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THE SCOTTISH GOVERNMENT'S WRITTEN EVIDENCE TO THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION (DDRB) FOR THE 2020-21 PAY ROUND

SCOTTISH GOVERNMENT HEALTH DIRECTORATES' SUBMISSION TO THE DDRB 2020

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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. This confirms the parameters which we would wish the DDRB to work within for their 2020-21 Report and Recommendations.

3. Our approach to public sector pay is governed each year by the Scottish Public Sector Pay Policy (SPSPP). The Minister for Public Finance and Digital Economy announced the draft SPSPP for 2019-20 on 6 February 2020. A copy of the draft Budget is available here, this is subject to parliament approval.

4. The key features of the 2020-21 Public Sector Pay Policy are:

   - providing a guaranteed basic pay increase of 3 per cent for public sector workers who earn below £80,000
   - continuing the requirement for employers to pay staff the real Living Wage, now set at £9.30 per hour
   - providing a guaranteed cash underpin of £750 for public sector workers who earn £25,000 or less
   - limiting to £2,000 the maximum basic pay increase for those earning £80,000 or more
   - allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries for addressing clearly evidenced equality issues in existing pay and grading structures.

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

EU Exit

12. As a responsible government, we must continue to prepare for all potential EU Exit scenarios, and we have put a great deal of care and effort into our preparations. The Scottish Government remain of the view that EU Exit, in whatever form it takes, will have a significant impact on our health and social care sector. Scotland benefits enormously from the hard work and dedication of many non-UK EU citizens who have made Scotland their home. Any immigration restrictions put in place by Westminster could have a major impact on our health workforce, where many health professionals from EU countries work in hard to recruit specialisms and geographical regions.

13. The Scottish Government is absolutely committed to safeguarding, as far as we are able to do so, the interests of individuals, including EU nationals who currently work in Scotland. The Cabinet Secretary for Health and Sport has issued a number of letters to non-UK EU staff working in the health and social care sector to reiterate how much we value them and want them to feel welcome in Scotland. To support EU citizens in this uncertain time, we have also launched the Scottish Government's 'Stay in Scotland' campaign. It provides practical advice on the EU Settlement Scheme application process and where individuals can access support with their application.

14. Although there may be changes to the current EU system of Mutual Recognition of Professional Qualifications, the UK Government confirmed on 4 April 2019 that EU staff who are currently practising here can continue to do so, even if we leave without a deal. This means that the professional status of registered health and care staff is unchanged for as long as they meet continuing requirements of statutory registration.

15. After exit day, professional qualifications awarded in the UK will no longer be covered by the EU Directive, but the EU has publicly stated that holders of UK qualifications that are registered in EEA countries and Switzerland will continue to be registered. However, in the absence of an agreement with the EU, the future recognition of UK qualifications will be determined by the national policy of individual EU Member States after exit day.

16. EU Exit continues to raise concerns in many other 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. Many of these topics cross into areas where Westminster still holds power and therefore we are limited in what actions we can take. We continue to ensure however that we are represented in all these areas and make sure that Scotland's voice is heard.

Longer Term Health and Social Care Strategy

17. We already have work underway to develop our longer term approach and to deliver balanced and sustainable services. As part of this we will continue to engage with our partners across health and social care services, and will set out our next steps in due course.

Everyone Matters: Our Workforce Strategy

18. Evidence shows that staff who are valued and supported deliver better patient and overall outcomes. Everyone Matters: Our Workforce Strategy is the current workforce policy for NHS Scotland. 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. Everyone Matters has now been extended and will run to 2021, whilst work on our longer term approach progresses.

19. Our Workforce Strategy for NHS Scotland includes the vision statement: 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

20. The five priorities for action being progressed through Everyone Matters are:
    - healthy organisational culture
    - sustainable workforce
    - capable workforce
    - a workforce to deliver integrated services and
    - effective leadership and management.

Review of Primary Care Out of Hours Services

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

22. Boards and Integration Authorities have made some significant progress towards implementing recommendations, particularly at a national level, e.g. in joint working between NHS 24 and Speciality Doctors and Associate Specialists (SAS) in the planning and delivery of services.

23. In the last four years the Scottish Government has invested £30 million (£10 million - 2016/17, £10 million - 2017/18, £5 million - 2018/19, and £5 million – 2019/20) to support implementation of Sir Lewis Ritchie's report on urgent care and out of hours services.

24. 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 improving out of hours services across Scotland. Following that meeting the Scottish Government established the Primary Care National Out of Hours Oversight Group. This group has brought together key stakeholders to identify priorities to make out of hours services more resilient and sustainable across Scotland.

Patient Engagement in GP Quality of Care

25. 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.

26. 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.

C. Economic and Labour Market Conditions in Scotland

Overview

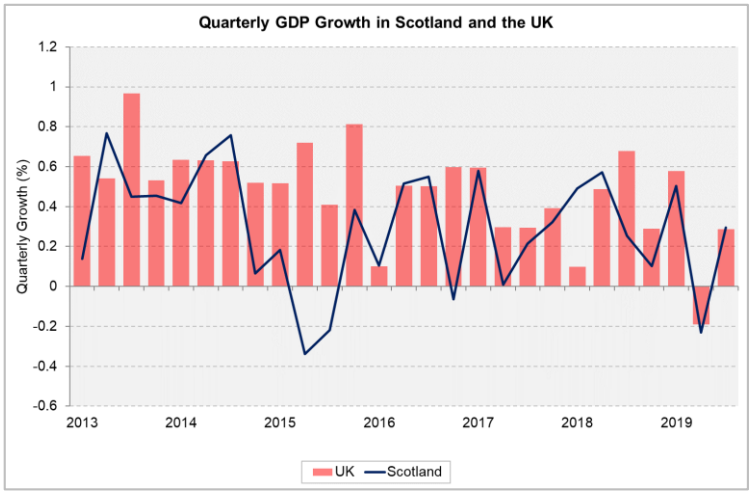
27. Growth in the Scottish economy slowed in 2019 amid on-going Brexit uncertainty and a weakening in the wider global economic environment. Scotland's labour market is performing strongly by historical standards although has shown recent signs that it might be softening with lower levels of employment. Nominal earnings continued to grow into 2019, though at a slower pace than in 2018, however this is forecast to strengthen in 2020. The inflation rate also fell over the year supporting further, though more moderate, real wage growth, with inflation projected to increase back towards its 2% target over the period to 2022[1].

28. Independent forecasts expect the pace of economic growth in Scotland to remain below trend in 2020, assuming some form of smooth Brexit.

[1] Data correct as of December 2019

Scottish Output[2]

29. The Scottish economy (and UK economy as a whole) grew 0.3% in Q3 2019, rebounding from a -0.2% contraction in the second quarter of the year. Scotland's output growth over the quarter was driven by the Services (0.2%) and Production (0.9%) sectors, offsetting flat growth in the Construction sector (0.0%).

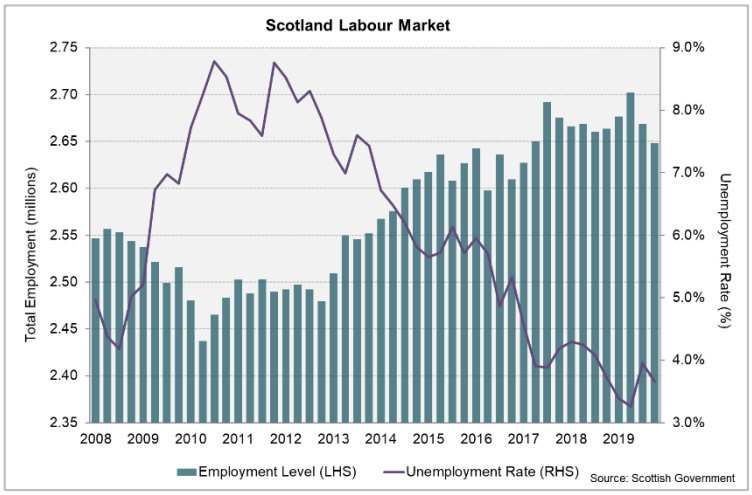


30. Quarterly growth was relatively volatile in 2019 with business activity, particularly with regards to stockpiling in the manufacturing sector, influenced by the Brexit deadlines in March and October.

31. Overall, the pace of growth slowed in 2019 with 0.6% growth in the first three quarters of 2019 compared to 1.3% growth over the same period in 2018. This reflects slower growth in the UK economy as a whole, which has been impacted by Brexit uncertainty alongside a wider slowdown in global economic growth.

Labour Market[3]

32. Scotland's labour market continued to perform strongly by historical standards in 2019, however has softened slightly in recent months from the record performances in employment and unemployment recorded at the start of 2019.



33. Figures for August to October 2019 show that the level of employment in Scotland has fallen by 16,000 over the year, with the employment rate falling to 74.5% (UK: 76.2%), having risen to a record high of 75.9% at the start of 2019.

[2] Data source: GDP Statistics. https://www2.gov.scot/Topics/Statistics/Browse/Economy/PubGDP/GDP2019Q3
[3] Data source: Labour Market Statistics for Scotland. https://www2.gov.scot/Topics/Statistics/Browse/Labour-Market/LMTrends

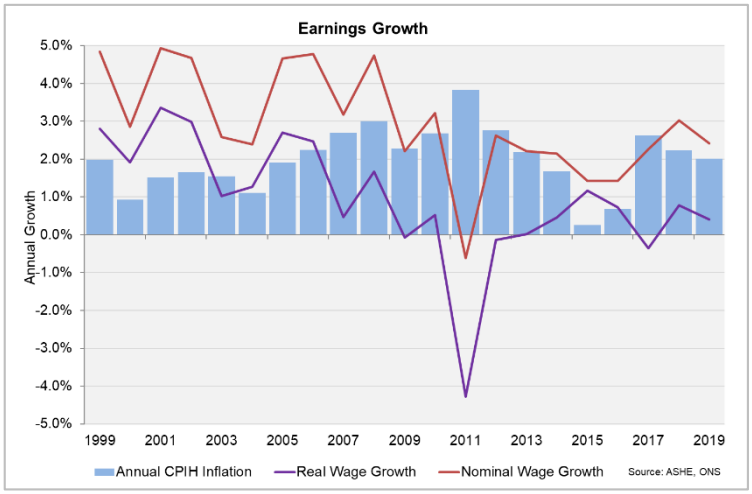
34. The unemployment rate has also fallen slightly over the past year to 3.7% (UK: 3.8%), though remains higher than its series low of 3.2% recorded at the start of 2019.

35. Correspondingly, the inactivity rate in Scotland – those neither in work or looking for work – has increased over the past year to 22.6% (UK: 20.8%).

Earnings[4]

36. Median full-time weekly earnings grew 2.4% in Scotland in 2019 to £576.70.

37. Median full-time weekly earnings in Scotland (£576.70) remains below the UK (£584.90) and are the fourth highest of the twelve UK countries and regions behind London (£736.50), the South East (£613.50) and East (£581.00).



38. The pace of growth over the year was below the UK (2.9%) and has slowed slightly from 3% in 2018. However, the pace of growth remains stronger relative to the pace of annual growth since 2012. Looking ahead, the Scottish Fiscal Commission[5] forecast average nominal earnings growth to strengthen gradually to 2.7% in 2020 and 2.9% in 2021.

39. The annual rate of inflation (based on Consumer Prices Index including owner occupiers housing costs (CPIH)) fell to 2.0% over the year to April 2019, down from 2.2% the previous year. Adjusting for this, real earnings growth in Scotland increased by 0.4% (UK: 0.9%) annually, down from 0.8% growth in 2018.

40. Latest inflation data shows that the inflation rate has continued its downward trend to 1.5% in November 2019. The Bank of England project that inflation will fall further at the start of 2020, before slowly picking back up to its 2% target over the period to 2022[6].

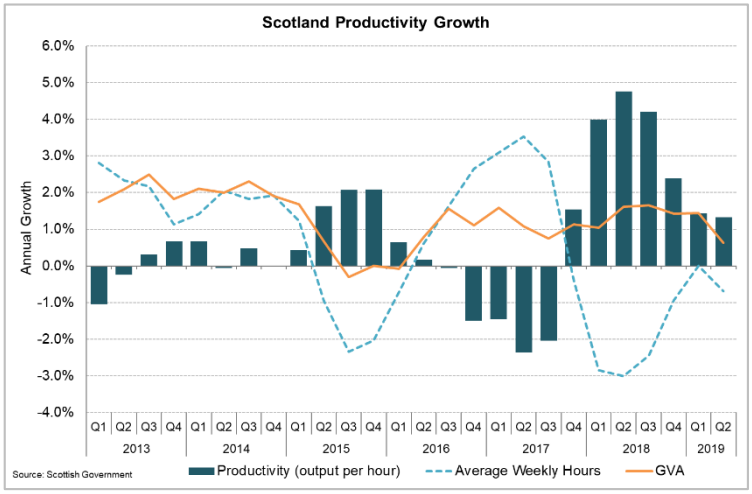
[4] Data source: Annual Survey of Hours and Earnings 2019. https://www2.gov.scot/Topics/Statistics/Browse/Labour-Market/Earnings

[5] http://www.fiscalcommission.scot/publications/scotlands-economic-and-fiscal-forecasts/scotlands-economic-and-fiscal-forecasts-may-2019/

[6] https://www.bankofengland.co.uk/monetary-policy-report/2019/november-2019

Labour Productivity[7]

41. Labour productivity continued to grow in Scotland in the first half of 2019, though at a slower rate than in 2018.



42. In Q2 2019, Scottish labour productivity (output per hour worked) grew 1.3% over the year, down from a recent peak of 4.8% in Q2 2018. The latest growth in productivity reflects further growth in output (0.6%), which has slowed from 2018, while average weekly hours worked continued to fall (-0.7%), though at a slower rate than in recent times.

43. Over the longer term, since 2007, labour productivity in Scotland has grown by 1.0% per year on average, compared to UK average annual growth of 0.3%.

Economic Outlook[8]

44. The Scottish economy is forecast to slow to around 1% growth in 2019, down from 1.4% in 2018, before picking up from 2020 onwards, though remaining below trend. Central forecasts assume some form of smooth Brexit transition, however, the uncertainty associated with this, alongside slower global growth, remain key downside risks to the economic outlook in Scotland.

Independent Scottish GDP Growth Forecasts (%)						
	2018 (outturn)	**2019**	**2020**	**2021**	**2022**	**2023**
Scottish Fiscal Commission	1.4	0.8	0.9	1.1	1.2	1.3
Fraser of Allander Institute		0.9	1.3	1.4	1.4	-
EY ITEM Club		1.0	1.4	1.5	1.7	1.8
PWC		1.6	1.3	-	-	-
OBR (UK)	1.4	1.2	1.4	1.6	1.6	1.6

[7] Data Source: Labour Productivity Statistics. https://www2.gov.scot/Topics/Statistics/Browse/Economy/PROD19Q2

[8] Non-Scottish Government forecasts for the Scottish economy presented in this report are widely available in the public domain: Fraser of Allander Institute https://www.strath.ac.uk/business/economics/fraserofallanderinstitute/economic_commentary/ , EY ITEM Club https://www.ey.com/uk/en/issues/business-environment/ey-scottish-item-club-forecast-2019. PWC http://www.pwc.co.uk/services/economics-policy/insights/uk-economic-outlook.html. No significance should be attached to the inclusion or exclusion of any particular forecasting organisation. The Scottish Government accepts no responsibility for the accuracy of material published in this comparison. Scottish Fiscal Commission Economic and Fiscal forecasts are available at: http://www.fiscalcommission.scot/

D. Resources, Affordability and Pay

Introduction

45. This chapter sets out the financial context including assumptions on funding available in 2020-21.

Funding growth

46. Since 2010, the Scottish Government's discretionary resource budget (day-to-day spending) has fallen by 2.8 per cent in real terms. The scale of this reduction has required difficult decisions to be taken about expenditure across Government and careful consideration of pressures and priorities in all portfolios.

47. Beyond 2020-21, budgets will not be known until the outcome of the UK Government's 2020 Spending Review, which may result in further cuts in some areas. The delayed UK Budget has meant that the Scottish Government has had to estimate the Barnett consequentials that could be forthcoming for Scotland at the planned UK Budget in March. In the event that there are material differences between these estimates and assumptions and the outcomes of the UK Budget, the Scottish Government will have the opportunity to revisit these plans during the financial year.

48. Despite the backdrop of a real terms reduction in Scotland's fiscal resource budget as outlined above, in 2020-21 we will deliver an above inflation increase for Health and Sport.

49. The 2020-21 Draft Scottish Budget increases investment in health and care services by over £1 billion to more than £15 billion for the first time, including allocating more than £100 million over and above Barnett consequentials to support front line spending.

Level 2	2019-20 Budget £m	2020-21 Budget £m
Health	14,311.2	15,327.9
Food Standards Scotland	16.0	16.0
Total Health and Sport	**14,327.2**	**15,343.9**
Of which:		
NHS Territorial Boards	10,070.1	10,704.0
NHS Special Boards	1,225.6	1,312.1
Community Health Services	1,853.5	2,109.0
Departmental Allocations	1,161.9	1,202.8

Affordability - the funds available

50. As outlined above, there will be additional resource funding for the Health and Sport portfolio of over £1 billion (7.1%) in 2020-21.

51. Funding for frontline NHS Boards will increase by £454 million (4.2%). NHS Territorial Boards will receive a cash terms uplift of 3.0%. In addition to this, those Boards furthest from National Resource Allocation Committee (NRAC) parity will receive a share of £17 million, which will mean that in 2020-21 no Board is further than 0.8% from its target funding share (as calculated by the NRAC formula).

52. The National Waiting Times Centre, Scottish Ambulance Service, The State Hospital and NHS 24, along with the NHS National Services Division and Scottish National Blood Transfusion Services (within NHS National Services Scotland) will also receive a baseline uplift of 3%. NHS National Services Scotland, Healthcare Improvement Scotland, and NHS Education for Scotland will receive funding uplifts of 2%, which includes funding towards pay costs.

53. Boards will also receive a share of money for improving patient outcomes, totalling £461 million, as outlined below.

Improving Patient Outcomes	19-20 Investment in reform (£m)	2020-21 Investment in reform (£m)	Increase for 20-21 (£m)
Primary Care	155.0	205.0	50.0
Waiting times	106.0	136.0	30.0
Mental Health and CAMHS	61.0	89.2	28.2
Trauma Networks	18.0	31.3	13.3
TOTAL	**340.0**	**461.5**	**121.5**

54. In addition to funding for frontline NHS Boards, the Scottish Government will further increase its package of investment in social care and integration. This investment will increase by a further £100 million, taking the total package of investment to £811 million, underlying our commitment to support older people and disabled people and recognise the vital role unpaid carers play. A further £200 million will be provided to support funding arising from the actuarial valuation of the NHS Pension Scheme will be provided in 2020-21.

55. The Scottish Government expects every public body to deliver efficiency savings of at least 3 per cent during the course of 2020-21 and NHS Boards' 2020-21 Annual Operating Plans suggest savings would exceed this level. All efficiency savings are available to be reinvested in the body that generates the saving.

Paybill

56. The medical and dental paybill is itemised by the following groups, as per the below.

Staff Group	2019-20 Estimated Paybill (£m)	2019-20 Average Basic Pay[1] (£000)
Foundation Years (FY1, FY2)	91.6	28.1
Specialty Training (SpR, StR, etc)	365.5	40.9
Consultant	853.5	97.1
Specialty Doctor	66.0	65.5
Associate Specialist	27.9	89.5
Other	141.3	69.9
TOTAL	**1,545.8**	

* Figures based on 2019-20 pay award and exclude Distinction Awards and Discretionary Points for Consultants.

[1] Salary as per NHS Circular: PCS(DD)2019/2

Pressures on funding

57. 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.

58. 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

General Update

59. 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.

60. 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 that of the scheme in England and Wales.

61. 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.

Taxation

62. There remains sustained concern about the impact of the Annual Allowance (AA) and Lifetime Allowance (LTA) tax limits on recruitment and retention of staff in the NHS, and on delivery of frontline services. Tax charges relating to breaches of the AA and LTA are leading to senior clinicians in particular to consider a range of unanticipated career choices. These include withdrawing from additional and out of hours working, opting out of the pension scheme entirely and taking early retirement. The tapered AA and the reduction in available carry forward of unused AA from previous tax years are particularly relevant in this regard.

63. Tax relief and the Annual Allowance (AA) and Lifetime Allowance (LTA) 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 AA 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 AA of £10,000. Similarly with other public service schemes, affected NHS pension scheme members can request "scheme pays" where any AA tax charge is paid by the scheme, with a permanent pension debit applied at retirement to cover this cost.

64. On 7 August 2019 the Department for Health and Social Care (DHSC) issued a consultation on flexibilities that could be offered within the Scheme to assist staff to better manage their pension growth and potential tax liabilities, allowing for variations in the amount staff can save into their pensions. Any flexibilities will be available for use in Scotland. Once the outcome of the DHSC consultation is known the NHS Scheme Advisory Board (SAB) will consider the proposals and how they might apply to the Scottish scheme with a view to introducing any changes to the Scheme in the next financial year.

65. On 18 November 2019, the Scottish Government published a policy on the recycling of employer contributions (REC) which allows those staff who believe they may be impacted by an AA tax charge in 2019-20 to opt out of the scheme, therefore controlling any further pension growth, and receive their employer's pension contribution back as a basic salary enhancement. This ensures there is no reduction in their total reward package. The REC policy is intended to provide staff with an alternative choice to reducing their work commitments, allowing them to continue to work in their present role and at their present level of service. This is a temporary policy running from 1 December 2019 to 31 March 2020, designed to provide an interim solution while awaiting the outcome of the DHSC's flexibilities consultation and the review of the tapered AA by HM Treasury.

66. A permanent solution is required that will allow NHS staff to continue to work at their present level without fear of unexpected tax bills related to pension saving. As pension taxation remains a reserved matter, we continue to lobby the Chancellor to take the opportunity of the UK Budget on 11 March 2020 to offer this permanent solution. We will however continue to act to mitigate the harmful

impact of pensions taxation rules on NHS Scotland staff and on front line service delivery from April 2020 should this prove necessary.

Impact on affordability

67. High participation in the NHS Pension Scheme suggests that the scheme remains affordable and a valued benefit for NHS staff. Participation in the pension scheme by [9] Hospital Doctors and Dentists has stayed consistently high at 93.3% at 30 September 2019 (down 1% compared to 30 September 2018) and compares well against scheme participation rates for all staff at 91.9%.

68. Whilst being down from 91% in September 2018, participation amongst [10] General Practitioners remains relatively high at 82% in September 2019. There is an indication that levels of GP participation fluctuate throughout the year as members opt in and out of the scheme and a snapshot of participation in any given month may not accurately reflect total participation across the year. [11] Dental Practitioner participation remains constant with 80% participating in the scheme, the same figure as in September 2018. Participation rates remain a regular consideration of the SAB.

69. Opt out Figures for the period 1 April 2018 to 30 September 2019 show 254 GPs and 20 Dental Practitioners have opted out of the scheme. We are unable to identify the number of hospital doctors and dentists who have opted out because SPPA pension data 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. 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.

70. The affordability of the scheme for tax payers and employers is managed through the valuation process and the employer cost cap which was introduced to the scheme in 2015. The employer cost cap ensures that the risks associated with pension provision are not met solely by the taxpayer, but are shared with scheme members. The employer cost cap is symmetrical where any downward breach results in a member’s benefits being improved and an upward breach of the cost cap require members benefits to be reduced.

71. The latest valuation of the scheme was based on data as at 31 March 2016 and included the first assessment of the employer cost cap. The valuation indicated that there had been a downward breach of the employer cost cap and as required by the scheme regulations the advice of the SAB was requested on how the cost breach could be rectified. The SAB considered and agreed on a number of proposed options which included changes to employee contribution rates and

[9] Information provided by Health Boards
[10] Information provided by PSD National Services Scotland
[11] Information provided by Dental Services NHS National Services Scotland

using actual instead of whole time equivalent pay to set a member's contribution rate.

72. In addition to the cost cap breach the UK Government announced a reduction in the SCAPE discount rate used in the valuation of unfunded public service schemes, from 3% to 2.4% in its 2018 budget statement. A reduction in the discount rate will – all other things being equal – increase the contributions employers are required to pay. That is because the rate 'discounts' future pension costs to a figure in today's terms. A lower discount rate means a smaller discount for the employer. Changes in the discount rate are not included when assessing changes in the employer cost cap.

73. It was anticipated that the employer cost cap rectification action would take effect from 1 April 2019 but in January 2019 the UK Government paused work in this area. The decision arose because of the decision from the Court of Appeal (McCloud (Judiciary scheme)/ Sargeant (Firefighters' scheme) cases) that held that the transitional protections provided as part of the 2015 reforms unlawfully discriminated on the grounds of age. The UK Government directed that the planned increases in employer contributions should go ahead from 1 April 2019 and the employer cost cap be paused while they sought leave to appeal the decision. The Supreme Court refused the UK Government's right to appeal on 27 June 2019 and the case will now refer back to the Employment Tribunal. The cost cap will be reconsidered once the impact of the decision is fully assessed in relation to any additional costs to the Scheme.

74. The UK Government also confirmed it would provide funding to schemes to cover the cost of increased employer contributions from April 2019. The Scottish Government's share of this funding is received funding based on the Barnett formula, which provides a proportion of the additional funding provided to the scheme in England and Wales. As these Barnett consequentials fell short of the costs, Scottish Ministers provided a top-up to ensure full funding to cover the 2019-20 increase to employer pension contributions for the NHS Pension Scheme.

75. The 2016 valuation confirmed that an increase in the employer contribution rate from 14.9% to 20.9% was required from 1 April 2019 to 31 March 2023.

Retirement Trends and Pensions

76. There were 73 GPs and 15 GDPs who took early retirement between 1 April 2018 and 31 March 2019. The reasons for early retirement are not requested on the application form so those details are not held by SPPA. Also, SPPA would not be notified where a member takes early retirement and re-joins the workforce without re-joining the pension scheme. The pension data held by SPPA does not distinguish between job roles so it is not possible to provide early retirement figures for hospital doctors and dentists.

F. Workforce Planning

HEALTH AND SOCIAL CARE WORKFORCE PLANNING

National Workforce Planning

77. 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.

78. With this in mind, Scotland was the first nation in the UK to publish a national health and social care workforce plan, and also the only one to have passed legislation that puts in place systems to ensure staffing for safe and high-quality care across both health and care settings. 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.

79. In the past, most NHS workforce planning was carried out by health boards, but with the shift in the balance of care, and the integration of health and social care, a new approach was needed.

80. The National Health and Social Care Integrated Workforce Plan was published 16th December 2019. This plan has been developed in partnership with COSLA and it sets out how health and social care services will meet growing demand to ensure the right numbers of staff, with the right skills, across health and social care services.

81. Along with the Integrated Plan, updated guidance on workforce planning has also been circulated to all health and social care organisations in Scotland - including Local Authorities, Integration Authorities, NHS Boards, voluntary sector and independent sector organisations. The guidance will help organisations to work together in integrated ways 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.

82. At 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.

83. 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 went live in April 2019.

84. Audit Scotland and others have drawn attention to the value of scenario planning in determining our needs for the future. A series of case studies and scenarios have been published alongside the Integrated Plan, covering health and social care professions which are particularly affected by growing demand. These scenarios will allow modelling of the numbers needed for future years, in response to growing demand. This supports the development of scenario planning at local and regional levels, and work with COSLA and other stakeholders will continue to further develop the scenarios outlined in the document. Key to the scenarios is the development and implementation by NHS Education for Scotland of the TURAS data intelligence platform, enabling workforce information across health and social care to be combined. The platform went "live" in April 2019.

Workforce data

85. 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

86. NHSScotland's staffing levels have increased by over 14,300 whole time equivalent (WTE) – a 11.3% increase (from 127,061.9 WTE at Sept 2006 to 141,425.2 WTE at Sept 2019).

87. Medical & Dental Consultant (including Director level consultants) numbers have increased by 1,868.6 WTE – a 51.4% increase (from 3,636.6 WTE at Sept 2006 to 5,505.1 WTE at Sept 2019).[12]

DDRB remit groups

88. **Table 1** shows that numbers of medical and dental staff in post have risen from 11,343.1 WTE in Sept 2008 to 13,745.6 WTE in Sept 2019. This represents an increase of 21.2%.

89. **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

90. NHSScotland is a large organisation, employing 141,425.2 staff (WTE) (as at September 2019). Given the natural turnover of staff in an organisation of this size, it will always carry some vacancies.

[12] Figures correct as at September 2019

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

92. The National Workforce Planning Group, which has been set up to take forward the recommendations in our Workforce Plan parts 1, 2 and 3, is also helping to co-ordinate and improve targeted recruitment activity to ensure key vacancies are filled by Boards.

93. **Table 3** shows that the number of vacant consultant posts increased by 21.3% (85 WTE) between September 2018 and September 2019 to 483.1 WTE, creating a vacancy rate of 8.2%. Of these vacancies, 253.4 WTE (4.3% of the establishment figure) had been vacant for six months or more at the census point, as shown in **Table 4**.

94. The number of vacant consultant posts in medical specialties was 475.6 WTE, an increase of 20.9% from September 2018. Of these, 250.9 WTE (52.7%) had been vacant for 6 months or more.

95. The number of vacant consultant posts in dental specialties was 7.5 WTE. Of these, 2.5 WTE (33%) had been vacant for 6 months or more.

96. **Table 5** shows joiners, leavers and turnover in the NHSScotland workforce by staff group and region for each financial year from 2011/12 to 2018/19. For medical and dental staff across Scotland, the turnover rate in 2018/19 was 9.3 WTE (calculated as the number of leavers divided by staff in post as at 31 March).

NHS Board Workforce Projections

97. All NHS Boards were asked to provide workforce projections for 2019-20 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.

98. As with all projections, these figures are estimates and are subject to change. NHSScotland projected staff in post changes for 2019-20 were published on 28 August 2019 on the Scottish Government website[13]:

99. The main findings for WTE staffing in financial year 2019-20 were:

- Medical staff is projected to increase by 591.3 WTE (up 5.0%).[14]
- Dental staff is projected to increase by 3.3 WTE (up 0.7%).

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

[14] 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

- Medical and Dental Support staff is projected to increase by 53.6 WTE (up 2.7%).

100. 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

101. The National Health and Social Care Workforce Plan's recruitment, training and education commitments include 100 more training places for GPs from 2019 and 50-100 additional medical undergraduate places by 2021. We will increase the number of GPs by at least 800 over 10 years to ensure a sustainable service that meets increasing demand. There will also be new investment in the wider multi-disciplinary teams to support GPs.

102. 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.

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103. The International Recruitment Unit has been created to improve NHS Scotland's resilience to target speciality areas that have been identified as at risk from EU withdrawal and where there are currently recruitment challenges. These four speciality areas are Anaesthetics, Psychiatry, General Surgery and Paediatrics.

104. The Scottish Government has agreed £625,000 to staff the unit at NHS Greater Glasgow and Clyde until December 2020 to support direct marketing for consultant grade vacancies, and manage the 'on-boarding' process for candidates. There is currently an exemption of all categories of doctors and nurses from the Tier 2 visa cap, which we intend to capitalise on through the recruitment unit.

105. We are waiting for an evaluation from the IRU's provision throughout phase one of the pilot (Jan to Dec 2019) and consider recommendations for 2020.

The Waiting Times Improvement Plan

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

107. 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. Boards are already developing detailed workforce plans to address the actions set out in the Plan.

108. The Waiting Times Improvement Plan will:

- Increase capacity across the system by expanding capacity at the Golden Jubilee Hospital, which has seen additional clinics run across various specialities assisting territorial Health Boards with the increased demand. In addition, we will accelerate the delivery of the existing Elective Centre Programme, meeting the commitment to invest £200 million in elective centres. As part of the Scottish Government's investment of £200 million to meet demand for elective procedures over the next 10 years, the Golden Jubilee is focusing on creating an expansion programme to treat more patients than ever before. Phase one of the expansion will deliver a new integrated eye unit opening in August 2020. This will support the delivery of 10500 cataract procedures per annum and 1215 outpatients appointments. This expansion will also support the delivery of the Waiting Times Improvement Plan and will continue to assist in sustainably after March 2021.

- Increase clinical effectiveness and efficiency by implementing targeted action plans for key specialties and mainstreaming key productivity improvement programmes, such as rolling out the virtual attendance potential of 'Attend Anywhere'. Usage of the Attend Anywhere Video Consultation platform continues to increase consultations being held each month and all territorial health boards have now signed up to using this service. It has seen particular benefits in the North of Scotland acute services and plans are now being considered on how to scale up its usage within primary and social care. Clinical feedback so far throughout implementation remains positive and the savings in time, costs and "health miles" have been extremely positive to date.

Elective Centres Policy

109. 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.

110. The first of the Centres will open at the Golden Jubilee in Clydebank in mid-2020, with the other centres opening during 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.

111. 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	Sep 19
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**	**13,745.6**
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	5,382.0
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	123.2
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	3,546.5
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	919.8
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	926.5
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	866.6
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	936.9
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	82.9
Dental officer	225.1	224.0	190.8	201.7	184.5	184.5	196.6	174.1	174.2	179.0	192.4	181.6
Other	179.0	243.3	319.1	369.0	403.1	413.8	419.0	467.2	755.0	760.5	1,035.5	779.7

Source: ISD Scotland

Table 2: NHSScotland workforce statistics - HCHS Staff (Headcount) by Specialty & Age Group, Sep 2019

	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	**718**	**2,858**	**2,521**	**1,918**	**1,942**	**1,725**	**1,620**	**1,257**	**503**	**180**	**15,242**
All medical specialties	**695**	**2,765**	**2,426**	**1,826**	**1,852**	**1,644**	**1,515**	**1,155**	**479**	**167**	**14,524**
All dental specialties	**23**	**93**	**96**	**92**	**91**	**82**	**106**	**102**	**24**	**13**	**722**
Acute internal medicine	16	51	41	34	28	19	11	10	7	1	218
Allergy	0	0	0	0	0	0	0	0	0	0	0
Anaesthetics	10	152	247	204	176	176	172	149	32	7	1,325
Audiological surgery	0	0	0	0	0	0	0	0	1	0	1
Cardiology	11	39	27	28	43	37	17	22	11	4	239
Cardiothoracic surgery	4	17	10	12	8	4	17	9	3	1	85
Chemical pathology	0	6	4	4	13	9	8	10	2	1	57
Child & adolescent psychiatry	1	5	19	21	28	23	20	10	4	0	131
Clinical genetics	0	0	3	2	4	7	3	5	4	0	28
Clinical neuro-physiology	0	0	0	3	4	2	0	2	0	0	11
Clinical oncology	2	12	24	20	37	24	28	15	3	6	171
Clinical pharmacology & therapeutics	0	0	2	0	2	2	3	5	0	1	15
Clinical radiology	0	63	102	71	77	75	55	59	18	9	529
Community dentistry	1	23	44	38	43	45	50	57	10	3	314
Community sexual and reproductive health	1	2	6	5	5	1	11	3	1	0	35
Dental & maxillofacial radiology	0	1	2	1	1	2	2	0	0	1	10
Dental public health	7	15	12	9	19	12	16	18	3	3	114
Dermatology	2	15	34	34	24	32	29	18	5	4	197
Diagnostic neuropathology	0	0	1	0	0	1	0	0	0	0	2
Emergency medicine	19	227	150	122	109	65	46	31	8	1	778
Endocrinology & diabetes	4	29	20	18	26	31	25	12	9	3	177

Forensic histopathology	0	1	0	0	0	1	0	0	1	0	3
Forensic psychiatry	0	10	21	9	12	11	10	1	3	0	77
Gastroenterology	6	28	22	27	28	25	30	10	8	4	188
General medicine	208	332	159	89	56	48	36	34	13	10	985
General practice	19	307	300	166	145	150	146	149	82	22	1,486
General psychiatry	21	161	111	95	131	102	131	75	31	12	870
General surgery	173	224	102	82	108	64	78	61	31	17	940
Genito - urinary medicine	0	0	9	6	10	7	9	6	1	0	48
Geriatrics	44	156	91	73	81	53	44	27	16	8	593
Haematology	2	23	33	32	31	17	27	18	12	2	197
Histopathology	1	17	38	28	29	32	16	19	8	3	191
Homeopathy	0	0	0	0	0	1	1	0	0	0	2
Immunology	0	0	0	0	3	0	0	1	1	1	6
Infectious diseases	6	18	13	9	9	10	7	4	2	2	80
Intensive care medicine	7	35	21	7	11	2	2	1	1	1	88
Medical microbiology & virology	0	8	14	18	13	14	17	7	4	3	98
Medical oncology	1	24	7	10	8	11	7	2	1	0	71
Medical ophthalmology	0	0	1	1	0	0	0	0	0	0	2
Neurology	4	14	13	15	24	18	14	13	4	1	120
Neurosurgery	5	20	15	8	16	10	3	7	3	2	89
Nuclear medicine	0	0	0	0	0	2	2	0	0	0	4
Obstetrics & gynaecology	17	121	129	89	91	83	78	59	24	3	694
Occupational medicine	0	1	2	2	3	3	5	4	0	2	22
Old age psychiatry	2	10	27	21	8	23	20	7	3	0	121
Ophthalmology	1	39	35	27	18	50	39	30	13	2	254
Oral & maxillofacial surgery	0	4	6	7	6	8	12	7	4	1	55
Oral medicine	0	1	1	2	1	1	0	2	2	1	11
Oral microbiology	0	0	0	0	0	0	0	0	0	0	0
Oral pathology	0	0	1	0	0	1	0	0	0	0	2
Oral surgery	3	26	20	17	6	7	15	2	2	1	99
Orthodontics	0	1	4	10	7	4	7	8	5	3	49
Otolaryngology	6	28	34	21	25	23	18	17	10	4	186

Paediatric and perinatal pathology	0	0	0	0	1	0	1	0	0	0	2
Paediatric cardiology	0	1	3	2	3	3	0	1	0	1	14
Paediatric dentistry	0	5	4	5	4	3	2	5	0	0	28
Paediatric surgery	13	10	11	8	9	7	6	5	1	0	70
Paediatrics	17	177	155	141	110	118	114	61	30	4	927
Palliative medicine	3	10	23	14	23	9	12	6	0	2	102
Plastic surgery	8	22	19	15	23	15	15	8	0	0	125
Psychiatry of learning disability	0	3	11	9	17	16	12	6	4	1	79
Psychotherapy	0	1	7	5	5	3	3	3	0	1	28
Public health medicine	0	5	6	16	18	20	23	36	14	5	143
Rehabilitation medicine	2	5	4	3	8	6	9	5	3	2	47
Renal medicine	6	26	26	17	18	20	18	13	1	2	147
Respiratory medicine	9	46	42	30	36	31	28	20	6	1	249
Restorative dentistry	0	4	8	13	11	8	16	12	2	2	76
Rheumatology	1	13	7	12	23	17	19	8	3	1	104
Surgical dentistry	0	0	0	0	0	0	0	0	0	0	0
Trauma & orthopaedic surgery	30	111	101	76	81	77	56	43	15	6	596
Tropical medicine	0	0	0	0	0	0	0	0	0	0	0
Urology	5	22	29	21	16	23	13	23	6	3	161
Vascular surgery	4	6	10	9	3	4	5	3	7	0	51
Not known dental specialty	12	21	3	3	3	2	3	0	1	0	48
Not known medical specialty	4	115	96	47	25	25	7	15	14	2	350

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 2019

	Sep-06	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15	Sep-16	Sep-17	Sep-18	Sep-19
All Specialties	**272.3**	**166.0**	**139.0**	**112.5**	**143.1**	**213.1**	**339.3**	**345.5**	**389.9**	**430.5**	**398.1**	**483.1**
All Medical Specialties[1]	**262.3**	**160.0**	**138.0**	**111.2**	**141.1**	**207.4**	**332.3**	**336.7**	**378.8**	**420.9**	**393.2**	**475.6**
Emergency Medicine	6.0	4.0	2.0	2.0	7.3	15.5	20.3	19.8	15.7	17.5	11.1	17.9
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	68.3
Medical Specialties	66.4	42.0	33.5	32.0	30.7	57.6	94.4	112.9	104.3	114.5	110.5	119.8
Geriatric Medicine	*9.0*	*4.0*	*8.5*	*7.0*	*3.0*	*11.0*	*12.0*	*10.0*	*8.0*	*18.8*	*18.0*	*23.9*
Psychiatric Specialties	52.8	36.3	15.5	8.0	8.7	25.2	37.3	40.3	41.8	58.8	65.1	78.4
Surgical Specialties	47.5	19.0	19.0	27.6	22.0	28.1	50.0	47.7	65.6	65.1	72.1	90.7
Paediatrics Specialties	16.8	16.0	14.0	13.0	15.9	13.0	19.0	20.8	33.2	25.1	16.0	21.5
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**	**7.5**

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 2019

			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	**5,865.0**	**5,382.0**	**483.1**	**253.4**	**8.2%**	**4.3%**
All medical specialties[2]	**5,770.6**	**5,295.0**	**475.6**	**250.9**	**8.2%**	**4.3%**
Emergency medicine	252.7	234.8	17.9	4.0	7.1%	1.6%
Clinical laboratory specialties	717.0	648.7	68.3	50.7	9.5%	7.1%
Medical specialties	1,425.2	1,305.4	119.8	72.6	8.4%	5.1%
Geriatric medicine	*206.5*	*182.6*	*23.9*	*15.0*	*11.6%*	*7.3%*
Psychiatric specialties	607.0	528.6	78.4	47.8	12.9%	7.9%
Surgical specialties	1,068.1	977.4	90.7	48.5	8.5%	4.5%
Paediatric specialties	370.9	349.4	21.5	3.8	5.8%	1.0%
All dental specialties	**94.4**	**86.9**	**7.5**	**2.5**	**7.9%**	**2.6%**

Source: ISD Scotland National Statistics, NHSScotland Workforce - Data as at 30 September 2019

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							
		11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Medical and dental staff (HCHS)																	
Scotland	Joiners	509.3	554.3	573.9	755.8	831.5	731.6	749.3	1,014.0	648	686	718	934	1,013	880	883	1,172
Scotland	Leavers	433.6	409.6	428.1	479.4	458.4	534.1	630.6	681.5	606	556	602	661	645	710	813	865
Scotland	Turnover	7.0	6.5	6.7	7.4	6.8	7.5	8.7	9.3	8.1	7.4	7.9	8.5	8.1	8.5	9.5	10.0
East Region	Joiners	84.6	138.8	128.3	261.1	164.6	195.6	128.1	280.6	93	201	183	345	194	225	160	324
East Region	Leavers	90.7	84.5	79.3	88.0	119.6	126.5	128.8	126.6	121	115	114	141	171	179	190	167
East Region	Turnover	6.6	6.2	5.7	6.1	7.4	7.7	7.5	7.5	7.4	7.1	6.7	8.0	8.7	9.0	9.3	8.3
North Region	Joiners	200.9	151.9	207.7	209.3	201.4	198.2	205.6	254.9	278	179	259	249	263	272	256	311
North Region	Leavers	144.0	143.0	151.1	185.3	167.8	161.0	179.9	171.8	212	199	200	244	242	217	235	221
North Region	Turnover	8.5	8.2	8.7	10.4	9.3	8.8	9.7	9.2	10.1	9.2	9.3	11.0	10.9	9.7	10.3	9.6
West Region	Joiners	246.6	281.0	260.5	314.7	455.6	353.1	442.8	465.2	311	330	304	380	506	403	490	532
West Region	Leavers	216.0	209.5	219.3	246.6	209.0	292.4	317.9	403.2	299	282	315	325	285	353	395	499
West Region	Turnover	7.2	6.9	7.1	7.9	6.5	8.5	9.1	11.2	8.3	7.8	8.6	8.9	7.7	9.0	10.0	12.3
National/Special	Joiners	5.8	19.2	11.4	26.0	76.6	54.1	26.8	58.6	6	20	13	32	147	64	51	73
National/Special	Leavers	10.7	10.3	12.7	13.3	16.7	29.0	54.6	23.9	15	14	15	18	20	52	60	39
National/Special	Turnover	8.1	8.1	9.2	9.7	11.2	13.8	23.2	11.4	9.8	9.7	10.0	12.2	12.3	18.0	19.9	13.4
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	9,881.7	7,037	11,172	11,361	11,871	11,562	11,534	11,451	11,732
Scotland	Leavers	7,755.0	7,049.8	7,216.1	7,891.5	8,449.6	8,418.6	8,853.5	8,522.6	9,962	8,986	9,256	9,996	10,588	10,573	11,079	10,657
Scotland	Turnover	6.1	5.6	5.7	6.1	6.4	6.3	6.6	6.4	6.6	6.0	6.1	6.5	6.8	6.8	7.1	6.8
East Region	Joiners	1,069.3	2,278.2	2,436.9	2,584.2	2,293.0	2,551.9	2,669.0	2,807.2	1,393	2,824	2,971	3,110	2,754	3,010	3,186	3,313
East Region	Leavers	1,803.7	1,626.0	1,816.8	1,914.6	2,220.1	2,181.8	2,160.4	2,216.6	2,325	2,064	2,327	2,447	2,754	2,770	2,739	2,762
East Region	Turnover	6.6	6.1	6.7	6.9	7.8	7.7	7.5	7.6	7.1	6.5	7.1	7.3	8.1	8.1	8.0	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	2,647.0	2,664	4,346	3,521	3,761	3,505	3,683	3,124	3,238

North Region	Leavers	2,171.1	2,332.3	2,371.4	2,663.2	2,781.3	2,637.8	2,831.5	2,726.6	2,845	3,026	3,054	3,401	3,516	3,325	3,574	3,432
North Region	Turnover	7.1	7.7	7.5	8.3	8.6	8.1	8.6	8.4	7.7	8.2	8.0	8.8	9.0	8.5	9.1	8.8
West Region	Joiners	2,182.0	2,982.4	3,900.3	4,008.5	4,321.4	4,131.0	4,201.8	4,329.6	2,809	3,707	4,678	4,759	5,091	4,823	4,900	5,051
West Region	Leavers	3,505.6	2,955.9	3,015.1	3,378.7	3,682.4	3,760.9	3,935.4	3,709.0	4,467	3,713	3,795	4,185	4,539	4,610	4,803	4,556
West Region	Turnover	5.9	5.1	5.2	5.8	6.2	6.3	6.6	6.2	6.4	5.5	5.6	6.1	6.6	6.6	6.9	6.5
National/Special	Joiners	517.7	836.7	959.9	1,114.0	1,197.3	1,047.7	1,160.2	1,078.7	695	985	1,067	1,282	1,430	1,144	1,321	1,224
National/Special	Leavers	685.2	725.2	771.6	841.3	812.7	833.0	892.2	835.1	834	900	961	999	975	1,010	1,063	997
National/Special	Turnover	6.1	6.5	6.9	7.4	7.0	7.0	7.3	6.8	6.7	7.3	7.7	7.9	7.6	7.6	7.9	7.3

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

112. 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.

113. 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 sets out plans for the development and training of GPs and the wider primary care multi-disciplinary team and was published April 2018[15].

114. This is backed up by the recent publication of Scotland's first Integrated Health and Social Care Workforce Plan for Scotland in December 2019. It sets out our aim to ensure everyone in Scotland receives the high-quality health and care services they need, at the right time and in the right place. [16]

Data Gap on Vacancies

115. The 2018 GP Contract means an increase of data collection. As part of this it is mandatory for practices to provide workforce data – including on GP and practice staff vacancies. This will facilitate future workforce planning. Scottish Government published The Primary Medical Services (GP Practice Data) (Scotland) Directions 2019 on 23 September 2019.

Recruitment and Retention – particularly for remote and rural

116. Scottish Government has invested £7.5 million in 2019/20 to support GP recruitment and retention. £2 million of this fund supports rural general practice with a comprehensive package of measures:

- We invested £400,000 to support IT improvements across remote and rural Health Boards, £117,252 to build change management support across island Health Boards, and £300,000 to support rural dispensing practices.

- The Pre-Hospital Emergency Care (PHEC) Fund of £100,000 reimburses remote and rural GP Practices for having GPs and practice employed practitioners (with BASICS training) on call for their expertise in an event of emergency near them.

- The Scottish Government is allocating £69,450 to NHS Shetland to support the Rediscover the Joy in General Practice Project. A collaboration of four rural Health Boards, Shetland, Orkney, Western Isles and Highland, will develop a scheme to attract experienced GPs to work in rural practices on a flexible basis for a capped number of weeks a year. GPs employed on the scheme would be provided with BASICs training and mentorship.

[15] Scottish Government - National Health and Social Care Workforce Plan part 3
[16] Integrated Health and Social Care Workforce Plan for Scotland

- We have significantly enhanced recruitment incentives by investing £400,000 in recruitment incentives for rural GP posts across Scotland, and £200,000 for relocation costs for GPs moving to rural posts in 2019/20.

- We have increased GP relocation packages from £2,000 to £5,000 and widened eligibility for recruitment incentives from island practices to all remote and rural practices.

- The Scottish Government has allocated £342,218 to NHS Highland to support the Scottish Rural Medicine Collaborative to develop recruitment and sustainability measures. We have also provided support for the GP for GP Scheme. This is a scheme which provides a confidential service in NHS Highland to General Practitioners 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.

117. 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

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

119. 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

120. NHS Education for Scotland (NES) is the education and training body for NHSScotland.

121. NES manages recruitment targets for postgraduate and pre-registration training programmes across the healthcare professions to ensure there is an appropriate supply of well-trained staff to meet current and future demand. NES, therefore, is constantly working on improvements on how to ensure the attractiveness of NHS Scotland as an employer, developing career pathways and widening access to opportunities. They hold an important role in ensuring the quality of the learning and

employment environment for undergraduate, post-graduate and pre-registration training.

122. For 2019, 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, either via a Royal College, NHS Education for Scotland, 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.

123. 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 NHS Education for Scotland (NES). This includes Broad-Based Training programme across Scotland with 14 posts advertised and 10 accepted. The new Improving Surgical Training pilot saw a 98% fill rate (45 posts). Local processes again resulted in 100% fill rates in Trauma and Orthopaedic Surgery level 1 (11 posts) and 100% in Obstetrics and Gynaecology level 3.

124. The recruitment arrangements for 2019 were rolled over from the 2018 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 2019 recruitment process offered 3 opportunities to apply for August 2018 start dates; from November 2018 for core and run through specialties, then February 2019 for ST3/ST4 levels, and March 2019 to apply to 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 2019 offering the opportunity to apply to core and ST3/ST4 higher training vacancies with a February 2020 start date.

125. In line with Scottish Government's aim to support and sustain Scottish General Practice, the First Minister announced in October 2015 an increase of GP Specialty Training places from 300 to 400. Scotland for the fourth year running has taken part in a further round of national GPST recruitment. The overall number of GPST places advertised was 340 and this resulted in an improved fill rate of 96% of the establishment of 1184.

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

UK-wide - Special Circumstances

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

The table below shows the number of special circumstances applications received and approved in 2019:

Recruitment Round	Eligibility		Appeals		Total Approvals
	Applications Received	Applications Approved	Appeals Received	Appeals Approved	
Round 1	101	34	25	11	45
Round 1 Re Advert	17	5	5	4	9
Round 2	37	13	9	8	21
Totals	**155**	**52**	**39**	**23**	**75**

The 2019 recruitment process saw a 19.2% rise in applications, compared with 2018. Of the 75 applicants approved as having special circumstances, 51 accepted a post in their preferred region; 25 of these would not have been offered the region based on their interview score alone. This means that these 25 applicants directly benefitted from the existence of the special circumstances process. There are still a high percentage of applicants who fail to provide the correct evidence for the eligibility panel and therefore do not get approval at that stage.

Targeted Enhanced Recruitment Scheme (TERS)

This scheme is offered to GP Specialty Trainee applicants accepting a post in a hard to fill area. This is a one-off payment of £20,000 and was offered across Scotland in the following programmes – Caledonian, Rural Track. Ayrshire and Arran, Dumfries and Galloway, Glasgow Clyde, Lanarkshire, and Eastward and Westward programmes in the East region. Across the 2019 recruitment rounds 123 posts were offered with 118 accepted.

Medical Trainee Recruitment – Outcomes

127. The overall 2019 trainee recruitment position was very positive, compared to 2015, the number of doctors newly appointed to Scottish training programmes in 2019 has increased by 19%. The overall fill rate of 92% is up from 85% in 2018. A total of 1042 medical trainees accepted posts in 2019 compared to 980 in 2018. (2019 published Recruitment Data)

128. The General Surgery fill increased to 100%, compared to 48% in 2018 which had been a concern. Early indications are that this improvement can be attributed to the success of the Improving Surgical Training initiative introduced in 2018.

129. 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. However, both of these specialties did see an improvement compared to 2018. Core Psychiatry with a 70% fill compared to

63% in 2018 while General Practice fill significantly improved from 84% in 2018 to 96% in 2019.

130. A key specialty which did not fill well is Acute Internal Medicine (although there was a 10% increase in the fill rate from 2018). The trend in Mental Health is a concern, although Core Psychiatry did improve the ST4 level specialties saw an overall decline from 72% to 61%. To help combat this trend the Royal College of Psychiatrists Scotland and NES are collaborating in a *Choose Psychiatry Campaign* initiative.

Medical Trainee Recruitment – Strategic response to Gaps in Training

131. The Scottish Government is fully aware there are challenges in recruitment and retention across NHS Scotland, 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.

132. 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.

133. UK Health Ministers have made clear that they attach considerable importance to delivering changes in medical education and training which 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.

134. 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.

135. There is now an overarching theme of work in improving junior doctors' working lives which 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.

136. 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.

137. 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. NHS Education for 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 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.

138. 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.

139. Recent GMC Trainee surveys in 2019 continue to report excellent training programmes in Scotland. Overall satisfaction is one of the 18 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 and Clinical Radiology were top among rankings for UK Deaneries and first equal for Core Medicine Training.

140. 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:

- 4 from the Mental Health Specialty Training Board (Child and Adolescent Psychiatry, General Psychiatry, Old Age Psychiatry and Psychiatry of Learning Disability);
- 6 from the Surgery Specialty Training Board (General surgery, Ophthalmology, Oral and Maxillo-Facial Surgery, Trauma and Orthopaedic Surgery, Urology and Vascular Surgery);
- 13 from the Medicine Specialty Training Board (Acute Internal Medicine, Clinical Oncology, Clinical Pharmacology and Therapeutics, Core Medical Training, Dermatology, Endocrinology and Diabetes Mellitus, Gastroenterology, Geriatric Medicine, Haematology, Medical Oncology, Medical psychotherapy, Neurology and Renal Medicine);
- 3 from the Diagnostic Specialty Training Board (Chemical Pathology, Clinical Radiology and Histopathology);
- 3 from the General Practice, Occupational Medicine and Public Heath Specialty Training Board (Broad Based Training, General Practice in a GP Practice, General Practice in Secondary Care);
- 4 from the Anaesthetics, Intensive Care Medicine and Emergency Medicine Specialty Training Board (Anaesthetics, Emergency Medicine, Intensive Care Medicine and Acute Common Care Stem Training;
- 3 for the Obstetrics, Gynaecology and Paediatrics Specialty Training Board (Community Sexual and Reproductive Health, Obstetrics and Gynaecology and Paediatrics).

Medical undergraduates

141. The Scottish Government Workforce Directorate 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.

142. For 2020-2021, the Scottish Ministers approved a medical undergraduate intake of 1,038. This maintains the 50 additional SG-funded places that the 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 Graduate Entry Medical programme (ScotGEM) places introduced in 2018, initially 40 places with another 15 added 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. The remaining 85 places, which have an increased GP focus, consist of 60 undergraduate places which commenced in 2019 and 25 places in 2020/21 for the new Healthcare Professionals programme.

Graduate Entry Medical Programme (ScotGEM)

143. 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 that will fund 55 students starting in the academic year 2018/19. It will have a focus on careers in primary care and a remote & 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 service to the NHS.

Healthcare Professionals Programme

144. This innovative course, at Edinburgh University, will allow experienced healthcare professionals to enter medicine and combine part time study with their existing job, with large parts of the course delivered online. It is designed to target high calibre candidates who are more likely to be retained in NHS Scotland.

SAS Doctors Development Fund

145. There are approximately 1300 SAS grade doctors and dentists working in NHS Scotland. 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 which 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, and a survey of clinical Directors who's SAS Doctors & Dentists have used the fund to enhance their skills, reported service benefits.

146. 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 (an 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.

147. In 2018/19, the SAS Board fully funded 22/24 (92%) of development applications received from SAS doctors working in 9 territorial boards, a (fully subscribed) National SAS Conference, and several local development days across Scotland.

148. Further details of the SAS Development Programme, including the 2019-2019 annual report, is available at https://www.scotlanddeanery.nhs.scot/your-development/specialist-and-associate-specialist-doctors-and-dentists/

H. Specific Staff Groups – Pay, Terms and Conditions

H.1 General Medical Practitioners

Introduction

149. This section provides information relating to general practice (independent contractor General Medical Practitioners (GMPs) and the delivery of contracted services through the NHS Boards. This section provides additional background to developments with the General Medical Services (GMS) arrangements in Scotland, and the implementation of the new contract in 2018.

Background

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

151. As of 1 October 2019, there were 935 GP practices[17] in Scotland and 84% were on the national GMS contract. The number of practices in Scotland has decreased by 9% from 1,023 practices in 2009, reflecting a trend towards larger practices with more GPs serving a larger number of patients. 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.

152. In 2018/2019:
- 787 practices operated under the GMS Contract;
- 98 practices operated under the 17C contract; and
- 61 practices operated under the 2C contract[18].

153. As of 30 September 2019, an estimated 39% of the GP workforce were male and 61% female, compared to 51% male and 49% female in 2008[19].

154. The average (or mean) size of a Scottish GP practice in terms of numbers of registered patients was 6,000 in 2019[20], 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

155. 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 SGPC.

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[17] ISD Scotland - General Practice - GP Workforce and practice list sizes 2009 - 2019
[18] Ibid
[19] Ibid
[20] Ibid

156. 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.

157. One of the core aspects of the new Contract is the new funding model as the Scottish Government recognises that an appropriate and secure level of income is a prerequisite to attracting GPs to the profession and ensuring the future sustainability of general practice.

158. The new contract will be introduced in two phases. Phase One included:

- 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 means that no GP will receive less than £84,630 NHS income per year (including pension contributions) for a whole-time post.

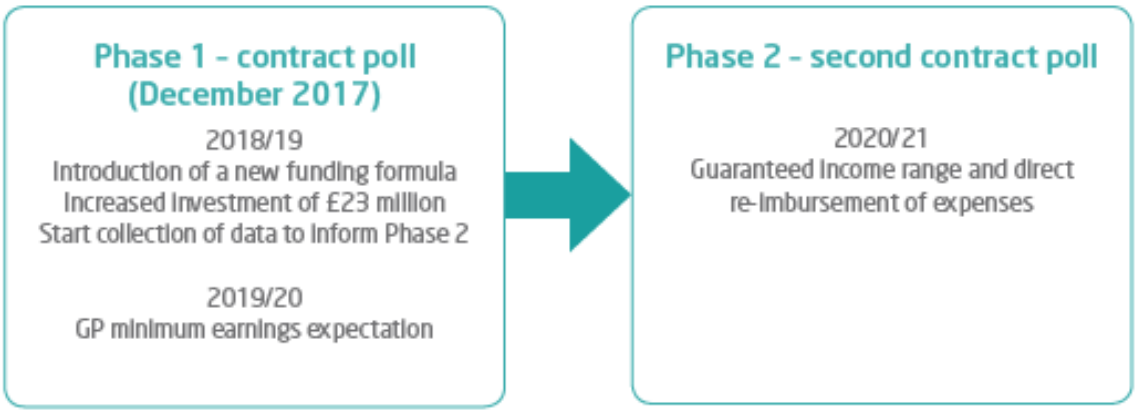
159. These initial changes will be followed by Phase 2, from April 2021, dependent on a further vote from the profession. Phase 2 will include:

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

160. These proposals are based on evidence from the 2017 Review of GP Earnings and Expenses[21], and will be supported by the investment of £250 million in direct support of General Practice by 2021/22.

[21] Deloitte - A Review of GP Earnings and Expenses Final Report

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



Pay and Contractual Uplift 2018/19

161. For 2019/20 the Scottish Government implemented the DDRB recommendation to uplift GP pay net of expenses by 2.5%[22]. In total the Scottish Government uplifted the GP contract by £23.224 million. This also included a 3% uplift to practice staff expense, and a 1.9% uplift to wider practice expense in line with CPI. This also included £4.2 million funding to cover population growth in 2019/20.

162. In agreement with the Scottish General Practitioners' Committee, the contractual uplift was applied consistently across all general practices, meaning that there was no negative impact on practices.

Investment in General Practice

163. Investment figures for 2018/19 were published on 19 September 2019[23]. They show that for the period 2018/19 the total spend on General Practice (including the reimbursement of drugs dispensed) was £992.5 million in Scotland, an increase of 6.53% from 2017/18. Total spend on General Practice 2018/19 (excluding the reimbursement of drugs dispensed) was £967.5 million in Scotland, an increase of 6.81% from 2017/18.

Agreement to Publish GP Earnings

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

165. In 2018/19 the sum of NHS Scotland non-dispensing payments made to 946 General Practices was £837.8 million[24]. Investment has increased by £43.7 million (5.5%) when compared to 2017/18 partly due to the introduction of the new GMS contract.

[22] Scottish Government news release - Pay rise for doctors and dentists - 30th August 2018
[23] NHD Digital - Investment in General Practice 2014/15 to 2018/19 England Wales Northern Ireland and Scotland
24 ISD Scotland - NHSScotland Payments to General Practice Financial Year 2018/19

• £699.2 million was paid to General Medical Services (GMS) contracted practices run by GPs[25];
• £101.0 million was paid to locally negotiated contracted practices (17C) run by GPs[26]; and
• £37.6 million was paid to NHS Board run practices (2C)[27].

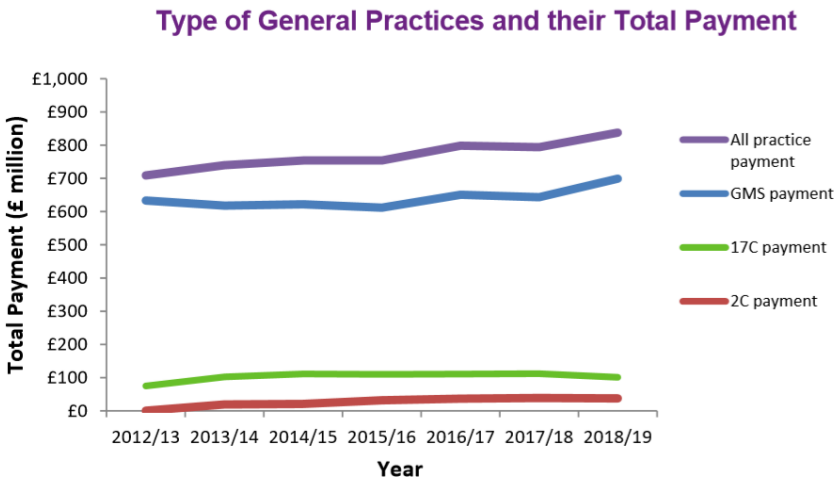


Figure 2 - Types of General Practices and their Total Payment[28]

166. Of the £837.8 million paid in 2018/19, the Global Sum was the largest payment amounting to £597.1 million to 946 General Practices[29].

167. In addition to the £837.8 million, £22.3 million was paid to 90 General Practices for dispensing services in 2018/19, similar to the previous year[30].

168. 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

169. The Scottish Health and Social Care Experience survey is carried out every two years, the 2017/18 survey was published in April 2018[31],

170. 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 survey

[25] Ibid
[26] Ibid
[27] Ibid
[28] Ibid
[29] Ibid
[30] Ibid
[31] Scottish Government - Health & Care Experience Survey 2017

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

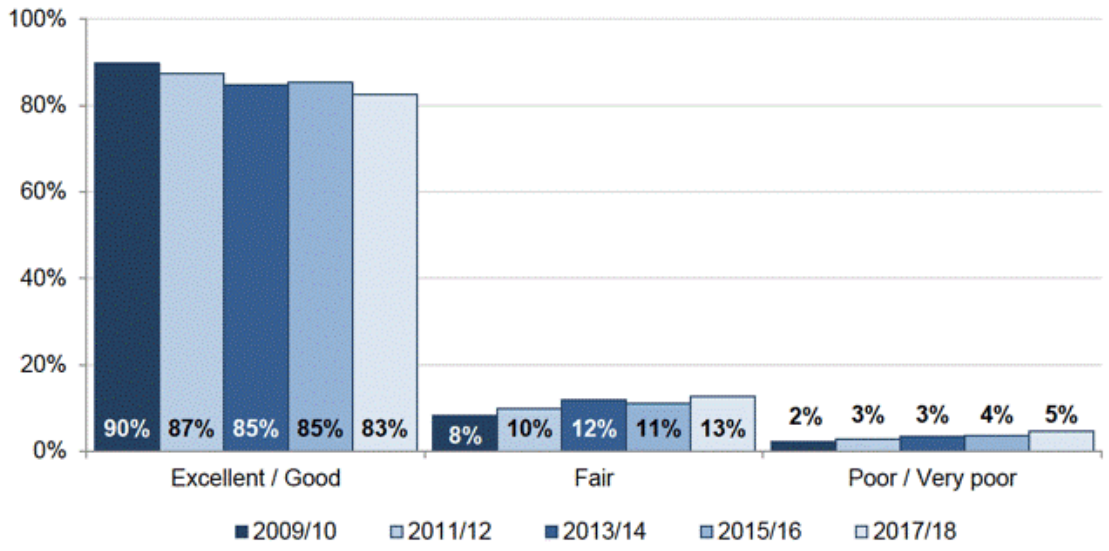
171. 83% of people rated the overall care provided by their GP practice positively, this was down two percentage points from the last survey.

172. 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.

173. 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.

174. 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 3 - Overall rating of care and treatment provided by GP practice (%)[32]



175. The number of GP consultations estimated to have taken place in Scotland in 2012-13 was 16.2 million[33]. This figure is likely to have risen in subsequent years.

176. Fieldwork for the 2019/20 survey is now live. The results are planned for publication in April 2020

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

Access

177. Most 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 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.

178. 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.

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

180. 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 contract, which is underpinned by the principle of ensuring patients can see the right person at the right place at the right time.

181. 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.

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

Care and Treatment

183. 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.

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

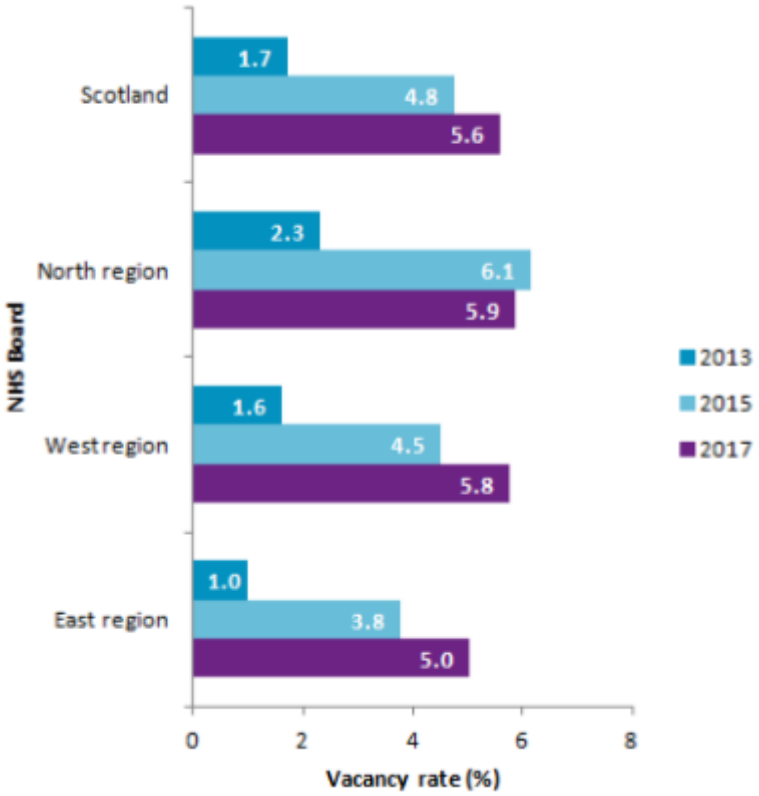
185. The statement with the lowest positive rating was 'I knew the healthcare professional well', with half of people (50%) rating it positively. This statement also has a significantly higher negative rating (26%) than the other statements. However,

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

186. According to the Primary Care Workforce Survey Scotland 2017[34] workforce survey, 24% of GP Practices reported that they had vacant GP sessions at 31 August 2017, in comparison with 22% of practices in 2015[35]. 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 4 - Vacant sessions as a percentage of total sessions (vacancy rate), Scotland; 2013 - 2017[36]

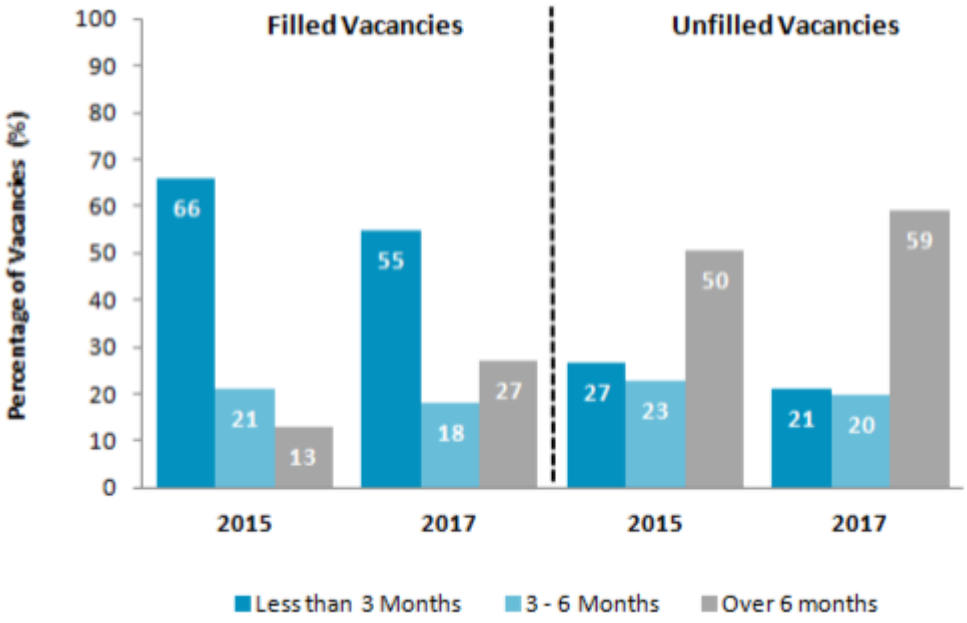


187. Of the vacancies that were unfilled at 31 August 2017, 59% had been vacant for over six months.

188. 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.

[34] ISD Scotland - Primary Care Workforce Survey Scotland 2017
[35] Ibid
[36] Ibid

Figure 5 - Length of vacancy, by filled and unfilled vacancies, Scotland; 2017[37]



Recruitment and Retention

189. 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 a ten year period. This includes the new Graduate Entry programme (ScotGEM) which will introduce 55 undergraduate places from September 2018 with a particular focus on rural medicine.

190. 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.

191. 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 NHS NSS to develop a new national GP Recruitment website – gp.jobs.scot – which was launched on 04 October 2018.

192. 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.

193. Seniority Payments for Scottish GPs are set out in chapter 10 of the annual Statement of Financial Entitlements (SFE)[38]. 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.

[37] Ibid
[38] General Medical Services Statement of Financial Entitlements 2019/20

194. Presently a GP has to work for six years before any seniority payment is made; for 6 years to achieve a payment of £600 per annum, for 21 years to achieve a payment of £5,129 per annum, for 36 years to achieve £10,258 per annum, with the maximum of £13,900 per annum payable being made at the 47 year point[39]. The contractor has to have been in an eligible post for more than 2 years in order to be able to apply.

195. The Scottish Government's annual bill for seniority payments to GPs was £17 million in 2018/19[40]. This is reducing as the number of senior GPs retire earlier, for instance the cost of seniority in the previous year 2017/18 was £ 17.7 million[41].

196. 'Golden Hellos' for Scottish GPs are set out in chapter 11 of the annual Statement of Financial Entitlements (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.

Figure 6 - Table setting out the rate of Golden Hello payments

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

197. 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

198. The Primary Care Workforce Survey Scotland 2017 estimated that 81% of GPs were Independent Contractors[42]. 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.

199. 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.

[39] Ibid
[40] NHS Scotland Payments to General Practice 2018/19
[41] Ibid
[42] ISD Scotland - Primary Care Workforce Survey Scotland 2017

200. 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.

GP Expenses

201. Scottish Government is currently collecting data on GP expenses. Until this exercise is complete, the availability of data on GP income and expenses remains that which is provided annually by NHS Digital on behalf of the four countries[43], and which, for the tax year 2017/18, was published on 29th August 2019. We invite DDRB to consider this report in its entirety, but for the purposes of independent contractor GPs in Scotland the report showed that:

202. The average taxable income for contractor GPs in General Medical Services in the UK was £107,500 in 2017/18. In Scotland the average taxable income for contractor GPs was £93,100.

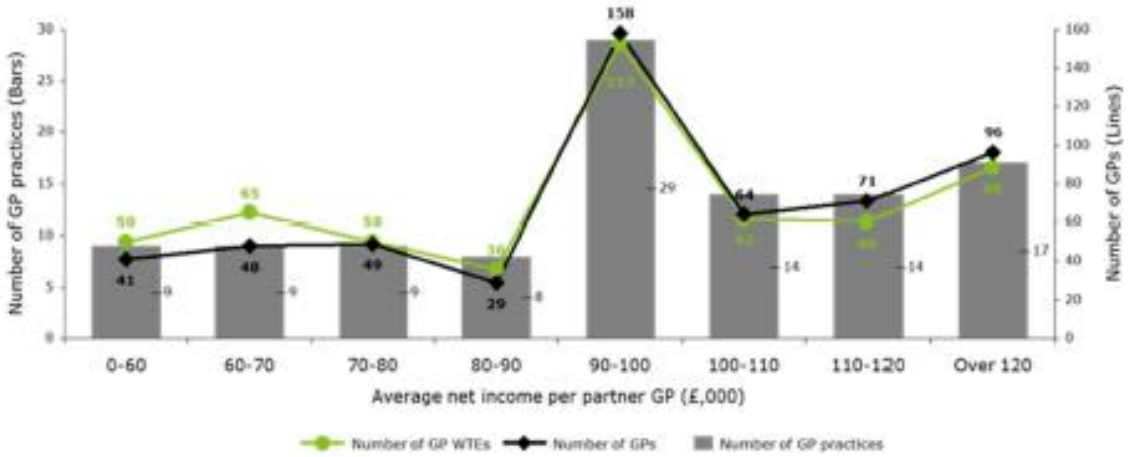
			Mean			
Country	Year	Report Population	Gross Earnings	Total Expenses	Income Before Tax	Expenses to Earnings Ratio
England	2016/17	19,850	£338,300	£228,700	£109,600	67.6%
	2017/18	20,350	£357,300	£243,900	£113,400	68.3%
	Change	+500	+5.6%	+6.6%	+3.4%	+0.7 Percentage Points
Scotland	2016/17	3,500	£202,300	£111,500	£90,800	55.1%
	2017/18	3,400	£208,400	£115,400	£93,100	55.4%
	Change	-100	+3%	+3.5%	+2.5%	+0.3 Percentage Points

Figure 7 – GPMS Contactor GPs – average earnings and expenses by country, 2016/17 and 2017/18[44]

203. During 2017 the Scottish Government commissioned Deloitte to undertake a Review of GP Earnings and Expenses[45]. This found that the average annual net income per Whole Time Equivalent (WTE)[46] GP Partner (including NHS and Private earnings[47]) 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.

[43] NHS Digital - GP Earnings and Expenses Estimates - 2017/18
[44] Ibid
[45] Deloitte - A Review of GP Earnings and Expenses Final Report
[46] 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.
[47] 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[48]



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

204. 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.

205. The Scottish Government and SGPC agree that we need better information and evidence to inform both accurate recompense of expenses and options for the long-term overall development of GP pay in Scotland. To this end, the new contract mandates data collection. This includes 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.

Workforce Data for Scotland

206. The Primary Care Workforce Planning Survey Scotland 2017 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[49]. The 2019 survey results are expected in March 2020.

207. 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

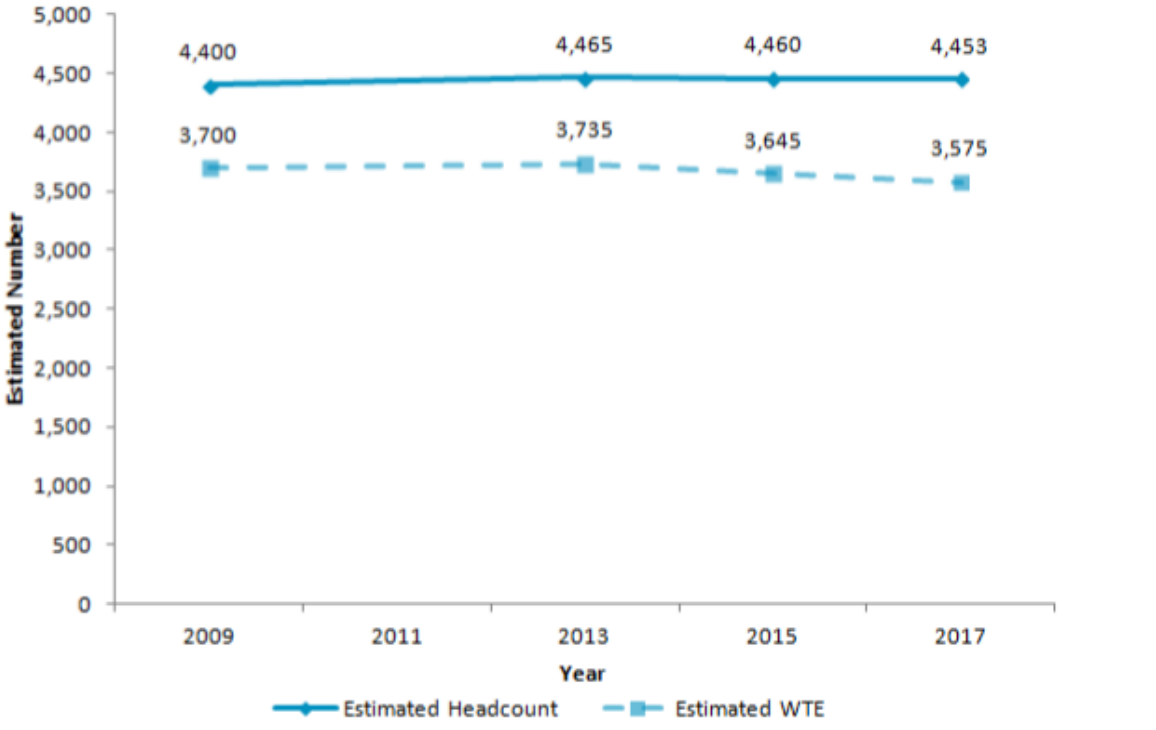
[48] Deloitte - A Review of GP Earnings and Expenses Final Report, p.15
[49] ISD Scotland - Primary Care Workforce Survey Scotland 2017

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.

208. 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[50] 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[51]



Source: Primary Care Workforce Survey Scotland 2017

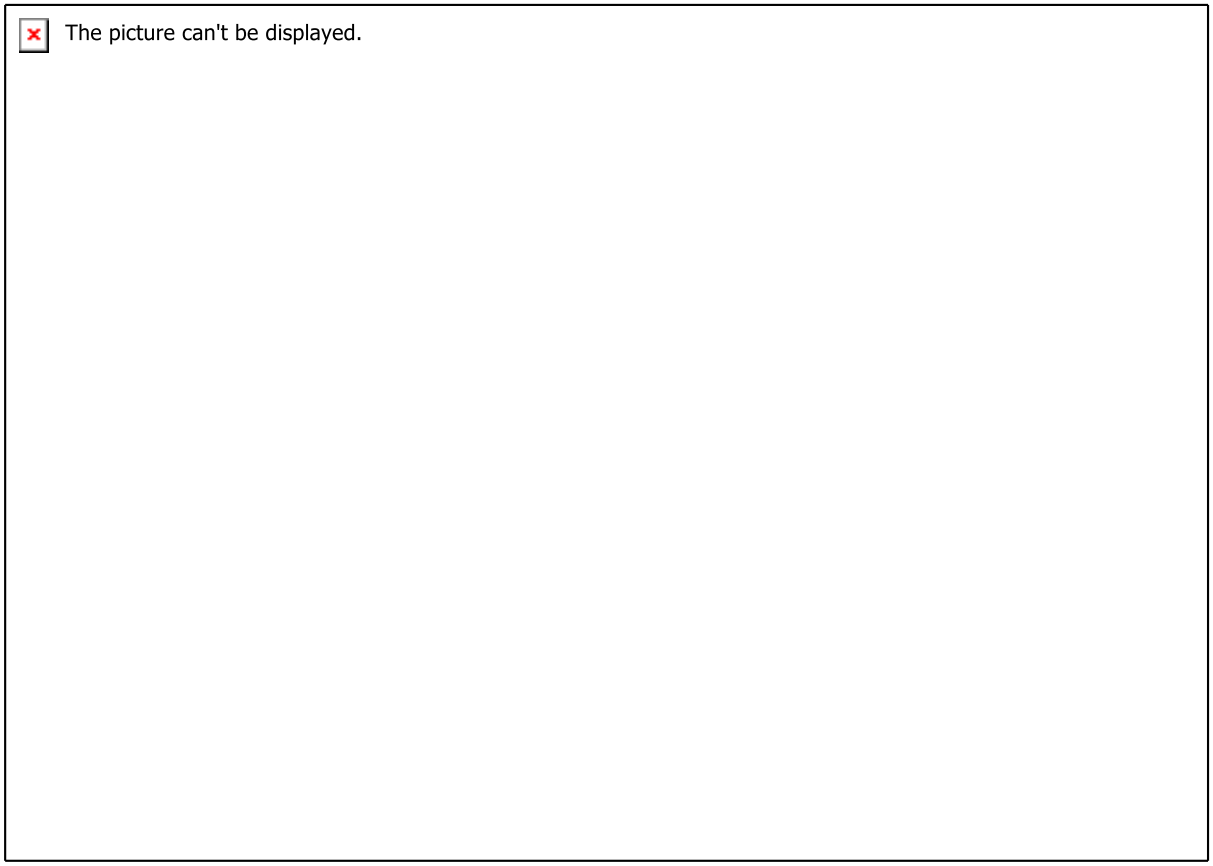
209. The estimated number (headcount) of registered nurses employed by general practices in Scotland at 31 August 2017 was 2,297. This is a slight increase from

[50] ISD Scotland - General Practice - GP Workforce and practice list sizes 2009 - 2019
[51] ISD Scotland - Primary Care Workforce Survey Scotland 2017

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.

210. 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.

Figure 10 - Estimated registered nurse headcount and Whole Time Equivalent, Scotland; 2009 – 2017[52]

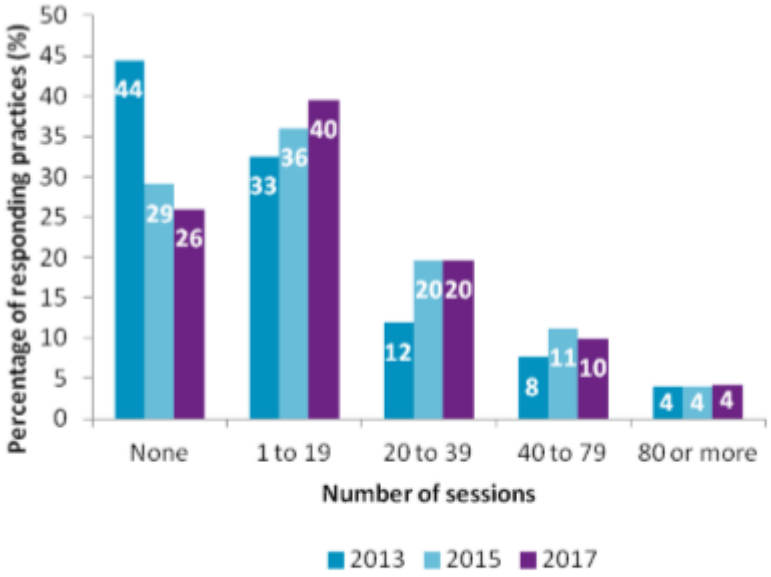


211. Responding practices had used GP locums and/or sessional GPs in the year ending 31 August 2017. An estimated 333 WTE was input to all general practices over this one year period. This is lower than the 350 WTE estimated from the 2013 survey.

212. 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.

[52] Ibid

Figure 11 - Number of internal locum sessions required over 12 months, Scotland; 2013 - 2017[53]



Source: Primary Care Workforce Survey Scotland 2017

213. 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.

214. The 2018 GP Contract mandates the provision of workforce data to be made mandatory. This will facilitate workforce planning in the future.

Working Hours

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

216. 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.

217. 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.

218. During 2017 the Scottish Government commissioned Deloitte to undertake a Review of GP Earnings and Expenses[54]. Like the workforce survey this was also

[53] Ibid
[54] Deloitte - A Review of GP Earnings and Expenses Final Report

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.

Figure 12 - Average weekly working hours by Partner GPs[55]

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

H. Specific Staff Groups – Pay Terms and Conditions

H.2 General Dental Practitioners

Introduction

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

220. 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).

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

Policy Development and Landscape

222. We continue to work to a policy development programme governed by the Oral Health Improvement Plan, published in January 2018. This document provided an overview for the development of NHS dental services with a focus on moving to a more prevention-based system of oral health care amongst the adult population, redesigning patient pathways to ensure a more sustainable oral health care system and reducing oral health inequalities.

223. A key part of our strategy has been the development of two 2018 Programme for Government commitments around improving oral health domiciliary care provision and targeting those communities most affected by oral health inequalities.

Domiciliary Care – New Arrangements

224. On 1 July 2019 we rolled out new arrangements for GDPs to complete a training and mentoring programme to be designated as GDPs with enhanced skills in domiciliary care provision. At present the majority of domiciliary care is either provided by GDPs working in the Public Dental Service (PDS) or a comparatively small proportion of independent contractor GDPs. The intention of the new policy initiative is to increase the up-take of domiciliary care provision amongst GDPs.

225. The programme was advanced through an early adopter initiative that enabled 30 GDPs to undergo training and mentoring. The first two cohorts of training since the roll-out of the arrangements nationally are also underway. Once training and mentoring is successfully completed GDPs are assigned to care homes. The new arrangements will be rolled out in the first phase to care homes as a suitable testing arrangement, before being expanded to people who require care in their own home.

226. The intention is to have a rolling programme of training and mentoring over the next 3-5 years ultimately increasing the numbers of GDPs with enhanced skills in domiciliary care to around 300 GDPs, approximately 10 per cent of the total

workforce of independent-contractor GDPs in Scotland. The new arrangements are supported with additional funding of £2m per year.

Oral Health Improvement – Childsmile Programme

227. We have made substantial improvements in oral health in Scotland through on-going initiatives such as our Childsmile Programme. This is an increasingly successful oral health programme which was introduced to reduce the decay rate and improve the oral health of young children. The programme may be summarised as follows:

- A 'core' element where toothpaste and toothbrushes are provided on a regular basis until the child is five years of age;

- A 'nursery' element where:
- every three- and four-year-old child attending nursery (whether it is a local authority, voluntary or private nursery) is offered free, daily, supervised toothbrushing;
- fluoride varnish application is offered to children in the 20 per cent most deprived areas of Scotland;

- A 'school' element where supervised toothbrushing and fluoride varnish application is offered to children up to primary 4 in the 20 per cent most deprived areas of Scotland;

- A 'dental practice' element where children receive supervised toothbrushing and regular dietary advice, with those between 2 and 5 years of age also being eligible for two fluoride varnish applications per year.

228. Evidence for the improvement in child oral health is now compelling and Scotland leads the world in preventive oral health amongst children. The state of oral health in children is monitored through the National Dental Inspection Programme (NDIP).

229. 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 2019 showed that 80 per cent of primary 7 children had 'no obvious decay experience' compared to 64 per cent in 2009. Similarly, for primary 1 children the 2018 report showed that 71 per cent had 'no obvious decay experience' compared to 58 per cent in 2008.

Table 1 – NDIP – Percentage of P7 children with 'no obvious decay experience'[56]

2009	2011	2013	2015	2017	2019
64	69	73	75	77	80

Table 2 – NDIP – Percentage of P1 children with 'no obvious decay experience'[57]

2008	2010	2012	2014	2016	2018

[56] ISD Scotland, NDIP report
[57] ISD Scotland, NDIP report

58	64	67	68	69	71

Oral Health Inequalities & the Oral Health Community Challenge Fund

230. NDIP also reports on the state of oral health between children by socio-economic quintile as measured by the Scottish Index of Multiple Deprivation. The latest report showed a slight narrowing of oral health inequalities, but the gap is significant and therefore a policy priority; 80 of children in the most affluent 20 per cent of the population had no obvious dental decay, compared with 53 per cent for the most deprived.

231. On 1 July 2019 the Scottish Government launched the Oral Health Community Challenge Fund. The Community Challenge Fund is a key Scottish Government commitment, within the 2018 Programme for Government, to support communities across Scotland to reduce oral health inequalities. The purpose of the Fund is to enable Third Sector organisations to deliver projects that support people living in areas of multiple deprivation to reduce oral health inequalities and support better early years oral health.

232. The Fund comprises 22 projects and is supported by £2.5 million of additional funding over the duration of the Fund. Projects will last to 31 March 2022, delivered in a range of settings across Scotland with the majority of projects lasting for the whole period of the funding (33 months).

New Model of Oral Health Care for Adult Patients

233. In her Ministerial forward to the publication of the OHIP, the previous Cabinet Secretary, Shona Robison, articulated the NHS dentistry challenge for government:

> *"As the oral health of the population improves, there are new challenges in taking forward NHS dentistry. The system at present is mainly about restorative services provided by General Dental Practitioners (GDPs), while the focus in the future must be to encourage a more prevention-based provision recognising the benefits of anticipatory care".*

234. We intend to realise this vision through a New Model of Oral Health Care for Adult Patients. The keystone of the new model will be an Oral Health Assessment (OHA) for patients. This will include a comprehensive assessment of oral health, including periodontal health, caries and soft tissue to provide an overall review of a patient's oral health. The OHA will also include factors or behaviours that influence oral health such as smoking and alcohol consumption.

235. The new system will require a significant cultural shift from the present with the emphasis on a prevention-based model of care including periodontal care. Patients will receive a personalised oral health care programme and a recall interval that will be informed by the present state and future risk to their oral health of their lifestyle behaviours and choices.

236. At present we are working with two Design Groups to develop the New Model. This component of the development work is likely to last for most of 2020. We intend to implement the new model through early adopter practices to provide an appropriate testing environment before any decision is made regarding national roll-out.

Access to NHS General Dental Services

237. As we reported in last year's evidence access to NHS dentistry, as measured by the number of patients registered with a NHS dentist, continues to increase. On 1 April 2010 the Scottish Government introduced lifetime registration of all patients who were registered with a dentist for GDS at that time. From this date patients who register with a NHS dentist remain registered unless they are deregistered by the dentist or they choose to move dentist.

238. As at September 2018, 94.3 per cent of adults were registered with a NHS dentist, and 94.1 per cent of children[58]. In the last five years the number of adults registered has increased by 21.2 per cent. The policy commitment of the Scottish Government is to ensure that everyone who wishes to have access to GDS is able to do so. This commitment has largely been met with 19 in every 20 people registered with a NHS dentist.

239. Actual attendance at the dentist is measure by participation; the measure is the number and proportion of people who are registered with a NHS dentist who actually attended in the previous two years. The latest figures were reported in last year's evidence and showed two thirds of adults attended in the last two years, and 84.1 per cent of children.

NHS and Private Provision

240. DDRB have specifically asked about NHS and private provision. NHS practices that meet the criteria for NHS commitment in Scotland are entitled to receive reimbursement of rent, either actual lease payments or notional payments, whichever is the lower, or notional payments if the practice is owned. The scheme requires practices to declare the proportion of their earnings that are NHS, as we abate for private earnings.

241. Table 3 shows the distribution of dental practices in Scotland broken by percentage share of NHS versus private income for 2018/19.

Table 3: NHS versus Private

% of practice income from NHS	Number of practices
90%+	324
75-89%	289
50-74%	150
<50%	126
No data	139
Total	1028

[58] Registration and Participation Statistics are due to be published in January 2020 for September 2019.

242. The position in Scotland is one where NHS is predominately the model for the majority of practices.

Workforce Position Report – Independent Contractors

243. Table 4 provides trend information on the numbers of independent contractor GDPs in Scotland providing GDS:

Table 4 – Non-Salaried GDPs (headcount)[59]

2011	2013	2015	2017	2019	% change
2,581	2,736	2,871	2,933	3,029	17%

244. This shows an increase of 17 per cent for the period 2011 to 2019 inclusive. Information on GDP workforce in Scotland is only available by headcount; there is no information available by full-time equivalent.

245. For 2019 we are expecting 164 graduates across Scotland[60] and 167 vocational trainees have completed their one-year post degree in-practice training[61]. This is significantly greater than the number of retirees; the trend position for retirees is shown at table 5 (this overstates the position with retirees as these figures also include 24-hour retirements).

Table 5 – GDP retirees[62]

2015/16	2016/17	2017/18	2018/19
81	67	61	67

Managing the Increase in GDP Numbers

246. We recognise that if the present workforce growth continues then we will need to take appropriate steps to manage this in the future. At present the workforce position is reflected in the increasing numbers of people being registered with a NHS dentist, and the increase in the amount of care and treatment being provided under GDS.

247. Our intention is to continue to grow the workforce in the short-term. As we have described above we have a number of policy commitments including the expansion of domiciliary care provision and an increasing workforce is an important catalyst for improving access to certain aspects of oral health care such as domiciliary care that has historically not featured as strongly with GDPs.

[59] ISD Scotland, NHS Scotland Workforce Statistics – as at 30th September

[60] There are three dental schools in Scotland, a graduate-only school at Aberdeen University, and two other schools at Dundee and Glasgow University that offer courses to both undergraduate and second-degree applicants.

[61] ISD Scotland, NHS Scotland Workforce Statistics -

[62] Figures from Scottish Public Pensions Agency

248. We have taken steps to limit workforce growth by setting a dental student intake limit of 135 students from Scotland, rest of the UK, and the EU[63]. Our expectation is that this will reduce the rate of growth in the dental workforce ensuring that the overall workforce position is sustainable in the short- to medium-term.

Remote and Rural Areas

249. Another compelling reason for continuing to grow the dental workforce is some difficulty with recruiting GDPs in certain remote and rural areas. The Scottish Government has been working closely with those NHS Boards which have a relatively high degree of remote and rural provision in their areas. A key issue for these Boards is the challenge of recruiting experienced GDPs to practice in these areas.

250. The present arrangements include a range of payments to provide an additional financial incentive to remote and rural areas. New dentists who have recently completed their vocational training can qualify for a recruitment and retention 'golden-hello' payment of up to £25,000 paid over a two year period. Dentists who are returning to the workforce after a period of five years may qualify for a payment up to £15,000.

251. We are presently looking at the recruitment and retention payments available to GDPs in remote and rural areas. It needs to be recognised that there will always be a challenge to recruit professionals to certain areas, and that while financial incentives may help to mitigate this problem, it is not a complete solution in itself. We are therefore working with our partners in NHS Education for Scotland and NHS Boards so that a suite of actions, both at a local and national level can be considered for how we proceed in the future.

Deprived Areas

252. Table 6 – Number, by location, of independent and PDS dentists in Scotland by deprivation category as at 30th September 2019[64]

SIMD 1	SIMD 2	SIMD 3	SIMD 4	SIMD 5	Unknown SIMD
1012	985	724	570	649	20

* 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.

253. Table 6 shows the majority of dentists working in those areas of higher socio-economic need in Scotland; for example, those working in the most deprived SIMD 1 category account for around a quarter of all dentists. One caveat that requires referencing is that while table 6 provides information on where dentists are located it does not necessarily follow that they are seeing patients from these areas. There will be a substantial overlap but not a complete match.

[63] The schools are allowed to supplement their in-take with international students.
[64] Scottish Dental Practice Board, Primary Care Dentistry Report, 2019

254. The present payment arrangements available to GDPs have a deprivation weighting; the Childsmile practice payments have a deprivation weighting and GDPs also receive additional payments for adults where the postcode of residence is in SIMD 1. As we move forward with the implementation of the OHIP programme we will be looking more closely at how we realign the resources available to NHS dental care to our policy priorities including how we ensure that we support dentists working with patient lists in more deprived areas.

GDP Earnings

255. The only information on GDP earnings is provided by NHS Digital. Earnings for principals (practice owners) has increased for the period 2013/14 to 2017/18 by 9.3 per cent. Earnings for associates have remained broadly flat over the same period

Table 7 – Average taxable income[65]

	2013/14	2014/15	2015/16	2016/17	2017/18
Principals	£98,400	£102,900	£110,800	£109,000	£107,600
Associates	£56,200	£55,000	£55,200	£56,400	£55,400
All GDS dentists	£68,000	£67,000	£67,700	£67,800	£67,100

256. The source material for these statistics is HMRC self-assessment tax returns; as well as including private earnings their primary function is for tax assessment, not to provide accurate NHS earnings.

257. We agree with DDRB that in the absence of full-time equivalent information it is difficult to interpret the information on GDP earnings. We need to be mindful that the dental workforce is increasingly being shaped by more part-time working and this is likely to have a significant bearing on average GDP earnings. As part of the annual expenses exercise in Scotland we ask for full-time equivalent information on each GDP within the practice (see below). This is an attempt to link earnings to full-time equivalent information on the GDP workforce.

258. GDPs also have an element of discretion over their earnings and can adjust their work-life balance accordingly. As relatively high paid professionals GDPs may substitute leisure for income. The nature of the present payment regime with a focus on item of service ensures that the substitution of leisure for income is likely to be a strong factor.

[65] NHS Digital, Dental Earnings and Expenses Reports

NHS Pay Awards

259. GDPs have recently benefited from awards of 2.55 per cent for 2018/19 and 2.5 per cent for 2019/20. Table 8 shows the increase in payments to GDPs for the period 2016/17 to 2018/19:

Table 8: Payments to GDPs (£m)

	2016/17	2017/18	2018/19
Gross Fees (including capitation/continuing care)	277.3	280.3	292.5
Allowances (including General Dental Practice Allowance)	40.0	40.4	41.6
Expense Reimbursements (including rent payments)	14.6	15.1	15.3
Total	331.9	335.8	349.4

260. The table summarises the main payments to GDPs providing GDS, including gross fees, capitation and continuing care payments, allowances and directly reimbursed expenses including reimbursement of rent expenses.

261. Gross item-of-service fees for 2018/19, compared with 2017/18, show an increase of 4.3 per cent. This is an encouraging increase and reflects both the value of the pay award for 2018/19, and NHS activity, both an increase in capitation and continuing care payments because of increased registrations, and the volume of NHS dental care being provided. We can also report that the forecast position for 2019/20 indicates a similar increase for the current financial year.

Expenses Exercise

262. DDRB has requested that an appropriate award for expenses should be determined separately through bilateral discussion between Scottish Government officials and BDA Scotland. We have tried to support this process by annual expenses enquiries. For the 2019/20 pay award we worked with Practitioner Services - the Division within NHS National Services Scotland responsible for making payments to independent contractor GDPs - to disseminate an expenses template.

263. The template was identical to that which was used for the 2018/19 pay award. As with previous exercises GDPs were not required to complete the template. The exercise failed to provide adequate information to help inform the award for expenses. In the absence of specific expenses information linked to NHS dental practice, the 2019/20 pay award incorporated an expenses increase of 3 per cent. Given the lack of information the most pragmatic approach is to use an inflation proxy for expenses.

264. For the period 2013/14 to 2015/16 a different approach was taken to expenses. A third party firm of dental accountants were contracted by the Scottish Government to work with a small sample of practices. This exercise was immensely invaluable and showed that dental practice expenses for the period were running at around 3 per cent per year. We continue to rest on this particular exercise for an assessment of expenses.

265. Going forward it is our intention to conduct an expenses exercise for the 2020/21 pay award. We believe that the template of information is sensible and not too onerous for GDPs to complete. This year we intend to work with BDA (Scotland) on marketing and highlighting the exercise to GDPs. We also intend to write directly to practice owners with 90 per cent or more NHS provision inviting them to participate in the exercise.

Non-Pecuniary Factors

266. We are taking forward a significant programme of work to support GDPs and the wider dental team. As part of the process of publishing the Oral Health Improvement Plan, we consulted widely across Scotland, including the hosting of roadshow events in various locations. We received 427 responses from the consultation; 564 people attended the roadshow events and 113 members of the public participated in focus group events.

Oral Health Improvement Plan – Consultation Exercise

267. This exercise helped to frame those non-pecuniary issues that have a major bearing on GDP morale and that of the wider dental team. The present administration and payment arrangements were a bar to the practice of modern dentistry and handicapped the practitioner in providing the best quality care for their patient. Generally speaking the payment arrangements were seen as far too complex and particularly for younger newly qualified dentists especially daunting.

New Model of Oral Health Care for Adult Patients

268. As we described above our response has been to accelerate a programme of change to address these concerns by bringing forward the development work on the New Model of Adult Oral Health Care. We recognise that while the primary purpose of this approach is to ensure we have an oral health care system that is appropriately patient-centred for the next generation of patients, it also needs to reflect the needs and address the concerns of GDPs and dental staff.

269. The intention is to have a model that is more intuitive, allows the dentist and team to exercise clinical discretion and is up-to-date with the latest clinical dental evidence and dental techniques that are being taught to dental students. The provisional timeline is to roll out the new model to early adopter practices in early 2022.

Central Disciplinary Unit

270. In OHIP we made a commitment to look at disciplinary procedures and the concerns dentists had around referral to the General Dental Council (GDC). The lack of local resolution in Scotland has been a significant issue for some time, and has led to many concerns amongst GDPs that disciplinary issues are being dealt with disproportionately by NHS Boards, by being referred unnecessarily to the GDC.

271. We can now report that NHS National Services Scotland (NSS) will host a Central Disciplinary Unit (CDU). The CDU will ensure that we have in place central administration of discipline committee cases providing NHS Boards with support for local resolution without recourse to the GDC.

272. Our expectation is that in time the CDU will ensure cases that could be dealt without recourse to the GDC are resolved appropriately. We hope that this development will remove the perception amongst GDPs that their morale is being affected by the threat of GDC referral.

Occupational Health Services

273. One of the early commitments from OHIP was the introduction of occupational health care services for GDPs and practice staff. We are mindful that many independent contractors and staff working in independent practice can feel disenfranchised by not being able to access support facilities that are available to NHS Board employed staff. The extension of NHS Board occupational health services to independent contractors and practice staff is an example of increasing the support available and ensuring they feel part of the wider NHS family in Scotland.

e-Dental Development Programme

274. We now have a defined programme of work under the aegis of the e-dental development programme to deliver the following IT initiatives:

- Access to the Emergency Care Summary (ECS) for Domiciliary Care Dentists;
- Improved integration of Dental Software Systems with other parts of NHS Scotland IT infrastructure, including e-referrals ensuring that there is improved communication between dental systems and referral responses;
- Introduction of e-orthodontic digital modelling and the phasing out of study models;
- Introduction of general accreditation for Dental Software System suppliers to support the new IT infrastructure for the New Model of Adult Oral Health Care and other elements of the eDental Development Programme.

275. GDPs and practice staff have on-going concerns about the resilience of IT infrastructure and the need to ensure they are integrated with the wider NHS IT system architecture in Scotland. Key programmes include the need to facilitate access to patient emergency care medical information for dentists, ensuring that more care can be provided in a primary care setting. We are also responding to concerns about the need to ensure there is a seamless referral system between dental IT systems in practice and other NHS IT systems.

276. We have also made significant progress in the last 2-3 years in moving from a paper-based system of payment and prior approval claims to an electronic system. From 1 April 2020 all payment and prior approval claims for both general dentists and orthodontics will be electronic.

Next Steps

277. We also recognise it's important to understand the concerns of GDPs and the dental team as we implement the OHIP programme. We have had initial discussions with BDA Scotland regarding a regular joint survey of GDPs in Scotland, covering those issues that affect morale and wellbeing in the workplace.

278. While we recognise that the morale and motivation survey we commission NHS Digital to do is an important snapshot of how GDPs are feeling about their working lives, the survey is once every two years, and is a four-country survey.

279. We envisage a Scottish-specific survey on at least a once a year basis that will reflect a wider range of questions and issues that are more relevant to the Scottish dental landscape.

H. Salaried Primary Care Dental Practitioners

H.3 Public Dental Service

Introduction

280. The Public Dental Service (PDS) is a service run directly by the NHS Board, the main role of which is to provide General Dental Services (GDS) for people with special care needs and those who cannot access care from independent contractor GDPs.

281. In the 1990s and early 2000s there was a significant shortage of independent contractors GDPs willing to provide GDS. Many NHS Boards made up the shortfall in provision by expanding the number of employed dentists in the PDS.

282. The landscape has now changed dramatically, largely as a consequence of significant and sustained increases in the numbers of independent contractor GDPs providing GDS in Scotland. As we reported in the main evidence section for dentistry, we have observed an increase of 17 per cent in independent contractor GDPs providing GDS for the period 2011 to the present. The longer-term trend in workforce numbers is even more significant, with the period from 2007 to the present showing an increase of 35 per cent.

PDS Workforce

283. Any commentary on the PDS workforce needs to be seen against the wider context of significant and sustained growth in the numbers of independent contractor GDPs. As a consequence, NHS Boards have been rebalancing provision from PDS to independent contractor GDPs for the majority of mainstream patients with routine treatment needs.

284. In the main evidence section for dentistry, we provided a summary of the new arrangements that have been introduced for domiciliary care oral health services. We have recognised that an ageing population will require a more significant role from independent contractor GDPs than at present. These new arrangements will see independent contractor GDPs working closely with their partners in the PDS to ensure the best quality oral health care is provided to people who cannot access care in a normal setting.

285. The Oral Health Improvement Plan sets out our vision for the future of NHS oral health care services in Scotland, to ensure that each part of the service, independent contractor GDPs, PDS and hospital dentistry is seeing an appropriate set of patients. For routine care and the majority of patients this will be provided by independent contractor GDPs.

286. The PDS will continue to have an important role in providing more complex dentistry in a primary care setting, thus avoiding recourse to hospital referral and care, seeing patients with particular needs, and in particularly remote and rural areas providing mainstream dentistry in areas with access problems.

H. 4. Consultants

Consultants

287. A tripartite forum with MSG (NHS Scotland employers/Scottish Government) and BMA Scotland meets regularly to discuss matters of common concern and, where appropriate, produce joint guidance on these areas.

288. The main issue of concern for Consultant staff at the moment is the pension taxation issue.

289. There is evidence that senior medical staff are making unanticipated choices to reduce or avoid unexpected pension tax charges, including reducing working hours, retiring early, refusing discretionary points, refusing additional duties and responsibilities and not applying for/rejecting promotion.

290. Pension taxation is a wholly reserved matter for the UK and the options available to the Scottish Government are limited. Urgent action is required by the UK Government to resolve this issue permanently.

291. The Scottish Government has introduced a policy of recycling employers contributions (REC) for affected staff who opted out of the pension scheme. More details are addressed in the **NHS Pensions and Total Reward section**.

H. 5. Distinction Awards (DAs) and Discretionary Points (DPs)

292. Since 2010, no new DAs have been made, the only Consultants still receiving these are those who were successful prior to the freeze being imposed. We have been clear that that existing arrangements for DAs and DPs would remain in place and our position, since 2010 has been that to increase or restore DADPs would go against SPSPP.

293. 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. There is no evidence to suggest that an adverse impact has resulted from the freezing of the value of DADPs.

294. Although DAs are frozen to new consultants, the availability of new DPs increase in line with the number of consultants in post. Scotland continues to offer an attractive pay package for Consultants along with the continued guarantee of No Compulsory Redundancy.

295. We are therefore not seeking any recommendations from DDRB and distinction awards and discretionary points.

H. 6. Junior Doctors including Improving Working Lives of Junior Doctors

Junior Doctors

296. Since the implementation of the working time regulations (WTR) average 48 hour working week in 2009, we have maintained 100% compliance with this.

297. NHS Employers and the BMA Scottish Junior Doctors Committee (SJDC) continue to meet regularly to agree and implement improvement actions that Junior Doctors want to see. Actions to date 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.

298. Ongoing work is currently focusing on employee experience including reviewing the current Code of Practice.

Single Employer Status

299. In August 2018, a single lead employer arrangement was implemented for Doctors in Training in NHSScotland. Under these arrangements, trainees continue to occupy and move between posts across all Health Boards as part of their training, but for administrative purposes, the 22 employers are reduced to four Health Boards, with trainees benefitting from having one employer for the duration of their training programme. This applies to all Doctors in Training, and work is underway to include Dentists in Training.

Doctors in Training New Deal Contract

300. 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.

301. Statistics based on the latest complete monitoring period (February – July 2019) show compliance remains at 98%. As is the nature of the New Deal, rotas do become non-compliant, necessitating rota review and re-design.

Average Pay Supplement for Junior Doctors

302. The average New Deal banding supplement in NHSScotland is 48.8% for the year April 2018 – March 2019. This represents a decrease from the previous average of 49.1% which has been caused by slightly lower levels of non-compliance.

303. 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.

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

304. The Scottish Government has declined to join contract discussions on SAS doctors proposed by the DHSC in England.

305. We have instead agreed to seek a Scottish solution to reform of the Specialty Doctor contract, and are working with employers and BMA Scotland to agree a Heads of Terms for contract reform, including the potential development of a Senior Specialty Doctor grade. This will then be used by all stakeholders to seek appropriate mandates to enter formal discussions to reform the SAS contract.

H. 8. Locums

306. The annual spend on agency medical locums in secondary care in NHS Scotland has reduced by 2.4% in 2018/19 from £100.4M to £98.0M.

307. This can be attributed to ongoing long term actions including:

- Expansion of the NHS Medical Staff Bank, on a local and regional basis.
- Implementation of bank pay rates equivalent to double time for Junior, SAS and Consultant grade staff.
- Ongoing governance arrangements that ensure that all internal options are pursued before and agency doctor is requested.
- A national framework agency contract to control pay and commission rates. Pay rates are equivalent to NHS rates of pay.
- Initiatives such as the Scottish Clinical Collaborative which has created a specialist Locum Bank of recently retired doctors to work in remote and rural areas, offering new temporary and semi-permanent opportunities.

308. We should however recognise that in order to ensure service continuity during times of planned and unplanned absences, an organisation as large and complex as NHS Scotland will always require a degree of temporary staff from both internal and external sources. Our actions are designed to ensure that agency staff are used as a very last resort.

I. Employee Experience, Morale and Motivation

Staff Experience and Wellbeing

309. The NHS Scotland Staff Governance Standard requires Health Boards to demonstrate that staff are provided with a continuously improving and safe working environment and that they are promoting the health and wellbeing of staff.

Specific measures

310. The iMatter Employee Engagement and Experience (continuous improvement) tool enables health and social care teams to take action to improve staff experience. iMatter is a team based tool that allows individual teams (rather than job families), managers and health and social care boards to measure, understand, improve and evidence staff experience.

311. This is in-line with key recommendation four from the Caring for doctors, Caring for patients report on team working – to develop and support effective multidisciplinary team working across the healthcare service. This recommendation also states that teams should have a shared purpose and clear objectives, one of which is team member wellbeing.

312. The Health and Social Care (iMatter) Staff Experience Report 2018 was published in February 2019. The report showed that overwhelmingly staff feel they are treated with dignity and respect (79%) and that their manager cares about their health and wellbeing (80%). The 2018 report included team stories that illustrate the continued dedication of staff to improving not only their experience, but also the care and services they deliver.

313. The 2019 report was published on 3 February 2020. iMatter will go-live for doctors in training in early 2020. An independent evaluation of iMatter and Dignity at Work was carried out by Strathclyde University in 2018/19. The report findings indicated that staff, managers, trade unions and professional organisations were supportive of iMatter as an effective tool for capturing staff experience and promoting staff engagement. It also recommended that a new dignity at work measurement tool should be developed by NHS Scotland and Health and Social Care partnership staff, using a similar methodology to that adopted to develop iMatter. Work is now underway to co-produce a new approach to identify dignity at work issues that will inform actions locally and nationally.

Health and Wellbeing

314. Health Boards provide a wide range of services and initiatives to promote and support the psychological wellbeing of staff. These include counselling services, employee assistance programmes and occupational health support.

315. The Managing Health at Work policy will be reviewed as part of the Once for Scotland policy review process, to provide more consistent approach to health and wellbeing.

316. The Health Secretary is chairing a Ministerial-led short-life working group on culture, with representation from across NHS Scotland, that includes Chairs, Chief Executives, staff-side, the Royal Colleges and the Professional and Regulatory bodies. This group has been tasked to specifically devise a plan to embed a behavioural charter across health and social care in Scotland.

317. We continue to meet with BMA and other stakeholders to identify and implement changes to improve wellbeing for NHS staff in the workplace.

318. Sickness absence rates have remained broadly stable and are marginally lower in 2019 than in 2007 (having decreased from 5.55% in 2007 to 5.39% in 2019). We expect Health Boards to work towards reducing sickness absence each year, with a national target of 4% or less.

International Recruitment (as part of Sustaining the Medical Workforce in Scotland)

319. The International Recruitment Unit was set up in 2019, to support direct marketing for hard-to-fill vacancies across NHS Scotland and manage the on-boarding process for candidates. The unit have focused on four specialties in 2019: psychiatry, anaesthetics, paediatrics and general surgery. These specialities were identified as hard-to fill vacancies across NHS Scotland which could be impacted by EU withdrawal. The first campaign for Psychiatrists launched in February 2019, and 12 candidates are being actively on boarded. Due to the nature of recruiting internationally, it can typically take between 6-18 months for candidates to commence their posts.

320. The three other campaigns are running concurrently. Candidates have been shortlisted in Anaesthetics and Paediatrics, and the IRU is liaising with individual health boards to match candidates to vacancies.

321. Funding for the Unit from the Scottish Government has been extended to the end of 2020, and we are currently consider what priorities the Unit should focus on, going forward, based on demand and supply of staffing across NHS Scotland which continue to be key considerations.

J. Conclusions and Recommendations

322. 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.

323. 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 basic pay increase of 3 per cent for public sector workers who earn below £80,000
- continuing the requirement for employers to pay staff the real Living Wage, now set at £9.30 per hour
- providing a guaranteed cash underpin of £750 for public sector workers who earn £25,000 or less
- limiting to £2,000 the maximum basic pay increase for those earning £80,000 or more
- allowing flexibilities for employers to use up to 0.5 per cent of pay bill savings on baseline salaries for addressing clearly evidenced equality issues in existing pay and grading structures.

324. 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 2020 to 31 March 2021.