding of this issue with a view to including further information in the 2009/10 edition of this report.*

7.13 In looking at expenses we need to take account of the fact that average earnings and expenses figures, being an average, are affected by the composition of the population which they cover. There are significant changes going on in the composition of the dentists covered in the earnings and expenses figures.

7.14 Changes in earnings and expenses reflect not just changes in pay rates and price changes. For example, if dentists work longer hours they have higher gross income

but also may have higher expenses (and higher net income). The figures are affected by changes in the type of work being done. For example the relatively high reported growth in Band 3 treatments should lead to additional laboratory cost payments (a rise in expenses) but if this is substituting for lower band work then for the same number of contract UDAs dentists have some freed up time which they can spend on other things. The net income figure is less affected than either gross income or expenses by changes in the type of work of work being done.

7.15 The averages cover dentists doing any NHS work in the year. A significant number of dentists come and go within year. With 20,500 covered by GDS or PDS contracts in 2009/10, we have 1,100 leavers and 1,800 joiners in a year ie 2,900 or 14% working for only part of the year. The numbers are set out below (Table 6e from 'Dental Statistics 2009/10').

**Table 6e: Number and proportion of dentists with NHS activity in the year ending 31 March, by dentist type, 2006/07 to 2009/10**

Number and per cent

| | Number | | | | | Per cent | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2006/07 | 2007/08 | 2008/09 | 2009/10 | % change 2008/09 to 2009/10 | 2006/07 | 2007/08 | 2008/09 | 2009/10 |
| **Total** | **20,160** | **20,815** | **21,343** | **22,003** | **3.1** | **100.0** | **100.0** | **100.0** | **100.0** |
| Providing performer | 7,585 | 7,286 | 6,778 | 6,279 | -7.4 | 37.6 | 35.0 | 31.8 | 28.5 |
| Performer only | 12,575 | 13,529 | 14,565 | 15,724 | 8.0 | 62.4 | 65.0 | 68.2 | 71.5 |

Notes:

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

7.16 As already noted, the changes from year to year are affected by contract holder dentists changing their business arrangements into companies. This is tax efficient. Some profit is retained in the company, which in turn makes a self-employment payment to the dentist. The profits retained in the company are no longer covered in these self-employed earnings figures.

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

7.18 Extracts from the NASDA results are in the table below. They show for four categories of expenses that expenses as a percentage of gross income fell in each category for both mainly NHS and mainly private dentists in 2008. In particular, there was a small reduction in the laboratory cost percentage for mainly NHS practices.

| | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|---|---|---|---|---|
| **Non-clinical staff wages (NASDA)** | | | | |
| NHS practices | 18.2% | 17.3% | 17.9% | 17.7% |
| Private Practices | 17.2% | 17.4% | 17.8% | 17.6% |
| **Laboratory costs (NASDA)** | | | | |
| NHS practices | 6.4% | 5.6% | 6.1% | 6.0% |
| Private Practices | 5.6% | 5.0% | 5.6% | 5.4% |
| **Materials costs (NASDA)** | | | | |
| NHS practices | 5.6% | 5.0% | 5.6% | 5.4% |
| Private Practices | 6.7% | 7.0% | 7.5% | 7.1% |
| **Other Non-Staffing Costs (Morris & Co)** | | | | |
| NHS practices | 16.4% | 16.8% | 15.7% | 15.6% |
| Private Practices | 23.0% | 23.2% | 23.6% | 21.4% |
| Note: 2006/07 figures for NHS practices are affected by temporary increase in income from transition to the new contract. 2005/06 NHS figures include PDS. | | | | |

## General Dental Practitioners: Recruitment, Retention and Motivation

Supply of dentists

7.19 The numbers of dentists providing NHS services is a relatively weak indicator of supply: it is the number of NHS patients and the amount of NHS service they receive that is more important and these continues to rise. It is nonetheless encouraging that numbers of dentists are also continuing to rise, up by 3.1% last year.

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

Future workforce supply

7.21 In the short to medium term, the position on workforce supply will be further enhanced by the 25% increase in undergraduate training begun in October 2005 and the fourfold increase in training places for dental therapists now in place. As a result, some 840 dentists qualified in summer 2010 – 25% more than the 2004 baseline - with the number of new graduates expected to rise to 915 in 2011 before levelling at around 900 per annum from 2012.

7.22 The Department's current estimates of future workforce supply strongly suggest that the supply of dentists will be able to meet demand for new services, even taking account of the dental procurements in train. The Dental Practice Board of Medical Education England plans to update the dental workforce review published in 2004, taking account of the reduction in the complexity of treatment and gradual implementation of NICE guidelines for longer recall intervals and growth in skill mix. These changes are gradually allowing greater value for money (quality and productivity) to be obtained from existing investment in dental services and from the existing dental workforce, rather than having to rely mainly on new procurements to increase capacity.

Motivation

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

7.24 The Department is hoping to work with the BDA and NHS Employers on a joint survey looking at motivation and morale for future evidence. This will depend on availability of resources.

7.25 There are, however, still a number of key issues with the way dentistry is delivered and managed which we intend to work with the profession to address. The Government is committed to piloting a new dental contract based on registration, capitation and quality, which will benefit dentists and patients by focusing on prevention and outcomes rather than the number of interventions. The Government's proposals will be developed and announced later this year

Vocational trainees and trainers

7.26 The increase in dental graduates referred to at paragraph 7.21 will create a need for a corresponding increase in places for vocational trainees. (Newly qualified dentists may not work in the NHS until they have completed one year's vocational training.) The Department works with Postgraduate Dental Deans to identify the areas in which the additional training places should be provided. Although the numbers are challenging, the Department does not anticipate major difficulties because of increased interest from dental practices in applying to take vocational trainees

7.27 The Department has not identified any increases in trainer workload but is discussing the future of VT schemes with the BDA in the context of the proposed two-year schemes. Trainer workload will be included in these discussions.

**General Dental Practitioners: Conclusion**

7.28 The net pay award for dentists in 2011/12 will be zero. The gross award will be determined by the Department after taking account of the data on expenses inflation and after applying efficiency. In making our determination we intend to build on the formula used by DDRB for expenses, and the evidence on non-staff expenses. This determination will be made after any necessary discussions with the BDA.

**Other Dental Staff Groups**

Salaried Primary Dental Care Dentists

7.29 There are around 1,400 salaried dentists (headcount: NHS IC data) working in salaried primary dental care services in England, delivering a range of dental public health programmes and providing dental patient care, including specialised care, for a range of priority and at-risk patient groups. They also provide the staffing of Dental Access Centres. At present, they are predominantly employed by the provider arm of

PCTs and are an important and valued part of the overall dental workforce. The Department's Transforming Community Services programme should support further improvements in the quality of salaried primary dental care. We will be supporting the NHS in better defining the role of salaried dentists to ensure that full account is taken of their service contribution as part of local work to transform the quality and productivity of community health services.

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

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

Dental Public Health Staff

7.32 Consultants in dental public health and trainees are employed on the generic terms and conditions of service for hospital and public health doctors and dentists. The review of capacity and capability in dental public health was published in March under the title *Improving oral health and dental outcomes: Developing the dental public health workforce in England.* The review shows how dental public health staff can improve oral health, reduce oral health inequalities, ensure patient safety and improve quality in dentistry. For this year, as with other staff groups at this salary point, there will be a pay freeze for consultants and trainees.

## CHAPTER 8: OPHTHALMIC MEDICAL PRACTITIONERS

### Summary

8.1 We remain firmly of the view that there should be a common sight test fee for optometrists and OMPs. Optometrists carry out over 99% of NHS sight tests, and we believe the DDRB's previous recommendations about the joint negotiation of a common fee continue to be relevant for this and future years. Discussions for 2011/12 will take place within the context of overall pay policy.

### Background

8.2 Between 31 December 2008 and 31 December 2009, the number of OMPs who were authorised by Primary Care Trusts in England and the number in Local Health Boards in Wales to carry out NHS sight tests increased from 364 to 365, and the number of optometrists increased from 9,910 to 10,369 an increase of 4.6%. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.

8.3 In 2009/10, 12.53 million sight tests were paid for by PCTs in England and LHBs in Wales. This was 4.4% more than in 2008/09. Within these figures, the proportion of sight tests carried out by OMPs was 0.4% in 2009/10.

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

8.5 To further support the NHS in planning and delivering primary eye care services, the Department of Health issued "Primary Care & Community Services – improving eye health services in July 2009".

## CHAPTER 9: NHS PENSIONS AND TOTAL REWARD

### The Current NHS Pension Scheme

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

9.2 Cost sharing arrangements were introduced in April 2008, which means that any further improvement in the value of benefits to employees following the four yearly valuation exercise, would need to be paid for by increasing staff contributions, changes to the benefit structure or a mixture of the two.

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

9.4 As part of the Pension Choice Exercise, eligible members of the 1995 Section receive a personalised pension statement, which compares benefits in the 1995 and 2008 Sections of the NHSPS, as well as an explanatory guide and a DVD to help inform their decision. The Pension Choice Exercise is due to end on 31 March 2012. Each Strategic Health Authority region will see two periods of Choice activity with staff aged 50 and over offered Choice during 2010/2011 and staff aged 49 and younger during 2011/2012.

<u>Self-employed Access to the Current Scheme</u>

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

<u>Emergency Budget in June 2010</u>

9.6 The Government announced in the Emergency Budget that there will be a shift to the Consumer Price Index (CPI) from the Retail Price Index (RPI), for the price indexation of public service pensions alongside benefits and tax credits. This will provide a more appropriate reflection of recipient's actual inflation experiences and ensures consistency with the measure used by the Bank of England. It is considered a

more appropriate measure for reflecting the actual inflation experiences of benefit and pension recipients. While the CPI is generally, but not always, lower than RPI, the NHS Pension Scheme will continue to be protected against price increases and uprated in line with state second pensions. This change will be effective from April 2011.

9.7 This change does not just impact on members of the NHS Pension Scheme, but on all members of occupational pension schemes and recipients of the state retirement pension.

9.8 The Government provides generous tax relief to save for a pension, to encourage individuals to take responsibility for retirement planning and to recognise that pensions are less flexible than other forms of saving. The cost of tax relief net of income tax paid on pensions paid doubled under the last Government to around £19 billion per annum by 2008/09.

9.9 To ensure that pensions tax relief remains fair and affordable, the Government confirmed in the June Budget that it would proceed with the previous Government's goal to reduce the cost of pensions tax relief by about £4 billion per annum. The Government announced at Budget 2010 plans to achieve this through an a approach that limits the amount of tax relief that those who make the highest pension contribution receive

Changes to the annual allowance

9.10 Following on from the Budget 2010 announcement mentioned above, on 14 October 2010, the Government announced that the annual allowance for tax-privileged pension saving will be reduced from £255k per annum to £50k per annum from April 2011. These changes will impact on both public and private sector contributors to occupational pension schemes. The lifetime allowance will also be reduced from £1.8m to £1.5m from April 2012. A consultation on options enabling people to meet tax charges from their pensions will commence in November.

9.11 To protect individuals who exceed the annual allowance due to a one-off "spike" in accrual, the Government will allow individuals to offset this against unused allowance from previous years. These tax changes will largely impact on high earners, for example those earning around £100k per annum and above. Of all the public service pension schemes, the NHS has the most members likely to be affected, in the region of 10,000 who will be for the greater part consultants and GPs.

Review of Public Service Pension Schemes

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

9.13 The Commission published an interim report on 7 October. This highlights the importance of providing good quality pensions to public servants, rejects a race to the bottom in pension provision, but concludes that there is a clear rationale for public servants to make a greater contribution if their pensions are to remain fair to taxpayers and employees, and affordable for the country. At the Spending Review,

the Government accepted these conclusions. In response to the Commission's interim recommendations, the Government will:

- commit to continue with a form of defined benefit pension;
- await Lord Hutton's final recommendation before determining the nature of that benefit and the precise level of progressive contribution required;
- carry out a public consultation on the discount rate used to set contribution rates in the public service pension schemes;
- implement progressive changes to the level of employee contributions that lead to an additional saving of £1.8 billion a year by 2014-15, equivalent to three percentage points on average, to be phased in from April 2012;
- exempt the armed forces from this increase in employee contributions;
- launch a consultation on the Fair Deal policy, which Lord Hutton noted can create a barrier to the plurality of public service provision and make it more difficult to achieve innovation, to report by summer 2011 informed by Lord Hutton's final recommendations on structural reform; and
- seek engagement with all stakeholders including trade unions.

9.14 As the new public service pension arrangements become clear and in light of the current pay freeze and financial challenges facing the public services, communicating the value of the NHSPS as part of the overall reward package will become increasingly important for employers and staff. Exploratory work is underway to ensure how the value of pensions and the total reward package might best be communicated to staff:

i) development and delivery of Annual Benefit Statements (ABS) for all staff which shows the value of personal and family benefits
ii) opportunity to expand ABS to include details of the overall reward package (annual leave, redundancy benefits – the latter for directly employed staff) and development of flexible benefits (ability for example, to sell annual leave).

**Total Reward**

9.15 The general NHS reward package for staff hospital doctors is very competitive at postgraduate training, career grade, and consultant levels. A medical career in the NHS remains highly attractive in terms of financial reward, wider reward packages, and job satisfaction.

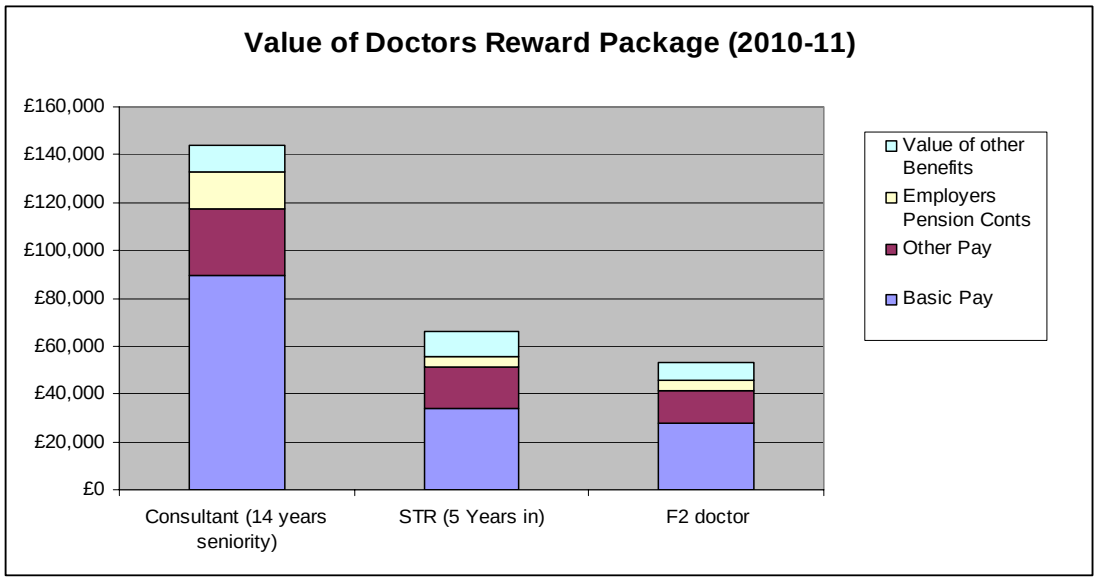
9.16 This benefit package currently includes the following:

- the retention of a good quality defined benefit pension with protection of the normal pension age of 60 for existing staff;
- high annual leave allowances: 35 days rising to 40 compared with 28 days statutory entitlement;
- excellent sick pay entitlement: six months full pay and six months half pay after 5 years;
- 30 days study leave available to doctors in training;

- 39 weeks of paid maternity leave (eight weeks at full pay, 18 weeks at half pay and 13 weeks at statutory levels);
- opportunities for flexible working; and
- extremely high levels of security of employment for doctors in the NHS - there have been very few redundancies. Doctors, along with other NHS staff, also have the protection of redundancy arrangements that compare with the best private sector arrangements.

9.17 The chart below monetarises the value of the total employment package. As well as base pay, it includes a representative value of other pay allowances and employer pension contributions at the actual rate paid. It includes the value of the additional holiday allowances over statutory provision and the value of sick pay provision above the statutory requirements based on average sickness absence levels. This understates the overall value of the package as it does not attempt to monetarise other important elements such as flexible working, childcare and maternity leave that do not apply to all doctors. It also understates the true value of pension contributions for most doctors as they tend to have higher than average benefits relative to the contributions that are paid on their behalf over the course of a career.

9.18 The chart shows that for doctors in training the value of employers' current pension contributions, in addition to annual, study and sick leave provisions above statutory requirements add over 20% to the value of the reward package. They are worth around £11,000 to a doctor in the second year of training, and around £14,000 to a doctor five years into training.




Notes:
Consultant: (14 years seniority 3 years after transfer) 42 days leave a year, assume 11 sessions worked, assume 5% on call allowance, assume 5 CEAs
STR: five years into training (2nd point, band 1A supplement), 40 days leave, 30 days paid study leave
FH02: (2nd year no banding) 35 days leave, 30 days paid study leave
Assume doctors take NHS average of 11.7 sick days per year and compare with SSP
Compare leave entitlement with statutory 28 days.

9.19 For consultants, the value of these benefits over statutory provision along with employer pensions contributions is over £26,000 and represent nearly 20% of the value of the reward package.

9.20 This work shows base pay as a proportion of total reward to be just over 60% for a consultant with 14 years seniority, and just over 50% for a doctor in training.

**ANNEX A**

## NHS STAFF SURVEY 2009

The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2009 NHS staff survey is the 7th annual survey of its kind. Almost 290,000 NHS staff were invited to take part in the survey and approximately 160,000 employees responded – a 55% response rate (same as in 2008).

| **Table A** | **Staff Job Satisfaction** (scale of 1 to 5) | | | **diff 2008/2009** |
|---|---|---|---|---|
| | **2007** | **2008** | **2009** | |
| All NHS staff (inc. medics) | 3.44 | 3.51 | 3.53 | 0.03 |
| | | | | |
| Medical / dental staff in all trusts | 3.49 | 3.55 | 3.57 | 0.03 |
| Medical / dental (in training) in all trusts | 3.53 | 3.52 | 3.56 | 0.04 |
| Medical / dental (consultants) in all trusts | 3.51 | 3.59 | 3.60 | 0.01 |
| Medical / dental (other) in all trusts | 3.47 | 3.51 | 3.54 | 0.04 |

| **Table B** | **Staff Intention to Leave** (scale of 1 to 5) | | | **diff 2008/2009** |
|---|---|---|---|---|
| | **2007** | **2008** | **2009** | |
| All NHS staff (inc. medics) | 2.73 | 2.59 | 2.54 | -0.05 |
| | | | | |
| Medical / dental staff in all trusts | 2.46 | 2.38 | 2.34 | -0.03 |
| Medical / dental (in training) in all trusts | 2.65 | 2.66 | 2.49 | -0.18 |
| Medical / dental (consultants) in all trusts | 2.35 | 2.26 | 2.28 | 0.02 |
| Medical / dental (other) in all trusts | 2.55 | 2.46 | 2.42 | -0.04 |

| **Table C** | **Staff engagement with their jobs** (scale of 1 to 5) | | | **diff 2008/2009** |
|---|---|---|---|---|
| | **2007** | **2008** | **2009** | |
| All NHS staff (inc. medics) | n/a | n/a | 3.86 | n/a |
| | | | | |
| medical / dental staff in all trusts | n/a | n/a | 3.97 | n/a |
| medical / dental (in training) in all trusts | n/a | n/a | 3.92 | n/a |
| medical / dental (consultants) in all trusts | n/a | n/a | 3.99 | n/a |
| medical / dental (other) in all trusts | n/a | n/a | 3.97 | n/a |

| **Table D** | **Staff Satisfaction with Pay** Percent of staff who are <u>not</u> dissatisfied with their pay (ie staff who said they were either satisfied, very satisfied or neither satisfied nor dissatisfied) | | | **change (since 2008)** |
|---|---|---|---|---|
| | **2007** | **2008** | **2009** | |
| All NHS Staff (inc. medics) | 54 | 60 | 64 | 4 |
| | | | | |
| medical / dental staff in all trusts | 72 | 75 | 78 | 3 |
| medical / dental (in training) in all trusts | 68 | 70 | 73 | 3 |
| medical / dental (consultants) in all trusts | 83 | 84 | 86 | 2 |
| medical / dental (other) in all trusts | 57 | 61 | 66 | 5 |

Source: NHS Staff Surveys 2007, 2008 and 2009

| Table E | Percent of staff working no additional paid hours | | | change (since 2008) |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | |
| All NHS staff (inc. medics) | 71 | 70 | 73 | 2.4 |
| | | | | |
| medical / dental staff in all trusts | 65 | 64 | 64 | -0.8 |
| medical / dental (in training) in all trusts | 64 | 63 | 71 | 8.0 |
| medical / dental (consultants) in all trusts | 59 | 58 | 57 | -0.9 |
| medical / dental (other) in all trusts | 74 | 72 | 70 | -1.5 |

| Table F | Percent of staff working no additional unpaid hours | | | change (since 2008) |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | |
| All NHS staff (inc. medics) | 46 | 47 | 47 | 0.4 |
| | | | | |
| medical / dental staff in all trusts | 36 | 34 | 33 | -0.8 |
| medical / dental (in training) in all trusts | 32 | 32 | 31 | -1.8 |
| medical / dental (consultants) in all trusts | 25 | 25 | 22 | -2.7 |
| medical / dental (other) in all trusts | 50 | 46 | 48 | 2.3 |

| Table G | Percent of staff who do not disagree that their trust is committed to helping staff balance their work and home life | | | change (since 2008) |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | |
| All NHS Staff (inc. medics) | 78 | 80 | 81 | 0.9 |
| | | | | |
| medical / dental staff in all trusts | 75 | 79 | 78 | -0.8 |
| medical / dental (in training) in all trusts | 71 | 76 | 74 | -1.3 |
| medical / dental (consultants) in all trusts | 73 | 78 | 76 | -2.2 |
| medical / dental (other) in all trusts | 80 | 83 | 83 | -0.3 |

| Table H | Percent of staff who do not disagree that their immediate manager helps them find a good work-life balance. | | | change (since 2008) |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | |
| All NHS Staff (inc. medics) | 82 | 83 | 84 | 1.0 |
| | | | | |
| medical / dental staff in all trusts | 75 | 78 | 78 | -0.6 |
| medical / dental (in training) in all trusts | 78 | 79 | 79 | 0.2 |
| medical / dental (consultants) in all trusts | 72 | 75 | 74 | -1.0 |
| medical / dental (other) in all trusts | 80 | 83 | 82 | -0.3 |

| Table I | Percent of staff who do not disagree that they do not have time to carry out all their work. | | | change (since 2008) |
|---|---|---|---|---|
| | 2007 | 2008 | 2009 | |
| All NHS Staff (inc. medics) | 74 | 73 | 72 | -0.4 |
| | | | | |
| medical / dental staff in all trusts | 69 | 70 | 70 | 0.2 |
| medical / dental (in training) in all trusts | 58 | 60 | 65 | 4.4 |
| medical / dental (consultants) in all trusts | 77 | 78 | 76 | -1.7 |
| medical / dental (other) in all trusts | 61 | 62 | 61 | -1.3 |

**ANNEX B**

**Costs of the new Specialty and Associate Specialist (SAS) Doctor Contracts – report to the Review Body on Doctors' and Dentists' Remuneration**

Summary

1. In April 2008, new contracts were introduced for specialty doctors (formerly staff grades) and associate specialist doctors. Modelling by NHS Employers and the British Medical Association, as part of negotiations, suggested that the additional costs of these new contracts would be 10% over the existing pay bill (ie total earnings) over time.

2. As a condition of HM Treasury approval of the new contracts and associated funding, all parties agreed that the additional costs would be monitored and reported to the Review Body on Doctors' and Dentists' Remuneration (DDRB).

3. **Analysis suggests that the additional costs of the new contracts (over existing pay bill), for doctors who had transferred by August 2009,4 were 9.8% of basic earnings (9.36% of total earnings).** This is in line with the predicted (and funded) costs. This paper describes how we have calculated this.

The dataset

4. Our dataset includes 4,816 doctors recorded on the Electronic Staff Record (ESR) as on the new contracts at any point between April 2008 and August 2009. This captures (using the unique identifier in ESR):

   - doctors who transferred from eligible job roles to the new contract;
   - doctors who are new joiners to the grades; and also
   - doctors (from either of these two groups) who moved out of the grades during that period .

   Doctors who transferred from the staff grade to the new specialty doctor grade and then regraded to associate specialist are recorded in this dataset only once.

   This figure of 4,816 doctors is different from any single month snapshot within this time period as it captures those moving onto and off the new contracts over the 17-month period.

Costs for the dataset

5. We have estimated the earnings of doctors who transferred or were appointed to the new SAS contracts between April 2008 and August 2009, assuming that all those who transferred qualified for back pay to April 2008. A full explanation of the methodology can be found in Appendix A.

6. Using this methodology, costs are:
   - basic earnings = £299m
   - total earnings = £365m

   with on-costs (employer contribution to pensions and national insurance) included:
   - basic earnings = £364m
   - total earnings = £444m

4 October 2009 was the earliest date that a sufficiently large dataset, 4816 doctors on the contracts as at August 2009, was available from ESR. We then examined the dataset, scrutinising the assimilation of individuals in order to inform and refine the assumptions, then calculated the costs in accordance with the agreed methodology . There were 6160 doctors recorded on ESR as on the new contracts as at June 2010.

7. These figures are significantly below the actual 2008/9 pay bill of £1,099m (including on-costs) for medical staff other than consultants and training grades (the "Other" line in DH pay metrics). Reasons for this include:

- The dataset includes all new joiners but only 50% of those eligible to transfer from the old contracts – ie transfer (for those electing to do so) is not yet complete; doctors choosing to transfer will only be placed on the new contracts once job planning has been completed
- Doctors for whom the old contract is more favourable have less incentive to move onto the new arrangements, and those with higher salaries are less likely to have moved across
- It is possible that some of those who have transferred may have left these grades subsequently
- The pay bill data uses a grouping that includes staff who are eligible for the new SAS contract and staff who are not5
- Possible higher proportion of staff grades than associate specialists moving to the new arrangements. 6

Calculating the additional costs – the counterfactual

8. The additional costs are calculated by comparing these estimated total earnings against a counterfactual estimate of what this group of doctors would have earned over the same period had they remained on (or been appointed on, for new joiners) the old contracts.

9. Counterfactual costs were calculated as follows:

i. Identifying the contract and incremental point that the doctor was on prior to moving to the new contract.
ii. Calculating the basic earnings for each doctor on his/her pre-assimilation contract and pay point from April 2008 until August 2009. This was done in two parts: (i) using actual earnings for the period prior to transfer onto the new contract and (ii) estimating expected earnings, given grade and incremental point, after transfer to the new SAS grade. Incremental pay rises were included in the hypothetical costs. The dates for incremental progression were kept on assimilation to the new contract.
iii. Estimating any additional earnings the doctors would have received, assuming no change in working pattern (except the increase in basic hours for Associate Specialists which is part of the contract). This was obtained by applying the same percentage earnings increase that was found under the new contract to the old contract for each doctor
iv. Applying the uplifts of 2.2% (for 2008/09) and 1.5% (for 2009/10) as approved by Government in response to DDRB recommendations. This ensures that we isolate, in comparing the actual costs and the counterfactual costs, only those costs that are a direct result of the new contract. It is possible that, in the absence of a new contract, the annual pay uplifts could have been different.

A full explanation of the methodology is at Appendix A.

---

5 The "Other" grouping in the pay metrics includes staff who are eligible for the new SAS contracts (staff grades, 'old' associate specialists, clinical medical officers and senior clinical medical officers); staff who are not eligible (salaried dentists and other HCHS dentists not covered by SAS arrangements); and staff who may be eligible (clinical assistants and hospital practitioners who are not GPs).

6 From the 2007 census we estimate that staff grades account for approximately 67% of those that are eligible for the new contracts; our dataset shows that 71% of staff who have transferred are on the Specialty Doctor contract.

10. Using this methodology, the estimated counterfactual costs are:

- basic earnings = £272m
- total earnings = £333m

with on-costs included:

- basic earnings = £332m
- total earnings = £406m

**This counterfactual suggests that the additional costs of the new contracts are:**

**9.8% of basic earnings**
**9.36% of total earnings**

Other factors to consider

11. The additional hours worked by Associate Specialists on the new contract may lead to savings elsewhere in the pay bill. Associate Specialists on the new contract are working a longer week (40 hours, up from 38.5). These extra hours may provide savings for the trust (eg allowing them to employ fewer doctors in other grades but still staff their service adequately). Improved job planning may also lead to a more efficient and effective service. It is not possible, however, to establish or quantify this; trusts will be looking at their workforce contribution in the round, and it is not possible to attribute changes directly to any aspect of new contractual arrangements.

12. It is worth noting that it is not possible, from analysis of those yet to transfer from the old contracts (or who might opt to remain on them), to determine whether those in the dataset are fully representative of the total who may transfer. They do however represent a substantial proportion of the likely final total.

*Pay & Employee Relations*

**Appendix A- Methodology and assumptions used**

The methodology and assumptions have been examined by DH's Revenue and Investment Branch. The degree of variability for each of the assumptions has been assessed and is considered to be very low.

Estimating current pay bill costs

This was done by:

1. Obtaining information on basic and total earnings for every doctor who had been on the new contract for at least one month. This was done using a month-by-month query from ESR spanning from March 2008 to August 2009.

2. Calculating the sum of all basic and total earnings of each doctor whilst they were on the new contract (either MC41 or MC46 grade codes).

3. Adding the earnings of the doctor from April 2008 until they moved onto the new grade code to their earnings after transfer. This is because the doctor effectively started on 1 April 2008 and back pay will only include the difference between the two figures.

4. Approximating the earnings of those doctors whose actual earnings before transfer were not clear (due to lack of data), using the current grade code, incremental point and the working pattern of the doctor. New Associate Specialists were assumed to have been on the old Associate Specialist contract and new Specialty Doctors were assumed to have been on the Staff Grade contract. The date of incremental date was assumed to be the same as on the new contract.

Assumptions used in estimating current pay bill costs:

- The recording of grade codes in ESR is correct. If trusts miscoded staff as being on the MC41 or MC46 grade code the costs of the contract may be overestimated. This would also raise the hypothetical costs.
- All doctors on the new SAS contracts have been picked up by the ESR pay bill query. If there are other staff not included in the dataset, the costs of both the actual and the hypothetical scenarios will be an underestimate
- Other than those identified as new starters, those without a grade code and incremental points on transition were NHS employees in an eligible grade from April 2008.
- All doctors *transferred* onto the contract qualified for back pay.
- All doctors in the dataset had been paid their back pay by August 2009.
- Doctors were assimilated to the correct point on the new contract.
- All doctors without a grade code had been on the old Associate Specialist contract if they appeared on the new Associate Specialist contract, and a Staff Grade doctor if they appeared on the Specialty Doctor contract on incremental point two or above.
- The incremental point was identified by calculating where the doctor must have been on the pre-assimilation pay grade with reference to the transitional guidance from NHS Employers
- Those without a grade code before appearing on the new Specialty Doctor contract at incremental point one are new starters and therefore do not qualify for back pay.

Estimating the counterfactual costs

This was done by:

1. Identifying the grade code and incremental point for each doctor in the dataset in the month before they moved over to the new contracts.

2. Calculating basic and total earnings for each doctor for the period between April 2008 and assimilation onto the new contract.

3. Calculating the earnings for each doctor after assimilation onto the new contract on the assumption that in the absence of the contract the doctor would have remained on the grade code and incremental point that he/she was on before moving to the new contract.

Then the following calculation was done:

Basic Salary:

[(Proportion of year on new contract before April 2009) x (annual basic salary for the doctor's pre-assimilation grade code and incremental point for 2008/9 pay scales) x (average WTE of doctor in that time)] + [(Proportion of year on new contract between April 2009 and August 2009) x (annual basic salary for the doctor's grade pre-assimilation code and incremental point for 2009/10 pay scales) x (average WTE of doctor in that time)]

This takes account of incremental pay rises by calculating the proportion of the year that each doctor has spent on each incremental point and adjusting the basic salary accordingly. If the incremental date could not be calculated it was assumed the time spent on which incremental point was proportional to the amount of time on the new contract. E.g. if a doctor had been on the new contract for a year it has been assumed that for 6 months of that year the doctor would have earned the basic salary at the lower incremental point and then moved up to the higher point.

Total Earnings:

(Basic salary calculation from above) x (same % of additional earnings over basic salary that the doctor was receiving on the new contract).

Assumptions used in calculating the counterfactual costs:

- Those without a pre-assimilation grade code on transfer to the new Specialty Doctor contract were assumed to have been a Staff Grade doctor. Those without a pre-assimilation grade code on transfer to the new Associate Specialist contract were assumed to have been an Associate Specialist on the old contract. New starters to either grade would have started in the same month, on the equivalent old contract.
- Where incremental dates were unavailable, it was assumed that the doctor spent a period on each pay point proportional to the time they had been on the new contract. E.g. if they were on the contract for the whole year it has been assumed that they spent 6 months on the lower pay point and 6 on the higher pay point.
- Those who progressed/regraded to the new Associate Specialist grade using the window of opportunity would have progressed/regraded to the old Associate Specialist grade at the same time in the absence of the new contract
- The working patterns (with regards to FTEs) of the doctors did not change once they moved onto the new contract.

- The % of total earnings above basic salary would be the same on the old contract as they have been on the new contract. This is likely to lead to an overestimation of the hypothetical costs (which include additional earnings) due to the greater scope to earn additional income on the new arrangements.
- Doctors who were not entitled to an automatic incremental pay rise (as they were on the discretionary or optional part of the pay scales or the top point of the non-discretionary or non-optional scales) were assumed to have had a 1 in 3 probability of receiving a discretionary or optional point in the year. This was modelled assuming an average basic salary constituting two-thirds based on the incremental point in April 2008 and one third based on an incremental rise.
- In the absence of new contracts, pay settlements in 2008/09 and 2009/10 would have been the same as the actual settlements of 2.2% and 1.5%.

**ANNEX C**

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

1. The table below, supplied by the NHS Pensions Division, part of the Business Services Agency[7], shows the number of consultants who received a pension award, from the NHS Pension Scheme between 1997 to 2010 by category of retirement. The figures include all retirements on grounds of age, ill health, premature retirements following redundancy or interests of efficiency and voluntary early retirement before age 60 (introduced from 6 March 1995). Where possible data is shown separately for each category. As with previous years' evidence, the figures relate to England and Wales as it has not been possible to dis-aggregate Welsh data for this exercise.

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

**Consultant Retirements and Reasons for Retirement**

| Year end 31 March | Age | Ill-health | Deferred Pension Benefits | Redundancy | Agreed Voluntary Early Retirement (AVER) | Voluntary Early Retirement (VER) | Unknown | Total Pension Awards |
|---|---|---|---|---|---|---|---|---|
| 1997 | 258 | 57 | 46 | 27 | * | * | 33 | **421** |
| 1998 | 295 | 52 | 48 | 19 | * | * | 35 | **449** |
| 1999 | 274 | 57 | 30 | 19 | * | * | 37 | **417** |
| 2000 | 294 | 54 | 36 | 11 | * | * | 28 | **423** |
| 2001 | 337 | 66 | 52 | 11 | * | * | 30 | **496** |
| 2002 | 355 | 65 | 41 | 7 | * | * | 28 | **496** |
| 2003 | 320 | 60 | 33 | 7 | * | * | 36 | **456** |
| 2004 | 362 | 56 | 44 | 16 | * | * | 44 | **522** |
| 2005 | 360 | 49 | 42 | 9 | * | * | 42 | **502** |
| 2006 | 487 | 52 | 52 | 7 | 4 | 44 | 51 | **697** |
| 2007 | 601 | 59 | 37 | 6 | 3 | 77 | 41 | **824** |
| 2008 | 649 | 60 | 24 | 9 | 6 | 90 | 37 | **875** |
| 2009 | 657 | 41 | 13 | 6 | 1 | 80 | 43 | **841** |
| 2010 | 792 | 7 | 4 | 1 | 1 | 97 | 67 | **969** |

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

3. It should be noted that the current extract may not be consistent with previous DDRB extracts due to a number of factors e.g. on-going program to cleanse member records. The NHS Pensions data recording system manages over 1.3 million active records most of which are subject to regular updates year on year. Retirement data will therefore represent a "snapshot" at a given period, which will be subject to change over time.

4. In addition to the above consideration, the BSA introduced a pension processing system in October 2005. The retirement data provided since September 2006, to assist

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

in supporting evidence/guidance for DDRB, represented the extract from this new pension processing system. This new system is designed to assist in the daily processing of pension calculations and will in the future support scheme valuation, however development to utilise the system for valuation has yet to be fully defined and validated. The latest information has been amended to reflect the latest extract over retrospective years, but comparisons across the yearly reports is not possible.

## LIST OF STATISTICAL TABLES

## TABLE 1

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

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

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

Notes:

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

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

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

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

(5) Cells highlighted have been amended since the last report - 2006/07 highlighted cells were originally based on provisional figures, tariff bands above 480 had been incorrectly grouped previously.

## TABLE 2

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

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

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

Notes:

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

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

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

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

(5) Cells highlighted have been amended since the last report - 2006/07 highlighted cells were originally based on provisional figures.

# TABLE 3

UK Medical Schools

**UK APPLICANTS AND ACCEPTED APPLICANTS FOR MEDICINE BY GENDER**

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

Source: UCAS Department of Research and Statistics

Notes

Applicants naming medicine at least once on an application form.

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

# TABLE 4

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

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

Source: UCAS Department of Research and Statistics.

Notes

1. These figures include those students from the UK who have applied to undergraduate

2. Applicants naming dentistry at least once on an application form.

3. The number of applications submitted per applicant changed over the years. From 1989 to 1993, the maximum was 5 applications. In 1994 it rose to 8 applications and was reduced to 6 applications in 1996, although the recommended number for dentistry remained at 5.

**TABLE 5: Hospital and Community Health Services medical and dental staff. United Kingdom at 30 September**

| | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | | 2006 | | 2007 | | 2008 | | 2009 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE | Headcount | FTE |
| United Kingdom [1] | | | | | | | | | | | | | | | | | | |
| Total | 90,991 | 79,032 | 95,181 | 84,235 | 99,347 | 88,707 | 106,467 | 95,841 | 110,515 | 100,447 | 114,125 | 104,897 | 116,254 | 107,517 | 121,071 | 112,105 | 125,461 | 117,107 |
| Consultant | 31,560 | 28,404 | 33,059 | 30,302 | 34,910 | 32,045 | 37,106 | 34,111 | 38,715 | 35,856 | 39,880 | 37,223 | 41,020 | 38,362 | 42,893 | 40,166 | 45,045 | 42,222 |
| Registrar Group [2] | 15,654 | 14,947 | 16,559 | 15,718 | 17,429 | 16,693 | 19,930 | 19,093 | 21,193 | 20,391 | 22,053 | 21,313 | 37,244 | 36,654 | 41,950 | 41,043 | 44,055 | 43,468 |
| Senior House Officer | 19,899 | 19,664 | 21,426 | 21,168 | 23,312 | 22,994 | 25,412 | 25,060 | 26,575 | 26,226 | 23,713 | 23,440 | 7,096 | 6,978 | 3,040 | 2,958 | 2,341 | 2,316 |
| Foundation Year 2 [3] | . | . | . | . | . | . | . | . | . | . | 4,284 | 4,280 | 6,248 | 6,233 | 6,950 | 6,925 | 7,360 | 7,376 |
| House Officer [4] | 4,832 | 4,822 | 5,238 | 5,217 | 5,259 | 5,249 | 5,545 | 5,530 | 5,921 | 5,901 | 6,204 | 6,188 | 6,575 | 6,533 | 7,510 | 7,481 | 7,911 | 8,012 |
| Associate Specialist/ Staff Grade | 8,057 | 6,786 | 8,514 | 7,658 | 8,746 | 7,907 | 9,409 | 8,396 | 9,831 | 8,715 | 10,698 | 9,460 | 11,177 | 9,862 | 11,835 | 10,373 | 12,307 | 10,631 |
| All Other Staff [5, 6, 7,8] | 11,063 | 4,408 | 10,457 | 4,172 | 9,764 | 3,819 | 9,128 | 3,652 | 8,333 | 3,357 | 7,338 | 3,000 | 6,943 | 2,895 | 6,998 | 3,160 | 6,558 | 3,082 |
| England | | | | | | | | | | | | | | | | | | |
| Total | 73,846 | 64,055 | 77,031 | 68,260 | 80,851 | 72,260 | 86,996 | 78,462 | 90,630 | 82,568 | 93,320 | 85,975 | 94,638 | 87,533 | 98,703 | 91,586 | 102,961 | 96,598 |
| Consultant [9] | 25,782 | 23,064 | 27,070 | 24,756 | 28,750 | 26,341 | 30,650 | 28,141 | 31,993 | 29,613 | 32,874 | 30,619 | 33,674 | 31,430 | 34,910 | 32,679 | 36,950 | 34,654 |
| Registrar Group [2] | 13,220 | 12,629 | 13,770 | 13,031 | 14,619 | 13,989 | 16,823 | 16,112 | 18,006 | 17,313 | 18,808 | 18,180 | 30,759 | 30,175 | 35,042 | 34,272 | 37,108 | 36,700 |
| Senior House Officer | 15,830 | 15,642 | 17,135 | 16,912 | 18,698 | 18,419 | 20,601 | 20,283 | 21,642 | 21,337 | 18,863 | 18,662 | 5,954 | 5,849 | 2,577 | 2,504 | 2,015 | 1,994 |
| Foundation Year 2 [3] | . | . | . | . | . | . | . | . | . | . | 3,693 | 3,690 | 4,830 | 4,823 | 5,509 | 5,497 | 6,015 | 6,055 |
| House Officer [4] | 3,742 | 3,733 | 4,010 | 3,989 | 4,003 | 3,994 | 4,273 | 4,259 | 4,663 | 4,645 | 4,905 | 4,890 | 5,240 | 5,203 | 6,050 | 6,025 | 6,364 | 6,467 |
| Associate Specialist/ Staff Grade [10] | 6,595 | 5,513 | 7,035 | 6,377 | 7,256 | 6,608 | 7,761 | 6,977 | 8,081 | 7,226 | 8,767 | 7,820 | 9,103 | 8,089 | 9,586 | 8,456 | 10,058 | 8,741 |
| All Other Staff [5] | 8,677 | 3,474 | 8,011 | 3,194 | 7,525 | 2,909 | 6,888 | 2,689 | 6,245 | 2,435 | 5,410 | 2,114 | 5,078 | 1,964 | 5,029 | 2,153 | 4,451 | 1,987 |
| Northern Ireland [11] | | | | | | | | | | | | | | | | | | |
| Total | 2,878 | 2,604 | 3,037 | 2,740 | 3,227 | 2,946 | 3,376 | 3,096 | 3,510 | 3,232 | 3,708 | 3,429 | 3,843 | 3,544 | 3,885 | 3,592 | 3,900 | 3,624 |
| Consultant [12] | 944 | 889 | 1,000 | 930 | 1,051 | 988 | 1,086 | 1,021 | 1,136 | 1,078 | 1,225 | 1,164 | 1,281 | 1,211 | 1,319 | 1,243 | 1,362 | 1,289 |
| Registrar Group [2] | 482 | 467 | 524 | 513 | 559 | 548 | 601 | 591 | 626 | 616 | 676 | 665 | 1,269 | 1,255 | 1,315 | 1,301 | 1,324 | 1,305 |
| Senior House Officer | 735 | 725 | 743 | 737 | 827 | 823 | 881 | 878 | 903 | 898 | 913 | 908 | 195 | 192 | 55 | 52 | 35 | 34 |
| Foundation Year 2 [3] | . | . | . | . | . | . | . | . | . | . | - | - | 137 | 137 | 242 | 242 | 243 | 243 |
| House Officer [4] | 189 | 189 | 215 | 215 | 224 | 224 | 223 | 223 | 234 | 234 | 220 | 220 | 233 | 233 | 235 | 235 | 241 | 241 |
| Associate Specialist/ Staff Grade [13] | 192 | 167 | 204 | 175 | 227 | 194 | 257 | 222 | 324 | 265 | 360 | 305 | 404 | 337 | 406 | 345 | 395 | 337 |
| All Other Staff [6] | 336 | 167 | 351 | 171 | 339 | 169 | 328 | 161 | 287 | 142 | 314 | 166 | 324 | 178 | 313 | 174 | 300 | 176 |
| Scotland [14, 15] | | | | | | | | | | | | | | | | | | |
| Total | 9,646 | 8,465 | 10,256 | 9,072 | 10,409 | 9,293 | 10,660 | 9,568 | 10,876 | 9,787 | 11,201 | 10,161 | 11,823 | 10,920 | 12,534 | 11,356 | 12,608 | 11,322 |
| Consultant [9] | 3,306 | 3,091 | 3,411 | 3,195 | 3,513 | 3,285 | 3,593 | 3,358 | 3,724 | 3,494 | 3,847 | 3,625 | 4,035 | 3,802 | 4,581 | 4,249 | 4,610 | 4,250 |
| Registrar Group [2] | 1,321 | 1,240 | 1,532 | 1,441 | 1,544 | 1,461 | 1,666 | 1,587 | 1,695 | 1,623 | 1,646 | 1,582 | 3,840 | 3,875 | 3,807 | 3,720 | 3,800 | 3,681 |
| Senior House Officer | 2,335 | 2,304 | 2,528 | 2,499 | 2,685 | 2,650 | 2,729 | 2,704 | 2,761 | 2,732 | 2,508 | 2,479 | 97 | 92 | .. | .. | .. | .. |
| Foundation Year 2 [3] | . | . | . | . | . | . | . | . | . | . | 485 | 483 | 1,033 | 1,025 | 926 | 914 | 852 | 828 |
| House Officer [4] | 716 | 716 | 803 | 803 | 798 | 797 | 802 | 802 | 767 | 766 | 793 | 793 | 781 | 777 | 903 | 899 | 964 | 963 |
| Associate Specialist/ Staff Grade | 684 | 573 | 690 | 578 | 691 | 579 | 718 | 589 | 760 | 627 | 779 | 638 | 892 | 732 | 1,076 | 879 | 1,007 | 814 |
| All Other Staff [7] | 1,358 | 543 | 1,364 | 556 | 1,251 | 521 | 1,215 | 529 | 1,222 | 546 | 1,188 | 562 | 1,194 | 617 | 1,346 | 696 | 1,491 | 786 |
| Wales | | | | | | | | | | | | | | | | | | |
| Total | 4,621 | 3,908 | 4,857 | 4,163 | 4,860 | 4,208 | 5,435 | 4,715 | 5,499 | 4,859 | 5,896 | 5,339 | 5,950 | 5,520 | 5,949 | 5,571 | 5,992 | 5,562 |
| Consultant [9] | 1,528 | 1,361 | 1,578 | 1,421 | 1,596 | 1,432 | 1,777 | 1,591 | 1,862 | 1,673 | 1,934 | 1,816 | 2,030 | 1,919 | 2,083 | 1,996 | 2,123 | 2,029 |
| Registrar Group [2, 16] | 631 | 611 | 733 | 733 | 707 | 696 | 840 | 803 | 866 | 839 | 923 | 886 | 1,376 | 1,349 | 1,786 | 1,750 | 1,823 | 1,783 |
| Senior House Officer | 999 | 993 | 1,020 | 1,020 | 1,102 | 1,102 | 1,201 | 1,194 | 1,269 | 1,260 | 1,429 | 1,392 | 850 | 846 | 408 | 402 | 291 | 287 |
| Foundation Year 2 [3] | . | . | . | . | . | . | . | . | . | . | 106 | 106 | 248 | 247 | 273 | 272 | 250 | 250 |
| House Officer [4] | 185 | 185 | 210 | 210 | 234 | 234 | 247 | 246 | 257 | 257 | 286 | 285 | 321 | 320 | 322 | 321 | 342 | 341 |
| Associate Specialist/ Staff Grade [10] | 586 | 533 | 585 | 528 | 572 | 526 | 673 | 608 | 666 | 596 | 792 | 697 | 778 | 704 | 767 | 694 | 847 | 739 |
| All Other Staff [8, 16] | 692 | 225 | 731 | 250 | 649 | 220 | 697 | 273 | 579 | 235 | 426 | 158 | 347 | 136 | 310 | 136 | 316 | 133 |

Source:
England: The Information Centre, Medical and Dental Workforce Census. 
Northern Ireland: Human Resource Management System
Scotland: NHS National Services Scotland, Information Services Division
Wales: Welsh Assembly Government, Medical and Dental Workforce Census

Notes:

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

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

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

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

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

[6] In Northern Ireland the Other category includes hospital/ general medical practitioners, medical/dental officers or practitioners, clinical assistants and medical research

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

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

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

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

[11] Northern Ireland data excludes full-time equivalents of less than or equal to 0.03

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

[13] In Northern Ireland, the reason for the increase in the associate specialist/staff grade group is that in the last few years, many medical officers have been re-graded as staff

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

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

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

' . ' denotes not applicable

' - ' denotes zero

'..' denotes not available

## TABLE 6: Three Month Vacancy Rate for All HCHS Doctors (excluding doctors in training and equivalents) and Consultants by specialty group by SHA

**Three month vacancy rates: March 2010**

vacancy rates (%)

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

The NHS Information Centre for health and social care Vacancies Survey March 2010



**Notes:**

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

# TABLE 7

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

England

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

The NHS Information Centre for health and social care Vacancies Survey March 2010


**Notes:**

1. The vacancy census excludes staff within training grades and their equivalents
2. Vacancy rates based on vacancy numbers and consultant staff in post figures as at 31 March each year and
3. Three month vacancies are vacancies as at 31 March each year which Trusts are actively trying to fill which
4. Three month vacancy rates are three month vacancies expressed as a percentage of three month vacancies
5. Percentages are calculated on unrounded figures and rounded to one decimal place.