



Department
of Health

Review Body on Doctors' and Dentists' Remuneration (DDRB) review for 2015: written evidence from the Department of Health

2015-16

Title: Evidence to DDRB on General Medical and Dental Practitioners
Author: Strategy and External Relations / Workforce /Pay, Pensions & Employment Services Branch / 13710
Document Purpose: Policy
Publication date: September 2014, re-published November 2014
Target audience: Review Body on Doctors' and Dentists' Remuneration (DDRB)
Contact details: Pay, Pensions and Employment Services Branch Workforce Division Strategy and External Relations Directorate Department of Health R2W12 Quarry House Quarry Hill Leeds LS2 7UE

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence/

© Crown copyright

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Review Body on Doctors' and Dentists' Remuneration (DDRB) review for 2015: written evidence from the Department of Health

2015-16

Prepared by

NHS Pay, Pensions and Employment Services
Workforce Division
External Relations Directorate
Department of Health

Contents

Executive summary	5
Chapter 1: NHS Context	7
Chapter 2: Economic Context	9
Chapter 3: NHS Finances	20
Chapter 4: GMP and GDP Workforce Issues	24
Chapter 5: General Medical Services Contractors	27
Chapter 6: General Dental Services Contractors	31
Chapter 7: Ophthalmic Medical Practitioners	32
Chapter 8: NHS Pensions and Total Reward	33
Chapter 9: Supplementary evidence	38
Annex 1: Chief Secretary to the Treasury Letter to DDRB	43
Annex 2: DDRB Remit Letter	46
Annex 3: Summary of Benefits, and Comparison of the Earlier Schemes with 2015 NHS Pension Scheme	48

Executive summary

Financial Context

The financial challenge facing the NHS is the biggest in its history. Despite real terms growth in its budget in successive years, it needs to continue to secure improved value from the taxpayer's investment if it is to meet the growing pressures it faces in the years to come both from an aging and growing population, and the need to improve the quality of care provided.

Pay restraint has been a key part of delivering improved value for money and the case for continued pay restraint across the public sector remains strong. Whilst public finances are returning to a more sustainable position as the UK economy begins to grow again, we continue to face a considerable fiscal challenge. Pay restraint in the public sector remains a necessary part of the Government's consolidation plans, helping to ensure that public sector jobs are protected and that the quality of public sector services is supported. Levels of pay need to be balanced with, and seen in the context of, the size of the primary and community care workforce as a whole and the Government's plans to increase capacity in these sectors (see Chapter 4).

A transformation in transparency

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

Under the pressure of a population with increasing co-morbidities, primary care provides an essential single point of contact for increasingly preventative services. However, employers cannot pay staff more without knowing what they are paying for. There is currently limited information on outcomes and the quality of primary care services. Increasingly, more information is becoming available, as outlined in Chapter 5, though more work is needed. CQC have begun a programme of inspections of the quality of GP practices and the services they promote

Our ask of the DDRB

The DDRB is invited to:

- **make recommendations on appropriate uplifts for General Medical Services (GMS) contracts and general dental service contracts**, in the context of public sector pay policy for 2015/16;
- **make recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay**, in line with other sectors of the NHS workforce. The Government and NHS England will make final decisions on the overall gross uplift for GMS and dental contracts in the light of DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

As set out in the remit letter, following the Government's announcement of a two year pay settlement for employed doctors and dentists in England, the DDRB is not required to report or to make recommendations or observations for the 2015/16 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

Our evidence to the DDRB

As last year, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy with separate evidence provided by:

- NHS England
- Health Education England

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

- in Chapter 1, the Government's priorities for the NHS
- in Chapter 2, the general economic outlook for the UK economy
- in Chapter 3, NHS finances
- in Chapter 4, the workforce policy context
- in Chapter 5, developments in general practice
- in Chapter 6, developments for General Dental Service contractors
- in Chapter 7, developments for Ophthalmic Medical Practitioners

- in Chapter 8, information on our progress with NHS Pensions and Total Reward Strategy
- in Chapter 9, our responses to the further questions raised by the DDRB.

Chapter 1: NHS Context

Government priorities for the NHS

- 1.1 The Department of Health Business Plan for 2014-2015¹ sets out the Government's priorities for the NHS:
- **Living and aging well:** preventing people from dying prematurely; transforming care outside hospital, focusing on the role of primary care in providing integrated out of hospital care; implementing social care reforms; and improving treatment and care of people with dementia
 - **Caring better:** improving the standard of care throughout the system; making a step change in the way technology and information is used; and demonstrating real and meaningful progress towards achieving true 'parity of esteem' between mental and physical health
 - **Preparing for the future:** improving productivity and long term sustainability and ensuring value for money for the taxpayer; contributing to economic growth; and developing organisational capability and the resilience of the Department to fulfil its stewardship role.

NHS Mandate

- 1.2 The refreshed Mandate from the Government to NHS England² which, together with the NHS Outcomes Framework³ sets out the strategic framework within which NHS England will discharge its responsibilities between April 2014 to March 2015, was published in November 2013. The Mandate is structured around 5 key areas where the Government expects NHS England to make improvements:
- preventing people from dying prematurely
 - enhancing quality of life for people with long-term conditions
 - helping people recover from episodes of ill health or following injury
 - ensuring that people have a positive experience of care
 - treating and caring for all people in a safe environment and protecting them from avoidable harm

¹ <https://www.gov.uk/government/publications/department-of-health-corporate-plan-2014-to-2015>

² <https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

³ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>

- 1.3 The NHS Outcomes Framework set out the outcomes and corresponding indicators used to hold NHS England to account for improving health outcomes using the same key areas set out in the Mandate (as described above).
- 1.4 These priorities place the emphasis on prevention and care alongside the focus on high quality treatment. Overall, this should result in greater integration between health and care and more care being provided in the community.
- 1.5 The Government has signalled that the Mandate to NHS England will remain relatively stable for 2015/16, without substantial changes.
- 1.6 The 2013 Spending Round Settlement means that the NHS is protected and will continue to grow in real terms in 2015/16. This means we can focus on our priorities e.g. mortality, care for older people, dementia and other long term conditions, and dignity and respect in care. The Settlement demonstrates our biggest ever commitment to integrated care and will enable the Department and NHS leaders to deliver solutions which are as efficient as possible.

Transforming Primary Care

- 1.7 Primary care, like the wider health system, faces rising demand from an ageing population, growing numbers of co-morbidities and increasing patient expectations. This is set against a backdrop of increasing pressure on NHS financial resources due to the global economic crisis. More than ever before, the role of primary and community care services in providing high quality, integrated out of hospital care is coming to the fore, supporting people to stay well and independent for longer and to avoid unnecessary hospital admissions.
- 1.8 The Government has made clear its intentions for general practice in *Transforming Primary Care: safe, proactive, personalised care for those who need it most*,⁴ strengthening the role of GPs in providing a more proactive and multidisciplinary service, particularly for the most vulnerable patients, while removing unnecessary burdens through simplifying the Quality and Outcomes Framework.
- 1.9 Looking forward, the Government is exploring how the system can stimulate new models of care to ensure that care is fully integrated around people's needs, and the key role that general practice can play within these models, both in their role as providers and also as commissioners of services.
- 1.10 The Government is also exploring how transparency can be improved and information about the quality of services can be made even more user friendly, not only for patients, but also commissioners and service providers.

NHS Pay Policy

- 1.11 As the remit letters from the Chief Secretary to the Treasury and the Parliamentary Under Secretary of State make clear, the case for continued pay restraint across the public sector remains strong. The Government's priority is to protect frontline patient services and pay restraint is an essential part of this strategy. That is why the Government took the difficult decision to award a 1 per cent non-consolidated payment

⁴ <https://www.gov.uk/government/publications/plans-to-improve-primary-care>

to 2014/15 to all NHS staff that were not eligible to receive increments. Other staff should have received increments worth at least 1 per cent. It is in this context that we are asking the DDRB to make its recommendations on pay for medical and dental contractors.

Chapter 2: Economic Context

Economic context and outlook for the economy

- 2.1 The Government's economic strategy set out in the June Budget 2010 is designed to protect the economy through the period of global uncertainty and support the process of recovery. This strategy is restoring the public finances to a sustainable path and the deficit is forecast to be halved by the end of 2014/15. The UK is seen as a relative safe haven, with low market interest rates helping keep interest payments lower for households, businesses and the taxpayer. This strategy has helped the Government equip the UK to compete in the global race.
- 2.2 UK economy is now on the path of recovery with positive growth since the second quarter of 2013. The UK economy grew by 0.8 per cent in each quarter of 2014 and the Office for Budget Responsibility (OBR) forecast the UK economy to grow by 2.7 per cent in 2014.
- 2.3 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. Implementation of the fiscal consolidation plans is well underway. By the end of 2013/14, around 70 per cent of the annual fiscal consolidation planned for the Spending Review 2010 period had been achieved, with around 65 per cent of the spending and all of the tax consolidation in place. 80 per cent of the total consolidation in 2015/16 is expected to be delivered through lower spending.
- 2.4 While a significant amount of fiscal consolidation has already been achieved, the deficit and debt will remain at unsustainable level. The public sector net debt is forecast to continue to rise this year and reach its peak in 2015/16. Despite the positive economic growth, significant risks remain to the structural position of the public finances. These include risks from external economic shocks (including ongoing weakness in the Euro area, financial instability in the emerging markets and the situation in Russia and Ukraine) and weak receipts growth due to slow earnings growth (affected by low pick up in productivity as well as shift in employment pattern towards more self-employed).
- 2.5 The OBR forecast inflation of 1.9 per cent in 2014 and 2.0 per cent in 2015 it to continue to remain at target in 2016. The Bank of England's latest inflation forecast, published in the August *Inflation Report*⁵ is little changed compared to the May report. The Monetary Policy Committee (MPC) expect inflation to be about 1.8 per cent from fourth quarter of 2014 onwards.
- 2.6 Labour market figures continued to strengthen in the first half of 2014. The OBR expects labour employment to continue to rise over the forecast period although with slower growth than that seen over 2013. The unemployment rate has fallen by 0.9

⁵ <http://www.bankofengland.co.uk/publications/Pages/inflationreport/2013/ir1303.aspx>

percentage points since the end of 2013, and is now 6.4 per cent down from the peak of 8.4 per cent in the final quarter of 2011. Wage growth remains weak with regular pay growth slowing to 0.6 per cent in the second quarter of 2014 compared to the same period last year. While private sector pay growth has recovered somewhat from its large decline in 2009, it is growing at only about 1-2 per cent per annum compared with the pre-recession trend of about 4 per cent per annum.

- 2.7 Public sector pay restraint has been a key part of the fiscal consolidation so far. The Budget 2013 announced the public sector pay awards in 2015/16 will be limited to an average of up to 1 per cent.

Growth

- 2.8 The UK has been hit by the most damaging financial crisis in generations and the government inherited the largest deficit since the Second World War. The Government's long-term economic plan has protected the economy through a period of uncertainty, and provided the foundations for the UK's economic recovery, which is now well established.
- 2.9 The Government's long-term economic plan is restoring the public finances to a sustainable path. The deficit has fallen by over a third as a percentage of GDP since 2009/10 and is forecast to have halved by the end of 2014/15. The Government's plan has ensured economic stability and provided the foundations for the recovery. In order to safeguard the economy in the long term, the Government continues to take decisive action through monetary activism and credit easing; deficit reduction; reform of the financial system; and a comprehensive package of structural reforms.
- 2.10 UK GDP growth has been positive since the second quarter of 2013 and growth has exceeded forecasts. The UK economy grew by 0.8 per cent in the second quarter of 2014 following 0.8 per cent growth in the first quarter. The level of UK GDP has surpassed its pre-recession peak for the first time in the second quarter of 2014. The recovery is also balanced across all the main sectors of the economy, with manufacturing, services and construction all growing by over 3 per cent in the second quarter on a year earlier.
- 2.11 Reflecting this increased momentum, the OBR Budget 2014 forecast revised up UK GDP growth in 2014 to 2.7 per cent compared to 2.4 per cent from the Autumn Statement 2013 forecast. GDP growth in 2015 was revised up to 2.3 per cent from 2.2 per cent.
- 2.12 However, external risks remain, reinforcing the case for stability in the Government's long term economic plan. These include slowing growth and financial instability in some emerging markets, and ongoing weakness in the Euro area. The situation in Russia and Ukraine is a new risk, and further deterioration is likely to have some impact on the UK. Abandoning the Government's long-term economic plan and the path of fiscal credibility would represent the most significant risk to the recovery.
- 2.13 The Government is delivering ambitious structural reforms to enable the UK to compete in a rapidly changing global economy. These reforms are a key part of the Government's economic strategy, alongside fiscal consolidation, monetary activism, and reform of the financial system.
- 2.14 To help equip the UK to succeed in the global race the Government is implementing the most radical programme of economic reform in a generation. These reforms include making the tax system more competitive, equipping the UK's young people for the

future, reforming the welfare system, increasing the income tax personal allowance and delivering improvements in the UK's infrastructure.

Table 2A: Forecasts for GDP growth 2014 to 2016

Forecasts for GDP growth (per cent)	2014	2015	2016
OBR (March Budget 2014)	2.7	2.3	2.6
IMF WEO (July 2014 update)	3.2	2.7	2.4
Avg. of independent forecasters (August 2014)	3.1	2.6	2.4

Inflation

- 2.15 Inflation has fallen significantly since its peak in September 2011. Consumer Price Index (CPI) inflation peaked at 5.2 per cent in September 2011 but fell back in 2012 as past rises in commodity and energy prices and VAT dropped out of the twelve month comparison. Inflation has been below the 2.0 per cent target for the last seven months and over the second quarter of 2014 was 1.7 per cent.
- 2.16 Compared to the Bank of England's May 2014 *Inflation Report*, the outlook for inflation in the August report is largely unchanged. In the central case, inflation falls back a little in the near term as the appreciation of Sterling bears down on import prices and, in turn, prices in the shops. The Bank of England expects inflation to remain around 1.8 per cent from the fourth quarter onwards.
- 2.17 The OBR expects the rate of inflation to remain close to the 2.0 per cent target for the rest of 2014, before settling at target in the second half of 2015. The OBR states in its March 2014 *Economic and Fiscal Outlook*⁶ that "anchored expectations are assumed to help keep inflation around target."

Table 2B: Forecasts for CPI Inflation 2014 to 2016

Forecasts for CPI Inflation (per cent change on a year earlier)	2014	2015	2016
OBR (March Budget 2014)	1.9	2.0	2.0
IMF WEO (April 2014)	1.9	1.9	1.9
Avg. of independent forecasters* (August 2014)	1.7	2.1	2.1

*Fourth quarter

⁶ <http://budgetresponsibility.org.uk/economic-fiscal-outlook-march-2014/>

Affordability

- 2.18 The Government inherited the largest deficit in post-war history due to the financial crisis and unsustainable pre-crisis increases in public spending. The historically high levels of borrowing risked undermining fairness, growth and economic stability in the UK. In 2010 the Government set out clear, credible and specific medium-term fiscal consolidation plans to return the public finances to a sustainable path.
- 2.19 The Government's fiscal strategy has been effective in providing protection against a challenging backdrop of global uncertainty and fiscal vulnerabilities. This has restored fiscal credibility, and allowed activist monetary policy and the automatic stabilisers to support the economy through the headwinds it faced in 2011 and 2012, consistent with the approach recommended by international organisations.
- 2.20 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. Substantial progress has been made, and the deficit has fallen by more than a third as a percentage of GDP since its peak (from 11.0 per cent in 2009/10, to 6.5 per cent of GDP in 2013/14). By the end of 2013/14, around 70 per cent of the annual consolidation planned for this Parliament had been achieved, with around 65 per cent of the spending and all of the tax consolidation in place. 80 per cent of the total consolidation in 2015/16 will be delivered by lower spending.
- 2.21 The improved economic outlook supports the public finances, with the 'underlying deficit' now expected to be around £95 billion lower over the forecast period than forecast at Budget 2013. However, although the structural deficit continues to fall year on year, the OBR judges that it has not been improved by stronger economic growth over the past year, which the OBR has judged represents an improvement in the economic outlook rather than an improvement in the economy's growth potential. Substantial risks remain to the structural position of the public finances. These risks include external economic shocks, such as those set out in paragraph 2.12, public spending pressures and weak receipts growth driven by disappointing earnings growth. Therefore, the balance of fiscal risks argues strongly for sticking to the Government's long-term economic plan.
- 2.22 The deficit and debt remain at unsustainable levels. This year, the deficit is forecast to be £95.5 billion (5.5 per cent of GDP), and public sector net debt is forecast to continue to rise to peak at 77.3 per cent of GDP next year (2015/16), at which point the Government is forecast to be spending around £59 billion on servicing its public debt – more than is planned to be spent on the Department for Education. With the deficit and debt still at these unsustainable levels, deviating from the long-term economic plan as set out in 2010 would be the biggest risk to the recovery. Maintaining a clear and credible path of deficit reduction, which is based on continued public sector spending control and public sector pay restraint, is essential to ensuring market confidence in the Government's ability to get the public finances back to a sustainable position.
- 2.23 The international fiscal context argues strongly in favour of maintaining a credible pace of deficit reduction. Despite significant progress since 2010, the European Commission forecasts that this year the UK will have the third largest deficit and the largest structural deficit in the European Union. Given this context, maintaining the current clear and credible path of deficit reduction is necessary in order to maintain the confidence of international bond markets.

2.24 The implication of fiscal consolidation for departmental spending levels can be seen in table 2C below, which shows resource DEL budgets for each department from the Public Expenditure Statistical Analyses 2013⁷. An estimated £164.3 billion in 2013/14 was spent on public sector pay, around 50 per cent of departmental resource spending.

Table 2C: Departmental Expenditure Limits

	£ billion		
	Estimate 2013-14	Plans 2014-15	Plans 2015-16
Departmental programme and administration budgets (Resource DEL excluding depreciation)¹			
Education	51.7	53.5	53.5
NHS (Health) ²	105.6	108.3	110.4
Transport	3.8	4.0	3.2
CLG Communities	2.0	2.5	1.1
CLG Local Government	16.6	13.8	12.1
Business, Innovation and Skills	14.8	13.8	13.2
Home Office	10.7	10.4	9.8
Justice	7.4	6.7	6.2
Law Officers' Departments	0.6	0.5	0.5
Defence ³	27.1	25.3	23.6
Foreign and Commonwealth Office	2.0	1.5	1.1
International Development	8.1	8.3	8.5
Energy and Climate Change	1.2	1.5	1.3
Environment, Food and Rural Affairs	1.8	1.8	1.6
Culture, Media and Sport	1.1	1.2	1.1
Work and Pensions	7.2	7.8	6.2
Scotland	25.5	25.8	25.8
Wales	13.9	13.7	13.7
Northern Ireland	9.7	9.7	9.7
Chancellor's Departments	3.2	3.6	3.3
Cabinet Office	2.2	2.3	2.0
Small and Independent Bodies	1.5	1.9	1.6
Reserve	0.0	2.4	2.5
Special Reserve	0.0	0.6	1.0
Adjustment for Budget Exchange ⁴	0.0	-2.2	0.0
Spending commitments not yet in budgets	0.0	0.0	0.9
Total Resource DEL excluding depreciation plans	317.8	318.7	313.9

Source: HM Treasury, March 2014

Labour market

2.25 Headline labour market figures continued to strengthen in the first half of 2014. Employment has risen by 451,000 since the end of 2013 bringing the employment level to 30.6m. The employment rate rose 0.9 percentage points to 73.0 per cent over the same period, in-line with its pre-recession peak. The OBR expects employment to continue to rise over the forecast period, but at a slower pace than the increase over 2013. Unemployment fell by 264,000 over the first half of 2014 and is down 437,000 over the year. The unemployment rate has fallen by 0.9 percentage points since the end of 2013, by 1.4 percentage points compared to the same period last year and down from the peak of 8.4 per cent in the final quarter of 2011. At 6.4 per cent the unemployment rate is 0.4 percentage points lower than forecast than the OBR forecast at Budget.

⁷ <https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa>

- 2.26 In the second quarter of 2014, the overall Labour Force Survey (LFS) employment level was 1.03 million above its pre-recession peak in the three months to May 2008. The number of vacancies increased by 119,000 over the year to 656,000 in the three months to July 2014, and is at its highest level since the three months to May 2008.
- 2.27 However, while employment growth remains robust and unemployment is falling wage growth remains weak. Regular pay growth (excluding bonuses) in the second quarter of 2014 slowed to 0.6 per cent on the year.

Employment and unemployment

- 2.28 The increase in the level of employment of 820,000 over the year to the second quarter of 2014 continues to see employment grow strongly and outpace forecasts for the OBR. Employment over the last year increased faster in the UK than in any other G7 country. The composition of the labour market has also changed over the last year with an increase in the share of total employment accounted for by self-employment, to 15 per cent from 14 per cent a year earlier. The composition of the labour market can have important implications for tax receipts with the self-employed typically paying less tax than employees.
- 2.29 The International Labour Organisation unemployment rate, which rose from a low of 5.2 per cent in the first quarter of 2008 to peak at 8.4 per cent (2.66m people) in the final quarter of 2011, has subsequently fallen to 6.4 per cent in the second quarter of 2014. Unemployment is down 437,000 on the year, the fastest annual decline since 1988.
- 2.30 Long term unemployment (unemployment of 12 months or more) stands at 738,000 in the second quarter of 2014, down by 171,000 over the year. Long-term unemployment now accounts for 35.5 per cent of total unemployment, a reduction of 0.6 percentage points on the year.
- 2.31 Working age inactivity (16-64) was down by 130,000 over the year with the inactivity rate falling by 0.4 percentage points to 21.9 percent. The fall in activity has been driven by a decline in female inactivity which is down 93,000.
- 2.32 Youth unemployment (16-24) fell by 102,000 in the second quarter of 2014 and down 206,000 on the year, the fastest decrease since records began. The youth unemployment rate stands at 16.9 per cent, down 2.1 percentage points on the year. Excluding people in full-time education (FTE), there were 502,000 unemployed 16-24 year olds, with a corresponding unemployment rate of 14.5 per cent.
- 2.33 The claimant count (the number of people claiming Jobseeker's Allowance) has fallen for twenty-one consecutive months and is down 420,000 in the year to July 2014, the fastest annual decline since December 1973.

Table 2D summarises these statistics:

Table 2D: Labour market statistics summary (Levels in 000s, rates in %)*

	2010	2011	2012	2013	2014 Q2
Employment level (All aged 16 and over)	29,019	29,166	29,519	29,896	30,597
Employment rate (All aged 16-64)	70.5	70.5	71.1	71.7	73.0
Unemployment level (All aged 16 and over)	2,476	2,564	2,548	2,460	2,077
Unemployment rate (All aged 16 and over)	7.8	8.1	7.9	7.6	6.4
Youth unemployment level (All aged 16-24)	932	985	992	954	767
Youth unemployment rate (All aged 16-24)	19.8	21.1	21.2	20.8	16.9%
Claimant Count	1,496	1,534	1,585	1,421	1,008**

* The latest public and private sector employment figures available are for the first quarter of 2014. These show that private sector employment rose by 355,000 on the quarter and was up by 795,000 over the year. This more than offsets the fall in public sector employment which decreased by 11,000 on the quarter and by 16,000 over the year. This takes into account of major reclassifications where large bodies employing large number of people have moved between the public and private sectors.

** Latest monthly data used (July 2014)

Public and private sector earnings

2.34 Earnings growth in the private sector continues to be weak and over the period since 2008 average earnings growth in the public sector has generally exceeded that in the private sector. While private sector pay growth has improved since 2009 (about 1-2 per cent per annum) we are yet to a return to growth rates seen before the recession (about 4 per cent per annum). Even after controlling for individual characteristics Institute for Fiscal Studies (IFS) study finds that the pay differential between public and private

sector workers still continues to be in favour of the former and above the pre-recession trend.

- 2.35 Average total pay growth (including bonuses) decreased by 0.2 per cent in the three months to June 2014 compared to the same three month period in 2013, the first time the rate has been negative since May 2009. This was mainly due to an unusually high growth rate in April 2013 as some employers who usually paid bonuses in March paid them in April last year to benefit from the lowering of the tax rate in April 2013. Regular pay growth (excluding bonuses) rose by 0.6 per cent over the same period. Inflation as measured by the Consumer Price Index increased by 1.9 per cent on the year to June, meaning that real pay growth continued to be negative over this period.
- 2.36 Average total private sector pay has recovered somewhat from its large decline in 2009 but remains mostly weak, growing by just 2.0 per cent in 2010 and 2.6 per cent in 2011, compared to above 4 per cent prior to the recession. Private sector pay growth weakened to 1.4 per cent in 2012 and 2013. Total private sector pay strengthened in the first quarter of 2014 and grew by 2 per cent but decreased to -0.1 per cent in the second quarter of the year.
- 2.37 Public sector (excluding financial services) average regular pay was 2.3 per cent in 2010 and 1.8 per cent in 2011. While this recovered slightly in the middle of 2012, growing by 2.3 per cent in the third quarter of 2012, it weakened towards the end of the year and continued to weaken in 2013 growing by 0.9 per cent. Pay in 2014 has picked up slightly, reaching 1.5 per cent in the first quarter before falling to 1.2 per cent in the second quarter.
- 2.38 The sharp drop in bonuses for the whole economy seen in 2009 put more downward pressure on total pay (pay including bonuses). While there were some tentative increases in the levels during 2010 and 2011, it has remained mostly subdued. Whole economy bonus pay growth has seen large fluctuations during 2013 with a fall of 4.9 per cent in March 2013 but an extremely large single month increase in April 2013 of 44.7 per cent corresponding to the shift in the timing of annual bonus payments. The base effects of the shifting of bonus payments meant that bonus payments were particularly weak in the second quarter of 2014, down -10.8 per cent. This has been a large drag on private sector pay in particular.
- 2.39 Table 2E sets out the differences in regular and total pay growth across years in the public and private sector.

Table 2E: regular pay (excluding bonuses) and total pay growth⁸

	Total Pay, annual growth			Regular pay, annual growth		
	All	Private	Public ⁹	All	Private	Public ⁶
2009	-0.1%	-0.9%	2.8%	1.7%	1.2%	3.0%
2010	2.4%	2.0%	2.2%	1.9%	1.5%	2.3%
2011	2.5%	2.6%	1.5%	2.0%	2.0%	1.8%
2012	1.4%	1.4%	1.7%	1.6%	1.8%	1.6%
2013	1.2%	1.4%	0.8%	1.0%	1.1%	0.9%
2014 Q2	-0.2%	-0.1%	0.9%	0.7%	0.9%	1.2%

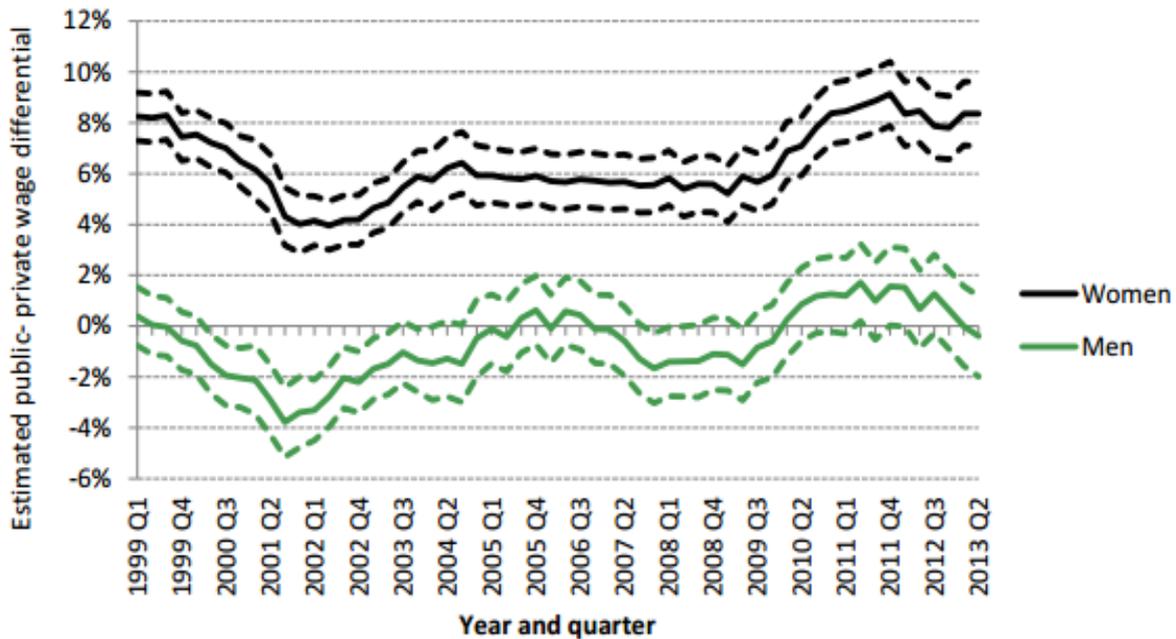
2.40 Since the introduction of the pay freeze and the policy of pay restraint, average earnings in the public sector (as measured by the ONS) continue to display positive growth for a number of reasons: the provision of £250 to those earning £21,000 or less during the two years of pay freeze, the fact that some three year pay deals only ended in September 2011, and an upwards pay drift due to continued constrained recruitment.

2.41 In addition, the public-private sector pay differential based on average hourly earnings controlling for worker characteristics, as published in the IFS report (December 2013) shows that the public sector premium still remains above its pre-recession level.

⁸ Source: ONS, AWE; HMT calculations annual percentage change for quarter one.

⁹ Public sector pay excluding financial services

Figure 1: Public-private hourly pay differential controlling for individual characteristics, IFS (December 2013)



Public sector pensions

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

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

2.44 Following a fundamental review of public service pension provision by the Independent Public Service Pensions Commission, the Government is introducing key changes to the pension element of the remuneration package. New public service pension schemes will be introduced in April 2015, which will:

- calculate pension entitlement using the average earnings of a member over their career, rather than their salary at or near to retirement;
- calculate pension benefits based on Normal Pension Age linked to the member's State Pension Age; and
- include an employer cost cap mechanism, which will ensure that the risks associated with pension provision are shared with scheme members to provide backstop protection for the taxpayer.

- 2.45 The changes being introduced through the Public Service Pensions Act 2013 will save an estimated £65 billion by 2061/62.
- 2.46 Wider changes to public service pension provision have also taken place. Progressive increases in the amount that members contribute towards their public service pension began in April 2012 and were phased in over three years, with the final increases made in April 2014. Members are now contributing an average of 3.2 percentage points more. This will deliver £2.8 billion of savings a year by 2014/15.
- 2.47 Protections from the impact of the contribution changes have been put in place for the lowest paid. Those earning less than £15,000 will see no increases; and those earning up to £21,000 (£26,000 for teachers) will not see increases of more than 1.5 percentage points by 2014/15.
- 2.48 Public service pensions will remain among the best available and will continue to offer members guaranteed, index-linked benefits in retirement that are protected against inflation. Private sector workers buying benefits in the market would have to contribute over a third of their salary each year to buy an equivalent pension.
- 2.49 Putting together the evidence on pension provision and pay levels – and recognising that there will be significant variation between and within individual workforces – the overall remuneration of public sector employees is above that of the market. The Government is therefore clear that any changes to public service pensions, including the progressive increase in contributions from 2012/13, do not justify upward pressure on pay.

Chapter 3: NHS Finances

Funding Growth

- 3.1 This chapter sets out the financial position for the NHS in 2015/16.
- 3.2 Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.3 per cent in real terms. The first three years of the current spending review period (2011/12 to 2013/14) have shown subdued growth, averaging 1.3 per cent per year in real terms.
- 3.3 Table 3A shows:
- Outturn NHS revenue expenditure figures from 1999/00 to 2013/14;
 - Revenue Departmental Expenditure Limits (RDEL), as agreed in the 2010 and 2013 Spending Reviews, for 2014/15 to 2015/16.

Table 3A – NHS Revenue Expenditure since 1999/00

Year		Revenue Net NHS Expenditure (2)(3) £bn	% increase	% real terms increase (4)
RB Stage 1⁽⁵⁾				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	7.9
2001/02	Outturn	47.3	10.8	7.8
2002/03	Outturn	51.9	9.8	7.3
RB Stage 2⁽⁶⁾				
2002/03	Outturn	56.9	-	-
2003/04	Outturn	61.9	8.7	6.7
2004/05	Outturn	66.9	8.1	5.2
2005/06	Outturn	74.2	10.9	8.9
2006/07	Outturn	78.5	5.8	2.8
2007/08	Outturn	86.4	10.1	7.4
2008/09	Outturn	90.7	5.0	2.2
2009/10	Outturn	97.8	7.8	4.9
2010/11	Outturn	102.0	4.3	1.6
Resource Budgeting - Aligned⁽⁷⁾				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	0.6
2011/12	Outturn	100.3	2.9	0.6
2012/13	Outturn	102.6	2.3	1.2
2013/14	Outturn	106.5	3.8	2.1
2014/15	Plan	109.7	3.0	0.7
2015/16	Plan	111.7	1.8	0.2

Notes

1. Expenditure figures are not consistent over the period (1990-00 to 2015-16) and this should be noted when making comparisons between years
2. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings DH in line with HMT presentation of the statistics
3. Expenditure excludes NHS (AME)
4. GDP as at 27/06/2014
5. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting basis
6. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis
7. Expenditure figures from 2009-10 to 2015-16 are on an aligned basis following the government's Clear Line of Sight programme

Share of resource going to pay

3.4 Table 3B shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time. Note that the HCHS workforce comprises staff working within hospital and community health settings; it therefore excludes General Practitioners, GP practice staff and General Dental Practitioners.

Table 3B– Increases in Revenue Expenditure and the proportion consumed by Paybill

Year	Increase in Revenue Expenditure	Increase in HCHS Provider paybill	Proportion of revenue increase on paybill	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
	(£bn)	(£bn)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4
2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1
2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	2.4	1.0	1.2	0.5
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.5	0.4	0.1	0.2
2013/14	3.9	0.5	13	2.3	0.3	1.3	0.2
Average	4.9	1.9	37	3.6	1.2	2.6	0.7

Notes

1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations
2. Excludes ALB and DH core staff expenditure
3. Excludes GPs
4. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR
5. Figures may not sum due to rounding

3.5 On average, between 2001/02 and 2013/14, increases to the HCHS paybill have consumed 37 per cent of the increases in revenue expenditure. Of this 37 percentage points, pay effects have consumed around 23 percentage points and volume effects around 14 percentage points.

3.6 HCHS pay is the largest cost pressure, on average it has accounted for around 37 per cent of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next year.

Pressures on NHS funding growth

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

- baseline pressures
- underlying demand
- service developments.

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

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

Allocation of resources

3.10 Table 3C shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

Table 3C – Disposition of Revenue Increase across Expenditure Components

Year	Increase in Revenue Expenditure (£bn)	Increase in HCHS Provider paybill (£bn)	Proportion of revenue increase on paybill (%)	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
				(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4
2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1
2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	2.4	1.0	1.2	0.5
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.5	0.4	0.1	0.2
2013/14	3.9	0.5	13	2.3	0.3	1.3	0.2
Average	4.9	1.9	37	3.6	1.2	2.6	0.7

Note:

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

- 3.11 There are £1.8 billion of increased revenue resources available in 2015/16 for the NHS to meet in-year pressures. This is lower than the previous three Spending Review periods, lower than the first three years of this Spending Review and lower than the planned disposition of resources for 2014/15.
- 3.12 2013/14 saw a significant reduction in paybill per FTE drift. However, this is likely to be a temporary effect. Apparent levels of drift were significantly affected by the temporary costs of managerial exit packages, associated with the NHS reform, in 2012/13 making 2013/14 earnings seem low in comparison. Furthermore, 2013/14 saw a significant increase in the HCHS workforce – likely in response to the Francis Report and addressing unsafe staffing risks. The increase in workforce growth was particularly strong for non-medics which neutralised the contribution of medical workforce expansion to higher drift compared to recent years. As recruitment tends to be towards the lower end of the pay scales this also had a depressing impact on average experience and hence pay levels which translated into lower drift. Such strong recruitment is not expected to continue particularly given affordability constraints, so drift is expected to increase from its 2013/14 levels. Additionally, in 2015/16, drift will be increased by around 0.2 percentage points due to changes in the NHS pension scheme employer contribution rate. As such, financial planning assessments suggest overall HCHS paybill per FTE drift could return to levels of around 1 per cent in 2015/16. The gross pressure from incremental progression adds costs approaching 2 per cent of the paybill.
- 3.13 The difficulty of allocating resources is therefore more acute than it has been in the previous 10 years. Of the £1.8bn available, demand pressures consume £1.6bn, even after an assumption that demand growth will be lower than in recent years due to the Better Care Fund. With the cost pressures being absorbed by improved productivity, £0.5 billion is assumed to be available for pay.

Financial Balance

- 3.14 Achieving financial balance in 2015/16 is reliant upon the Better Care Fund diverting activity from the acute sector, high levels of labour productivity, and a continued bearing down on prices for procurement, drugs, and pay.

Conclusion

- 3.15 The NHS has received a better Spending Review settlement than almost all other parts of the public sector, including a commitment to real terms increases in health spending in 2014/15 and 2015/16. However, although generous compared to other departments, this represents the biggest financial challenge in the history of the NHS.
- 3.16 The NHS is delivering on this challenge and has so far met its savings targets in 2011/12, 2012/13, and 2013/14. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services.

Chapter 4: GMP and GDP Workforce Issues

Policy context

High level strategy and policy context for workforce planning

- 4.1 The Government is committed to supporting a world class healthcare education and training system underpinned by robust workforce planning with providers of NHS commissioned services taking the leading role.
- 4.2 The Department and Health Education England (HEE) share a vision for education and training and planning for future workforce needs that is built from NHS providers up and underpinned by accurate, comprehensive, complete and timely workforce information. This will ensure the workforce truly reflects the needs of local service users, providers, and commissioners of healthcare both in acute, community and public health settings.

Health Education England

- 4.3 HEE was issued with a refreshed mandate by the Secretary of State for Health on 1 May 2014. This sets out the key priorities for HEE from April 2014 to March 2015. *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values: a mandate from the Government to HEE*¹⁰ reflects the updated strategic objectives of the Government in the areas of workforce planning, health education, training and development for which HEE and the Local Education and Training Boards (LETBs) have responsibility.
- 4.4 HEE will provide its own evidence and in doing so will address the priorities set out in the mandate.

Transforming Primary Care

- 4.5 HEE has been asked to deliver the workforce development commitments required of it in *Transforming Primary Care*, which sets out the Government's ambition for improving out-of-hospital care, starting with the most elderly and vulnerable in society. HEE has been asked to work with the appropriate health and care organisations to act upon the workforce implications of the ambition for out-of-hospital care, with rapid progress to be made during 2014. *Transforming Primary Care* contains new major commitments to review and increase capacity in the primary and community workforce.
- 4.6 **Make available 10,000 primary and community care professionals by 2020.** The 10,000 is expected to reflect growth across the primary and community workforce, including GPs. The Department will work with HEE and other stakeholders to inform detailed planning for the future primary care workforce including the required skills.
- 4.7 **Improve recruitment, retention and return to practice.** The Government is working with NHS England, HEE and key stakeholders to consider how to improve recruitment, retention and return to practice in primary and community care. This commitment

10

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Deliverin_g_Accessible.pdf

envisages NHS England and HEE working with stakeholders including Royal College of Nursing and Royal College of General Practitioners to address the pressures practices are facing in recruiting, retention and return to practice in primary and community care.

Shape of training

4.8 As part of the 2013/14 mandate commitment to ensure GP training produces practitioners with the required competencies to practice in the new NHS, HEE are continuing to work with the Devolved Administrations and the Department of Health on the response to the recommendations for postgraduate specialty training outlined in David Greenaway's *Shape of Training Report*¹¹, and the provisional findings of NHS England's review of primary care services. The case for enhanced GP training will be explored further as part of the response to *Shape of Training*, and HEE will work with the General Medical Council (GMC) and other key stakeholders on any required amendments to the training curricula to ensure competence in any new areas, for example mental health conditions, learning disabilities, autism and paediatric care. The group has been asked to report back in summer 2015.

GMP trainees

4.9 The Department has recognised the need to increase the GP workforce. Through the current mandate, HEE has been asked to ensure that 50 per cent of trainees completing foundation level training enter GP training programmes by 2016. To further support the growth of the GP workforce, HEE will undertake additional work on GP recruitment and retention, return to practice and reducing attrition rates creating additional numbers of GPs is a vital part of national initiatives to shape the future of general practice services in England and to meet patient's needs. Additional numbers of GPs will help to manage some of the current pressures in primary care arising from an ageing population, growing co-morbidities, increasing patient expectations and increasing pressures on NHS finances.

GMP trainers grant

4.10 As noted in the Department's evidence for 2014, the Department is currently working with the BMA, the RCGP and HEE to develop a tariff based approach for funding clinical placements in GP practices for medical student and trainees. Tariffs for placements in secondary care were introduced in 2013 and 2014. During 2014 the Department has continued work to develop tariffs for placements in GP practices, and has been working with GP practices to better understand the costs incurred with having medical students and trainees on placement with them. The intention is that tariffs for placements in GP practices would supersede the funding currently provided through the GP trainer's grant. This is a challenging area of work that the Department continues to prioritise.

11

GDPs – oversupply issue

4.11 HEE asked the Chief Dental Officer for England to lead a review of dental training numbers working with the Health Education England Advisory Group (HEEAG) for dentistry and the Centre for Workforce Intelligence (CFWI). As part of this review CFWI produced a baseline projection of the likely workforce situation between now and 2040 if no change were made to current training plans. The baseline review projection suggested that if no action were taken there would be a very significant over supply of Dentists widening to 2040. Following discussions with the Department of Health and the Department for Business Innovation and Skills, it was agreed that HEE would implement a 10 per cent reduction in dental student numbers for the 2014 intake.

Chapter 5: General Medical Services Contractors

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

Background

- 5.2 In England, there are around 7,900 GP practices¹², which act as both the gateway to and co-ordinator of patient access throughout their care journey. They are usually the first point of contact for a patient seeking treatment or advice about their health.
- 5.3 General practice plays a key role throughout people's lives in helping people to stay well through prevention and support for self-management of conditions; diagnosing and managing the connection to specialist or multi-disciplinary care; and directly providing care and treatment. At its core is a registered list of patients which enables practices to provide continuity of care, coupled with an ability to look at physical, mental and social needs in the round, identifying and managing risk and ensuring that people can access the full range of services they need.
- 5.4 GPs and nurses in general practice see over 800,000 people a day – that is around 300 million contacts every year.
- 5.5 However, general practice, like the wider health system, faces rising demand from an ageing population, growing numbers of co-morbidities and increasing patient expectations. This is set against a backdrop of increasing pressure on NHS financial resources due to the global economic crisis. More than ever before, the role of primary and community care services in providing high quality, integrated out of hospital care is coming to the fore in order for people to stay well and independent for longer and to avoid unnecessary hospital admissions.
- 5.6 With demand on GPs' skills and time intensifying, we need to ensure that we take advantage of the opportunity to innovate in primary care, to strive for continuous quality improvement, and to remove the barriers to change, for instance, by reducing the unnecessary burdens placed on GPs' time.
- 5.7 Locally, there are many examples of innovation and excellence taking place to meet these new challenges. For instance, we are seeing many examples of general practices coming together in networks or federations in order to provide access to a wider range and higher quality of services to their patients through the pooling of knowledge, skills and resources.
- 5.8 Across England, the Government has already made clear its intentions for general practice to continue to strive for improvement through the changes made to the GP

¹² <https://www.hscic.gov.uk/catalogue/PUB13849/nhs-staf-2003-2013-gene-prac-rep.pdf>

Contract for 2014/15. Earlier this year, we published *Transforming Primary Care: safe, proactive, personalised care for those who need it most*¹³. This document set out our ambitions for the future of primary care, bringing together the work from the last year on how we can strengthen the role that general practice can play in supporting vulnerable older people and our ambitions for the service more widely.

GP contract 2014/15

- 5.9 The 2014/15 GMS contract implemented a number of the key ambitions set out in *Transforming Primary Care*. For example, requiring practices to ensure that all patients aged 75 or over have a named accountable GP who is responsible for coordinating their care, and that the 2 per cent most vulnerable patients on their registered list have a proactive care plan that has been developed with their GP and a multidisciplinary team across the practice and community services.
- 5.10 In addition, the 2014/15 contract introduced a number of other important changes for patients: improved online access to GP services for patients, better information for patients to make choices about the quality of the services they access and more choice of practice that they can register with.
- 5.11 In response to GPs' concerns about increasing bureaucracy and workload, the 2014/15 contract reduced the number of Quality and Outcomes Framework indicators by over a third. This change was intended to enable GPs to spend more time with their patients.

Improving Quality

- 5.12 All providers of primary medical and primary dental care are required to be registered with the Care Quality Commission (CQC) and to meet a set of registration requirements that set the required standards of care. All GP practices will receive a quality rating, based on an inspection of their premises, which will be published. The system will identify good as well as poor care in order to support commissioning decisions and a more informed user choice, as well as providing assurance that the fundamental standards are met and action is taken where improvements are needed.
- 5.13 Looking forward, the Department is exploring how the system can stimulate new models of care to ensure that care is fully integrated around people's needs, and the key role that general practices can play within these models, both in their role as providers but also as commissioners of services. NHS England, as commissioner of primary medical care services, is developing its strategy for the commissioning of general practice over the coming years, including how it can stimulate and support innovation and new models of care in general practice.

13

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

Transparency

- 5.14 There is currently limited information on outcomes and quality in primary medical care. Without this kind of information, it can be unclear what expenditure on general practice is delivering.
- 5.15 Increasingly, more information is available, both for patients, for example through the National General Practice Profiles¹⁴, and for commissioners and service providers, for example through the GP web tool¹⁵. CQC's programme of inspections of GP practices is part of this move towards greater transparency. However, further work is needed in this area.

Salaried GPs

- 5.16 There are model terms and conditions for salaried GPs, including a minimum and maximum of a pay range. Those employing salaried GPs (e.g. NHS trusts, GP contractors) may choose to use these, but it is not mandatory. There are no pay scale points or increments within the range. It is for the employer to determine the level of salary and whether and how pay should vary over time.
- 5.17 Last year the DDRB recommended that the pay range minimum and maximum should increase by 1 per cent for 2014/15. This was agreed, as being most consistent with decisions for other NHS-employed staff. In line with that, we would propose to increase the minimum and maximum by 1 per cent for 2015/16.

Formula approach to uplift

- 5.18 We recognise and agree with the DDRB's concerns over the uplift formula as used in previous years, in the absence of a more robust solution. The Government would welcome views from the DDRB on how recommendations for the uplift could be improved from the current the formula-based approach.
- 5.19 A key part of this will be to increase transparency over GP earnings in future years, to provide a richer and timelier source of information from which the DDRB can base their recommendations. The Government is working with NHS England and the BMA to agree how best to achieve this. However, the Government recognises that much of this information is not currently available to the DDRB in making their recommendation for 2015/16.

¹⁴ <https://fingertips.phe.org.uk/profile/general-practice>

¹⁵ <https://www.primarycare.nhs.uk>

Conclusion

- 5.20 The Government recognises the key role General Medical Practitioners play in understanding, and planning for, the needs of their local populations. With the NHS facing unprecedented financial pressures against a backdrop of increasing demand, general practice will be central in managing those pressures.
- 5.21 However, the Government needs to continue to secure affordability across the NHS. Budget 2013 announced that public sector pay awards in 2015/16 will be up to 1 per cent. This follows two years of public sector pay freeze. Therefore, the Government would expect the recommendation for General Medical Practitioners will be taken in this context.

Chapter 6: General Dental Services Contractors

- 6.1 We recognise and agree with the DDRB's concerns over the uplift formula as used in previous years in the absence of a more robust solution. The Government would welcome views from the DDRB on how recommendations for the uplift could be improved from the current the formula-based approach. Budget 2013 announced that public sector pay awards in 2015/16 will be up to 1 per cent. This follows two years of public sector pay restraint policy of 1 per cent and before this, two years of public sector pay freeze. Therefore, the Government would expect the recommendation for General Dental Practitioners will be taken in this context.

Moving towards a new national dental contract

- 6.2 The Coalition Agreement committed the Government to introducing a new NHS dental contract based on registration, capitation and quality with the aim of improving oral health and increasing access to NHS dentistry. The Government also committed to piloting the key quality and capitation elements needed to design such a contract.
- 6.3 Piloting began in 2011. Currently there are approximately 90 practices testing key elements needed to design a new contract. The various payment models are intended to test different behavioural responses to the slightly different ways of remunerating for capitation and quality.
- 6.4 In April 2014, the Parliamentary Under-Secretary of State (Health) announced our intention to move to a more advance stage of contract reform. This would involve selected practices prototyping whole variants of a possible new system. This will commence during 2015/16.
- 6.5 However we are not yet in a position to be able to announce when a new contract will be rolled out nationally.

Chapter 7: Ophthalmic Medical Practitioners

- 7.1 The Department of Health remains firmly of the view that there should be a common sight test fee for optometrists and Ophthalmic Medical Practitioners (OMPs), which is consistent with previous DDRB recommendations for joint negotiation of the fee. Optometrists carry out over 99.8 per cent of NHS sight tests. Discussions are to take place with representatives of the professions on the implementation of government pay policy. Commissioning of the NHS sight testing service in England is the responsibility of the NHS England.

Background

- 7.2 Between 31 December 2012 and 31 December 2013, the number of OMPs who were authorised by the NHS England in England and the number in Local Health Boards in Wales to carry out NHS sight tests decreased from 318 to 301, and the number of optometrists increased from 11,624 to 11,937 an increase of 2.6 per cent. The General Ophthalmic Services continue to attract adequate numbers of practitioners of good quality with appropriate training and qualifications.
- 7.3 In 2013/14, 13.55 million sight tests were paid for by NHS England and LHBs in Wales. This was 3.3 per cent more than in 2012/13. Within these figures, the proportion of sight tests carried out by OMPs was 0.2 per cent in 2013/14.
- 7.4 The surveys, which the Department has conducted into the working patterns of optometrists and OMPs, show that the majority of OMPs practise part-time. Half of the sight tests carried out by OMPs are part of a hospital appointment.

Chapter 8: NHS Pensions and Total Reward

Introduction

- 8.1 The Government is undertaking a range of changes to pensions for in both the public and private sectors. These include the new state pension, a review of the State Pension Age, the introduction of auto-enrolment and the Public Services Pension Act 2013 which legislates for the forthcoming changes to public service schemes, including the NHS Pension Scheme.
- 8.2 The table and Annex 3 demonstrates that the new NHS Pension Scheme, in place from 1st April 2015, will continue to provide a generous pension to doctors and dentists and remains one of the best available. A similar inflation-proof pension of £68,000 a year would require a pension of pot of nearly £2 million in the private sector. Higher paid NHS staff continue to pay a reasonable amount for their pension, contributing a similar proportion of their salary as other NHS staff on lower incomes once tax relief is taken into account. They also receive a 14 per cent employer contribution to their pension in the form of deferred pay; from 1st April 2015 this will increase to 14.3 per cent.
- 8.3 The current NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary with two sections – 1995 and 2008. The key differences between the two sections are different normal pension ages and accrual rates. Around two thirds of staff are currently in the 1995 Section and a further third now in the 2008 Section.

Total Reward Statements

- 8.4 The Public Service Pensions Act 2013 introduces a new legal requirement on public sector schemes to provide benefit information statements to members in pensionable service annually. For NHS staff employed in organisations using the Electronic Staff Record (ESR) this will be enhanced to a Total Reward Statement (TRS). The TRS aims to ensure that staff are fully aware of the benefits they receive as a total remuneration package, including pension, pay and leave, as evidence gathered by both HMT and the NHS via staff workshops demonstrated that employees do not understand this fully. For example, many are not aware that they receive 14 per cent employer contribution toward their pension package. For staff in organisations not using the ESR (which includes many GPs, dentists and locums), they will receive an annual benefit statement (ABS) as per the requirements of section 14 of the Public Service Pensions Act 2013. As with annual benefit statements, total reward statement content will be generated annually to ensure that we achieve optimum impact on NHS employees.
- 8.5 The national rollout of TRS has now commenced for officer members of the NHSPS; there is a pilot planned for practitioner members in 2014. Feedback from the officer pilots was positive, and it is hoped that the practitioner pilot will be equally successful.

Progress towards implementation of the 2015 scheme

- 8.6 Good progress has been made in partnership with the NHS Trades Unions, including BMA and BDA, as well as NHS Employers, in developing the new NHS Pension Scheme and agreeing the detailed business rules based on the Proposed Final Agreement (published in March 2012).
- 8.7 The draft regulations for the 2015 Scheme will follow a further consultation process in autumn 2014. Employee contribution rates from 1st April 2015 have been published¹⁶ and remain broadly the same as they are at present in the 2014-15 scheme year.
- 8.8 The valuation of the existing NHS Pension Scheme, as at 31 March 2012, has been completed using the methodology set out in the HMT Valuation Directions enacted through provisions in the Public Services Pension Act 2013. The valuation report was published on 9 June 2014¹⁷.
- 8.9 The overarching principle behind the Government's approach to valuations of the public service pension schemes is that these valuations should measure the true costs of providing pension benefits, and that these costs should be fully reflected in employer contribution rates from 1 April 2015.
- 8.10 Although public service schemes like the NHS have no actual fund, they are valued as if they do and the contributions are being invested to create a notional fund that needs to be equal to the liabilities being built up. This means that if longevity improves, staff retire earlier than expected, or pay is higher than expected a past service deficit is created that has to be paid off.
- 8.11 The approach to the valuation also included the use of a new discount rate for valuing public service pensions. The discount rate, which is used to value the current cost of future pension payments and the rate of notional returns made on previous contributions to the scheme, was reduced from 3.5 per cent plus RPI to 3 per cent plus CPI as a result of a consultation in 2010. This in effect reduces the notional rate of return made on contributions to the scheme, and increases the present costs of future benefit payments. All things being equal, this increases the costs of providing pension benefits under the scheme.
- 8.12 As a result of the valuation, the employer contribution rate from 1 April 2014 will be 14.3 per cent, and increase of 0.3 per cent on the current employer contribution rate. There will potentially be further pension pressures in 2016 onwards with the end of contracting out of the second state pension as a result of the introduction of the new state pension from April 2016, which will mean an increase in national insurance contributions for both employees (1.4 per cent) and employers (3.4 per cent). These changes will not have an effect before the next Spending Review.

¹⁶ See Chapter 4 of

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345789/NHSPS_Update_Document.pdf

¹⁷ <https://www.government/publications/nhs-pension-scheme-actuarial-valuation>

Review into working longer

8.10 The NHS Pension Scheme Proposed Final Agreement included the provision that in the new scheme, for pension accruals post 2015, the Normal Pension Age (NPA) should be set equal to the State Pension Age (SPA). This reflects the requirements of the Public Service Pensions Act 2013. Since September 2012 there has been an on-going tripartite review involving the Department of Health, NHS Employers and the NHS trade unions to address the impact of working longer in the NHS, with particular reference to staff working on the frontline and those with physically demanding roles, including the emergency services. This is known as the Working Longer Group (WLG), which delivered its initial report to the Department of Health in March 2014. The Working Longer Steering Group will continue to meet regularly. More information on the group can be found on the NHS Employers website¹⁸. The overall aim of the working longer review was to identify and share examples of good practice that will enable staff to continue working to SPA, the March 2014 report delivered a number of recommendations in this regard.

Review on access

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

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

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

8.13 The wider access review, included in the Proposed Final Agreement, was NHS specific and was developed in partnership with the DH, HMT, Trade Unions, Independent Sector and NHS Employers – building on the new Fair Deal provisions. The review resulted in additional provision within the NHS Pension Scheme, from 1 April 2014, allowing independent providers (IPs) of NHS clinical services with an APMS contract or a NHS

¹⁸ <https://www.nhsemployers.org/your-workforce-/pay-and-reward/pensions/impact-of-working-longer-review/working-longer-review-steering-group>

Standard Contract – including services procured under ‘Any Qualified Provider’ – to enrol eligible employees in the NHS Pension Scheme. IPs are able to choose from two levels of access, or to maintain the default position where they comply with the new Fair Deal only.

Changes in employee pension contributions

- 8.14 Even with the increases in employee contribution rates implemented across the last three years, the NHS Pension Scheme remains an excellent investment for retirement. The Government Actuary’s Department calculate that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.
- 8.15 It should also be borne in mind that if members choose to leave the scheme they will lose the NHS employer contribution to their pension – currently 14 per cent. Members would also give up their death-in-service benefits which may mean needing to review their life insurance arrangements.
- 8.16 In determining the distribution of contribution increases, a key Government objective is to limit any commensurate increase in instances of members choosing to opt-out from the scheme. Consequently the Department has continued to review opt-out data from the scheme administrators to evaluate the impact of the first, second and third year of increases which have been applied from 1 April 2012. Trade Unions and NHS employer representatives have also reviewed this data. The evidence shows that there has been no significant change, and staff continue to value membership of the scheme.
- 8.17 High earners are likely to benefit from higher rate tax relief on their pension contributions. This meant that before contributions were raised in April 2012, members with full-time earnings over £60,000 actually paid a contribution rate that was lower than colleagues who earned half that amount, once tax relief had been taken into account.
- 8.18 Net of tax relief, the proposed 2014-15 contribution rates mean that a doctor on a salary of £80,000 will only actually contribute 0.66 per cent more than a nurse earning £30,000. The Department does not consider this a disproportionate outcome for high earners. See table 8A.

Table 8A - 2014-15 contributions after tax relief (net)

Full-time pay	2013-14 contribution rate net of tax relief	2014-15 contribution rate net of tax relief	Net contribution rate increase (percentage points)	Additional cost (£ per month)
£10,000	4%	4%	0%	0
£15,000	4%	4%	0%	0
£20,000	4.24%	4.48%	0.24%	4
£25,000	5.44%	5.68%	0.24%	5
£30,000	7.2%	7.44%	0.24%	6
£40,000	7.2%	7.44%	0.24%	8
£60,000	6.78%	7.5%	0.72%	36
£80,000	7.38%	8.1%	0.72%	48
£130,000	7.98%	8.7%	0.72%	78

Chapter 9: supplementary evidence

- 9.1. The DDRB has raised a number of follow up questions to the evidence submitted in September 2014. Our responses to the additional questions are set out below.

Questions relating to the DDRB report 2013

- 9.2. **Please respond to the request from last year's report to consider the seniority payment schemes for both GMPs and GDPs to assess their compliance with age legislation and to make changes where necessary, and to report back.**
- 9.3. **General Dental Practitioners (GDPs)** – Seniority payments for GDPs were abolished in 2011. Transitional arrangements were put in place. Those who met the criteria and were eligible at the time continue to receive seniority payments. However, as there are no new entitlements, seniority payments will disappear eventually as the current recipients reach retirement.
- 9.4. **General Medical Practitioners (GMPs)** – The seniority pay scheme was closed to new entrants from 1 April 2014, and will be abolished entirely from 1 April 2020. The GPC and NHS Employers will monitor annual reductions in expenditure on seniority pay from 2014/15 onwards and, to the extent that annual reductions fall short of a 15% annual reduction, will agree action in the following year to achieve this reduction. Funding will be re-invested into 'global sum' which is the amount paid to a GP practice per each patient that is registered with them. We believe this is a fairer system of funding.
- 9.5. **Please respond to the request from last year's report to consider whether there are any discrimination issues linked to the length of pay scales for any of DDRB's remit groups, and if there are, how they are to be addressed.**
- 9.6. The remit to Government has set for the DDRB to make recommendations this year is limited to contractors (GMPs and GDPs) in England. Therefore we have only provided evidence relating to those groups that fall within the remit.

Questions relating to the BMA evidence

- 9.7. **In its evidence, the BMA is seeking a common recommendation for all doctors, wherever they work. You are therefore invited to submit evidence covering all groups in order for DDRB to consider this request.**
- 9.8. The remit the Government has set for the DDRB to make recommendations this year is limited to contractors (GMPs and GDPs) in England. Therefore we have only provided evidence relating to those groups within the remit.
- 9.9. **The BMA has called for a debate on health service funding, focussing on how to reconcile increasing demand with universal and comprehensive care, without targeting the terms and conditions of NHS staff. It comments that doctors are being asked to work increasingly longer hours and more intensely, but without any recognition or compensatory reward, and further on top of continuing real terms pay cuts. How do you respond to these points?**

- 9.10. The remit for the DDRB to make recommendations this year is limited to contractors (GMPs and GDPs) in England. Therefore we have only provided evidence relating to those groups within the remit.
- 9.11. In relation to general practice and primary care, we recognise the hard work that GPs do. Our publication, *Transforming Primary Care*, sets out our vision for more proactive, personalised, joined-up care. We made significant changes to the GP contract for 2014/15 to reduce unnecessary bureaucracy and to free up time to allow GPs to provide more proactive, holistic care, particularly for older people and those with more complex needs. We removed a substantial number of targets in the Quality and Outcomes Framework that GPs told us were getting in the way of providing holistic care for patients. Furthermore, we introduced named, accountable GPs for everyone aged 75 or over to promote greater continuity of care.
- 9.12. We have reached a negotiated settlement for the 2015/16 GMS contract which will mean that everyone in England, including children, will get a named GP personally accountable for co-ordinating proactive, tailored care to their physical and mental needs. In addition, more patients will be able to book appointments and order repeat prescriptions online and patients will be able to access their medical records online.
- 9.13. We have invested £50 million this year through the Prime Minister's Challenge Fund to help over 1100 practices, covering 7.5 million people, to develop new ways of improving GP access, including 8am to 8pm opening seven days a week and greater use of telephone, email and video consultations. We have committed to invest another £100 million into the scheme next year.
- 9.14. Through the £3.8 billion Better Care Fund, we are also ensuring that clinical commissioning groups (CCGs) and local authorities work together to invest in a range of community-based services that will work alongside GPs to provide more integrated health and care services. This will take place next year. To make early progress, £200 million has been made available this year to local authorities to implement their integration plans.
- 9.15. Finally, we are also working closely with HEE, NHS England and the professions to improve recruitment, retention and return to practice, both for GPs and for other key parts of the local workforce such as community nurses. HEE will ensure a minimum of 3,250 trainees per year enter GP training programmes in England by 2016. This equates to approximately half of the annual number of trainees completing foundation training and moving into specialty training.
- 9.16. NHS England published its 5-year Forward View¹⁹ in October 2014. We welcome the contribution the Forward View makes to this discussion and look forward to working with NHS England and its partners to ensure that the NHS can meet the challenges it faces over the next five years and beyond.

¹⁹ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

- 9.17. **The BMA argues that the continuation of tiered contributions in a CARE pension scheme undermines the principle of collective provision. How do you respond to this point? Are there any plans to further discuss contribution rates? (Also mentioned as an issue by the BDA)**
- 9.18. In the short-term, 70% of active member liabilities will be associated with members who will remain in the existing final salary scheme under the transitional protection arrangements. There will also be significant numbers of members with a protected final salary link who move into the 2015 scheme. For these reasons, the retention of the tiered employee contributions structure up to 2019 is appropriate. A commitment has been made to stakeholders to reconsider the contribution structure from 2019 as this percentage, and the associated liabilities, begin to reduce.

Questions relating to the BDA evidence

- 9.19. **Are you able to provide us with a comprehensive list of reimbursements?**
- 9.20. The individual rate for units of dental activity which is included in contracts between commissioners and providers of dental services is set locally and depends on local need and circumstances. The only exception to this is the non-domestic rates where contractors are entitled to receive reimbursement of payments in respect of its non-domestic rates for practice premises. The Department does not therefore hold a list of expenses and reimbursements centrally.

Questions relating to the Health Education England evidence

- 9.21. **What is the take up of the additional GMP training places? What is the conversion rate for GMP trainees to GMP placements?**
- 9.22. It is the responsibility of Health Education England (HEE) to plan and develop strategy for training and recruiting trainees within the primary care workforce to meet the service needs. Across the UK, 89.3% of GMP training posts have been filled and in England 87.6% of the GMP training posts have been filled.
- 9.23. The Department is working closely with HEE, NHS England and the professions to improve recruitment, retention and return to practice, both for GPs and for other key parts of the local workforce such as community nurses. HEE will ensure a minimum of 3,250 trainees per year enter GP training programmes in England by 2016. This equates to approximately half of the annual number of trainees completing foundation training and moving into specialty training.
- 9.24. **What is the DH view on the question posed by HEE: at what rate do we need to grow the GP workforce to meet forecast demand? How do you respond to the comment on the lack of a compelling narrative on the future demand for GMPs?**
- 9.25. Transforming Primary Care sets out our vision for more proactive, personalised, joined-up care. It also sets out an expectation of 10,000 more staff available to primary and community care. This plan needs to be responsive to ensure the appropriate mix of staff, but we are planning for at least 5,000 more GPs by 2020.

- 9.26. NHS England, in its Five Year Forward View, set out the future direction for primary care and the key role it will play in delivering healthcare. HEE is leading a review of the primary care workforce which will consider new skill sets for delivering services in primary care, including general practice. This review will inform plans for future demand for GMPs and other primary care staff.

Questions relating to the Department of Health evidence

- 9.27. **Some of last year's recommendations by DDRB were rejected on the basis of "the continuing need for pay restraint right across the public sector to support fiscal consolidation, together with the unprecedented financial challenge facing the NHS...#157; (DH remit letter, 26 August 2014). How do you square that position with the public statements about increasing access to the NHS, the continuing growth of the workforce already in the pipeline and possibly in excess of those numbers?**
- 9.28. The Government has made it clear that its main priority is to protect numbers of front-line staff delivering high quality patient care. It decided that accepting the recommendations of the NHS PRB and DDRB for the pay of NHS staff in 2014/15 would put front-line jobs at risk and therefore took the difficult decision that staff would receive an award worth at least 1% either through increments or a non-consolidated 1% but not both. Pay restraint continues to be an essential part of the Government's strategy for fiscal consolidation and the delivery of high quality patient services on a sustainable basis.
- 9.29. **Are you able to provide a separate analysis of the paybill per FTE drift for the DDRB remit groups?**
- 9.30. Table 9A sets out the estimated paybill per FTE Drift for specific Hospital and Community Health Services (HCHS) Medical Staff Groups.

Table 9A: estimated paybill per FTE Drift for Specific Hospital and Community Health Services (HCHS) Medical Staff Groups

	Estimated Paybill per FTE Drift 2012/14
Consultants (including Directors of public health)	0.4%
Registrars	-1.0%
Other doctors in training	-2.8%
Hospitals practitioners & clinical assistants	3.6%
Other medical and dental staff	0.6%
Locums	-0.4%
All HCHS Doctors	0.2%
Excluding Staff Group Mix	-0.2%

Notes –

Paybill per FTE Drift is the growth in average paybill per FTE in excess of the headline pay award. Pay point mix of staff within occupational groups; changes in additional earnings (non-basis pay) patterns; and employer on-cost effects.

As such, paybill per FTE drive reflects movement in average paybill per FTE and does not solely reflect the earnings growth of individuals. For example, the recruitment of new consultants to the bottom of the payscale will depress average salaries and offset some of the effects of salary progression for existing staff members. Similarly, relatively strong growth in the numbers of staff in a relatively high earning staff group, such as consultants, increases average salaries and paybill per FTE drive. The data provided is primarily based on earnings and staff number information published by the Health and Social Care Information Centre. This is supplemented with unpublished data, from the Electronic Staff Record, to estimate the employer on-cost component of average paybill. It includes HCHS dentists as part of the HCHS medical staff.

9.31. Can you breakdown the 10,000 into the different staff groups?

9.32. HEE's review of the primary care workforce will involve detailed work to consider the skill sets to deliver different models of care. HEE will align this work with emerging proposals from key initiatives, for example, Shape of Training Review and the Shape of Caring Review led by Lord Willis. More detail of the different staff groups will be available when this work is progressed.

9.33. Please keep us informed on what strategies emerge for improving recruitment, retention and return to practice.

9.34. The Department is exploring with other national stakeholders how recruitment, retention and return to practice can be improved. This may include, for example, supporting GPs to return from a career break.

9.35. We are concerned that another year has passed without a resolution to the ongoing question of the GMP trainer's grant. What is your current timetable for

resolving this issue? What is your proposal for uplifting the GMP trainer's grant for 2015-16?

- 9.36. Initial proof of concept work to test and improve the costing methodology was completed early this year. Since then HEE, on behalf of the Department, has been trying to widen the testing of this methodology and pilot it in different areas of England. Despite involving three Local Education and Training Boards it has been difficult to engage practices in this process and get feedback.
- 9.37. HEE is continuing to work with GP practices to pilot the cost collection over the next six months. This timetable is contingent on securing the engagement of further GP practices and HEE is pursuing different ways of doing this. The cost collection work will be used to establish transitional tariffs which reflect the relative costs of different types of placement, for example undergraduate medical students versus GP specialist registrars.
- 9.38. The Department's proposal is that the GMP trainer's grant for 2015/16 should be subject to the same adjustment as the tariff that applies to placements in secondary care.

Annex 1: Chief Secretary to the Treasury Letter to DDRB

OFFICIAL



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

Review Body Members
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

31 July 2014

Dear Review Body Members

PUBLIC SECTOR PAY 2015-16

I would like to thank you for your work on the 2014-15 pay round. I am strongly convinced of the role of the pay review bodies in determining national pay awards in the public sector and appreciate the important part the pay review bodies have played over the last four years. For a number of review bodies this has included providing expert advice and oversight of wider reforms to pay policy and systems of allowances, in addition to the annual award. I am confident the changes brought about by the pay review body recommendations in these areas are making a significant contribution to the improvement and delivery of public services.

2. You will have seen that for the 2014-15 pay round there were some review body recommendations which, after careful consideration, the Government decided were unaffordable at this time. I hope you will appreciate this was a difficult decision and that the Government continues to greatly value the contribution of the pay review bodies in delivering robust, evidence-based pay outcomes for public sector workers.

OFFICIAL

OFFICIAL



3. The Autumn Statement of 2013 highlighted the important role in consolidation that public sector pay restraint has played. The fiscal forecast shows the public finances returning to a more sustainable position. However, the fiscal challenge remains and the Government believes that the case for continued pay restraint across the public sector remains strong. Reasons for this include:

a. Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

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

4. As you are aware, for 2014-15 the Government adopted an approach by which all staff in the NHS received at least an additional 1% of their basic pay. All staff not eligible to receive incremental pay have been given a 1% non-consolidated payment in 2014-15. Other staff will have received an increase worth at least 1% through incremental progression.

5. Unfortunately, the NHS trade unions are not prepared to negotiate an affordable alternative, although we are still open to new proposals. Therefore it is our intention to take the same approach in 2015-16. As a result, the DDRB will not be asked to make recommendations on a pay award for employed doctors and dentists in the 2015 pay round.

6. I note that the DDRB would welcome a proactive and systematic approach to considering contractual issues at an appropriate stage of the consultant and doctors in training negotiations and we will consider taking up

OFFICIAL

2

OFFICIAL



this offer, subject to progress in the negotiations. The Department of Health will write at an appropriate juncture with more details. They will also set out the remit for independent contractors in the usual manner.

7. I look forward to your reports, and reiterate my thanks for the invaluable contribution made by the Review Body on Doctors' and Dentists' Remuneration during the course of this Parliament.

A handwritten signature in black ink, which appears to read 'Danny Alexander', is written over a faint, illegible typed name. The signature is fluid and cursive.

DANNY ALEXANDER

OFFICIAL
3

Annex 2: DDRB Remit Letter



Department
of Health

*From Dr Dan Poulter MP
Parliamentary under Secretary of State for Health*

*Richmond House
79 Whitehall
London
SW1A 2NS*

Tel: 020 7210 4850

Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 8
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE

26th August 2014

POC5000882726

Dear Paul,

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander, on 31 July 2014 confirming the Government's approach to the 2015/16 pay round.

I should first wish to add my own thanks to that of the Chief Secretary for the robust and independent advice that the Government receives from the Review Body on Doctors' and Dentists' Remuneration (DDRB). I can assure you that we value this advice very highly and attach considerable importance to the role of the DDRB, informed as it is by expert, impartial and independent judgement. This is true even where, as in the previous review round, the continuing need for pay restraint right across the public sector to support fiscal consolidation, together with the unprecedented financial challenge facing the NHS, meant that we are not able to accept your recommendations in full.

As the Chief Secretary signalled in his letter, following the Government's announcement of a two year pay settlement for employed doctors and dentists in England, the DDRB is not required to report or to make recommendations or observations for the 2015/2016 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

This two year settlement does not apply to independent contractors.

NHS England will shortly be commencing discussions with the BMA General Practitioners Committee on potential improvements to the 2015/16 General Medical Services contract, and with the BDA General Dental Practice Committee on potential improvements to the contractual framework for general dental services. Whilst it is always possible that such discussions may result in an agreed approach to uplift, we are proceeding on the assumption that DDRB will make recommendations on uplifts for both contractor groups. If that position changes as a result of negotiations, we will of course let you know as soon as possible.

The DDRB is, therefore, invited to make recommendations on appropriate uplifts for the two contractor groups. We would particularly welcome DDRB's recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay, in the context of public sector pay policy for 2015/16. The Government will make the final decisions on the gross uplift for GMS and dental contracts in the light of the DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

As the Chief Secretary indicates, the case for continued pay restraint across the public sector remains strong. Whilst public finances are returning to a more sustainable position as the UK economy begins to grow again, we continue to face a considerable fiscal challenge. Pay restraint in the public sector remains a necessary part of the Government's consolidation plans, helping to ensure that public sector jobs are protected and that the quality of public sector services are supported.

This year, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy. Separate detailed evidence will be provided by NHS England's independent primary care contractors. As always, while DDRB's remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay review round and to communicate this to you directly.

I look forward to receiving your report on independent contractors early next year.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Dan Poulter', with a long horizontal line extending to the right.

Dr Dan Poulter

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

Annex 3: Summary of benefits, and comparison of the earlier schemes with 2015 NHS Pension Scheme

Feature or Benefit	1995		2008		2015
	Officers	Practitioners	Officers	Practitioners	All staff
Staff group	Officers	Practitioners	Officers	Practitioners	All staff
Method	Final Salary	CARE	Final Salary	CARE	CARE
Accrual rate	1/80 th	1.4% of uprated earnings per year	1/60 th	1.87% of uprated 50earnings per year	1/54 th
Retirement Lump Sum	3 x pension plus optional further commutation up to HMRC limit	3 x pension plus optional further commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit
Normal Pension Age	60 (or 55 for special classes)	60	65	65	SPA
In-service earnings revaluation	N/A	Pensions Increase + 1.5%	N/A	Pensions Increase + 1.5%	CPI + 1.5%
Deferred benefits revaluation	Pensions Increase	Pensions Increase	Pensions Increase	Pensions Increase	CPI
Member Contributions	5% - 14.5% depending upon level of pensionable pay or earnings		5% - 14.5% depending upon level of pensionable pay or earnings		5% - 14.5% depending upon level of pensionable pay or earnings
Death in service	2 x pensionable pay or average annual earnings		2 x reckonable pay or average annual earnings		Same as 2008 section
Survivor benefits	Spouse & partner pension based on accrual of 1/160 th		Spouse & partner pension based on accrual of 1/160 th		Same as 2008 section
Retirement flexibilities	None. Full retirement from NHS service required before pension can be paid. Unable to re-join the scheme once benefits have been taken.		Early/late retirement factors on an actuarially neutral basis, draw down of pension on partial retirement and ability to retire and return to the scheme		Same as 2008 section
Ill-health retirement	Basic ill-health retirement = no actuarial reduction for early pension payment. Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.		Basic ill-health retirement award = no actuarial reduction for early pension payment. Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.		Basic ill-health retirement award same as 2008 section Higher tier ill-health retirement award = enhance pension by 50% of prospective service to NPA.