

NHS Employers' evidence to the Pay Review Body on Doctors' and Dentists' remuneration 2009/2010

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Contents

NHS Employers key messages to the Review Body	5
1. NHS Employers	6
Who we are	6
About our evidence	7
2. General	8
Affordability	9
Financial position in the NHS	10
Review of Financial Planning and Cost Pressures	11
Efficiency Savings	11
The potential impact of a higher than forecast pay award	13
Pay and Increments	14
Pay implications of the new SAS contract	14
NHS Medical and Dental Workforce	16
NHS Medical and Dental Workforce Earnings	17
Turnover	21
Modernising Medical Careers	23
Staff Satisfaction Survey	24
3. Employer Views	26
Results from our questionnaire	26
London Weighting	28
Conclusion	28
4. Workforce Development	29
NHS Jobs	29
Temporary staffing	30

	Next Stage Review	32
	Staff Attitudes	33
5.	Pension and ill health retirement	37
	NHS Pension Scheme Review	37
	New arrangements	38
	Ill Health Retirement benefits	38
	Impact of Cost Sharing	39
6.	Consultants	40
	Service Improvement Programme	40
	Contract maintenance and guidance	41
	Summary	42
7.	Staff Grades and Associate Specialists	43
8.	Doctors in training	45
	Modernising Medical Careers	45
	Foundation Training	45
	Specialty Training	47
	Future of the Medical Workforce	49
	The effect of Modernising Medical Careers on pay scales	50
	Flexible Training	50
	Banding Supplements	52
	Overall pay	54
	GP Specialty Registrars (GP StRs)	54
9.	Salaried General Medical Practitioners (GMPs)	56

10.	General Medical Services	57
11.	Salaried primary care dental services	58
	Acceptance and implementation of new contractual arrangements	58
	Change to negotiating forum and contract maintenance	58
	Salaried dentist numbers and retention	58
12.	General Dental Practice Services	61
	Introduction	61
	NHS Employers recommendations	61
	2008/9 award	61
	Management of historic contracts	61
	Impact on planned investment in services	62
	Access to Dental Services	62
	Opportunities to expand services	62
	GDP earnings	63
	Impact on salaried primary care dental services	63
	Passing on pay increases	64
	Practice Expenses	64
Annex A	Pay Review Body questionnaire	65
Annex B	Review of NHS cost pressures and financial planning	74
	2009/10-2010/11	

NHS Employers key messages to the review body

- **The whole reward package needs to be considered - including pensions, tangible and non-tangible rewards - with regard to its effectiveness in enabling the NHS to recruit the correct number of staff, the correct skill mix of staff and the correct application of those skills, to do all the things required of the service.**
- **Employers views are therefore based on three key areas: recruitment and retention; financial considerations, linked to the tariff; and staff morale.**
- **Recruitment and retention are generally stable in relation to doctors and dentists, suggesting that the pay system is largely fit for purpose and needs only limited changes.**
- **Relative to colleagues in other occupations in the NHS doctors and dentists are more satisfied with the circumstances of their employment.**
- **Employers want an award that is fair to staff but also recognises the need for organisations to achieve financial balance.**
- **Employers believe that an award of 2% would be affordable, providing there is a corresponding uplift in the tariff for 2009/10, for directly employed doctors and dentists.**
- **Employers believe that there should be no uplift to the gross contract values in General Dental Services.**
- **Employers feel strongly that any unfunded increases in earnings would lead to cost savings elsewhere and potentially impact on patient services and care, jeopardising the local delivery of the overall NHS strategy.**
- **Employers would welcome a multi-year award for doctors and dentists to the end of the Comprehensive Spending Review (CSR) period, to give stability and predictability for employers and staff.**
- **In relation to the General Medical Services, NHS Employers will, in agreement with the British Medical Association (BMA) and Department of Health (DH), submit evidence in November.**
- **Our evidence is based on the views of NHS organisations – gathered through hundreds of employer engagement activities across the past year, regional HR networks, focus group activity and a questionnaire – and NHS Employers policy board.**

1. NHS Employers

Who we are

- 1.1 NHS Employers is the arm of the NHS Confederation responsible for workforce and employment issues. It is the voice of NHS organisations in England and delivers a range of services to other UK countries in respect of the NHS.
- 1.2 Nationally, NHS Employers provides advice and support to employers and shares information and best practice in order to help the NHS provide better care for patients. The work of NHS Employers helps employers in the NHS to recruit, retain and develop the numbers and skill mix of staff required to deliver excellent services, treatment and care, while improving the working lives of staff working in the NHS. While part of the NHS Confederation, NHS Employers has its own distinct governance arrangements, director, policy board and assembly. NHS Employers has four key roles:
 - negotiating on behalf of employers
 - representing employers
 - supporting employers
 - promoting the NHS as an employer of excellence.
- 1.3 Workforce and employment issues are of key importance to the overall strategy of the NHS and form an intrinsic part of wider service issues. NHS Employers was set up to ensure that the service itself drives the workforce agenda, and so employers in the NHS drive the work of NHS Employers. We represent the views of employers within the NHS in England, including foundation trust views, and act on their behalf in the following:
 - pay and negotiations
 - planning the workforce
 - workforce productivity
 - employer of excellence
 - HR policy and practice
 - the workforce implications of system and structural reform.
- 1.4 The Department of Health remains responsible for developing policy standards for the health and social care workforce, setting the broad policy framework for the service within which NHS Employers operates.
- 1.5 NHS Employers also provides the 'machinery' for negotiations on a UK basis by way of a secretariat. The Department of

Health in England may have an observer role at pay negotiations while the devolved administrations each attend as negotiating members.

About our evidence

- 1.6 Our aim is to provide authoritative and comprehensive evidence on issues related to the remit of the Doctors' and Dentists' Review Body (DDRB). The evidence is based on information collected from employers in the NHS, via a questionnaire, specifically designed to provide credible and authoritative evidence from employers, and through many hundreds of contacts with the NHS through our networks, reference groups, our own governance structure and dealing with queries and giving advice directly to the service.
- 1.7 This evidence seeks particularly to address issues on funding and an updated report on cost drivers and financial planning is attached at Annex B.
- 1.8 A copy of the letter seeking information and the questionnaire are at Annex A. Around a third of employers of doctors and dentists in the NHS in England responded to our questionnaire. The responses we have received are representative of all types of employers. Discussions were also held with groups of senior staff and at regional meetings.
- 1.9 The evidence has been endorsed by the NHS Employers policy board.

2. General

- 2.1 The purpose of the reward package in the NHS, as for any employer, is to ensure the recruitment and retention of the appropriate numbers of staff, the appropriate skill and knowledge mix among the staff, and the correct quality of application of that skill and knowledge at the correct place and time, to provide the services required.
- 2.2 Reward, of course, is not only about pay rates. It is also about tangible and non-tangible non-pay rewards. It encompasses pensions – deferred wages, conditions of service and how staff are managed. It is about the total reward. In effect, this evidence is about what people do, what they are paid and how they are managed.
- 2.3 The Department of Health has published research as part of the Next Stage Review, looking at what affects staff in the NHS. Based on surveys and group discussions, the research identified factors that matter to staff. Crucial among these were involvement, including being treated with trust, being listened to, understanding the big picture and working together. In effect, what matters to staff is having a worthwhile, supported, resourced job with opportunities.
- 2.4 The findings of the NHS Staff Survey, conducted by the Healthcare Commission in relation to staff satisfaction, are addressed elsewhere in this submission.
- 2.5 While economic conditions have effects on the labour market and on affordability, the primary drive of any recommendations of the Review Body need to reflect the primary drive of any reward strategy in the NHS – that is, to recruit, retain and motivate the appropriate numbers, skill mix and quality of medical and dental staff.
- 2.6 In comparison to other professional jobs in the economy, doctors and dentists are in an occupation on which prevailing economic circumstances have a limited effect since the employment and contracting of doctors and dentists is largely within the NHS in the UK, with only 3 per cent receiving their primary income from other sources, such as those in academic work. Competition with the wider labour market and the wider economic circumstances are not thought to be the primary factors in the recruitment and retention of doctors and dentists.

Affordability

- 2.7 NHS employers recognise that the definitive sources of evidence on the economic context and affordability are HM Treasury and the Health Departments. In advance of the PCT allocations being announced for 2009/10 and the NHS tariff being published, employers will have to take a view on the affordability of their workforce. A key national guidance paper supporting local operational and financial planning for 2009/10 and beyond is expected to be published by the Department of Health during the autumn of 2008 and will include:
- Details of a new formula for the allocation of resources to PCTs
 - Individual PCT allocations for 2009/10 onwards
 - The level of uplift being applied to the national tariff for 2009/10
 - Clarification of key deliverables for 2009/10 and beyond
- 2.8 Whilst awaiting publication of that guidance, local financial planning has been based on best available data and estimates. These have also been used to underpin the analysis in our Review of NHS cost Pressures and Financial Planning in 2009/10 to 2010/11.
- 2.9 The headline revenue settlement announced for 2009/10 in the Comprehensive Spending Review for the 2008/09 to 2010/11 was 6.7 per cent per cent growth. Organisations are expected to deliver 3 per cent in cash releasing efficiency savings which equates to an effective increase of less than 4 per cent.
- 2.10 The financial position of the NHS, together with the current financial positions of NHS trusts, helps form a view on affordability for the sector. Last year, NHS Employers looked at the cost drivers and financial planning assumptions across individual NHS organisations from 2007/08 to 2010/11 for inclusion in their evidence to the Review Bodies in 2008/09. A similar investigation (attached as Annex C) has been undertaken this year to:
- Determine whether the costs or financial planning assumptions have changed since then and;
 - Analyse the latest financial planning assumptions and financial forecasts being made for 2009/10 and 2010/11
- 2.11 It is important to consider the impact of both current and future inflation levels on affordability of any recommendation. Fuel price increases in particular are imposing unexpected costs on

NHS organisations both in terms of running their businesses and in relation to the delivery of goods and services to them. This also led to significant increases to car allowances paid to staff for the first time in 7 years.

- 2.12 According to the Office for National Statistics, the Consumer Price Index (CPI), the Government's target measure of inflation was 4.7 per cent in August, up from 4.3 per cent in July. The main upward pressure came from housing and household services due to a rise in average gas and electricity bills this year, compared with the fall last year. There was a large downward effect from the price of heating oil which fell by more than last year, following a reduction in the price of crude oil. Further large upward pressures came from food and non-alcoholic beverages. There was a large downward pressure from transport costs, mainly due to the price of fuels and lubricants. The future of oil prices over the coming year remains uncertain and since the main upward pressures are from food and non-alcoholic beverages, there are risks associated with food and oil that may increase costs for NHS organisations and put pressure on budgets and hence affordability.

Financial position in the NHS

- 2.13 The final accounts for the end of year 2007/08 show that the NHS delivered an overall surplus of £1,667 million with NHS organisations planning to maintain a contingency at this level for 2008/09 and beyond. Financial returns for the first quarter of 2008/09¹ show that the NHS (excluding foundation trusts) is forecast to deliver an overall surplus of £1.75 billion. As a proportion, this represents just over 2 per cent of total NHS resources. All of the surplus sits with NHS organisations and is intended to provide stability and flexibility to deliver plans for service development, sustainability and enhancement over the next decade, which have been set out by staff and clinicians involved in the Next Stage Review.
- 2.14 Monitor, the independent regulator of foundation trusts, reported on the finances of the 89 authorised foundation trusts to 31 March 2008. It reported a combined net surplus over the twelve month period of £514 million.
- 2.15 The surpluses are non-recurrent and have generally been achieved through short-term measures which will not generate such savings year-on-year. Examples include the postponement of essential investment through temporary delays to patient care initiatives. Such measures cannot be repeated each year due to

¹ The Quarter, Quarter 1 2008/09 NHS Finance, Performance and Operations, Department of Health

the longer-term and permanent impact they would have upon patient care and activity/waiting list targets.

- 2.16 Existing non-recurrent savings are not therefore available for investment in recurrent areas of expenditure, such as staff pay. To do so would generate un-funded recurrent commitments for future years thus returning the NHS to the boom and bust cycle which has contributed to the significant historic deficits seen over recent years.
- 2.17 The financial position and financial management of the NHS continues to improve though and further repayments of historic deficits and strengthening of individual organisations' balance sheets should be expected. This remains dependent upon continued robust management of financial plans and overall control of recurrent commitments. The number of organisations facing a deficit at the end of 2007/08 was five and the overall deficit was £125 million.

Review of financial planning and cost pressures

- 2.18 The 2008/09 analysis, contained within the 2008/09 review body evidence of NHS Employers, was broadly in-line with the current expenditure baselines for all NHS organisations, indicating the robustness of the assumptions and forecasting of organisations.
- 2.19 In summary there were three main factors impacting upon the previous financial planning assumptions being made by most NHS organisations:
- Higher than anticipated financial allocations for 2008/09
 - Additional national commitments linked to Lord Darzi's Next Stage Review
 - An increase in efficiency targets from 2.5% to 3.0%
- 2.20 PCTs previous planning assumptions were for an increase in their centrally allocated revenue resource limits of 3.5% for 2008/09 onwards. The Comprehensive Spending Review proposed an increase in NHS spending by an average of 4% above inflation each year through to 2010/2011. The specific one year allocation announcement for 2008/09 increased PCT allocations in England from £70.35 billion in 2007/08 to £74.20 billion, an actual increase of 5.46%.

Efficiency savings

- 2.21 The Comprehensive Spending Review announcement included confirmation that the minimum expected annual efficiency saving was being increased from 2.5% to 3.0% alongside the expectation of further value for money reforms realising annual

net cash-releasing efficiency savings of at least £8.2 billion by 2010/2011.

- 2.22 NHS organisations contributing to the review of cost drivers and financial planning all stated that the ability to continue to deliver year-on-year marginal efficiency is now significantly diminished and organisations are having to focus on more 'process improvement' to deliver future efficiency savings. Such process improvement, it was stated, generally needs up-front investment to deliver medium to longer-term savings.
- 2.23 Money within the NHS budget is not specifically allocated to spend on annual pay increases. The pay bill at PCT level is met from the overall allocation of funding for PCTs. Resources for trusts come to them via the PbR tariff. As pay is by far the greatest element of expenditure across the NHS, typically 65 – 70 per cent of expenditure within provider trusts, cost pressures against these budgets forms a significant risk to the employing organisation.
- 2.24 Careful consideration must be given to the impact on services of any pay increase not reflected in PCT allocations or tariff. Employers stress that affordability is dependant on an appropriate increase in the tariff for 2009/10 given the confirmed spending plans over the 2008/9 and 2009/10.
- 2.25 The work commissioned on cost pressures on the service indicates likely cost pressures facing NHS organisations include:
- **Impact of 2008/09 pay review body recommendations**
Individual financial plans for 2008/09 included provision for pay awards generally averaging 2.5%. The main actual awards made for 2008/09 varied from 2.2% to 2.75% and the detailed financial impact upon individual NHS organisations will have varied according to their staff mix. For example, those with high levels of Agenda for Change staff, such as ambulance trusts, will have needed to set aside additional financial provisions as a result of their overall cost of pay awards being above their initial 2.5% assumption.
 - **Uncertainty around the introduction of International Financial Reporting Standards (IFRS)**
From 1 April 2009, IFRS are being introduced to all public sector organisations. These may require organisations to include assets funded through private finance to appear on individual organisations' balance sheets. These could be subject to annual depreciation charges to reflect the

decline in assets' worth and a capital charge, currently set at 3.5%, to reflect the opportunity cost of tying up public resources.

2.26 Additional factors for 2009/10 and 2010/11 have been identified as creating particular cost pressures in 2009/10:

- The continued achievement of waiting time targets such as the 18 week referral to treatment target and 2 week cancer waiting time targets
- Introduction of the new SAS contract - the new contract was introduced on 1 April 2008. In 2009/10, organisations will face costs of £76m due to the contract's implementation
- Rises in referral levels during the first quarter of 2008/09 of generally between 15% and 20%
- Pay progression – individuals are awarded annual increments over and above their annual pay award. Most organisations recognise that this effect will only last until the effect of staff turnover and “churn” offsets the cost of annual increments being awarded. However, the introduction of new contracts during 2003 and 2004 for most NHS staff, including Consultants, means that this process is still being felt.
- The double impact of fuel price rises through rising staff mileage rates as well as a significant rise in energy prices for what is traditionally a large, geographically dispersed and varied estate. Revisions to mileage allowances alone will create an additional cost pressure of £17 million
- Inflation in the cost of fuel, drugs, food and other goods and services has put significant pressure on affordability.
- European Working Time Directive (EWTD) – some provider organisations pointed to cost pressures from the impact of the EWTD upon junior doctors' hours.
- VAT now payable on agency staff under Employment Agencies Act
- Agenda for Change multi-year deal, year two arrangements – 2.54 per cent cost pressure on the NHSPRB pay bill due to agreed 2.45 per cent uplift to the pay scales in addition to the removal of the minimum point on the pay scale and additional increases to pay points in bands 5 and 6.

The potential impact of a higher than forecast pay award

2.27 The ability of NHS trusts to fund a pay award in excess of the levels incorporated within existing financial plans varies between

sectors.

- 2.28 All organisations should expect to, and have indicated, that small variations in pay awards from planned levels would generally be manageable within day-to-day operational contingencies as was the case with the slightly higher level of 2008/09 award.
- 2.29 However, the majority of acute, mental health and ambulance trust income is determined actually or notionally by the nationally set tariff uplift. Therefore such organisations face a significant risk that future pay awards for NHS staff will be higher than accounted for in the tariff uplift and a large additional cost pressure would be created for those organisations unless, as is not traditionally the case, the rate of tariff uplift is revisited.
- 2.30 Significant increases to future pay awards would therefore require the revisiting of operational financial plans and the potential for direct patient care, service quality or nationally set access targets to be jeopardised. In this respect, as an indication only, a 1% variation in anticipated pay awards would predominantly absorb many trusts total operating contingencies and working capital reserves without any consideration for other in-year financial risks arising.
- 2.31 PCTs however, advised that the level of financial exposure associated with annual pay awards is not as great for PCTs as it is for other NHS organisations. This is due to the fact that direct pay costs only account for approximately 10% of a typical PCTs expenditure baseline. PCTs with a large provider arm will have a greater exposure against direct pay costs but certainly not at levels of between 65% and 80% as seen with acute, mental health and ambulance trusts.

Pay and increments

Pay implications of the new SAS contract

- 2.32 The new contract for Staff and Associate Specialist (SAS) doctors applies to over 2000 WTE associate specialists, approximately 5,000 staff grades and 1,600 other staff grade doctors. The implementation date for the new contract was 1 April 2008 and it is anticipated that the transfer of existing SASC staff will take place during the financial year 2008/09. Under the new contract, specialty doctors have access to incremental scales, worth 5 to 10 per cent and associate specialists 3 to 9 per cent. An increase is also received on 1 April for the first 2 years that relates to the contracts' implementation.

2.33 Specialty doctors will receive:

- An average increase on basic pay of 5 per cent in 2008/09 and 2009/10, solely as a result of the new contract's implementation. Depending on current incremental points, individual increases will range from 4 to 8 per cent in year one and 2 to 6 per cent in year two
- An average increase in 2008/09 of 6.6 per cent and 8.8 per cent in 2009/10 as a result of the increases awarded as part of the new contract implementation and incremental progression. Individual pay increases will range from 3.7 per cent to 13.5 per cent in year one and 2.1 per cent to 14.8 per cent in year two.

2.34 Associate specialists will receive:

- An average increase on basic pay of 1.8 per cent in 2008/09 and 3.5 per cent in 2009/10, as a result of the new contract's implementation alone. Depending on current incremental points, individual increases will range from up to 4.6 per cent in year one and up to 9.1 per cent in year two.
- An average increase in 2008/09 of 2.6 per cent and a further 1.6 per cent in 2009/10 as a result of the increases awarded as part of the new contract implementation and incremental progression. Individual pay increases will range from up to 13.1 per cent in year one and up to a further 4.4 per cent in year two.
- These figures do not include the increase received due to the re-basing of the contract from 38.5 to 40 hours in the new contract which results in a 4 per cent increase.

2.35 These figures do not include any future headline pay awards and percentage increases relate to increases on 2008/09 salaries prior to transfer to the new contract.

Increments

2.36 All hospital doctors continue to have access to incremental pay scales. For newly appointed consultants these increments are worth an average of 4 per cent of basic pay, excluding any clinical excellence awards.

2.37 In the financial year 2010/2011, specialty doctors and associate specialists will have access to incremental progression every year or once every two or three years, depending on their position along the pay spine.

2.38 Doctors in the SAS grades benefit from average increments of between 3 and 10 per cent of basic pay.

- 2.39 Doctors in training grades receive incremental increases of between 4 per cent and 8 per cent.
- 2.40 It is important that these additional increases in basic pay are factored into decisions about the recommended level of uplift.

NHS medical and dental workforce

- 2.41 The total NHS workforce decreased for the first time since 1997 in 2006 and decreased again in 2007 by 0.6 per cent. The total headcount was reduced by 7,670. Of 1.2 million HCHS staff employed in the NHS, 94,638 are doctors, making up 8 per cent of the workforce.
- 2.42 Against this background, the medical and dental workforce continued to grow during 2007, although at a slower rate than in previous years. There were 87,533 FTE HCHS medical and dental staff in September 2007, compared to 85,975 in 2006. These figures show an increase of 1,588 FTE or 1.8 per cent. Since 1997, the number of FTE HCHS medical and dental staff has increased by 53 per cent from 57,099
- 2.43 Figures for consultants showed that there were 33,674 consultants, the highest figure ever but that the growth rate had slowed from an average annual rate of 2.4 per cent over the previous 10 years to 1.1 per cent from 2006 to 2007. The slowest growth rate was seen in the doctors in training cohort which increased by 1.1 per cent compared to an average rate of 4.4 per cent over the preceding 10 years. The reduced rate of growth does not arise from a reduction to the supply of doctors but a change in the length of time a doctor spends in training. The number of English medical school graduates has increased year-on-year since 2001/02 and is expected to reach 5,800² in 2008/09.
- 2.44 Over the last ten years the number of associate specialists and staff grades has increased by an average of 8 per cent and 9 per cent respectively. In 2007, associate specialists increased by 7.7 per cent and staff grades by 2.0 per cent. The continued growth in the associate specialist workforce is due to the introduction of the new SAS contract and the closure of the associate specialist grade which will take place at the end of 2008/09.

² Higher Education Funding Council <http://www.hefce.ac.uk/aboutus/health/numbers.htm>

NHS medical and dental workforce earnings

- 2.45 The NHS Information Centre produces a quarterly publication of NHS Staff Earning Estimates which show a breakdown of medical workforce earnings by staff group, taken from the Electronic Staff Record (ESR). Roll out of the ESR is now complete and the most recent data represents 99 per cent NHS organisations.
- 2.46 Changes in the average earnings by staff group can be due to actual increases in individuals' pay due to pay awards and incremental progression or changes in the composition of the workforce due to pay reforms and/or the impact of new organisations joining the sample. A separate analysis of earnings has shown that some of the changes in earnings are due to changes in the sample rather than true changes in average salary.
- 2.47 The following figures are taken from the NHS Staff Earnings Estimates in June 2008. They represent basic pay and total pay from the first quarter in 2008 and comparisons are made with the same quarter of 2007 in Table 1.
- 2.48 Foundation year 1 trainees receive an average basic salary of £21,600 and their average total earnings are £31,500. These figures show an average additional earnings equivalent to £9,900 or 46 per cent of basic pay. Their average basic pay has increased by 3.3 per cent since the previous year whilst total earnings have gone down by 1.3 per cent. The reduction in total earnings is probably due to a reduction in the banding supplements, reflecting the 48-hour working week limit introduced through the Working Time Regulations.
- 2.49 Foundation Year 2 staff receive an estimated basic pay of £29,100 and total pay of £43,000. These figures equate to average additional payments of £13,900 or 48 per cent of basic pay. Figures from the first quarter of 2007 show a reduction in average earnings of 1.7 per cent and 6.3 per cent in basic and total pay, respectively.
- 2.50 Specialty Registrars earn an average basic salary of £36,200 and an average total salary of £56,100. The estimated average additional earnings for this group add 55 per cent to their basic pay. These figures show a 5.5 per cent and 6.5 per cent reduction on the 2007 figures.
- 2.51 Apparent reductions in the average salaries of FY2/SHO and Registrar grades are not the result of real reductions in earnings. Implementation of the Modernising Medical Careers programme has resulted in most staff transferring from the SHO to the

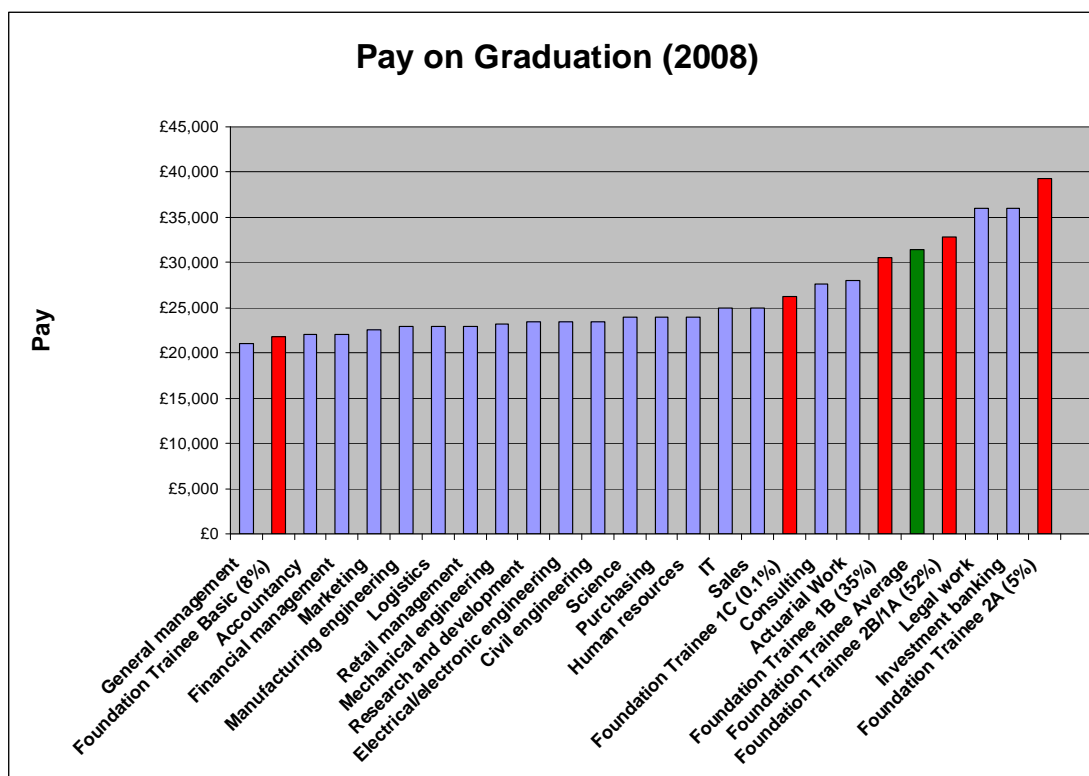
Registrar pay scales. The resultant effect of this has been to reduce the average earnings of both the FY2/SHO group and Registrar staff groups in the earnings estimates. A better indication of individual increases received by doctors in training is given by the annual pay awards and increments received as set out above.

- 2.52 Associate specialists have a mean basic salary of £73,000 and a mean total salary of £79,400. This figure represents an increase of 9 per cent on basic pay or an average £6,400 in additional earnings. The median salary is higher than the mean basic and total pay suggesting a positive skew in associate specialist earnings. Staff grades are estimated to earn a basic salary of £56,100 and an additional 10 per cent in additional pay. Their average total earnings equate to £61,900. Individual comparable figures for staff grades and associate specialists do not exist from the previous year but when grouped together, staff grade and associate specialist salaries have increased by 4.7 per cent in basic pay and 6.6 per cent in total pay over the twelve month period from the first quarter of 2007.
- 2.53 There are two types of contractual arrangements in place for consultants, referred to as “2003” and “pre-2003”. 93 per cent of Consultants are being paid on the 2003 contract. The mean total earnings of consultants is estimated at £115,400, for those on the 2003 contract and £98,900 for those on the pre-2003 contract, including Clinical Excellence Awards. These figures are payments received from NHS organisations only and do not include private earnings or earnings of Consultants paid by universities. For those on the new contract, the total earnings have increased by 3.3 per cent over the year from the first quarter of 2007 to the same period in 2008, reflecting the pay award and increments. Analysis of the data has shown that the figures presented are a true reflection of the increase in earnings and are not skewed due to changes in the ESR sample. The increase exceeds the pay award reflecting increment increases.
- 2.54 Doctors earnings were compared to national levels of pay across the private and public sectors and across other professional groups in the DDRB 37th report, 2008. Doctors’ and dentists’ remuneration compared favourably with other professional groups, excluding actuaries who were considered a special case due to their financial services sector involvements. It was also noted that the lowest spine point for consultants is in the top 5 per cent of the national pay distribution.
- 2.55 Earnings for foundation doctors in training at the start of their postgraduate medical careers compare favourably with those of graduate recruits in other sectors as is illustrated in graph 1

- 2.56 Average earnings, excluding bonuses, rose by 3.7 per cent in the year to July 2008, unchanged from the three months to June, 2008. Average earnings, including bonuses or regular pay, rose by 3.5 per cent in the year to July, up 0.1% from the previous period.
- 2.57 In the year to July, pay growth (excluding bonuses) in the private and public sector stood at 3.7 per cent. Including bonus payments, private sector growth stood at 3.5 per cent, compared with 3.3 per cent for the public sector.

Grade	Mar-07				Mar-08				Mean % increase on basic pay from additional earnings	Average % change from last year in basic pay	Average % change from last year in total pay
	Mean basic salary per FTE	Mean total earnings per FTE	Mean additional earnings	Mean % increase on basic pay	Mean basic salary per FTE	Mean total earnings per FTE	Mean additional earnings				
Foundation Year 1/House	£ 20,900	£ 31,900	£ 11,000	53%	£ 21,600	£ 31,500	£ 9,900	45.8%	3.3%	-1.3%	
Foundation Year 2/Senior House Officer	£ 29,600	£ 45,900	£ 16,300	55%	£ 29,100	£ 43,000	£ 13,900	47.8%	-1.7%	-6.3%	
Registrar Group	£ 38,300	£ 60,000	£ 21,700	57%	£ 36,200	£ 56,100	£ 19,900	55.0%	-5.5%	-6.5%	
Consultants (Old)	£ 80,800	£ 93,900	£ 13,100	16%	£ 83,600	£ 98,900	£ 15,300	18.3%	3.5%	5.3%	
Consultants (New)	£ 83,200	£ 111,800	£ 28,600	34%	£ 85,900	£ 115,400	£ 29,500	34.3%	3.2%	3.2%	
Associate Specialists	NCF	NCF	NCF		£ 73,000	£ 79,400	£ 6,400	8.8%			
Staff Grade	NCF	NCF	NCF		£ 56,100	£ 61,900	£ 5,800	10.3%			
AS&SG combined	£ 59,200	£ 63,800	£ 4,600	8%	£ 61,998	£ 68,008	£ 6,009	9.7%	4.7%	6.6%	

Table 1: Medical and dental basic and total earnings by grade in March 2007 and March 2008. The table also shows the percentage change over the course of the year



Graph 1: Median salaries across various sectors; the green bar is the median and average for FY1 pay, the red bars the actual pay values for the various bands.

Turnover

2.58 Medical staff turnover statistics³ show that the turnover rate for all medical staff (excluding doctors in training) leaving the NHS was 10.1 per cent from September 2005 to September 2006. Consultants have the lowest turnover rates at 6.3 per cent whilst hospital practitioners and clinical assistants have the highest turnover rate of medical staff groups at 24.8 per cent. 18% of the turnover from the medical and dental workforce was from those aged 60 and over. Turnover rates are shown by medical and dental grade in table 2. The turnover rate for non-medical staff was slightly higher over the same time period at 10.9 per cent.

2.59 The latest survey of absence and labour turnover from the Confederation of British Industry (CBI)⁴ showed that national turnover rates in 2007 were 14.7 per cent. Turnover rates between sectors ranged from 31 per cent in retail to 13 per cent in the public sector. Consultants' and Associate Specialists'

³ Medical staff turnover 2005/06, published by the NHS Information Centre on 31st August 2007
<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-turnover>

⁴ CBI/AXI Absence and Labour Turnover Survey 2008

turnover rates are lower than the overall public sector but rates for other grades of doctors and dentists are higher, reflecting the normal movement expected among doctors in training and doctors undertaking sessional work.

Grade	Turnover from the NHS	Turnover from the NHS and internal turnover
All medical staff (excluding doctors in training)	10.1 per cent	11.1 per cent
Consultants	6.3 per cent	7.3 per cent
Associate Specialists	8.9 per cent	9.4 per cent
Staff Grades	17.5 per cent	18.9 per cent
Senior Dental Officer	13.3 per cent	13.8 per cent
Dental Officer	21.5 per cent	22.6 per cent
Other medical staff	34.9 per cent	35.9 per cent

Table 2: Turnover rates of medical and dental staff from September 2005 to September 2006 by staff grade.

2.60 Vacancies⁵ for medical and dental staff were last published in March 2008 by the NHS Information Centre. The vacancy rate for medical and dental staff, excluding training grades, was 0.9 per cent. This rate has decreased every year since comparable vacancy data became available in 2003 when vacancy rates were 4.7 per cent. The three month vacancy rate for Consultants was also 0.9 per cent. Geographically, the highest rate for medical and dental staff was in the North East SHA (1.6 per cent). For consultants, the highest rates are in the North West and London at 1.3%. The lowest rate was in the West Midlands (0.6 per cent). By specialty, the highest vacancy rates were in Accident and Emergency (2.7% per cent) and Dental (2.3 per cent). The lowest rates were in Anaesthetics and Oncology at 0.4per cent. Specific pockets of high vacancy rates are apparent by specialty at a regional level.

⁵ NHS Workforce Vacancy Survey, 2007. Vacancy rate is the ratio of FTE vacancies to the number of FTE staff in post plus the number of vacancies. The rate is expressed as a percentage.

Staff Group	Vacancy rates in March each year (per cent)					per cent change in 2008
	2004	2005	2006	2007	2008	
<i>All medical and dental staff</i>	4.3	3.1	1.8	1.1	0.9	-0.2
<i>Consultants</i>	4.4	3.3	1.9	1.2	0.9	-0.3
<i>Other doctors and dentists (excluding training grades)</i>	4.1	2.6	1.7	0.7	1.0	0.3

Table 3: Vacancy rates of medical and dental staff

2.61 Vacancies in the non-medical staff groups were lower. Qualified and unqualified nursing cohorts showed the lowest vacancy rates at 0.5 per cent and 0.4 per cent, respectively. Considering all of the main non-medical staff groups, either London or the South East Coast had the highest vacancy rate in the majority of staff groups. The lowest vacancy rates were in the South West. All NHS vacancy rates were below the nationally available statistic of 2.5 vacancies per employee jobs in June 2008.

Modernising Medical Careers

2.62 The Independent Inquiry into Modernising Medical Careers led by Professor Sir John Tooke published its final report on 8 January 2008. The report accepted NHS Employers analysis that it is essential to join up service planning, workforce planning and training at national policy level, SHA level and local health economy level, and that decisions on these difficult areas should not be left solely to the medical profession to resolve. Work programmes with other stakeholders continue, exploring key themes such as the shape and structure of future medical training, workforce planning mechanisms, the position of international medical graduates, the role of the post-CCT doctor, and the development of leadership and management skills across the profession.

2.63 Many of the recommendations from the Tooke Inquiry were subsequently revisited in the Health Select Committee report published on 8 May 2008. NHS Employers had provided written and oral evidence reaffirming that employers have a shared aim with the medical profession of ensuring that the best candidates are appointed to training places and that staff are treated fairly throughout the process. Patients need the best doctors with the highest quality training and there is no doubt the old system of training needed reform. In retrospect it was easy to see that

some things in 2007 could have been done differently. Clarity of objectives and governance, longer lead-in times, wider testing of some elements and better communications would all have made a difference.

- 2.64 Much of this was addressed and improved late in 2007, after the MTAS system was suspended, and again during the 2008 recruitment process. Employers reported that they have appointed many excellent specialty trainees. The longer term effect on the morale of doctors in the transition cohorts is yet to be assessed, however we know that many trainee doctors were appointed to their preferred location or specialty, and the PMETB trainees survey (referred to in chapter 8) confirms improving satisfaction with the quality of training under MMC.

Staff Satisfaction survey

- 2.65 The 2007 NHS Staff Survey, reporting in March 2008, indicates that doctors and dentists are more likely than their colleagues in other occupations within the NHS to report that they are satisfied or very satisfied with their level of pay. Indeed, when compared to their non-medical colleagues doctors and dentists are more satisfied with their pay, less likely to be planning to leave their trust, more satisfied with their jobs, healthier, get better access to training and learning, are safer and less stressed, although report experiencing a poorer quality of life than the average for all NHS staff.
- 2.66 The NHS Staff Survey asked a number of questions relating to staff satisfaction with different aspects of their employment. The average score for job satisfaction (ranging from 1 for very dissatisfied staff to 5 for very satisfied) was 3.44. Doctors and dentists scored 3.49, compared to scores of 3.40 in 2006; consultant medical/dental staff scored a little higher on this measure at 3.51; as did doctors/dentists in training, scoring 3.53.
- 2.67 On individual questions related to job satisfaction, doctors and dentists generally scored higher than average. 77 per cent were satisfied with the support they received from colleagues compared to 75 per cent of all staff; 77 per cent were satisfied with the amount of responsibility they were given (68 per cent for all staff); 73 per cent were satisfied with the opportunities they had to use their skills (64 per cent for all staff); 48 per cent were satisfied with their level of pay (30 per cent for all staff).
- 2.68 A further measure of job satisfaction is provided by the three questions asked annually relating to the intention to leave current jobs or search for new positions. The responses for doctors and dentists show a significantly lower level of intent to

leave than the all staff average. In response to the statement “I often think about leaving this trust”, 26 per cent of doctors and dentists agreed compared with 36 per cent of all staff. Asked if they would be looking for a new job within the next 12 months, 19 per cent answered yes compared to 24 per cent of all staff. Only 12 per cent of doctors and dentists agreed with the statement, “As soon as I can find another job I will leave this trust” compared to 18 per cent of all staff. 20 per cent of consultants and of SAS doctors have 15 or more years service at their current employer suggesting stability in the workforce compared to other NHS occupations.

- 2.69 When asked if they have suffered “work related stress” in the preceding 12 months, 26% of all medical and dental staff say they had, compared to 33% of all NHS staff.
- 2.70 In relation to work-life balance, doctors and dentists’ responses indicate that job flexibility and the opportunity to balance their working and home lives are not always as accessible as for other colleagues. 33 per cent felt their employer was committed to helping staff balance work and home life compared to 40 per cent of all staff; 40 per cent felt their line manager helped them to find a good balance (53 per cent of all staff) and 51 per cent felt they could approach their line manager to talk about flexible working (63 per cent of all staff).
- 2.71 13 per cent of all staff had personally experienced physical violence at work in the last 12 months either from patients or their relatives. The figure is lower for doctors and dentists at 7 per cent. These figures have remained stable for three years.
- 2.72 There are no significant differences in figures for bullying and harassment of doctors and dentists from those of other staff groups, with bullying, harassment and abuse by patients standing at 23 per cent and by relatives of patients at 18 per cent. In relation to experiencing bullying and harassment from colleagues, the average for doctors and dentists is 15 per cent, and for all NHS staff is 17 per cent.

3. Employer views

Results from our questionnaire

- 3.1 Employers in the NHS in England considered the four most important factors for assessing pay recommendations should be:
- the financial position of the trust
 - recruitment and retention
 - the level of the tariff
 - staff morale
- 3.2 Employers are very clear that any cost pressure through unfunded pay increases would have an adverse affect on services. Most employers indicated that an unaffordable pay increase would lead to necessary cost savings elsewhere. The four most likely consequences given by employers were:
- a reduction in the quality of services
 - delayed planned expansion of services
 - a reduction in the number of posts
 - failure to meet targets set by government.
- 3.3 Affordability is linked to the level set for pay in the tariff. Employers have to be able to meet commissioned levels of service and national targets without compromising patient care or financial balance. Similar financial constraints will apply at PCTs and some mental health services even though they are mainly not covered by the tariff prices. Affordability of pay awards can be compromised by assumptions of efficiency gains which may be more difficult to achieve in some places rather than others.
- 3.4 Employers reported whether they faced recruitment and retention difficulties during the past year, the grade and speciality involved, and whether any difficulties were severe or not. Half of the trusts responding to the questionnaire reported recruitment and retention difficulties in relation to doctors and dentists, over the year to August 2008, and just over 10 per cent of them reported a total of 35 doctors and dentists recruitment difficulties as “severe”. Most common among the specialty areas involved in those 35 examples were A&E (5 examples), Haematology (4 examples), Anaesthetics (4) and salaried dentists (3). 32 of the severe difficulties were related to labour shortages, the other causes being said to be location (in 1 case) and MMC (in 2 cases). Many of the labour market difficulties may have been generated by the short term locum shortage caused by the changes to the doctors in training recruitment

system, coinciding with changes to UK immigration arrangements which may have affected the potential supply of overseas trained doctors.

- 3.5 Pay was not cited in all the difficulties reported by employers, except in relation to salaried dentists. The new contract for this group was only implemented in the spring of 2008 and it remains too early to confirm its effect.
- 3.6 The most common approaches reported as in use by employers to solve recruitment and retention problems were:
- The use of locum cover (both from external agencies and internal arrangements)
 - Job plan changes
 - Skill mix changes
 - Overseas recruitment.
- 3.7 A small number of employers reported the use of local labour market supplements.
- 3.8 Non-pay measures in use at employer level to aid recruitment and retention were:
- Flexible hours working
 - Flexible retirement arrangements
 - Childcare support
 - Career breaks schemes
 - Annualised hours
 - Term time only working
 - Return to practice arrangements
- 3.9 Employers are strongly of the view that medical and non-medical staff should have an award that extends to the end of the Comprehensive Spending Review period. However, any multi year award would need to be at an affordable level, with a corresponding uplift to the tariff. It could also be assumed that such an award could only be accommodated within the limits of public sector pay policy. A minority prefer that economic and market conditions be assessed annually.
- 3.10 About half of the employers returning the questionnaire report seeing benefits from pay reform quoting most often:
- improved working practices,
 - reductions in waiting times,
 - improvements in productivity,
 - improved team working,
 - improved recruitment and retention.

- 3.11 The majority of employers have indicated to us that they would prefer a percentage increase rather than a flat rate increase for medical staff. They have told us that they do not believe extra pay should be targeted at any particular medical or dental groups.

London weighting

- 3.12 Half of the responses to the questionnaire expressed an opinion on whether the level of London weighting was adequate, and 80 per cent of those employers thought that it was adequate, although in London based trusts this view was held by 66% of the responses.

Conclusion

- 3.13 Taking all of this into account, NHS Employers, on behalf of employers of doctors and dentists in the English NHS, would like to see a fair and reasonable national pay award that recognises the need for local employers to achieve financial balance and is consistent with the resources available to the NHS and reflected in the 2009 tariff uplift.
- 3.14 The tariff has not yet been published making it difficult for employers to make an accurate assessment of affordability. However, it is clear that organisations will have to deliver efficiency gains over and above the CSR three per cent target to finish the financial year in balance. This conclusion is based on headline pay awards in line with public sector pay policy restrictions of two per cent in addition to cost pressures of 1.6 per cent on pay budgets. Taking into account the impact on staff, it is therefore suggested that an award of two per cent is affordable.

4. Workforce development

- 4.1 Following the implementation of revised pay and contractual arrangements across different staff groups a number of potential benefits including improvement in workforce productivity were identified. The new contractual arrangements provide a mechanism to explore new roles and different ways of working to support changes in service delivery.
- 4.2 NHS Employers' workforce productivity forum continues to work on sharing understanding and securing engagement on measurement techniques and establishing a revised set of appropriate workforce metrics. With staff costs accounting for 75 per cent of NHS running costs, the rostering of staff and how their time is managed can have a significant impact on expenditure. NHS Employers published a guide during October 2007 to assist trusts in choosing and implementing an electronic rostering system. Electronic rostering can assist trusts to control demand for temporary staff, optimise the use of permanent staff, and reduce overhead costs through integration with payroll systems.
- 4.3 Work continues on a combined analysis of the latest patient and staff attitude surveys to identify the links between good HR practices, resulting in staff being more satisfied, and better patient experiences and outcomes.
- 4.4 NHS Employers has sought to promote the engagement and involvement of staff to improve the performance of NHS organisations and the experience of patients. A national conference, during July 2008, examined with trusts and staff side representatives the importance of staff engagement to policy initiatives such as the Next Stage Review and world class commissioning of services, and the link between how staff feel about their work and the performance of NHS organisations and patient outcomes.

NHS Jobs

- 4.5 NHS Jobs, the e-recruitment service for the NHS, delivered to NHS trusts by NHS Employers, after nearly four years of operation, is now used by virtually all of the NHS as their primary source of candidate attraction. The service hosted over 155,000 adverts during the last 12 months, from over 650 NHS organisations. With over 100,000 unique visits every day, the service is proving popular for both candidates and NHS trusts and is now widely regarded by potential staff as the primary online source for vacancies within the NHS.

- 4.6 The NHS Jobs service was used to host the MMC Round 2 vacancies from June 2007. This raised the profile of NHS Jobs within the medical community and increased both the number of adverts for, and the number of applications to, medical vacancies.

Temporary staffing

- 4.7 The use of temporary staffing in the NHS continues to be a key area of workforce expenditure which employers are controlling. While temporary staff are essential for delivering flexibility, and for dealing with short term capacity fluctuations, costs are often higher and so prolonged or excessive usage is not cost effective. The responses to the questionnaire indicate that the use of locums (from both internal and external sources) is a common measure for dealing with recruitment difficulties or for filling short term service gaps such as maternity cover.
- 4.8 NHS Employers has published guidance for trusts on the effective management of temporary staffing and a number of projects have supported employers in this area. These have included projects on electronic rostering, national and regional procurement, temporary workforce planning and skill mix, all of which have involved employers working together and sharing information and approaches. The use of staff banks, particularly those including NHS Professionals, mean employers are making more cost-effective use of temporary and locum staffing on a sustainable basis.
- 4.9 The extent of the control being exerted by employers over locum and temporary staffing costs is illustrated by the fall in expenditure on this, in NHS hospital and community services, of a third between 2004 and 2007, from £1.732 million to £1,170 million⁶. It is expected that the scope for further reduction is more limited and that expenditure will stabilise at current levels.
- 4.10 In the case of medical staff there have been reports during 2008 of difficulties recruiting locum staff, particularly for short term assignments. NHS Employers undertook a survey of employers in March 2008 to ascertain the reasons for this. The feedback was that there were several contributory factors:
- Reduced availability of International Medical Graduate (IMG) doctors who have been discouraged from working in the UK by:
 - The BMA and others claiming that the introduction of MTAS in 1997 would leave 10,000 doctors in

⁶ Flexible Staffing Services in UK Health and Care Markets 2008, Laing and Buisson

the UK without posts⁷ (and therefore competing for work in the UK and internationally)

- confusion and misunderstanding over the recent changes to the immigration rules introducing a points based system and restricting the access to UK training posts of IMGs entering the UK after February 2008

- The creation of additional training posts in 2007-08 (more than ever before) and introduction of 'run-through' posts without breaks between the basic and higher specialist training elements, which have served to reduce the 'pool' of doctors between or without posts and therefore available to take short term service posts
- Some increased demand for doctors as reductions in hours of work to meet European Working Time Directive (EWTD) requirements take effect and additional posts are created
- A mismatch between the doctors available and the specialties and levels at which locum cover is sought
- Controls on costs (via the PASA framework) have made working as a locum less lucrative or attractive.

4.11 Despite these difficulties, employers are not reporting that difficulties in securing temporary medical staff are having serious implications for service delivery.

4.12 However, following the completion of Foundation and Specialty Training recruitment and the start of the August 2008 intake of doctors an updated NHS Employers' snapshot survey of employers is underway, to continue to monitor the impact on temporary staff arrangements.

4.13 A number of developments will help alleviate the situation:

- NHS Employers is preparing guidance for overseas-based medical graduates on the immigration rules, reaffirming that work is available in the UK for the right candidates, and the various routes by which it may be sought
- NHS Employers is preparing guidance for employers on the application of the immigration rules to doctors and, together with the UK Border Agency, promoting understanding of the new points based immigration system and its impact on the right to work

⁷ <http://www.bma.org.uk/pressrel.nsf/wlu/PGAY-6ZWDMJ?OpenDocument&vw=wfmms>
<http://www.bma.org.uk/pressrel.nsf/wlu/STRE-73GJDN?OpenDocument&vw=wfmms>
<http://news.bbc.co.uk/1/hi/health/6584403.stm>

- The Department of Health is working with medical Royal Colleges to develop the Medical Training Initiative (which allows IMGs to enter the UK for up to two years to work and train in recognised posts)
- A reduction in the number of fixed term specialty training posts (FTSTAs) - doctors leaving these schemes will be available for service work, including locum activity, if they have been unsuccessful in applications for further specialty training
- 'Re-balancing' specialty training numbers in 2009 with expansion in specialty areas of clinical need and curtailment of opportunities in areas of oversupply
- Employers will be implementing skill mix, cross cover between specialties and other changes to prepare for EWTD compliance by August 2009, and seeking to reduce reliance solely on medical practitioners including locum doctors, especially at night under Hospital at Night (H@N) initiatives.

4.14 In addition employers are increasingly taking their own local initiatives such as reviewing the skill mix within services, for example reducing reliance on training posts and creating more attractive specialty doctor and other permanent service roles.

4.15 Also, NHS Professionals is involved in work to develop 'contingent' workforce models, establishing flexible labour pools able to work across a range of employers covering the more predictable levels of locum need.

4.16 These arrangements may prove attractive to individuals seeking more flexible employment opportunities.

Next Stage Review

4.17 The Next Stage Review 'High Quality Care for All', led by Professor Lord Darzi, was published on 30 June 2008. An NHS Employers briefing summarising the key points from an NHS service perspective is available at <http://www.nhsemployers.org/workforce/workforce-2899.cfm>. There are implications for the medical workforce outlined in the report, with some further details provided in two documents: 'A High Quality Workforce' and the 'Government Response to the Health Select Committee Report on Modernising Medical Careers'.

4.18 As local commissioning expertise develops and new providers emerge through social enterprise and joint service initiatives, different workforce challenges will emerge, both in terms of supply and demand and also skills and knowledge availability.

However, the detail, range and extent of these challenges remain to be seen.

Staff attitudes

- 4.19 NHS Employers is very supportive of the Department of Health's work in identifying what matters to staff. Employers in the NHS remain concerned about staff morale. The issues relating to morale need to be addressed by individual employers, although they are not believed to be directly related to pay. Importantly, improved morale will not be achieved by simply giving a higher pay award.
- 4.20 Employers continue to recognise the positive impact of the Improving Working Lives (IWL) standards on staff morale and motivation. The NHS Employer survey cites significant use of flexibility in employment initiatives which continue to have a positive impact on the service including flexible working, term time only working, flexible retirement arrangements, career breaks, return to practice and annualised hours.
- 4.21 The annual staff survey conducted by the Healthcare Commission is also vital in helping identify what can be done to improve the experience of staff in the NHS.
- 4.22 Results from the survey are informing work being done by employers at a local level to improve conditions and practices, as well as to benchmark their performance against other employers. The survey results are also informing the work being undertaken by NHS Employers.
- 4.23 The results from the latest survey, conducted during October and November 2007, continue to show that staff, and particularly doctors and dentists, have a positive view of working in the NHS as shown by the staff satisfaction levels referred to earlier. In comparison with many organisations, satisfaction with the NHS as an employer is still good but there is still a need to work hard locally and nationally to make sure that the NHS remains a place where people want to work.
- 4.24 The NHS continues to be seen as a desirable place to work. A study by NHS Careers and Skills for Health – joint sponsors of the Health Learning and Skills Advice Line - shows that healthcare is the third most desirable sector to work in. It was surpassed only by the creative and cultural sector and the broadcast, film and video industries. (The Health Learning and Skills Advice Line provides careers information, advice and guidance for NHS staff. Free, expert, independent and confidential, the service is run by learndirect Careers Advice.) Some significant reports from the Staff Survey are given in Table 4.

Selected Staff Survey data	% appraisal in last 12 months	% having a well structured appraisal review	% appraised and having a personal development plan	% receiving job related training in last 12 months	% suffering work related stress in last 12 months	% experience bullying and harassment from colleagues	Work pressure felt by staff 1 – low;5 - high	% satisfied or very satisfied with their pay	Staff satisfaction rating 1-low; 5 high
All NHS staff	62	25	53	77	33	17	3.17	30	3.44
All medical/dental staff	76	29	69	83	26	15	3.09	48	3.49
Medical/dental (consultant)	83	31	76	83	27	16	3.31	62	3.51
Medical/dental in training	82	36	73	85	24	16	2.89	42	3.53
Medical/dental (other)	63	27	56	82	25	15	2.89	32	3.47

Table 4: Selected reports from the Health Care Commission NHS Staff Survey 2008

- 4.25 NHS Employers and trade unions agreed during 2008 to review the future of the Improving Working Lives (IWL) initiative in England and similar initiatives elsewhere in the UK.
- 4.26 There were discussions around the scope for developing a national statement covering the guiding principles that underpin IWL, which could be included in terms and conditions within the NHS.
- 4.27 It is recognised that in a modern NHS improving the working lives of staff contributes directly to better patient care through improved recruitment and retention – and because patients want to be treated by well-motivated fairly rewarded staff, the NHS Staff Council has:
- Recognised that modern health services require modern employment conditions
 - Understands that staff work best for patients when they can strike a healthy balance between work and other aspects of their life outside work
 - Encouraged joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff
 - Encouraged the valuing and support of staff in the contribution they make to patient care and meeting service needs
 - Encouraged personal and professional development and training opportunities that are accessible and open to staff irrespective of their working patterns
 - Encouraged the development of a range of policies and practices that enable staff to manage a healthy balance between work and their commitments outside work
- 4.28 NHS Employers has run two campaigns to address issues raised by staff in the NHS Staff Survey. The first was on raising awareness of the issues of work related stress and the second on bullying and harassment. Both campaigns included road shows at NHS sites, poster and leaflet campaigns and web based advice for both management and staff.
- 4.29 Work continues with employers and with the Health and Safety Executive on implementing the Stress Management Standards across the service. The success of this approach is shown by the 4 per cent reduction in reported levels of work related stress in the staff survey and it is hoped that the incidence of work related stress will continue to reduce.
- 4.30 Reported levels of staff bullying and harassment are unchanged in the latest staff survey and NHS Employers is continuing to

work with employers and experts in the field to reduce the amount of bullying.

- 4.31 A sub group of the NHS Staff Council – the Partnership for Occupational Safety and Health in Healthcare (POSHH) – is currently working on the development of occupational health and safety standards for the NHS, to bring England in line with Scotland and Wales where they already exist. It is also working to re-launch the Back in Work campaign and Awards to address the issue of musculo-skeletal problems in staff.

5. Pension and ill health retirement reviews

NHS Pension Scheme Review

- 5.1 NHS Employers and the NHS trade unions joint recommendations on the new arrangements for the NHS Pension Scheme were accepted by Health Ministers in October 2007. The new arrangements came into affect on 1 April 2008.
- 5.2 Employers and NHS trade unions agree that pensions are deferred pay and recognise that the employer contribution makes up a significant proportion of remuneration for members of the NHS Pension Scheme.
- 5.3 NHS Employers also believes that contributions made by employees to the pension scheme are deferred pay. The increase in contributions made by employees, as detailed in 1.7 below, reflects improvements in the benefits structure and increases in the cost of providing benefits. The tiered contribution arrangements are a method of sharing those costs between members more equitably in future. The increase in contribution rates reflects a shift in the balance between current pay and deferred pay but should not be seen as a reduction in overall pay. The increase in contributions from members will pay for increases in the value of benefits they will receive. As the employer contribution remains the same, it should therefore be seen as neutral in pay terms.
- 5.4 There is an increased awareness of the importance of pension provision and the value of public service pension schemes such as the NHS. NHS Employers believes that there is increased awareness of the value of their pension among NHS staff. A “choice exercise” for all staff will commence during 2009 to decide whether to transfer to the new scheme, and this will further raise awareness about the value of the pension scheme to staff. It is expected that the positive impact of the NHS Pension Scheme on recruitment and retention will increase.
- 5.5 NHS Employers recognises the importance of a final salary pension scheme as a recruitment and retention tool, particularly in relation to retaining the older workforce. The number of final salary schemes open to new members has dropped during 2007/8. Barely one-sixth of schemes are accessible to newcomers, according to research reported by Aon Consulting during August 2008, down from about a quarter during 2007 and about half five years ago. However, the falling number of such schemes has meant that those employers which still have defined benefit plans have an edge in retaining staff. The researchers involved described final salary schemes as “gold dust for the employees who still have them”.

New arrangements

- 5.6 The NHS Pension Scheme continues to be a high quality final salary pension scheme costing from 2008 around 20.5 per cent of pay.
- 5.7 Members of the pension scheme prior to 1 April 2008 retain their current normal pension age (60 in most cases) and a 1/80th final salary pension with a 3/80th lump sum. They will in future have the option to commute pension for additional lump sum up to 25 per cent of the value of the pension. New entrants joining the scheme from 1 April 2008 will move to a final salary scheme with 1/60th accrual (worth around 6 per cent higher) and with lump sum of up to 25 per cent of pension. However, their normal pension age will be 65.
- 5.8 Employee contribution rates have changed from 1 August 2008 following the 2008/9 Agenda for Change pay award of 2.75 per cent. Members with pensionable pay up to £20,224 will pay five per cent; those earning from £20,225 to £66,789 will pay 6.5 per cent (with manual workers in this band continuing to contribute 5 per cent for one year only - 2008/09). Those earning from £66,790 to £105,318 will pay 7.5 per cent and those earning over £105,319 will pay 8.5 per cent. These figures are based on 2008/09 salary levels and will be up-rated annually.
- 5.9 The rationale for differential contributions is that higher paid staff tend to enjoy significantly higher earnings from career progression. Modelling of career patterns carried out for the review showed that higher paid staff paid significantly less in contributions per pound of pension than lower paid staff. However, high earners will benefit from the removal of the earnings cap (£108,600 in 2006/7).

Ill health retirement benefits

- 5.10 Ill health retirement (IHR) benefits are an integral part of the NHS pension scheme which may be paid early to members, and some former members, who retire early because they are unable to carry out their duties due to permanent ill health.
- 5.11 NHS Employers and the NHS trade unions worked in partnership to agree a set of new ill health retirement benefits and these were implemented alongside the new NHS pension scheme arrangements on 1 April 2008.
- 5.12 As part of this work an enabling agreement to support employers and staff in the management of sickness absence was agreed and implemented on the same date. This enabling agreement aims to incentivise NHS organisations to proactively manage sickness absence, the starting point of all ill health retirements. This agreement will help to mitigate risks to the service and the NHS Pensions Scheme posed by premature and unnecessary ill

health retirements, particularly as the normal pensionable age for new joiners post 1 April 2008 has risen to age 65.

- 5.13 A tiered approach has been implemented for the determination of ill health retirement benefits, recognising that the different levels of benefits for members should be dependent on the severity of their condition and the likelihood of them being able to work again.
- 5.14 The minimum qualifying service for ill health retirement remains at two years. However, the previous minimum qualifying service of five years for ill health retirement enhancements has been removed.
- 5.15 Underpinning the introduction of these new IHR arrangements is the need to ensure the continuation of high quality benefits as part of a comprehensive pension package to support recruitment and retention initiatives in the NHS.

Impact of cost sharing

- 5.16 The cost sharing agreement that underpins the new pension arrangements provides for a cap on employer contributions of 14 per cent from 2016 with an interim cap of 14.2 per cent until then. The current contribution rate is 14 per cent.
- 5.17 The basic principle behind the design and application of cost sharing and capping, is that factors that change the expected value of members' benefits, as assessed by the scheme actuary, should be taken into account.
- 5.18 A partnership group, involving management and staff side representatives, with expert advice, has been set up under the auspices of the NHS Staff Council to consider the emerging valuation work (prepared by the Government Actuary) at each valuation. The first valuation that will take place in the context of the cost sharing regulations is the funding valuation with a valuation date of 31 March 2008. Funding valuations will then take place every 4 years.
- 5.19 Subject to the overall employer cap, the group will make recommendations to government (health departments and HM Treasury) on how to implement the valuation results; in terms of any increase (or decrease) to employee contributions or alternatively changes to the benefit structure to reduce (or increase) costs.

6. Consultants

- 6.1 The number of consultants employed by the NHS in England has continued to grow, with headcount up 2.4 per cent since September 2006
- 6.2 The latest available NHS Workforce Vacancy Survey from the Health and Social Care Information Centre show a further decrease in vacancies and a general absence of recruitment and retention difficulties.
- 6.3 As consultant numbers continue to increase and any residual recruitment and retention difficulties continue to diminish, employers report that non pay solutions to any localised challenges remain as effective or more effective, than increases in levels of pay. The contractual provisions that underpin annualised hours and flexible working are reported to be both welcome and a contributor to increases in the levels of consultant morale and motivation. Consequently, employers report that the provision within the consultant contract for the payment of recruitment and retention premia is still used only infrequently and for limited periods. The current provisions for the local level design and use of recruitment and retention premia continue to be deemed satisfactory by employers, and no change is sought to these arrangements.

Service improvements programme – sharing the benefits

- 6.4 NHS Employers had been commissioned by the DH to run a programme to support employers and consultants in identifying, sharing and measuring the service improvements that had been realised through the effective implementation of the 2003 consultant contract. The programme, involving 44 trusts, has been run by NHS Employers' Large Scale Workforce Change team.
- 6.5 The participant trusts met in October 2007 and attended best practice workshops to develop their own thinking and understand how they could adopt and adapt these ideas locally. They also decided on their particular focus for the programme and then produced an initial aim statement and draft action plan. The plan outlined improvements to be implemented at individual trusts and how teams would measure the benefits they expected to achieve for patients, consultants and trusts.
- 6.6 The participant trusts met again in January 2008 to update on progress which included sharing learning on refining consultant job planning, annualised hours and robust objective setting. Regional progress meetings where achievements were shared were held in March and a final event for project teams was held in May. The final learning event, which is also open to delegates from non participating trusts, takes place in October 2008 and a

session will also be included at the NHS Employers conference in November 2008.

6.7 The respondents to the questionnaire were asked whether they had experienced benefits arising from pay reform in relation to doctors and dentists. Roughly half of those replying to that question said they had, suggesting that the benefits promised from pay reform are available but are not yet being realised at every place or to the fullest extent. The most common benefits quoted were:

- improved working practices
- reductions in waiting times for treatment
- improved team working
- improvement in service quality
- improved recruitment and retention
- reductions in time to complete treatments
- introduction of new working roles

6.8 Where employers reported other factors they emphasise the importance of job planning in achieving benefits, with increased transparency and accountability involved.

Contract maintenance and guidance

6.9 NHS Employers has published, so far during 2008, two pay circulars related to consultants. An amendment has been made to the pre 2003 and 2003 terms and conditions of service and the 2003 model contract relating to the introduction of revised NHS Pension Scheme arrangements.

6.10 These, and other housekeeping changes, mean the 2003 terms and conditions of service now appear in their seventh version and the pre 2003 Terms and Conditions of Service now appear in their ninth.

6.11 Earlier guidance on Supporting Professional Activities (SPAs), suggesting some parameters for assessing the time required to undertake SPA duties, has been revised and reissued. This arises from employer reports that they are entering into more robust discussions with consultants over the content and outputs required from SPA duties.

6.12 Since November 2007 the NHS Employers website has hosted online versions of the consultant job planning toolkit, contract implementation workbook and the appeals process document bundle as a resource for employers. These documents had been unavailable online since the NHS Modernisation Agency website had been shut down.

Summary

- 6.13 Employers in the NHS are content that the 2003 contract continues to work well and see no current need for further revisions.
- 6.14 With regard to the DDRB's recommendations for 2009, it continues to be NHS Employers position that we seek no difference in the increase awarded to those on the pre and post 2003 consultant contracts.

7. Staff grades and associate specialists

- 7.1 A joint proposal had been submitted to the Government late in 2006 and preparations were made to complete the detailed terms and conditions of service documentation.
- 7.2 Following Government approval, the BMA membership voted in favour of acceptance. The new contracts were introduced from 1 April 2008.
- 7.3 Close working between the relevant secretariats has resulted in a set of jointly agreed documents being published, including frequently asked questions, flowcharts and guidance, to support the implementation of the new arrangements.
- 7.4 Both NHS Employers and the BMA have been actively promoting the detail of the contracts through published documentation and through dissemination events. NHS Employers held three events, attended by over 350 delegates from employers in the NHS.
- 7.5 A very low level of queries on implementation suggests that this approach has been effective in preparing employers for the introduction of the new contract.
- 7.6 A new grade called 'specialty doctor' has been introduced from 1 April 2008. It is expected that staff grade doctors and some Clinical Assistants, and CMOs will transfer to this contract. Following a limited opportunity for eligible doctors to apply for re-grading to associate specialist (AS), the AS grade will close to new entrants after 31 March 2009.
- 7.7 In parallel a new contract has been introduced for associate specialist posts.
- 7.8 Service benefits fall into the four broad categories of supported job planning, a common working week, a new pay structure, and integrated career development through planned time for supporting activities.
- 7.9 The contract was negotiated and accepted by all four UK health departments. Local discussions, in respect of detailed implementation in each country, are continuing.
- 7.10 The parties to the agreement believe the contract will be beneficial to both doctors and to the service when implementation is complete.
- 7.11 Initial indications from employers are that the new contract has been offered to all eligible staff and that the number of expressions of interest has been high.

- 7.12 Employers recognise that the new contract is a positive step, bringing these doctors' contracts into line with other medical contracts. Employers are making use of documentation and processes already available for the consultant contract (on which the SD and AS contracts are based) in the implementation of the new contracts.
- 7.13 Assimilation to the new rates of pay is staged in England in a slight variation to the original proposal.
- 7.14 In moving to the new contract, doctors receive an assimilation pay increase of one annual increment, between 4 and 15 per cent of basic salary, delivered in two stages on 1 April 2008 and 1 April 2009.
- 7.15 In considering a general pay increase the impact of the assimilation increment should be taken into account.

8. Doctors in training

Modernising Medical Careers

- 8.1 NHS Employers has played a substantial role in representing service interests in reviewing the strategic direction of Modernising Medical Careers (MMC), chiefly through the MMC Programme Board and its related working groups, looking at the rules and processes for recruitment in 2008 and further changes required for 2009 and beyond. Through our policy board, medical workforce forum, workforce bulletin feedback, responses to DH-led consultations, and supported by regional events, we have tested service views on a range of issues, including best recruitment and selection practice and planning the future supply of trainees within each specialty.
- 8.2 NHS Employers has supported incremental change within a “mixed economy” of specialty-specific improvements, whilst retaining and consolidating the key training structures required for providing a quality training environment. This should provide a clear career pathway for trainees to progress towards the certificate of completion of training (CCT). We have called for improved flexibility so that trainees can build up their transferable competencies to move more easily between specialties, or to follow alternative career pathways through the revamped specialty doctor route, supported by the new contract, to continue their professional development.
- 8.3 Employers have needed ongoing support, advice and information to realise the benefits of MMC for both the profession and the service and it is essential to have employer input into the decisions being taken on changes to medical training. We have maintained regular communications with service leaders on the continuing development of MMC and the timetable for change. Employers see having the right doctors in the right jobs for the benefit of both patients and the profession as a priority and NHS Employers will continue to support the service in achieving that objective.

Foundation training

- 8.4 NHS Employers continued to help to shape the rules and processes that governed the successful recruitment of another 6,000 graduates into foundation training beginning in August 2008. Nearly all applicants to the available programmes were appointed to their first-choice foundation school, using a centralised electronic system and supported by detailed guidance from the UK Foundation Programme Office, both of which worked well. NHS Employers is keen to see whether any changes to eligibility and selection processes are needed once larger numbers of applicants seeking entry, either from UK medical schools or from overseas, leads to more competition for jobs.

- 8.5 NHS Employers has called for early notice to be given of any changes to funding streams for foundation programmes so that SHA and local workforce planning can progress smoothly. NHS Employers also aims to participate in the initial evaluation of the foundation programme beginning shortly, as a basis for further work by the newly formed Medical Education England on the future of the programme.
- 8.6 NHS Medical Education England is likely to start work on advising on education, training and supply of medical staff from 1 January 2009. Employers will be keen to see an examination of career pathways and training outside of existing training routes, such as in the career grades. They are also thought to be interested in developing 'modular credentialing', allowing doctors to switch between specialties and into and out of training, with levels of skill and competence already achieved recognised; maintain priority for UK and EEA doctors for UK medical training posts (via the immigration rules); and develop and encourage a flow of doctors between the UK and the rest of the world through an expanded Medical Training Initiative (MTI) – under which doctors may enter the UK for up to two years.
- 8.7 For the first time earlier in 2008, foundation doctors were included in the PMETB trainees' survey and results show that they are broadly satisfied with their training. They have higher scores for induction and educational supervision than post-foundation trainees. That said, nearly half of the foundation doctors surveyed reported they had felt forced to cope with clinical problems beyond their competence or experience. Only 40 per cent reported that they found structured feedback assessments helpful. We believe overall that the two-year Foundation Programme is working well, but would support continued improvements to careers advice during undergraduate training and within the programme itself. Further research is also needed on making sure that competencies gained through foundation training are consolidated thereafter.
- 8.8 The 2007 NHS staff survey suggests that doctors and dentists are more likely than their colleagues to be appraised, for those appraisals to be well structured and to have a personal development plan. Doctors in training indicated 73 per cent had a Personal Development Plan compared to 53 per cent on average for all NHS staff. Doctors are also more likely to report that they get job related training, learning or development with 83 per cent reporting that compared to an average for the NHS of 77 per cent.

Specialty training

- 8.9 There remains wide support across NHS organisations for the key principles of improved training and robust competency assessment procedures through MMC. After the problems associated with the 2007 recruitment exercise, NHS Employers helped shape the essential changes agreed for 2008 recruitment with a return to local, deanery-based recruitment.
- 8.10 At the time of writing, most specialty recruitment for 2008 has been concluded for the majority of training posts commencing on 6 August 2008. The provisional average fill-rate to specialty training was 87 per cent at the end of round 1 of recruitment, and this will have subsequently increased before the start date. However, national figures may mask some localised variations by geography and specialty.
- 8.11 Further analysis reported to the MMC programme board shows that there were some changes in applicant behaviour in 2008, influenced by the events of 2007, and the publication of competition ratios and use of national recruitment for some specialties. The average number of applications increased from 3.7 to 5.2. Geography seems less important than specialty, with less than 10 per cent in both 2007 and 2008 applying to only one deanery area/unit of application (UoA), and average numbers of UoAs applied to per applicant were similar at 3.4 in 2008 versus 3.1 in 2007.
- 8.12 No national data is collected on the problems experienced by employers where they have vacancies at the end of a deanery-led specialty recruitment round and whether locum or replacement is needed to avoid service gaps. Employers can experience difficulties if they receive late notification of the allocation of recruited doctors within rotations and late changes where doctors withdraw to take posts elsewhere.
- 8.13 To help minimise service difficulties, NHS Employers has worked with the MMC team to make clear that, once doctors have accepted a contract offer, they should adhere to it, and the notice period provided in that offer, before being allowed to make any move. Deaneries were asked to support this position in any recruitment activity after round 1 by not offering programme start dates where doctors had existing contractual commitments they should meet. The BMA's guidance to doctors has been to accept this stance, which is in line with the GMC's Good Medical Practice that doctors must give reasonable notice where they intend to withdraw from a commitment.
- 8.14 It is important that these operational problems, and others reported by doctors, help to inform planning for recruitment in 2009. In September the MMC programme board will agree plans for specialty recruitment in 2009. These are expected to show further improvements to the process used during 2008.

NHS Employers has been represented on the “task and finish group” which has recommended for next year:

- Improved initial information to candidates, in line with the possible new ‘employment agency’ status of some recruiters (including deaneries).
- Improved information on posts and rotations, within job descriptions, particularly regarding participating hospitals/geographic locations
- Greater use of national recruitment in some (subject to the programme board being satisfied about the robustness of the arrangements proposed)
- A national application form (allowing for some variation by specialty while standardising employer information)
- Availability of all posts through NHS Jobs (in addition to any other listing e.g. on a deanery/college site)
- Consideration of a coordinated timetable for some specialties, with substantial overlap of applicants, incorporating an ‘offers period’ during which offers will be made. This should reduce the proportion of doctors facing a ‘stick or twist’ dilemma, particularly between closely-related specialties. The acceptance time limit will remain at 72 hours to maximise the offers that can be made over the course of the recruitment exercise
- The establishment of minimum standards for ‘applicant support’ from deaneries and other recruiters
- The delivery of key information on fill rates and applicants, with most recruiters using the same IT support system

8.15 A key issue for employers is ensuring that the provision of information by deaneries or recruiters does not establish any contractual commitment on the part of the prospective employer, for example in respect of supplementary pay banding.

8.16 NHS Employers believes that MMC is now providing opportunities for doctors to experience high-quality structured in-programme training and this is good for their morale and motivation and better for patient care. The Postgraduate Medical Education and Training Board (PMETB) surveys of medical trainees and trainers conducted during 2007 can be viewed on a trust-by-trust and specialty-by-specialty basis via a web-reporting tool at <http://reports.pmetb.org.uk>. With the quality of education and training provision increasingly under scrutiny, employers will wish to compare their standing against the national range of scores and develop action plans accordingly.

- 8.17 In the PMETB survey, trainees reported higher rates of overall satisfaction with their training than in previous years. The national score (this time including foundation trainees also) rose from 75.97 in 2006 to 78.17 in 2007. One key issue of concern was flexible training where almost 22 per cent of female trainees reported that they wanted to train flexibly (i.e. less than full-time, or with time gaps allowed) but were not doing so, compared to just over seven percent of male trainees. The proportion of those training flexibly varies by specialty group, with the surgical specialty group having the lowest proportion. However, PMETB noted that when comparing flexible trainees to full-time trainees, there are no differences in the medical error, overall satisfaction or clinical supervision scores.
- 8.18 As part of the Next Stage Review, work will be undertaken by key stakeholders, including NHS Employers, to define the roles of the doctor within the clinical workforce, as practitioners, partners and leaders. There will be a consensus statement produced in the autumn based on work being led by the NHS Medical Director.

Future of the medical workforce

- 8.19 The implementation of MMC as a major training reform, together with implementation of the Next Stage Review, will have significant implications for employers, who must understand the impending changes to postgraduate medical training and service configuration, their effect on the structure of the junior medical workforce, and how these changes might impact upon service delivery. In the next 10 to 20 years, we expect that the way in which some NHS services are delivered will change. We need a medical workforce capable of adapting to this change.
- 8.20 Many NHS stakeholders are looking at this important area. NHS Employers has recently held a series of workshops looking at what will change and how the service needs to respond.
- 8.21 Indications are that employers believe:
- There should be a more modular approach to training that provide for a range of attractive and fulfilling career pathways.
 - Medical training and services should be aligned to the needs and expectations of patients.
 - There needs to be a greater understanding of the aspirations and expectations of future generations of doctors, and career pathways that attract the best candidates into the profession.
 - There should be an appropriate balance between service delivery and creating a supportive environment for learning.
 - Workforce planning should be multi-disciplinary, based on the needs of health service provision, with

more refined tools and systematic engagement with employers.

- A small planned oversupply in the medical workforce is desirable to improve quality and allow for a flexible response to changing demographics and service needs.
- Clear and transparent decisions about medical graduate numbers are needed, including whether we continue to incorporate international medical graduates into our medical training plans.
- It should be quickly established whether we will need, and can train, the increasing numbers of medical graduates expected over the next five years, ensuring they are equipped to make informed decisions about their future careers.

The effect of modernising medical careers on pay scales

- 8.22 Last year, following the introduction of the two-year foundation programme, the NHS introduced a single specialist training grade. This addressed the needs of the training structure in place at the time.
- 8.23 Subsequent changes to the training pathway in a number of specialties, uncoupling 'core' from 'higher' specialty training, has required the creation of a new pay scale for trainees in core specialty training posts. The introduction of this scale is purely an administrative exercise, mirroring as it does the pay scale and conditions of service for fixed term specialty registrar appointments at the same level, enabling the identification and separation in payroll and HR records of the two training regimes.
- 8.24 Arrangements for the assimilation of senior house officers into the new Specialty Registrar grade are generally complete; there remain a small number of trainees who were in SHO posts in August 2007 and who continued in that post and grade until this year. It is expected that all SHOs in accredited training posts will have transferred to the new grade by August 2008.

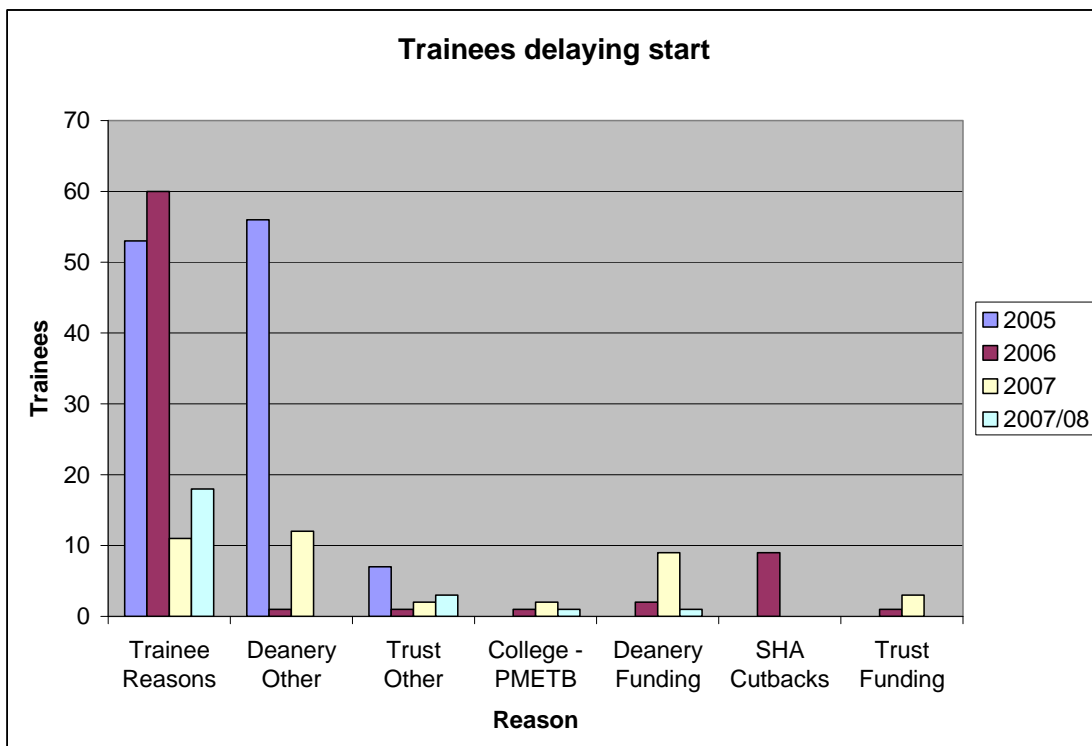
Flexible training

- 8.25 The proportion of people taking advantage of flexible training options was less than expected, probably reflecting difficulties associated with MMC. Nevertheless, the number of flexible trainees continues to increase.



Graph 2: Flexible Trainees in England 1994 - 2008

8.26 Evidence, collected on a six-monthly basis by postgraduate deaneries in the UK, suggests that in general the trainees seeking flexible working arrangements are able to access them. Given the scale of the NHS and the variability of local circumstances it might be expected that access would vary between areas, but this does not seem to be significant.

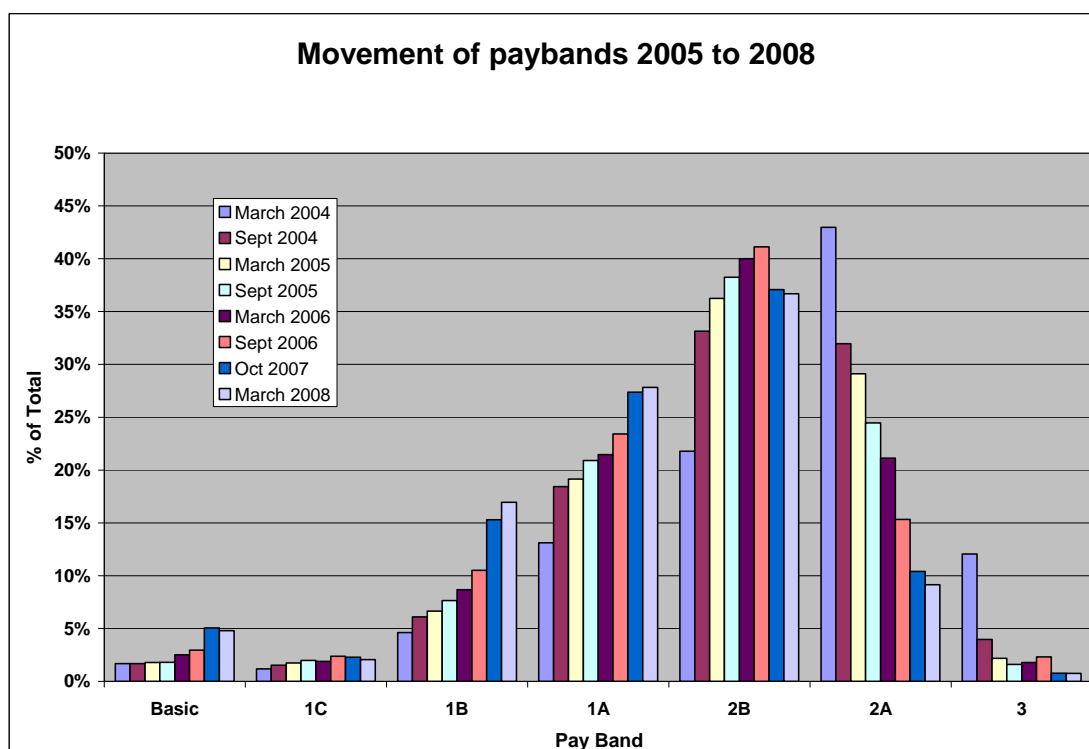


Graph 3: Trainees delaying start

- 8.27 In 2007/8 23 trainees had the start of their flexible training delayed. This is significantly better than 2005 when 116 were delayed, and suggests that access to flexible training is improving. The major reason for delay in each year came from the trainee rather than from service limitations, and in 2007/8 only four trainees were reported as having their application for flexible training rejected.
- 8.28 There has been virtually no feedback about difficulties experienced by trainees wishing to access flexible training and on problems encountered by employers seeking to accommodate them. This is of an order of magnitude less than experience under the old arrangements and is an indication that the new system is operating as intended. This suggests that there is no need to amend current arrangements.
- 8.29 A joint NHS Employer and BMA group is to review flexible training; this has met once already to agree a remit for the review – the next meeting is planned for September 2008.

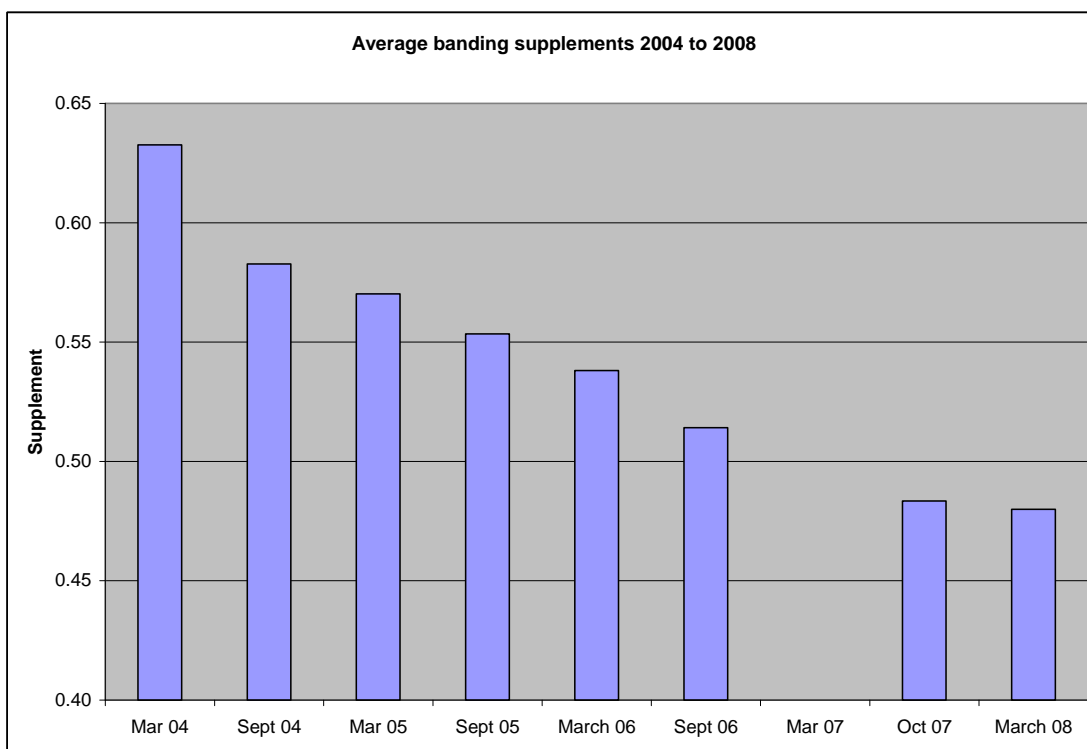
Banding supplements

- 8.30 The pay supplements currently in place are intended to reflect the amount of work done and appropriately reflect the unsocial elements of the work. Employers continue to see no reason to revisit the general value of banding supplements or their relationship to basic pay at this time.



Graph 4: Movement of pay bands 2005 - 2008

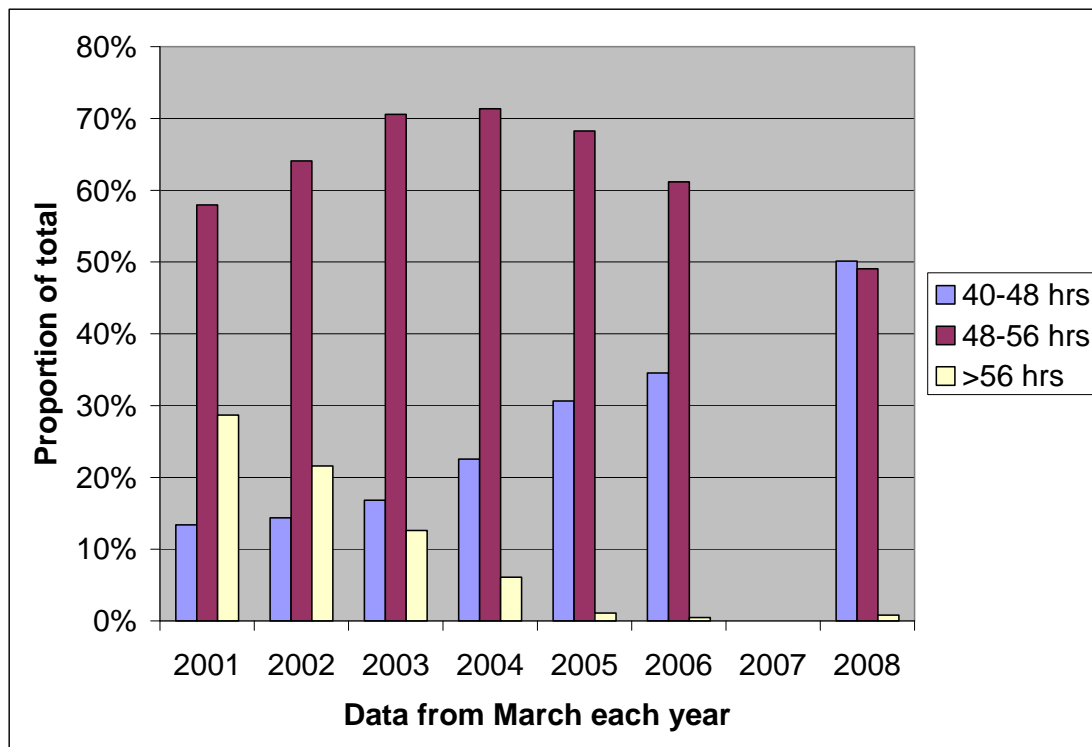
- 8.31 The most recent monitoring data, from March 2008, indicates an average supplement for compliant posts (some 98 per cent of doctors in training), of almost 48 per cent. This figure is based on reported working patterns and takes no account of pay protection which, while bandings are falling in general, as a result of the pressures of the forthcoming 48 hour week under EWTD, will be a significant factor for many doctors.
- 8.32 The average supplement in payment should continue to decline as working hours reduce by August 2009, although given the current slowing of the trend it is not expected to fall significantly below 45 per cent. This small and continuing reduction in banding supplements cannot be seen in isolation. It happens because the working arrangements - hours of work and intensity as defined under the contract – are reducing. It would be inappropriate to maintain overall pay at existing levels while reducing hours – this would be to increase effective pay rates without service benefits.



Graph 5: Average banding supplements 2004 - 2008

- 8.33 During the recruitment to training posts during 2007, recruitment figures and press reports suggested there was a very high and encouraging level of interest in entry to training. This suggests that not only is medicine an attractive career but that salaries also continue to be attractive.
- 8.34 The reported level of oversubscription to training places during 2007, did not result in the predicted 10,000 doctors without jobs – the general situation appears to be that trusts are now having some difficulty in recruiting sufficient locum doctors to cover rotas. The reason may be changes to entry requirements for

international medical graduates, or problems with the 2007 recruitment process itself, but there is no evidence that pay itself is an adverse factor.



Graph 6: Proportion of earnings from banding supplements 2001 - 2008

8.35 From a similar perspective, medical and dental salaries, particularly overall pay on graduation, remain competitive and attractive, and there continues to be no shortage of qualified applicants to vacancies at all levels of training in most specialties.

Overall pay

8.36 Given that annual increments already add around 4 - 6 per cent to basic pay, any increase for doctors in training for 2009/10 should be within public sector expectations and affordable by the service.

GP specialty registrars (GP StRs)

8.37 There appears a general consensus amongst those responsible for GP training that the employment arrangements for this group of trainees should, at some point in the future, be aligned with those of hospital trainees, so as to facilitate the movement of trainees from trust to GP practice and vice versa without a change of contractual arrangements, and using a single lead employer covering all phases of the training programme.

8.38 The supplement for GP specialty registrars (GP StRs) was originally set at 65 per cent of basic salary not to reflect the working arrangements of the post, as it would for a hospital

trainee, but as a recruitment instrument to reflect the average supplement then payable in a hospital training post, in order not to provide a disincentive to hospital trainees considering a move into general practice, particularly when GP recruitment was weak. Recruitment to GP training programmes continues to be strong and the argument for a recruitment payment for this particular branch of training is weakened.

- 8.39 To align the GP contractual arrangements with those of hospital trainees will not be achieved overnight, nor should it be. To pay GP StRs on the same basis as a hospital trainee would see the supplement reduce from its current level of 50 per cent to between 20 per cent and 40 per cent and perhaps, in the case of those few GP StRs undertaking little or no out-of-hours work, to zero. Pay parity with hospital trainees should be the aim and further progress towards that should be made. With strong recruitment to GPR training and the continuing disparity between pay in hospital and in general practice for similar hours of work and intensity, it is appropriate to reduce the GPR supplement further. The GPR recruitment supplement could be reduced to 45 per cent for those entering GPR training placements after April 2009, continuing the trend toward alignment.
- 8.40 A pilot exercise in the North West is seeking to demonstrate the advantages to both trainee and employer of a single lead employer arrangement. It is hoped that this will bring GP and hospital contracts closer together while not disadvantaging either group.

9. Salaried general medical practitioners (GMPs)

- 9.1 The salary range for Salaried General Medical Practitioners (GMPs) employed in primary care organisations is between £52,462 and £79,167, with starting pay, progression and review determined locally. Demand for this group of staff continues to be high; the majority of employers continue to report that the pay range is appropriate and that there are no recruitment problems.
- 9.2 NHS Employers has continued to press the BMA's General Practitioners Committee to enter into discussions on updating the Salaried General Medical Practitioners model offer letter and terms and conditions of service. Revised documents cannot, therefore, be issued.
- 9.3 NHS Employers is seeking an increase to the pay range in line with that of other directly employed doctors.

10. General Medical Services

- 10.1 NHS Employers has been mandated by the Department of Health for England to review, with the BMA's GP Committee, the GMS contract for 2009/10. Discussions are continuing with the GPC and progress is being made, though we remain some distance from an agreed settlement. Therefore NHS Employers will, as previously agreed, continue to work with the Health Departments and the GPC in agreeing by the end of September the role of DDRB in pricing the 2009/10 contract; and submit evidence to DDRB for 2009/10 during November 2008.

11. Salaried primary care dental services

Acceptance and implementation of new contractual arrangements

- 11.1 In last year's evidence, it was reported that negotiations on revised terms and conditions and pay scales for this staff group had been completed. A ballot of the eligible members of the British Dental Association (BDA) took place in November 2007 and produced a high majority (86 per cent) in favour of introducing the new arrangements.
- 11.2 The NHS Primary Care Contracting team held three road shows in January 2008 to explain the impact of the new contract more fully to primary care trust managers and dental clinical directors. NHS Employers also published a number of frequently asked questions which have been agreed with the BDA/DH.
- 11.3 As well as the summary agreement and terms and conditions of service, which were published in January 2008, NHS Employers published appraisal guidance and guidance on job planning in November 2007.
- 11.4 Any new appointments made after 4 February 2008 have been made to the new arrangements. It was anticipated that existing dentists would move to the new arrangements by May 2008, and indications from employers are that implementation has gone smoothly. It was agreed that any increase in pay as a result of staff moving to the new contract will be backdated to 1 June 2007.

Change to negotiating forum and contract maintenance

- 11.5 In March 2008, NHS Employers assumed responsibility from the DH to run the negotiating machinery for England and to provide secretariat support for the employers negotiating team in England. A new negotiating forum with the BDA has been established and is expected to meet formally for the first time in the spring of 2009.

Salaried dentist numbers and retention

- 11.6 There are about 1,300 salaried dentists, typically employed through about 120 PCTs. 12 per cent of the PCT responses to our questionnaire indicated experiencing difficulties over the preceding 12 months in recruiting salaried dentists and suggesting that the cause was a combination of pay, in competition with the General Dental Services, and most applicants not meeting the requirements of the job specification, suggesting a lack of experience in community dental work. This seems to reflect the historical position in the salaried dental service, where it has often been seen as an under resourced "Cinderella" service, with less investment and leadership, and poorer premises than in the General Dental Service.

- 11.7 The introduction of the new contract, which applies to existing community dental officers, senior dental officers, assistant clinical directors and clinical directors, is designed to improve recruitment and retention among such posts. While delivering increased pay, the contract also provides for very important non-pay aspects of the employment contract, such as job planning, which has been seen in comparable medical employment contracts as beneficial to staff and patients; and rewards clinical as well as managerial roles. Employers also report continued growth in spending on dental services, which has the potential to remedy some of the non-pay barriers to recruitment.
- 11.8 The total costs of the contract will increase the pay bill for salaried dentists by £2.5m in year one, increasing to £7.5m by year five. The new contract provided salaried dentists with increases of between 2 per cent and 19 per cent in basic pay on moving to the new contract and access to annual increments worth between 2 per cent and 11 per cent. Table 5 shows the old grade, the new grade, percentage increases received on transfer to the new contract and the annual increments available. By May 2008, 1,300 salaried dentist had transferred to the new contract.

Old grade	New grade	Increase received on transfer to the new contract, per cent	Annual increments received, per cent	New salary, £
Community Dental Officer	Salaried Dentist A	4 to 12	4 to 11	36,792 to 55,188
Senior Dental Officer	Salaried Dentist B	3 to 19	2 to 5	57,232 to 66,941
Assistant Clinical Director	Salaried Dentist B* (for Assistant Clinical Directors only)	2 to 7	3	68,474 to 72,564
Clinical Director	Salaried Dentist C	1 to 7	3	68,474 to 78,694

Table 5: Salary ranges, annual increments and increases received on transfer from the existing salaried dentists grades to the new contract grades.

- 11.9 The new contract is in its first year of implementation and full pay and other effects will emerge over the next four years. NHS Employers will be overseeing the operation of the new contract and its benefits realisation for patients, employers and staff. The implementation and use of the contract will be subject to discussion with the British Dental Association, and any issues arising can be raised with DDRB in future years.

11.10 With regard to the DDRB's recommendations for 2009, it is NHS Employers view that the same increase should be applied to this staff group as to other directly employed doctors and dentists.

12. General dental services

Introduction

- 12.1 Following the implementation of the new General Dental Services contract in 2006, Primary Care Trusts (PCTs) have been successfully expanding NHS dental capacity through a variety of means: tendering for new provision, increasing capacity in existing providers both temporarily and on a permanent basis, and as a consequence PCTs are reporting the successful achievement of the 18 week orthodontic waiting time targets.
- 12.2 NHS Employers (NHSE) has previously submitted evidence to the DDRB based on the outcomes of PCT completed questionnaires. However, in preparation for this year, NHSE commissioned the NHS Primary Care Contracting to conduct a focus group comprised of PCT Commissioners, Finance and Dental leads to capture the views and opinions of PCTs on the 2008/09 and 2009/10 pay awards. A broad cross section of 15 PCTs were represented and the views of the group have been used to inform this evidence.

NHS Employers recommendations

- 12.3 Based on the feedback received from the focus group, NHSE recommends no uplift for 2009/10 to gross contract values.

2008/09 Award

- 12.4 It has been reported to NHSE that the 2008/09 award had a detrimental affect on the management and commissioning of General Dental Services. PCTs would like less national prescription, allowing them more local flexibility in the provision and management of services. It was felt that the 2008/09 award was unintentionally generous given an apparent decrease in practice expenses.

Management of historic contracts

- 12.5 Some PCTs reported difficulty in managing contracts with existing providers. Many PCTs have inherited contracts with a wide range of Units of Dental Activity (UDA) values for what is essentially the same service as a result of the implementation of the new contract. A blanket pay award does not allow PCTs to successfully renegotiate contracts to ensure efficiency savings are made, access targets are met and the quality of services are improved. A recommendation of no increase for 2009/10 will allow PCTs to manage contracts more effectively and locally invest in providing additional and improved services in ways that are more responsive to local requirements. This would also allow PCTs the opportunity to locally negotiate efficiency

savings, as are required in other areas of the NHS, and thereby improving value for money.

Impact on planned investment in services

- 12.6 The lead time for the commissioning of new services is approximately 4 to 5 months to allow for the tendering process to be completed. Many PCTs had estimated a circa 1.5 per cent pay award in 2008/09 and put plans in place to spend funds on this basis.
- 12.7 Funds that had been identified for service improvement and investment across a range of services had to be reallocated to fund the 3.4 per cent recommended increase.
- 12.8 A recommendation of no increase will allow PCTs to invest in areas of deficiency as identified locally, and ensure that patient need is at the heart of decisions on investment in dental services.

Access to dental services

- 12.9 NHSE is pleased to report that PCTs are successfully tendering for new services thus improving access to NHS dentistry. Current contract values are already attracting high interest from providers and there is an apparent willingness across a range of providers to provide NHS services. There is no requirement for the value of these contracts to be increased in order to attract more providers.
- 12.10 One PCT in the north of England received 46 expressions of interest (from local and non-local providers, including independent contractors and large corporate providers) to provide non-specialist services in a part of its region where it had previously found difficulty in attracting GDPs to work.
- 12.11 Great Yarmouth and Waveney PCT were encouraged by the high level of expressions of interest received from local and non local dental contractors in relation to their open tender for additional general dentistry and specialist orthodontic capacity.
- 12.12 A recommendation of no increase for 2009/10 will allow PCTs to offer appropriate premia, via the normal local contracting processes, in areas where it has been historically difficult to recruit and retain GDPs.

Opportunities to expand services

- 12.13 The Department of Health recently extended the ring-fence on PCTs' dental budgets until 2011. In some cases PCTs have also added significant sums from their unified budget to top-up this ring-fenced fund in response to local demand for additional services.

12.14 Examples of proposed and actual additional investment include:

PCT	Investment
Telford & Wrekin PCT	Proposed additional capital spend of £970,000 in order to increase estate and overall infrastructure in order to improve quality and access to NHS dentistry.
Tower Hamlets PCT	Committed an additional £1m revenue funding (recurrently) from non-ring fenced funds for dentistry 2008/09 and are anticipating further non-ring fenced funds to be allocated within commissioning intentions for 2009/10.
Great Yarmouth & Waveney PCT	Invested £959,000 in 2008/9 to reduce specialist orthodontic waiting times. A further £1.2 million will be spent this year on additional UDA's to improve access and reduce waiting times.

12.15 Coupled with the large national increase in the dental budget, this presents significant opportunities for contractors to bid for new work and provide additional services. A national uplift in 2009/10 may affect the ability of PCTs to invest in these areas, and respond to the needs of patients. Any uplift may also decrease the number of providers tendering for new work. There would be little incentive for providers to improve the quality, or increase the range, of services provided, since they would receive increased funding for existing services regardless of improved efficiency, quality or access.

12.16 PCTs would welcome the ability to commission services as driven by local need, without unfunded cost pressures arising from pay and earnings recommendations exceeding the assumptions made in commissioning negotiations.

GDP earnings

12.17 The average net profit (before income tax) for provider-performer dentists in 2006/07 was £117,0838 (based on a population of 5,633 dentists) compared to £94,639 for non-associate dentists (based on a population of 3,725 dentists) and £114,068 for first party associates (based on a population of 3,318 dentists) in 2005/06. PCTs have reported to us that GDPs were themselves surprised by the level of the 2008/09 uplift and many had reported to PCTs that they were expecting a maximum of a 1.5% uplift (if any at all).

Impact on salaried primary care dental services

12.18 An unintended consequence of last year's pay award for GDPs has been difficulty in recruiting dentists to work in salaried primary care dental services (SPCDS). PCT provider services are working hard to deliver high quality services that offer value

⁸ Dental earnings and expense report 2006.07. The NHS Information Centre, September 2008.

for money, often in deprived areas, but are not operating on a level playing field. General dental practice is perceived as an easier, better paid option, with no requirement for generating the efficiency savings required of other NHS providers. Despite the investment in SPCDS, an increase in GDS earnings could further discourage dentists from working in this area, despite the significant improvements in the contract for SPCDS dentists, referred to in Chapter 11, designed to improve the recruitment and retention of salaried dentists.

Passing on pay increases

12.19 The 2008/09 uplift of 3.4% included an increase in GDP's personal remuneration of 2.2%. Evidence suggests that this increase was not always passed on to performers.

Practice expenses

12.20 It was felt that the 2008/09 uplift was generous considering the reduction in complexity of dental treatment and a reported decrease in expenses. The current expenses to earnings ratio (EER), as reported by the NHS Information Centre for providing-performer GDS dentists, is 63.0%. Due to the changes in the contract and the classification of dentists, it will be several years until it is possible to measure the trend in expenses through the NHS Information Centre's data.

12.21 The 2008/09 award, in effect, gave general dental practitioners (GDPs) an even greater pay increase due the decrease in practice expenses. A recommendation of no increase for 2009/10 would help restore the balance between net income and expenses, allowing for a net pay increase to be absorbed from the reduction in expenses.

12.22 The NHS is heavily critical of the use of Retail Price Index (RPI) in the formula from which last year's recommendation was calculated. It was felt that it is not an appropriate measure for the changes in cost and has led to an overestimation of practice expenses.

12.23 NHSE would want to work with the DDRB, the Department of Health and the BDA to examine and assess the components of a formula approach that appears to have awarded a perhaps unintentionally generous pay award for 2008/09 and that does not take into account other factors, such as expected efficiencies.

Annex A

Pay review 2009/10 – your organisation's views

Dear colleague

You will be aware from our 'workforce Bulletin' that NHS Employers will be submitting evidence, on behalf of all NHS organisations, to the pay review bodies for 2009/10. To help us do this, we need your organisation's views by 11 August.

We know that the review bodies really value evidence that is directly influenced by employers and we are asking all NHS organisations to complete a short questionnaire, covering the key areas for:

- the NHS Pay Review Body – our evidence will focus on recruitment and retention, following the agreement to a three-year pay deal for staff covered by Agenda for Change
- the Doctors' and Dentists' Pay Review Body – we are seeking evidence on similar areas to last year, covering the financial position for trusts, affordability within the tariff, fairness and preferred distribution of any award

We will be contacting chairs and non-executives separately about the Senior Salaries Review Body and seeking views from PCTs about contracts to provide primary medical and dental services.

You can submit your organisation's views by completing the questionnaire either on-line or printing off a paper copy and posting your completed form to us. Both are available at www.nhsemployers.org/payreview09 where you will also find more details about the process for 2009/10. The questionnaire should take no longer than 30 minutes to complete.

Please make every effort to submit a completed questionnaire to ensure that we have a strong evidence base. The more information we receive, the more credibility and authority our evidence is likely to have on behalf of all employers. We will be submitting our written evidence in September, followed by oral evidence in early December and we will continue to update you on this work through the NHS Workforce Bulletin and our website.

Thank you for your help and support.

Yours sincerely

Gill Bellord

Director of Pay, Pensions and Employment Relations, and
Deputy Director, NHS Employers

NHS Employers evidence for the pay review bodies for 2009/2010

NHS Employers is submitting evidence on behalf of NHS organisations to the pay review bodies for the 2009/10. We need employers' help to ensure that we have strong evidence, based on up-to-date information, which represents employers' current views. To help us do this, we would be grateful if you can complete this questionnaire – one per organisation - that covers the key areas for the NHS Pay Review Body and Doctors and Dentists Review Body.

We need your completed questionnaire by 11 August 2008, to ensure that we can collate all the responses and submit the evidence in September 2008. This questionnaire is also available on our website at www.nhsemployers.org

If you have any queries about completing this questionnaire, please email payreview09@nhsemployers.org Many thanks.

NHS Employers evidence to the NHS Pay Review Body and the Doctors and Dentists Pay Review Body 2009/2010

Name of organisation that this evidence is submitted on behalf of:

.....

Address:

.....

Telephone number:

Email:

Agenda for Change (i.e. staff other than doctors, dentists and certain very senior managers)

1. The multi-year agreement includes the following clause:

“The NHS PRB will continue to gather evidence throughout the period of this agreement. In the event that the NHS PRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and 2010/11.”

This means that we need to continue to collect evidence from you on recruitment and retention to the NHS, for the NHS Pay Review Body to consider. Please provide your organisation’s views on this area below:

Doctors and dentists

2. What are the three most significant priorities in assessing pay levels for doctors and dentists for 2009/2010?

Recruitment	
Retention	
Staff Morale	
Financial position of the organisation	
Tariff levels	
Other	

If "other" please give details below

3. What are the three most likely consequences, if there is a higher pay award for doctors and dentists than you believe is affordable?

Reduction in service capacity	
Delayed planned expansion of service provision	
Reduction in quality of service	
Reduction in quality of care	
Reduction in the number of posts	
Increased unfilled vacancies	
Redundancies	
Failure to meet targets set by government	
Failure to meet business objectives set by your Board	
Other	

If "other" please give details below

4. Should any award cover the final two years' of the Comprehensive Spending Review for doctors and dentists? Please tick one of the boxes below

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

5. Should any pay increase be the same percentage for all grades of directly employed doctors and dentists? Please tick one of the boxes below

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

5.1 If “no”, which doctors or dentists should receive a higher award compared to their colleagues? (please tick the relevant boxes below)

Consultants	<input type="checkbox"/>
Doctors in training	<input type="checkbox"/>
SAS doctors	<input type="checkbox"/>
Salaried dentists	<input type="checkbox"/>
Salaried GPs	<input type="checkbox"/>

6. During the past 12 months, have you had difficulties in recruiting or retaining doctors and dentists?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If yes, please indicate where below

Grade and speciality where had difficulty	Main cause of the problem eg. pay level, location, labour shortage	Severity of the problem in relation to patient care		
		Mild	Moderate	Severe

7. Have any of the following approaches been used to resolve any recruitment and retention problems in relation to doctors and dentists. Please tick the relevant boxes.

Use of locums from NHS Professionals	
Use of locums from other agencies	
Use of internal locum cover	
Job plan changes	
Skill mix changes	
Local labour market supplements i.e. R and R Premia	
Overseas recruitment	
Other	

If "other" please give details below

8. Are any of the following non-pay measures in use in relation to doctors and dentists? Please tick the relevant boxes

Career breaks	
Return to practice	
Childcare support	
Flexible hours	
Annualised hours	
Flexible retirement arrangements	
Term time only working	
Other	

If "other" please give details below

9. Has your organisation experienced benefits from pay reform in relation to doctors and dentists? Please tick one of the boxes below

Yes	
No	

9.1 If so, which of the following apply:

Improved working practices	
Improvement in productivity	
Improvement in service quality	
Reductions in waiting times for treatment	
Reductions in the time taken for patients to complete their treatment	
Introduction of new working roles	
Introduction of new working techniques	
Introduction of improved technologies/equipment	
Improved team working	
Improved recruitment and retention	
Other	

If "other" please give details below

10. Is the current level of London weighting for doctors and dentists adequate? Please tick one of the boxes below.

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Primary care organisations

11. If you directly employ salaried general practitioners does the current pay range meet your requirements? Please tick one of the boxes below

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If no, please explain any difficulties with the current pay range

12. Please add any further comments on your organisation's views on the pay and reward of doctors and dentists

Thank you for your submitting evidence on your organisation's behalf. This will help NHS Employers provide strong evidence which represents employers' current views.

We would also value your feedback about the process, to help inform how we gather evidence next year - this should take a couple of minutes. Please tick the relevant boxes below.

1. Have you completed a pay review questionnaire for NHS Employers before?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

2. Did you find this form easy to complete?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

3. Did you think that you had enough time (around 4 weeks) to complete the questionnaire?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

4. Did you think the questions were easy to understand?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

5. How easy was it to gather your organisation's views on these areas?

Very	<input type="checkbox"/>
Fairly	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

6. How did you find out about the questionnaire? Please tick the relevant boxes

NHS Workforce Bulletin	<input type="checkbox"/>
Interchange Alert	<input type="checkbox"/>
NHS Employers website	<input type="checkbox"/>
NHS Employers forum/event	<input type="checkbox"/>
HR network	<input type="checkbox"/>
A colleague	<input type="checkbox"/>
Other (please give details)	<input type="checkbox"/>

Please post your completed questionnaire to the following address, to arrive by 11 August 2008:

**2009/10 Pay Review
NHS Employers
2 Brewery Wharf
Kendell Street, Leeds LS10 1JR**

Annex B

Review of NHS cost pressures and financial planning 2009/10 – 2010/11

Contents

(i). Executive Summary	4
1. Introduction and Process	8
2. Update on 2008/09 and Generic Issues	10
3. Primary Care Trusts	14
4. Acute Trusts	18
5. Mental Health Trusts	22
6. Ambulance Trusts	24
Appendices:	
A Outline Project Scope	27
B NHS Cost Drivers and Financial Planning 2007/08 – 2010/11	28

Executive Summary

Introduction

This report has been prepared for NHS Employers by Philip Grant to supplement and inform NHS Employers evidence to the Pay Review Bodies for 2009/10 and 2010/11. It follows the production of the report prepared by NHS Employers for the 2008/09 Pay Review Bodies setting out the cost drivers and financial planning assumptions being made across individual NHS organisations for the period 2007/08 to 2010/11.

In line with the process followed in 2008/09, individual face-to-face review meetings were held with a reduced selection of representative NHS organisations. The purpose of these meetings was to initially investigate whether actual costs or planning assumptions had materially changed following the 2008/09 review and then to analyse the latest financial planning assumptions and financial forecasts being made for 2009/10 – 2010/11.

Review of 2008/09

All meetings confirmed that the expenditure analysis contained within the 2008/09 report was broadly in line with current expenditure baselines for all NHS organisations. Some variations may exist between similar organisations based on factors such as size of provider function, specialties covered and geographical location but contributors nevertheless confirmed that the 2008/09 expenditure baseline analysis was not untypical.

There has been a significant overall improvement in the financial position across the NHS and this is well documented. Taken as a whole, the financial position of the NHS at the end of 2007/08 was a surplus in excess of £1.6 billion and individual NHS organisations are planning to maintain operational contingencies at the same level in 2008/09 and beyond.

The surplus is non-recurrent and has generally been achieved through short-term measures which will not generate such savings year-on-year. An historic example includes the deferment of essential investment from one year to the next through temporary delays to patient care initiatives. Such measures cannot be repeated each year due to the longer-term and permanent impact they would have upon patient care and activity/waiting list targets.

Existing non-recurrent savings are not therefore available for investment in recurrent areas of expenditure, such as staff pay. To do so would generate un-funded recurrent commitments for future years thus returning the NHS to the boom and bust cycle which has contributed to the significant historic deficits seen over recent years.

The financial position and financial management of the NHS continues to improve though and further repayments of historic deficits and strengthening of individual organisations balance sheets should be expected. This remains dependent upon continued robust management of financial plans and overall control of recurrent commitments.

PCTs previous planning assumptions were for an increase in their centrally allocated revenue resource limits of 3.5% for 2008/09 onwards. The comprehensive spending review announced in the autumn of 2007 proposed an increase in NHS spending by an average of 4% above inflation each year through to 2010/2011. The specific one year allocation announcement for 2008/09 increased PCT allocations in England from £70.35 billion in 2007/08 to £74.20 billion, an actual increase of 5.46%.

Individual PCT allocations were announced for a one year period only and despite the announcement of general future funding for the NHS, there are a number of factors which mean it remains difficult for PCTs to forecast their likely income levels for 2009/10 and beyond.

The supporting comprehensive spending review action plans and 2008/09 operating framework for the NHS also outlined a number of additional commitments and targets for NHS organisations as previously highlighted in the Foreword to the NHS Employers 2008/09 report.

Additional national commitments, whilst often for determination locally, have also been established through central guidance. These include the vision for the future of the NHS as set out in the Strategic Health Authority supporting plans underpinning the final Next Stage report, as well as the newly set out suite of local stretch targets published as part of the Operating Framework for 2008/09.

The comprehensive spending review announcement also included confirmation that the minimum expected annual efficiency saving was being increased from 2.5% to 3.0% alongside the expectation of further value for money reforms realising annual net cash-releasing efficiency savings of at least £8.2 billion by 2010/2011.

All contributors to this review were unanimous in stating that the ability to continue to deliver year-on-year marginal efficiency is now significantly diminished and organisations are having to focus on more 'process improvement' to deliver future efficiency savings. Such process improvement, it was stated, generally needs up-front investment to deliver medium to longer-term savings.

A number of examples were quoted of how the required efficiencies were delivered in 2007/08 and are anticipated to be delivered in 2008/09. These include:

- One-off asset sales
- Additional PbR activity (where possible)
- Procurement hub savings (driving down prices through suppliers)
- Resource Accounting and Budgeting (RAB) reversal savings
- Operational vacancy savings, recharge arrangements etc
- Service redesign and demand management initiatives

Impact of 2008/09 pay review body recommendations

Individual financial plans for 2008/09 included provision for pay awards generally averaging 2.5%. The main actual awards made for 2008/09 varied from 2.2% to 2.75% and the detailed financial impact upon individual NHS organisations will have varied according to their staff mix. For example, those with high levels of Agenda for Change staff, such as ambulance trusts, will have needed to set aside additional

financial provisions as a result of their overall cost of pay awards being above their initial 2.5% assumption.

However, for ambulance trusts in particular, the additional cost of pay awards on top of all other operational cost pressures for 2008/09 is being met through the deferment of planned developments which has created non-recurrent savings but delayed the implementation of essential initiatives aimed at improving patient care and response time targets.

2009/10 Operating Framework and PCT Allocations

A key national guidance paper supporting local operational and financial planning for 2009/10 and beyond is expected to be published by the Department of Health during the autumn of 2008 and will include:

- Details of a new formula for the allocation of resources to PCTs
- Individual PCT allocations for 2009/10 onwards
- The level of uplift being applied to the national tariff for 2009/10
- Clarification of key deliverables for 2009/10 and beyond

Whilst awaiting publication of that guidance local financial planning has been based on best available data and estimates and these are also used to underpin the analysis within this report.

Additional factors for 2009/10 and 2010/11

There were a number of further specific factors identified as creating particular cost pressures for 2009/10 and 2010/11. These included:

- The continued achievement of waiting time targets such as the 18 week referral to treatment target and 2 week cancer waiting time targets
- Rises in referral levels during the first quarter of 2008/09 of generally between 15% and 20%
- The double impact of fuel price rises through rising staff mileage rates as well as a significant rise in energy prices for what is traditionally a large, geographically dispersed and varied estate
- The issue of Agenda for Change staff bandings, as raised by many trusts, which are reporting on-going pressures relating to grading appeals
- Pay drift, also linked to new pay bandings, whereby staff previously at the top of a scale now qualify for annual increments again
- For ambulance trusts, 'Call connect' sustainability will continue to create cost pressures for the foreseeable future

International Financial Reporting Standards

International Financial Reporting Standards (IFRS) being introduced to all public sector financial statements by The Treasury require individual organisations balance sheets to include the value of assets under its ownership or control. Whilst most government departments and public bodies have introduced IFRS with effect from 1 April 2008, the Department of Health on behalf of the NHS has secured a 12 month deferment to 1 April 2009.

The very significant implications for the NHS are that assets funded through private finance have until now generally not appeared on NHS balance sheets and therefore not been subject to an annual depreciation charge to reflect its decline in worth, typically calculated as a percentage of its original cost, and a capital charge, currently set at 3.5% to reflect the opportunity cost of tying up public resources.

Under IFRS, many such assets funded through PFI or LIFT type arrangements are likely to be required to appear on the NHS organisation's balance sheet and therefore generate an additional cost to meet the depreciation and capital charges. For large multi-million pound developments, such as new hospitals, funded through PFI arrangements this cost pressure will be many millions of pounds.

At the time of writing, national discussions are on-going between HM Treasury, the Department of Health and representatives of NHS organisations to secure a workable solution to this issue. At one extreme this could add a cost pressure of several hundred million pounds to NHS organisations whilst at the other extreme a non-cash 'circular' transaction may be appropriate for which the net cost to the public purse could be zero. The exact detail of the introduction of IFRS across the NHS from 1 April 2009 is awaited.

The potential impact of a higher than forecast pay award

The ability of NHS trusts to fund a pay award in excess of the levels incorporated within existing financial plans varies between sectors.

All organisations should be expected to, and have indicated that, small variations in pay awards from planned levels would generally be manageable within day-to-day operational contingencies as was the case with the slightly higher level of 2008/09 award.

However, the majority of acute, mental health and ambulance trust income is determined, either directly or notionally by the nationally set tariff uplift and therefore such organisations face a significant risk that future pay awards for NHS staff will be higher than accounted for in the tariff uplift and a large additional cost pressure would be created for those organisations unless, as is not traditionally the case, the rate of tariff uplift is revisited.

Significant increases to future pay awards would therefore require the revisiting of operational financial plans and the potential for direct patient care, service quality or nationally set access targets to be jeopardised. In this respect, as an indication only, a 1% variation in anticipated pay awards would predominantly absorb many trusts total operating contingencies and working capital reserves without any consideration for other in-year financial risks arising.

For ambulance trusts in particular, evidence highlighted for this review provided a clear relationship between higher pay costs and a failure to achieve response time targets directly linked to quality of patient care.

PCTs however, advised that the level of financial exposure associated with annual pay awards is not as great for PCTs as it is for other NHS organisations. This is due to the fact that direct pay costs only account for approximately 10% of a typical

PCTs expenditure baseline. PCTs with a large provider arm will have a greater exposure against direct pay costs but certainly not at levels of between 65% and 80% as seen with acute, mental health and ambulance trusts.

Chapter 1: Introduction and process

Introduction

- 1.1 This report has been prepared for NHS Employers by Philip Grant to supplement and inform NHS Employers evidence to the Pay Review Bodies for 2009/10 and 2010/11. It follows the production of the report prepared by NHS Employers for the 2008/09 Pay Review Bodies setting out the cost drivers and financial planning assumptions being made across individual NHS organisations for the period 2007/08 to 2010/11.
- 1.2 The report prepared for the 2008/09 Pay Review Bodies covered the three year planning period to 2010/11. The main focus of this latest review and report is to investigate where actual costs or planning assumptions have materially changed from those set out previously rather than the wholesale replication of the analysis of costs and financial planning processes across every organisational area of the NHS.

Process

- 1.3 On the basis of the above principles, a reduced initial selection of NHS organisations were identified on a representative basis covering each main NHS organisation type. Initial contact was made with each of those organisations to establish agreement to support this review and identify any potential barriers to the required parameters of the review (e.g. annual leave arrangements conflicting with the timeframe of the review).
- 1.4 The initial focus of this 2009/10 review was to re-establish the accuracy and robustness of the 2008/09 report prepared by NHS Employers. The Foreword attached to that report invited Chief Executives to comment on:
 - whether the review had captured the key cost pressures anticipated locally?
 - whether local estimates of cost pressures varied significantly from those within the report?
 - whether there were further material factors regarding income and expenditure?
 - whether there were other changes such as R&D levies or specialist services that should have been included?
 - whether the range of efficiency requirements (from traditional Gershon levels of 2.5% to latest CSR levels of 3% and the additional levels identified in the report) were realistic and deliverable?
- 1.5 This latest review considered the direct responses received to these questions immediately following the report being prepared and circulated in October 2007. It also specifically asked the relevant finance leads from the newly selected organisations for their current views in relation to these questions.

- 1.6 Where comments were received (and could be triangulated or independently evidenced) from this initial component of the 2009/10 review and which would potentially require the 2008/09 figures or report to be updated, they are included within the relevant section of this latest report. A general update on a number of the 2008/09 assumptions is included within chapter 3; 2008/09 Update and Generic Issues.
- 1.7 In line with the process followed in 2008/09, individual face-to-face review meetings were held with the relevant strategic financial planning leads from the small group of selected organisations. The purpose of these meetings was to initially establish the answers to the questions posed following the 2008/09 review and then to analyse the latest financial planning assumptions and financial forecasts being made for 2009/10 – 2010/11.
- 1.8 This report was subsequently prepared from that analysis and shared with all participating organisations to ensure accuracy and highlight any areas where individual views or information had been mis-represented. This component of the process also allowed for a period of peer review between the selected organisations and the presentation of the overall analysis within the report.
- 1.9 The timescale for the review was around 4 weeks with the original review specification being agreed during week commencing 4 August 2008 and the draft report being submitted to NHS Employers during week commencing 1 September 2008.
- 1.10 The following organisations were selected and kindly contributed to the analysis elements of the review and to the peer review of this report. On behalf of NHS Employers their input and support is acknowledged and very much appreciated.
- Leeds Primary Care Trust
 - Northampton General Hospital NHS Trust
 - North Lincolnshire Primary Care Trust
 - Rotherham, Doncaster & South Humber Mental Health Foundation Trust
 - Yorkshire Ambulance Service NHS Trust

Chapter 2: Update on 2008/09 and generic issues

- 2.1 The initial focus of this 2009/10 review was to re-establish the accuracy and robustness of the 2008/09 report prepared by NHS Employers. The Foreword attached to that report invited Chief Executives of individual NHS organisations to comment on a number of factors relating to the report's accuracy, reasonableness and completeness.
- 2.2 All comments received were in agreement with the overall tone of the report, the general level of financial pressures identified and the additional levels of efficiency required over and above Gershon levels. However, finance directors and senior financial planners highlighted a number of factors which had either changed since the production of the 2008/09 report or had arisen since and created a potential new cost pressure for the future.
- 2.3 This chapter sets out those generic factors which generally apply or affect all NHS organisations whereas chapters 3 to 6 address issues specific to individual sectors of the NHS i.e. Primary Care Trusts, Acute Trusts, Mental Health Trusts and, Ambulance Trusts.

Overall NHS financial position

- 2.4 The significant overall improvement in the financial position across the NHS is well documented. Taken as a whole, the financial position of the NHS at the end of 2007/08 was a surplus to a level in excess of £1.6 billion and individual NHS organisations have been instructed to plan for similar surpluses in 2008/09. However, a number of factors should be emphasised which reinforce specific elements of NHS Employers verbal and written evidence to the pay review bodies for 2008/09.
- 2.5 The current surplus is non-recurrent and has been achieved through short-term measures which will not generate such savings year-on-year. Examples include the deferment of essential investment from one year to the next through temporary delays to patient care initiatives. Such measures cannot be repeated each year due to the longer-term and permanent impact they would have upon patient care and activity/waiting list targets.
- 2.6 Existing non-recurrent savings are not therefore available for investment in recurrent areas of expenditure, such as staff pay. To do so would generate un-funded recurrent commitments for future years thus returning the NHS to the boom and bust cycle which has contributed to the significant historic deficits seen over recent years.
- 2.7 The level of the current surplus is only around 2.0% of turnover. As discussed during the verbal evidence session of the 2008/09 pay review round, good business practice for any other sector of the UK economy is to plan for and maintain working capital and contingency reserves in excess of this level. Unforeseen circumstances and unplanned costs are equally likely across the NHS as with any other industry and the lack of even the most

minimal contingency reserves are another reason why the NHS has traditionally fallen into deficit so easily.

- 2.8 The NHS is not yet universally in surplus. There are still parts of the NHS in deficit and a range of individual NHS organisations which are either carrying recurrent deficits or have not yet repaid the significant short-term borrowing which was required to cover accumulated deficits over the past few years. Further planned surpluses are required to correct this underlying or accumulated shortfall in resources.
- 2.9 Similarly, the requirement on NHS trusts and foundation trusts to achieve a breakeven position over the short to medium term rather than on a year by year basis means that some are only just achieving, or have not yet even achieved a 3 or 5 year breakeven position despite declaring an in-year surplus for 2007/08.
- 2.10 The financial position and financial management of the NHS continues to improve though and further repayments of historic deficits and strengthening of individual organisations balance sheets should be expected. This remains dependent upon continued robust management of financial plans and overall control of recurrent commitments.

2007/08 Comprehensive spending review

- 2.11 As set out in the Foreword to the 2008/09 financial planning and cost pressures review, the full impact of the announcement of the comprehensive spending review for 2008/09 to 2010/11 had not yet been incorporated into individual organisations medium term financial plans. In summary there were 3 main factors impacting upon the previous financial planning assumptions being made by most NHS organisations:
- Higher than anticipated financial allocations for 2008/09
 - Additional national commitments linked to Lord Darzi's Next Stage Review
 - An increase in efficiency targets from 2.5% to 3.0%
- 2.12 PCTs previous planning assumptions were for an increase in their centrally allocated revenue resource limits of 3.5% for 2008/09 onwards. The comprehensive spending review proposed an increase in NHS spending by an average of 4% above inflation each year through to 2010/2011. The specific one year allocation announcement For 2008/09 increased PCT allocations in England from £70.35 billion in 2007/08 to £74.20 billion, an actual increase of 5.46%.
- 2.13 Individual PCT allocations were announced for a one year period only and despite the announcement of general future funding for the NHS, there are a number of factors which mean it remains difficult for PCTs to forecast their likely income levels for 2009/10 and beyond and these are set out in section 3 of this report.

- 2.14 The supporting comprehensive spending review action plans and 2008/09 operating framework for the NHS outlined a number of additional commitments and targets for NHS organisations. As highlighted in the Foreword to the NHS Employers 2008/09 report. These include:
- improve access to GP services, with additional resources for over 100 new GP practices and 150 new health centres open seven days a week
 - ensure cleaner hospitals, with the introduction of MRSA screening for all elective patients next year and emergency admissions within 3 years, deep cleaning of hospitals and increased powers for matrons and ward sisters
 - create a more innovative NHS, with a new Health Innovation Council increasing Department of Health Research and Development spending to over £1 billion by 2010/11, taking the single fund for health research to £1.7 billion.
- 2.15 Additional national commitments, whilst often for determination locally, have also been established through central guidance. These include the full vision for the future of the NHS as set out in the Strategic Health Authority supporting plans underpinning the final Next Stage report, as well as the newly set out suite of local stretch targets published as part of the Operating Framework for 2008/09.
- 2.16 The comprehensive spending review announcement also included confirmation that the minimum expected annual efficiency saving was being increased from 2.5% to 3.0% alongside the expectation of further value for money reforms realising annual net cash-releasing efficiency savings of at least £8.2 billion by 2010/2011 (through locally determined measures such as improving community based services helping those with long-term conditions avoid traumatic and expensive emergency admissions, reducing variations in productivity and improving procurement practices).

Impact of 2008/09 pay review body recommendations

- 2.17 Individual financial plans for 2008/09 included provision for pay awards generally averaging 2.5%. The main actual awards made for 2008/09 are shown in the following table.

Staff Group	2008/09 Pay Award
Agenda for change	2.75%
Very senior managers	2.2%
Consultants, the staff, specialty and associate specialist groups of doctors	2.2%
Doctors in training and salaried dentists	2.2%
Salaried general medical practitioners	2.2%

- 2.18 The detailed financial impact upon individual NHS organisations will have varied according to their staff mix. For example, those with high levels of Agenda for Change staff, such as ambulance trusts, will have needed to set aside additional financial provisions as a result of their overall cost of pay

awards being above their initial 2.5% assumption. The impact upon other NHS organisations varies along with the consequential implications and these are set out in the following chapters 3 to 6.

International Financial Reporting Standards

- 2.19 Under IFRS being introduced to all public sector financial statements by The Treasury, individual organisations balance sheets will be required to include the value of assets under its ownership or control. Whilst most government departments and public bodies have introduced IFRS with effect from 1 April 2008, the Department of Health on behalf of the NHS has secured a 12 month deferment to 1 April 2009.
- 2.20 The very significant implications for the NHS is that assets funded through private finance have until now generally not appeared on NHS balance sheets and therefore not been subject to an annual depreciation charge to reflect its decline in worth, typically calculated as a percentage of its original cost, and a capital charge, currently set at 3.5% to reflect the opportunity cost of tying up public resources.
- 2.21 Under IFRS, many such assets funded through PFI or LIFT type arrangements are likely to be required to appear on the NHS organisation's balance sheet and therefore generate an additional cost to meet the depreciation and capital charges. For large multi-million pound developments, such as new hospitals, funded through PFI arrangements this cost pressure will be many millions of pounds.
- 2.22 At the time of writing, national discussions are on-going between HM Treasury, the Department of Health and representatives of NHS organisations to secure a workable solution to this issue. At one extreme this could add a cost pressure of several hundred million pounds to NHS organisations whilst at the other extreme capital charges and depreciation are a non-cash 'circular' transaction for which the net cost to the public purse is zero. The exact detail of the introduction of IFRS across the NHS from 1 April 2009 is awaited.

Chapter 3: Primary Care Trusts

Review of 2008/09

- 3.1 The review of PCT financial plans undertaken as part of the background analysis to this report confirmed that the PCT expenditure analysis contained within the 2008/09 report was broadly in line with current expenditure baselines for a 'typical' PCT. Some relatively large variations are likely to exist between PCTs based on factors such as size of provider function and geographical location, however, it would not be possible within the scope of this review to provide a separate representative analysis of each such PCT size and organisational structure. PCT contributors nevertheless confirmed that the 2008/09 expenditure baseline analysis was not untypical.
- 3.2 A significant factor which has changed since the preparation of the 2008/09 financial plans is the overall financial landscape across PCTs. The improvement in the financial position of the NHS over the past twelve months is well documented and this is particularly noticeable within PCTs as set out in paragraph 2.4 to 2.10.
- 3.3 A review of current year (2008/09) individual commitments and cost pressures highlighted that most factors had varied very little from the initial 2008/09 planning assumptions. The main cost pressures for PCTs' remain as:
- Secondary care emergency and elective activity growth levels
 - Achievement of patient waiting time targets
 - Continuing care
 - Primary care prescribing
 - Annual pay awards combined with incremental pay drift linked to new pay bandings such as Agenda for Change scales
- 3.4 As with all NHS organisations, the pay review bodies three year pay award for Agenda for Change staff was at a higher level than anticipated. Initial planning had included a provision of 2.5% for 2008/09 pay uplift compared to the 2.75% awarded for year 1 of the three year agreement.
- 3.5 However, subject to the size of the PCT provider arm functions, direct pay costs are a relatively small component of PCT expenditure baselines and therefore such a variation was generally within limits manageable through day-to-day contingency planning. The majority of NHS staff costs fall within provider organisations and the indirect cost implications for PCTs are generally covered through their payments to provider trusts determined by the nationally set tariff uplift.
- 3.6 There have been some high profile drug recommendations through the National Institute for Health and Clinical Excellence (NICE) including further advancements in drugs for the treatment of cancer and wet age related

macular degeneration (e.g. Lucentis). However, despite these one-off high cost recommendations, PCTs advised that overall primary care prescribing costs are being maintained within the previously advised 8% net increase in prescribing budgets.

Allocations

3.7 As stated in paragraph 2.12, PCTs' previous planning assumptions were for an increase in their centrally allocated revenue resource limits of 3.5% for 2008/09 onwards. The comprehensive spending review proposed an increase in NHS spending by an average of 4% above inflation each year through to 2010/2011.

3.8 For 2008/09, PCTs had previously indicated that they were planning for an increase in allocations of approximately 3.5%. The actual allocation increases for 2008/09 were on average 5.46%. The higher than anticipated allocation has been utilised in a structured and systematic manner covering the following areas:

- Implementing the new requirements of the CSR action plan as set out in paragraph 2.14
- Progressing local action to further advance delivery of national patient waiting times such as the maximum 18 weeks from referral to treatment and the two week cancer targets
- Making good the previous reliance on non-recurrent sources of funding to underpin additional recurrent expenditure
- Re-establishing essential balance sheet strength after several years of deterioration through non-recurrent solutions to historic financial difficulties
- Non-recurrent repayment of historic accrued deficits
- Establishing working capital and operational business contingencies in line with good financial practice and Strategic Health Authority guidance

3.9 For 2009/10 onwards, there are a number of factors which mean it is currently difficult for PCTs to forecast their likely allocation and income levels:

- The 2008/09 allocations were made for a single year rather than the planned three year allocation announcement. The allocations for 2009/10 onwards are expected alongside the publication of the 2009/10 Operating Framework in the autumn of 2008
- Work has been progressing nationally on the establishment of a more robust allocation formula which may significantly change the target allocation for individual PCTs and therefore result in comparatively higher or lower annual growth funding between individual PCTs
- The CSR announcement stated that NHS allocations would increase by an average of 4% above inflation over the coming years. However, it has been difficult to reconcile historic above inflation growth levels to 'real' levels of inflation as experienced by individual NHS organisations or as published through the various national inflation measures

- 3.10 In advance of the publication of PCT allocations for 2009/10 onwards, PCTs are typically making initial planning assumptions supported by Strategic Health Authority guidance which anticipates allocation increases for 2009/10 and 2010/11 of between 5.5% and 6.3%.

Additional factors for 2009/10 and 2010/11

- 3.11 There were a number of further specific factors identified as creating particular cost pressures for ambulance trusts during 2009/10 and 2010/11.
- 3.12 As previously stated, the biggest commitment for PCTs is the purchase of healthcare from NHS provider trusts. The annual increase in the price of such services is predominantly determined by the nationally set tariff published by the Department of Health as part of its Operating Framework and PCT Financial Allocations announcement which for 2009/10 is expected during October 2008. In the meantime, PCTs and NHS provider trusts are basing financial planning assumptions on interim guidance provided through Strategic Health Authorities.
- 3.13 The interim assumptions being used by the PCTs contributing to this review are for a gross tariff increase of 5.8% in 2009/10 and 2010/11 which reduces to a net increase of 2.8% when allowing for the delivery of 3% efficiency savings by provider organisations. These assumptions will of course be revisited once the Operating Framework has been published in the autumn of 2008.
- 3.14 There are a number of cost pressures being faced by PCTs which are significantly in excess of normal annual inflationary levels but for which the baseline expenditure levels remain a relatively minimal overall financial commitment. Such pressures include the rising cost of litigation insurance, employee mileage reimbursement rates linked to rising fuel costs and, rising continuing care costs due to the same reasons identified previously. Due to the minimal overall financial baseline for these commitments the additional annual increases are generally being financed through day-to-day operational business contingencies.
- 3.15 However, a number of significant cost pressures remain for PCTs including the continued and increasing patient care targets such as the 18 weeks referral to treatment target, the 2 week cancer wait targets and separate requirements to reduce the incidence of healthcare acquired infections. All such targets are continuing to create further recurrent cost pressures for PCTs as the achievement of the targets becomes ever more difficult as higher % improvements are required. An associated cost pressure is that related to recurrently making good previous non-recurrent sources of financing used to deliver previous years targets in these areas.
- 3.16 There is well documented evidence in recent weeks of an increasing and unexpected challenge to the future delivery of the 18 week target (as well as a number of other waiting time targets). During the first three months of 2008/09 referrals rates for patients requiring secondary care consultations or procedures have increase by significantly higher rates than would

normally be expected. Rates appear to vary but PCTs reporting annual like-for-like increases of between 15% and 20% are not uncommon.

- 3.17 Whilst the causes of these increases are currently being investigated and potential options being considered, a 15% to 20% increase in activity against PCTs biggest financial commitment as commissioners would create an additional cost pressure in excess of PCTs operational contingencies. This could remove any financial flexibility to cover future business risks such as higher than anticipated pay awards.
- 3.18 Alongside the operational financial risks to PCTs is the continued requirement being set by Strategic Health Authorities for individual PCTs to all achieve a year end financial surplus in line with 'Control Totals' which collectively will deliver the national surplus being planned across the NHS. For 2008/09 these are set at broadly the same level as the 2007/08 financial surplus of £1,667million (approximately 2%). As identified previously such a surplus is in line with good financial practice and normal business operating contingencies.

The potential impact of a higher than forecast pay award

- 3.19 PCTs advised that the level of financial exposure associated with annual pay awards is not as great for PCTs as it is for other NHS organisations. This is due to the fact that direct pay costs only account for approximately 10% of a typical PCTs expenditure baseline. PCTs with a large provider arm will have a greater exposure against direct pay costs but no PCT will have pay costs of between 65% and 80% as seen with acute, mental health and ambulance trusts.
- 3.20 Due to this relatively small financial exposure for PCTs, any marginal increases in pay award above forecast or planned levels are generally manageable within day-to-day operating contingencies. The majority of the risk on NHS pay falls to other provider NHS organisations as set out in chapters 4, 5 and 6. For PCTs as commissioners of these services the costs are generally covered through the fixed tariff uplift and any subsequent or in-year variations in cost are for the provider trust to financially manage.

Chapter 4: Acute Trusts⁹

Review of 2008/09

- 4.1 The review of acute trust financial planning undertaken as part of the background analysis to this report confirmed that the acute trust expenditure analysis contained within the 2008/09 report was broadly in line with current expenditure baselines for a 'typical' acute trust. Some relatively large variations are likely to exist between trusts based on factors such as specialties covered and multi-location providers. For example, the 2008/09 report referred to the higher drugs costs of specialist cancer centres.
- 4.2 It would not be possible within the scope of this review to provide a separate representative analysis of each such acute trust but contributors nevertheless confirmed that the 2008/09 expenditure baseline analysis was not untypical of an NHS acute trust or foundation trust.
- 4.3 A significant issue raised through this review was the level of efficiency savings required in 2008/09 to deliver trusts overall financial plans. For acute trusts the 2008/09 report advised that an additional 1.5% efficiency would typically be required over and above the historic tariff efficiency provision of 2.5% (i.e. 4% overall). However, a figure of approximately 5% has not been stated as being the level of efficiency saving required of acute trusts to deliver the 2007/08 financial balance and 2008/09 financial plans.
- 4.4 The acute trust contributor was not alone in stating that the ability to continue to deliver year-on-year marginal efficiency is now significantly diminished and organisations need to focus on more 'process improvement' to deliver future efficiency savings. Such process improvement, it was stated, needs up-front investment to deliver medium to longer-term savings and would include initiatives such as automation of administrative functions.
- 4.5 A number of examples were quoted of how the required efficiencies were delivered in 2007/08 and are anticipated to be delivered in 2008/09. These include:
- One-off asset sales
 - Additional PbR activity (where possible)
 - Procurement hub savings (driving down prices through suppliers)
 - Resource Accounting and Budgeting (RAB) reversal savings
 - Operational vacancy savings, recharge arrangements etc
- 4.6 As with all NHS organisations, the pay review bodies three year pay award for Agenda for Change staff was at a higher level than anticipated. Initial planning had included a provision across all trust staff groups of 2.5% for 2008/09 pay uplift. The higher actual Agenda for Change level of 2.75%

⁹ Foundation trusts have different financial regimes to non foundation trusts and not all the statements below will be relevant to them

awarded for year 1 of the three year agreement was funded through use of operational contingencies and savings as a result of lower awards for other staff groups.

- 4.7 Whilst most acute trusts were able to declare a non-recurrent surplus at the end of 2007/08, these were within levels which have previously been referred to within this report as good financial practice i.e. below 2%. It must be emphasised that because of the historic financial challenges within the NHS, 2007/08 was for many trusts the first year in which they achieved the overall 5 year breakeven position and the realisation of non-recurrent in-year surpluses were often required to repay working capital loans needed as a result of past years' deficits.

Additional factors for 2009/10 and 2010/11

- 4.8 The biggest current uncertainty for acute trusts for 2009/10 is the lack of clarity regarding the national tariff uplift which is expected to be announced alongside the publication of the Operating Framework and PCT allocations in October 2008. In the meantime, trusts are using a range of planning assumptions which, in respect of the national tariff uplift, are typically between 2.4% and 2.8%.
- 4.9 However, for 2009/10, the requirement for acute trusts to deliver internal cost improvement programmes above the inherent efficiency level within the national tariff remains. Overall net efficiency savings targets are once again in the region of 5% and a range of initiatives will be deployed to deliver such savings, these include estate rationalisation, rostering improvements and increases in day-case rates.
- 4.10 There were a number of further specific factors identified as creating particular cost pressures for acute trusts during 2009/10 and 2010/11. These include the generic cost pressure created as a result of rising fuel costs. NHS trusts generally purchase their energy through the 'spot' market rather than through any future 'hedging' arrangement and therefore recent and future forecast rises in energy prices are felt instantly by the trust.
- 4.11 Combined fuel prices rises over the past few months are resulting in additional cost pressures for a typical acute trust of in excess of £1million. Whilst this has prompted greater local action on the delivery of more energy efficient equipment, building and energy management systems, this significant cost pressure remains for trusts to cover from in-year savings and operating contingencies.
- 4.12 Pay drift was still quoted as a significant financial risk. For acute trusts whose main expenditure item is their pay-bill, annual incremental drift in excess of 1% continues to create a considerable additional financial cost pressure. The example was quoted of nurses within pay bands 4 or 5, who may not traditionally move between employing organisations during their careers, are now receiving annual increments under Agenda for Change for potentially the forthcoming 3 – 5 years whereas previously they were at the

top of their pay band.

- 4.13 Most acute trusts are developing and implementing local action plans to manage the financial risk across a number of other traditional cost pressure areas. These include litigation insurance where trusts are improving their local risk management arrangements and thereby securing a reduction in premiums payable through the Clinical Negligence Scheme for Trusts (CNST).
- 4.14 Another example is that regarding training and development funding (e.g. MADEL & SIFT) which was causing some significant uncertainty during 2007/08. The actual impact of revised allocation arrangements, whilst varying between organisations, was not as bad as generally expected and conversations are already underway to ensure robust planning and forecasting underpin these funds for 2009/10 and beyond.
- 4.15 The potential cost pressures associated with the adoption of IFRS outlined in chapter 2 are likely to be greatest for acute trusts and NHS trusts (although any NHS organisation with a large privately financed capital development will face significant charges). The awaited solution to this 'circular' funding issue will identify the extent to which additional cost pressures will be placed on individual organisations with, or without, additional balancing resources.
- 4.16 In the meantime, the introduction of IFRS appears to be "driving a reality check" – by potentially putting such capital schemes onto organisational balance sheets, such schemes become far more transparent and this has helpfully started to raise questions about the extent of financial commitment being entered into. An additional factor affecting such schemes at the current time is the difficulty many private sector partners are experiencing when trying to secure commercial credit and financing facilities at preferential rates. The current 'credit crunch' means credit charges are, where approved at all, generally higher.
- 4.17 A further challenge to acute trust and provider trusts more generally is the implementation and development of 'World Class Commissioning' skills across commissioning PCTs. This initiative is being led by the Department of Health in a bid to strengthen the commissioning skills and capacity within PCTs as "leaders of the local NHS". The intention is to more directly dictate provider organisations NHS activities to ensure they fit with and meet local health needs assessments and strategic planning undertaken by PCTs.
- 4.18 The issues and risks this raises with provider organisations is the desire of PCTs to provide more healthcare within local community and primary care settings. This is being underpinned by initiatives such as practice based commissioning which is raising the profile of local GPs as commissioners as well as providers of more services traditionally provided in a hospital setting. This creates a potential loss of income and contribution to fixed costs for acute trusts.

- 4.19 Similarly, PCTs are strengthening their contracting expertise which is resulting in more frequent and robust challenges to acute trusts activity coding and charging mechanisms and therefore creating what some see as a 'mini-industry' of administrators, counters and data coders which potentially contribute little to direct patient benefit.
- 4.20 Conversely, a recent National Audit Office report points to the importance of such information to inform the decision making process of strategic health needs assessment and service planning.

The potential impact of a higher than forecast pay award

- 4.21 Acute trust evidence and contributors indicate that small variations in pay awards from planned levels are generally manageable within day-to-day operational contingencies as was the case with the slightly higher level of 2008/09 award.
- 4.22 However, whilst the majority of trust income is determined by the nationally set tariff uplift, a significant risk is transferred to all provider trusts that future pay awards for NHS staff will be higher than accounted for in the tariff uplift and a large additional cost pressure is created for those organisations unless, as is not traditionally the case, the rate of tariff uplift is revisited.
- 4.23 Under the current circumstances, any small variances to future pay awards would be met from within operational contingencies. More significant increases to future pay awards would require the revisiting of operational financial plans and the potential for direct patient care, service quality or nationally set access targets to be jeopardised. In this respect, as an indication only, a 1% variation in anticipated pay awards would predominantly absorb many trusts total operating contingencies and working capital reserves without any consideration for other in-year financial risks arising.

Chapter 5: Mental Health Trusts

Review of 2008/09

- 5.1 As with other NHS organisations, the mental health trust expenditure analysis contained within the 2008/09 report was confirmed as broadly in line with current expenditure baselines. The mental health contributor to this latest review quoted baseline pay expenditure at 70% of total expenditure which is marginally higher than the analysis provided for 2008/09 but overall there were no material differences and the detailed expenditure profile remains generally the same.
- 5.2 As with acute trusts, the issue was raised through this review of the level of efficiency savings required in 2008/09 to deliver trusts overall financial plans. For mental health trusts the 2008/09 report advised that an additional 2.7% efficiency would typically be required over and above the historic tariff efficiency provision of 2.5% (i.e. 5.2% overall) and this was confirmed.
- 5.3 The view of the acute trusts was reinforced through the mental health trust view that the ability to continue to deliver year-on-year marginal efficiency is now significantly diminished and organisations need to focus on more 'process improvement' to deliver future efficiency savings.
- 5.4 A number of examples were quoted of how the required efficiencies were delivered in 2007/08 and are anticipated to be delivered in 2008/09 for mental health trusts. These include:
- Estate rationalisation
 - Business rates refunds
 - Additional activity for new commissioners
 - Operational vacancy savings, planned contingencies etc
- 5.5 As with all other NHS organisations, the pay review bodies three year pay award for Agenda for Change staff was at a higher level than anticipated. Initial planning had included a provision across all trust staff groups of 2.5% for 2008/09 pay uplift. The higher actual Agenda for Change level of 2.75% awarded for year 1 of the three year agreement was funded through use of operational contingencies and savings as a result of lower awards for other staff groups.
- 5.6 The lack of Payment by Results (PbR) principles and established tariffs covering mental health services are often quoted by mental health trusts as an example of how financial flexibility and efficiency gains are very difficult to achieve compared to acute trusts. This is because whilst generally still funded on a block financial basis mental health trusts cannot generally increase their income by providing a corresponding increase in levels of activity. In acute trusts the ability to earn greater income through PbR tariff

activity is a valuable lever in achieving efficiency gains and additional contributions to fixed costs.

Additional factors for 2009/10 and 2010/11

- 5.7 There were a number of specific factors identified as creating particular cost pressures for mental health trusts during 2009/10 and 2010/11.
- 5.8 Fuel price rises have a double impact through rising staff mileage rates as well as a significant rise in energy prices for what is traditionally a geographically dispersed and ageing mental health estate.
- 5.9 A number of grievances and appeals relating to Agenda for Change remain outstanding despite time having moved on since its implementation.
- 5.10 Joint commissioning arrangements alongside local authority partners create a potential financial risk for mental health trusts. There continues to be financial pressures upon local authority budgets and this has the effect of putting indirect pressure upon NHS budgets under such joint commissioning arrangements.
- 5.11 Overall, for 2009/10 and 2010/11, mental health trusts continue to rely on delivering annual efficiency savings in excess of the 3% levels set nationally.

The potential impact of a higher than forecast pay award

- 5.12 As with acute trusts, small variations in pay awards from planned levels within mental health trusts are generally manageable within day-to-day operational contingencies as was the case with the slightly higher level of 2008/09 award. However, more significant increases to future pay awards combined with the lack of flexibility which is still offered to other NHS trusts through PbR mechanisms, together with the on-going cost pressures highlighted above means that most mental health trusts would have little flexibility to meet additional large pay pressures other than to directly divert funding set aside for service developments and other day-to-day running costs.

Chapter 6: Ambulance Trusts

Review of 2008/09

- 6.1 As with other NHS organisations, the ambulance trust expenditure analysis contained within the 2008/09 report was confirmed as broadly in line with current expenditure baselines. Small variances are evident between geographical locations, such as within and outside of London but the overall expenditure profile remains generally the same.
- 6.2 A review of current year commitments and cost pressures highlighted a number of factors which varied from the initial 2008/09 planning assumptions. Noticeably, these included the pay review bodies three year pay award for Agenda for Change staff which account for approximately 99% of ambulance trust employees. Initial planning had included a provision of 2% for 2008/09 pay uplift and this was considerably lower than the 2.75% awarded for year 1 of the three year agreement.
- 6.3 Similarly, the cost pressure associated with the change in measurement of the response target from the time of call connection rather than despatch of the response vehicle has been particularly challenging for all ambulance trusts. For a typical trust this has created a cost pressure of between 5% and 10% of turnover over a two year period.
- 6.4 It remains the case for the majority of trusts that the requirements to achieve operational financial balance and response time targets at the same time are not easily balanced. It was explicitly stated during this review that the award of a higher than planned 2008/09 pay award has directly contributed to a worse than required response time performance and a risk to patient care.
- 6.5 The additional cost of pay awards on top of all other operational cost pressures for 2008/09 is being met through the deferment of planned developments which has created non-recurrent savings but delayed the implementation of essential initiatives aimed at improving patient care and response time targets. Such savings remain non-recurrent in nature and in pre-committing future years funding do not meet good financial practice expectations.
- 6.6 As with mental health trusts, the lack of Payment by Results (PbR) principles and established tariffs covering ambulance services are often quoted by ambulance trusts as an example of how financial flexibility and efficiency gains are very difficult to achieve compared to acute trusts. This is because whilst generally still funded on a block financial basis ambulance trusts cannot increase their income by providing a corresponding increase in levels of activity. In acute trusts the ability to earn greater income through PbR tariff activity is a valuable lever in achieving efficiency gains and additional contributions to fixed costs.

Additional factors for 2009/10 and 2010/11

- 6.7 There were a number of further specific factors identified as creating particular cost pressures for ambulance trusts during 2009/10 and 2010/11.
- 6.8 Fuel price rises continue to cause an additional cost pressure over and above the day-to-day costs of maintaining their vehicle fleet. Although fuel costs are a relatively small component of ambulance trusts expenditure baseline (circa 2%) and the additional fuel costs are partially mitigated by continued investment in more fuel efficient vehicles and more advanced fleet utilisation techniques, the extreme rise in petrol and diesel costs experienced by all other sectors of the UK economy are as much a factor affecting ambulance trust financial planning.
- 6.9 Similarly, many ambulance trusts have reported on-going pressures relating to the introduction of Agenda for Change staff bandings over the past 2-3 years and which remain outstanding. Two particular issues were quoted. The first relates to continued grading appeals on behalf of previously band 4 ambulance technicians which are often being re-classified as band 5 posts and creating a cost pressure of several £m's.
- 6.10 The second factor relating to Agenda for Change is the introduction of a new band 3 post to partner trained paramedics in 2-man ambulances. This initiative has been introduced partially in response to the above grading appeals relating to ambulance technicians. However, such skill mix changes are being heavily resisted by relevant trade union representatives.
- 6.11 'Call connect' sustainability will continue to create cost pressures for the foreseeable future despite the introduction of appropriate solutions having been planned and predominantly completed. This continuing pressure has been created as a result of the use of non-recurrent means to deliver improvements to date and the need to meet such costs through recurrent means in future years.
- 6.12 A further area of cost pressure is that relating to national requirements underpinning Emergency Preparedness. Each ambulance trust is required to have in place and maintain "Hazardous Area Response Teams" for which funding is provided directly by the Department of Health to the value of £2.5m. However, it has been emphasised that the full costs of meeting this mandatory requirement is instead estimated to be £3m.
- 6.13 An additional factor affecting many areas of the NHS is the continued growth of the principle of contestability. For ambulance trusts the potential loss of fixed cost income from 'Patient Transport Services' and some Urgent Care (e.g. Category C calls) services means greater pressure on meeting the full costs of essential emergency services.
- 6.14 In advance of the publication of the 2009/10 Operating Framework by the Department of Health, ambulance trusts are collectively asking for a recommended net uplift of 4.5% for their services covering each of the financial years 2009/10 and 2010/11. This would comprise of a gross 7.5%

uplift to cover inflation and the above cost pressures partially then offset by a 3% efficiency saving target. At the time of writing the exact detail of the future Operating Framework is not known.

The potential impact of a higher than forecast pay award

- 6.15 Overall, the ambulance trust evidence highlighted for this review provided a clear relationship between higher pay costs and a failure to achieve response time targets directly linked to quality of patient care.
- 6.16 Despite continuing to invest in and develop a more efficient fleet and high quality service, the lack of the flexibility which is still offered to other NHS trusts through PbR mechanisms and the on-going balance sheet pressure created by the above cost pressures means that most ambulance trusts have little flexibility to meet additional pay pressures other than to directly divert funding set aside for service developments and other day-to-day running costs.

Appendix A

Outline Specification:

The preparation of a brief report for NHS Employers summarising the forecast recurrent financial position across the NHS for the coming 3 years. To include and be based upon an initial review of NHS Employers 2007/08 report with an update based upon the latest financial planning assumptions being made by:

- 2 Primary Care Trusts
- 1 Acute Trust
- 1 Mental Health Trust
- 1 Ambulance Trust

Such an update to particularly consider:

- (a) handling of 2007/08 and 2008/09 surplus
- (b) analysis of recurrent v. non-recurrent position (including context of non-recurrent surplus and anticipation of latest available information regarding NHS allocations for 2009/10 - 2011/12)
- (c) an understanding of the impact of the introduction of International Financial Reporting Standards (IFRS)
- (d) an understanding of the impact of various current cost pressures informing overall inflation levels
- (e) an indication of likely affordable pay award levels for years 2009/2010 and 2010/20
- (f) a summary statement of the potential impact upon NHS organisations of a pay award above recurrent affordable levels

Timescale:

Subject to early agreement of this proposal and the availability of key NHS personnel a summary report should be available as requested by around 5 September 2008. This will include a limited process of peer review across the individual participating organisations included.

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Appendix B



NHS Cost Drivers and Financial Planning 2007/08 – 2010/11



A part of the NHS Confederation
working on behalf of the 

Foreword

The Government's announcement on the outcome of the Comprehensive Spending Review (CSR) for 2008/09 to 2010/11 made on 9 October 2007 included a proposed increase in spending on the NHS by an average of 4% above inflation per year, taking its total budget from £90 billion in 2007/08 to £110 billion in 2010/11.

In addition, it was announced that this additional investment will be accompanied by further value for money reforms realising annual net cash-releasing efficiency savings of at least £8.2 billion by 2010/2011 (through locally determined measures such as improving community based services helping those with long-term conditions avoid traumatic and expensive emergency admissions, reducing variations in productivity and improving procurement practices).

This announcement was accompanied by commitments to:

- improve access to GP services, with additional resources for over 100 new GP practices and 150 new health centres open seven days a week
- ensure cleaner hospitals, with the introduction of MRSA screening for all elective patients next year and emergency admissions within 3 years, deep cleaning of hospitals and increased powers for matrons and ward sisters
- create a more innovative NHS, with a new Health Innovation Council increasing Department of Health Research and Development spending to over £1 billion by 2010/11, taking the single fund for health research to £1.7 billion.

This report sets out an initial assessment of the existing NHS cost pressures as identified by a selection of NHS organisations and sets them in the context of the CSR announcement prior to further clarity regarding the detailed utilisation of the additional resources and value for money savings announced. However, even in the immediate days after the CSR announcement there is emerging information regarding the centralised or ring-fenced utilisation of future NHS resources.

It is provided to support NHS Employers evidence to the pay review bodies as well as for NHS Chief Executives to help inform local planning and seek further views to inform national financial awareness and planning assumptions. Chief Executives are invited to comment on:

- whether this review has captured the key cost pressures anticipated locally?
- whether local estimates of cost pressures vary significantly from those within this report?
- whether there are further material factors regarding income and expenditure?
- whether there are other changes such as R&D levies or specialist services that should be included?

- whether the range of efficiency requirements (from traditional Gershon levels of 2.5% to latest CSR levels of 3% and the additional levels identified in this report) are realistic and deliverable?

Comments are welcomed by the report authors:

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Contents

Executive Summary	4
1. Introduction	6
2. The NHS Confederation and NHS Employers	6
3. Review Process	6
4. Generic Cost Pressures	7
5. Primary Care Trusts	9
6. Acute Trusts	12
7. Mental Health Trusts	14
8. Ambulance Trusts	15
9. Sensitivity and Risk Management	16
Appendices:	
A. Extract from 2007/08 Pay Review Body comments	18
B. Participating organisations	19

Executive Summary

This review which has been undertaken across a broadly representative range of NHS trusts has highlighted a number of cost pressures which have wholly or partially been built into local financial planning and risk management arrangements. Some of these are over and above the cost pressures anticipated within the national Operating Framework and Financial Planning guidelines.

The tables provided in sections 5-8 highlight the anticipated increase in income for each type of NHS trust and how that increase in income is expected to cover the forecast expenditure patterns. Further clarity regarding the utilisation of the CSR announced average 4% real terms increase in NHS spending over the 3 years 2008/09 to 2010/11 will be required in order to determine the accuracy of the income assumptions used (drawn from the Operating Framework guidance for 2007/08).

In each organisations assessment it is clear that there will continue to be a very challenging financial position for the foreseeable future. Each organisational sector of the NHS has consistently highlighted that in order to achieve an in-year breakeven position they are having to identify and deliver additional levels of efficiency savings over and above the expected or imposed Gershon levels of 2.5%. This does not take into account the requirement, where appropriate, to generate in-year surpluses to repay accumulated prior year deficits.

As an example of this difficulty, a typical acute trust would expect the national tariff levels to be set with an in-built cash releasing efficiency saving of 2.5%. The table below shows that the trust would expect to have to deliver a further 1.51% efficiency in 2008/09 to achieve in-year balance.

Table 1: Forecast Income and Expenditure Imbalances 2008/09 to 2010/11

	2008/09 weighte d Uplift %	2009/10 weighte d Uplift %	2010/11 weighte d Uplift %
Income			
Primary Care Trusts	3.43	3.43	3.43
Acute Trusts	2.44	2.44	2.44
Mental Health Trusts	2.42	2.42	2.42
Ambulance Trusts	5.00	5.00	5.00
Expenditure			
Primary Care Trusts	4.56	4.35	3.43
Acute Trusts	3.95	3.95	3.28
Mental Health Trusts	5.11	5.62	4.82
Ambulance Trusts	7.06	7.06	7.06
Additional Efficiency Required			
Primary Care Trusts	1.13	0.92	0.00
Acute Trusts	1.51	1.51	0.84
Mental Health Trusts	2.69	3.20	2.40

Ambulance Trusts	2.06	2.06	2.06
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Over the 3 year period to 2010/11, there is a noticeable improvement in the underlying financial projections. However, there are still material additional efficiencies required by 2010/11 and there is no in-built contingency within these assumptions to cover any new or increased patient care targets that might be introduced during this period.

For the 2008/09 pay review bodies, this report clearly identifies where the increased expenditure on the NHS in 2008/09 – 2010/11 will go and why the indicative levels of pay uplift of 2.5% would cause significant financial pressure.

For the Comprehensive Spending Review, this evidence suggests that the level of funding increase for the NHS, whilst not needing to be maintained at recent levels, needed to be set at realistic levels according to the attached analysis and to fully take account of likely future increases in national targets or new clinical priorities.

It should be emphasised that this report is based upon a limited range of NHS organisations and factors known at the time (Summer 2007). There are some examples of where these local planning assumptions are individually or collectively different to some national planning assumptions being made and this will be due to one or more legitimate reasons including:

- differences between national and local cost profiles
- different planning assumptions regarding staff pay pressures such as staff turnover and recruitment costs
- different understanding regarding future political and clinical priorities

This report should therefore be read with the caveat that it applies at a specific point in time and based on local information from a selected cross representation of NHS organisations. It is anticipated that it will be updated over time as further national and local information becomes available.

1. Introduction

- 1.1 This report has been prepared by the NHS Confederation and NHS Employers following a review of cost drivers and financial planning assumptions being made across individual NHS organisations for the period 2007/08 to 2010/11.
- 1.2 The main purpose of this report is to:
- inform the Comprehensive Spending Review 2008/09 – 2010/11 on behalf of the NHS; and,
 - provide supporting evidence to the NHS Employers submission to the Pay Review Bodies for 2008/09 on behalf of employing organisations in the NHS. The review bodies made a number of comments relating to the lack of financial clarity about affordability and expenditure levels across the NHS as part of their 2007/08 pay award recommendations (see Appendix A).

2. The NHS Confederation and NHS Employers

- 2.1 The NHS Confederation is an independent body that brings together the full range of organisations that make up the modern NHS. We work with our members to improve health and health services by:
- influencing policy and public debate
 - supporting health leaders through networking and sharing information
 - promoting excellence in employment to improve the working lives of staff.
- 2.2 NHS Employers is the arm of the NHS Confederation responsible for workforce and employment issues, working on behalf of NHS organisations in England. Our mission is to achieve excellence for patients, the public and staff by supporting the leadership of the new NHS.
- 2.3 NHS Employers represents employers' views and act on their behalf in the current policy areas of:
- pay and negotiations
 - planning and workforce
 - productivity
 - employer of excellence
 - HR policy and practice.

3. Review Process

- 3.1 This review has been undertaken through a series of structured face-to-face interviews with senior financial management officials (predominantly Finance Directors and Deputies) across a

representative range of separate NHS organisations. The interviews have focused on the individual organisations cost base, internal financial planning assumptions and anticipated/potential cost pressures over the coming three year planning cycle.

- 3.2 It should be recognised that the starting point for such local planning assumptions was, as expected, the Department of Health (DH) Operating Framework guidance. However, without exception, each organisation interviewed pointed to a range of factors and local circumstances which required the Operating Framework assumptions to be updated in a number of areas to ensure that internal financial planning and risk management was as robust as possible.
- 3.3 Some organisations involved also emphasised that the disparity between elements of the DH guidance and their own professional view of financial planning risks meant that financial plans submitted to either the DH or Monitor did not necessarily fully capture the range and level of financial assumptions being utilised internally for their own financial management. There will therefore be subtle but nonetheless material differences between the cost driver analysis of this review and that utilised by DH officials.
- 3.4 The organisations who kindly participated in this review are listed at Appendix A. All contributors are thanked for their honesty and openness during discussions and in recognition of the level of detail and personal opinion often provided, this report does not directly attribute any specific comments or views.
- 3.5 Should you require any further information regarding this report or the review upon which it is based you may contact Philip Grant, Director of Finance Advisor philip.grant@nhsemployers.org or Nigel Edwards, Policy Director nigel.edwards@nhsconfed.org

4. Generic Cost Pressures

- 4.1 This report sets out the comparative baseline expenditure and future cost pressures for a typical PCT, Acute Trust, Ambulance Trust and Mental Health Trust. In the analysis provided for acute trusts, comparisons are made highlighting the differences between a typical district general hospital, a regional specialist trust and a recognised national cancer centre.
- 4.2 For all organisations involved within this review there were a number of consistencies with regard to future planning assumptions being made. These are set out in this section whilst the following organisation specific sections of this report highlight cost pressures or issues which are generally unique to those particular types of trust.

Pay

- 4.3 As pay is by far the greatest element of expenditure across the NHS, typically 65 - 70% of expenditure within provider trusts, cost pressures against these budgets form a significant risk to the employing organisation.
- 4.4 Without exception every organisation was, unsurprisingly, using the NHS Operating Framework guidance as the basis for a starting point of 2.5% pay inflation over the coming years. However, again without exception, all organisations were clear on their need to recognise and plan for additional pressures above this level against their pay budgets.
- 4.5 Additional pressures over and above annual pay inflation included:
- Agenda for change pay drift – recognising the wider pay bands of agenda for change and that many long standing employees may no longer be at the top of their grade. This causes a short term cost pressure whilst individuals are awarded annual increments over and above their annual pay award. Most organisations recognise that this effect will only last two or three years until the effect of staff turnover / “churn” offsets the cost of annual increments being awarded.
 - Agenda for change appeals – some organisations highlighted that some agenda for change grading appeals are still outstanding and will result in some, albeit hopefully small, rising impact upon pay budgets.
 - Consultant contract and European Working Time Directive (EWTD) – similarly some provider organisations pointed to a residual level of cost pressures from the continuing review of Programmed Activities within consultants job plans and particularly the impact of the EWTD upon junior doctors’ hours.

- 4.6 The level of additional pressure on pay budgets varied across individual organisations but for the purpose of this review a broad average of 1.6% of organisational pay bills is identified for the coming 2 to 3 years before reducing back towards a cost neutral level.
- 4.7 All Finance Directors interviewed were also quick to point out that the growing national practice of *phasing* annual pay awards created only non-recurrent “savings” at a local level. They consistently wanted to emphasise to Senior Civil Servants and Politicians of the need to make good the recurrent costs as a first charge against the following years growth allocation or tariff increase. Some pointed to this practice as repeating the past problems of using non-recurrent “fixes” as a sticking plaster over growing recurrent problems.
- 4.8 For this reason, many organisations have prudently planned for the recurrent cost of all pay awards in 2007/08 and have utilised the non-recurrent slippage towards contingency plans or the reduction of accumulated deficits.
- 4.9 There was further general concern at what many Finance Directors perceived to be a deteriorating relationship with staff representative bodies and trade unions. Some expressed a belief that the Treasury pay forecasts were becoming increasingly optimistic given the rising levels of inflation and the appetite of the unions to challenge recent pay awards, as was seen with the un-rest associated with the phasing of the 2007/08 nurses pay award.

Insurance / Litigation Costs

- 4.10 One of the highest relative cost pressures being experienced and anticipated to continue into the foreseeable future was that of rising insurance costs such as premiums for the Clinical Negligence Scheme for Trusts (CNST).
- 4.11 Anticipated increases in premiums were generally around 10% per annum but this will of course vary depending upon the claims history and specialty mix of the organisation. In this respect Finance Directors at Womens and Childrens hospitals sited these costs as their most significant pressure. (see section 6)

Connecting for Health

- 4.12 All organisations pointed to the uncertainty they felt about predicting the likely future costs they would have to cover locally to support the continuing roll out and development of the Connecting for Health programme. Some acute trusts raised their concern at the functionality of some CfH systems and that they were having to continue investment in existing or new locally provided services because they provided or maintained the previously developed level of required service.

- 4.13 The rising and continual costs of local hardware and training were a consistent theme and one which has, at this stage, generally only been included within financial plans at conservative levels.

5. Primary Care Trusts

5.1 PCTs felt they sometimes have a lower profile than secondary care provider trusts when it comes to indicators of cost pressures within the NHS. However, PCTs can in reality provide a clearer indication of the overall affordability of the demands being placed on the NHS. As holders of the 'purse strings' PCTs are generally responsible for paying for:

- the healthcare and drugs provided by primary care contractors;
- the activity undertaken in secondary care trusts;
- new national targets and clinical priorities;
- additional patient care activity to meet reduced waiting time targets; and,
- increasingly, the direct provision of community based patient care services.

5.2 The traditional and significant difficulty for PCTs in managing their financial responsibilities is that the bulk of the above areas of expenditure are typically demand led and often outside the direct control of the PCT or its employed workforce. For example, primary care prescribing (circa 12% of a PCTs expenditure) and secondary care emergency and elective activity (circa 55-60% of a PCTs expenditure) are both driven by the clinical decision making of independent primary care contractors who have traditionally sat outside the PCTs formal scheme of delegation and financial management framework.

5.3 Table 2: Cost Pressures in a Typical Primary Care Trust

	2007/08 Baseline %	2008/09 Budget Uplift %	2008/09 weighte d Uplift %	2009/10 weighte d Uplift %	2010/11 weighte d Uplift %
Income					
NHS: -Rev Resource Limit	94.50	3.50	3.31	3.31	3.31
- Other	2.00	2.40	0.05	0.05	0.05
Non NHS / Other	3.50	2.00	0.07	0.07	0.07
Total Income	100.00		3.43	3.43	3.43
Expenditure					
Direct Staff Costs/Pay	10.11	4.10	0.41	0.41	0.41
Supplies and Admin	2.48	2.50	0.06	0.06	0.06
Healthcare:					
- Primary Care	11.99	2.50	0.30	0.30	0.30
Contractors	12.21	8.00	0.97	0.97	0.97
- Primary Care Prescribing	56.09	2.50	1.40	1.40	1.40
- NHS Secondary Care		1.43	0.80	0.80	0.00

- 18 week activity (on SLA)*	4.96 0.43	2.50 100.00	0.12 0.43	0.12 0.22	0.12 0.10
- Non-NHS Providers					
- Continuing Care	0.42	10.00	0.04	0.04	0.04
Cost of Capital	1.31	2.00	0.03	0.03	0.03
- Depcn/Cap Charges					
Other					
Total Expenditure	100.00		4.56	4.35	3.43

(* see para 5.9)

- 5.4 There were a number of PCT specific issues and cost pressures highlighted by this review. Some were clear and quantifiable and therefore were generally included within individual PCTs own financial planning. Others were based on broader concerns voiced by the Finance Directors and were more difficult to quantify or even estimate for future years.
- 5.5 One of the biggest individual cost pressures already being experienced by PCTs is that relating to the well documented Continuing Care services. The pressures for PCTs come from 3 different issues:
- The development of detailed guidelines establishing where an ever growing population of patients, and relatives of patients, receiving continuing care services should expect those services to be funded, or part funded, by PCTs;
 - The cost pressures being experienced within Local Government and the similar steps being taken within that sector to reduce expenditure and increase efficiencies. This is increasing the pressure on the NHS through PCTs to pick up funding for areas of continuing care that Local Government would argue has traditionally been funded as Social Care but they believe should be nursing care; and
 - The high profile legal cases of 'Coughlan' and 'Grogan' which set a ruling for certain types of care which must be funded as nursing care by PCTs.
- 5.6 Table 2 above includes an average of the cost pressures being experienced by PCTs. This is regularly evidenced by a doubling of continuing care budgets over each of the two year period 2007/08 – 2008/09 as an increasing case load and appeals level is being seen.
- 5.7 Primary care prescribing costs have, for a number of years, been increasing at a rate well above inflation. This is not due to the costs of the existing 'basket' of drugs increasing but is, in fact, due to new higher cost drugs entering the market and an increasing volume of drugs being prescribed (as a result of an increasing population and a range of clinical initiatives such as the GP Quality Outcomes Framework).
- 5.8 Overall, PCTs are generally planning for net increases in expenditure of around 8% but this takes into account the effect of savings being achieved through drugs coming off patent and an ever increasing use

of generic prescribing.

- 5.9 Some PCTs are more advanced than others in progress to achieve the 18 week referral to treatment target by December 2008. Indeed the PCTs involved within this review included an early adopter of this target from which evidence was available of the increase in costs required and the time period over which the step change in additional activity was needed to be maintained.
- 5.10 All PCTs were continuing to experience volatile cost pressures as a result of secondary care activity excluded from tariff. This included a wide variation in levels of expenditure being agreed with provider trusts to cover NICE drugs and specialist services which often compounded the pressures being seen within tariff services such as high complexity procedures, excess bed days and increasing levels of short lengths of inpatient stays.
- 5.11 Some of the PCTs involved whose geographical location included areas of inward economic investment and population growth (such as the Thames Gateway and areas around the Milton Keynes effect in the Northern Home Counties) spoke of their most significant cost pressures to include the risk of 'allocation lag'.
- 5.12 This results in such PCTs having to fully fund the cost of healthcare for their growing population from the first day they move into their locality. This is despite the PCTs belief that there is a flaw in the technical methodology which calculates the additional funding those PCTs should receive for the new population over the three year cycle of the allocation process. Such PCTs would point to compelling evidence which shows a variation between the population forecasts used by the Office of National Statistics and those predicted by the Office of The Deputy Prime Minister.
- 5.13 Even without some cost pressures included, Table 2 above clearly shows a funding gap between anticipated income and cost pressures. Most PCTs stated that the cost pressures shown included for the effect of required minimum levels of efficiency Savings within their own management costs and provider functions. Therefore the difficulty highlighted in paragraph 5.2 becomes ever more apparent when needing to deliver greater efficiencies to maintain financial balance (even before many PCTs have started to consider how they will repay accumulated prior year deficits).
- 5.14 To emphasise this point, the financial planning assumptions include for the forecast tariff uplift over approximately 65% of PCT expenditure (when also including PCTs own provider functions and other contracted services where the tariff is used as a proxy for negotiated uplift). The forecast tariff increase of 2.5% already provides for a minimum Gershon efficiency of 2.5%.

- 5.15 At this stage, PCTs pointed to a range of efficiency/saving and income generation schemes of varying levels of challenge. These included:
- Negotiation with their Strategic Health authority over the return of allocation top-slices being used for local strategic contingency reserves;
 - Greater emphasis upon the potential achievements possible from Practice Based Commissioning;
 - Secondary care activity reduction schemes such as primary care front end presence within A&E departments (such actions clearly raise further the efficiency challenge with secondary care trusts); and,
 - Further scrutiny upon primary care prescribing patterns.

6. Acute Trusts

6.1 Table 3 below provides financial planning data for a typical 'District General Hospital'. However, it should be noted that depending upon the type of acute trust the expenditure profile and level of future cost pressures can vary.

6.2 Table 3: Cost Pressures in a Typical District General Hospital

	2007/08 Baseline %	2008/09 Budget Uplift %	2008/09 Weighted Uplift %	2009/10 Weighted Uplift %	2010/11 Weighted Uplift %
Income					
NHS Clinical:					
- Tariff	76.95	2.50	1.92	1.92	1.92
- Non-Tariff	13.58	2.40	0.33	0.33	0.33
NHS Non Clinical:					
- MADEL/SIFT etc	2.68	2.00	0.05	0.05	0.05
- Other	0.34	2.00	0.01	0.01	0.01
Non NHS / Other	6.45	2.00	0.13	0.13	0.13
Total Income	100.00		2.44	2.44	2.44
Expenditure					
Pay	67.90	4.10	2.78	2.78	2.11
Non-Pay					
- Drugs	2.85	7.50	0.21	0.21	0.21
- CNST	1.68	10.00	0.17	0.17	0.17
- Premises	4.95	1.50	0.07	0.07	0.07
- Vehicles/Fuel	1.34	1.50	0.02	0.02	0.02
- Supplies	9.05	1.50	0.14	0.14	0.14
- Other	5.36	1.50	0.08	0.08	0.08
Healthcare from other Providers	2.60	2.00	0.05	0.05	0.05
Cost of Capital					
- Depcn/Cap Chges	4.27	10.00	0.43	0.43	0.43
Other	0.00	1.50	0.00	0.00	0.00
Total Expenditure	100.00		3.95	3.95	3.28

- 6.3 All acute trusts pointed to cost pressures relating to drugs in the same manner as PCTs (as set out in paragraphs 5.7 and 5.8). The exact level of future provision made by individual trusts depended upon their specialty profile and case mix. For example a non-specialist trust would generally apply in the region of an 8% uplift to their drugs budgets based on similar principles to the PCT. A Womens and Childrens trust would apply a slightly lower rate because of the lack of higher cost specialist drugs such as those for cancer.
- 6.4 However, very specialist trusts such as regional cancer centres explained how the tariff pricing methodology penalised them in respect of drugs and their internal uplift needed to be higher. The tariff pricing is based on the average of all providers and therefore the element of tariff uplift applying to drugs represents an 'average' hospital that has an 'average' level of all specialties. A cancer provider will tend to have only the high cost drug intensive elements of an 'average' provider and therefore not receive a high enough increase to its tariff income to reflect the higher increase in costs associated with the rapidly developing cancer drug market.
- 6.5 Finance Directors of Womens and Childrens hospitals would, on the other hand, point to the more litigious nature of maternity and childrens healthcare and therefore provide evidence that they in turn are penalised through the element of tariff uplift relating to CNST premiums. Table 3 above represents an average cross-specialty trust.
- 6.6 Views relating to efficiency savings unite Finance Directors from every acute trust. There is a strong view that they are being hit with a 'double whammy' of efficiency targets. Firstly, a significant and growing element of trusts income is through the payment by results regime and dictated by the annual central setting of the tariff. The tariff automatically builds in the national requirement for Gershon cash releasing efficiencies.
- 6.7 Table 3 above demonstrates the point Finance Directors make which is that even on top of having their income effectively 'top-sliced' for efficiency savings they then have to make further savings of equal or higher levels to balance their on-going income and expenditure commitments. Many trusts openly pointed to further internal savings targets of 2% on top of the tariff which equated to overall efficiencies of between 4 and 5%.
- 6.8 A further area of concern which united Finance Directors was the apparent central 'raiding' of training and research funding such as MADEL, SIFT and MPET. 2006/07 had seen an alleged significant reduction to support the wider financial pressures across the NHS. However, trusts point to the trainees already in post and whose salaries the trusts must continue to fund even if the central training support funds are cut. There was general concern that this practice may continue but no provision is currently being made in financial

plans.

7. Mental Health Trusts

7.1 In general, the cost pressures highlighted by Mental health trusts were not dissimilar to those for acute trusts and Table 4 below sets out the forecast pressures for a typical Mental Health trust.

7.2 Table 4: Cost Pressures in a Typical Mental Health Trust

	2007/08 Baseline %	2008/09 Budget Uplift %	2008/09 Weighte d Uplift %	2009/10 Weighte d Uplift %	2010/11 Weighte d Uplift %
Income					
NHS Clinical:					
- Tariff	0.00	2.50	0.00	0.00	0.00
- Non-Tariff	94.34	2.40	2.26	2.26	2.26
NHS Non Clinical:					
- MADEL/SIFT etc	1.86	2.40	0.04	0.04	0.04
- Other	3.80	3.00	0.11	0.11	0.11
Non NHS / Other	0.00	3.00	0.00	0.00	0.00
Total Income	100.00		2.42	2.42	2.42
Expenditure					
Pay	68.79	4.80	3.30	3.85	3.09
Non-Pay					
- Drugs	2.52	5.00	0.13	0.13	0.13
- CNST	0.09	10.00	0.01	0.01	0.01
- Premises	3.27	6.40	0.21	0.19	0.17
- Supplies	0.93	2.70	0.03	0.03	0.03
- Other	10.56	3.90	0.41	0.39	0.37
Healthcare from other Providers	7.38	5.00	0.37	0.37	0.37
Cost of Capital					
- Depreciation	3.46	10.00	0.35	0.35	0.35
- Capital Charges	2.99	10.00	0.30	0.30	0.30
Other	0.00	0.00	0.00	0.00	0.00
Total Expenditure	100.00		5.11	5.62	4.82

7.3 There were some minor areas where the Mental Health trusts involved in the review pointed to differing pressures as compared to acute trusts:

- Drugs – interestingly there was very wide variation in the drugs forecasts being used by different Mental Health providers. There was consistency around the reasons for increased pressure on drugs budgets being due to increased development and use of drugs such as anti-psychotics, anti-depressants and Alzheimers inhibitors. However, the significant variations in subsequent cost growth forecasts may be as a result of variations in clinical practice between key clinicians and consultants. On average however the cost pressure against drugs was slightly lower than for acute trusts and PCTs;

- Premises – the traditional nature of the mental health estate means that such providers generally have a more dispersed premises portfolio of older and smaller properties with a greater degree of backlog maintenance and this is reflected in the higher premises pressure shown in table 4 above.

8. Ambulance Trusts

8.1 As would be expected, the cost base and future cost pressures within Ambulance trusts vary in a number of ways to other NHS trusts.

8.2 Table 5: Cost Pressures in a Typical Ambulance Trust

	2007/08 Baseline %	2008/09 Budget Uplift %	2008/09 Weighted Uplift %	2009/10 Weighted Uplift %	2010/11 Weighted Uplift %
Income					
NHS Clinical:					
- Tariff	0.00	0.00	0.00	0.00	0.00
- Non-Tariff	94.52	5.00	4.73	4.73	4.73
Non NHS / Other	5.48	5.00	0.27	0.27	0.27
Total Income	100.00		5.00	5.00	5.00
Expenditure					
Pay	80.00	3.60	2.88	2.88	2.88
Non-Pay					
- Drugs	0.18	2.00	0.01	0.01	0.01
- vehicles	8.17	2.00	0.16	0.16	0.16
- Fuel	1.83	2.00	0.04	0.04	0.04
- CNST	2.00	10.00	0.20	0.20	0.20
- Premises	5.00	2.00	0.10	0.10	0.10
- Other	1.41	2.00	0.03	0.03	0.03
Cost of Capital	1.41	10.00	0.14	0.14	0.14
Volume and target growth*			3.50	3.50	3.50
Total Expenditure	100.00		7.06	7.06	7.06

8.3 Once again the biggest element of the trusts cost base is that relating to staff and pay. In this respect ambulance trusts highlighted consistent themes relating to pay drift and outstanding grading appeals associated with Agenda for Change. The latter point was causing on-going cost pressures particularly relating to Ambulance Technicians and whether these should be band 4 or 5.

8.4 Maintaining and running the vehicle fleet is understandably a high cost to the trusts but positively the rapidly rising fuel prices are seemingly being offset by better management of the fleet and moving to more fuel efficiency and cost effective vehicles.

8.5 The larger anticipated percentage increase in income compared to other NHS trusts was stated as being due to all ambulance services being non-tariff and therefore negotiated through block contracts. In this respect future volume growth and increasing targets needs to be

negotiated and funded transparently through an increase in the block value with commissioners.

- 8.6 A particular target related cost pressure was given as an example relating to the call to response time which is being adjusted to start from the time of connection if the incoming 999 call rather than the time of a response being initiated by the call handler. As length of calls are approximately 110 seconds before a vehicle is despatched this has a significant impact upon the future achievement of 8 minute response times.
- 8.7 A further impact of this change is that ambulances need to be despatched earlier in the call before a full assessment of the callers needs and nature of the call have been established. This can mean that ambulances are being despatched unnecessarily and tying up valuable resources that are not then available for other calls.

9. Sensitivity and Risk Management

- 9.1 The analysis provided for each type of organisation in the previous sections of this report include the known and quantifiable cost pressures identified by relevant finance directors as well as some of the key financial risk areas. The sensitivity of the financial forecasts provided are subject to a significant number of continuing risks and the extent to which they can be appropriately managed within existing budget flexibilities.
- 9.2 The following risks are those, which at the time of writing, have been identified as having the highest risk to individual financial forecasts.
- 9.3 Table 6: Key Future Financial Risks

	Details	Organisations at Risk
Future NICE recommendations	The increasing cost of drugs across the NHS is well documented and a growing number of high profile recommendations around high cost drugs serves to increase the costs even further.	PCTs are at significant risk as they cover all primary care prescribing as well as being the responsible commissioners for drugs outside of tariff (most mental health and high cost specialist drugs). Acute providers face the risk of drugs otherwise included within tariff.
Equal pay claims	There is a concern amongst many Finance Directors across the NHS	Whilst this may apply within all organisations, acute

	that the recent well documented equal pay claims of some staff groups will result in more claims and additional costs in other organisations and across a greater number of staff groups.	trusts appear most at risk.
CNST	The increasingly litigious nature of the UK health economy and rising insurance costs continue to place this expenditure high on the financial risk profile across the NHS.	Whilst all NHS organisations are subject to CNST/insurance costs – this risk is greatest in certain types of specialist acute providers (such as women’s and children’s).
	Details	Organisations at Risk
New clinical priorities/Govt targets	The costings and forecasts included within this report cover the known existing targets and clinical priorities as set out by the Government. Any additional targets or priorities are not budgeted for and would create a corresponding financial risk.	All NHS organisations are exposed to this risk to varying degrees.
Fuel / energy prices	Whilst fuel prices have stabilised to some extent over the last 12 months, the experience of the last 5 years has made many Finance Directors cautious and this remains a potentially volatile cost area.	All organisations have fuel and energy costs to varying levels. Most at risk would appear to be Mental Health providers due to the ageing and dispersed nature of their estate and ambulance trusts with their fleet fuel costs.
Reducing secondary care activity	The current policy direction of the NHS as set out in “Commissioning a patient led NHS” means that PCTs are seeking to	This will clearly affect acute and mental health trusts who are having to continue to cover fixed costs whilst commissioners

	reduce in-hospital activity and increase provision in community and primary care settings.	put downward pressure on levels of activity (thus reducing income linked to the tariff)
Rising continuing care costs	Paragraph 5.5 of this report documents the areas of increasing cost for PCTs. Many believe this to be a significant risk that may result in additional costs considerably higher than included within section 5.	PCTs
Revisions to education & training funding	As identified in paragraph 6.8 there is widespread concern that central budgets and allocation processes may continue to change thus exposing relevant trusts to additional financial risk.	Provider trusts
Revisions to research funding	There is similar concern relating to research funding as there is with education funding set out above.	Provider trusts

Appendix A

Extract from Pay Review Bodies 2007 Report

Paragraph	Comment
1.37	We have not been able to ascertain to our own satisfaction where the increased expenditure on the NHS in 2007/08 will go and why the maximum affordable increase in pay is 1.5%, as proposed by the Health Departments and NHSE.
1.40	We were still not able to arrive at even an approximate breakdown of how the increased expenditure in 2007/08 was forecast to be allocated between the different elements.
1.41	The Health Departments could not provide details of the increases in non-pay costs.
1.49	We regret that, despite the importance that the Health Departments and NHSE attach to affordability, they have not been able to explain the budget (and, as we note above, the relationship between output targets and pay) in sufficiently transparent terms for us to understand why the maximum affordable increase is 1.5 per cent, as they claim. We therefore strongly urge the Health Departments and NHSE to improve the presentation of evidence on the available budget next year.

Appendix B

Participating Organisations

Birmingham Women's Health Care NHS Trust

Christie Hospital NHS Foundation Trust

Cumbria Partnership NHS Trust

Derby Hospitals NHS Foundation Trust

Doncaster Primary Care Trust

Doncaster and South Humber Healthcare NHS Trust

Guy's and St Thomas' NHS Foundation Trust

Lambeth Primary Care Trust

Lancashire Teaching Hospitals NHS Foundation Trust

London Ambulance Service NHS Trust

Milton Keynes General NHS Trust

Norfolk and Waveney Mental Health Partnership NHS Trust

Northamptonshire Primary Care Trust

Tower Hamlets Primary Care Trust

NHS Employers and the NHS Confederation would like to extend their thanks to the above organisations and to the individual officials who kindly contributed to this review. Their assistance and valuable input is very much appreciated.

NHS Employers

supporting • promoting • representing

NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. The NHS workforce is at the heart of quality patient care and we believe that employers must drive the workforce agenda. We work with employers to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

NHS Employers is part of the NHS Confederation.

Contact us

For more information on how to become involved in our work, email getinvolved@nhsemployers.org

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