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THE SCOTTISH GOVERNMENT'S WRITTEN EVIDENCE TO THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB) FOR THE 2019-20 PAY ROUND

SCOTTISH GOVERNMENT HEALTH DIRECTORATES' SUBMISSION TO THE DDRB 2019

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A. Introduction

1. This evidence has been prepared by the Scottish Government Health and Social Care Directorates (SGHSCD) and we are now pleased to be able to submit this to you for your consideration.

2. Our remit letter to the Review Body on Doctors' and Dentists' Remuneration (DDRB) from the Cabinet Secretary for Health and Sport has been submitted in conjunction with our evidence. This confirms the parameters which we would wish the DDRB to work within for their 2019-20 Report and Recommendations.

3. Our approach to public sector pay is governed each year by the Scottish Public Sector Pay Policy (SPSPP). The Cabinet Secretary for Finance, Fair Work and the Economy announced the draft SPSPP for 2019-20 on 12 December 2018 as part of his budget announcements and this has was agreed by the Scottish Parliament on 31 January 2019.

4. The main features of the SPSPP are:

- providing a guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent for those earning above £36,500 and below £80,000;
- a flat increase of £1,600 for those earning £80,000 or more ;
- a cash underpin of up to £750 for those employees who earn less than £25,000
- continuing the policy commitment to No Compulsory Redundancy.

5. The SPSPP also continues to provide the flexibility for employers to consider using up to 1 per cent of paybill savings on baseline salaries for:

- non-consolidated payments, but only for employees already on the maximum of their pay range (who no longer benefit from progression) or on spot rates; and
- other affordable and sustainable changes to their existing pay and grading structures where there is clear evidence of inequality issues.

6. The Scottish Government continues to value the independent view which the DDRB offers on doctors' and dentists' pay and recognises the role that they will play in determining the final pay uplifts in order to ensure that our health service staff are treated at least as fairly as those in any of the UK nations.

Strategic Aims and Principles

7. The SPSPP is based on the following principles:

- To invest in our public sector workforce which delivers top class public services for all, supports employment and the economy, while providing for sustainable public finances.
- To provide a distinctive pay policy which is fair, affordable, sustainable and, through the targeting of resources, delivers value for money in exchange for workforce flexibilities.
- To deliver a pay policy that reflects real life circumstances, protects those on lower incomes and recognises recruitment and retention concerns.

Key SPSPP Priorities

8. The SPSPP has been developed in recognition of Scottish Ministers' commitment to our Programme for Government. Ministers have considered the impact that rising inflation and social security cuts are having on working households, and what public sector employers can reasonably expect in the context of a Scottish Budget squeezed by a continued UK Government austerity policy.

9. Ensuring public sector organisations are able to recruit and retain staff, is crucial to ensuring that Scotland's economy remains strong and so appropriate investment in Scotland's public services remains a priority.

10. The aim of the SPSPP is to take a progressive approach to pay, allowing public sector employers to provide proportionate pay increases, combined with flexibilities to address local circumstances. This Government will continue its commitment to the real Living Wage and maintain its position on No Compulsory Redundancy.

Key Features of the Policy for Medical and Dental staff

11. This written evidence supports the SGHSCD's longer term approach to developing the future medical and dental workforce through a clear total reward package whilst considering issues of affordability.

B. The Scottish Context

Review of Primary Care Out of Hours Services

12. Since the publication of Professor Sir Lewis Ritchie's commissioned report, *Pulling Together – Transforming Urgent Care for the People of Scotland* on 30 November 2015, Boards have been working towards implementing its 28 recommendations.

13. Boards and Integration Authorities have made some significant progress, particularly at a national level, e.g. in joint working between NHS 24 and SAS in the planning and delivery of services.

14. In the last three years, the Scottish Government has invested £25 million (£10 million – 2016/17, £10 million – 2017/18, £5 million – 2018/19) to support the recommendations on urgent care and out of hours services.

15. A national meeting with relevant stakeholders, including the BMA and RCGP, was held in August 2018 to look at short, medium and long term solutions to improve out of hours services across Scotland and a further meeting took place on 22 January 2019.

Patient Engagement in GP Quality of Care

16. Public engagement is at the heart of any change to Primary Care and we will continue to engage with patient representative groups as the new GP Contract is implemented and Primary Care is transformed. This will build on the views and feedback from the public received through the National Conversation, the Health and Care Experience Survey, and the Our Voice Citizens' Panels.

17. In addition there are robust statutory arrangements in place for NHS Boards and Integration Authorities to work closely with professionals and local communities when delivering sustainable new models of care and support that are focused on improving outcomes.

EU Exit

18. EU Exit is likely to have a significant impact on the health and social care sector within Scotland, not least because Scotland's health sector benefits enormously from the contribution made by staff from across the EU. The free movement of people from the EU has allowed skilled and experienced health professionals to work in our NHS, where they often fill vacancies in hard to recruit specialisms and geographical regions. The removal or curtailment of free movement could have potentially serious consequences for the recruitment and retention of health workers in Scotland. EU Exit could also negatively impact the free movement of medical researchers between Scotland and other EU countries, affecting the ability of our academic institutions to attract medical students to come here to study and train, which will impact on the provision of healthcare.

19. Changes to the current EU system of Mutual Recognition of Professional Qualifications are also likely as a result of EU Exit. This would have the potential to hamper further the recruitment of doctors and dentists from the EU to Scotland. The Scottish Government strongly supports maintaining the EEA-wide reciprocal system of automatic recognition of qualifications for healthcare workers.

20. The evidence shows that EU Exit is already damaging recruitment of European staff to the NHS. For example, a November 2018 BMA survey of 1,527 EEA-trained doctors across the UK found that 78% are unconvinced by the promises that have been made that their rights will be protected in the event of a no-deal Brexit, 37% were unaware of the Westminster Government's settled status scheme and 35% are considering moving abroad. In addition, figures published in November 2018 by the Nursing and Midwifery Council show that the dramatic decline seen in the number of applicants from the EEA for UK registration in the year after the EU referendum (an 87% year on year drop) has not stopped. In fact, it has been compounded by the loss of almost 2,500 experienced EEA nurses and midwives across the UK in the past year, many of whom gave the continuing uncertainty over their future here as a specific reason for leaving the UK.

21. Despite the agreement of the Withdrawal Agreement and Political Declaration in November 2018, much damaging uncertainty remains. The UK Parliament has yet to ratify the deal reached with the EU. That is why the Cabinet Secretary for Health and Sport issued a letter to all EU staff working in the NHS in Autumn 2018, highlighting that their contribution is valued and that we are doing all we can to help secure their rights post-Brexit. The Cabinet Secretary followed this up with further letters to EU staff working in health and social care settings on 20 December 2018.

22. In addition to its potential impact on the workforce, EU Exit also raises concerns in areas such as medicines, medical devices and clinical trials, access to future EU funding and the rights of Scottish citizens to access state-provided healthcare across the EU.

23. The Scottish Government is continuing to make representations in all these areas and is working hard with NHS Boards to mitigate risks and potential implications, where that is possible, in the context of a situation that is fluid and rapidly developing.

Future Vision for Health and Social Care

24. As 2020 approaches, it is now time to begin the co-design and co-production of the next iteration of the Vision for Health and Social Care to 2030 and beyond. It will be crucial to ensure that the Vision authentically embraces and speaks to, and for, both the NHS and social care sector, and is a Vision that all health and social care partners from NHS Boards, to COSLA, to the third and care home sectors, embrace. The Vision should also be one that makes sense and is understood by every person who uses health and social care services. It is therefore essential that the Vision is co-produced through genuine engagement with the leaders, workers and users of services.

25. Work on the co-design of the Vision commenced in January 2019.

Everyone Matters: 2020 Workforce Vision

26. Evidence shows that staff who are valued and supported deliver better patient and overall outcomes. Everyone Matters: 2020 Workforce Vision is our workforce policy for NHS Scotland and our commitment to valuing the workforce and treating people well. Published in June 2013, Everyone Matters was developed with input from more than 10,000 people across NHS Scotland including trade unions, professional organisations and partners in the delivery of care.

27. Our Workforce Vision for NHS Scotland states: We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values. Together we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.

Our values for NHS Scotland are:
- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

28. Since the launch of Everyone Matters, there have been four annual implementation plans identifying key priorities and actions. In 2018, we also published a refreshed version of the existing vision and values, alongside a two-year Everyone Matters Implementation Plan for 2018-20. This Plan focuses on continuing and consolidating the good work already underway, building on previous annual Implementation Plans and the actions set out in these, and working towards delivering further progress by 2020.

29. The five priorities for action being progressed through the Implementation Plans are:
- healthy organisational culture
- sustainable workforce
- capable workforce
- a workforce to deliver integrated services and
- effective leadership and management.

30. The landscape in which health and social care is delivered is changing and we have therefore started work to consider what a vision for the health and social care workforce might look like from 2020 onwards. This work will be closely aligned with that taking place on the development of a future vision for health and care in Scotland.

31. In considering this, we will take into account:
- Programme for Government
- The SPSPP following the Scottish budget statement and Spending Review announcements
- 2020 Workforce Vision and Beyond
- Service transformation
- Transformational Change

- Board Reform
- Impact of High Cost Areas on recruitment and retention; analysis of factors leading to regions having recruitment and retention difficulties.
- Funds available - financial position, efficiency targets and pay bill analysis (to a consistent method); mechanisms available for targeting pay.
- Inflation target update on where and how this must feature in the Review Body's thinking.
- EU Withdrawal
- Leadership and Talent
- Productivity
    - The progress made towards securing the improvements identified in the Lord Carter of Coles Report, and the role played by doctors and dentists in that process
    - The contribution of the various components of the remit group, particularly consultants, towards improvements in productivity
- Wider NHS initiatives i.e. the Quality Strategy, Better Together programme; Health and Social Care Integration; Sustainability and 7 Day Services; Review of Primary Care Out of Hours Services.
- Patients at the heart
    - Update on Local and National approaches to medical and dental staff engagement and the impact on quality of patient care.
    - Update on direction of travel, key strategies and how the medical and dental workforce supports these.

C. Economic and Labour Market Conditions in Scotland

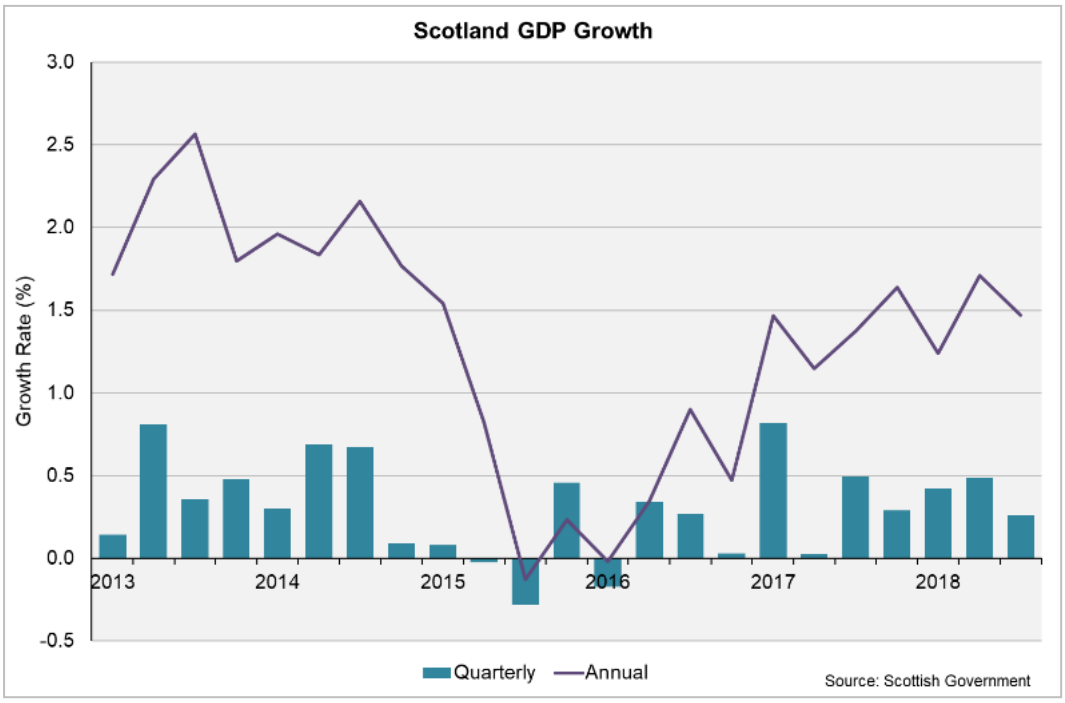
Overview

32. The Scottish economy has grown at a stable pace in 2018, continuing a pattern of stronger growth over the past 18 months. This stronger performance has also been reflected in the labour market which has seen unemployment fall to its lowest rate on record. Nominal earnings growth continued to pick-up over the year to April 2018, coupled with an easing in inflation, resulted in real wage growth rebounding back into positive, though relatively weak, growth. The outlook for the Scottish economy is for the pace of output growth to remain broadly stable over the next couple of years. However, Brexit and particularly a 'no deal' Brexit, remains the key risk and uncertainty to the short term outlook.

Scottish Output

33. Scottish GDP grew 0.3% in Q3 2018 (UK: 0.6%), slightly slower than the pace of growth in the first half of the year. Growth was driven by the Services (0.3%) and Construction (2.7%) sectors, offsetting a contraction the Production sector (-0.7%).

34. Over the past year as a whole (Q3 2017 to Q3 2018), the Scottish economy has grown 1.5% (UK: 1.5%) with growth broad based across the Services, Production and Construction sectors.

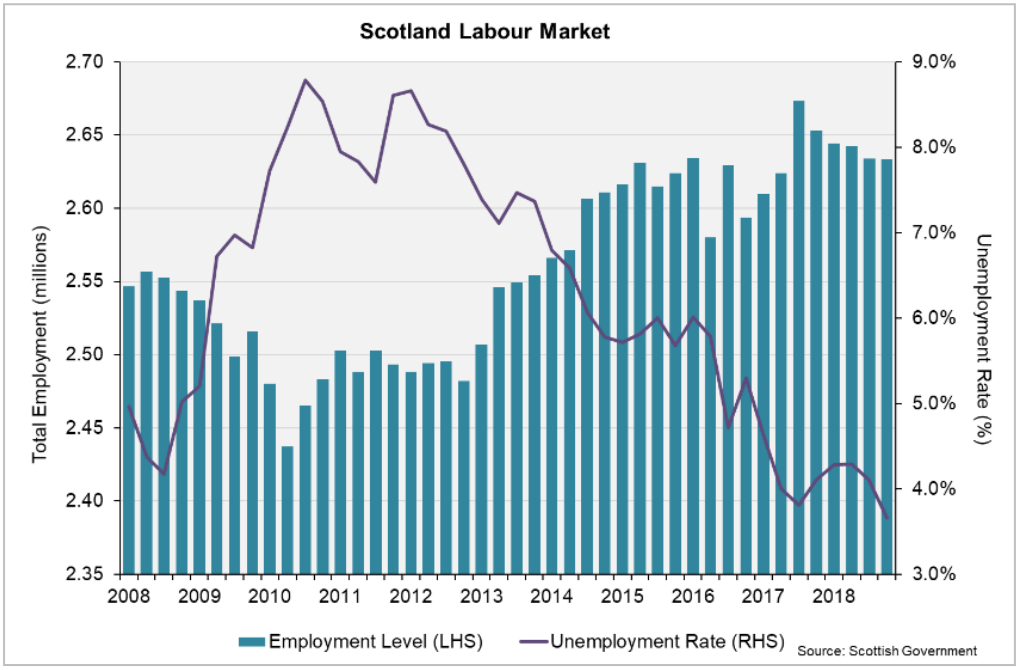


35. While the pace of growth has softened slightly in the latest quarter, it continues a pattern of stronger growth over the past 18 months. This has been underpinned by a stronger global economy and the weaker exchange rate supporting Scotland's exporting industries, alongside stronger confidence and activity in the Oil and Gas sector.

Labour Market

36. The Scottish labour market has continued to perform strongly in 2018 with figures for August to October 2018 showing the unemployment rate fell over the past year to 3.7% (UK: 4.1%) – its lowest rate on record.

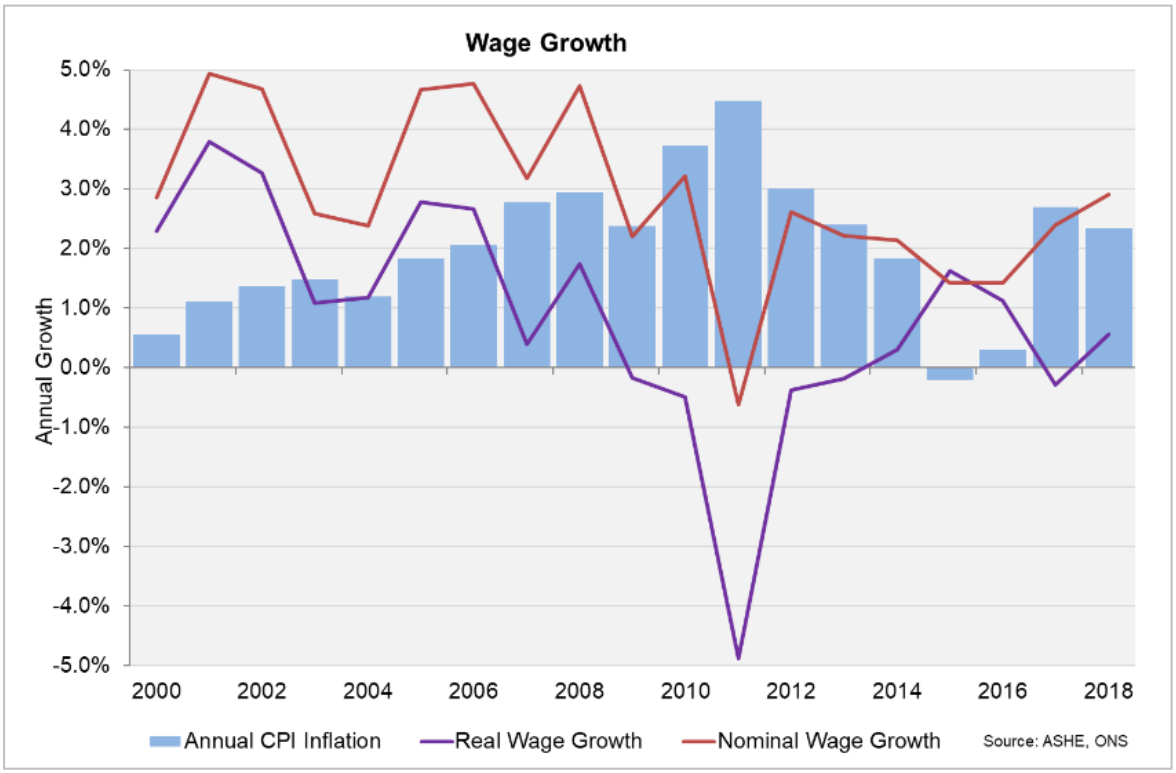
37. There has been a fall in the number of people employed in Scotland over the past year and a rise in the number of people inactive. However the employment rate (75.0%) remains close to its record rate of 75.8% in 2017. The main fall in employment over the past year was in full-time jobs, which have fallen by 24,000, while part-time jobs fell by 1,000.



Earnings

38. Median full-time weekly earnings grew by 2.9% in Scotland in 2018 (UK: 3.4%) to £563.20. The pace of growth had picked up from 2.4% growth in 2017 and 1.4% growth in 2016. In 2018, Scotland's median full-time weekly earnings are the third highest of the UK countries and regions behind London (£713) and the South East (£589).

39. CPI inflation rose by 2.3% over the year to April 2018, down from 2.7% the previous year, resulting in real wage growth in Scotland of 0.6% (UK: 1.0%) over the period.

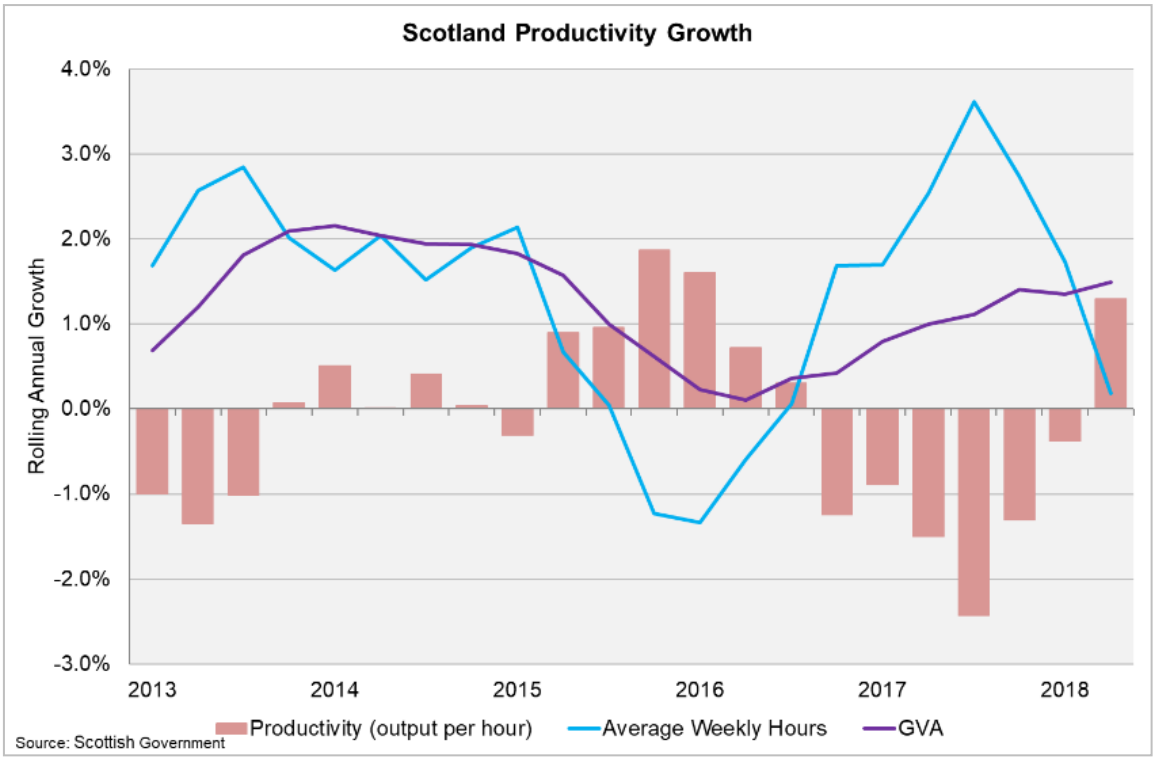


Labour Productivity

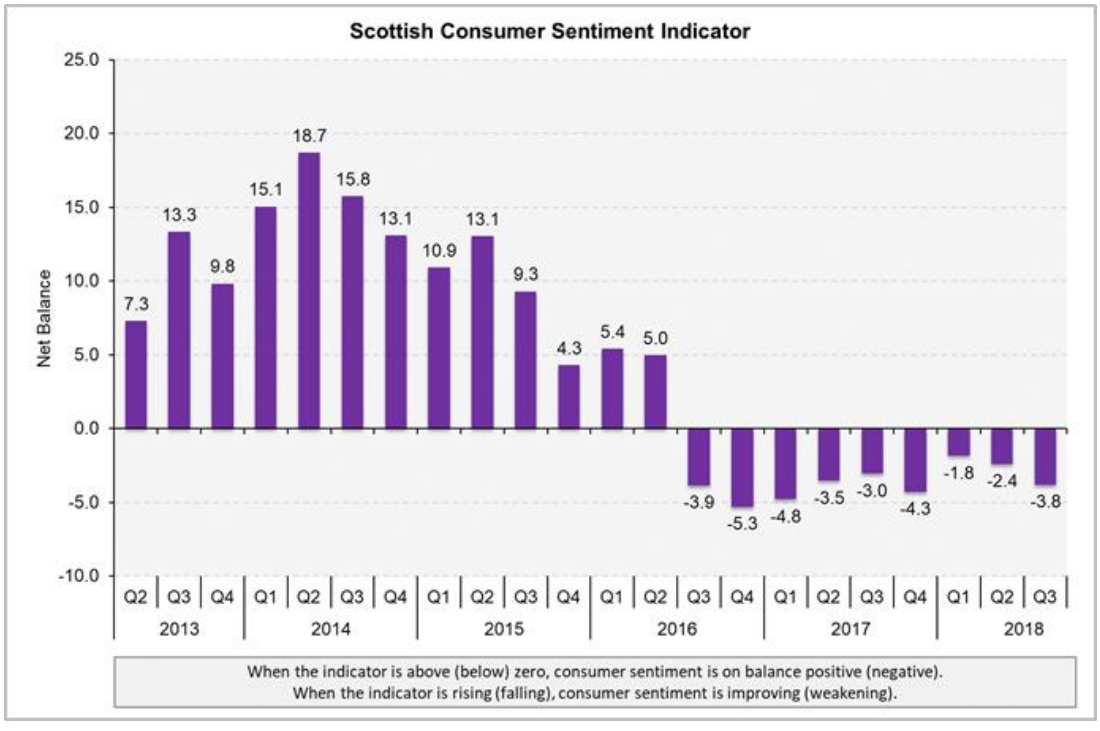
40. The pattern of stronger output growth over the past 18 months is reflected in a rebound in labour productivity performance over the period.

41. In Q2 2018, Scottish labour productivity (output per hour worked) grew over the year by 1.3%, reflecting that the growth in output (1.5%) was higher than the growth in average hours worked (0.2%).

42. Over the longer term, since 2007, labour productivity in Scotland has grown by 7.7% compared to UK growth of 2.6%. This has narrowed the historical gap in productivity between Scotland and the UK.



Consumer Sentiment



43. In Q3 2018, the Scottish Consumer Sentiment Indicator was -3.8, indicating that consumer sentiment was on balance negative. Consumer Sentiment has been negative since the EU referendum and more recently has been on a downward trend in 2018.

44. In Q3 2018, there was a notable weakening in sentiment regarding expected economic performance over the next 12 months. The indicator for Scotland was 15.2, its lowest level since the series began – implying that the balance of respondents expect economic performance to be weaker in 12 months' time. This likely reflects heightened uncertainty regarding Brexit and its risks to the economic outlook.

Economic Outlook

45. Looking ahead to the rest of the year, the RBS Purchasing Managers Index has signalled further positive growth in private sector business activity in Scotland. However, consistent with consumer sentiment in Scotland, business optimism has also fallen over the year. For 2018 as a whole, independent forecasts estimate the pace of growth to remain broadly stable from 2017 at around 1.4%.

46. The key risk to Scotland's economy over the next 6-12 months continues to be the uncertainty associated with Brexit, and in particular the risk of 'no-deal', which is impacting on business confidence and investment. We may also see increased volatility in economic data over the course of the year with firms' potentially bringing forward activity such as stock purchases to hedge against disruptions in supply lines and to consolidate their supplies.

Independent Scottish GDP Growth Forecasts (%)							
	2017 (outturn)	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Scottish Fiscal Commission	1.4	1.4	1.2	1.0	1.0	1.1	1.2
Fraser of Allander Institute		1.3	1.4	1.5	1.4	-	-
EY ITEM Club		1.6	1.0	1.4	1.5	1.7	-
PWC		1.5	1.5	-	-	-	-
OBR (UK)	1.7	1.3	1.6	1.4	1.4	1.5	1.6

D. Resources, Affordability and Pay

Introduction

47. This chapter sets out the financial context including assumptions on funding available in 2019-20. It also highlights the challenges the Scottish Government Health and Social Care Directorates face in terms of demographic change, rising demand and expectations, and financial constraints.

Funding growth

48. The scale of the real terms reduction in the Scottish Government budget for the period 2010-11 to 2019-20 has required difficult decisions to be taken about expenditure across Government and careful consideration of pressures and priorities in all portfolios.

49. In 2019-20 we will deliver an above inflation increase for Health and Sport, against a backdrop of Scotland's fiscal resource budget being reduced by 6.9 per cent in real terms by the UK Government between 2010-11 and 2019-20.

50. The 2019-20 Scottish Budget delivers additional resource funding of almost £730 million (5.5%) for health and care services. This includes support for the roll out of 'Frank's Law' which will extend free personal care to all those who need it. All resource consequentials have been passed on to support health and care.

Affordability - the funds available

Level 2	2018-19 Budget Bill £m	2019-20 Draft Budget £m
Health	13,583.8	14,311.2
Of which:		
NHS Territorial Boards	9,718.2	10,090.1
NHS Special Boards	1,184.3	1,225.6
Community Health Services	1,647.7	1,853.6
Departmental Allocations	1,033.6	1,141.9
Food Standards Scotland	15.3	16.0
Total Level 2	13,599.1	14,327.2
of which:		
Fiscal Resource	12,874.8	13,607.5
Non-cash	273.1	273.6
DEL Capital	341.2	336.0
Financial Transactions	10.0	10.0
AME	100.0	100.4

51. As outlined above, there will be additional resource funding for the Health and Sport portfolio of £733 million (5.6 per cent) in 2019-20. This represents a real terms increase of £489 million (3.7%).

52. Funding for frontline NHS Boards will increase by £430 million (4.2%). NHS Territorial Boards will receive a cash terms uplift of 2.6%. In addition to this, those Boards furthest from National Resource Allocation Committee (NRAC) parity will receive a share of £23 million, which will mean that in 2019-20 no Board is further than 0.8% from its target funding share (as calculated by the NRAC formula). The four patient facing National Boards (Scottish Ambulance Service, NHS24, Golden Jubilee and The State Hospital) will each receive a minimum 2% budget increase. NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education for Scotland and NHS Health Scotland will receive a flat cash settlement.

53. Boards will also receive a share of money for improving patient outcomes, totalling £149 million, as outlined below.

Improving Patient Outcomes	**2018-19 Investment in Reform £m**	**2019-20 Investment in Reform £m**	**Increase for 2019-20 £m**
Primary Care	120	155	35
Waiting Times	56	146	90
Mental Health and CAMHS	47	61	14
Trauma Networks	10	18	8
Cancer	10	12	2
TOTAL	243	392	149

54. In addition to funding for frontline NHS Boards, the increased health budget will support a £120 million package of investment in social care and integration, underlying our commitment to support older people and disabled people and recognise the vital role unpaid carers play, and a further £120 million to support funding arising from the actuarial valuation of the NHS Pension Scheme.

Paybill

55. The medical and dental paybill is estimated at £1.4 billion for 2018-19. This consists of the following pay groups:

Staff Group	2018-19 Estimated Paybill £m	2018-19 Average Basic Pay[1] £000
Foundation Years (FY1, FY2)	83	28
Specialty Training (SpR, StR, etc)	285	40
Consultant	771	95
Specialty Doctor	60	63
Associate Specialist	30	86
Other	137	64
TOTAL	**1,365**	

* Figures based on 2018-19 pay award and exclude Distinction Awards and Discretionary Points for Consultants.

[1] Salary, as per NHS Circular: PCS(DD)2018/2

Pressures on funding

56. The additional funding outlined above is directed to support frontline services however, with people living longer, and the increased cost of new technology and drugs, this means that the NHS will continue to face budgetary pressures that require both investment and reform of services.

57. The Scottish Government expects all Health Boards to take reasonable steps to live within their means and make best use of the available resources as part of a balanced approach to finance and performance. The Scottish Government and NHS Boards will need to ensure a continued focus on developing plans which deliver the triple aim of better care, better health and better value and that support a shift in the balance of care to community health services.

E. NHS Pensions and Total Reward

58. The NHS Pension Scheme in Scotland continues to be an integral part of the NHS remuneration package and remains an invaluable recruitment and retention tool.

59. Occupational pension policy in general is reserved to the UK Government. Pension benefits and employee contributions in the Scottish NHS Pension Scheme are tightly constrained by a mixture of UK Government financial and legislative controls and benefits mirror the scheme in England and Wales.

60. Reformed public service pension schemes, including the NHS Scheme, were introduced in 2015. The statutory framework for the schemes is set out in the Public Service Pensions Act 2013 (the Act) scheme regulations and Treasury regulations and directions made under the Act. The framework requires actuarial valuations of the schemes to be undertaken every four years.

61. The valuations provide two key outcomes in setting the employer contribution rate for the Scheme to ensure that the full costs of the schemes are recognised and met where they are incurred; and test whether certain costs (employer cost cap costs) have moved from target levels set in 2015.

Employer contributions

62. Whilst there have been a number of downward cost pressures in relation to the Scheme, the key financial assumption used as part of the valuation process of unfunded schemes is the discount rate. Known as the SCAPE discount rate, this was reduced from 3.0% pa above CPI to 2.8% pa above CPI from April 2016 and was subsequently reduced to 2.4% pa above CPI following an announcement by the UK Government in its October 2018 budget statement.

63. The valuation assesses what each scheme needs now in order to meet future liabilities. The higher the discount rate, the quicker the notional assets grow, so the less is needed now. The lower the rate, the higher the level of funding needed now to meet those future liabilities and that feeds through to employer costs. Hence, a reduction in the discount rate feeds through to higher employer contributions.

64. This change in the SCAPE discount rate has impacted significantly on the employer contribution rate. The current rate of 14.9% it is set to increase from 1 April 2019 to 20.9%. This revised rate should apply through to 31 March 2023 after which the next valuation (based on data as at March 2020) will set the employer contribution rates from 1 April 2023.

65. In its budget statement the UK Government confirmed it will provide funding to cover the additional costs arising from the discount rate change. As at January 2019, discussions with HM Treasury were ongoing to confirm the extent of that funding.

Employer Cost Cap

66. The employer cost cap was designed to protect the taxpayer against significant unexpected increases in member costs. Where costs increase or decrease by 2% or more, scheme regulations require action to be taken to bring the costs back to their original value. In line with all unfunded public service schemes the employer cost cap for the NHS Scheme has been breached downwards triggering a requirement for steps to be taken to return cost cap costs to target levels.

67. Unlike the valuation in setting scheme employer contribution rates the SCAPE discount rate is not applied when measuring movement in the employer cost cap. Hence the downward cost pressures principally around a reduction in the assumed increase in live expectancy and lower than assumed public sector pay are not offset by the change in the SCAPE discount rate and have therefore resulted in a reduction of more than 2% in the set employer cost cap and consequently a breach which requires rectification.

68. The scheme regulations provide that Scottish Ministers must ask for Scheme Advisory Board (SAB) advice on what remedies should be taken to recalibrate the employer cost cap. This would expect to include an increase in benefits, reduction in employee contributions or a combination of the two. However, constraints being applied by HM Treasury restrict a reduction in employee contributions and, in December 2018, the SAB proposed a number of options to rectify the cost cap breach.

69. Pension schemes across the public service, including the NHS Scheme in Scotland, provided age related transitional protections to eligible members when the 2015 reforms were introduced. These allowed members close to retirement to remain in their final salary scheme. The transitional protections have been legally challenged by members of the UK Judiciary scheme ("McCloud & Others") and firefighters ("Sargeant & Others"), on the basis that the protections discriminate on the grounds of age and (indirectly) gender and ethnicity.

70. On 20 December 2018, the Court of Appeal found in favour of the claimants, finding that no legitimate aims had been established by the UK Government and that therefore there was no objective justification for the age discrimination. The decision referred the case back to the Employment Tribunal but did not suggest any remedial action.

71. Although the UK Government is seeking permission to appeal this decision, if it is unsuccessful, the Employment Tribunal will require action to remedy the established age discrimination which will require changes being made to the transitional protections. The timescale of any remedy is uncertain given both the UK Government's appeal and the final detail of any remedy agreed.

72. The Chief Secretary to the Treasury confirmed in a written statement on 30 January 2019 that the cost cap element of the valuation will be paused in anticipation of the costs that may arise from any remedy agreed as a result of the Court of Appeal cases. The statement also confirmed that the planned employer contribution

increases will be introduced from 1 April 2019 and that the cost cap will be considered once any remedy costs had been confirmed.

Contributions

73. Prior to its consideration of the employer cost cap breach the SAB were considering the structure and rates of employee contributions for the period 1 April 2019 to 31 March 2023 whilst still aiming to deliver an annual yield of 9.8%. A number of options were under consideration including a change to how a member's contribution rate is set. Currently this is based on the members whole time pay but the SAB were considering using a member's actual pay.

74. Moving to using actual pay reduces the contribution rates for part-time members but at the same time reduces the yield received from employee contributions. One of the SAB's recommendations to rectify the employer cost cap (see above) includes this change and funding that cost from the cost cap breach. The cost cap element of the valuation has been paused so further consideration of how contributions are set will be considered once the cost cap is concluded. The earnings bands used to set the rate of contribution a member pays are uprated each year to reflect the annual service pay award The following employee rates were subject to consultation in December 2018, and will be implemented from 1 April 2019. This change maintains the current rates but adjusts the pay bands to reflect the latest pay award.

Column 1 *Pensionable pay band*	*Column 2* *Contribution percentage rate*
Up to £17,864	5.2%
£17,865 - £23,112	5.8%
£23,113 - £28,747	7.3%
£28,748 - £53,025	9.5%
£53,026 - £75,703	12.7%
£75,704 - £116,360	13.7%
£116,361 to any higher amount	14.7%"

75. These rates will continue to use a member's whole time equivalent pay to set the rate due.

Taxation

76. Tax relief and the Lifetime Allowance (LTA) and Annual Allowance (AA) remain reserved. The current AA limit is £40,000 but, from 6 April 2016, the UK Government introduced tapered AA as a mechanism to control the cost of providing tax relief to higher paid earners. It works by reducing a person's annual allowance by £1 for every £2 of 'adjusted income' earned over £150,000, up to a maximum reduction of £30,000. Individuals with an adjusted income of more than £210,000 are provided with a re-adjusted tapered annual allowance of £10,000.

77. There remains considerable concern that the application of AA charges is having a significant impact across all public service schemes. The SAB has a priority in its work plan for 2019 to consider the impact of both the AA and LTA on scheme membership and what flexibilities may be available to better manage the impact of AA and LTA on scheme members. This will consider any flexibilities on how much pension can accrue during a tax year and also highlight the facility which allows members to elect for the scheme to pay their AA or LTA tax charge via a reduction in their pension. In addition, there is also a joint employers and trade union group considering the impact of AA on public service pensions. This group is led by the Fire Leaders Association and has representatives from the British Dental Association and Scottish Public Pensions Agency (SPPA).

Participation and opt out information

78. Participation in the Scheme by Hospital Doctors and Dentists[1] remains high at 94.3% as at 30 September 2018 (down 0.7% compared to 30 September 2017). For General Practitioners[2] for the Scheme year 2017-18 participation is 91% and for Dental Practitioners[3] 80% were in the Scheme 2017-18.

79. Figures for the period 1 April 2017 to 30 September 2018 show 137 GPs and 2 Dental Practitioners opted out of the Scheme. However the pension data held by SPPA does not distinguish between job roles only between “officer members” (those employed) and practitioner members (GPs and Dentists). When members opt out of the Scheme they do not always give a reason. Some may opt out of the Scheme in one employment because they are already in the Scheme in respect of another employment. Also many will opt straight back out when auto enrolment puts them back into the Scheme every 3 years. There is also some indication that members have opted out of the Scheme, but then have opted back in, as a means to restrict their pensions growth against the AA limit.

80. The SAB plans to consider the impact and management of AA and LTA charges will help to identify participation trends related to opt-out of Scheme membership.

81. The available participation rates for Hospital Doctors and Dentists reflects well against the total participation rates of all staff less GPs and Dental Practitioners as at 30 September 2018 – 94.3% against the total of 90.6%. Participation rates remain a regular consideration of the SAB considering impacts of opt outs across the whole Scheme membership.

[1] Information provided by Health Boards
[2] Information provided by PSD NHS National Services Scotland
[3] Information provided by Dental Services NHS National Services Scotland

Early Retirements

82. There were 73 GPs and 32 GDPs who took early retirement between 1 April 2017 and 31 March 2018. The reasons for taking early retirement are not requested on the application form so those details are not held by SPPA.

Future Changes

83. The key amendments to the Scheme in the following year will arise from the agreed changes implemented to rectify the employer cost cap breach (as set out above). These may include changes to the structure and rates of the current employee contributions for members of the 2015 CARE scheme and improvements to specific benefits of the Scheme – for example, this may include an improvement to the current accrual rate of 1/54th.

84. The SAB will also be considering how management of AA and LTA charges can be improved for members which may include flexibilities introduced to the scheme regarding managing the level of pension accrual.

F. Workforce Planning

MEDICAL AND DENTAL WORKFORCE PLANNING

National Workforce Planning

85. Scotland's health services, like those across the United Kingdom and abroad, face a number of challenges, including an increasing demand for services, global staffing shortages in some medical specialties such as Radiology, and difficulties recruiting to rural areas. In this context, a more consistent and sophisticated approach to health workforce planning is required to sustain high quality services for everyone in Scotland.

86. Accordingly, Scotland was the first nation in the UK to publish a national health and social care workforce plan, but also the only one committed to Safe Staffing legislation that covers both health and social care settings.

87. The National Health and Social Care Workforce Plan (published in three parts from 2017 to April 2018), produced a number of recommendations which, when delivered, will bring about improvements in workforce planning across health, primary care and social care.

88. The next iteration of this Plan is the production of a fully integrated health and social care workforce plan in early 2019.

89. At a national level, we are working closely with NHS Boards to further develop the capacity to model and scenario plan the health and social care workforce in response to a range of service challenges, and key to this is the development and implementation by NHS Education for Scotland of a supply-side data platform, enabling workforce information across health and social care to be combined. The platform is scheduled to go live in April 2019.

90. Progress is also underway to deliver a series of commitments to address workforce challenges, including the commitment to increase GP numbers by 800 over the next 10 years and an additional £3m to increase the number of radiology trainees in Scotland by at least 50 over the next 5 years.

Public Audit and Post-Legislative Scrutiny Committee (PAPLS)

91. Paul Gray, Director-General Health & Social Care, Scottish Government and Chief Executive, NHSScotland appeared before the Public Audit and Post-Legislative Scrutiny Committee on 20 December 2018 to provide evidence in relation to Workforce Planning. Details of the questions raised and the answers supplied can be found here[4].

[4] https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/110619.aspx

Workforce data

92. While we continue to set a consistent and strategic approach to workforce planning, it is vital to ensure that we have the right staff in the right place at the right time to deliver health services across Scotland. The most recently available national workforce statistics are outlined below:

NHS Scotland

93. NHSScotland's staffing levels have increased by over 12,700 WTE – a 10.0% increase (from 127,061.9 WTE at Sept 2006 to 139,764.9 WTE at September 2018).

94. Medical & Dental Consultant (including Director level consultants) numbers have increased by 1,848.2 WTE – a 50.8% increase (from 3,636.6 WTE at Sept 2006 to 5,484.8 WTE at September 2018).

DDRB remit groups

95. Table 1 shows that numbers of medical and dental staff in post have risen from 11,343.1 WTE in September 2008 to 13,538.2 WTE in September 2018. This represents an increase of 19.4%.

96. Table 2 shows HCHS staff by specialties and age group. For medical specialties, the largest age group was 25-29. For dental specialties, the largest age group was 50-54.

Vacancies

97. NHSScotland is a large organisation, employing 139,764.9 staff (WTE) (as at September 2018). Given the natural turnover of staff in an organisation of this size, it will always carry some vacancies.

98. For certain consultant posts (Radiology, Geriatrics, Psychiatry) and in certain parts of Scotland, Health Boards can find it more challenging to fill vacancies. Some specialties, such as Radiology, continue to experience international shortages.

99. The National Workforce Planning Group, which has been set up to take forward the recommendations in our Workforce Plan, is also helping to co-ordinate and improve targeted recruitment activity to ensure key vacancies are filled by Boards.

100. Table 3 shows that the number of vacant consultant posts decreased by 8.7% (37.4 WTE) between September 2017 and September 2018 to 393.1 WTE, creating the lowest vacancy rate of 6.8% since December 2016. Of these vacancies, 258.1 WTE (4.5% of the establishment figure) had been vacant for six months or more at the census point, as shown in Table 4.

101. The number of vacant posts in medical specialties was 388.2 WTE, a decrease of 7.8% from September 2017. Of these, 255.6 WTE (65.8%) had been vacant for 6 months or more.

102. The number of vacant posts in dental specialties was 4.9 WTE, the lowest figure since September 2012. Of these, 2.5 WTE (51%) had been vacant for 6 months or more.

103. Table 5 shows joiners, leavers and turnover in the NHSScotland workforce by staff group and region for each financial year from 2011/12 to 2017/18. For medical and dental staff across Scotland, the turnover rate in 2017/18 was 8.7 WTE (calculated as the number of leavers divided by staff in post as at 31 March).

NHS Board Workforce Projections

104. All NHS Boards were asked to provide workforce projections for 2018-19 to enable the Scottish Government and NHS Boards to assess the current workforce and skills mix to ensure this is appropriate to meet current and future needs.

105. As with all projections, these figures are estimates and are subject to change. NHSScotland projected staff in post changes for 2018-19 were published on 28 August 2018 on the Scottish Government website[5].

106. The main findings for WTE staffing in financial year 2018/19 were:

- Total staff in post (including Management non AfC) is projected to increase by 996.6 WTE (up 0.7%).
- Medical staff is projected to increase by 570.3 WTE (up 4.5%). This figure should be treated with caution, as part of the increase may be due to some GP trainees being counted by NES and also their territorial board of placement.
- Dental staff is projected to increase by 1.4 WTE (up 0.3%).
- Medical and Dental Support staff is projected to increase by 21.5 WTE (up 1.1%).
- Nursing and Midwifery staff is expected to remain stable with a modest increase of 19.1 WTE (under 0.01% increase).
- Allied Health Profession staff is projected to increase by 167.5 WTE (up 1.4%).
- Other Therapeutic Services staff is projected to increase by 120.3 WTE (up 2.7%).
- Healthcare Science staff is projected to increase by 12.9 WTE (up 0.2%).
- Personal and Social Care staff is projected to decrease by 1.4 WTE (down 0.1%).

[5] https://www.gov.scot/publications/nhs-board-projected-staff-post-changes-2018-19/

- Ambulance Support Services staff is projected to decrease by 7.2 WTE (down 0.3%).

- Support Services staff is projected to increase by 18.9 WTE (up 0.1%).

- Administrative Services staff is projected to increase by 73.3 WTE (up 0.3%).

- A sub-set of Administrative Services is Management (non AfC including non-executive board members) and this staff group is projected to increase by 2.0 WTE (up 0.4%).

107. Workforce projections are part of the normal planning process undertaken by all NHS Boards to ensure that changes to the NHS workforce are driven by and reflect service redesign in order to maintain and enhance the quality of care while increasing efficiency. All projections have been developed in liaison with local staff side representatives in each NHS Board.

SUSTAINING THE MEDICAL WORKFORCE IN SCOTLAND

108. Workforce supply and demand pressures are compounded by an ageing workforce, an ageing population and the unknown impact of Brexit. Effective workforce planning not only has to account for these external factors but also for the changes in the nature of the demands being placed on our health and care services. The Integrated Health and Social Care Workforce Plan will ensure we have the right people in the right place at the right time to continue to deliver high quality care that meets the needs of Scotland's population.

109. We have established a National Workforce Planning Group to support implementation of the recommendations in the National Health and Social Care Workforce Plan[6]. The recommendations cover four main themes: guidance, re-design, data and intelligence, and recruitment, training and education.

110. A key objective is to gather and improve data to inform our needs in terms of its analysis and our ability to factor in the effects of increased demand. This will encompass developing medical specialty supply/demand profiles to support sustainability of medical specialties; improving the Primary Care Workforce Survey so we know more about GP numbers and trends; and building research-informed data on the career influences, motivations and choices made by medical trainees to help sustain future supply;

111. Key to this is the development and implementation by NHS Education for Scotland of a data platform, enabling workforce information across health and social care to be combined. The platform is scheduled to go live in April 2019.

112. The Scottish Government will circulate updated guidance on workforce planning to Boards alongside the Integrated Health and Social Care Workforce Plan

[6] National health and social care workforce plan: part one
National health and social care workforce plan: part two
National health and social care workforce plan: part three

in early 2019, which will help Boards to monitor trends in supply and demand; factor in demographic and other changes affecting the workforce, including retirement; inform recruitment strategies across different areas – particularly in a regional context – and professions; and help bring further intelligence and co-ordination to the student intake process.

113. We have already announced that we will undertake additional international recruitment activity in this financial year (2018/19), in order to promote the resilience of NHSScotland as a result of EU Withdrawal. We have centrally funded the creation of an international recruitment unit to co-ordinate this work on behalf of NHS Scotland Health Boards.

114. The Unit will be commencing formal recruitment activity shortly, beginning with a campaign for psychiatrists. Other campaigns will be sequenced throughout 2019, in line with our recruitment priorities. This will include campaigns for Anaesthetists, Paediatricians and Emergency Medicine specialists.

115. In the meantime, we have already taken action to increase medical supply in future years through the following measures:

- By 2020-21, we will have increased the number of medical places in Scottish universities from 848 in 2015/16 to 1038 (an increase of 22%), the 190 extra places include:
    - We have sustained the funding for 50 additional widening access places, introduced in 2016.
    - 55 undergraduate medical places through the new Scottish Graduate Medical School (ScotGEM – from September 2018)
    - From 2019, 85 additional undergraduate places at the Universities of Aberdeen, Edinburgh and Glasgow, announced in the National Workforce Plan will be introduced.
- 2 pre-medical entry programmes for medicine, which commenced in September 2017, and from 2019 the number of funded places will increase from 40 to 50.
- Some 190 additional specialty training posts in response to service demand.
- 100 additional GP training posts.

The Waiting Times Improvement Plan (WTIP)

116. In October 2018, the Scottish Government published the Waiting Times Improvement Plan (WTIP), which sets out a range of actions that will deliver major change in access to care.

117. The WTIP will require a combination of an increase in output from the current workforce resources, a reconfiguring of the way in which we utilise resources and an overall increase in the workforce. Health Boards are already developing detailed workforce plans to address the actions set out in the Plan.

118. The WTIP will:

- Increase capacity across the system by expanding capacity at the Golden Jubilee Hospital (through 2019/20) and bringing unused physical capacity on

stream (by October 2019). In addition, we will accelerate the delivery dates of the existing Elective Centre Programme, meeting the commitment made in 2016 to invest £200 million in elective centres.

- Increase clinical effectiveness and efficiency by implementing targeted action plans for key specialties and clinical areas (from October 2018) and mainstreaming key productivity improvement programmes, such as rolling out the virtual attendance potential of 'Attend Anywhere' (from December 2018).

- Working alongside local communities and those who use services, design and implement new models of care by accelerating whole-system design of local patient pathways through health and social care integration and driving regional service reconfiguration to the benefit of patients through the regional delivery and national Boards' plans (through 2019/20).

119. Action with the workforce is crucial to achieving this. Over the next 12 months, we will:

- Enhance workforce capacity in key specialties such as urology, dermatology, and general surgery.

- Initiate investment of £4 million in domestic and international recruitment.

- Improve career pathways for key specialities such as Advanced Nurse Practitioners and General Nurses.

National Elective Centres Programme

120. The strategic aim of the National Elective Centre Programme is to provide additional capacity for a growing population and to provide infrastructure to meet the needs of an elderly population estimated to be 25%-30% higher in 2035 than at present and therefore has significant workforce implications. The Elective Centres will commission additional capacity on a phased basis that will align to this expected increase in demand, providing treatment in new diagnostic and treatment centres that are being built across the country.

121. The first of the centres will open at the Golden Jubilee in early 2020, with the other centres opening during 2021 and early 2022. These facilities will deliver additional capacity for Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI), outpatients, day surgery and short stay theatre procedures for several specialities including orthopaedics, ophthalmology and general surgery.

122. Work is underway with NHS Board contacts to scope the workforce requirements around the new Elective Centres.

Table 1: NHSScotland workforce statistics - HCHS Medical & Dental Staff (WTE) by Group

	Sep 08	Sep 09	Sep 10	Sep 11	Sep 12	Sep 13	Sep 14	Sep 15	Sep 16	Sep 17	Sep 18
All HCHS medical and dental staff	**11,343.1**	**11,328.4**	**11,440.3**	**11,960.7**	**11,943.9**	**12,181.4**	**12,698.9**	**12,812.1**	**13,117.7**	**13,239.3**	**13,538.2**
Consultant	4,234.4	4,252.5	4,375.1	4,428.5	4,476.2	4,584.6	4,890.7	5,026.7	5,174.5	5,189.8	5,357.5
Director (Clinical, Medical & Dental)	48.3	53.9	59.2	76.9	82.6	81.2	83.6	74.7	129.2	134.5	127.2
Doctor in Training (with NTN)	3,173.8	3,222.7	3,076.9	3,667.7	3,591.6	3,739.9	3,955.4	3,893.7	3,359.0	2,978.2	3,113.4
Doctor in Training (no NTN)	545.9	461.2	589.5	308.8	278.8	197.0	242.6	205.3	716.7	1,177.9	996.8
Foundation house officer year 2	914.0	828.0	861.8	784.0	800.7	787.5	886.2	786.5	778.1	790.6	852.2
Foundation house officer year 1	899.4	963.3	824.7	956.0	988.5	1,072.3	883.5	1,036.6	978.7	998.3	847.7
Specialty doctor	1,047.6	1,008.7	1,057.9	1,080.0	1,050.8	1,042.9	1,058.5	1,056.4	953.8	939.5	935.8
Senior dental officer	75.7	70.8	85.2	88.0	87.3	77.7	82.8	90.8	98.5	91.0	79.6
Dental officer	225.1	224.0	190.8	201.7	184.5	184.5	196.6	174.1	174.2	179.0	192.4
Other	179.0	243.3	319.1	369.0	403.1	413.8	419.0	467.2	755.0	760.5	1,035.5

Source: ISD Scotland

Table 2: NHSScotland workforce statistics - HCHS Staff (Headcount) by Specialty & Age Group, Sep 2018

	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65+	All ages
All specialties	**783**	**2,826**	**2,356**	**1,912**	**1,910**	**1,714**	**1,646**	**1,221**	**487**	**157**	**15,012**
All medical specialties	**764**	**2,723**	**2,256**	**1,813**	**1,823**	**1,629**	**1,529**	**1,126**	**456**	**145**	**14,264**
All dental specialties	**19**	**103**	**100**	**99**	**87**	**85**	**118**	**95**	**31**	**12**	**749**
Acute internal medicine	15	59	37	27	22	16	13	10	5	1	205
Allergy	0	0	0	0	0	0	0	0	0	0	0
Anaesthetics	6	153	266	198	186	162	189	138	30	8	1,336
Audiological surgery	0	0	0	0	0	0	0	1	0	0	1
Cardiology	10	38	33	34	39	33	19	25	6	3	240
Cardiothoracic surgery	6	14	9	9	9	9	12	9	3	1	81
Chemical pathology	0	6	5	2	17	8	9	12	3	1	63
Child & adolescent psychiatry	1	10	21	11	28	21	18	13	3	0	126
Clinical genetics	0	0	4	3	2	8	4	7	2	0	30
Clinical neuro-physiology	0	0	0	4	2	2	1	1	0	0	10
Clinical oncology	3	16	21	25	31	22	27	10	4	5	164
Clinical pharmacology & therapeutics	0	0	1	1	2	2	4	4	1	0	15
Clinical radiology	1	66	85	68	75	70	54	55	20	10	504
Community dentistry	1	24	37	47	45	43	55	55	15	4	326
Community sexual and reproductive health	0	2	5	7	3	6	5	3	0	0	31
Dental & maxillofacial radiology	0	1	1	1	0	2	1	0	1	1	8
Dental public health	1	14	19	11	14	15	22	17	4	1	118
Dermatology	2	15	32	25	28	30	26	17	7	4	186
Diagnostic neuropathology	0	0	2	0	1	0	0	0	0	0	3
Emergency medicine	29	205	141	113	98	64	42	32	7	1	732

Endocrinology & diabetes	6	25	22	17	23	37	17	11	9	3	170
Forensic histopathology	0	0	0	0	0	1	0	0	0	0	1
Forensic psychiatry	0	4	17	6	17	9	10	4	1	0	68
Gastroenterology	5	25	23	23	30	26	25	15	6	4	182
General medicine	223	322	159	105	55	61	49	49	28	17	1,068
General practice	33	370	326	164	145	148	153	134	71	16	1,560
General psychiatry	25	152	104	101	128	106	136	68	27	11	858
General surgery	194	200	84	94	111	74	89	57	34	9	946
Genito - urinary medicine	0	0	6	6	8	6	7	4	2	0	39
Geriatrics	53	143	71	72	64	57	36	30	14	7	547
Haematology	3	23	25	40	29	17	23	26	6	3	195
Histopathology	2	19	32	26	38	21	16	17	11	1	183
Homeopathy	0	0	0	0	0	1	1	1	0	0	3
Immunology	0	0	0	2	1	0	1	1	1	0	6
Infectious diseases	0	25	10	9	8	9	9	3	2	1	76
Intensive care medicine	6	23	25	9	7	3	1	1	4	0	79
Medical microbiology & virology	0	4	12	19	10	15	15	9	1	4	89
Medical oncology	4	22	10	9	10	12	3	2	0	0	72
Medical ophthalmology	0	0	1	1	0	0	0	0	0	0	2
Neurology	3	18	6	21	26	16	17	13	4	1	125
Neurosurgery	6	19	11	10	13	8	6	6	3	0	82
Nuclear medicine	0	0	0	0	0	2	2	0	0	0	4
Obstetrics & gynaecology	20	125	102	92	87	90	79	48	31	1	675
Occupational medicine	0	0	2	2	4	3	8	2	0	2	23
Old age psychiatry	1	14	21	20	19	22	24	11	3	0	135
Ophthalmology	6	38	27	28	26	48	37	37	7	2	256
Oral & maxillofacial surgery	1	6	8	7	5	7	9	7	4	0	54
Oral medicine	0	0	1	3	1	0	0	2	1	1	9
Oral microbiology	0	0	0	0	0	0	0	0	0	0	0
Oral pathology	0	1	0	0	0	1	0	0	0	0	2

Oral surgery	12	38	22	16	6	10	15	1	4	2	126
Orthodontics	0	2	5	7	7	7	8	7	2	2	47
Otolaryngology	4	27	36	16	27	22	18	15	11	4	180
Paediatric and perinatal pathology	0	0	0	0	1	0	1	0	0	0	2
Paediatric cardiology	0	0	2	3	2	3	0	1	0	1	12
Paediatric dentistry	0	2	4	4	5	1	2	5	0	0	23
Paediatric surgery	7	16	7	13	7	7	5	4	1	0	67
Paediatrics	25	173	147	126	118	114	105	65	32	6	911
Palliative medicine	1	14	20	16	17	6	14	6	2	2	98
Plastic surgery	3	26	21	15	22	13	15	7	0	0	122
Psychiatry of learning disability	0	3	11	13	18	14	18	4	5	0	86
Psychotherapy	0	3	8	2	3	3	3	5	0	1	28
Public health medicine	0	5	8	11	19	20	26	33	14	2	138
Rehabilitation medicine	2	7	3	5	7	5	9	7	5	0	50
Renal medicine	3	37	23	9	18	25	21	9	3	1	149
Respiratory medicine	14	32	30	33	34	29	26	17	4	2	221
Restorative dentistry	0	2	8	14	11	8	20	11	6	1	81
Rheumatology	1	20	3	14	23	18	16	10	2	4	111
Surgical dentistry	0	0	0	0	0	0	0	0	0	0	0
Trauma & orthopaedic surgery	28	126	94	74	85	79	48	41	16	6	597
Tropical medicine	0	0	0	0	0	0	0	0	0	0	0
Urology	6	25	25	21	13	27	18	17	7	2	161
Vascular surgery	1	12	10	5	1	2	0	1	0	0	32
Not known dental specialty	5	22	6	1	1	2	2	0	1	0	40
Not known medical specialty	5	41	55	40	19	12	12	12	7	3	206

Source: ISD Scotland

Note:
An employee may hold more than one appointment in NHSScotland, and is counted under each area they work in as well as in the overall total - therefore, the sum of all headcounts within individual categories may not equal the overall headcount total.

Table 3: NHSScotland - Consultant Vacancies by Specialty - Trend to 30 September 2018

	Sep-06	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15	Sep-16	Sep-17	Sep-18
All Specialties	**272.3**	**166.0**	**139.0**	**112.5**	**143.1**	**213.1**	**339.3**	**345.5**	**389.9**	**430.5**	**393.1**
All Medical Specialties[1]	**262.3**	**160.0**	**138.0**	**111.2**	**141.1**	**207.4**	**332.3**	**336.7**	**378.8**	**420.9**	**388.2**
Emergency Medicine	6.0	4.0	2.0	2.0	7.3	15.5	20.3	19.8	15.7	17.5	11.1
Clinical Laboratory Specialties	36.4	28.7	31.2	18.8	30.7	37.0	58.0	45.7	68.7	85.7	70.2
Medical Specialties	66.4	42.0	33.5	32.0	30.7	57.6	94.4	112.9	104.3	114.5	107.5
Geriatric Medicine	*9.0*	*4.0*	*8.5*	*7.0*	*3.0*	*11.0*	*12.0*	*10.0*	*8.0*	*18.8*	*18.0*
Psychiatric Specialties	52.8	36.3	15.5	8.0	8.7	25.2	37.3	40.3	41.8	58.8	63.1
Surgical Specialties	47.5	19.0	19.0	27.6	22.0	28.1	50.0	47.7	65.6	65.1	72.1
Paediatrics Specialties	16.8	16.0	14.0	13.0	15.9	13.0	19.0	20.8	33.2	25.1	16.0
All Dental Specialties	**10.0**	**6.0**	**1.0**	**1.3**	**2.0**	**5.7**	**7.0**	**8.8**	**11.1**	**9.6**	**4.9**

Source: ISD Scotland National Statistics, NHSScotland Workforce

Note:

1. The sum of the individual sub-specialties will not equal the "All Medical Specialties" total as only a selection of sub-specialties have been presented here.
Consultants – includes Consultants and Directors of Public Health. Excludes Clinical/Medical/Dental Directors as vacancy data for these posts are not published.

Table 4: NHSScotland workforce statistics - Consultant Establishment[1], Staff in Post and Vacancies by Specialty[2], Sep 2018

			Length of Vacancy		Vacancies as a Percentage of Establishment	
	Establishment	**Staff in Post**	**Total Vacancies**	**Vacant 6 months or more**	**Total**	**6 months or more**
All specialties	**5,750.6**	**5,357.5**	**393.1**	**258.1**	**6.8%**	**4.5%**
All medical specialties[2]	**5,654.8**	**5,266.6**	**388.2**	**255.6**	**6.9%**	**4.5%**
Emergency medicine	240.4	229.3	11.1	10.1	4.6%	4.2%
Clinical laboratory specialties	712.3	642.1	70.2	59.2	9.9%	8.3%
Medical specialties	1,432.7	1,325.2	107.5	72.9	7.5%	5.1%
Geriatric medicine	*201.0*	*183.0*	*18.0*	*12.0*	*9.0%*	*6.0%*
Psychiatric specialties	596.0	532.9	63.1	39.1	10.6%	6.6%
Surgical specialties	1,065.5	993.4	72.1	38.1	6.8%	3.6%
Paediatric specialties	367.1	351.1	16.0	8.0	4.4%	2.2%
All dental specialties	**95.8**	**90.9**	**4.9**	**2.5**	**5.1%**	**2.6%**

Source: ISD Scotland National Statistics, NHSScotland Workforce - Data as at 30 September 2018

Notes:

1. Establishment value is calculated as: Establishment=staff in post + total vacancies (not including posts under review).

2. The sum of the individual sub-specialties will not equal the "All medical specialties" total as only a selection of sub-specialties are presented here.

Table 5: NHSScotland workforce statistics - joiners, leavers and turnover by staff group for financial year

		WTE							Headcount						
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Medical and dental staff (HCHS)															
Scotland	Joiners	509.3	554.3	573.9	755.8	831.5	731.6	749.3	648	686	718	934	1,013	880	883
Scotland	Leavers	433.6	409.6	428.1	479.4	458.4	534.1	630.6	606	556	602	661	645	710	813
Scotland	Turnover	7.0	6.5	6.7	7.4	6.8	7.5	8.7	8.1	7.4	7.9	8.5	8.1	8.5	9.5
East Region	Joiners	84.6	138.8	128.3	261.1	164.6	195.6	128.1	93	201	183	345	194	225	160
East Region	Leavers	90.7	84.5	79.3	88.0	119.6	126.5	128.8	121	115	114	141	171	179	190
East Region	Turnover	6.6	6.2	5.7	6.1	7.4	7.7	7.5	7.4	7.1	6.7	8.0	8.7	9.0	9.3
North Region	Joiners	200.9	151.9	207.7	209.3	201.4	198.2	205.6	278	179	259	249	263	272	256
North Region	Leavers	144.0	143.0	151.1	185.3	167.8	161.0	179.9	212	199	200	244	242	217	235
North Region	Turnover	8.5	8.2	8.7	10.4	9.3	8.8	9.7	10.1	9.2	9.3	11.0	10.9	9.7	10.3
West Region	Joiners	246.6	281.0	260.5	314.7	455.6	353.1	442.8	311	330	304	380	506	403	490
West Region	Leavers	216.0	209.5	219.3	246.6	209.0	292.4	317.9	299	282	315	325	285	353	395
West Region	Turnover	7.2	6.9	7.1	7.9	6.5	8.5	9.1	8.3	7.8	8.6	8.9	7.7	9.0	10.0
National/Special	Joiners	5.8	19.2	11.4	26.0	76.6	54.1	26.8	6	20	13	32	147	64	51
National/Special	Leavers	10.7	10.3	12.7	13.3	16.7	29.0	54.6	15	14	15	18	20	52	60
National/Special	Turnover	8.1	8.1	9.2	9.7	11.2	13.8	23.2	9.8	9.7	10.0	12.2	12.3	18.0	19.9
All staff															
Scotland	Joiners	5,388.4	8,930.7	9,361.4	9,874.4	9,572.4	9,740.2	9,625.0	7,037	11,172	11,361	11,871	11,562	11,534	11,451
Scotland	Leavers	7,755.0	7,049.8	7,216.1	7,891.5	8,449.6	8,418.6	8,853.5	9,962	8,986	9,256	9,996	10,588	10,573	11,079
Scotland	Turnover	6.1	5.6	5.7	6.1	6.4	6.3	6.6	6.6	6.0	6.1	6.5	6.8	6.8	7.1
East Region	Joiners	1,069.3	2,278.2	2,436.9	2,584.2	2,293.0	2,551.9	2,669.0	1,393	2,824	2,971	3,110	2,754	3,010	3,186
East Region	Leavers	1,803.7	1,626.0	1,816.8	1,914.6	2,220.1	2,181.8	2,160.4	2,325	2,064	2,327	2,447	2,754	2,770	2,739
East Region	Turnover	6.6	6.1	6.7	6.9	7.8	7.7	7.5	7.1	6.5	7.1	7.3	8.1	8.1	8.0
North Region	Joiners	2,045.9	3,436.6	2,842.3	3,091.0	2,824.9	3,012.4	2,563.8	2,664	4,346	3,521	3,761	3,505	3,683	3,124

North Region	Leavers	2,171.1	2,332.3	2,371.4	2,663.2	2,781.3	2,637.8	2,831.5	2,845	3,026	3,054	3,401	3,516	3,325	3,574
North Region	Turnover	7.1	7.7	7.5	8.3	8.6	8.1	8.6	7.7	8.2	8.0	8.8	9.0	8.5	9.1
West Region	Joiners	2,182.0	2,982.4	3,900.3	4,008.5	4,321.4	4,131.0	4,201.8	2,809	3,707	4,678	4,759	5,091	4,823	4,900
West Region	Leavers	3,505.6	2,955.9	3,015.1	3,378.7	3,682.4	3,760.9	3,935.4	4,467	3,713	3,795	4,185	4,539	4,610	4,803
West Region	Turnover	5.9	5.1	5.2	5.8	6.2	6.3	6.6	6.4	5.5	5.6	6.1	6.6	6.6	6.9
National/Special	Joiners	517.7	836.7	959.9	1,114.0	1,197.3	1,047.7	1,160.2	695	985	1,067	1,282	1,430	1,144	1,321
National/Special	Leavers	685.2	725.2	771.6	841.3	812.7	833.0	892.2	834	900	961	999	975	1,010	1,063
National/Special	Turnover	6.1	6.5	6.9	7.4	7.0	7.0	7.3	6.7	7.3	7.7	7.9	7.6	7.6	7.9

Notes:

Leavers are defined as employees who were in post as at 31 March year n and not in post at 31 March year n+1.

Joiners are defined as employees who are in post as at 31 March year n+1 and were not in post at 31 March year n.

Turnover is calculated as the number of leavers divided by staff in post as at 31 March year n.

Medical figures exclude training grades. This is to avoid the distortion caused by the frequent rotation of staff in training placements.

GP Workforce Planning in Scotland

123. A key change in the 2018 GP Contract is that GPs will become more involved in complex care and system wide activities, necessitating a refocusing of GP activity. As we refocus the GP role, we expect GPs to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team.

124. To achieve this, the training needs of GPs and members of the wider primary care multi-disciplinary team, will need to be considered, developed and delivered. The National Health and Social Care Workforce Plan: Part 3 Primary Care[7] sets out plans for the development and training of GPs, and the wider primary care multi-disciplinary team, and was published April 20188.

Data Gap on Vacancies

125. The 2018 GP Contract means an increase in data collection. As part of this it will be mandatory for practices to provide workforce data – including on GP and practice staff vacancies. This will facilitate future workforce planning. The Scottish Government is currently agreeing what dataset will be collected with the Scottish General Practitioners Committee (SGPC) of the BMA to allow collection to begin.

Recruitment and Retention – particularly for remote and rural

126. In addition, as part of the 2018 Contract package, we are investing a further £7.5 million in 2018/19 to support GP recruitment and retention. £2 million of this fund will provide additional support for remote and rural practices which should help to encourage recruitment and retention. This includes:

- Support for the GP for GP Scheme. This is a scheme which provides a confidential service in NHS Highland to GPs and their families at times of stress or illness, when they have difficulty going to their own GP. In the past it has supported Highland GPs with problems such as stress, depression, inability to cope, marital problems and bereavement. This scheme has been extended to remote and rural GPs across Scotland.

- A Relocation Package. This will incentivise GPs to relocate to rural practices by offering re-location costs, including where eligible, rent for 12 months, removal and storage costs, etc. up to a maximum amount of £5,000 per supported GP.

- Substantially expanding the existing Golden Hello schemes to all remote and rural practices.

- Support for Dispensing Practices. Through the work of the Dispensing Short-Life Working Group, funding is to be used to cover training costs for dispensing staff. Funding will also be provided to dispensing practices to rollout Quality Improvement activities around interventions for patients on Non-steroidal Anti

[7] Scottish Government – National Health and Social Care Workforce Plan part 3

Inflammatory Drugs with support from Healthcare Improvement Scotland. Finally funding will be provided to support the costs associated with implementing the Falsified Medicines Regulations which come into effect in February 2019.

- SWAN IT in rural practices – to improve secure internet connections for rural GP practices.

- Rediscover the Joy of General Practice – a collaboration of four rural Health Boards, Shetland, Orkney, Western Isles and Highland, to develop a scheme to attract experienced GPs to work in rural practices on a flexible basis for a maximum number of weeks a year. GPs employed on the scheme would be provided with BASICs training and mentorship.

- Reflect and rejuvenate – a project to support GP retention. A collaboration of rural health boards to encourage urban and rural GPs to take part in 1-3 week exchanges. This fund would support the travel and accommodation expenses of GPs taking part in exchanges. Administration will be provided by the NHS Shetland HR team, set up to support Rediscover the Joy of General Practice (above).

127. The programme is taking forward proposals that promote Scottish general practice as a positive career choice, support medical students to actively choose general practice, inspire doctors in training to select speciality training in general practice, and encourage our alumni to stay in/return to Scotland, as well as those wanting to work in rural and economically deprived areas.

Generation 'Y' – more choosing to be salaried

128. The new GP contract has been designed to make becoming an independent contractor more attractive to young GPs. This includes proposals to stabilise practice and individual GP Partner income, reducing the risks of becoming a GP Partner and reducing GP workload.

129. However, the Scottish Government recognises that there is still an important, continuing role for salaried GPs. The new GP Contract maintains the specification that salaried GP Contracts should be on terms no less favourable than the BMA Model Contract.

G. Education and Training

Medical Trainee Recruitment – Process

130. For 2018, Scotland continued with the UK-wide specialty recruitment portal (Oriel) for all specialties. Applications to UK recruited specialties were managed by a national lead for the specialty, via either a Royal College, NHS Education for Scotland (NES), Northern Ireland Medical and Dental Training Board or Health Education England on behalf of the UK. The recruitment ran to a nationally agreed timetable to allow the synchronisation of application dates, interviews and offers, providing consistency for candidates. This UK-wide recruitment process continues to provide candidates across the UK with a consistent and fair recruitment process working to nationally agreed processes and timetables.

131. A small number of specialties either do not have UK agreed recruitment processes or are only recruited within Scotland; these specialties were recruited using the Oriel system and managed by NES. This included the introduction of the Broad-Based Training programme across Scotland with 12 posts advertised and accepted (note one candidate subsequently withdrew before commencement of training). The new Improving Surgical Training pilot was also introduced with 100% fill rate (47 posts). Local processes again resulted in 100% fill rates in Trauma and Orthopaedic Surgery level 1 (15 posts), and 100% in Obstetrics and Gynaecology level 3 (7 posts).

132. The recruitment arrangements for 2018 were rolled over from the 2017 timelines and processes. Since the introduction of Oriel, applicants register once, search for all vacancies and information on lead recruiting organisations, manage and book interviews and assessment centres, and receive offers all within the one system. The 2018 recruitment process offered 3 opportunities to apply for August 2018 start dates; from November 2017 for core and run through specialties; then February 2018 for ST3/ST4 levels and March 2018 to apply for re-advertised core and run through vacancies. Offers to candidates were made as soon as possible following interview, thus securing high quality trainees within Scotland. In addition, a further recruitment window in August 2018 was offered allowing the opportunity to apply to core and ST3/ST4 higher training vacancies – with a February 2019 start date.

133. In line with the Scottish Government's aim to support and sustain Scottish General Practice, the First Minister announced in October 2015 an increase of GP Surgical Training (GPST) places from 300 to 400. Scotland for the third year running has taken part in a further round of national GPST recruitment. The overall number of GPST places advertised was 347 and this resulted in a fill rate of 84% of the establishment of 1184.

134. Ongoing or new initiatives to improve the working lives of trainees include:

1. UK-wide - Special Circumstances

Applicants could state at the point of application whether they had any special circumstances that required them to be in a geographic region. Subject to them meeting the conditions for special circumstances and being eligible for an offer, they were then allocated a post in their preferred region.

Throughout the 2018 recruitment process, 130 applicants across the UK submitted a special circumstances application, 59 were approved. 32 of the approved applicants were offered and accepted a post in their preferred region; 19 of these would not have been offered their preferred region had the special circumstances pre-allocation process not existed.

2. Enhanced Preferencing and Offer Exchanges- UK wide

Enhanced preferencing and offer exchanges were introduced in 2018 in recognition that applicants' personal circumstances can change for any number of reasons between the point of application and offer. This process allows applicants to amend their geographical preferences throughout the recruitment process, and even after offers have been made. Prior to the introduction of this process, applicants would make their preferences shortly after application and would not be permitted to amend these.

Data shows that 642 applicants amended their preferences after initial offers were received, where they had not personally received an offer. All of these applicants were subsequently offered a post that they had preferenced. 1509 applicants who had received an offer amended their preference choices after the offer had been received.

Medical Trainee Recruitment – Outcomes

135. As in previous years, fill rates in some specialties and geographies remain challenging. Round 1 achieved 100% fill in all core training programmes except Core Psychiatry and General Practice.

136. Key specialties which did not fill well include Acute Internal Medicine (although there was a 7% increase in the fill rate from 2017) and for the third year, General Surgery. The latter will be carefully observed to monitor any new trend as a result of the GPST initiative for 2018 recruitment mentioned above. The ongoing trend in Mental Health is a concern, but remains static from previous years.

Medical Trainee Recruitment – Strategic response to Gaps in Training

137. The Scottish Government is fully aware there are challenges in recruitment and retention across NHSScotland for certain categories of trainee recruitment and in filling established posts. While, in overall terms, Scotland continues to do well in filling trainee posts through national recruitment systems, we recognise there are many reasons why gaps in training occur and that responses to these should take account of wider strategic aims and challenges, and be more attuned to trainee needs.

138. In the strategic context, we are working in a collaborative way with Scottish and UK partners to implement the recommendations of the UK Shape of Training Steering Group report, published 11 August 2017.
http://www.gov.scot/Publications/2017/08/9303/downloads

139. UK Health Ministers have made clear that they attach considerable importance to delivering changes in medical education and training that will align to key transformational priorities and commitments that will contribute towards a more sustainable medical workforce in Scotland. The Scottish Government Shape of Training Implementation Group continues to oversee this important phase of work, and has identified early priorities for curricula change, credentialing of specialist skills and enhanced training for GPs. It is recognised that the scale of change required is considerable and will take time to fully come to fruition, but Ministers wish to maintain the considerable momentum already achieved through the UK review process, as there are real benefits to accrue for patients, service providers and trainees.

140. The above also aligns with further work carried out by the NHS Boards, NES and the BMA. In 2018 our Strategy for Attracting and Retaining Trainees (StART) initiative was concluded with initiatives now part of our core work in recruitment and supporting training. We have continued with 'Scotland: home of medical excellence' as the key theme that underpins our marketing strategy. Focus has now moved toward retention activities to recognise the need for flexibility in the training journey.

141. There is now an overarching theme of work in improving junior doctors' working lives that encompasses strategies to improve retention and make the role safer and more effective in providing patient care and gaining learning. Recent developments across NHS Scotland include the launch of the lead employer model which removes the complexity of doctors having to change employer when they rotate through training placements, sometimes three times in a year. Remaining with one employer during their training programme has reduced costs for employers in Occupational Health and other employment checks and given doctors in training the stability of longer-term contracts making rental or mortgage applications easier and reducing the burden of paperwork each time they rotate.

142. The development of the Turas platform to include a Turas People module that supports the necessary information sharing across employing and placement Boards and the development of national employment policies means greater consistency of support and employment for doctors in training. Current efforts include the development of engagement strategies to improve retention including maintaining contact and support during periods out of training, further improvements to rotas reducing sequential night duty and working week, online videos highlighting success stories of individuals, and the review of the scheme attracting overseas doctors to undertake international medical training fellowships.

143. The Scotland Deanery is responsible for ensuring the quality management of postgraduate medical education and training to the standards set by the General Medical Council (GMC).

The General Medical Council: Sets standards for ensuring that doctors are trained to an appropriately high level. It is the regulator for undergraduate and postgraduate medical education in the UK.

The Scottish Government: Facilitates and supports the delivery of postgraduate medical education in Scotland. NES is directly accountable to the Scottish Government as are all NHS Scotland Health Boards.

Health Boards in Scotland: Deliver the training, either in hospitals or in General Practice surgeries. Doctors in training enter a programme and rotate through a number of hospitals or practices to make sure they get a wide range of experience in their chosen specialty. They have to cover a curriculum that is approved by the GMC before completing their training.

144. The Scotland Deanery and the Medical Directorate of NES quality manage the training delivered by the Boards on behalf of the GMC to make sure it is delivered to the right standards and covers the curriculum for the specialty. This is done by getting regular reports and feedback from the trainees and the Boards themselves, and by a programme of visits to ensure that the Boards are providing the time and resources to the trainees to get the best training.

145. Recent GMC Trainee surveys in 2018 continue to report excellent training programmes in Scotland. Overall satisfaction is one of the 15 quality indicators within the GMC National Training survey and is good reflection of the overall training environment. Overall satisfaction for training in Scotland in Community, Sexual and Reproductive Health, Ophthalmology and Medical Psychotherapy were top among rankings for UK Deaneries.

146. There are 8 Specialty Training Boards and 7 of the 8 had many specialties in the top 50% for overall satisfaction for training among rankings for UK Deaneries. This includes:

- 6 of the 7 mental health specialties (Child and Adolescent Psychiatry, Core Psychiatry, General Psychiatry, Medical Psychotherapy, Old Age Psychiatry and Psychiatry of Learning Disability);
- 8 of the 12 surgical specialties (Cardiothoracic Surgery, Core Surgical Training, Neurosurgery, Ophthalmology, Oral and Maxillo-Facial Surgery, Paediatric Surgery, Plastic Surgery and Trauma and Orthopaedic Surgery); 10 of the 17 medical specialties (Acute Internal Medicine, Core Medical Training, Endocrinology and Diabetes Mellitus, Gastroenterology, Genito-Urinary Medicine, Geriatric Medicine, Haematology, Infectious Diseases, Medical Oncology and Palliative Medicine);
- 2 of the 4 diagnostic specialties (Clinical Radiology and Histopathology); 1 of 3 for the General Practice, Occupational Medicine and Public Heath Specialty Training Board (General Practice in a GP Practice);
- 4 of 5 for the Anaesthetics, Intensive Care Medicine and Emergency Medicine Specialty Training Board (Anaesthetics, Core Anaesthetics, Emergency Medicine and Intensive Care Medicine) and

- 2 of 3 for the Obstetrics, Gynaecology and Paediatrics Specialty Training Board (Community Sexual and Reproductive Health and Obstetrics and Gynaecology).

Medical undergraduates

147. The Scottish Government Health Workforce Division convenes the Medical Undergraduate Group to consider the annual Scottish medical school intake. This group's main purpose is to ensure an appropriate supply of good quality trained doctors to meet the needs of NHSScotland's medical workforce whilst avoiding, or minimising, the possibility of medical unemployment.

148. For 2019-2020, Scottish Ministers approved a medical undergraduate intake of 1,013. This maintains the 50 additional SG-funded places that Scottish Ministers approved from 2016. These places were specifically targeted at students from non-traditional widening access backgrounds in response to the need to grow and widen access to the medical establishment to support the strategic aims for transformed primary and community care delivery in Scotland. It also includes the 55 funded ScotGEM places introduced in 2018, and 60 additional undergraduate places to commence in 2019 as part of the 100 additional undergraduate places the Scottish Ministers committed to under Part 1 of the National Health and Social Care Workforce Plan.

Graduate Entry Medical Programme (ScotGEM)

149. The ScotGEM programme is a component of Scotland's approach towards meeting the current and future needs of NHSScotland. It forms part of Scotland's commitment to create a more sustainable medical workforce and encourage more people into a career in healthcare, whatever their background. It is a four-year programme. It will have a focus on careers in primary care and remote and rural working – offering students the opportunity to experience how rewarding working in these settings is. The programme will offer students a 'return of service' bursary to support the retention of more graduates from Scotland's medical schools in Scotland and providing services to our NHS.

SAS Doctors Development Programme

150. There are approximately 1250 SAS grade doctors and dentists working in NHSScotland. They make up about 25% of the senior medical workforce and are often appointed to these posts at an early stage in their career compared to those pursuing a Consultant position. In keeping with our coherent strategic approach to medical and dental workforce issues, we continue to place considerable importance in ensuring that the aims and objectives that underpin this programme and the significant funding (£500k per annum) that is provided by Scottish Government to support it are fulfilled. Feedback from the doctors and dentists who have benefitted from the fund is that they are grateful for the development opportunity it affords. In addition, a survey of clinical Directors (whose SAS Doctors & Dentists have used the fund to enhance their skills), reported service benefits.

151. The programme aims to direct national funding to those SAS Doctors and Dentists whose clinical teams are seeking to develop new or improved clinical services, or to enhance their role within the clinical team, and where funding is not otherwise provided by the employing Health Board. If approved, funding is available to support costs for training, salary backfill, or completion of training to apply for a Certificate of Eligibility for Specialist Registration (CESR). In addition, funding has enabled the appointment of an Associate Postgraduate Dean (a SAS Doctor) to provide leadership of the programme, the creation of a national network of Educational Advisers (who are themselves SAS Doctors or Dentists) to support local SAS Doctors and Dentists, and to guide them (and their employing Health Boards) to make best use of this funding opportunity.

H. Specific Staff Groups – Pay, Terms and Conditions

H.1 General Medical Practitioners

Introduction

152. This section provides information relating to general practice (independent contractor GMPs) and the delivery of contracted services through NHS Boards. This section provides additional background to developments with the GMS arrangements in Scotland, and the implementation of the new GP Contract in 2018.

Background

153. The majority of GMPs working to provide primary medical services in Scotland are independent contractors, self-employed or partnerships running their own GP practices.

154. As of 1 October 2018, there were 944 GP practices[9] in Scotland and 84% are on the national General Medical Services contract. The number of GMS practices increased in 2018, mostly due to new funding arrangements put in place for GMS practices. GMPs operating under Section 17C or 2C arrangements provide services based on locally agreed contracts, and any uplift in investment for these arrangements is a local matter for the Health Board. As of 1 October 2018:

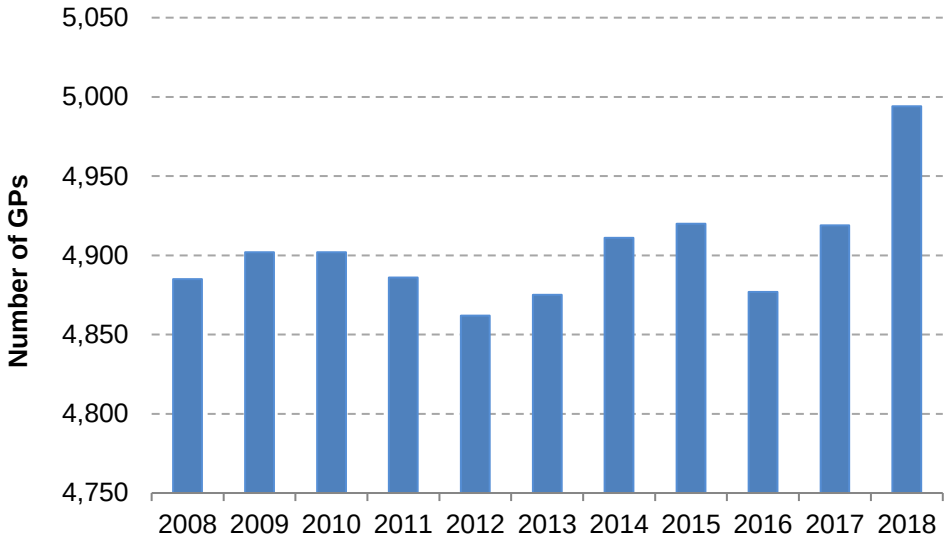
- 789 practices operated under the General Medical Services Contract;
- 121 practices operated under the 17C contract; and
- 58 practices operated under the 2C contract.

155. The headcount of GPs in Scotland is 4,994. This is a slight rise of 75 GPs compared to last year. Prior to 2018, the headcount of GPs had remained roughly constant at around 4,900 since 2008[10].

156. In September 2018, an estimated 39% of the GP workforce were male and 61% female, compared to 51% male and 49% female in 2008[11].

[9] ISD Scotland - General Practice - GP Workforce and practice list sizes 2008–2018
[10] Ibid
[11] Ibid

Figure 1 - Headcount of all GPs in Scotland[12]



157. The average (or mean) size of a Scottish GP practice in terms of numbers of registered patients was 6,000 in 2016[13], however there was considerable variation, ranging from under 200 patients for practices in remote locations or practices which addressed specific health needs of patients (e.g. those with challenging behaviours or homelessness), to practices of over 20,000 patients in densely populated urban areas.

2018 GMS Contract

158. The 2018 Contract came into effect on 1st April 2018. It was agreed through a process of collaborative negotiations between the Scottish Government and the Scottish GP Committee (SGPC).

159. The contract includes:

- Improving access for patients;
- Addressing health inequalities and improving population health, including mental health;
- Providing financial stability for GPs;
- Reducing GP workload through the expansion of the primary care multidisciplinary team;
- Increasing support for GPs and GP infrastructure;
- Increasing transparency on general practice funding, activities and workforce to assist strategic planning, commissioning and delivery of primary care services; and
- Making general practice a more attractive profession for existing GPs, junior doctors and undergraduate medical students.

160. One of the core aspects of the new GP Contract is the new funding model as the Scottish Government recognises that an appropriate and secure level of income

[12] Ibid
[13] Ibid

is a prerequisite to attracting GPs to the profession and ensuring the future sustainability of general practice.

161. The new contract will be introduced in two phases. Phase One includes:

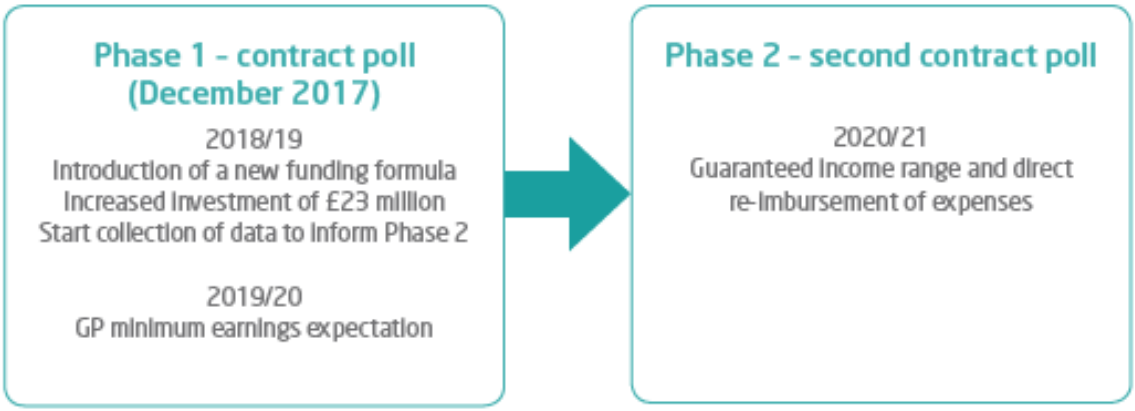
- A new workload formula to better match resource to demand;
- Additional investment of £23 million to allow most practices to gain from the new funding formula, whilst the remaining practices have received an income guarantee to protect their income level to ensure no practice was destabilised; and
- From April 2019, a GP Partner whole-time-equivalent minimum earnings expectation. This will mean that no GP should receive less than the £80,430 NHS income per year (including pension contributions) for a whole-time post. Current evidence suggests that around 20% of GPs will benefit from the introduction of this 'income floor.'

162. These initial changes will be followed by Phase 2, from April 2020, dependent on a further vote from the profession. Phase 2 will include:

- Introducing an income range for GP Partners that is comparable to consultants; and
- Directly reimbursing practice expenses.

163. These proposals are based on evidence from the 2017 Review of GP Earnings and Expenses[14], and will be supported by the investment of £250 million in direct support of General Practice by 2021/22.

Figure 1 - Phases of the proposed Funding Model under the 2018 Contract



Pay and Contractual Uplift 2018/19

164. For 2018/19 the Scottish Government implemented the DDRB recommendation to uplift GP pay net of expenses by 3%[15]. In total the Scottish Government uplifted the GP contract by £23.7 million. This also included a 3% uplift to practice staff expense, and a 3% uplift to wider practice expense in line with RPIX. This also included £2.9 million funding to cover the costs of population growth in 2018/19.

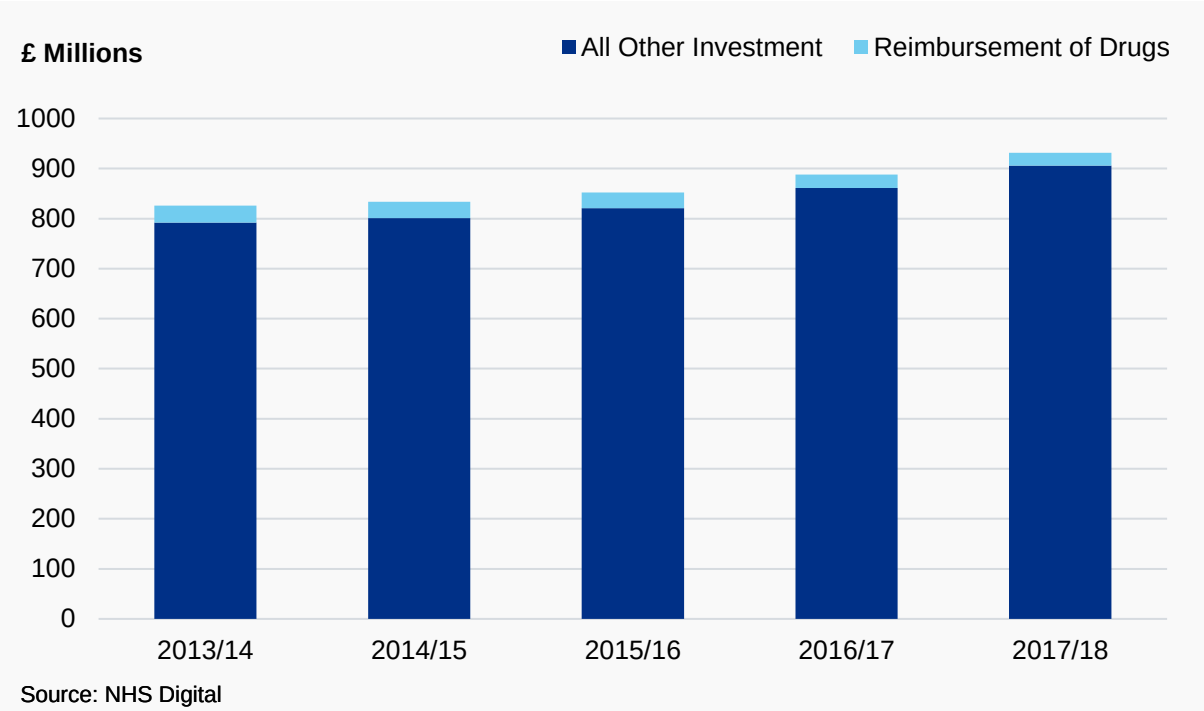
[14] Deloitte - General Practice - GP Workforce and practice list sizes 2008–2018 Final Report
[15] Scottish Government news release - Pay rise for doctors and dentists - 30th August 2018

165. In agreement with the SGPC, the contractual uplift was applied consistently across all general practices, meaning that there was no negative impact on practices.

Investment in General Practice

166. Investment figures for 2017/18 were published on 20 September 2018[16]. They show that for the period 2017/18 the total spend on General Practice (including the reimbursement of drugs dispensed) was £931.7 million in Scotland, a real terms increase of 4.93% from 2016/17. Total spend on General Practice 2017/18 (excluding the reimbursement of drugs dispensed) was 905.8 million in Scotland, a real terms increase of 5.17% from 2016/17.

Figure 2 - Investment in General Practice in Scotland 2013/14 to 2017/18[17]



Source: NHS Digital

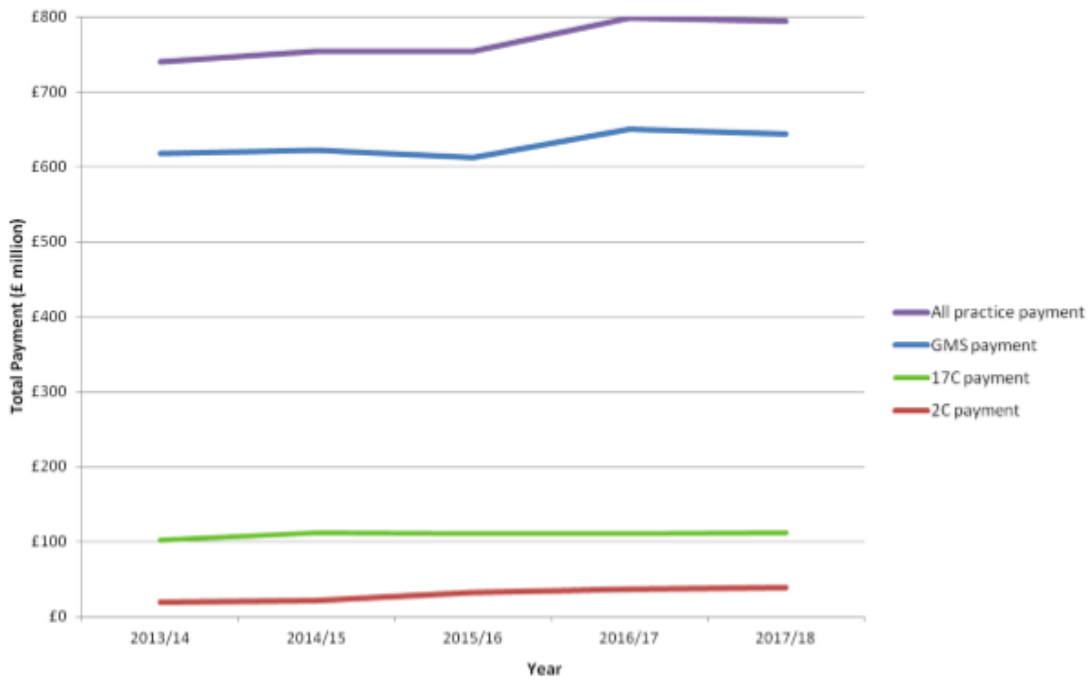
Agreement to Publish GP Earnings

167. Following an agreement between Scottish Government and the SGPC, NHS payments to practices have been published since May 2015 beginning with the publication of 2013/14 data.

168. In 2017/18 the sum of NHSScotland payments made was £794.1 million to 959 General Practice service providers. It appears that investment has decreased by £4.3 million (0.54%) when compared to 2016/17. When the impact of a Quality and Outcomes Framework double payment in 2016/17 is adjusted for, payments to general practice actually increased by £21.0 million (2.7%) in 2017/18.

[16] NHS Digital - Investment in General Practice 2013/14 to 2017/18 England, Wales, Northern Ireland and Scotland
[17] Ibid

Figure 3 - Type of General Practices and their Total Payment[18]



169. The Global Sum was the largest payment made in 2017/18. This amounted to £582 million to 959 General Practice service providers.

170. In addition to the £794.1 million, £22.9 million was paid to 92 General Practices for dispensing services in 2017/18, similar to the previous year.

171. £4.5 million was paid to 894 General Practices for quality leads sessions in the new Transitional Quality Arrangements.

172. The new contract means an increase of data collection. This will include requiring all practices to provide data on earnings, expenses, hours and sessions. This data will be held confidentially and processed by NHS National Services Scotland Practitioner Services. Only anonymised, non-identifiable data will be provided to the government and NHS Boards for the purpose of analysis.

Patient Experience

173. The Scottish Health and Social Care Experience survey is carried out every two years, the 2017/18 survey was published in April 2018[19]

174. Over 130,000 individuals registered with a GP practice in Scotland responded to the 2017/18 Health and Care Experience Survey. The survey asked respondents to feed back their experiences of their GP practices and out of hours care. The

[18] ISD Scotland - NHS Scotland Payments to General Practice 2017
[19] Scottish Government - Health & Care Experience Survey 2017

survey also asked about experiences of social care services and asked specific questions of those with caring responsibilities.

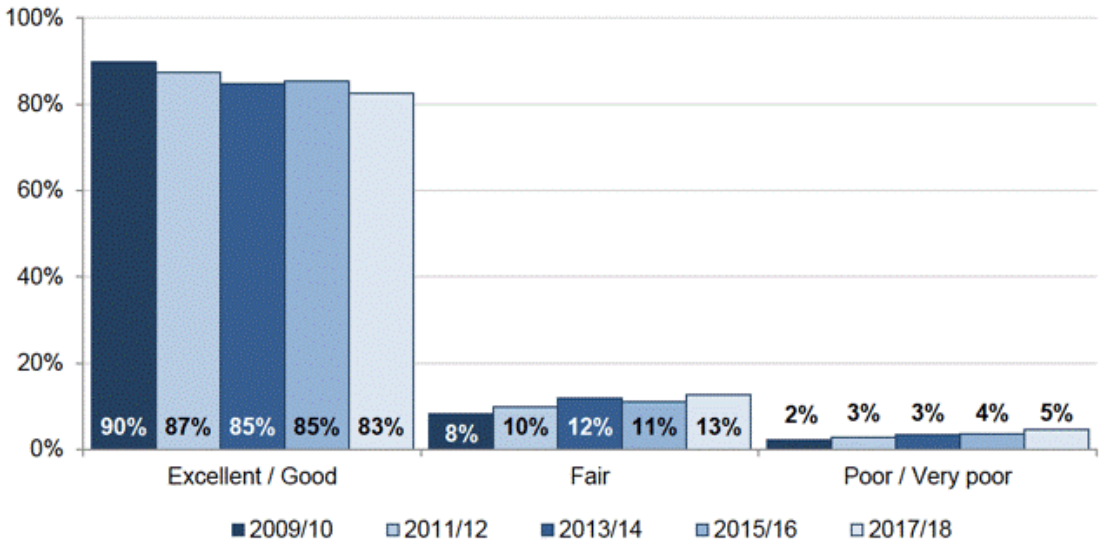
83% of people rated the overall care provided by their GP practice positively, this was down two percentage points from the last survey.

87% of people found it easy to contact their GP practice in the way that they want to and around three quarters were happy with their GP practice opening hours.

67% of people rated the arrangements for getting to see a doctor positively and 70% of people rated the arrangements for getting to see another medical professional positively.

93% of people were able to obtain two working day access to their GP practice; this is a slight increase from the previous survey. Around two thirds of people were allowed to book an appointment at their GP practice three or more working days in advance – a significant decrease from the previous survey.

Figure 4 - Overall rating of care and treatment provided by GP practice (%)[20]



175. The number of GP consultations estimated to have taken place in Scotland in 2012-13 was 16.2 million[21]. This figure is likely to have risen in subsequent years.

Access

176. The majority of people (87%) found it easy to contact their GP practice in the way that they want, with half of people finding it very easy. In previous surveys, respondents were asked how easy they found it to get through to their GP practice

[20] Scottish Government - Health and care experience survey 2017 to 2018: national results
[21] ISD Scotland - Practice Team Information (PTI) Annual Update (2012/13)

on the phone specifically and this was also rated very positively, with 82% of people saying they found it easy in both 2015/16 and 2013/14.

177. Respondents were asked what they thought of the opening hours of their GP practice:

- 76% of people were happy with them;
- 17% of people were not happy with the opening hours – for most of these people this was because it was too difficult to get time away from work during the practice's opening hours (14% compared to 3% who did not like the opening hours for another reason); and
- 6% of people were not sure what the opening hours of their GP practice were.

178. This is consistent with responses to this question in previous years

179. A review of patient access to GP services across the country in partnership with the British Medical Association (BMA) was included in the GP contract agreement for 2014/15, in order to support practices and NHS Boards to both better understand the challenges and to make any necessary improvements to access. This focus has been maintained in the new GP Contract, which is underpinned by the principle of ensuring patients can see the right person at the right place at the right time.

180. In Scotland we are transforming primary care, including the development of multidisciplinary teams, supported by extra investment through the Primary Care Fund. This will put in place long-term, sustainable change within GP services that can better meet changing needs and demands, to ensure that patients can access the right person at the right time.

181. The Primary Care Fund is also supporting and accelerating the use of digital services by GP practices, such as by funding the development of webGP and online appointment booking to improve patient access.

Care and Treatment

182. When asked to rate the care provided by their GP practice overall, 83% of people rated it positively. This shows a decrease of two percentage points compared to the previous survey and a decrease of seven percentage points compared to the first Health & Care Experience Survey in 2009/10.

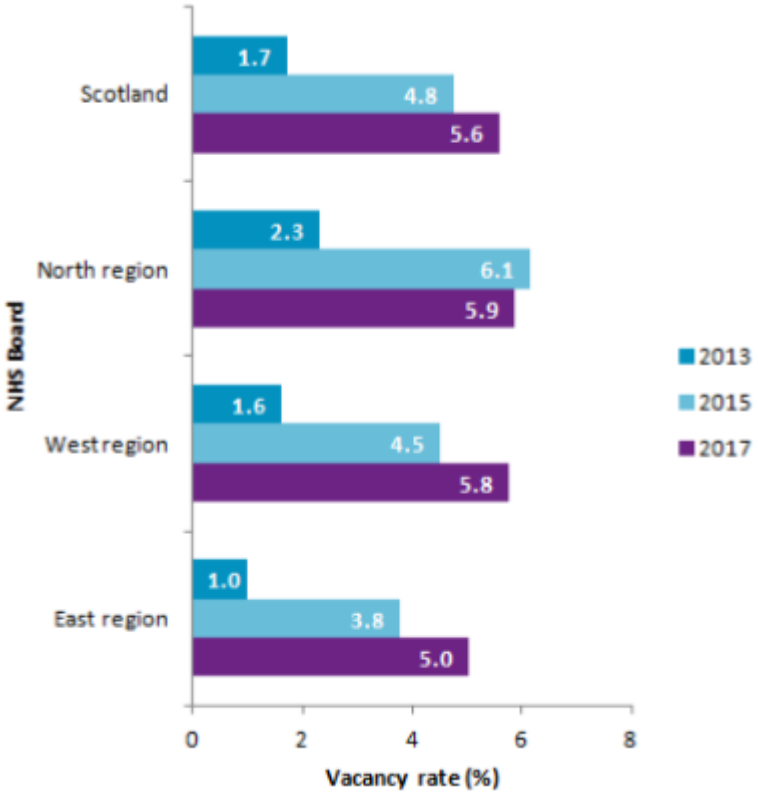
183. The most positively rated statements were 'I understood the information I was given' and 'I was listened to' (95 and 93% positive respectively).

184. The statement with the lowest positive rating was 'I knew the healthcare professional well', with half of people (50%) rating it positively. This statement also has a significantly higher negative rating (26%) than the other statements. However, those who had contacted their GP practice more frequently in the last 12 months were more likely to respond positively to this statement.

Vacancy, Turnover and Attrition Rates

185. According to the latest workforce survey, 24% of GP practices reported that they had vacant GP sessions at 31 August 2017, in comparison with 22% of practices in 201522. The headcount of GP vacancies reported by practices was 240, equating to WTE vacancies of 184. The vacancy rate (as a percentage of total sessions) was 5.6%. Vacancy rates reported by the survey increased in the majority of areas compared to the results of the 2015 survey however, decreases were seen in NHS Forth Valley, NHS Highland, NHS Orkney and NHS Western Isles.

Figure 5 - Vacant sessions as a percentage of total sessions (vacancy rate), Scotland; 2013 - 2017[23]

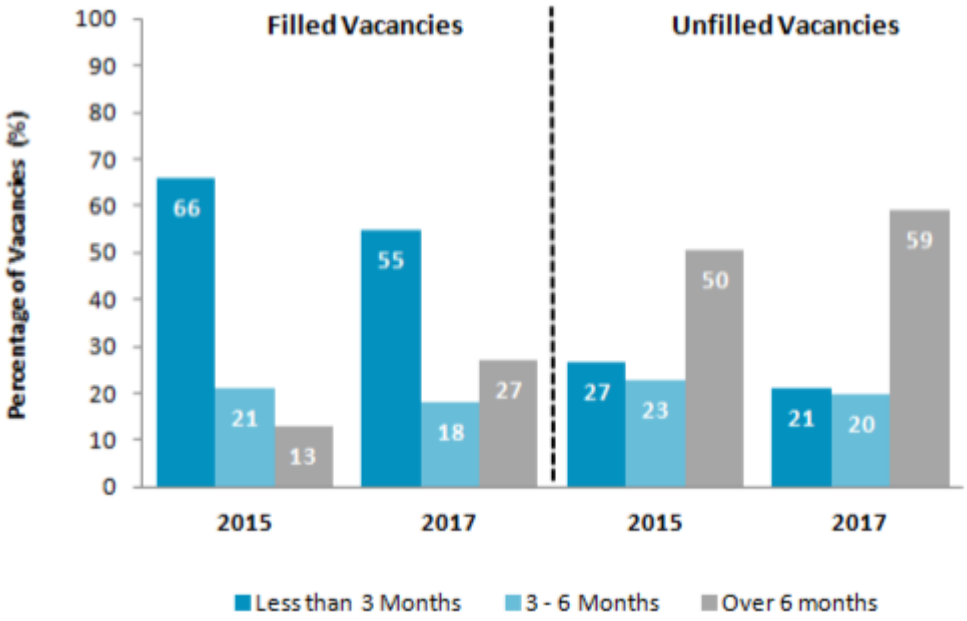


186. Of the vacancies that were unfilled at 31 August 2017, 59% had been vacant for over six months.

187. The headcount of GP vacancies during the 12 months prior to 31 August 2017 was 583. 343 had been filled by 31 August 2017; 240 remained unfilled.

[22] ISD Scotland - Primary Care Workforce Survey Scotland 2017
[23] Ibid

Figure 6 - Length of vacancy, by filled and unfilled vacancies, Scotland; 2017[24]



Recruitment and Retention

188. There will be a marketing campaign with a focus on rural to promote GP as a career choice and a strategy to recruit at least 800 GPs over the next ten years. This includes the ScotGEM programme which will introduce 55 undergraduate places from September 2018 with a particular focus on rural medicine.

189. There will also be continued support for GPST bursaries. 102 of the 400 posts will attract a £20,000 bursary for hard to fill posts including those in remote and rural practices.

190. We are supporting better recruitment and retention through an enhanced and expanded Scottish Rural Medicine Collaborative (SRMC) - a partnership of ten rural Health Boards - to help target and tailor support to recruiting in primary care services in remote and rural areas. SRMC worked in collaboration with NSS to develop a new national GP Recruitment website – gp.jobs.scot – which was launched on 4 October 2018.

191. We are putting in place a comprehensive package of retention measures (including coaching and mentoring schemes) to support GPs, helping combat workload pressures and retain them in the workforce.

192. Seniority Payments for Scottish GPs are set out in chapter 11 of the annual Statement of Financial Entitlements (SFE)[25]. Seniority Payments reward experience, based on years of reckonable service adjusted for superannuable income factors. Seniority Payments are made to the practice for payment to individual GPs.

193. Presently a GP has to work for six years before any seniority payment is made; for 21 years to achieve a payment of £5000 per annum, for 36 years to

[24] Ibid

[25] General Medical Services Statement of Financial Entitlement 2018/19

achieve £10,000 per annum, with the maximum of £13,900 per annum payable being made at the 47 year point. The contractor has to have been in an eligible post for more than 2 years in order to be able to apply.

194. The Scottish Government's annual bill for seniority payments to GPs was in the region of £18.45 million in 2015/16. This is reducing as the number of senior GPs retire earlier, for instance the cost of seniority the previous year (2013/14) was in the region of £19 million.

195. 'Golden Hellos' for Scottish GPs are set out in chapter 12 of the annual SFE. Golden Hellos are a lump sum payment to doctors who are starting out as GP performers in their first eligible post. Posts are considered to be eligible if they are attracting payments for remoteness, rurality or deprivation. Golden Hellos can also be paid to new GP performers if the local Health Board believes the practice is experiencing significant difficulties around recruitment and retention. These are just for GPs in GMS practices with the exception of Golden Hellos for remoteness and rurality which are for all practices regardless of contractual status.

Rate of Golden Hello payments

Reason	Payment
Recruitment Difficulty	£5,000 (minimum)
Remoteness or Rurality	£10,000
Deprivation	£7,500 - £12,500

196. The rate of payment for part time GPs, with a time commitment fraction of less than 4 sessions per week is 60% of the full payment.

Salaried GPs

197. The Primary Care Workforce Survey Scotland 2017 estimated that 81% of GPs were Independent Contractors[26]. It estimated that there were around 749 salaried GPs (17%) and 81 GP retainees (2%). The survey also recorded a small number of returner GPs, with an estimated headcount of 9 across Scotland and a small number of Enhanced Induction GPs, with an estimated headcount of 4 across Scotland.

198. The survey also found that salaried GPs are more likely to work fewer sessions per week than GP Partners – with a third working up to 4 sessions per week, compared with 8% of partners.

199. The introduction to this document sets out a breakdown of the GP workforce by gender, however we do not have current data to indicate whether these GPs were independent contractor or salaried GPs.

[26] ISD Scotland - Primary Care Workforce Survey Scotland 2017

GP Expenses

200. Until a dataset for collection is agreed under the new Scottish GP Contract, the availability of data on GP income and expenses remains that which is provided annually by NHS Digital on behalf of the four countries, and which, for the tax year 2016/17, was published on 30th August 2018[27]. We invite DDRB to consider this report in its entirety, but for the purposes of independent contractor GPs in Scotland the report showed that: the average taxable income for contractor GPs in General Medical Services in the UK was £103,700 in 2016/17. In Scotland the average taxable income for contractor GPs was £90,800.

GPMS contractor GPs - average earnings and expenses by country, 2015/16 and 2016/17[28]

			Mean			
Country	Year	Report Population	Gross Earnings	Total Expenses	Income Before Tax	Expenses to Earnings Ratio
England	2015/16	18,300	£315,600	£210,800	£104,900	66.8%
	2016/17	19,850	£338,300	£228,700	£109,600	67.6%
	Change	+1550	+7.2%	+8.5%	+4.6%	+0.8 Percentage Points
Scotland	2015/16	3,600	£196,600	£107,100	£89,500	54.5%
	2016/17	3,500	£202,300	£111,500	£90,800	55.1%
	Change	-100	+2.9%	+4.1%	+1.5%	+0.6 Percentage Points
Wales	2015/16	1,600	£248,100	£154,700	£93,400	62.3%
	2016/17	1,600	£256,300	£159,900	£96,500	62.4%
	Change	0	+3.3%	+3.4%	+3.3%	+0.1 Percentage Points
Northern Ireland	2015/16	1,150	£195,600	£103,500	£92,000	52.9%
	2016/17	1,200	£195,200	£104,700	£90,500	53.6%
	Change	+50	-0.2%	+1.1%	-1.7%	+0.7 Percentage Points

Source: NHS Digital

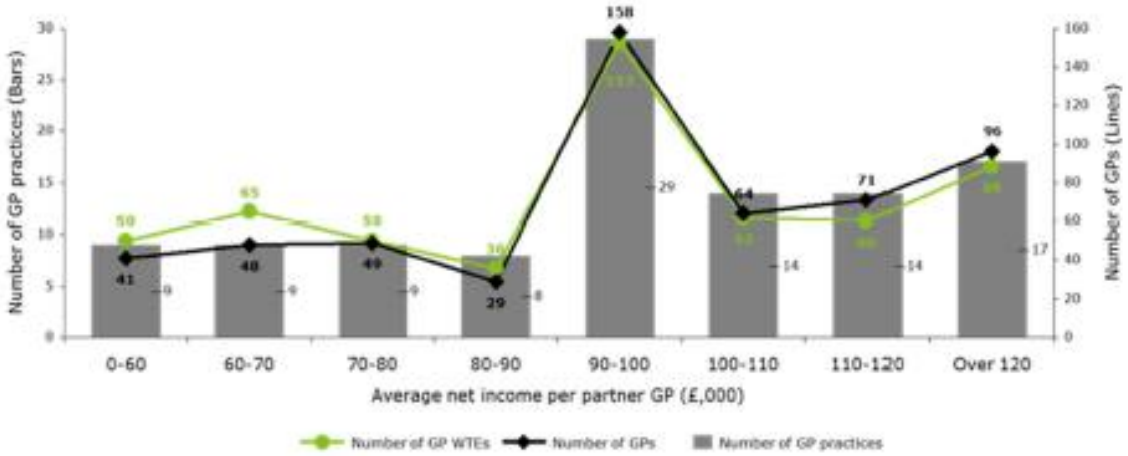
201. During 2017 the Scottish Government commissioned Deloittes to undertake a Review of GP Earnings and Expenses[29]. This found that the average annual net income per Whole Time Equivalent (WTE)[30] GP Partner (including NHS and Private earnings[31]) was £98,700. It also found that 70% of practice costs (on average) were staffing costs, followed by premises which accounted for 16% of practice costs.

[27] NHS Digital - GP Earnings and Expenses Estimates - 2016/17
[28] Ibid
[29] Deloitte - A Review of GP Earnings and Expenses Final Report

[30] Due to the independent contractor status of general practice, there is no agreed definition of Full Time Equivalent. WTE is used instead and is based upon the total number of hours worked by partners in a practice divided by 40.

[31] The ratio of NHS to Non-NHS earnings could not be calculated on the data available.

Figure 8 - Distribution of practice average net income per WTE GP Partner[32]



Notes: Net income per partner GP is expressed in terms of Whole Time Equivalent; Source: Deloitte analysis based on Practices' Financial Accounts and Questionnaire.

202. There was some evidence indicating that partners in urban practices earned on average more than partners in remote practices. No correlation between average net income and deprivation was found. There was also some limited evidence that larger practices had a higher net income per partner GP than smaller practices.

Workforce Data for Scotland

203. The Primary Care Workforce Planning Survey Scotland captures aggregate workforce information from Scottish general practices and each of the NHS Board-run GP Out of Hours services. It provides the most comprehensive information available on the staffing cohort of general practice, both in hours and out of hours, but does not provide the cost. The costs of running a practice are a matter for the GP partners, including what pay they award employees. The 2017 survey was published in March 2018[33].

204. The 2017 results for Scottish general practices are based on survey data received from 774 Scottish general practices, 82% of Scotland's practices. The results include information on

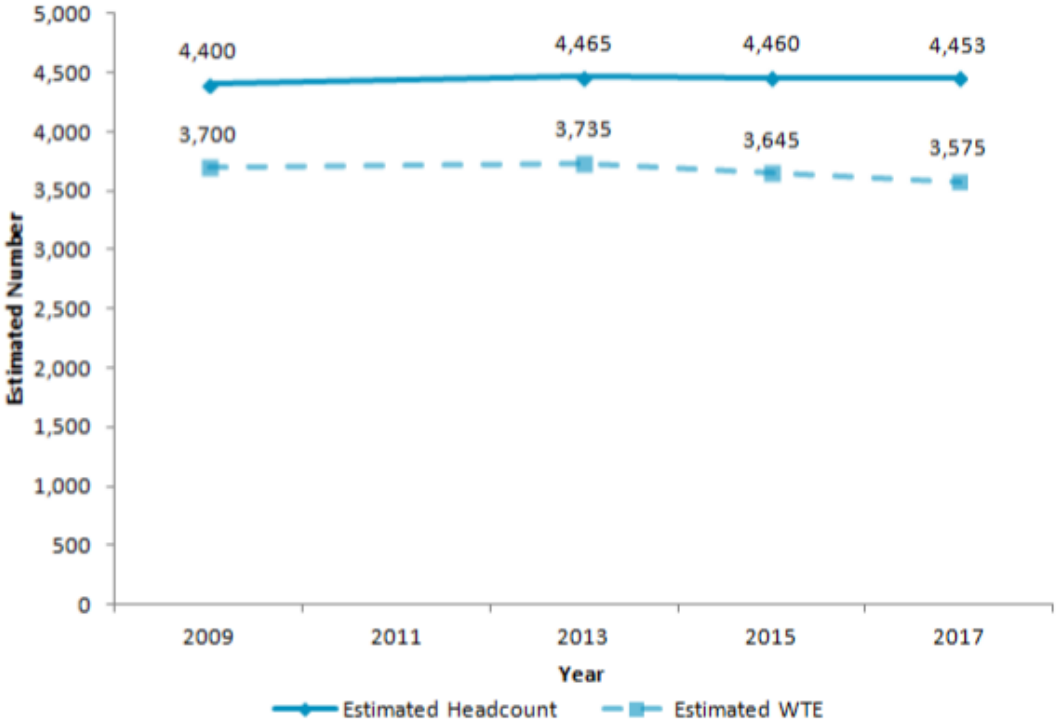
- Estimated WTE numbers of GPs in post in Scottish general practices, along with information on patterns of sessional commitment by age and gender (a GP's week is typically defined in terms of sessions rather than hours, with a working day generally being comprised of two or sometimes three sessions).
- Estimated headcount and WTE numbers of nurse practitioners and other registered nurses employed by Scottish general practices, along with information on the age profile of these staff.
- Use of locum GP time and extra nurse time by Scottish general practices.
- Known vacancies for these professional groups in general practices at a fixed census date.

[32] Deloitte – A Review of GP Earnings and Expenses Final Report p.15
[33] ISD Scotland – Primary Care Workforce Survey Scotland 2015

205. The 2017 results for GP Out of Hours (OOH) services are based on a survey of the GP OOH services in each of the 14 NHS Boards in Scotland. The results include information on:-

- The demographic profile of GPs working in GP OOH services in Scotland.
- The demographic profile of nurse practitioners and other registered nurses employed by GP OOH services in Scotland.
- The estimated WTE number of GPs in post in Scottish general practices declined by 4% between 2013 and 2017 (from 3,735 to 3,575).
- Routinely available GP headcount information[34] indicates a slight increase in the numbers of GPs working in general practices.

Figure 9 - Estimated GP headcount and Whole Time Equivalent, Scotland; 2009 – 2017[35]



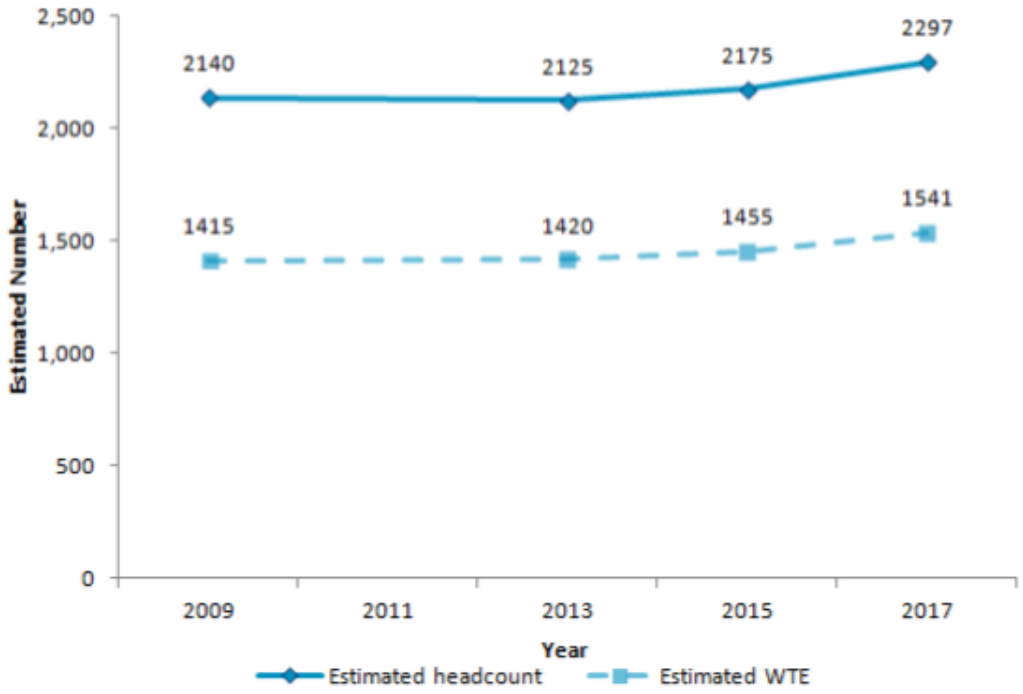
Source: Primary Care Workforce Survey Scotland 2017

206. The estimated number (headcount) of registered nurses employed by general practices in Scotland at 31 August 2017 was 2,297. This is a slight increase from 2,125 registered nurses in 2013. A quarter of these (543) were Nurse Practitioners or Advanced Nurse Practitioners, 1,732 of these were General Practice / Treatment Room Nurses.

207. An estimated WTE 1,541 registered nurses were employed by Scottish general practices in 2017, an increase of 9% from 1,415 in 2009. The figures from this survey do not represent the entire registered nurse workforce working in Scottish general practices. They exclude nurses who are employed by NHS Boards but who work in independent contractor practices.

[34] ISD Scotland – General Practice – GP Workforce and practice list sizes 2008-2018
[35] ISD Scotland – Primary Care Workforce Survey Scotland 2017

Figure 70 - Estimated registered nurse headcount and Whole Time Equivalent, Scotland; 2009 – 2017[36]



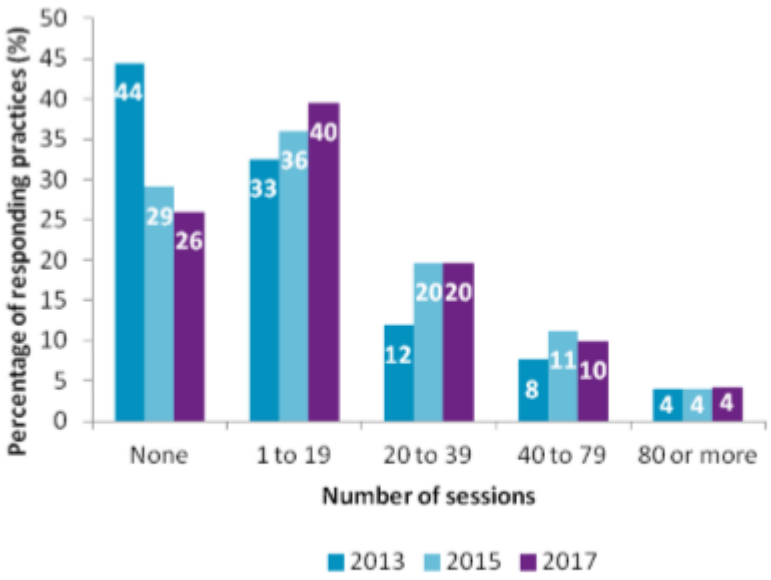
Source: Primary Care Workforce Survey Scotland 2017

208. Responding practices had used GP locums and/or sessional GPs in the year ending 31 August 2017. An estimated 333 WTE was input to all general practices over this one year period. This is lower than the 350 WTE estimated from the 2013 survey.

209. In addition, 74% of responding practices reported that one or more of their own GP(s) had worked extra sessions over the year, over and above their regular sessional commitments. These extra sessions (for example to cover for colleagues on annual leave or sick leave) collectively amounted to an estimated 50.7 WTE of GP time over the year.

[36] Ibid

Figure 81 - Number of internal locum sessions required over 12 months, Scotland; 2013 - 2017[37]



Source: Primary Care Workforce Survey Scotland 2017

210. An estimated WTE 399 healthcare support workers and 89 phlebotomists were employed by Scottish general practices in 2017. The estimated WTE of healthcare support workers increased by 33%, from 300 in 2013 however there was a 11% decrease in WTE phlebotomists, from 100 in 2013.

Working Hours

211. The Primary Care Workforce Survey Scotland 2017 gathered information on GPs working in GP Out of Hours services.

212. Results from the 2017 survey showed that for the year ending 31 August 2017, GPs aged under 35 input an average of 4 hours each per week, less than half the weekly average for GPs aged 45 and over.

213. Whilst GPs aged under 35 accounted for 18% of the overall number of individuals who contributed to GP Out of Hours services over the year, their combined hours accounted for 11% of the total hours input to those services over the same period. In contrast, GPs aged over 45 accounted for 45% of the overall headcount but 58% of the total hours input over the survey year.

214. During 2017 the Scottish Government commissioned Deloittes to undertake a Review of GP Earnings and Expenses[38]. Like the workforce survey this was also based on a sample of GP practices, and found that GP commitment ranged from under 10 hours per week to over 60 hours per week.

[37] Ibid
[38] Deloitte - A Review of GP Earnings and Expenses Final Report

Figure 12 - Average weekly working hours by Partner GPs[39]

p5	p25	p50	p75	p95
9.8	31.6	37.5	43	60

Source: Deloitte analysis based on Practices' Financial Accounts, Questionnaire and ISD Scotland

[39] Deloitte - A Review of GP Earnings and Expenses Final Report, p. 38

H.2 General Dental Practitioners and Dental Practice Expenses

Introduction

215. This evidence refers to General Dental Practitioners (GDPs) that provide NHS General Dental Services (GDS).

216. GDPs are independent contractors who have undertaken to provide NHS dental services on behalf of NHS Boards. They can either be GDPs who are owners, directors or partners of a dental practice (principals) or self-employed GDPs who enter into arrangements with principal GDPs, that is neither partnership nor employment (associates).

217. Independent contractors may engage assistant dentists, including vocational dental practitioners, to assist with the provision of GDS.

Policy Development/Landscape

218. The policy landscape in NHS Dentistry in Scotland will increasingly be shaped by the Oral Health Improvement Plan, published by the Scottish Government in January 2018.

219. We have made real progress in improving Scotland's oral health, particularly for children as a result of the Childsmile programme. Similarly, there are now over 5 million people registered with a NHS dentist, a record figure and we have also seen an unprecedented increase in the numbers of GDPs providing NHS dental services, an increase of 35 per cent since 2007.

220. The intention of the Oral Health Improvement Plan is to build on these successes but also meet the challenges of the future, including the need to address oral health inequalities and an ageing population, particularly around the provision of oral health domiciliary care.

221. As part of the 2018 Programme for Government we are planning considerable changes to how NHS Boards provide oral health domiciliary care. At present there is an imbalance or inequality of provision between people who are able to attend a surgery in person and those who are dependent on receiving oral health care in a domiciliary setting, such as a residential care home or in their own home.

222. Given the increase in the numbers of GDPs providing NHS dental services, the intention is to increase the level of participation amongst GDPs in providing routine oral health domiciliary care by introducing a new set of arrangements that will allow GDPs to train and become designated by NHS Boards as practitioners with enhanced skills in domiciliary care. The initial focus will be on residents of care homes with a later roll out for people who are cared for in their own home.

223. The same Programme for Government also announced a new £2.5 million Community Challenge Fund to help tackle inequalities by supporting communities and families to take positive action to improve oral health. The purpose of the Fund is to enable third-sector partners to work with people in deprived communities to reduce oral health inequalities by tackling directly the challenges that arise as a consequence of lifestyle behaviours, and wider social-cultural factors that prevent positive health choices being made.

224. The overall aim is to refocus our approach in dentistry so that it supports better oral and population health. A clear driver is the requirement to reposition NHS dental services so there is more emphasis on prevention and anticipatory care. The intention is to move to a preventive care programme which means that patients will be seen according to their oral health need.

225. At the centre of the new approach will be an Oral Health Risk Assessment (OHRA). This will include a comprehensive clinical examination and a discussion about lifestyle choices, for example diet, alcohol and smoking and how these impact on the patient's oral health. The patient will receive a personalised care plan in relation to oral cancer, gum disease and decay according to their degree of risk.

226. There will be on-going assessments between reviews, with a much greater focus on the discussion that dental practitioners have with patients about their care, and the development of tailored dental interventions for the specific needs of each patient in their care.

Achievements in NHS Dentistry: Contextual Report

Improvements in Child Oral Health

227. The Scottish Government's flagship Childsmile Programme continues to make significant progress in improving the oral health of children in Scotland. Childsmile is delivered by health visitors, oral health teams, staff in nurseries and schools, and dental practices. It concentrates on preventive actions such as tooth-brushing and fluoride varnish application.

228. The progress made by Childsmile in improving oral health can be seen through the results of the National Dental Inspection Programme (NDIP). The NDIP reports annually on the oral health status of primary school children in Scotland, alternating each year between primary 1 and primary 7 children. The most recent NDIP report in 2018 showed that 71 per cent of P1 children had 'no obvious decay experience' compared to 58 per cent in 2008. Similarly, for P7 children the 2017 report shows that 77 per cent had 'no obvious decay experience', compared to 59 per cent in 2007.

Table 6 – NDIP – Percentage of P1 children with 'no obvious decay experience'[40]

2008	2010	2012	2014	2016	2018
58	64	67	68	69	71

Table 7 – NDIP – Percentage of P7 children with 'no obvious decay experience'[41]

2007	2009	2011	2013	2015	2017
59	64	69	73	75	77

Growth in NHS Registration Rates

229. Access to NHS dentistry, as measured by the number of patients registered with a NHS dentist, continues to increase year-on-year. As at September 2018, 94.2 per cent of the population was registered with a NHS dentist, compared to 87.7 per cent in September 2012. This is a record figure and represents an increase of 23.5 per cent since 2012 and an increase of 2.8 per cent between 2017 and 2018.

Table 8 – Patient registration[42]

	Adults	% of adults	Children	% of children	Total number	total %
Sep-18	4,142,110	94.3%	969,316	94.1%	5,111,426	94.2%
Sep-17	4,007,202	91.2%	963,926	93.6%	4,971,128	91.6%
Sep-16	3,894,981	89.1%	963,046	93.3%	4,858,027	89.9%
Sep-15	3,750,082	86.4%	956,417	92.8%	4,706,499	87.6%
Sep-14	3,599,096	83.4%	948,713	91.9%	4,547,809	85.0%
Sep-13	3,417,637	79.6%	930,511	89.9%	4,348,148	81.6%
Sep-12	3,228,087	75.5%	910,342	87.7%	4,138,429	77.9%

230. The improved access is consistent across all of Scotland evidenced by the increase in patient registrations in each NHS Board area. The increase in registration rates is particularly encouraging in remote and rural areas, including island communities. For instance, NHS Orkney has seen an increase of 34.1 per cent in patient registrations between 2012 and 2018.

[40] ISD Scotland, NDIP report
[41] ISD Scotland, NDIP report
[42] ISD Scotland, Registration and Participation Statistics – figures as at 30th September

Table 9 – Patient registration by NHS Board area[43]

	2012	2018	% change
Ayrshire & Arran	310,766	357,013	14.9%
Borders	79,859	95,593	19.7%
Dumfries & Galloway	112,721	130,894	16.1%
Fife	266,337	330,792	24.2%
Forth Valley	239,954	285,783	19.1%
Grampian	336,268	481,496	43.2%
Greater Glasgow & Clyde	926,334	1,140,718	23.1%
Highland	208,703	269,660	29.2%
Lanarkshire	534,749	631,864	18.2%
Lothian	636,074	810,736	27.5%
Orkney	13,325	17,867	34.1%
Shetland	14,464	21,207	46.6%
Tayside	315,741	374,597	18.6%
Western Isles	17,331	20,866	20.4%
Total*	4,012,626*	4,969,086*	

*As this is a breakdown of registration by NHS Board area the number of people registered differs from the National Statistics as these figures do not include people who are registered but their NHS Board area could not be determined.

Increase in Patient Attendance

231. The absolute number of people, adults and children, who attended their dentist in the last two years has increased by 8.2 per cent for the period 2012 to 2018.

Table 10 – Participation[44]

	Adults	% of adults	Children	% of children	Total number	Total %
Sep-18	2,758,439	66.6%	815,678	84.1%	3,574,117	69.9%
Sep-17	2,762,909	68.9%	823,052	85.4%	3,585,961	72.1%
Sep-16	2,729,860	70.1%	826,294	85.8%	3,556,154	73.2%
Sep-15	2,691,729	71.8%	826,086	86.4%	3,517,815	74.7%
Sep-14	2,647,208	73.6%	825,594	87.0%	3,472,802	76.4%
Sep-13	2,578,269	75.4%	816,149	87.7%	3,394,418	78.1%
Sep-12	2,500,074	77.4%	804,182	88.3%	3,304,256	79.8%

Participation is defined as 'contact with GDS for registration, examination or treatment in the last two years'. It is restricted to patients who are registered with an NHS dentist and therefore does not include patients who only attend for occasional or emergency treatment.'[45]

[43] ISD Scotland, Registration and Participation Statistics – figures as at 30th September
[44] ISD Scotland, Registration and Participation Statistics – figures as at 30th September
[45] ISD Scotland, Registration and Participation Statistics – figures as at 30th September

NHS Provision Remains Strong

232. NHS provision, as measured by the proportion of dental practices in Scotland with 75 per cent or more of practice earnings from NHS work, is relatively high in Scotland. For example, in 2017 around 70 per cent of practices, that submitted returns, earned 75 per cent or more of their income from NHS work. The general trend in Scotland has been a move away from private to NHS care and treatment.

Table 11 – % of practice income which is NHS in 2017/18[46]

% of practice income from NHS	Number of practices
90%+	359
75-89%	262
50-74%	151
<50%	118
No data	136
Total	1026

State of the Workforce

Workforce Headline Figures (short- and long-term trends)

233. There has been a substantial increase in the number of non-salaried GDPs in recent years. The number of GDPs in Scotland as at September 2018 was 3,052 compared to 2,385 in September 2008. This constitutes an increase of 28 per cent in GDP numbers since 2008 and an increase of 1.6 per cent between 2017 and 2018.

234. EU nationals play a vital role in in the provision of dental services, with around 1 in 10 dentists across Scotland from the EU, which is why we are working closely with them, through our EU Dental Network, to ensure appropriate action is taken to protect our workforce from the impact of Brexit.

Table 12 – Non-salaried GDS Dentists[47]

2008	2010	2012	2014	2016	2018	% change
2,385	2,594	2,679	2,870	2,972	3,052	28%

235. The increase in the GDP workforce means that there are 56.3 dentists per 100,000 of the population providing NHS care and treatment in 2018, compared to 45.9 in 2008.

[46] PSD, GP234 data
[47] ISD Scotland, NHS Scotland Workforce Statistics – as at 30th September

Table 13 – GDPs per 100,000 of the population[48]

	Population (millions)	Workforce	Rate per 100,000
2008	5.20	2,385	45.9
2018*	5.42	3,052	56.3

*Please note the 2018 figure uses 2017 population estimates

Workforce flows

Student Numbers

236. Both intake to dental schools and graduate numbers continue to be very strong. Demand for dentistry courses remains high, with on average around eight applications per space available.

Table 14 – Student intake and graduate numbers at Scottish dental schools[49]

	Intake	Graduates
2015	155	180
2016	155	185
2017	155	171
2018	155	176*

*provisional

237. As NHS dentistry in Scotland continues to attract large numbers of well qualified young people into the profession, the policy of the Scottish Government is to maintain an in-take of Scottish, Rest of the UK and EU students to 135 per year, with any balance made up of international students.

Dental Student Support Grant (DSSG)

238. As reported last year, we have introduced a new targeted Dental Student Support Grant (DSSG). The DSSG pays £4,000 per year to students with a household income of less than £34,000 in return for a commitment to work in NHS dentistry in Scotland following graduation for one year, per year of support they receive. The DSSG is available to students beginning their BDS from September 2017. Students who began their BDS on or before September 2016 will continue to be eligible for the DUBS.

[48] Population projections from National Records Scotland; Workforce data from ISD Scotland, NHS Scotland Workforce Statistics – as at 30th September
[49] NHS Education Scotland

Vocational Dental Training Numbers (in-flow)

239. To practise independently in the NHS in Scotland, a GDP, unless otherwise exempt, is required to complete a vocational training period of one year duration. VDPs are a useful measure of the numbers of recently qualified graduates entering the profession to practise NHS dentistry. The numbers in training remain strong with each yearly cohort constituting around 5 per cent of the total workforce of GDPs in Scotland.

Table 15 – VDP numbers[50]

2012	2013	2014	2015	2016	2017	2018
179	191	166	171	175	181	167

240. In order to support the VT training programme, in addition to the reimbursement of the salary of the VT in full, the trainer/practice is entitled to receive a number of additional payments and benefits from the additional earnings of the vocational trainee(s). In 2014 there was a review of payments for vocational trainers, which resulted in an increase in the trainers' grant to £1,167 a month for trainers with less than 4 years' experience, and £1,250 per month for trainers with more experience.

Retirement Rates (out-flow)

241. Retirement rates of GDPs in Scotland are comparatively low, with only 61 people retiring during the 2017/18 financial year[51] This represents only 2 per cent of the overall workforce.

Table 16 – Number of dentists retiring per year[52]

2015/16	2016/17	2017/18
81	67	61

Net Flows

242. The net increase in workforce numbers in Scotland is the consequence of a strong VDP training programme and a relatively low retirement rate. On average we are observing a net inflow of around 100 GDPs in Scotland. It should also be noted that while VDP is the main route in to dentistry in Scotland it is not the only avenue and the net in-flow rate will be higher.

Distribution of the GDP Workforce: Deprived Areas

243. Table 12 shows the distribution of GDPs by Scottish Index of Multiple Deprivations (SIMD) and each SIMD category represents 20 per cent of the population. The number of GDPs working in SIMD 1 and 2 areas represents almost 50 per cent of the total number of GDPs. Whilst this does not necessarily mean that GDPs are treating patients from deprived areas, it is a reasonable approximation.

[50] ISD Scotland, NHS Scotland Workforce Statistics – figures as at 30th September
[51] This figure includes 24 hour retirements.
[52] SPPA

Table 17 – Number, by location, of independent and PDS dentists in Scotland by deprivation category as at 31st March 2018[53]

	SIMD 1	SIMD 2	SIMD 3	SIMD 4	SIMD 5	Unknown SIMD
Ayrshire & Arran	137	47	20	25	4	-
Borders	3	40	12	9	4	3
Dumfries & Galloway	34	31	19	6	-	-
Fife	68	101	38	16	32	-
Forth Valley	23	49	53	14	51	-
Grampian	26	52	52	88	156	-
Greater Glasgow & Clyde	363	185	193	91	94	1
Highland	22	99	60	34	6	-
Lanarkshire	131	117	76	83	35	2
Lothian	90	131	100	98	221	5
Orkney	-	8	3	11	-	1
Shetland	-	-	12	3	-	-
Tayside	66	73	43	88	29	1
Western Isles	-	-	6	11	-	-
Total*	963	933	687	577	632	13

* Dentists may work in more than one NHS Board area and across different SIMD categories therefore the total number of dentists will exceed the total workforce numbers.

244. The mix of payments and incentives in Scotland encourages GDPs working with relatively deprived communities. For example, Childsmile payments have a deprivation weighting, where the dentist would be entitled to a payment of £17.14 per child in SIMD 1-3 compared to a payment of £5.62 per child in SIMD 4-5.

Improvements in remote and rural provision

245. Scotland has seen a substantial increase in the number of people registered for NHS dental services and the number of GDPs in remote and rural areas. By way of illustration we have taken four board areas, Highland which is typically remote and rural and the three island boards. Registration growth has been significant across all four Boards.

[53] Scottish Dental Practice Board, Primary Care Dentistry Report, 2018

Table 18 – Percentage of patients registered[54]

	2008	2010	2012	2014	2016	2018
Highland	41.7%	54.1%	65.3%	73.4%	79.1%	83.7%
Orkney	43.3%	47.8%	61.9%	70.8%	78.5%	81.2%
Shetland	53.5%	63.8%	62.3%	78.6%	86.4%	91.9%
Western Isles	45.6%	51.7%	62.9%	61.2%	59.2%	77.4%

Table 19 – Total number of dentists[55]

	2008	2010	2012	2014	2016	2018
Highland	195	209	237	237	238	224
Orkney	15	16	18	22	18	16
Shetland	23	10	14	11	15	15
Western Isles	19	18	19	15	13	17

'Golden Hellos' – Recruitment and Retention Allowance

246. There are a range of incentive payments to attract dentists to remote and rural areas. Dentists joining a dental list in certain NHS Board areas within 3 months of completing their vocational training period may qualify to claim a 'golden-hello' allowance.

247. Dentists in designated areas can claim an allowance of £25,000 over two years and those in 'non-designated' areas can claim £10,000[56]. At present areas with designation status are:

- NHS Orkney, NHS Shetland, and NHS Western Isles

248. While non-designated areas include the following:

- Coldstream in NHS Borders; Annan, Dalbeattie, Dumfries, Gretna, Newton Stewart and Stranraer in NHS Dumfries and Galloway; Banff, Fraserburgh and Huntly in NHS Grampian; and Isle of Bute, Islay & Jura, Lochgilphead, Mull & Iona, and Tarbert in NHS Highland.

249. The areas for inclusion are subject to periodic review to ensure that the allowance is targeted to those areas that require additional financial incentives to ensure adequate recruitment and retention of GDPs.

[54] ISD Scotland, Registration and Participation Statistics – figures as at 30th September
[55] ISD Scotland, NHS Scotland Workforce Statistics – as at 30th September
[56] Other dentists who join a dental list in these areas for the first time or who re-join a dental list after a break of 5 years can also claim a 'golden hello' allowance. In such cases the payment for joining a dental list in a 'designated' area is £15,000 paid over two years and in a 'non-designated' area is £5,000.

Remote Areas Allowance

250. A remote areas allowance is also available to dentists who provide GDS on an island or a mainland location which has less than 0.5 persons per hectare. The purpose of this allowance is to compensate GDPs working in remote and rural areas with lower populations, where without additional financial support, it would prove financially challenging to provide GDS as an independent contractor.

Pay and Expenses

Trends in pay

251. According to latest NHS Digital figures, the average taxable income for GDPs in Scotland has increased by 0.1 per cent, from £67,700 in 2015/16 to £67,800 in 2016/17. Principal dentists had an average taxable income of £109,000 in 2016/17 compared to £110,800 in 2015/16, a decrease of 1.7 per cent. Associate dentists had an average taxable income of £56,400 in 2016/17 compared to £55,200 in 2015/16, an increase of 2.1 per cent.

Table 20 – Average taxable income[57]

	2012/13	2013/14	2014/15	2015/16	2016/17
Principals	£97,400	£98,400	£102,900	£110,800	£109,000
Associates	£57,200	£56,200	£55,000	£55,200	£56,400
All GDS dentists	£68,800	£68,000	£67,000	£67,700	£67,800

252. The figures from NHS Digital for earnings of dentists should be treated with caution. The figures are based on self-assessment tax returns and are not adjusted for FTE. While the income of principals has increased substantially over the period, associate income has remained broadly flat. This corresponds with other evidence that practice agreements have tended to put downward pressure on the earnings of associates.

NHS Pay Awards

253. From 2013/14 to 2018/19 the respective pay awards have been: 2.51%; 1.71%; 1.16%; 1.13%; 2.25%; and 2.55% which corresponds to a cumulative increase of 11.31%.

Table 16 shows the value and range of payments to independent contractors in Scotland. Gross fees (and capitation and continuing care fees) continues a year-on-year increase over the period 2013/14 to 2017/18.

[57] NHS Digital, Dental Earnings and Expenses Reports

Table 21 – payments to GDPs

Contractual Payments	2013/14	2014/15	2015/16	2016/17	2017/18
Gross Fees (Item of Service, continuing care, capitation)	258.7	266.5	274.1	277.3	280.3
Allowances (GDPA, commitment and seniority payments)	38.7	39	39.4	40	40.4
Expense Reimbursements (rent, rates, sickness, maternity/paternity/adoptive leave, IT)	12.6	13.9	14.8	14.6	15.1
Access Incentives (recruitment & retention, remote areas, SDAI)	3.3	2.3	1.7	1.37	1.7
Training & Development (CPD, VT Practice, Recruitment and Training, DUBS/DSSG)	12.7	12.8	12.6	13.3	13*
Clinical Initiatives/Good Practice (sedation practice, clinical audit, clinical & special waste^)	2	1.5	1.7	0.9	0.5
Other payments (Employer Superannuation Payments)	15.3	15.9	17.8	17.9	18
Total	**343.3**	**351.9**	**362.1**	**365.4**	**369***

* Provisional
^From 2016/17 this is part of an Outcomes Framework

Comparable Earnings

254. The earnings of self-employed GDPs remain competitive. The average earnings for principals is in the top five per cent of taxable incomes in the UK and the earnings of associates is in the top ten per cent.

Gender Differences

255. DDRB specifically asked about gender differences. Whilst payments data shows a difference in the earnings between male and female GDPs it should be noted that this is not calculated on a FTE basis.

Table 22 – Earnings by gender and average gross fees paid per gender[58]

	Number of GDPs	Gross Fees paid	Average Gross	% of fees
Female	1425	£139,331,264	£97,776	41%
Male	1510	£197,882,047	£131,048	59%

Expenses exercises

256. It has proved difficult to determine an appropriate pay award for GDPs in recent years because of the limited information available on practice expenses. DDRB have taken the view that expenses should be determined in discussion

[58] Practitioner Services Division

between Scottish Government and BDA Scotland. While we accept this position, our view is that any discussion needs to be based on appropriate information. In recent years we have commissioned a number of expenses exercises to gather information which could be used to inform the pay award.

257. The second exercise provided information on around 30 practices with 90 per cent or more NHS activity. The report provided a valuable insight for the period 2013/14 to 2015/16, showing that practice income had held up and net profit had been fairly constant over the period. During this period, there was a marginal increase in expenses resulting in the average expenses to earnings ratio increasing from 53.3% to 55.7%. The report also showed that there has been downward pressure on gross earnings, while taxable income has remained stable over the period. The information provided in this report was used to help inform the 2017/18 pay award of 2.55%.

258. Going forward it is our intention to continue with regular expenses exercises. We are currently working with Practitioner Services Division (PSD) to produce a standard expenses template which they can issue to all NHS practices.

Non-Pay Elements

Working hours

259. The Scottish Government (as part of a UK study) commissioned NHS Digital to analyse the working hours of GDPs in Scotland. The latest findings from 2017/18 show that on average dentists work 38.2 hours per week. This figure includes both full and part-time dentists and shows that around three quarters of this time is spent on NHS work. The remainder of their time is spent on private dentistry.

Morale

260. We recognise the importance of maintaining the morale of the dental workforce, which is why we have taken forward an Occupational Health (OH) scheme for GDPs, members of the dental team, and practice staff. The new OH service provides access to a variety of services, including support for mental health and wellbeing. We have also introduced new pathways to provide support for local resolutions to disciplinary issues in order to reduce the number of referrals to the GDC, which can be stressful for practitioners.

Conclusion

261. The landscape in NHS dentistry has improved substantially in recent years. There is now a record number of people registered with a NHS dentist and there has been significant progress in the oral health of children through Childsmile. There has also been a substantial increase in the number of GDPs in Scotland in recent years. NHS dentistry in Scotland continues to attract large numbers of well qualified people into the profession with dental school intake and graduate numbers remaining strong.

262. A series of pay awards has ensured that remuneration for self-employed GDPs in Scotland remains competitive and work is ongoing to build engagement with the profession to better understand practice expenses. The importance of non-pecuniary factors in the morale of the workforce has been reflected in the introduction of an OH service and new disciplinary pathways.

H.3 Salaried Primary Care Dental Services

Public Dental Service

263. Following a review, the Community Dental Service and Salaried GDS merged from 1 January 2014 to become the Public Dental Service (PDS). The main role of the PDS is to provide GDS for people with special care needs and those who cannot access care from independent GDPs and should complement the mainstream independent GDS provision.

264. In recent years we have seen a substantial increase in the number of independent GDPs providing NHS General Dental Services in Scotland. NHS Boards have increasing sought to look at the appropriate balance of service provision in their respective areas, between GDPs and the PDS. In many areas of Scotland we have seen a shift in service provision, where patients that require routine care and treatment being seen by GDPs, with the PDS increasingly concentrating on providing services that involve more complex care, perhaps with the patient on referral from the GDP.

265. As we might expect, the balance in service provision varies significantly between different areas of Scotland, with remote and rural areas typically relying more on PDS provision than areas with substantial populations. We anticipate that the PDS – which constitutes around 12 per cent of the NHS workforce of dentists in Scotland – will continue to remain at the forefront in the delivery of dental care to priority groups, such as people with a disability and the homeless.

266. The issues that affect GDPs typically also read across to the PDS. The rising tide of recruitment and retention has had a general beneficial impact on the PDS service, with many dentists preferring the status of employment terms and conditions, opposed to being an independent contractor. The general picture of recruitment and retention to the PDS remains fairly robust, although there are particular challenges in some of the more remote and rural areas of Scotland.

267. The payment regime for the PDS is tailored to meet these challenges. For example, the Scottish Government has an equivalent set of ‘Golden Hello’ payments to attract dentists to the PDS service in remote and rural areas. As we have noted in the main evidence section for GDPs this pays a newly qualified dentist joining the dental list £25,000 if the area is a ‘designated area’, and £10,000 if the area is a ‘non-designated’ area.

H.4 Consultants including Improving the working lives of Consultants

268. The Improving Consultants Working Lives Group, involving MSG (NHS Scotland employers and the Scottish Government) and BMA Scotland aims to discuss matters of common concern and produce joint guidance in these areas. Guidance on promoting the Retention of Existing Consultants was agreed and issued in May 2018. Following guidance issued in 2016 on Consultant Job Planning, further discussions are currently ongoing in this area, with a particular focus on the non-Direct Clinical Care aspects of consultant job planning.

H.5 Junior Doctors including Improving the working lives of Junior Doctors

269. Since the implementation of the WTR average 48 hour working week in 2009, we have maintained 100% compliance with this legislation.

270. Working in partnership with NHS Employers and the BMA Scottish Junior Doctors Committee (SJDC), we continue to agree and implement changes to working patterns to ensure staff are well rested and fit for work, and have a positive experience of working in NHSScotland. To date these include:

- Abolishing all junior doctors working seven night shifts in a row.
- Ensuring no junior doctor works for more than seven days / shifts in a row.
- The implementation of a minimum rest period of 46 hours off after any period of full shift night working. A target date for full implementation has been set for August 2019, with an 85% compliance target by February 2019. This 85% target was met in November 2018.

271. We continue to centrally approval all Junior Doctor rotas before they are implemented to ensure that they meet the legal and contractual limits, and that employers are implementing the Scottish Government actions around improving the working lives of junior doctors.

Single Employer Status

272. In August 2018, a single lead employer arrangement was implemented for Doctors in Training in NHSScotland. Under the new arrangements, trainees will continue to occupy and move between training posts across all Health Boards as part of their training, but for administrative purposes, the 22 employers are being reduced to four Health Boards, with trainees benefitting from having one employer for the duration of their training programme. This will apply initially to Doctors in Training, but will later include Dentists in Training from August 2019.

Doctors in Training New Deal Contract

273. As per the New Deal contract, compliance continues to be monitored on a biannual basis, with centralised reporting to the Scottish Government. This reporting allows compliance figures to be reported and average bandings to be calculated.

274. Statistics based on the latest complete monitoring period (February – July 2018) show compliance remains high at 98%. As is the nature of monitoring compliance, rotas do become non-compliant for short periods of time, necessitating rota review and re-design.

Average Pay Supplement

275. The average banding supplement paid to Doctors in Training in NHSScotland is 49.1% for the year April 2017 – March 2018. This represents a slight increase from the previous average of 48.8% which has been caused by higher levels of temporary non-compliance, which is a recurring factor of the New Deal contract.

48 Hour Maximum Working Week

276. The Scottish Government has committed to implementing a maximum 48 hour working week for Junior Doctors with no averaging of hours as is currently allowed under the Working Time Regulations.

277. In order to progress this work, an independent Expert Working Group (EWG), chaired by a retired Post Graduate Dean, has been formed and will be working to Terms of Reference agreed by the Cabinet Secretary for Health and Sport which will not only focus on the 48 hour maximum working week but also include consideration of qualitative consequences of rota changes including the impact on fatigue and work/life balance for Junior Doctors and the risks and implications for service delivery, patient safety and impact on other staff groups. The EWG is modelling 48 hour working weeks from a number of different rotas and specialties and will pilot specific rotas to check they achieve educational approval, and assessing the qualitative impact for Junior Doctors. The EWG will ensure preliminary conclusions and recommendations are made by the end of 2019.

H.6 Distinction Awards (DAs) and Discretionary Points (DPs)

278. We were clear in our 2018-19 evidence to the DDRB that existing arrangements for Distinction Awards and Discretionary Points (DADPs) would remain in place. Despite the Review Body recommendations for a 2% uplift in value and for the current freeze to the DADPs to be lifted, we opted not accept this recommendation. Our position, since 2010 has been that to increase or restore DADPs would go against SPSPP.

279. We noted, as part of their response to the DDRB 2018-19 Report, that the UK Government confirmed that they would not be applying the recommended 2% uplift to the value of the Clinical Excellence Awards in England either. Furthermore, recently announced changes to the schemes in NHS England include time-limited, non-pensionable local awards (Discretionary Points) and a reform of the national scheme (Distinction Awards) effective from April 2018.

280. The Scottish Government values the enormous contribution NHS Scotland staff makes to our health service. It is right that our aim is to attract and retain highly-skilled and much sought-after staff. However, there is no evidence to suggest that an adverse impact has resulted from the freezing of the value of DADPs.

281. Although DAs are frozen to new consultants, the availability of new DPs increase in line with the number of consultants in post and, as we are now at record high numbers of consultants, that figure continues to increase. Scotland continues to offer an attractive pay package for Consultants along with the guarantee of No Compulsory Redundancy

H.7 Specialty and Associate Specialists (SAS) Doctors and Dentists

282. There are already agreements (through the SAS Charter), and funding, (through the SAS Development Programme) in place to support the development of SAS Doctors.

283. The Charter acknowledges the fundamental role that SAS Doctors hold in the delivery of high quality, safe medical care for patients in Scotland. The Charter also outlines a series of measures which should be taken to ensure that SAS Doctors are fully supported during their ongoing career and professional development.

284. The SAS Development Programme seeks to direct national funding to those SAS Doctors and Dentists whose clinical teams are seeking to develop new or improved clinical services, or to enhance their role within the clinical team, where funding is not otherwise provided by the employing Health Board. If approved, funding is available to support costs for training, salary backfill, or completion of training to apply for a Certificate of Eligibility for Specialist Registration (CESR). The level of funding available on an annual basis for the Programme is £500,000.

285. In addition the funding has enabled the creation and training of a network of Educational Advisers (themselves SAS Doctors or Dentists) to galvanise and guide other SAS Doctors and Dentists to make best use of this funding and to liaise with local Health Boards to ensure best use of it.

286. While there are clearly existing mechanisms in place to support SAS grades we recognise the benefits of discussion on whether these are sufficient or whether more could be done in this area. Around half of the Scottish respondents to the BMA's SAS Charter survey reported that they had had either no time, or not enough time in recent months, for professional development.

287. As with the other medical staff cohort meetings, Scottish Government and NHS Scotland Employers (through the Management Steering Group (MSG)) are meeting with BMA Scotland to develop the SAS grade as a whole in line with both the needs of individuals and the service across NHS Scotland.

288. The remit and discussions are based on an agreed framework which covers the development of SAS doctors in terms of; status, value; recognition, recruitment and retention, motivation and career structure.

289. There were two recent surveys to NHS Scotland. One sought feedback on progress to date in implementing the Scottish SAS Charter, identifying both what has been achieved and those areas where further progress is required for consideration at Scottish national level. The other looked at recruitment, retention and motivation in the SAS grades, and why the specialty doctor grade is not as attractive as it might be. This survey sought to obtain a better understanding of the size and shape of the challenges in these areas and develop work to establish what actions might be jointly agreed to improve the situation.

290. Work around better vacancy data and a comprehensive SAS workforce profile from which to draw conclusions and develop action on the issue of recruitment and retention of SAS doctors, and developing the SAS grade is also ongoing.

H.8 Locums

291. Consultant staffing numbers in NHSScotland are at a record high level, up by over 50% under this Government. More than 60% of Consultants in NHSScotland are aged under 50.

292. Spend on medical locums in secondary care has reduced in NHSScotland from £109,218,000 in 2016/17 to £100,382,137 in 2017/18, a reduction of 8.8%. This is mainly due to our improvement actions, which include expanding the NHS Staff Bank to include medical staff in all acute NHS Boards (with currently nearly 3,000 doctors registered and available to work) and enhanced governance arrangements which ensure that when a locum is requested, all other options are considered before an Agency is contacted. Our aim was to ensure that all doctors have access to an NHS Staff Bank, at any point in their career from Trainee to Consultant, even in retirement. We have achieved this by operating Medical Staff banks, the majority of which are linked up to provide a regional service. It should however be recognised that any organisation as large and complex as NHSScotland will always have the need for temporary staff to fill planned and unplanned absences.

293. Many doctors approaching retirement do not want to fully immediately stop practicing, and a Staff Bank provides an opportunity to continue to work in NHSScotland without a “fixed” commitment. Recognising that, we have been working in partnership with the Health Boards and the Royal College of Surgeons to create a specialist Locum Bank of recently retired surgeons from all over NHSScotland who have expressed an interest in working in remote and rural areas, offering new temporary and semi-permanent opportunities. This has multiple benefits including:

- Providing high quality staff to rural areas who have been reliant on ad-hoc agency locums.
- Stabilisation of service provision through a consistent and motivated workforce.
- Retention of highly skilled workers in the system.
- Reducing the cost of locum staff in rural general hospitals.
- The ability to provide high quality training to relevant local staff.

294. Feedback from both Medical Staff and local hospitals has been extremely positive, and other specialist areas have shown an interest in these opportunities. We will continue to work to expand this service to other areas and medical grades.

I. Employee Experience, Morale and Motivation

National Staff Experience Measurement

295. We know that improved staff experience supports improved care and that is why we are continually working to find better ways of improving staff experience.

296. The Cabinet Secretary for Health and Sport agreed that in 2018 staff experience would be measured using iMatter only. This position was established in view of our independent evaluation of our staff experience measures (the iMatter Continuous Improvement Model and the Dignity at Work Survey that was undertaken in 2017).

297. Staff and key stakeholders from our Health Boards, and those Health and Social Care Partnerships (HSCPs) that have also chosen to participate, will be engaged in the evaluation. This work is underway and is expected to be concluded in April 2019 with the outcomes being reported to the Scottish Workforce and Staff Governance Committee (SWAG) in June 2019. These outcomes will help to inform our future approach to measuring staff experience.

298. The iMatter results in the Health and Social Care Staff Experience Report 2017 show that an increasing number of staff are engaged and empowered in their roles with an overall Employee Engagement Index of 75. This included a score of 88 for those respondents who say that they clearly understood their role and responsibilities; and a score of 82 for those respondents who reported that they were treated with dignity and respect. A score of 74 was achieved for those who responded that they would recommend their organisation as a good place to work.

299. The report contains 23 stories from health and social care teams showing how they have already responded to their iMatter results and taken action on feedback to improve patient and staff experience outcomes.

300. A copy of the full report, which contains comparative information on the Dignity at Work questions asked in the 2015 national staff survey, can be accessed via the following link: http://www.gov.scot/ISBN/9781788516020

301. The report of Health and Social Care Staff Experience in 2018 was published on 1 February 2019 and provides national and Health Board results for iMatter including team stories. https://www2.gov.scot/Publications/2019/02/6760

302. The Scottish Government continue to work in partnership with Health Boards to ensure that iMatter is fully utilised and the benefits are realised. Managers and leaders working within Boards, and participating HSCPs, are expected to give full consideration to this Report. They are also encouraged to consider the team stories within the national report for shared learning and results of local reports should also be considered. Any areas of success should be celebrated and where possible rolled out. Any areas that offer an opportunity for improvement should be discussed locally to develop plans in view of other current initiatives. Health Boards should feed actions for improvement into their Staff Governance Monitoring process.

NHS Scotland Global Citizenship Programme

303. For many years, staff from across NHSScotland have made a significant personal and professional contribution to global health work in developing countries. This valuable work not only helps to reduce common challenges such as disease epidemics, but also provides mutual learning opportunities for individual staff and our health service, ultimately benefitting people in Scotland.

304. To increase NHSScotland's global health contribution, we launched the Global Citizenship Programme in June 2018. The Programme supports the Scottish Government's International Development Strategy, in particular the commitment to support the strengthening of capacity in the area of health by making it easier for all NHSScotland staff to participate in global citizenship, both in Scotland and abroad. The approach adopted builds on best practice, including the work that NHS Borders has developed over the last 20 years with their twinning arrangement with St Francis Hospital, Zambia.

305. Traditionally, global citizenship has been considered through the lens of overseas placements. However, staff from across NHSScotland contribute in multiple and innovative ways, including: mentoring healthcare staff from low and middle income countries who come and work in NHSScotland in order to observe or develop new skills and learning; providing remote support, including virtual learning, networks, coaching and mentoring using a wide range of technology; and fundraising to support local initiatives and health-partnership work and through the everyday choices they make in the products they buy.

306. There is clear evidence that involvement in global health benefits the Scottish population through a reinvigorated, self-sufficient, innovative and productive workforce. As this unique approach to Global Citizenship develops, it will be important to understand more about the impact this valuable work has on NHSScotland staff and to maximise the opportunities to realise the benefits for staff, the healthcare system and ultimately patients.

J. Conclusions and Recommendations

307. Our remit letter to the DDRB from the Cabinet Secretary for Health and Sport confirms the parameters which we wish the DDRB to work within for their 2019-20 Report.

308. We believe our SPSPP provides a fair deal for Scottish Public Sector staff given the overall economic context. The evidence presented sets out the overall policy context and background within which NHSScotland is working – but we would ask the DDRB to consider its recommendations within the confines of SPSPP which are:

- providing a guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent for those earning above £36,500 and below £80,000;
- a flat increase of £1,600 for those earning £80,000 or more ;
- a cash underpin of up to £750 for those employees who earn less than £25,000
- continuing the policy commitment to No Compulsory Redundancy.

309. As in previous years, the Scottish Government continues to value the independent view which the DDRB offers on doctors' and dentists' pay and recognises the role that they will play in helping to determine pay levels for NHSScotland medical and dental staff and invite you to make recommendations for the year from 1 April 2019 to 30 March 2020.