



Review Body on Doctors' and Dentists' Remuneration

Thirty-Seventh Report 2008

Chairman: Ron Amy, OBE



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**Presented to Parliament by the Prime Minister
and the Secretary of State for Health**

**Presented to the Scottish Parliament by the First Minister
and the Cabinet Secretary for Health and Wellbeing**

**Presented to the National Assembly for Wales by the
First Minister and the Minister for Health and Social Services**

**Presented to the Northern Ireland Executive by the First Minister,
Deputy First Minister and Minister for Health, Social Services
and Public Safety**

**by Command of Her Majesty
April 2008**

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. This review was conducted under the terms of reference introduced in 1998, amended in 2003 and 2007 and reproduced below.

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services in the Welsh Assembly Government and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive on the remuneration of doctors and dentists taking any part in the National Health Service.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

the need to recruit, retain and motivate doctors and dentists;

regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should also take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing of the Scottish Parliament, the First Minister and the Minister for Health and Social Services of the Welsh Assembly Government, the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive and the Prime Minister.

The members of the Review Body are:

Ron Amy, OBE¹ (*Chairman*)

Dr Margaret Collingwood

Katrina Easterling

Professor Alasdair Smith²

Professor John Beath

Hugh Donaldson

David Grafton

David Williamson³

The Secretariat is provided by the Office of Manpower Economics.

¹ Ron Amy was appointed to the Review Body by the Prime Minister from August 2007.

² Professor Alasdair Smith was appointed to the Review Body by the Secretary of State for Health from August 2007.

³ David Williamson was appointed to the Review Body by the Secretary of State for Health from August 2007.

Contents

List of tables and figures	vi
Summary of conclusions and recommendations	vii
<i>Chapter</i> 1: Economic and general considerations	1
2: Main pay recommendations for 2008-09	21
3: General medical practitioners	25
4: General dental practitioners	40
5: Salaried primary dental care services	55
6: Ophthalmic medical practitioners	58
7: Doctors and dentists in hospital training	59
8: Consultants	65
9: Staff and associate specialists/non-consultant career grades	76
<i>Appendix</i> A: Detailed recommendations on remuneration	81
B: The 2007-08 settlement	94
C: Numbers of doctors and dentists in the NHS	95
D: The evidence	102
E: Pay comparability: levels	103
F: Previous reports	109
G: Abbreviations and Acronyms	111

List of tables and figures

		Page
<i>Tables</i>	1.1 Remit groups for the 2008 review, at September 2006, United Kingdom	2
	1.2 Status of contracts for each of our remit groups	2
	3.1 GMPs' earnings, expenses and income, 2002 – 2006, United Kingdom	30
	8.1 Clinical Excellence Awards made by ACCEA in 2007	71
	8.2 Distinction awards made by SACDA in 2007	72
		Page
<i>Figures</i>	1.1 Total number of medical and dental staff 2002 – 2006, United Kingdom	7
	1.2 Inflation: Consumer Prices Index, Retail Prices Index, Retail Prices Index excluding Mortgage Interest Payments, January 2003 – December 2007	10
	1.3 Basic pay ranges of DDRB remit groups, November 2007, compared with the national pay distribution and other professional groups, full-time rates	17
	1.4 DDRB main award, earnings, settlements and inflation, 2001 – 2007	18
	1.5 Annual gross median earnings of DDRB's groups, 1998-99 to 2006-07, full-time rates	18
	3.1 Numbers of GMPs, 2004 – 2006, Great Britain	26
	3.2 GMPs' turnover: expenses and income 2002-03 to 2005-06, United Kingdom	31
	4.1 NHS earnings as a percentage of total earnings for 1999-2000 to 2005-06, Great Britain (non-associate dentists)	44
	4.2 The expenses to earnings ratio for 1999-2000 to 2005-06, Great Britain (non-associate dentists)	47
	8.1 Number of consultants in the Hospital and Community Health Services, 1999 – 2006, United Kingdom	68
	9.1 Number of staff grades and associate specialists in the Hospital Community and Health Services, 2000 – 2006, United Kingdom	77

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Our remit group now comprises approximately 183,000 doctors and dentists in the United Kingdom. Consultants, general medical practitioners (GMPs), general dental practitioners (GDPs) (in England and Wales), salaried dentists (in England) and doctors and dentists in training are all working under new contracts which have come into force since 2000. New contracts are expected to be in place soon for the salaried dentists in Wales, Scotland and Northern Ireland, and the new contract for staff and associate specialists/non-consultant career grades (SAS/NCCGs) is due to be balloted shortly.

We do not see any major cause for concern in the recruitment and retention evidence we have received and note that, in general, medicine and dentistry continue to be attractive careers, though it is clear that some career paths are more popular than others. Motivation and morale appear to have been affected by both the government's decision to stage our award from last year and the problems surrounding the Medical Training Application Service.

The economic and financial background to this review suggests that we may be entering a period of difficulty and restraint. Gross domestic product growth is forecast to slow markedly this year, and, amongst other things, this is likely to have adverse implications for government finances. At the same time, substantial upward pressures on inflation are expected, in particular from higher energy and food prices, and a fall in the value of the pound. The Bank of England's latest central projection suggests that the Consumer Prices Index (CPI) will exceed the government's 2 per cent inflation target throughout the year, at times by some distance. The other key measure, the all-items Retail Prices Index (RPI), stood at 4.1 per cent in January. Forecasters expect it to fall during 2008, although because of the inflationary pressures mentioned above, perhaps not as much as some initially forecast. There will be some downward pressure from slowing house prices and lower mortgage interest rates that are not captured in CPI.

The British Medical Association (BMA) asked us to recommend increases of between 3.6 and 4.3 per cent for the different groups it represents. The British Dental Association (BDA) sought an increase of 7 per cent in the gross earnings base for 2007-08 for GDPs, and proposed that salaries and allowances for all practitioners in the salaried primary dental care services (SPDCS) should also increase by 7 per cent.

The Health Departments said that the balance between the interests of staff and those of patients would be served best by us recommending that pay for independent contractor GMPs should remain at current levels, and that GDP contracts and basic pay for salaried doctors and dentists should be increased by 1.5 per cent. On the other hand, NHS Employers told us that a headline uplift of up to 2 per cent would be affordable. The evidence on expenditure plans that was presented to us appears to show pay as the residual after all the other priorities have been accounted for. If we are to fulfil our remit, we need to be able to interrogate the assumptions behind the spending plans, and it is therefore essential that the affordability evidence is presented in the clearest possible terms and that assumptions are justified. In the end, we were not persuaded that 1.5 per cent (or, indeed, 2 per cent) was the maximum that could be afforded.

We have made our recommendations for what we believe to be a fair and reasonable uplift, taking into account the economic and other evidence provided by the parties and the various aspects of our remit. We have endeavoured to balance the need to recruit, retain and motivate doctors and dentists with the funds available and the inflation target. After careful consideration, we have decided that all salaried members of our remit group should receive the same basic increase. We **recommend for 2008-09 a base increase of 2.2 per cent to the national salary scales for doctors and dentists** (paragraph 2.14).

For 2008-09, we **recommend that the value of Clinical Excellence Awards, commitment awards, distinction awards and discretionary points should be increased by 2.2 per cent**, in line with our main pay uplift recommendation (paragraph 8.35). We endorse and **recommend the Scottish Advisory Committee on Distinction Awards' proposal to distribute a further three A+ awards, eight A awards and 16 B awards** (paragraph 8.29). We endorse and **recommend the proposal that the budget for higher Clinical Excellence Awards should be increased in line with the number of consultants eligible for an award** (paragraph 8.26). We also endorse and **recommend the Advisory Committee on Clinical Excellence Awards' proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards to be made at each level in 2008-09** (paragraph 8.26).

For independent contractor GMPs, we **recommend the parties jointly to consider our role for the future and either to agree a mechanism whereby we can make recommendations on GMPs' net incomes, or to remove independent contractor GMPs from our remit and settle future changes to the contract by negotiation** (paragraph 3.18). For this year, we feel able to recommend only on the global sum element of the contract since there are negotiations on the General Medical Services contract in progress between the BMA and the government. We **recommend an increase in the global sum for each 'weighted patient', in line with the general uplift of 2.2 per cent which we are recommending for doctors in the Hospital and Community Health Services. However, the increase in the global sum needs also to take some account of practice expenses and therefore we recommend that the global sum payments per 'weighted patient' be increased by 2.7 per cent from £54.72 to £56.20 for 2008-09** (paragraph 3.32). The parties have agreed that future uplifts to the global sum should also seek to reduce the reliance upon correction factor payments; therefore we **recommend that paragraph 1.6 of the Revisions to the GMS contract 2006-07¹ apply in full and the corresponding correction factor payments be reduced where relevant for 2008-09** (paragraph 3.33). We estimate that the effect of these recommendations will be to increase expenditure under the global sum by approximately 0.2 per cent.

The number of salaried GMPs continues to rise and we believe that they should be able to negotiate an annual pay review as part of their terms and conditions. We **recommend that the salary range for salaried GMPs is increased by 2.2 per cent for 2008-09** (paragraph 3.38).

GMP registrars receive a substantial supplement² despite having a working pattern which, unlike that of trainee hospital doctors, is on the whole, less intense and involves few if any additional hours. General medical practice continues to be an attractive career choice and we note that the banding supplements paid to hospital doctors are falling as their hours are reduced. We therefore think it appropriate that the supplement for GMP registrars is again adjusted downwards, although in fairness, we consider that those doctors currently receiving the higher level of supplement should keep their existing entitlement. We **recommend that the supplement for GMP registrars entering training placements on or after 1 April 2008 be reduced from the current rate of 55 per cent to 50 per cent** (paragraph 3.42).

¹ *Revisions to the GMS Contract 2006-07*. NHS Employers and the BMA, February 2006. Available from: <http://www.nhsemployers.org/pay-conditions/primary-2450.cfm>

² The supplement is paid to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged compared to hospital doctors in training. It was introduced at a time when recruitment into general practice was poor.

While the work continues to develop the new structure of remuneration for GMP trainers, we believe we should do no more than uplift the value of the trainers' grant in line with the other fees and allowances on which we are required to recommend. We therefore **recommend that the GMP trainers' grant be increased by 2.2 per cent for 2008-09** (paragraph 3.48). We also **recommend that the GMP educators' pay scales should be raised by 2.2 per cent for 2008-09** (paragraph 3.51).

We again **recommend that doctors engaged in sessional work for community health services and work under collaborative arrangements should continue to set their own fees**, in line with the trend for local commissioning of services (paragraph 3.54).

We support the payment of rewards to those who perform best, but to avoid any risk of discrimination, we believe that the performance should be objectively demonstrated in each individual case. For 2008-09, we **recommend that seniority payments for GMPs remain at current levels** (paragraph 3.56).

We continue to view London weighting as a labour market issue and as we have not received any evidence of problems of recruitment and retention in London, we see no reason to revise our previous recommendation to freeze London weighting and **recommend that supplements for London weighting should remain at their existing levels for 2008-09** (paragraph 1.59).

For GDPs, we **again recommend that the parties work together, or commission joint independent work, on dental expenses, focusing specifically on the non-staffing element** (paragraph 4.43). With regard to the uplift, we **recommend that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 2.2 per cent after allowing for an increase in expenses**. We have again applied our formula which weights the different elements and in consequence we **recommend that an uplift of 3.4 per cent be applied to the gross earnings base under the new contract for 2008-09 for GDPs in England and Wales**. We recommend uplifting gross fees, commitment payments and sessional fees so that this will result in an increase in GDPs' income of 2.2 per cent in Scotland and Northern Ireland after allowing for an increase in expenses. Therefore, this year we are recommending that the uplift of 3.4 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland (paragraph 4.67).

For doctors and dentists in hospital training, we **recommend that the percentage values of the banding multipliers be maintained at current rates for another year** (paragraph 7.12).

For the other fees and allowances on which we are required to recommend, unless they are specifically mentioned elsewhere in the report, we recommend that these be **increased by 2.2 per cent for 2008-09** (paragraph 2.15).

Our main recommendations on pay levels are:

	<i>Point on scale³</i>	<i>Recommended scales 1 April 2008 £</i>
<i>Hospital doctors and dentists – main grades (full-time salaries):</i>		
Foundation house officer 1	minimum	21,862
	maximum	24,591
Foundation house officer 2	minimum	27,116
	maximum	30,663
Specialty registrar (full)	minimum	28,976
	maximum	45,562
Specialty registrar (fixed term)	minimum	28,976
	maximum	38,336
House officer	minimum	21,862
	maximum	24,591
Senior house officer	minimum	27,116
	maximum	37,755 ⁴
Specialist registrar ⁵	minimum	30,231
	maximum	45,562 ⁶
Consultant (2003 contract, England and Scotland for main pay thresholds)	minimum	73,403
	maximum (normal)	98,962
	maximum (CEA ⁷)	34,956
	CEA ⁸ (bronze)	34,956
	CEA (silver)	45,955
	CEA (gold)	57,443
	CEA (platinum)	74,676
Consultant (2003 contract, Wales)	minimum	71,138
	maximum	92,357
	maximum (commitment award ⁹)	25,248

³ Salary scales exclude additional earnings such as those related to banding multipliers for doctors in training.

⁴ To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21, and Thirty-First Report, paragraph 6.46.

⁵ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁶ Additional incremental point in 2004, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of the Thirty-Third Report.

⁷ A local Clinical Excellence Award (CEA) scheme operates in England, whereby consultants become eligible for an award after one year's service. The figure presented represents the value of the maximum CEA awarded by local committee.

⁸ Higher national CEAs awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA) in England and Wales.

⁹ A total of eight commitment awards are awarded (one every three years) once the maximum of the scale is reached.

	<i>Point on scale³</i>	<i>Recommended scales 1 April 2008 £</i>
Consultant (pre-2003 contract)	minimum	60,944
	maximum (normal)	79,001
	maximum (discretionary ¹⁰)	25,248
	distinction award ¹¹ 'B'	31,486
	distinction award 'A'	55,098
	distinction award 'A +'	74,768
Staff grade practitioner	minimum	33,264
	maximum (normal)	46,935 ¹²
	maximum (discretionary)	62,310 ¹³
Associate specialist	minimum	36,769
	maximum (normal)	65,840 ¹²
	maximum (discretionary)	79,756 ¹³
Clinical medical officer	minimum	31,865
	maximum	43,942
Senior clinical medical officer	minimum	45,029
	maximum	64,212
Band A: Salaried dentist	minimum	36,792
	maximum	55,188
Band B: Salaried dentist	minimum	57,232 ¹⁴
	maximum	66,941
Band C: Salaried dentist ¹⁵	minimum	68,474 ^{16, 17}
	maximum	78,694
Community dental officer	minimum	33,768
	maximum	52,893 ¹⁸

¹⁰ Discretionary points are now only awarded in Scotland. Local CEAs have replaced the scheme in England, while commitment awards have replaced it in Wales. Discretionary points remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA or commitment award.

¹¹ From October 2003, national CEAs replaced distinction awards in England and Wales. Distinction awards continue to be awarded in Scotland, and remain payable to existing holders in England and Wales.

¹² Top incremental point extended in 2004, see paragraph 8.42 of the Thirty-Third Report.

¹³ Additional discretionary point in 2004, see paragraph 8.38 of the Thirty-Third Report.

¹⁴ Salary point is the entry level to band B but is also the extended competency point at the top of band A.

¹⁵ Managerial dentist posts with standard service complexity are represented by the first four points in the band C range, those with medium service complexity are represented by points two to five of the range and those with high complexity by the highest four points of the band C range.

¹⁶ Salary point is the entry level to band C but is also the extended competency point at the top of band B.

¹⁷ The first three points on the band C range represent those available to current assistant clinical directors under the new pay spine.

¹⁸ Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report.

	<i>Point on scale³</i>	<i>Recommended scales 1 April 2008 £</i>
Senior dental officer	minimum maximum	48,254 65,214 ¹⁹
Assistant clinical director	minimum maximum	64,122 69,085 ¹⁹
Clinical director	minimum maximum	64,122 73,070 ¹⁹

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OFFICE OF MANPOWER ECONOMICS
 27 February 2008

¹⁹ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First Report.

Part I: Overview

CHAPTER 1: ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

- 1.1 For this, our Thirty-Seventh Report, we have again divided the report into nine chapters, comprising this introduction, a chapter with our main pay recommendations and a chapter on each of our remit groups: general medical practitioners (GMPs), general dental practitioners (GDPs), salaried primary dental care services (SPDCS), ophthalmic medical practitioners, doctors and dentists in hospital training, consultants, and staff and associate specialists/non-consultant career grades (SAS/NCCGs). Appendix A sets out the detailed pay scales resulting from our recommendations.
- 1.2 In this introductory chapter we set out the overall context for our review, including the essential facts about our remit groups, how we have collected evidence, and the current economic background. The chapters for each remit group discuss some of these matters in more detail. Our terms of reference, which have been revised this year, are set out at the beginning of this report. The main recommendations of our previous report are summarised in Appendix B.
- 1.3 Data used to produce the tables and graphs in this report come from different sources for each of the four countries. Data for England come from the Information Centre (IC), data for Wales from the Welsh Assembly Government (WAG), data for Scotland from Information Services Division (ISD) which is part of the NHS National Services Scotland and data for Northern Ireland, included for the first time this year, from the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI).
- 1.4 Whilst data for 2006 are available for England, Scotland and Northern Ireland, there are no headcount figures available for Hospital and Community Health Services (HCHS) staff for Wales for 2006, nor will these become available for future reports. This is due to the introduction of the Electronic Staff Record system in Wales during 2006 as problems were encountered with the extract of medical and dental staff. Consequently, some of the tables and charts in this report do not include Wales for 2006 and others use 2005 data as these are the latest available. Data for Northern Ireland are not always produced to the same level of disaggregation as for the other countries and therefore the information for Northern Ireland is not as detailed as for the rest of the United Kingdom. Additionally, there are no Northern Ireland data available prior to 2000.
- 1.5 Our remit groups now comprise approximately 183,000 doctors and dentists. The breakdown by group is given in Table 1.1. Further details are given at Appendix C.

Table 1.1: Remit groups for the 2008 review, at September 2006, United Kingdom¹

	Full-time equivalents	Headcount
Consultants ²	37,076	39,801
Associate specialists/staff grades	9,359	10,572
HCHS registrar group	21,267	21,997
FHO1/2, house officers and senior house officers	33,642	33,906
Other staff ³	3,078	7,492
General medical practitioners ⁴	*	43,850
General dental practitioners ⁵	*	24,560
Ophthalmic medical practitioners	*	463
Total	*	182,641

Source: The Information Centre, Welsh Assembly Government, Information Services Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

* Data not available.

1. HCHS data for Wales are September 2005, GMP and GDP data for Northern Ireland are October 2006 and ophthalmic medical practitioner data for Northern Ireland are April 2006.
2. The grade of consultant also includes Directors of Public Health.
3. Includes hospital practitioners, clinical assistants, and public health and community medical and dental staff not elsewhere specified.
4. Includes independent contractor GMPs, salaried GMPs and GMP registrars.
5. Includes principal GDPs, assistants and vocational practitioners, GDPs working in Personal Dental Services, and salaried dentists working in General Dental Services.

1.6 Within our remit groups, GMPs, GDPs and consultants have all had new contract arrangements since 2000; the SPDCS in England have just voted to accept a new contract and the protracted negotiations for SAS/NCCGs appear, at the time of writing, to be entering their final stages. The way in which junior doctors are trained has also been undergoing a radical change, following the publication of *Modernising Medical Careers*.¹ The table below gives an outline of the situation for each remit group and the changes are described more fully in the relevant chapters.

Table 1.2: Status of contracts for each of our remit groups

General medical practitioners	New contract from 1 April 2004.
General dental practitioners	New contract from 1 April 2006 – England and Wales (slight variations in each country). Negotiations underway in Northern Ireland.
Salaried primary dental care services	New contract in England now being implemented – backdated to 1 June 2007; Scotland, Wales and Northern Ireland considering their positions.
Doctors and dentists in training	New contract from December 2000. Changes to training from 2004.
Consultants	New contract from October 2003 – contract differs in each of the four countries. Fewer than 13 per cent of consultants in England, Scotland and Northern Ireland remain on the old contract in each country.
Staff and associate specialists/non-consultant career grades	Awaiting outcome of ballot (at time of writing).

¹ *Modernising medical careers: the next steps. The future shape of foundation, specialist and general practice training programmes.* Department of Health, April 2004. Available from: <http://www.dh.gov.uk/assetRoot/04/07/95/32/04079532.pdf>

- 1.7 The new contracts are still quite recent for many of our remit groups and there is still some way to go before they will be fully established. In some cases there are different contractual arrangements for each of the four countries. Therefore, as before, we have approached the round on the basis of seeking to stabilise what has been agreed between the parties. The terms of the contracts are outside our remit; however, we offer comment throughout the report on elements of the contracts that we believe affect aspects of our remit.

Changes to the remit

- 1.8 In July 2007, the government extended our remit to include staff working in Northern Ireland. At the same time, some other changes were made to the terms of reference.
- 1.9 The former “output targets” part of the remit has been removed and replaced by the need for us to have regard to “the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved”. The remit also now makes specific reference to the need for us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.
- 1.10 We welcome these changes and in particular the removal of output targets, as in past reports we have noted that the Health Departments were unable in evidence to clarify the relationship between pay and output targets. We note that, other than providing evidence relating to Northern Ireland, the parties did not specifically address the new elements of the terms of reference in their evidence, although the British Medical Association (BMA) commented that it was pleased by the changes.

The devolved countries

- 1.11 Our remit now covers the whole of the United Kingdom so in this report, unless we specify that remarks are relevant only to England, Wales, Scotland or Northern Ireland, we refer to the entire United Kingdom.
- 1.12 The WAG, the Scottish Executive Health Department (SEHD) and the DHSSPSNI all said that their evidence, which appeared as separate chapters within the overall evidence for the Health Departments, complemented the evidence from the other Health Departments in that it drew attention to any policies that were distinctive in Wales, Scotland or Northern Ireland.
- 1.13 The evidence from the BMA, the British Dental Association (BDA) and the Dental Practitioners’ Association (DPA) covered the whole of the United Kingdom, drawing out differences and specific issues where appropriate. NHS Employers’ evidence, however, related only to England.

Northern Ireland

- 1.14 In response to the extension of our remit to Northern Ireland, the Office of Manpower Economics commissioned a series of background reports on the labour market there, and in particular, on how it compares with that of the rest of the United Kingdom. This work has been funded by the DHSSPSNI and carried out by an independent research body, the Economic Research Institute of Northern Ireland (ERINI). We have received the first two reports in this research programme and they are available on our website. They both deal with the general background, providing information respectively on sources of labour market data for the Province² and a comparison of the Northern Ireland and Great Britain labour markets³. A third report covering a more detailed comparison of the labour markets at regional level will be available later this year. ERINI's work for 2008-09 will concentrate on the specific labour market for our remit groups.
- 1.15 At this stage, therefore, we can only note some particular general aspects of the labour market in Northern Ireland, and in particular, the key differences with the rest of the United Kingdom. As with the United Kingdom generally, the employment level in Northern Ireland has reached a record high, although it remains below the United Kingdom average, as does economic activity with a lower proportion of the inactive actually wanting to work. However, the unemployment rate is well below the United Kingdom average and is the lowest of all the regions. The public sector accounts for a much higher proportion of overall employment than in the United Kingdom. Some 42 per cent of all female workers are employed in the sector, with 25 per cent employed specifically in health and social work – a higher proportion than elsewhere in the United Kingdom. Although in general terms earnings in Northern Ireland are lower than in the United Kingdom, the public sector is by far the more attractive earnings option, and on average public sector workers are paid nearly a third more than those in the private sector. This, and the high proportion of female workers in the higher-paying public sector, means that there is no gender pay gap overall. Compared to Great Britain, Northern Ireland has a younger workforce. Finally, gross value added per head, a measure of productivity, is only 80 per cent of the United Kingdom average, making Northern Ireland the third least prosperous region in the country as a whole.
- 1.16 Looking ahead, ERINI raises the likelihood of a 're-balancing' of employment in the public and private sectors as a result of a slower growth in public expenditure. This may, in turn, initially slow the rate of growth in overall employment. Even so, ERINI notes that health and social work, which has experienced the biggest rise in public sector employment so far this decade, is forecast to continue to rise at a faster rate.

² Jessica Bennett. *Sources of labour market information for Northern Ireland*. Office of Manpower Economics, July 2007. Available from: <http://www.ome.uk.com/downloads/OME%20Report%201%20-%20Sources%20of%20Labour%20Market%20Information%20for%20NI%20-%20Final%20Draft%20-%20Sept%2007.doc>

³ Jessica Bennett. *The labour market: a Northern Ireland and Great Britain comparison*. Office of Manpower Economics, December 2007. Available from: http://www.ome.uk.com/downloads/The%20labour%20market_%20A%20Northern%20Ireland%20and%20GB%20comparison.doc

Last year's recommendations⁴

- 1.17 Last year we recommended a pay award which took account of the government's arguments on affordability and was weighted in favour of the lowest paid members of the remit groups. We calculated that the proposed uplift would increase the overall pay bill for HCHS medical staff by 2 per cent overall. We therefore regret that the recommendations in our last report were not implemented in full; in particular, that government chose to stage the awards in England and Wales,⁵ although in Scotland the uplift was paid in full. Moreover, we consider that the adverse effect on doctors' and dentists' morale and additional work that resulted for payroll departments outweighed any saving achieved by staging the award. It also created unwelcome differences in the treatment of NHS staff in different parts of the United Kingdom. In this context we note the comments in NHS Employers' evidence on the negative effects of staging the pay rise. They said that it was not a helpful financial practice as it created a hidden recurrent cost pressure against future years' funding and was demoralising for staff.
- 1.18 The SEHD did not accept our recommendation last year for additional funding to be made available for distinction awards in Scotland, to cover the newly eligible senior academic GMPs. This recommendation would not have been costly to implement, and rejecting it risks a loss of goodwill among senior academic GMPs and again undermines our recommendations as well as the distinction awards scheme, since it potentially disadvantages consultants who might otherwise have been eligible for an award. We return to this issue in Chapter 8.

The evidence

- 1.19 We received written evidence from the Health Departments, comprising the Department of Health, the WAG, the SEHD and the DHSSPSNI, from NHS Employers⁶, the Advisory Committee on Clinical Excellence Awards (ACCEA), the Scottish Advisory Committee on Distinction Awards (SACDA), the BMA, the BDA and the DPA. The main evidence can be read in full on the parties' websites (see Appendix D). As last year and in an effort to make this report shorter, we have not paraphrased large portions of the evidence, although we continue to refer to issues raised by the parties in their evidence.
- 1.20 The parties provided supplementary written evidence in response to other parties' evidence and to our requests. In addition we heard oral evidence from the Minister of State for Health Services, Ben Bradshaw, the Parliamentary Under Secretary of State for Health Services, Ann Keen, the Health Departments, NHS Employers, the BMA, the BDA and the DPA.

Comments on the evidence

- 1.21 We continue to be grateful to the parties for their time and effort in preparing and presenting evidence to us, both in writing and orally, and for the speed with which they have responded to our numerous questions and requests for supplementary evidence. We also appreciate the improvements made by the parties in response to our comments on the evidence in our last report, supporting assertions specifically with clear and concrete evidence and presenting evidence relevant to our remit. However, the later delivery of the initial evidence from almost all the parties compressed the already very tight timetable for our deliberations.

⁴ The main recommendations of our previous report are summarised in Appendix B.

⁵ Awards for community dentists in Wales were not staged.

⁶ The evidence from NHS Employers was based on information collected from employers through a questionnaire, which was sent to Chief Executives, Human Resource Directors and other board members of NHS organisations in England.

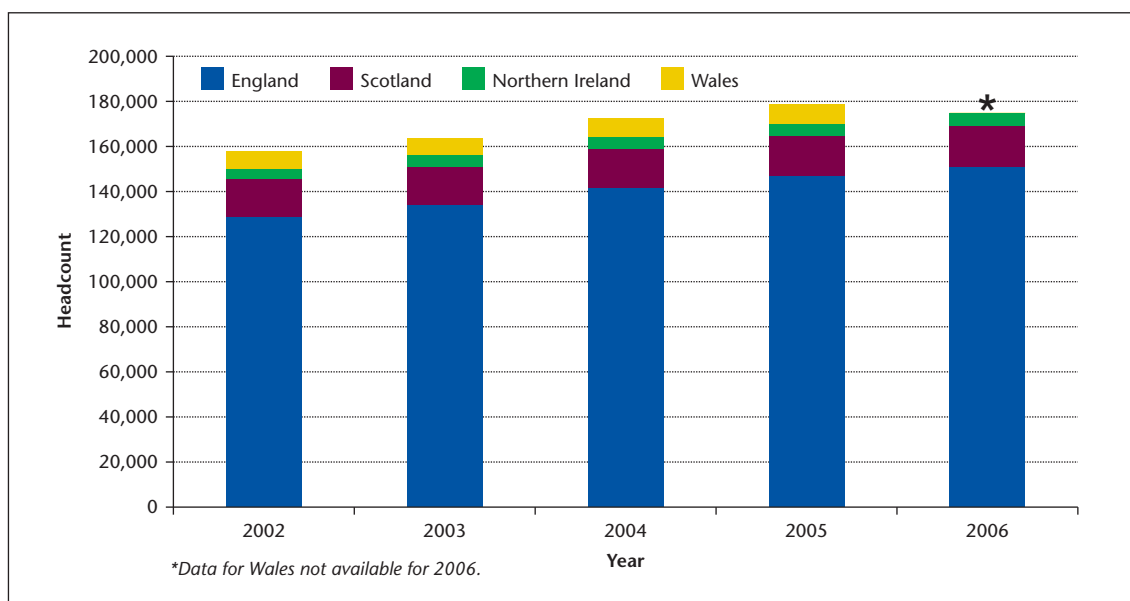
Recruitment and retention

- 1.22 The Health Departments said that there was a very healthy recruitment and retention position which they believed would continue for some time. They reported that there were now more than 125,000 doctors working in the NHS, almost 35,000 more than in 1997, as well as record levels of doctors in training in United Kingdom medical schools. They also told us that preliminary findings from research by Ipsos MORI in 2007 suggested that pay was no longer the key issue it had been in the 1990s. However, the BMA disputed the interpretation of this survey, and we would not expect professionals to place pay at the top of any list of priorities. We believe that pay continues to have a material influence on recruitment, retention and motivation.
- 1.23 The WAG reported that there were no significant recruitment and retention difficulties in Wales and that most trusts were able to fill posts from a good field of candidates, while half of trusts in Wales considered recruitment to have improved in the past year. It said that improved vacancy rates were a direct result of robust recruitment and retention and showed that pay was about right at present. In Scotland, the SEHD told us that it had good work-life balance policies that enabled many staff to work at times which suited them and fitted around family commitments. It said that there were good career prospects associated with personal development plans and access to continuing professional development, all of which played a part in staff retention. It also said that it treated seriously requests from older workers to work beyond age 65 and that it was developing policies to encourage this to happen. It believed that there was no evidence that a high cost of living increase was necessary to deal with recruitment and retention. The DHSSPSNI said that the Appleby Report⁷ in 2005 had concluded that although the Northern Ireland health and social care sector did not appear to have been significantly under-resourced up till then, it would come under increasing pressure to replicate improvements in health outcomes envisaged for the United Kingdom by Wanless⁸. It believed that the ability to recruit staff in a competitive market was a major consideration for the level of pay uplift, but that the recruitment and retention of medical and dental staff was fairly stable, though with pockets of local difficulties in a few specialties such as paediatrics.
- 1.24 NHS Employers said that recruitment and retention had been generally stable with no shortage of applicants for vacancies in most specialties. They noted that the number of medical and dental staff in England had continued to grow in 2006, though at a slower rate than previously. All trusts participating in their survey had reported reductions in temporary staff usage and there had been a reduction in expenditure on medical locums in mental health trusts between 2003-04 and 2006-07. They indicated that concerns about recruitment and retention were limited to specific professional groups and geographical locations. Some employers had reported that non-pay solutions were having a positive impact on recruitment and retention, for example, flexible working and job planning. Where there were difficulties in the recruitment and retention of doctors, these related to consultants in certain specialties.
- 1.25 The BMA expressed concern that the number of home applicants for places in United Kingdom medical schools had fallen; we comment on this more fully in Chapter 7. However, it noted that the United Kingdom medical workforce had continued to grow in headcount terms in 2006, though at a significantly lower rate than in the recent past; it reported that overall growth was 2 per cent.

⁷ Professor John Appleby. *Independent review of health and social care services in Northern Ireland*. DFPNI, August 2005. Available from: http://www.dfpni.gov.uk/appleby_review_final_report.pdf

⁸ Derek Wanless. *Securing our future health: taking a long-term view. Final report*. HM Treasury, April 2002. Available from: http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm

Figure 1.1: Total number of medical and dental staff 2002 – 2006, United Kingdom



Sources: The Information Centre, Welsh Assembly Government, Information Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

- 1.26 The Health Departments reported that recruitment to the medical workforce was healthy and that women now comprised 39 per cent of the total medically qualified doctor workforce. However, since September 2006 there was some evidence to suggest a slow down in the growth of the workforce and a modest reduction in demand for medical staff in some organisations. They said that medicine remained an attractive career option, with strong competition for places in medical schools and for specialty training places in the NHS. They also told us that they did not need to rely on overseas doctors as much as in the past and that they had reached a position where domestic supply met demand. They said that although they were no longer centrally recruiting international doctors, the United Kingdom remained an attractive destination for international doctors who continued to apply for employment and training in the United Kingdom and made an important contribution to the NHS.
- 1.27 The Health Departments reminded us that NHS staff were employed by individual NHS employers and doctors could be expected to move between NHS employers as they progressed their careers. They said that the turnover rate was 9.8 per cent for the total NHS workforce, although some organisations had announced plans to reduce posts to generate savings and improve efficiency. However, they reported that only 2.5 per cent of redundancies between 1 April 2006 and 31 March 2007 were medical staff. The WAG reported that the three most common reasons for leaving were: other NHS employment, relocation and retirement.
- 1.28 NHS Employers told us that financial turnaround had been achieved through a reduction in the temporary workforce, clinical support staff and managers, rather than large reductions in the permanent clinical workforce. They said that in a workforce of over 1.3 million, the full-time equivalent had fallen by 0.7 per cent between 2005 and 2006, and the headcount by 1.3 per cent. Where workforce reductions had been necessary, they had largely been delivered through control of vacancies and reductions in agency expenditure; redundancies had been minimal. They said that the situation with redundancies was much less acute now than a year ago, although some organisations continued to have local reconfiguration programmes that included the need to review staffing.

- 1.29 We do not see any major cause for concern in the recruitment and retention situation and note that, in general, medicine and dentistry continue to be attractive careers, though it is clear that some career paths are more popular than others. Our detailed comments on the evidence on recruitment and retention can be found later in the report, in the chapters relating to the individual remit groups.

Motivation and morale

- 1.30 NHS Employers reported that 49 per cent of the respondents to its survey said that morale had stayed the same and 44 per cent that it had deteriorated. They said that where there was deterioration in morale, the recent difficulties around recruitment to junior doctor training were cited as the main cause. However, the recent NHS reconfiguration, financial problems and workforce reductions in some areas had also had an impact on morale across the service. The employers surveyed did not believe that there was any deterioration in morale directly related to pay, or that the solution would be found in simply giving a higher pay award. They told us that in a few cases the number of staff intending to leave their jobs had fallen or was below average for their sector, while job satisfaction had remained broadly the same. They believed that there was a continuing positive impact of the Improving Working Lives⁹ standard on morale and motivation, and that this particularly related to flexible working, compressed hours, annualised hours and term-time working.
- 1.31 The Health Departments did not provide us with any general evidence on motivation and morale, although both the WAG and the DHSSPSNI commented that morale had stayed the same over the previous 12 months.
- 1.32 The BMA told us that levels of motivation and morale differed across the medical profession. It said that there had been widespread disappointment over the recommendations in our last report and that there had been anger when the government decided to implement the recommendations in stages so as to contain the pay increases in-year within its intended limits. This anger had been exacerbated because the NHS ended the financial year 2006-07 in surplus of £510 million. It believed that the problems with training posts would affect radically the traditional view of job security within the medical profession and that this demonstrated the control that a monopoly employer could have over the labour market. The BMA asked that we should bear this in mind when making comparisons with other professions.
- 1.33 We have already referred to the government's staging of last year's uplift and we think that it is understandable that the much publicised problems with the Medical Training Application Service have led to a loss of confidence across the profession in the broader management of health policy. We make further comments on motivation and morale throughout the report, in the relevant sections for each remit group.

Productivity

- 1.34 The BMA was keen that productivity should be taken into account when recommending the uplift although it considered that the data on NHS finances in the Health Departments' evidence ignored the contribution made by the NHS workforce to meeting the demand pressures on the NHS. The BMA said that the pressures from meeting targets contributed directly to the productivity of the workforce and it argued that pay should reflect this contribution. However, the Health Departments

⁹ Improving Working Lives is a scheme by which NHS employers and staff can measure the management of human resources. Organisations are 'kite-marked' against their ability to demonstrate a commitment to improve the working lives of their employees.

disagreed and said that given the extremely complex estimates of NHS productivity, with associated wide confidence intervals, they did not believe that these measures should feed directly into this year's pay deliberations. Although the DHSSPSNI thought that, if productivity gains were to become a feature of our recommendations, there would be scope to apply this in Northern Ireland as part of a wider reform programme, it was not seeking a recommendation on productivity levels; the productivity gap would be addressed with employers and in consultation with staff representative groups.

- 1.35 We recognise that there are important issues about the measurement of productivity in public services and that progress has been made^{10 11} in addressing these issues. Real productivity improvements may well have been achieved in the NHS, but we agree with the Health Departments that the methodology of public sector productivity measurement is not yet sufficiently robust to be used as a basis for judging the affordability of pay awards. Furthermore, whereas in a private sector business increases in productivity generate additional net revenue to contribute to the pay bill, in a public service there is not necessarily such a direct link between productivity and affordability.

General economic context and the government's inflation target

- 1.36 As usual we have reviewed the general economic context, with particular regard to the government's inflation target which we are obliged to take into account in our deliberations. We note that economic growth, which has remained above trend through 2007, is forecast to slow markedly in 2008 as the economy responds to weaker world activity, tighter credit restrictions, reduced consumer consumption, and falling real incomes. The Bank of England in its February 2008 *Inflation Report*¹², argues that the risks lie markedly on the downside. The average of forecasts for 2008 puts gross domestic product growth at 1.8 per cent, compared to over 3 per cent in 2007. Such a slowdown is likely to have adverse implications for the public finances.
- 1.37 At the same time, however, we also note that substantial upward pressures on inflation are expected to emerge during the year. As the Governor of the Bank of England recently said: "2008 is likely to see higher energy prices, higher food prices and, with a lower exchange rate, higher import prices, pushing inflation above the 2 per cent target"¹³. The central projection in the Bank of England's *Inflation Report* suggests that the Consumer Prices Index (CPI) will exceed the government's 2 per cent target for much of the year, possibly rising above 3 per cent during the summer before falling back to around 2.5 per cent. In the shorter term, technical amendments to the index relating to how changes in domestic gas and electricity prices are incorporated will lead to a temporary increase in inflation measures. As at January 2008, the CPI showed an increase of 2.2 per cent over the previous 12 months.

¹⁰ *Atkinson review: final report. Measurement of government output and productivity for the national accounts.* Palgrave Macmillan, 2005. Available from: http://www.statistics.gov.uk/about/data/methodology/specific/publicSector/atkinson/final_report.asp

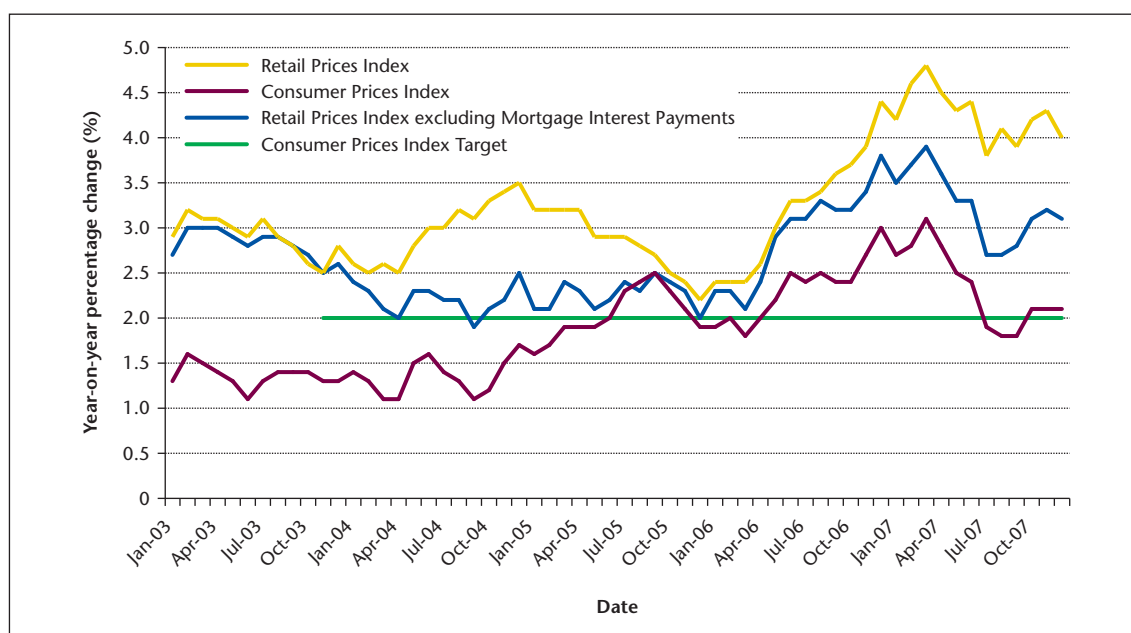
¹¹ UK Centre for the Measurement of Government Activity. *Public service productivity: health.* Office for National Statistics, February 2006. Available from: [http://www.statistics.gov.uk/articles/nojournal/PublicServiceProductivityHealth\(27_2_06\).pdf](http://www.statistics.gov.uk/articles/nojournal/PublicServiceProductivityHealth(27_2_06).pdf)

¹² *Inflation report: February 2008.* Bank of England, 2008.

¹³ Speech by Mervyn King, Governor of the Bank of England to IoD South West and CBI, Bristol, 22 January 2008. Available from: <http://www.bankofengland.co.uk/publications/speeches/2008/speech333.pdf>

1.38 The other key measure, the all-items Retail Prices Index (RPI), stood at 4.1 per cent in January 2008. Forecasters currently predict that this measure will fall during 2008, with the average of forecasts at 2.5 per cent for the fourth quarter of the year. These forecasts assume downward pressures on RPI, notably from static or lower house prices and reductions in mortgage interest rates – elements not captured in CPI – will offset, to some extent, rising prices elsewhere. However, the inflationary pressures may mean that the fall in RPI is not as great as some initially forecast.

Figure 1.2: Inflation: Consumer Prices Index, Retail Prices Index, Retail Prices Index excluding Mortgage Interest Payments, January 2003 – December 2007



Source: The Office for National Statistics

1.39 The median of pay awards across the whole economy stayed around 3.5 per cent during 2007, with half of awards at or between 3 per cent and 4 per cent. We do not have sufficient evidence to draw any conclusions about settlement levels in 2008. Growth in average earnings has recently settled at around 4 per cent, including bonuses, for the whole economy, or 3.6 per cent if bonuses are excluded. In recent years earnings growth in the public sector has been of the order of one percentage point below that in the private sector. Earnings growth including bonuses is forecast to average 4 per cent during 2008 as a whole.

1.40 Many commentators have drawn attention to the recent stability in earnings growth given a fairly robust labour market in 2007: employment has reached record levels, unemployment has fallen and vacancy rates are up on 2006. In addition, whole economy productivity per head is above trend. In these circumstances some pick-up in earnings growth might have been expected but has yet to materialise. We also note that earnings growth remains within the maximum 4.5 to 4.75 per cent that the Bank of England has said is the maximum compatible with the inflation target. The Bank's original statement was concerned with prolonged earnings growth as a measure of labour utilisation, and the then Deputy Governor was at pains to emphasise that the Bank did not consider it should second-guess what businesses should or should not pay their employees.¹⁴

¹⁴ Speech by Mervyn King to the Employment Policy Institute, 1 December 1998. Available from: <http://www.bankofengland.co.uk/publications/speeches/1998/speech29.htm>

Affordability and the Health Departments' expenditure limits

- 1.41 This year, affordability was again the main theme throughout the evidence submitted by the Health Departments and NHS Employers, with warnings of the serious consequences for patient care and staffing levels that would result from any uplift above that budgeted. We have considered this evidence carefully during our deliberations and summarise it below.
- 1.42 The Health Departments said that it was vital that this year's recommendations took full account of the wider fiscal and macroeconomic situation. The key issue with the fiscal context was the amount of money available for current spending over the Comprehensive Spending Review period and this was the tightest spending review in nearly a decade. They stressed that all pay costs must be met from Departmental allocations and that there was no flexibility to move funding between the revenue budget and capital budget. The fixed funding envelope for the NHS meant that if pay increases were higher than planned, other costs would need to be lower. They stressed that higher pay settlements would lead to lower levels of employment and would put at risk further improvements to NHS care. They told us that around 60 per cent of expenditure within the HCHS (and 46 per cent of total expenditure) was on pay, so that even very small changes in pay had a substantial effect on the affordability constraints of NHS organisations and each additional 0.5 per cent increase in pay for our remit group added about £46 million to the pay bill. They explained that the government had a three-year process of financial and service planning and that pay settlements above the planned level meant that the Health Departments would have to revise plans for all three years. A range of other commitments for drugs, goods and services, and additional investment over the next three years could be put at risk if a higher pay award than had been budgeted for was agreed.
- 1.43 The WAG added that a higher than affordable pay rise would impact on services through a reduction in the quality of care as a result of a reduction in staff numbers, although this would not necessarily be through redundancies. It said that the impact of the Comprehensive Spending Review was expected to be a significant reduction in the flexibility to manage the financial pressures in NHS Wales in 2008-09. It would need to make efficiency savings of at least 2 per cent to meet ongoing service costs, in addition to eliminating underlying deficits.
- 1.44 The SEHD noted that the outcome of the Comprehensive Spending Review would lead to a tight 'fiscal' situation and there would be less money in relative terms to meet the aspirations of staff than in recent years. It said that high pay awards would lead to a reduction in staff employed and put at risk the delivery of key services.
- 1.45 For Northern Ireland, the DHSSPSNI told us that a pay award in line with inflation was the most that could be afforded; anything higher would impact on planned patient services, could lead to a direct impact on planned growth and ultimately result in targets not being met. It defined affordability as living within the allocated budget and said that an affordable pay settlement was necessary to ensure the continued development of patient services, planned growth and the achievement of agreed service targets. It said that pay comprised 55 per cent of the total DHSSPSNI resource Departmental Expenditure Limit and that Northern Ireland faced similar constraints on affordability as the other parts of United Kingdom. If pay continued to increase at or around the same levels as in England, there would be a greater proportionate impact on other policy areas.

- 1.46 NHS Employers reiterated much of the evidence given to us by the Health Departments relating to the impact of the Comprehensive Spending Review and told us that employers strongly believed that further cost pressures through unfunded pay increases would impact on services and necessarily lead to cost savings elsewhere, including: reductions in posts; vacancy freezes; impact on planned growth; and reduction in capacity. They said that the Comprehensive Spending Review had announced a 4 per cent annual increase in real terms for the NHS from 2008-09 up to 2011-12, which was only around half the growth in funding over recent years (since 2000). They explained that affordability was linked to the tariff¹⁵ and primary care trust (PCT) allocations (although the tariff had not been announced when their initial evidence was submitted). Employers had to be able to meet commissioned levels of service and national targets without compromising patient care or financial balance, but it would not be possible to assess affordability for individual organisations as the tariff was based on an average across the NHS. They said that money within the NHS budget was not specifically allocated to spend on annual pay increases. The pay bill at PCT level was met from the overall allocation of funding for PCTs, while resources for trusts came through contract income. They emphasised that pay was by far the greatest element of expenditure within provider trusts and that cost pressures against these budgets formed a significant risk to the employing organisation.
- 1.47 NHS Employers asked us to consider carefully the impact that any pay increase deemed unaffordable would have on services; affordability was dependent on an appropriate increase in the tariff for 2008-09 following the recent confirmation of the spending plans for 2008-09 onwards. Further cost pressures above basic annual inflationary uplifts included drugs costs, litigation and insurance costs, and continuing care costs. They said that it was increasingly challenging for organisations to identify cumulative year on year savings without jeopardising patient care. NHS Employers told us that the Comprehensive Spending Review settlement brought with it a political and public expectation of new service developments and greater standards of access and quality. The review of cost pressures facing NHS organisations had highlighted the need for organisations to deliver efficiency savings, ranging from 0.8 to 3.2 per cent above the original 2.5 per cent efficiency target. They claimed that public sector pay policy restricted headline pay awards to 2 per cent and that a headline uplift of 2 per cent in conjunction with the 1.6 per cent additional cost pressures on NHS pay budgets would require additional efficiency savings above the revised efficiency target of 3 per cent. If there was to be a multi-year award, this would need to be at an affordable level, with a corresponding uplift to the tariff. NHS Employers stated that key future financial risks were: future National Institute for Health and Clinical Excellence (NICE) recommendations; equal pay claims; the Clinical Negligence Scheme for Trusts (CNST);¹⁶ new clinical priorities and government targets; fuel and energy prices; reducing secondary care activity; rising continuing care costs; revisions to education and training funding; and revisions to research funding.
- 1.48 The BMA told us that it had been unconvinced by the Health Departments' affordability arguments last year. It pointed out that Scotland was able to implement our recommendations in full, as were Wales and Northern Ireland for non-medical and dental staff. It noted that pay settlements were now averaging around 3.5 per cent and that the tendency for differentials to widen persisted. It believed that inflation would be below or close to the government's target and there would be no need to

¹⁵ The tariff is the scale of charges for the services provided by acute trusts to primary care organisations.

¹⁶ CNST is a scheme of risk pooling. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by or in relation to NHS patients treated by or on behalf of those NHS bodies.

constrain public sector earnings growth of up to 4.5 per cent. It said that NHS resource growth in 2008-09 would be between 5.5 and 6.5 per cent in cash terms, supplemented by efficiency gains.

- 1.49 Last year we asked the Health Departments and NHS Employers to improve the presentation of their evidence on the available budget and we appreciate the volume of information that was provided this year. Nevertheless, we find that the evidence has again proved to be somewhat inconclusive. We remain puzzled that the devolved authorities, although each receiving different percentage increases in their allocations from the Comprehensive Spending Review,¹⁷ all recommend the same pay uplift as affordable. We found it hard to reconcile the financial projections for non-pay expenditure (including expenditure on drugs) with the narrative evidence of the Health Departments. We recognise that, in a spending review, the government will make strategic decisions about planned expenditure on pay alongside other priorities, and indeed that making the right decisions about pay will have a very high strategic priority for an organisation which depends so much on a highly qualified and strongly motivated workforce. However, when expenditure plans are presented to us, pay appears to be the residual after account has been taken of all other priorities. If we are to fulfil our remit, we need to be able to interrogate the assumptions behind the spending plans, and it is for this reason that we think it is essential that the Health Departments present their evidence on affordability in the clearest possible terms and justify these assumptions.

NHS deficits and surplus

- 1.50 The BMA drew our attention to the NHS surplus of £515 million in 2006-07 and to the forecast surplus of £983 million for 2007-08. However, the Health Departments urged us not to misinterpret the forecast surplus for 2007-08 as a signal that the NHS could afford higher pay rises as most of the surplus would not be available for new service costs in 2008-09. They noted that while the NHS as a whole had returned to financial stability, there was still a small number of NHS bodies facing “significant financial challenges”; for example, Wales had a deficit of £28 million for 2006-07.
- 1.51 NHS Employers added that although the NHS as a whole was forecast to deliver a surplus at the end of 2007-08, 6 per cent of organisations were still expected to be in deficit. Furthermore, a surplus was not a recurrent resource and would therefore not be available for pay uplifts. They said that the NHS had been in a position of financial recovery over the past two years. It had delivered a surplus in 2006-07, reduced the percentage of organisations in deficit to 22 per cent and reduced the gross deficit¹⁸ to £911 million. Projections for 2007-08 were also positive. They said that most of the gross deficit in 2006-07 was with PCTs (69 per cent compared to 47 per cent in 2005-06), following a sharp reduction in NHS trusts’ deficit. The financial position of acute trusts had improved to a greater extent than that of PCTs and only 5 per cent of foundation trusts were in deficit at the end of 2006-07. Nevertheless, while the overall financial position of the NHS had improved since last year, the net position masked a significant number of individual organisations that remained in financial deficit and further work was required to reduce gross deficits and support those organisations with the most difficulties. They said that it was also clear that the organisations would have to deliver efficiency gains above the new Comprehensive Spending Review target of 3 per cent to finish the financial year in balance.

¹⁷ For 2008-09, the real terms increases in the Departmental Revenue Expenditure Limits are: England 3.9 per cent; Wales 1.3 per cent; Scotland 1.59 per cent; Northern Ireland 1.05 per cent.

¹⁸ Gross deficit is the sum total of deficits of all organisations that overspend.

Pay drift

- 1.52 The Health Departments argued that their financial planning was based on the suggested pay settlements set out in evidence and included an average of 1.6 per cent pay drift across the HCHS. They told us that the projected growth in HCHS medical earnings per full-time equivalent (2008-09) was 1.1 per cent; made up from 1.00 per cent for consultants, -0.70 per cent for training grades, and 6.36 per cent for other medical staff (mainly comprised of SAS/NCCGs and anticipating the new contract). They remained convinced that the prospect of incremental progression softened the impact of pay awards that were below inflation.
- 1.53 NHS Employers said that all hospital doctors and salaried dentists had access to pay scales with increments which ranged from an average of 4 per cent for consultants, 5 to 9 per cent for SAS grades and 4.2 to 8.2 per cent for doctors in training. They believed that these increases should be factored into our decisions about the recommended level of uplift and told us that additional pressures above annual pay inflation included: Agenda for Change pay drift; Agenda for Change appeals; the consultant contract; and the European Working Time Directive.
- 1.54 The BMA criticised us for sending mixed signals on pay drift in our last report and said that it did not accept the calculations on pay drift that NHS Employers had imported from the Health Departments. It believed that incremental progression should not be taken into account when calculating uplift, and said that for consultants, progression was now at longer intervals and was no longer automatic. Consultants at the top of their pay scales relied on our annual recommendation.
- 1.55 We have previously set out our views on pay drift¹⁹ and see no reason to change these, even though the parties continue to calculate pay drift differently. As we have said before we do not believe that pay drift arising from increased overtime or other payments for higher volumes of work, or from the effects of recently negotiated contracts, including incremental pay scales, should be offset against the annual award. The pay drift consequences of those contracts were foreseeable when they were negotiated. We believe that if we were to offset the earnings growth arising from increments from our recommended pay award, it would undermine the fundamental principle on which incremental pay scales are based. Incremental scales should reward increasing experience and loyalty to the employer. Moreover, both parties agree to the pay increases delivered by increments when staff are employed. It is therefore entirely inappropriate to ask us to take account of such increases when considering our general uplift.

Overall NHS strategy – patients at the heart

- 1.56 A new element of our remit is that we should have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. We did not receive any direct evidence relating to this, although it was a recurrent theme in the evidence on affordability from the Health Departments and NHS Employers that increases above what they had budgeted would impact on patient care. We ask the parties to address this issue more directly when preparing evidence for the next round so that we may better assess its implications for pay.

¹⁹ Review Body on Doctors' and Dentists' Remuneration. *Thirty-fifth report*. Cm 6733. TSO, 2006. Paragraphs 2.54 – 2.56. Available from: <http://www.ome.uk.com/downloads/35th%20Report%202006.pdf>

Legal obligations on the NHS including anti-discrimination legislation

- 1.57 A further addition to our remit this year is that we should take account of the legal obligations on the NHS, including anti-discrimination legislation in relation to age, gender, race, sexual orientation, religion and belief, and disability. Again, we received no specific evidence for this aspect of our remit, and we ask the parties to address this in their evidence for the next round.

Regional and local pay variations: the effect on recruitment and retention (London weighting)

- 1.58 Last year we recommended that the supplements for London weighting should remain at their existing levels for 2007-08 and said that unless evidence in future years indicated that labour market conditions in London had changed, we did not intend to revisit this decision.
- 1.59 The Health Departments told us that they agreed with our recommendation and asked that rates of London weighting should continue to be held steady in cash terms. They noted that the consultant contract had provision for employers to pay a recruitment and retention premium of up to 30 per cent of normal starting salary under certain circumstances and sought no further regional or local differentiation in doctors' pay for 2008-09. The SEHD added that the position on regional pay had not changed markedly since last year and it was not currently considering any further measures. The DHSSPSNI believed that public sector pay should reflect the circumstances specific to the local labour market. NHS Employers said that the current rate of London weighting was adequate. We received no other evidence from the parties and conclude that the supplements for London weighting should remain at their current levels. We therefore **recommend that supplements for London weighting should remain at their existing levels for 2008-09.**

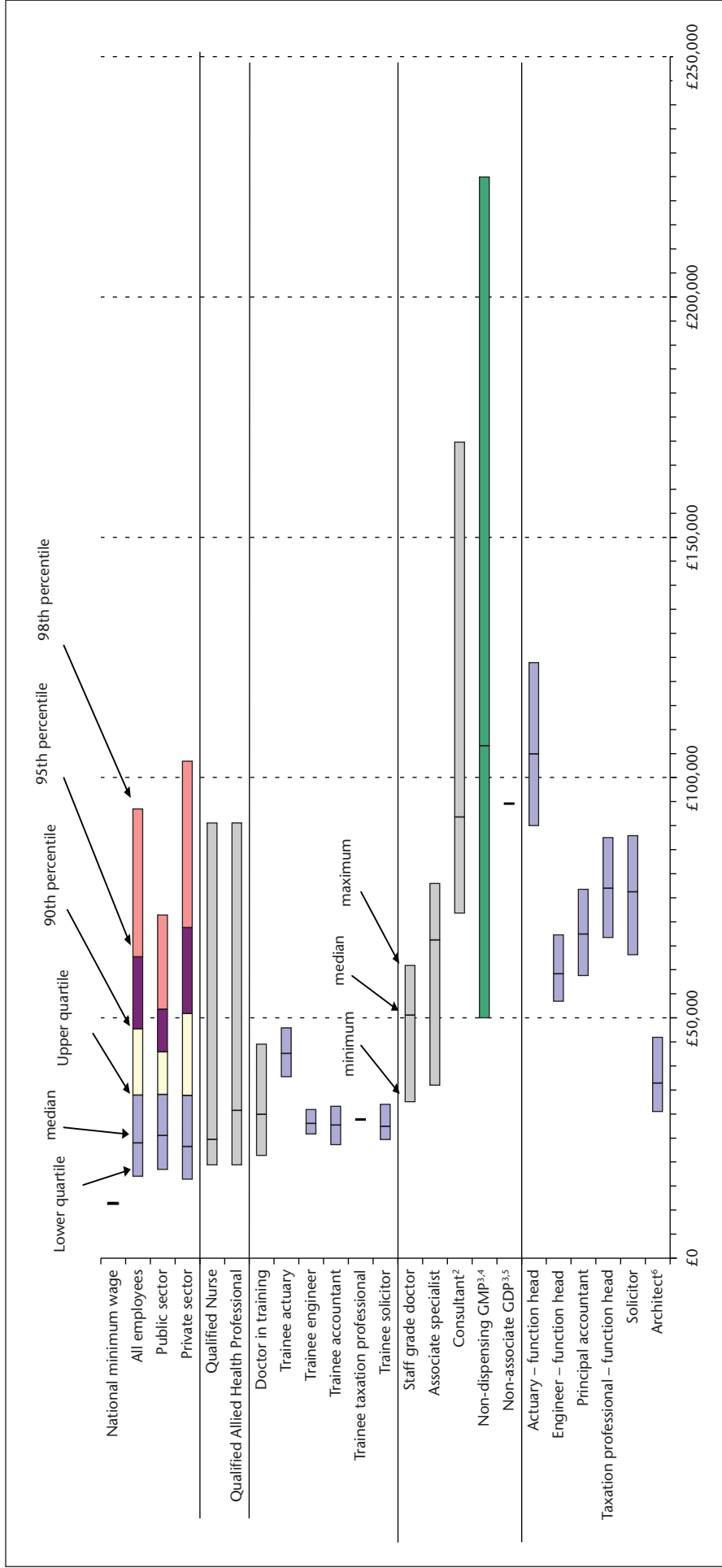
Pay comparability

- 1.60 Each year our secretariat provides us with an assessment of the pay position of our remit groups relative to other groups who could be considered appropriate comparator professions, and against recent trends in general pay and price inflation measures. We look at both pay levels and movements. The specific comparator professions that we use are solicitors, actuaries, accountants, architects, taxation professionals and engineers.
- 1.61 Our assessment of the relative remuneration levels of our remit group has been made more difficult this year as the Office for National Statistics (ONS) decided to cut the sample size of the 2007 'wave' of the Annual Survey of Hours and Earnings (ASHE) – a key source of statistical information on earnings – by 20 per cent overall, but by 30 per cent in the public sector areas of most interest to us. While ONS implemented the cut in a way that ensured earnings data remained reliable at high levels of aggregation, such as for the public sector, private sector and whole economy, results at lower levels of aggregation, including for specific occupations such as doctors and dentists, now have wider margins of error attached to them, making them less reliable for our purposes.
- 1.62 In common with several other bodies which have responsibilities for public sector pay, we are very disappointed by the stance ONS has taken on ASHE despite the representations from the Office of Manpower Economics which provides our secretariat. We urge the government to provide the necessary funding to enable ONS to reverse the ASHE sample cut in future waves of that survey.

Pay levels

1.63 Figure 1.3 shows the basic pay ranges of our remit groups in the HCHS sector as at 1 November 2007, and the median basic pay levels within the ranges. For non-dispensing independent contractor GMPs, we have indicated figures for the broad range of profit (only 6 per cent earn an income below this range of £50,000 – £225,000 and only 2 per cent above it) and for non-associate GDPs the mean profit as published by the IC using data from Her Majesty's Revenue and Customs (HMRC) for the financial year 2005-06, the latest year for which actual accounts data are available from HMRC. These pay levels have been compared with the national basic pay distribution and with the inter-quartile basic pay ranges of the comparator professions as described above. In general, we note that the pay ranges of our remit groups compare favourably with those of other professions, with the exception of actuaries and we consider that actuaries' pay reflects their involvement in the financial services sector, where earnings tend to be high. We also note that the pay range of consultants is competitive when compared to most other comparator professions and that the lowest spine point is in the top 5 per cent of the national pay distribution. Our assessment shows that total earnings for doctors and dentists in training are competitive once their out-of-hours supplement is taken into account, but their basic pay appears less competitive. Total earnings for senior house officers/foundation year 2s are above the average of most of the comparators, except actuaries and taxation professionals. We return to this in more detail in Chapter 7. A selection of comparative graphs is included in Appendix E.

Figure 1.3: Basic pay ranges of DDRB remit groups, November 2007, compared with the national pay distribution and other professional groups¹, full-time rates



Sources: The Low Pay Commission, The Office for National Statistics, NHS Employers, The Information Centre, Celre, Hay Group and the Royal Institute of British Architects

¹ Pay level comparisons are made with specific roles in other professions (see Annex A of Appendix E).

² The consultant range includes Clinical Excellence Awards (CEAs) (58 per cent of consultants received a CEA and a level 2 local award is considered the median for all consultants).

³ Estimated mean net incomes for 2005-06 for all (both full-time and part-time) GMPs and GDPs (the latest available data).

⁴ The range given excludes the bottom 6 per cent (who earn less than £50,000) and the top 2 per cent (who earn £225,000 or more).

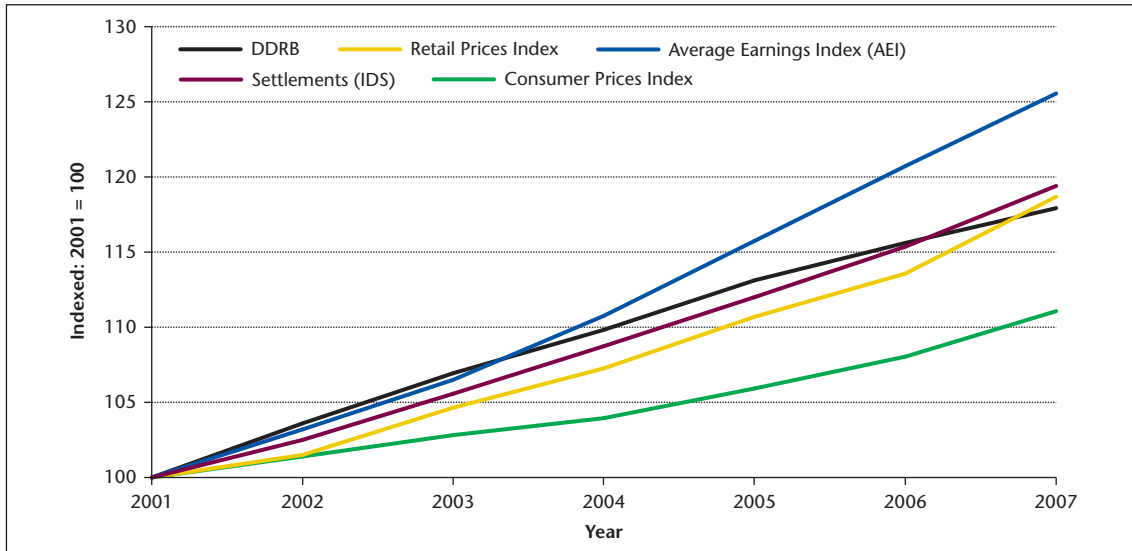
⁵ A non-associate GDP is a dentist who works in a stand-alone business; there is no range available for non-associate GDPs.

⁶ Data for architects are for 2006 rather than 2007.

Pay movements

1.64 We have also looked at how our basic awards over recent years have compared to settlements and earnings in the wider economy, and the main measures of inflation (CPI and RPI) (see Figure 1.4). However, our recommendations are not linked, automatically or otherwise, to any particular index of pay or inflation.

Figure 1.4: DDRB main award, earnings, settlements and inflation, 2001 – 2007



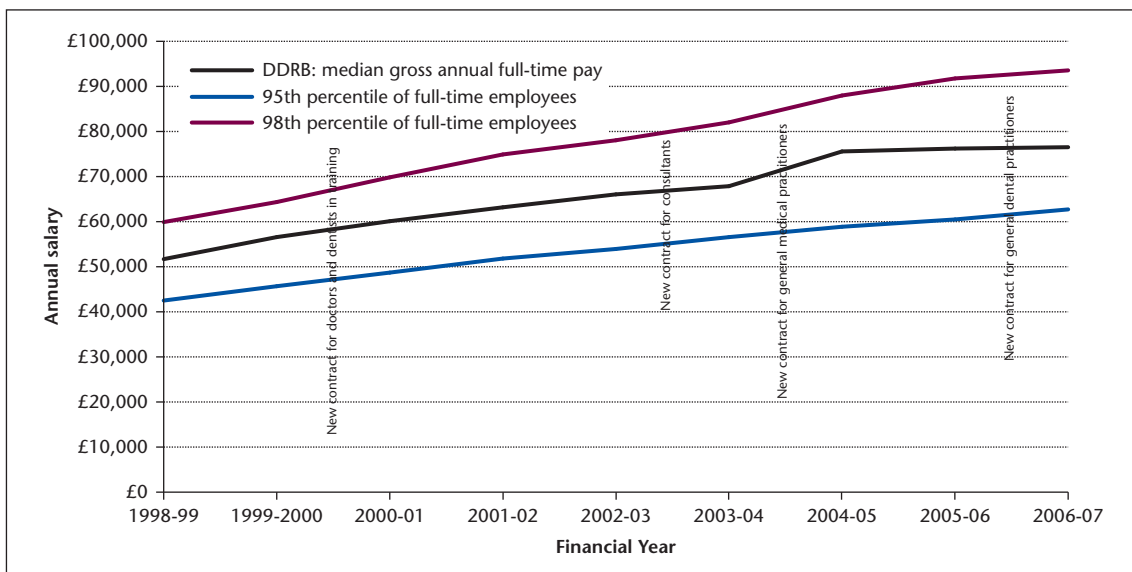
Sources: Review Body on Doctors' and Dentists' Remuneration, The Office for National Statistics, Incomes Data Services (IDS)

Notes: The AEI shown is the headline rate, RPI data and CPI data as at April of each year shown.

Settlements are IDS pay settlements, median, by number of pay reviews, at April each year (quarterly figures).

1.65 As in previous years, we have looked at how the earnings of our remit groups have evolved over time. Movements in their earnings are influenced by a number of factors including the basic award, overtime payments, incremental progression, performance payments and pay reform.

Figure 1.5: Annual gross median earnings of DDRB's groups, 1998-99 to 2006-07, full-time rates



Source: Annual Survey of Hours and Earnings (ASHE) – The Office for National Statistics

- 1.66 Figure 1.5 shows the earnings growth for our remit groups employed in the HCHS as a whole. We note from this figure that the earnings of our remit groups have remained between the 95th percentile and the 98th percentile over the last eight years.

Total reward: pensions and fringe benefits

- 1.67 The Health Departments told us that pensions were an important part of the total reward package. They said that changes to the scheme from 1 April 2008 represented an improvement in the value of the NHS pension scheme, once longevity was taken into account, which was why it was proposed that staff contributions should increase to pay for these improvements. The highest earning members would pay 1.5 or 2.5 per cent more in contributions. In Scotland, they expected that pension considerations would remain a real factor in determining recruitment and retention of existing and potential staff and asked us to include this in our assessment of headline pay increases.
- 1.68 NHS Employers said that they agreed with the NHS trade unions that pensions were deferred pay and they recognised that the employer contribution made up a significant proportion of remuneration for members of the NHS pension scheme. They also believed that contributions made by employees to the pension scheme were deferred pay. They said that the increase in contributions from members would pay for increases in the value of benefits they would receive. As the employer contribution remained the same, it should therefore be seen as neutral in pay terms. They said that they expected the positive impact of the NHS pension scheme on recruitment and retention would increase and noted that high earners would benefit from the removal of the earnings cap.
- 1.69 The BMA and BDA had jointly commissioned an analysis of the relative value of the NHS pension scheme to doctors and dentists,²⁰ and a separate report on fringe benefits.²¹ The BMA said that the report had concluded that the impact of the new pension scheme would be to increase the value for GMPs and decrease the value to consultants (other than at age 40), but that the value to both groups would remain lower than for private sector employees at similar incomes in defined benefit schemes. The BDA added that, while it was a substantial benefit to GMPs and other groups in the scheme and although the scheme compared favourably with other schemes available in the private sector, it did not compensate for the lack of other fringe benefits, for example company cars, bonus schemes or employee share schemes. Those in the commercial sector typically enjoyed a wider range of fringe benefits. The BDA pointed out that from April 2008 the cost of membership of the NHS pension scheme would increase substantially for most members. For fringe benefits, the BMA said that although they were ahead of the market in relation to a number of benefits (principally holiday entitlement) doctors remained behind in market practice in relation to a number of key benefits (life assurance, car provision, private health insurance). It noted that the analysis did not cover bonus payments.

²⁰ *Relative values of the NHS pension scheme for doctors and dentists*. Hewitt, 12 October 2007.

²¹ Andrew MacLeod. *Competitive review of benefit and perquisite provision in the UK*. Hewitt, 21 August 2007.

- 1.70 There are separate pension schemes for practitioners (GMPs and GDPs) and other doctors. Both are unfunded, defined benefit schemes. The key difference is that the practitioners' scheme pays a pension based on career average revalued earnings, while the scheme for hospital doctors (and all other NHS workers) pays a pension calculated as a proportion of final salary. This reflects the fact that practitioners' NHS earnings are likely to reach a plateau (in real terms) relatively early in their careers, and may even drop off in later years as they reduce the intensity of their work, while hospital doctors' earnings will typically peak immediately before retirement as a consequence of career progression, increments and clinical excellence or other awards.
- 1.71 We note with interest the two reports by Hewitt, which were presented to us as supplementary evidence, and the report by Watson Wyatt²² prepared for the Review Body on Senior Salaries. These demonstrate that pensions are a valuable benefit for our remit group. The NHS schemes are inherently more secure than those in the private sector and have the advantage of being defined benefit schemes, while the private sector is increasingly moving to defined contribution schemes. Nevertheless, we accept that the level of benefits overall is not high in comparison either with typical private sector schemes for senior staff or with other public sector schemes. Moreover, NHS doctors and dentists do not have access to benefits available to many senior staff in the private sector, such as variable bonus payments, share schemes and long-term incentive plans. A full comparison of total reward would include all such benefits, as well as pay and pensions, but we do not have the information to carry out such a comparison. Nevertheless, in the light of the reports by Hewitt and Watson Wyatt, we consider that pension provision for NHS doctors and dentists is broadly in line with that for comparable groups in both the public and private sectors. Consequently there is no case for adjusting our pay recommendations to take account of pensions. However, given the importance of pensions in total reward, we shall continue to consider this issue in future rounds.

Conclusions

- 1.72 The main conclusions that we draw from our examination of the economic and general evidence are:
- the need for restraint in public sector pay awards;
 - despite a surplus of £515 million in 2006-07, a small proportion of organisations are still in deficit and affordability continues to be a major concern for the NHS;
 - although the pay ranges of our remit groups do not appear to be out of step with those of the comparator professions, total earnings for doctors and dentists in training are competitive only once their out-of-hours supplement is taken into account; their basic pay appears less competitive;
 - that, as pension provision for NHS doctors and dentists is broadly in line with that for comparable groups in both the public and private sectors, there is no case for adjusting our pay recommendations to take account of pensions; and
 - that, with the exception of the problems surrounding the Medical Training and Application Service for junior doctors, there are no significant problems affecting recruitment, retention or motivation for our remit group.

²² *Report on the comparison of the pension schemes of the senior civil service, judiciary and senior military.* Watson Wyatt, 4 January 2008.

CHAPTER 2: MAIN PAY RECOMMENDATIONS FOR 2008-09

The parties' proposals

- 2.1 We have carefully considered all the evidence from the parties who, as in previous years, have presented arguments pointing to very different conclusions. The parties' proposals are covered in more detail in the relevant chapters, but we give details of their overall proposals below.
- 2.2 The Health Departments said that it was vital that awards were consistent with the achievement of the Consumer Prices Index target of 2 per cent and the proposals set out in their written evidence, although they did not explain how, in their view, different levels of award would affect achievement of that target. They proposed an increase in basic pay for salaried doctors and dentists of 1.5 per cent; initially this excluded staff and associate specialists/non-consultant career grades (SAS/NCCGs), for whom a new contract is under negotiation, but they subsequently said that they were content for us to consider this group as part of our normal deliberations. They said that pay was only one element of the total reward package which staff received and that other key elements included pensions, annual leave, opportunities for flexible working and work-life balance, career development and access to training. In their view it was necessary to balance the need to recruit, retain and motivate staff against the need to maximise the funds available to meet non-pay cost pressures and deliver ambitious service improvements. The Health Departments told us that although they were having discussions over the possibility of a multi-year pay award for Agenda for Change staff, they considered that given the ongoing changes to medical pay, and particularly the impact of the working hours regulations on junior doctors' pay and the potential for a new SAS contract, they were seeking a recommendation for a one-year deal. However, they said that this did not rule out such discussions in future.
- 2.3 The Welsh Assembly Government said that an increase of no more than 1.5 per cent would be the most balanced option for Wales and the Scottish Executive Health Department sought an increase of 1.5 per cent for all Scottish medical staff. It said that this was affordable and appropriate in the context of trends in medical salaries over recent years and would enable them to fund competing priorities within a tight budget. For Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPSNI) said that it favoured a percentage rather than a flat rate increase, and that the increase should be the same for both medical and non-medical staff. In line with the other Health Departments, it sought a 1.5 per cent uplift. The DHSSPSNI said that there was strong support among health and social care employers for a multi-year (preferably a three-year) pay deal as this would assist the planning of resources and service provision whilst providing some stability and assurance for staff on future increases. It said that Northern Ireland was committed to implementing national pay policy defined by United Kingdom guidance, and that the presumption was that the Department of Health's rationale for a pay settlement of around 1.5 per cent should apply to Northern Ireland.
- 2.4 NHS Employers said that, taking into account the impact on staff, a 2 per cent increase would be affordable while requiring organisations to deliver efficiency savings above the levels indicated in the government's spending review. They favoured a percentage rather than a flat rate increase and believed that medical and non-medical staff should receive the same award. They did not think that extra pay should be targeted at any of the medical groups. They said that the factors they considered most important when assessing the pay uplift were the financial position of the trust, the level of inflation, the latest tariff and staff morale. They sought a fair and reasonable national pay award that recognised the need for local employers to

achieve financial balance and was consistent with the resources available to the NHS and reflected in the 2008 tariff. They said that the pay increase should take account of both cost of living pressures and the impact on staff morale. NHS Employers favoured an agreement for an award over three years, but they told us that they had had no discussions with the BMA about the level of a multi-year agreement, although the BMA said that such an agreement had been discussed in principle about a year ago. Nevertheless, NHS Employers believed that a multi-year agreement could be accommodated within the limits of public sector pay policy.

- 2.5 The British Medical Association (BMA) believed that the general level of settlements this year should be at least enough to protect the value of existing contracts relative to Retail Prices Index (RPI) inflation and to reflect NHS productivity. It said that this pointed to a settlement of between 3.6 and 4.3 per cent. Those figures did not include any retrospective adjustment for what the BMA saw as a failure to maintain the profession's position in previous years.
- 2.6 The British Dental Association suggested that all NHS dentists should receive a 7 per cent increase to their net NHS earnings before tax. The Dental Practitioners' Association wanted an increase sufficient to recruit, retain and motivate dentists to work within the NHS but gave no specific figure for an increase; it told us in oral evidence that this was because it believed that the levels of the base contracts were fundamentally flawed.

Main pay recommendations for 2008-09

- 2.7 We have made our recommendations for what we believe is a fair and reasonable uplift, taking into account the economic and other evidence provided by the parties and the various aspects of our remit. In particular, we have endeavoured to balance the need to recruit, retain and motivate doctors and dentists, with the funds available and the government's inflation target. We are not persuaded that 1.5 per cent, which the Health Departments asked us to recommend, is the maximum amount that could be afforded. Indeed, NHS Employers believed that a 2 per cent increase would be affordable.
- 2.8 We are satisfied that there are no significant problems of recruitment or retention for our remit groups generally. Motivation and morale remain adequate, although they may have been damaged by the government's decision to stage last year's pay award where it resulted in increases above 2 per cent, and by problems with the Medical Training Application Service. Most doctors and dentists are enjoying the benefits, including increased pay and reduced hours in many cases, of new contracts. Revised contracts for the remaining groups could be in place soon. Thus there are no pressures this year that would point to the need for a significant pay increase for our remit groups.
- 2.9 Downward pressure comes from two sources: the government's argument that low pay increases are necessary to meet the government's inflation target, and a sharp reduction in the rate of growth of public spending under the current Comprehensive Spending Review. Along with other commentators^{1,2} we do not accept the first argument. Inflation is an economy-wide phenomenon and while public sector pay increases may be part of the phenomenon, they do not drive the process. Indeed,

¹ Andrew Oswald. Letters to the editor: four reasons to cast doubt on public pay policy. *Financial Times* 9 January 2008: 14

² Norma Cohen. Inflation driven by potatoes. *Financial Times* 10 January 2008: 4

public sector pay has a less direct effect on prices and costs than private sector pay. Moreover, we do not believe that our remit groups are seen by wage negotiators elsewhere as setting a 'going rate' for others to follow. However, we do accept that the government needs to control public spending, and that a high award to our remit group would be likely to reduce the funding available for improvements in patient care. Nevertheless, we are not persuaded that the award this year needs to be as low as the government's proposal of 1.5 per cent. The correct figure is ultimately a matter of judgement, and having considered all the evidence, we conclude that a basic pay increase of 2.2 per cent would be appropriate this year.

- 2.10 We could find no reason to differentiate between all the salaried members of our remit group. We have recommended the same award for staff and associate specialists/non-consultant career grades as we believe it is important that any recommendations we make do not influence the outcome of the forthcoming ballot. Special considerations apply to independent contractor general dental practitioners (GDPs) and general medical practitioners (GMPs) who are running small businesses. Their awards need to take account of changes in their expenses.
- 2.11 For GDPs we **recommend that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 2.2 per cent after allowing for an increase in expenses.** In order to achieve this we recommend that an uplift of 3.4 per cent be applied to the gross earnings base under the new contract for 2008-09 for GDPs in England and Wales. We recommend uplifting gross fees, commitment payments and sessional fees so that this will also result in an increase in GDPs' income of 2.2 per cent in Scotland and Northern Ireland after allowing for an increase in expenses. Therefore, this year we are recommending that the uplift of 3.4 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland.
- 2.12 Our consideration of the increase for GMPs was made difficult by the ongoing negotiations between the BMA and the government on the General Medical Services (GMS) contract. GMPs under the new GMS contract are paid under several different headings, some of which are negotiated locally. We **recommend an increase in the global sum for each 'weighted patient', in line with the general uplift of 2.2 per cent which we are recommending for doctors in the Hospital and Community Health Services.** However, the increase in the global sum needs also to take some account of practice expenses and therefore we recommend that the global sum payments per 'weighted patient' be increased by 2.7 per cent from £54.72 to £56.20 for 2008-09. Because of the way in which the contract is structured, this uplift will not affect all practices equally. Only a minority will actually receive an increase and we estimate that the effect will be to increase total expenditure under the global sum heading by 0.2 per cent. However, as well as the outcome of the current negotiations between the BMA and the government, we expect that most GMPs will also receive increases from other sources, including the locally negotiated elements of the contract.
- 2.13 Although NHS Employers and the DHSSPSNI said that they would favour a multi-year award over three years, they did not provide sufficient evidence to support this; nor had NHS Employers apparently done more than float the idea with the BMA. Furthermore, the evidence was presented on the basis of recommendations for one year. Our recommendations are therefore made for 2008-09.

- 2.14 **We recommend for 2008-09 a base increase of 2.2 per cent to the national salary scales for doctors and dentists.** The detailed recommendations for each group can be found in the relevant chapters.
- 2.15 **For the other fees and allowances on which we are required to recommend, unless they are specifically mentioned elsewhere in the report, we recommend that these be increased by 2.2 per cent for 2008-09.**
- 2.16 There is a full summary of our conclusions and recommendations at the beginning of this report. Appendix A sets out the detailed pay scales arising from our recommendations.

Part II: Primary Care

CHAPTER 3: GENERAL MEDICAL PRACTITIONERS

Introduction

- 3.1 The core traditional role for general medical practitioners (GMPs) is the family doctor, working either in General Medical Services (GMS) or in Personal Medical Services (PMS), in the primary care sector of the NHS. We are concerned only with the GMS which is governed by a United Kingdom-wide contract. Doctors working in PMS contract locally with primary care organisations (PCOs) or, in some cases, Strategic Health Authorities. However, local contracts tend to follow the main features of the GMS contract.
- 3.2 Most of the doctors working in the GMS are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses. However, some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. A new contract was introduced throughout the United Kingdom on 1 April 2004. The contract is with the practice rather than with individual GMPs. The contract allows for gross income under several different headings:
- basic services (this is known as the global sum, a payment based on the number of patients registered with the practice);
 - enhanced services (for example, dermatology or sexual health clinics);
 - PCO administered funding (to cover expenses such as premises and IT, as well as seniority payments and payments for dispensing practices); and
 - Quality and Outcomes Framework (QOF) (payments to GMPs for achieving various government priorities such as managing chronic diseases, providing extra services including child health and maternity services, organising and managing the practice, and achieving targets for patient experience). Practices are currently able to earn up to 1,000 points a year, each worth £124.60.
- 3.3 Independent contractor GMPs can earn income from a wide range of professional activities. Many also do work for the NHS outside the contract and this is rewarded through fees and allowances, including payments to GMP educators, and the GMP trainers' grant. Payment for work in community hospitals and sessional fees for doctors in the community health service for work under collaborative arrangements are also outside the contract, and doctors set their own fees for this work.
- 3.4 Salaried GMPs are employed either by PCOs or by independent contractor practices. The pay range for salaried GMPs is at Appendix A.
- 3.5 The latest data show that at 30 September 2006 there were over 43,000 GMPs in practices with NHS contracts in the United Kingdom.

The evidence

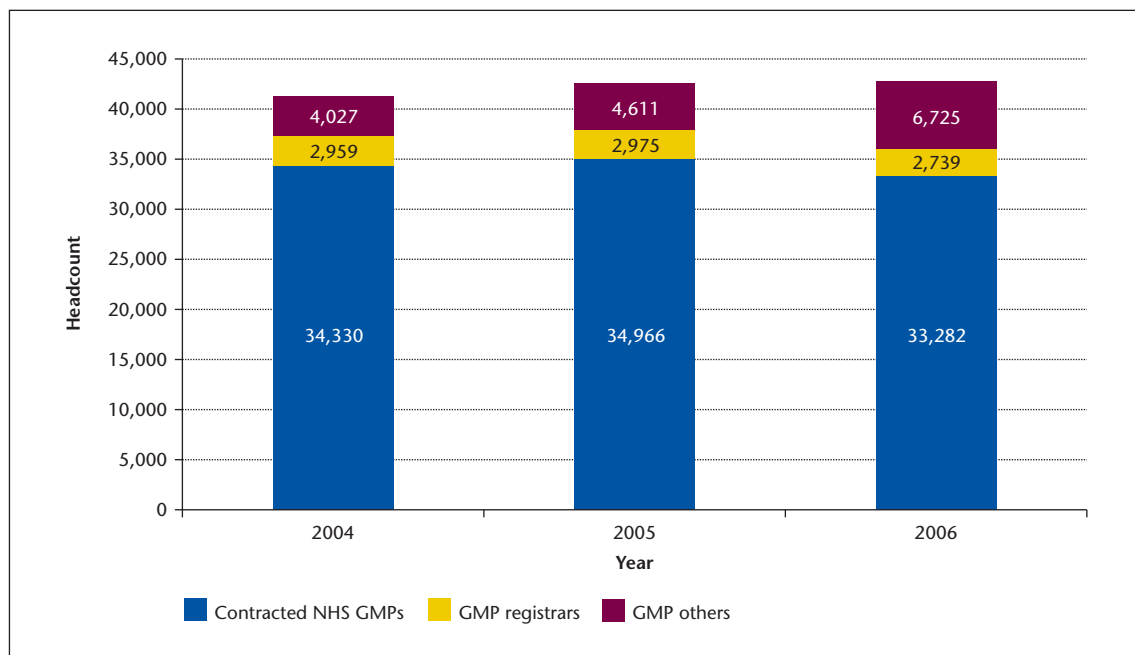
3.6 We have received evidence relating to GMPs from the Health Departments, NHS Employers and the British Medical Association (BMA). The main evidence can be read in full on the parties' websites (see Appendix D). It covered a range of issues affecting GMPs, in addition to basic pay, and these issues are addressed in the following paragraphs.

Recruitment and retention

3.7 The Health Departments told us that there was no evidence to suggest that there were any problems with recruiting or retaining GMPs and that general practice was an increasingly attractive option for junior doctors. They said that vacancy rates for GMPs were down and that in Wales recruitment and retention had improved considerably since the implementation of the new practice-based contract and the GMP vacancy rate had dropped to its lowest level for years. NHS Employers reported a fall in the vacancy rate for GMPs.

3.8 The Health Departments said that approximately 85 per cent of GMPs in Great Britain were independent contractors. NHS Employers reported anecdotal evidence that new GMPs were more likely to be employees in salaried posts than partners drawing profits from a practice and Figure 3.1 confirms this; the recent rise in the proportion of salaried GMPs is particularly evident. In October 2006, there was a total of 1,110 GMPs in Northern Ireland but here the breakdown between independent contractor and salaried GMPs is not available.

Figure 3.1: Number of GMPs, 2004 – 2006, Great Britain



Sources: The Information Centre, Welsh Assembly Government, Information Division Scotland.

Notes: "GMP others" includes salaried GMPs and GMPs who work flexible arrangements. Northern Ireland data not included as no GMP breakdown is available.

Motivation and morale

- 3.9 Drawing on several surveys of job satisfaction, the Health Departments reported that the greatest improvements in satisfaction among GMPs, between 2004 and 2005, were with remuneration and hours of work. They said that job satisfaction scores among GMPs were generally high and had risen since the new contract was introduced. GMPs, particularly those working part-time, had a higher level of leisure time satisfaction than hospital doctors and scores had risen over recent years. The new GMS contract had made it more financially practicable and affordable for GMPs to work part-time and one in four GMPs now did so. There had been a sharp rise in satisfaction with career prospects between 2002 and 2005. They also told us that GMPs in the United Kingdom reported higher satisfaction with their pay than GMPs in France, Germany, Italy and Spain.
- 3.10 NHS Employers noted that part of the rationale for the new GMS contract was to boost the morale of GMPs and address the problems of recruiting a new workforce and retaining the existing one. They reported emerging evidence that suggested that GMPs' morale had improved since the introduction of the new contract, although there had been reduced morale amongst contractors following the zero per cent pay award for 2007-08 which had led to a subsequent withdrawal of goodwill.
- 3.11 The BMA believed that the recommendations in our last report failed to protect the value of the new contract and that the zero recommendation meant a decrease in net income. In the BMA's view, it also completely failed to recognise the demotivating impact of such reductions in real pay. The BMA said that there was a widespread view that morale was not as high as it should be given the aims of the newly introduced contract for GMPs and the investment made in it; reasons included the negative publicity that continued to surround the new contract, fuelled by government attacks on GMPs' levels of income. The new contract should have been motivating for the profession. The BMA said that GMP morale had been badly damaged by a number of recent factors: the Secretary of State's decision to interfere retrospectively with pensions' dynamising factors for 2003-08; the perceived erosion of the GMS contract; the negative press coverage and government spin about out-of-hours care; pressure for extended opening and criticism of GMPs; the difficulty in receiving money from PCOs experiencing deficits and imposed financial stringency, for example, some PCOs had denied maternity payments; and the absence of a pay rise over the last two years. It said that we should understand the impact of our failure to uplift the contract. The new contract had initially improved morale, but there was a risk of a return to pre-contract morale problems if there was no uplift this year.

Workload

- 3.12 The Health Departments stated that the GMS contract offered real opportunities for improving services and the working lives of GMPs and practice staff through different ways of working and utilising the skill mix in different ways. They said that it was likely that practice nurses, practice managers and other members of the practice team undertook much of the work arising from the QOF, and that practice nurses and other practice staff were taking on a greater proportion of the workload than before. They told us that the reported number of hours worked per week had fallen by approximately four hours (2004-05); the average self-employed GMP's weekly average working hours had dropped from 43.5 hours in 1992-93 to 36.3 hours in 2006-07, with much of the fall attributable to a reduction in the out-of-hours commitment; the average number of patients seen in surgery consultations had dropped, but the length of consultations had increased which they believed was a possible indicator of the complexity of consultations; there had been a significant reduction in time spent on

home visits; and the amount of time spent on telephone consultations, and the volume of telephone consultations had also decreased.

- 3.13 The BMA said that the new contract had provided workload benefits for GMPs, for example the ability to opt out of out-of-hours care, but that it was unfair to imply that GMPs were now doing less work during their contracted hours as GMP contractors had responsibility for patient care for 52.5 hours per week. It noted that the Technical Steering Committee's 2007 workload survey¹ showed that GMP partners in 2006-07 worked hours similar to the most comparable figures in the last workload survey in 1992-93. The BMA's own opinion survey² showed that respondents considering themselves to be full time had worked a mean of 46 hours per week (excluding out-of-hours work but including administrative work) and that 30 per cent of respondents had done out-of-hours clinical work averaging 19 hours per month. The workload survey demonstrated that working patterns had changed, for example consultations were longer and more complex because GMPs increasingly had to deal with conditions that had previously been dealt with in secondary care. The BMA said that the increased consultation time was a major indicator of the increased quality of patient care and that the opinion survey reflected these views. The BMA's opinion survey had also found that 71 per cent of respondents were experiencing a large amount of work-related stress.

Independent contractor GMPs

- 3.14 The Health Departments said that since the introduction of the new GMS contract: there had been significant growth in investment in primary medical care; GMP pay had increased significantly in cash and real terms relative to other NHS staff; GMPs were retaining a higher proportion of their earnings as profit; GMP workload had decreased significantly; and job satisfaction had increased significantly. They pointed out that there was no direct or sole relationship between nationally agreed contract income and overall GMP remuneration. The Health Departments said that the average income/profit of all GMPs (including those working part-time) in 2005-06 was £111,971 and estimated that the income/profit share of a GMP working full time was around £136,000. They said that estimates suggested that GMPs have been more successful than the Department of Health originally envisaged in driving down their costs and maintaining profits in response to the 2006-07 negotiated settlement and our recommendations for 2007-08. They believed that the pay position of independent contractor GMPs remained very favourable relative to other professional groups. NHS Employers also told us that GMP income had significantly increased since the introduction of the new GMS contract.
- 3.15 The BMA said that although GMP profit had increased, so had expenditure on services, and that there had been increased investment in staff and practices since the new contract. It believed that the negotiated pay settlement of 2006-07 and our recommendation for 2007-08 would have had a serious impact on GMP profit in the last two years. In the opinion survey³ carried out by the BMA, 82 per cent of GMPs said that practice expenses had increased between April 2006 and April 2007, and in the BMA's opinion, the zero increase recommended in our last report had resulted in a pay cut. It told us that staff pay was by far the largest cost of running a practice and that GMPs would not be able to continue to absorb all costs of their practices if

¹ BMA, NHS Employers and Department of Health. *2006/07 General practice workload survey*. Information Centre, 2007. Available from: <http://www.ic.nhs.uk/webfiles/publications/gp/GP%20Workload%20Report.pdf>

² *National survey of GP opinion*. BMA, October 2007. Available from: [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgpsurvey07/\\$FILE/NationalsurveyGP2007.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgpsurvey07/$FILE/NationalsurveyGP2007.pdf)

³ *National survey of GP opinion*. BMA, October 2007. Available from: [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgpsurvey07/\\$FILE/NationalsurveyGP2007.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFgpsurvey07/$FILE/NationalsurveyGP2007.pdf)

income remained static. The BMA believed that the lack of any increase in income for two years running was unprecedented in the NHS and represented a “unique and worrying development”. It noted that there had been no change to the global sum since 2004-05.

- 3.16 Subsequently, the government made an offer to the BMA to recycle some existing money for QOF points and to make available a further £100m of new money for the GMS contract in England (a 1.5 per cent increase in the contract). This would be in return for agreement to a package of contract changes that they considered would make more effective use of existing resources in the GMS contract to improve access, in particular through GMP practices providing extended opening. The Department of Health has told us that the first call on this additional investment would be any net investment required to implement any recommendation we might make on GMP pay. Any balance remaining would be used to invest in improvements to services for patients. On 21 December 2007, by which time our deliberations were well underway, the Department of Health offered an alternative set of proposals and said that if GMPs rejected the initial offer, the government intended to impose changes to the contract, to increase access (opening hours) among other changes, but the investment guarantee would be lost. At the time of writing the BMA is in the process of polling its members. The Department said that it hoped we would be able to make recommendations consistent with either outcome of the BMA poll.
- 3.17 Although we commend the approaches being made to improve the contract, we are concerned that negotiations have started mid-round. Last year,⁴ we made it clear that our role should not be to step in at the last moment when negotiations have failed and we asked the parties to reach agreement on our role in respect of independent contractor GMPs by the beginning of the round. We said that if we were to make recommendations, full evidence should be submitted in good time for us to reach a well-founded decision. We therefore do not find the current situation satisfactory. To enter into negotiations in the middle of the round is unhelpful and makes it extremely difficult for us to achieve an acceptable outcome. It remains unclear to us whether or not we should have a role in the longer term in recommending on the GMS contract elements subject to negotiation. The Health Departments and NHS Employers have said in their evidence that while they recognised our legitimate role in making recommendations on GMP remuneration, they considered that it was not reasonable or practicable to expect us to price any elements of the new GMS contract. Furthermore, in oral evidence NHS Employers said that they found our role on independent contractor GMPs uncomfortable and would prefer to negotiate with the BMA on the entire contract and then bring joint agreements to us.
- 3.18 We therefore ask the parties to review our role on the contract before the next round. If we are to continue to make recommendations on GMPs’ remuneration, it needs to be clear on which elements of the contract we should make recommendations and what the effect of those recommendations is likely to be on GMPs’ earnings. We therefore **recommend the parties jointly to consider our role for the future and either to agree a mechanism whereby we can make recommendations on GMPs’ net incomes, or to remove independent contractor GMPs from our remit and settle future changes to the contract by negotiation.** For this round, we have set out (later in this chapter) our views on which elements of the contract we consider it appropriate to make a recommendation this year.

⁴ Review Body on Doctors’ and Dentists’ Remuneration. *Thirty-sixth report*. Cm 7025. TSO, 2007. Paragraph 3.29. Available from: <http://www.ome.uk.com/downloads/Cm%207025.pdf>

Independent contractor GMPs' earnings

3.19 To assist us in understanding the significant increase in gross earnings, percentage profit and net income for the average GMP during the period 2002-03 to 2005-06, the Health Departments provided us with the following table (Table 3.1), which is based on information provided by Her Majesty's Revenue and Customs (HMRC); we have also presented this as a graph (Figure 3.2).

Table 3.1: GMPs' earnings, expenses and income, 2002 – 2006, United Kingdom

United Kingdom GPMS GMPs						
Financial Year	Gross Earnings	Total Expenses	Net Income (before tax)		Expenses to Earnings Ratio	
			£	%		
	£	£	£	Annual Increase	Cumulative Increase	
2002/03 ⁽¹⁾	183,136	110,822	72,314	–	–	60.5
2003/04	201,630	120,064	81,566	12.8	12.8	59.5
2004/05	230,096	129,926	100,170	22.8	38.5	56.5
2005/06 ⁽²⁾	245,020	135,016	110,004			
2005/06 ⁽³⁾	246,987	135,016	111,971	11.8	54.8	54.7

Source: Health Departments and Her Majesty's Revenue and Customs

(1) Based on GB results and restated to equivalent UK basis

(2) Headline 2005–06 figures

(3) Headline 2005–06 figure restated for estimated 2004–05 PCO superannuation "Clawback"

Note:

The figures in the table above are averages and include the full range of general practitioner results, including dispensing doctors. However, the inclusion of dispensing doctor results does not significantly distort the average picture. The figures also include income from all sources, including private.

See detailed 2002-03, 2003-04, 2004-05 and 2005-06 HMRC figures and explanation at:

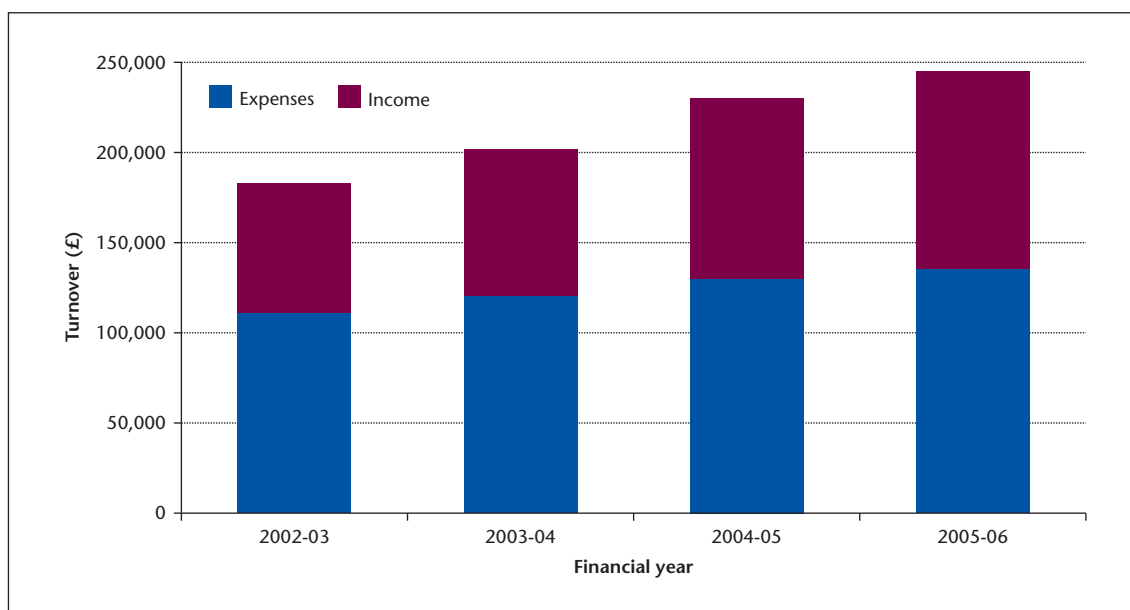
<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-2002-03>

<http://www.ic.nhs.uk/servicesnew/GMPsearnex04>

<http://www.ic.nhs.uk/pubs/GMPsearnex0405/earnexrep/file>

<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice>

Figure 3.2: GMPs' turnover: expenses and income 2002-03 to 2005-06, United Kingdom



Source: The Information Centre using Her Majesty's Revenue and Customs data

- 3.20 GMP net income has shown a significant increase since the new contract. While the BMA viewed this as an intentional consequence, the Health Departments maintained that GMPs were expected to reinvest a proportion of their profits in their business in order to maintain and improve patient services. They said that historically, this investment had been around 60 per cent, but by 2005-06 it had reduced to 55 per cent. This meant that GMPs now retained a significantly higher proportion of their earnings as profit. The Health Departments told us that in 2004 they had agreed with the BMA that it was not practicable or appropriate to try to cost the differential expenses to earnings ratios over the various income streams, and that the overall assumption had been that the aggregated level of reinvestment of earnings by practices would continue at 60 per cent; therefore profit (taken from earnings) would continue at 40 per cent.
- 3.21 NHS Employers also said that the percentage of GMP earnings invested back into the business had reduced over time while the proportion of income that was taken as profit had increased. Historically, GMPs had retained approximately 40 per cent of their earnings as profit, but in 2004-05 this increased to 43.5 per cent. In oral evidence, NHS Employers said that although they did not necessarily agree with the Health Departments' call for the reintroduction of a balancing mechanism to claw back any overpayments, they did think that if the 60:40 expenses to profit ratio had been maintained, the cumulative increase in income for GMPs would be much nearer to the intended 36 per cent increase (rather than the 54.8 per cent shown in Table 3.1).
- 3.22 The BMA noted that the expenses to earnings ratio decreased from 59.5 per cent in 2003-04 to 56.5 per cent in 2004-05, but maintained that it was Ministers' intention that GMP profits should rise with new contract. It said that the decrease in the expenses to earnings ratio was not simply an indication that GMPs were taking more income from their practices. It could also be explained by changes in the way GMPs were paid under the new contract; for example: GMPs were no longer responsible for some elements of business expenditure; practice partnerships now included non-clinical members; and the new contract encouraged flexible working and portfolio

careers. The BMA said that it could see no argument for the introduction of any 'balancing mechanism'; there was now a far greater risk associated with running a GMS or PMS contract and higher profits were a return to this risk.

- 3.23 We are aware of ways in which GMPs can influence their net income both within and outside the contract. NHS Employers gave us examples which included registering more patients or increasing the geographical coverage; improving the efficiency of the business; achieving more QOF points through higher quality work; bidding to provide more enhanced services; influencing or renegotiating expenses once reimbursement levels have been agreed (for example, rent reviews, re-mortgaging); third party income opportunities (such as sub-letting premises); and (for dispensing practices) prescribing more or different items. They told us of further opportunities to influence profits outside the contract, for example, by working out-of-hours sessions, by GMPs with special interests providing primary or secondary care sessions, and by undertaking other locum sessions or private work.

Independent contractor GMPs: pay recommendations for 2008-09

- 3.24 The Health Departments said that the factors we used to determine our recommendation (for no increase in GMP pay) under the GMS contract in 2007-08 were still pertinent when considering a recommendation for 2008-09. In their evidence they said that they saw no justification for increasing GMP pay for 2008-09 in the absence of corresponding improvements in the level and quality of services provided. They stressed that excessive or unaffordable pay increases would affect the wider NHS, although it would be unlikely to affect GMP contractors directly as, under the new contract, no self employed GMP contractors were at risk of redundancy or of losing their contracts with their PCT; any losses would therefore fall disproportionately on other staff groups. Nevertheless, they said that if we did decide to recommend any uplift for GMP pay for 2008-09, it would be essential that such a recommendation were dependent on changes to other GMP income streams; achievement of efficiency gains by general practice; improving equity of income distribution; improvements to the QOF; and realigning the earnings to expenses ratio. They said that we should also consider the case for a balancing mechanism to address the significant shift in the expenses to earnings ratio and levels of funding above that negotiated through the Gross Investment Guarantee;⁵ it was principally these factors that had led to a disproportionate increase in GMP practice profits and hence to net income. However, as we noted earlier in this chapter, the government subsequently made an offer to GMPs which would, if accepted, result in 1.5 per cent more in contract money being available in return for additional services.
- 3.25 NHS Employers reminded us that the GMS contract was not a contract for GMP pay but suggested that we might consider it appropriate to make a recommendation for the uplift across elements of the contract. However, they noted that the complexity of the contract was evident when attempting to assess the effect on GMP pay of uplifting different income streams. In oral evidence, NHS Employers said that if the negotiations on changes to the contract with the BMA were successful, the parties would provide joint evidence on efficiencies; but if an agreement was not reached, they did not consider that an uplift would be appropriate.
- 3.26 The BMA stated that it had reached agreement with NHS Employers and the Health Departments to rely on us to determine the level of any contractual uplift. It suggested a straightforward increase in the principal components of the GMS contract, of a weighted average of an appropriate net income uplift in line with our

⁵ The Gross Investment Guarantee refers to the minimum level of investment in the new GMS contract.

judgement and an allowance for expenses increases based in part on the rate of inflation and in part on earnings movements. In oral evidence, the BMA said that it was not appropriate to look at pay relativities with consultants because GMPs were working under completely different contractual arrangements.

- 3.27 Neither the Health Departments nor NHS Employers agreed with the BMA's proposed methodology for an increase. The Health Departments said that the main problem with the BMA's methodology was that it took no account of the very significant, and in part unintended, increase in GMP pay/practice profits over recent years.
- 3.28 The evidence for this round was equivocal. On the one hand we were persuaded that recruitment and retention of GMPs is fully satisfactory at present. Moreover, the latest available information, for 2005-06 (see Table 3.1 above) shows that GMPs' net income was still on an upward trend while expenses continued to fall as a proportion of practice earnings. GMPs may have been able to agree increases in the elements negotiated locally with PCOs or to increase their income by the other means mentioned above. On the other hand, GMPs have seen no increase in the centrally determined payments under the contract since its inception in 2004. The improvement in their job satisfaction appears to be threatened by a combination of several years with no increase in the core elements of the contract and a perception (we make no comment on whether or not that perception is justified) that the government is trying to erode at least some of the GMPs' gains from the new contract. Moreover, common sense suggests that GMPs' expenses are subject to inflation like everything else and they cannot continue indefinitely to reduce them as a proportion of practice income.
- 3.29 Our task this year is complicated by several considerations. First, as noted above, the Health Departments have made an offer to GMPs and the BMA is currently polling its members on that offer. We do not wish to influence the result of that poll in either direction. Secondly, we welcome the evidence on expenses which suggests that GMPs are managing their practices efficiently by reducing expenses as a proportion of turnover and we do not wish to reduce their incentive to continue to do so. Paragraph 1.10 of the *Revisions to the GMS contract 2006-07*⁶ explicitly recognises the responsibility of the Health Departments and NHS Employers to achieve improvements in efficiency and value for money. Thirdly, we do not see it as our role to intervene in the setting of health and policy priorities. Those are matters for the government and doctors themselves to agree. QOF points form part of the current negotiations and we therefore make no recommendation on them.
- 3.30 Having considered the various income streams that make up the GMS contract, we do not recommend any change to the pricing of the enhanced services components of the contract. These are subject to local tendering procedures. Nor do we recommend a change to the pricing of the directed enhanced services which are voluntary or time limited, and subject to the public sector wide requirement to deliver efficiency improvements of 3 per cent a year. We think that other PCO administered funding (for example, premises, IT, locums) should continue to be determined locally. We deal with seniority payments at the end of this chapter. We are therefore not recommending an increase, particularly in the light of the ongoing negotiations between the parties, to these elements of the contract.

⁶ *Revisions to the GMS contract 2006-07*. NHS Employers and the BMA, February 2006. Available from: <http://www.nhsemployers.org/pay-conditions/primary-2450.cfm>

- 3.31 We nevertheless believe it is appropriate this year to recommend an increase in the core part of the contract, the global sum⁷, while leaving other parts for local or national negotiation. We understand that there are significant, unwarranted variations in GMP income caused solely by the operation of the minimum practice income guarantee (MPIG)⁸ regardless of the workload and patient care provided by individual GMPs and their practices. The MPIG is not time-limited, so that the correction factor⁹ payments have also stayed at the same level because there has been no increase to the global sum since 2004-05. NHS Employers told us that the operation of MPIG and the distribution of correction factor payments meant that, for exactly the same provision of core essential patient services, GMP income varied from £54.72 per patient (for those practices not receiving any correction factor payments) to over £120 per patient. This was because a practice's MPIG related directly to its income from the old contract under which funding was inequitable. Moreover, it was typically practices in more deprived areas that received less income per patient, although their patients had greater needs. They said that the zero uplifts over the last two years meant that those practices had continued to receive a comparably low income.
- 3.32 We recommend an increase in the global sum payment (which currently stands at £54.72) for each 'weighted patient' in line with the general uplift of 2.2 per cent which we are recommending for doctors in the HCHS. However, we believe that the increase in the global sum should also take some account of practice expenses and we believe that the Retail Prices Index excluding Mortgage Interest Payments (RPIX)¹⁰ is the most appropriate measure of the increase in those expenses. In the absence of more detailed data on the ratio of earnings to expenses for the various income streams to the GMS contract, we have decided to use the broad split reported by the IC, from analyses of HMRC data, of how turnover is split between GMP income and GMP expenses; this gives a ratio of earnings to expenses of 45:55. Using a similar formula to that we have developed for general dental practitioners, we calculate that an overall increase of 2.7 per cent in the global sum is appropriate (2.2×0.45 for earnings) + $(3.1$ (i.e. RPIX) $\times 0.55$ for expenses). **We recommend an increase in the global sum for each 'weighted patient', in line with the general uplift of 2.2 per cent which we are recommending for doctors in the HCHS. However, the increase in the global sum needs also to take some account of practice expenses and therefore we recommend that the global sum payments per 'weighted patient' be increased by 2.7 per cent from £54.72 to £56.20 for 2008-09.** Because of the operation of the MPIG, as explained above, most practices will not receive any increase in payments as a result of this increase in the global sum. Their MPIG will continue to be higher than the increased global sum, and the increase will simply reduce their correction factor payments. However, those practices with a global sum above or close to their MPIG will receive an increase. We estimate that the effect of this recommendation will be to increase expenditure under the global sum by approximately 0.2 per cent.

⁷ The **global sum** covers essential services for all registered patients and all baseline core practice running costs. Prices are set through annual negotiation and are weighted according to the needs of patients; for example, age, deprivation.

⁸ **MPIG** is a guarantee of minimum practice income levels intended to ensure practice stability during the introduction of the contract. It was set to ensure that practice income from the global sum was at least equal to historic total practice income from the red book payments prior to the new contract; it does not take into account new additional practice income from enhanced services or the QOF.

⁹ The **correction factor** is a payment made to practices to reflect the difference between MPIG and the global sum payment for practices' registered list size. Around 90 per cent of practices receive the correction factor because their global sum is less than MPIG.

¹⁰ We have used RPIX as a measure because this excludes housing costs. The cost of premises comes under PCO administered funding which is directly reimbursed.

- 3.33 We note from NHS Employers that no conditions applied to the correction factor payments, which were guaranteed indefinitely until paragraph 1.6 of the agreed 2006-07 revisions to the contract confirmed that the payments were to become transitional: it states, “future uplifts to the global sum should seek to reduce the reliance upon correction factor payments and, therefore, release an element of the correction factor envelope”. We therefore **recommend that paragraph 1.6 of the Revisions to the GMS contract 2006-07 apply in full and the corresponding correction factor payments be reduced where relevant for 2008-09.**
- 3.34 As explained above, this year we do not make recommendations for any increase to the other aspects of the contract, namely the QOF, enhanced services and PCO administered funding, although if our remit remains unchanged this will not preclude us from making recommendations on other aspects of the contract in future years. However, we repeat that, as set out earlier in this chapter, and indeed in paragraph 3.29 of last year’s report, that our current role in respect of the GMS contract is unclear and unsatisfactory and must be resolved.

Salaried GMPs

- 3.35 The Health Departments told us that the model terms and conditions of service for salaried GMPs were intended to be the minimum, and that employers were free to offer more favourable terms to reflect local needs and circumstances. They had seen no evidence to suggest that the current salary range was inappropriate. They said that the average salaried GMP worked 23.8 hours per week with an average net income of £46,905 (2005-06); the full-time equivalent pay for this would be around £74,000 per annum. Salaried GMPs were more likely to work flexible part-time hours than were self-employed GMPs and there were no problems with recruitment and retention. The Department expected that the trend towards salaried GMPs, which it said represented 16.3 per cent of the workforce,¹¹ would continue. It noted that the 2006 census data had indicated that about 93 per cent of salaried GMPs in England were employed by GMP practices and 7 per cent by PCOs.
- 3.36 NHS Employers said that the demand for this group of staff continued to be high, that the majority of employers continued to report that the pay range was appropriate and that there were no recruitment problems. They reported that discussions with the BMA over the updated model offer letter and terms and conditions had not progressed as quickly as they would have liked. NHS Employers sought an uplift to the pay range that was in line with that of other directly employed doctors.
- 3.37 The BMA noted that salaried GMPs made up over 15 per cent of workforce. Their numbers had risen by 58.9 per cent between 2005 and 2006. It requested that the model terms and conditions for salaried GMPs state that they would receive an annual pay increase in line with our recommendation. It would be helpful if we could recommend a percentage increase to the range for PCO-employed salaried GMPs. The BMA said that the current minimum of the range should be raised in recognition of the level of skill and responsibility undertaken, and that it would like the top of the range increased to remunerate more fairly GMPs employed by PCOs who undertake more responsible roles such as running GMP practices and other more specialised work. A survey of salaried GMPs throughout the United Kingdom conducted by the Health Policy and Economic Research Unit¹² was submitted as supplementary evidence and showed that the full-time equivalent of some GMS and PCO employed

¹¹ Salaried GMPs (GMS other and PMS other) represent 16.3 per cent of the GMP (excluding retainers and registrars) workforce.

¹² *Survey of salaried GPs: final report*. Health Policy and Economic Research Unit, October 2007.

GMPs was below the minimum salary of £51,332 recommended in our last report. The survey also revealed that the contracts of employment of a number of GMS and PCO employed GMPs did not conform to the nationally agreed minimum terms and conditions of service; furthermore, some salaried GMPs did not have a written contract of employment.

- 3.38 Our view continues to be that we would be surprised to find that salaried GMPs were entering into contracts that did not provide for some form of annual pay review, and we expect salaried GMPs to ensure that this aspect is covered in their contractual arrangements. As the demand for salaried GMPs is increasing, we believe that they should be able to negotiate an annual pay review as part of their terms and conditions. We **recommend that the salary range for salaried GMPs is increased by 2.2 per cent for 2008-09.**

GMP registrars

- 3.39 Both the Health Departments and NHS Employers sought a further reduction in the supplement¹³ paid to GMP registrars, from 55 per cent to 50 per cent of basic salary for those entering GMP registrar training placements after April 2008.
- 3.40 The Health Departments said that the average banding supplement paid to hospital doctors had fallen to 52 per cent in England and 57 per cent in Wales (where it was expected to fall further by April 2008). NHS Employers explained that it wished to move towards an alignment in pay between trainees undertaking similar work in GMP practices and in hospitals in order to facilitate the movement of trainees between trusts and GMP practices without a change of contractual arrangements. It told us that it wanted full alignment as soon as possible, but that 2009 would be a sensible point by which it could reasonably reduce the supplement to 40 per cent and open discussions with the profession about contract alignment. It said that recruitment to GMP training programmes was strong and there was evidence that junior doctors were finding general practice an attractive career choice. Since 1997 the number of GMP registrars had increased by 70 per cent. Anecdotally, doctors were attracted into GMP training due to the opportunity to control their workload, the earning potential and improved work-life balance.
- 3.41 The BMA stated that the number of GMP registrars had fallen by 11.2 per cent in 2006, and that this was the most significant reduction for over a decade. It believed that the decrease in the GMP registrar supplement (recommended in our last report) would have a negative effect on recruitment into general medical practice and that it had made an enormous difference to GMP registrars' income over the year. It said that total GMP registrar pay in November 2007 would be £1,580 to £2,501 less than in 2006. The BMA sought an uplift to GMP registrar basic pay based on increasing living, training and certification costs and requested no further reductions to the supplement without a commensurate rise in the basic pay level for junior doctors.
- 3.42 As we have said before, GMP registrars receive a substantial supplement despite having a working pattern which, unlike that of trainee hospital doctors, is on the whole, less intense and involves few if any additional hours. We believe that general medical practice continues to be an attractive career choice and note that the banding supplements paid to hospital doctors are falling as their hours are reduced. Therefore, we think it is appropriate that the supplement for GMP registrars again be adjusted downwards. However, we consider that those doctors currently receiving the

¹³ The supplement is paid to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged compared to hospital doctors in training. It was introduced at a time when recruitment into general practice was poor.

higher level of the supplement should keep their existing entitlement rather than see their pay supplement reduced. We **recommend that the supplement for GMP registrars entering training placements on or after 1 April 2008 be reduced from the current rate of 55 per cent to 50 per cent.**

GMP trainers' grant

- 3.43 The Health Departments told us that the independent review of remuneration for GMP trainers had been delayed; however, they stressed their commitment to this and reported that they were discussing with the Committee of General Practice Education Directors (COGPED) how it would be taken forward. In view of the delay, and until further information was available and implementation of the new arrangements agreed, the Health Departments proposed that the GMP trainers' grant be increased by no more than the increase they proposed for other salaried doctors (i.e. 1.5 per cent).
- 3.44 The BMA said that the trainers' grant fell short of covering the workload involved and the costs of appraising GMP registrars. It reported that the workload had increased during the past year because of additional work related to the new Membership of the Royal College of General Practitioners examinations and the new trainee curriculum. In addition, the survey of GMP training practices¹⁴ submitted as supplementary evidence had confirmed that the current GMP trainers' grant should be significantly increased to reflect the workload of GMP trainers and the financial costs incurred. The BMA sought a general increase in GMP trainers' pay to ensure that it kept pace with other groups. It also noted that in some places, particularly rural areas where travel was an issue, it appeared that the recruitment of GMP trainers was well below the national average.

Supplement for trainers' continuing professional development

- 3.45 The Health Departments said that in 2005-06 and 2006-07 the £750 supplement recommended by us was paid to GMP trainers to boost their continuing professional development. However, they had agreed with the BMA and COGPED that our last report did not require payment of this supplement in 2007-08. In oral evidence, the Department of Health told us it was not persuaded that a supplement towards continuing professional development for GMP trainers was the correct solution and that it would prefer a practice based payment. It undertook to follow up this issue as part of the review of remuneration for GMP trainers.
- 3.46 The BMA initially told us that it believed there were no plans for this payment to be made in 2007-08 and that this would effectively be a pay cut. However, it subsequently reported that GMP trainers in Scotland were to receive the supplement. It pointed out that participation in continuing professional development was expected from trainers whether or not they had trainees and asked that the £750 continuing professional development payment (adjusted for inflation) be incorporated into the trainers' grant and made available to all trainers, whether or not they have a trainee allocated to them, to provide recompense for ongoing continuing professional development needs.

¹⁴ *Review of GP training practices: survey of current GP trainers and trainees. Report.* Health Policy and Economic Research Unit, October 2007.

- 3.47 We regret that the supplement of £750 a year for additional continuing professional development of GMP trainers continues to cause problems. It was our intention that this supplement, recommended in our Thirty-Fourth Report,¹⁵ should continue and be paid for one year even if no trainee were allocated to the trainer. We believed that we had made this clear in our report last year.¹⁶ We reiterate that we expect the Health Departments to take appropriate action to ensure that our recommendation is implemented, at least until such time as the review of remuneration for GMP trainers is complete.
- 3.48 With regard to the trainers' grant, we await with interest the results of the review of remuneration for GMP trainers and we urge the parties to take account of the survey of GMP trainers and trainees carried out by the Health Policy and Economic Research Unit¹⁷ as well as the costs of continuing professional development for being a trainer. As last year, we believe that until this review is complete we should simply increase the value of the trainers' grant in line with the other fees and allowances on which we are required to make recommendations. We therefore **recommend that the GMP trainers' grant be increased by 2.2 per cent for 2008-09.**

GMP educators

- 3.49 'GMP educator' is a generic term for course organisers, GMP tutors and Associate GMP Directors; these are salaried doctors, employed by the deaneries. The Health Departments said that they saw no evidence to suggest that pay levels were causing problems with recruitment or retention and therefore proposed that their pay should rise by no more than the increase proposed for other salaried doctors (i.e. 1.5 per cent).
- 3.50 On the other hand, the BMA said that the failure to increase GMP educators' pay meant it lagged behind that of other GMPs and that it was becoming increasingly difficult to match the backfill costs for medical practitioners. It reported that in a survey carried out by the United Kingdom Conference of Educational Advisors in 2007,¹⁸ the reduced remuneration for medical educators compared to clinical practice was given as a reason for leaving deanery employment; some deaneries had also reported difficulty in recruiting new GMP educators because of this. The BMA therefore sought a larger increase to the GMP educators' pay scale to reflect the fact that their pay had fallen so far behind that of GMP contractors.
- 3.51 We are not convinced of the need for a differential uplift for this group of doctors. As GMP educators are not self-employed, it is appropriate to draw a parallel with other salaried GMPs, and that their pay should be increased in line with such doctors. We therefore **recommend that the GMP educators' pay scales should rise by 2.2 per cent for 2008-09** in line with our recommendation for salaried GMPs.

¹⁵ Review Body on Doctors' and Dentists' Remuneration. *Thirty-fourth report*. Cm 6463. TSO, 2005. Paragraph 2.53. Available from: <http://www.ome.uk.com/downloads/OME%20-%20DDPRB%202005%20Cm%206463.pdf>

¹⁶ Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report*. Cm 7025. TSO, 2007. Paragraph 3.41. Available from: <http://www.ome.uk.com/downloads/Cm%207025.pdf>

¹⁷ *Review of GP training practices: survey of current GP trainers and trainees*. Health Policy and Economic Research Unit, October 2007.

¹⁸ *Workforce survey report*. United Kingdom Conference of Educational Advisers, July 2007.

GMPs working in community hospitals

- 3.52 We received no evidence from any of the parties specifically relating to GMPs working in community hospitals. The remuneration of those working in community hospitals is agreed locally, and is not a matter for us. However, we would expect such doctors to be in demand given the moves by government to increasingly provide health and social services in local communities.

Sessional fees for doctors in the community health service and fees for work under collaborative arrangements

- 3.53 In our last two reports we recommended that, in the absence of any evidence to allow us to take an informed view on the level of these fees, doctors engaged in this work should set their own fees. Although the BMA is content with this position, NHS Employers again argued for an increase not exceeding the inflation target and expressed concern that allowing doctors to set their own fees may cause regional discrepancies and make it difficult to manage any fee increases.
- 3.54 We reiterate that we would welcome moves by the parties to review the fees, but if they require us to make a recommendation, they must provide us with evidence that demonstrates why and how we should make recommendations on these fees. In the meantime, in line with the trend for local commissioning of services, we **recommend that doctors engaged in sessional work for community health services and work under collaborative arrangements should continue to set their own fees.**

Seniority payments

- 3.55 Last year we asked the parties to consider whether seniority payments complied with the spirit of the new legislation on age discrimination. The Health Departments told us that they believed it was unlikely that the current GMP seniority scheme would be found discriminatory on age discrimination grounds. They said that the relevant regulations made it lawful to discriminate in relation to the terms offered to workers (including partners) where the aim was to reflect a higher level of experience, to reward loyalty or to increase or maintain the motivation of the worker. However, the Department of Health was concerned about the fairness of the current scheme, which it perceived to be anomalous in the context of a practice-based contract for services whereby signatories to the contract could include nurses and practice managers, in addition to GMPs, and said that it would be looking into seniority payments again. In view of the projected earnings and increased profit for GMPs, it proposed that seniority payments should remain at their current values for 2008-09. The BMA said that seniority payments were not intended to be a recruitment and retention mechanism, rather they constituted a personal payment and were one of the principal components of the new contract. It sought the same uplift as for other elements of the contract.
- 3.56 We feel some discomfort over the potential unfairness of seniority payments, which as the Department of Health has observed, may not apply to all parties to the contract. We ask the parties for evidence next year on the purpose, fairness and effectiveness of these payments and for an explanation of the intention behind their inclusion in the new GMS contract. In particular we wish to see evidence to demonstrate that those receiving seniority payments are more productive, i.e. that they provide more or better care for their patients. We support the payment of rewards to those who perform best, but to avoid any risk of discrimination we believe that the performance should be objectively demonstrated in each individual case. **For 2008-09, we recommend that seniority payments for GMPs remain at their current levels.**

CHAPTER 4: GENERAL DENTAL PRACTITIONERS

Introduction

- 4.1 Our remit covers all independent general dental practitioners (GDPs) in primary care who are contracted to provide NHS dental services.
- 4.2 As we conduct this review, GDPs in England and Wales are in the second year of working under the new NHS contract. Dental services in Scotland are changing too as a result of the implementation of the Scottish Executive's *Action Plan*¹. Additionally there are plans in Northern Ireland for a new contract which may be piloted in 2008. In our last two years' reports we noted the emergence of different approaches to NHS dentistry in England and Wales and in Scotland. This year we note that Northern Ireland may go down a third route. For this reason, we have decided to present the evidence for Scotland and for Northern Ireland separately, later in this chapter.

The evidence

- 4.3 This year, we received written and oral evidence from the Health Departments, NHS Employers, the British Dental Association (BDA) and the Dental Practitioners' Association (DPA). The main written evidence can be read at the parties' websites (see Appendix D). The parties have raised a number of issues in addition to the uplift to GDPs' contract values or fees, which we consider and respond to later in this chapter.

Dental strategy and contracts in England and Wales

- 4.4 First, we describe briefly the arrangements for NHS dental services in England and Wales. From 1 April 2006 GDPs have had local contracts with primary care organisations (PCOs). In England these are primary care trusts (PCTs) and in Wales they are Local Health Boards (LHBs). PCOs hold budgets for dental services for their areas and they agree contract values with either providers (practices or companies) or performers (individual GDPs) for a particular level of service. This is specified in terms of an annual level of units of dental activity (UDAs). The level of service is reported in terms of courses of treatment (CoT), but these are converted into UDAs based on the most complex component of the CoT. The contract service level was based on the level of dental activity during the reference period October 2004 – September 2005. This figure was then reduced by 5 per cent in England and 10 per cent in Wales to establish the contract level of activity. GDPs receive payment of their contract values on a monthly basis.
- 4.5 Patient charges work on a three-band system where each band comprises a range of treatments. The higher the band, the higher the charge, but within any one band the charge is uniform although cost and complexity of the treatment may vary.
- 4.6 As at 31 March 2007, there were 21,041 dentists on open NHS contracts in England and 1,186 in Wales.
- 4.7 As described in the Department of Health's evidence, the government launched reforms to NHS dental services in April 2006. This reformed system was designed to:
- support access improvements by putting the local NHS in charge of commissioning local services and deciding where to locate new services;

¹ *An action plan for improving oral health and modernising NHS dental services in Scotland*. Scottish Executive, 2005. Available from: <http://www.scotland.gov.uk/library5/health/apioh-00.asp>

- provide dentists with the stability of an agreed annual income in return for an agreed level of patient care, measured through overall courses of treatment (rather than individual items); and
 - simplify the charging system by introducing just three charges, linked to overall courses of treatment (rather than individual items).
- 4.8 Under the new arrangements, because these contracts are held by *providers*, PCTs in England and LHBs in Wales can now purchase replacement services if a dentist ceases to provide NHS treatments. Providers then pass on the work to dental *performers* unless the provider and performer are one and the same. However, there is no guarantee that these dental performers will receive any uplifts made to the dental contract because they do not receive work directly from the PCT or LHB.
- 4.9 As stated in last year's report, as at April 2006, 89 per cent of initial contract offers had been signed and 11 per cent of offers, equating to 4 per cent of the total UDAs, had been rejected. Of dentists accepting offers, almost 35 per cent had done so in dispute. This year, the Department of Health said that based on more recent information up to the end of June 2007, of the 2,884 contracts signed in dispute 223 still remained unsettled and the remainder were expected to be settled within the next few months. It also told us that in only 18 cases (as of November 2007) had the contractor not accepted the outcome.
- 4.10 According to the Welsh Assembly Government (WAG), 97 per cent of dentists providing NHS care in Wales signed up for the new contract and the contracts signed by these accounted for a little over 95 per cent of the level of NHS dental services being provided prior to 1 April 2006.
- 4.11 NHS Employers stated that, when surveyed, the key reasons PCTs gave for dentists electing not to sign were related to contract specification and the wide target population to which dentists were being asked to deliver services. These providers wanted to be selective about who they provided a service to (for example treating only children), they did not wish to take on new patients, or alternatively, they wanted to retain small NHS contracts and maintain a large percentage of private work.
- 4.12 The BDA and DPA also provided evidence on the implementation of the new contract. The BDA observed that 396 of the contracts signed in dispute were yet to be resolved 12 months after the introduction of the contract. Both the BDA and the DPA were concerned about the proportion of providers not meeting their UDA targets and facing claw-back. For example, a BDA sample survey of Local Dental Committees and PCTs suggested that around a third of all dentists were being penalised for either overshooting or undershooting their target. In addition, the BDA passed on evidence from the NHS obtained through a Freedom of Information request showing that, from information on 8,507 contracts, 47 per cent had not achieved the minimum target of 96 per cent of contracted UDAs. The DPA evidence this year included the results of a survey of 194 dentists (representing 650 providers). This revealed that 49.5 per cent of those surveyed were angry, and a further 37.6 per cent disappointed, with the present NHS general dental services (GDS) terms and conditions. This same survey also showed that 61.8 per cent described their practice UDA target as difficult or impossible.

- 4.13 The BDA reported that many dentists were confused as to why they had missed their UDA target, given their surgeries had been open as normal and their appointment books full. In an attempt to allay the fears of dentists who could not attain their UDA requirements, the BDA wrote to the Chief Dental Officer in August 2007 to ask for an amnesty for those dentists who had completed a significant amount, but not all, of their UDAs for 2006-07. However, the BDA said that this request was swiftly rejected. Consequently, the BDA had been lobbying hard for the removal of UDAs as the sole contract monitoring tool. The BDA therefore urged us to support its call for the removal of UDAs as the sole performance management tool and for its replacement by a range of qualitative and quantitative performance indicators, which may or may not include a revised form of the UDA which it regards as acceptable to the profession whilst providing flexibility for PCT and LHB commissioners. In addition to this, the BDA called on the government to make two important changes to the NHS patient charge revenue system and wanted to see us endorse and recommend:
- that the whole of a PCT's dental commissioning budget should be paid directly to the PCT. (The BDA stated that currently around 25 per cent of a PCT's budget had to be collected through the patient charge revenue but lack of predictability over receipts understandably led them to be nervous about fully commissioning all the services that their budgets could potentially support); and
 - that the restoration of the link between the NHS patient charge revenue and the overall spend on dentistry was re-established in order to maintain a safeguard on the total expenditure available to commission NHS dentistry.
- 4.14 We have considered the BDA's proposed changes. However, we do not think it appropriate for us to determine the details of where the funding for dentistry comes from within the PCT budget and therefore do not take a position on these proposals. We will continue to consider the more general issue of funding as part of our remit and continue to ask that the parties submit evidence on this issue.
- 4.15 We note that there appears to have been a shortfall in patient charge revenue below the 25 per cent that is assumed in the financial plans and that in 2007-08 funding allocations to PCTs have been adjusted to allow for this. The Department of Health has also stated in its evidence that a dental practice's NHS income and the annual services it agrees are not affected by how much money is raised from patient charges. However, as access is one of the key elements for patients, we would be concerned if it were the case that unwillingness to bear the financial risk from a shortfall in patient charge revenue were to lead PCTs to under-commission the provision of dental services. We should like to have clear evidence on this for our next report.
- 4.16 The BDA also expressed concern about the future of the arrangements noting that many dentists were apprehensive about 2009 when PCTs and LHBs would have greater freedom in choosing whom to commission. The BDA said it believed that the true impact of the disputed 2006 contracts would only come to fruition at this later date because many who signed in dispute remained dissatisfied with their NHS contract and only accepted it in the hope that their situation would improve and to ensure the transitional stability of the practice.
- 4.17 We note with interest the continuing information on the take-up of the new contract, both in terms of the current contract and the new arrangements from 2009. The percentage of GDPs who accepted the new contract is encouraging and it appears that PCTs and LHBs have commissioned new or additional dental services to replace those dentists who have chosen not to sign the new contract, or to expand services. However, the survey evidence from the profession shows that amongst those who

have signed, there appears to be a significant proportion of dentists who remain sceptical about the reforms. This is of concern to us as we must consider the motivation of dentists. We will continue to monitor the situation and any implications for the new arrangements planned for 2009.

Access to dental services

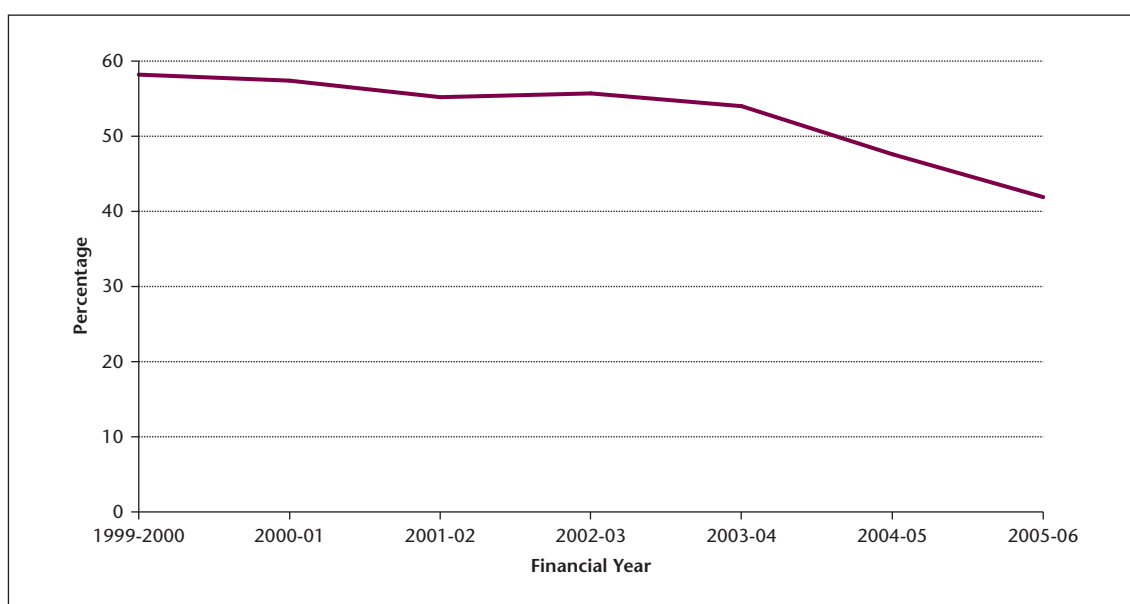
- 4.18 Improving access to NHS dental services is a government priority. It is linked to our remit as we have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. Now that PCTs and LHBs hold budgets for commissioning dentistry and dentists are expected to benefit from freed-up capacity from working in new ways, the new local commissioning arrangements are expected to be able to deal with problems of access to dentistry more effectively.
- 4.19 The Department of Health commented that access had been the single most difficult and high-profile issue for NHS dental services for the last 15 years and that the key test of the reforms would therefore be their ability to support improved patient access to services. The Department of Health noted that PCTs had commissioned more services in 2006-07 than were delivered in the last year of the old system. The Department also provided us with examples of successful tenders recently undertaken by PCTs in areas where access to dentistry had been difficult; these suggested increasing levels of interest from dentists and corporate bodies.
- 4.20 The WAG told us that its investment of £30 million in additional funding for the contract had made a notable difference to access. Consequently, problems were now confined to a very few areas. Further progress was expected over the next few months after which it hoped that everyone in Wales who wanted access to a NHS dentist would be able to do so. We are pleased to hear of this improvement and look forward to receiving evidence of progress for our next review.
- 4.21 NHS Employers reported that the majority of PCTs surveyed said that they had commissioned new or additional primary care services in the past 12 months. Additionally, the majority of those giving a positive response said that they had not encountered any difficulty in finding dentists or corporate bodies to provide these services.
- 4.22 However, BDA evidence drew our attention to reports published by Citizen's Advice and Which? that showed NHS access was still an issue. The Citizen's Advice survey² showed patients in England and Wales still faced significant problems in finding an NHS dentist, whilst the Which? survey³ showed significant regional variation with just over half the practices surveyed reporting that they were not accepting any new NHS patients. The BDA also carried out their own survey of member practitioners, the results of which were that 85 per cent of respondents said the new contract had not improved access to NHS dentistry.

² *Gaps to fill: CAB evidence on the first year of the NHS dentistry reforms.* Citizens Advice Bureau, March 2007. Available from: http://www.citizensadvice.org.uk/index/pressoffice/press_index/press_20070327c.htm

³ Check-up on NHS dentistry: dental contracts – one year on. *Which?* March 2007. Available from: http://www.which.co.uk/files/application/pdf/070326_%20Checkupdentistry_br-445-113803.pdf

4.23 These claims paint differing pictures on access but could be consistent with improvements occurring within some PCTs and LHBs but not in others. One source of data that was not referenced by any of the parties on the issue of access is the Information Centre (IC) analysis of Her Majesty's Revenue and Customs (HMRC) tax data⁴ showing how dentists' NHS earnings as a percentage of total earnings had changed over the period 1999-2000 to 2005-06. The series for all non-associate dentists, those working in a stand-alone business, is shown in Figure 4.1, though the same pattern is mirrored when the data is broken down by age, gender or location. This steady downward trend, which seems to have accelerated since 2003-04, can be interpreted in two ways. One is that dentists in general are switching their treatment portfolio from NHS treatments to private treatments. This might, for example, be in response to an increase in demand for cosmetic dentistry, but could be that adult patients no longer are being offered NHS treatment. A second interpretation is that the proportion of dental practices that are committed to the NHS is falling. What this all points to is that we really do not have a clear picture on access to NHS dentistry and that access to NHS dentistry may not be stabilised as has been claimed. In respect of the government's objective to ensure access to an NHS dentist (in all regions of the United Kingdom), we suggest that there is still some way to go. PCTs and LHBs may need to consider setting aside additional funding for NHS dentistry specifically to meet this objective.

Figure 4.1: NHS earnings as a percentage of total earnings for 1999-2000 to 2005-06, Great Britain (non-associate dentists)



Source: The Information Centre using Her Majesty's Revenue and Customs data

Recruitment and retention

4.24 The Department of Health pointed out that at the end of March 2007 there were around 21,000 dental performers listed on NHS contracts in England which was significantly higher than the 18,800 providing services in 2003. It said that this number was around 500 fewer than in March 2006 because some dentists had rejected the new contract. However, the Department of Health noted that many who did not sign had relatively few NHS patients and therefore services were proportionately less affected by the workforce drop.

⁴ *Dental earnings and expenses report 2005-06*. The Information Centre, September 2007. Available from: <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-report-2005-06>

- 4.25 The Department of Health evidence again drew attention to the 25 per cent increase in the number of undergraduate training places, which began in October 2005, and to the fourfold increase in training places for dental therapists that were referred to in our last report. Alongside this, the Department noted that it was still too early to update the conclusions of the 2003 workforce review to assess the optimum level of future workforce supply.
- 4.26 The BDA again highlighted to us some difficulties that vocational dental practitioners (VDPs) were having securing post-vocational training (VT) employment. The BDA survey of VDPs found that, by summer 2007, 22 per cent had still not managed to secure post-VT employment for the coming year; three percentage points up on the same measure taken 12 months earlier. In addition to this, the BDA said that only a third of VDPs reported that they had been fully able to pursue the post-training career of their choice; two-thirds reported that either they had not, or had only partially, been able to do so.
- 4.27 Alongside these issues with VDPs, the BDA also reported concern that the continued unattractiveness of working in the NHS was likely to result in a gradual decline in the number of VT trainers, despite there being sufficient funding in the system to train a larger number of VDPs. The BDA reported that a cohort of highly experienced VT trainers had declared that this would be their last year as a VT trainer, stating that the increasing pressure of being a VT trainer had directly influenced their decision. The BDA noted that there had been a marked reduction in the number of applications from dentists wishing to be VT trainers.
- 4.28 New pension arrangements have been agreed and will apply from April 2008 across the NHS. All parties provided details of these changes. Dentists' pension benefits are calculated as 1.4 per cent of their total pensionable pay (i.e. their pensionable pay accumulated over their working lifetime) and this is updated annually. The Department of Health drew attention to the recruitment and retention benefits of this, stating that the NHS had an excellent reward package for dentists. The BDA also commented that findings indicated that for GPs the scheme represented an important aspect of their commitment to the NHS. We note the changes that have been agreed and will continue to consider pension benefits as part of total reward for dentists and all our other remit groups.
- 4.29 We will continue to monitor the recruitment and retention of dentists closely. We believe that workforce numbers and UDAs are both relevant measures for us to consider, since the former is a measure of supply and the latter reflects demand. The BDA has quite rightly raised the issue of recruitment to the workforce needed to provide NHS dental services and, as we have said in our previous reports, we find it difficult to assess the extent to which the NHS is under-provided with GPs and how this will change over the coming years. We continue to ask the Department of Health for greater clarity about the resources needed and the scale of patient demand so that we can use this as a basis for assessing the issue of recruitment and retention. In particular we hope to hear more news of the planned update of the conclusions from the 2003 workforce review. The commitment of those GPs operating within the NHS is a valuable resource that we are required to support, within the other constraints of our remit. Additionally, as we comment earlier in this chapter, it is difficult to predict what effect the contract changes in 2009 will have; therefore, retention will need to be carefully monitored across those changes. We make our recommendations for 2008-09 with this in mind.

Capital support

- 4.30 The Department of Health again reported to us that £100 million of capital funding had been made available over 2006-07 and 2007-08 to take forward infrastructure improvements to NHS primary care dental services. It said that this amount built on the £80 million capital investment already going towards modernising dental education establishments and supporting the 25 per cent expansion in dental training places. These arrangements have not changed from last year. However, over the summer we received some anecdotal evidence from PCTs and GDPs that there was some confusion about what this funding could be used for within dental surgeries. We therefore request for our next review a report on how and where the capital funding was spent.

Practice cost allowance

- 4.31 The BDA noted that last year we did not follow its proposals to recommend a practice cost allowance in England and Wales. The BDA expressed disappointment that we have neither accepted the need for an introduction of a practice allowance in England and Wales nor, in their view, convincingly countered its conviction that there would be positive potential benefit in retaining and improving the morale of NHS dentists. As stated in our last report, the BDA previously argued that there were a number of factors that had raised or would shortly raise the cost base of dental practices: the new registration and training requirements of dental care professionals, additional and stricter infection control guidelines and the move towards single-use items. It said that since this was not built in to the contract value, some adjustment was required and that this should be done via the introduction of a practice cost allowance. We note the BDA's view on this issue.

Practice goodwill

- 4.32 The BDA has raised again the issue of practice goodwill; that under the new arrangements there is no guarantee that PCTs and LHBs will commission NHS dental services from a dental practice if a new owner takes control. However, the Department of Health told us last year that in the event of a practice being sold to another owner it expected PCTs normally to commission services from the new owner in order to avoid disruption to patients.
- 4.33 Over the summer, we received some anecdotal evidence from PCTs and GDPs suggesting that, in practice, PCTs are commissioning NHS dental services from new owners; this is encouraging, although we wish to know whether it reflects the general position. We therefore ask both parties to monitor the position and would like to see them submit further evidence on this for our next review.

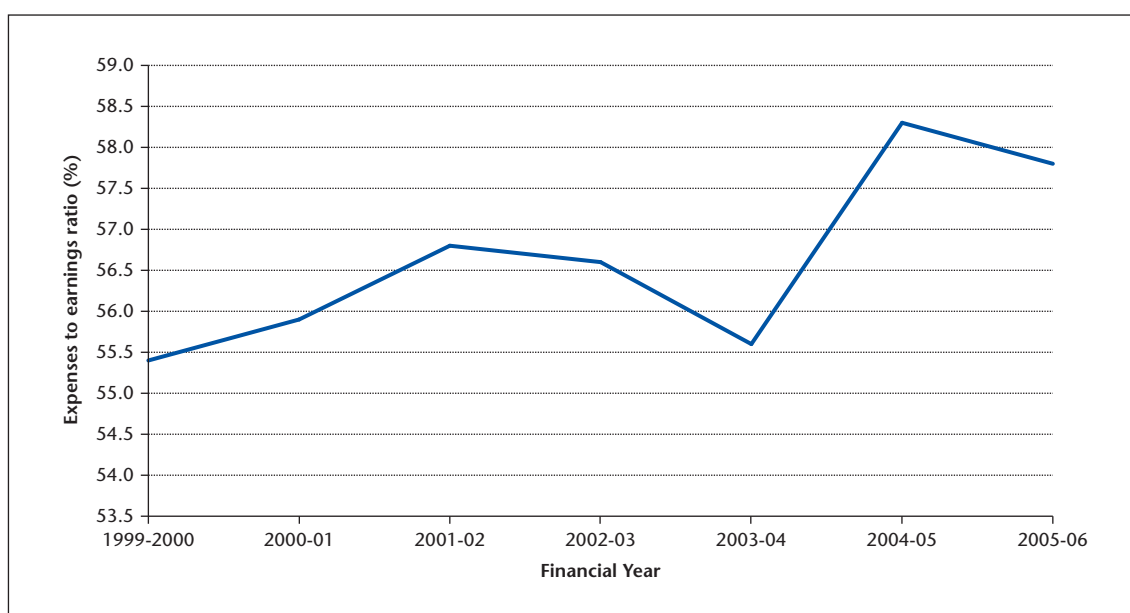
Practice expenses

- 4.34 In making our judgement on the uplift to GDPs' contract values we take into account both dentists' own remuneration and their practice expenses. We have used a formula to derive the expenses element and combined expenses with dentists' take home pay.
- 4.35 On practice expenses, we have had differing views from the parties on movements in the expense ratio and the likely movements in input prices and unit costs in general. On the expense ratio, both the BDA and the Department of Health have drawn our attention to movements between the 2003-04 and 2005-06 tax years. The analysis is undertaken by the IC and is based on actual data on dentists' earnings and expenses using HMRC tax return information. These data cover dentists who worked under the old GDS contract and their earnings and expenses from NHS and private sources.

The expenses to earnings ratio

4.36 2005-06 is the latest year for which the IC has published results on the expenses to earnings ratio⁵. In its evidence on trends the Department of Health focused on the most recent year for all non-associate dentists for whom the expenses ratio fell slightly from 58.3 per cent to 57.8 per cent in 2005-06. Additionally, it highlighted non-associates with a high level of NHS commitment where the ratio had fallen from 52.1 per cent in 2003-04 to 49.6 per cent in 2005-06. The BDA, on the other hand, focused instead on a longer timeframe for all non-associate dentists where the ratio had risen from 55.6 per cent in 2003-04 to 57.8 per cent in 2005-06. As Figure 4.2 indicates, the data do suggest that between 1999-2000 and 2005-06, the trend in this ratio for all non-associate dentists has been upwards. While it is true, that if one disaggregates these data, there is some variation in this pattern across groups, most sub-groups appear to have moved broadly in line with this general trend. However, it has not been possible to get a comparable run of data classified by NHS commitment. It would be useful to see this.

Figure 4.2: The expenses to earnings ratio for 1999-2000 to 2005-06, Great Britain (non-associate dentists)



Source: The Information Centre using Her Majesty's Revenue and Customs data

4.37 Notwithstanding the above, the important issue is what has happened to expenses under the new contract and that did not come into force until April 2006. However, until the analysis of the 2006-07 tax data is available, it will not be possible to make any comment at all about the possible impact of the new contract on the expense ratio and it will need some years of data before any real inference can be drawn. This leads us to conclude that we should continue to use the figure in our last report.

Input prices and volumes

4.38 The Department of Health said it believed that evidence clearly showed that under the new contract dentists were carrying out simpler courses of treatment, meaning the consumables and appliances costs would significantly reduce with a major effect on practice expenses. It argued that: consumables and laboratory costs each formed

⁵ The expenses to earnings ratio is the percentage of earnings spent on expenses rather than income.

around 15 per cent of expenses; there was a 5 per cent reduction already built into dentists' baseline activity, as measured by UDAs; and activity within banded courses was down by 11 per cent overall and by 35 per cent for advanced treatments, leading to both consumables and laboratory costs decreasing in volume terms. The Department provided data showing that between 2003 and 2007, there appeared to have been a reduction in the complexity of a range of treatments with dentists carrying out 35 per cent fewer advanced treatments and some 11 per cent fewer other treatments and it drew our attention to data compiled by the National Association of Specialised Dental Accountants that showed a reduction between 2001-02 and 2005-06 in the percentage of cost of sales as a proportion of turnover for NHS dental practices from 17.0 per cent to 11.9 per cent, essentially due to the constancy in the cost of sales in what was a period of rising turnover.

- 4.39 The Department of Health also drew our attention to data from the *Dental Directory*, a company it said had nearly 50 per cent of the United Kingdom dental supplies market, which had not increased prices since January 2005 and its new catalogue (which was then due in September 2007) would mean a weighted increase for all these items was only 0.75 per cent per annum over this period. On other input prices, it suggested that staff costs had increased by 3.3 per cent (as used last year) and appeared to accept that the increase in the Retail Prices Index (RPI) was appropriate for the other items that make up costs. It concluded that the results of applying all of these adjustments to the formula using current values would be an uplift of *minus 2* per cent. The Department's comments on the formula are considered in more detail later in this chapter.
- 4.40 The BDA evidence on costs covered staffing and new cost items. On staff costs, it pointed to the relatively high correlation (0.78) between growth in the median hourly pay for healthcare and related personal service staff (HRPS) – which we used as the indicator in our last report – and the growth in the average earnings index and suggested that we use forecasts of the latter. It also drew our attention to three new elements of cost: compulsory dental nurse registration, the increase in single-use items, and the costs of strengthened decontamination requirements. The BDA has suggested that the first two of these would cost £25 million and that the £5 million additional funding by the government (equating to £6,000 per practice) to deal with the last of the three was a considerable underestimate of the actual cost. It pointed to trial data from Scotland that suggested a figure well in excess of that. Finally, the BDA remained concerned that our approach, when assessing the movements in dental expenses, was retrospective.
- 4.41 HMRC data on dentists' earnings and expenses, published by the IC, revealed that:
- non-associate dentists, those who worked alone, earned more from private work than from the NHS during 2005-06. Overall, dentists working under the GDS earned 42 per cent of their gross income from NHS work compared with 48 per cent in the previous year;
 - average income, after expenses had been deducted, was highest for 2005-06 among dentists who were practice owners. They received an average annual income of £114,000. Dentists who used the facilities within another dentist's practice earned less; on average £61,000. Dentists who practised alone earned an average of £95,000. When quarter four only figures were used, average annual income was £99,000 for dentists who practised alone, with those that had a high commitment to the NHS earning £96,000 and those with low NHS commitment earning £101,000; and

- for dentists who practised alone, average expenses for their NHS and private work combined were shown to be £129,000 in 2005-06 (accounting for 58 per cent of overall income). This proportion remained unchanged from the previous financial year. Average expenses incurred by practice owners were £240,000 in 2005-06 (accounting for 68 per cent of their overall income), and for users of other dentists' facilities they were £31,000 (33 per cent of overall income).
- 4.42 The detailed breakdown of expenses for 2005-06 for dentists who practised alone was: business⁶ (9 per cent), premises (8 per cent), salary and wages (30 per cent), car and travel (2 per cent), interest and depreciation (7 per cent), net capital allowances (3 per cent) and other items⁷ (40 per cent). These proportions are very similar to the breakdown in 2004-05.
- 4.43 We are pleased to see more detailed information on expenses from the parties this year. In particular that the information provided includes data sources and further avenues for research. However, as we have indicated in previous reports, it is important that there is agreement between the parties on what constitutes the relevant cost base for dental practices so that the appropriate drivers of dental expenses and indicators of how they are changing can be identified. We believe it is in their interests to reach a mutual understanding on this matter. We do not think it is appropriate for us to undertake or commission such work given that the relevant knowledge of the technology of providing dental services resides with both parties. Therefore, again we **recommend that the parties work together, or commission joint independent work, on dental expenses, focusing specifically on the non-staffing element** and look forward to receiving agreed, joint evidence on this next year.
- 4.44 We are pleased to note in IC data this year the inclusion of expenses and earnings information for different types of GDPs, although these data are historical and cover GDPs working under the old GDS contract in its final year of 2005-06. We also note that there are different expenses to gross income ratios depending on whether the GDP is a practice owner, operates within another practitioner's premises or practises alone. The weights that we use in our formula are intended to cover the personal remuneration and expenses of an 'average' practitioner working in the NHS.

Dentistry in Scotland

- 4.45 In contrast to dentistry in England and Wales, where the responsibility for dental services is devolved to a local level, there is a Scotland-wide approach to dental services, with some elements of local flexibility. The remuneration system for general dental services is primarily based on item-of-service fees for adults and children, capitation and some continuing care payments. There are also centrally funded allowances available to dentists.
- 4.46 As at 31 March 2007, there were 2,186 non-salaried dentists registered to provide NHS treatment in Scotland.

⁶ Business – includes repairs and renewal of business premises and machinery, the cost of general office expenses, covering administration, advertising, promotion, legal and professional costs, and bad debts and other finance charges.

⁷ Other items – includes cost of sales, i.e. the cost of purchasing raw materials/items sold.

- 4.47 The Scottish Executive Health Department (SEHD) said the three-year *Action Plan*⁸ was two years through and most targets had been met; it was committed to spending £237 million on primary care dental services over three years. The total number of NHS dentists had consistently risen, there had been an increase in Vocational Trainee Golden Hellos, an increase in the number of dental graduates taking up Scottish posts and £11,000 had been paid to dentists returning to work after five years or more. There were a number of allowances potentially available to dentists which included: a general practice allowance (69 per cent qualified for this allowance); a remote area allowance; a sedation allowance; a deprived area allowance; and a recruitment and retention allowance. In addition to these, dentists could be eligible for rent reimbursement and also dental access initiatives were paid to GDPs willing to make a sustained commitment to the NHS. Finally, over £1 million was transferred to NHS Boards to help meet costs for management of clinical waste. The percentage of Scottish dentists' remuneration paid by way of grants and allowances was 18 per cent for the financial year 2006-07.
- 4.48 The BDA commented that some areas in Scotland had long waiting lists for NHS dentists and noted that although there had been the introduction of a raft of initiatives and allowances to support dentists in their working lives, there had been no government evaluation of their impact. As yet it was unclear whether or not these were having an effect on improving the recruitment of NHS dentists in these areas and thus improving access to dental services for patients. The BDA also noted that strengthened decontamination requirements had recently been introduced in Scotland and raised concerns about whether the funding of £5 million promised by the Scottish Executive would be adequate. Additionally, the BDA raised concerns about the situation of VT trainers, as it also did in respect of England and Wales. It noted that VT trainers were now being asked to train more than one vocational dental trainee, with advertisements indicating ratios of 1 to 4 and 1 to 8.

Dentistry in Northern Ireland

- 4.49 The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) has overall responsibility for the provision of health service dentistry by general dental practitioners in Northern Ireland. In turn, each Health and Social Services trust is responsible for making arrangements for such services in its own area. As for Scotland, there is a country-wide approach to dental services, with some local flexibility. The remuneration system for general dental services is primarily based on item-of-service fees for adults and children, capitation and some continuing care payments. A number of centrally-funded allowances are also available to dentists. Before Northern Ireland was added to our remit, our recommendations were traditionally applied to the Northern Ireland workforce.
- 4.50 As at October 2006, the latest available data, there were 782 GDPs registered to provide NHS treatment in Northern Ireland.
- 4.51 The DHSSPSNI published its *Primary Dental Care Strategy* in November 2006⁹ and the reforms contained within the strategy included: local commissioning of services; access to appropriate dental care; a clear definition of treatments available under the health service; a greater emphasis on disease prevention; guaranteed out-of-hours services; and a revised remuneration system to reward dentists fairly for operating in

⁸ *An action plan for improving oral health and modernising NHS dental services in Scotland*. Scottish Executive, 2005. Available from: <http://www.scotland.gov.uk/library5/health/apioh-00.asp>

⁹ *Primary dental care strategy*. Department of Health, Social Services and Public Safety, September 2006. Available from: http://www.dhsspsni.gov.uk/dental_strategy_2006.pdf

the new arrangements. The DHSSPSNI was involved in negotiations with the Dental Practice Committee of the BDA with the aim of agreeing a new contract for practitioners in Northern Ireland. It hoped to pilot the new contract in 2008. The DHSSPSNI stated there was a steady drift of dentists to the private sector in the country, which was affecting access. Consequently, extra money, a total of £6.4 million of which £4.5 million was recurrent (effectively provided from April 2007), had been provided to cover practice allowances, sterilisation and infection-control procedures and additional vocational training allowances.

- 4.52 The BDA also noted the contract negotiations and saw the recent extra funding for dentistry as a step in the right direction. As it did for the other United Kingdom countries, the BDA stated that there was a decline in VT trainers in Northern Ireland, highlighting that only 30 out of 40 VT places for which funding was available were taken up in 2007-08. The issue of VT trainers consequently appears to be a United Kingdom-wide one.
- 4.53 We have considered the issue of VT trainers and ask the parties to provide further information. In particular, we expect next year's evidence to include their views on our role with respect to VT trainers, the numbers and recruitment issues for this group and evidence indicating whether VT trainer numbers are affecting the recruitment of VDPs.

Pay recommendations for 2008-09

- 4.54 The Department of Health said that it had examined various aspects of the formula. It proposed adjustments to allow assumptions to be made about changes in complexity of treatment and to allow for different assumptions about inflation in laboratory costs and in the cost of consumables to differ from each other as necessary. The Department of Health consequently considered that an increase in gross contractual payments of 1.5 per cent, which would allow for any unanticipated increase in expenses, would be appropriate at this time. The WAG shared the Department's view that the recommendation should be a simple increase in net pay and expenses which reflected the changes in the supply of dentists and the change in the type of work provided, particularly the move to simpler courses of treatment with a lower expenses element and requested an increase of no more than 1.5 per cent. The SEHD said it would welcome an uplift to dentists' fees and recommended an increase of 1.5 per cent and the DHSSPSNI said that the Department of Health rationale for a pay settlement in the region of 1.5 per cent should also apply to Northern Ireland.
- 4.55 NHS Employers said that a headline pay uplift of 2 per cent would be affordable while requiring organisations to deliver efficiency savings above the levels indicated in the government's spending review. They also commented that they did not expect us to make recommendations, as we had in the past, based on a formula that looked simply at the wider economy movements in prices and costs. They said that any recommendation we made in relation to gross contract values should take account of the significant benefits for dentists of the new contractual arrangements, in particular the evidence that simplified courses of treatment were reducing practice expenses as a proportion of gross earnings.
- 4.56 The BDA asked us to recommend that for 2008-09, all NHS dentists should receive a 7 per cent increase to their net NHS earnings before tax. Underpinning the request for all dentists, the BDA took regard of the RPI figures for both the last two years, and the awards which we made for those years to those working in the GDS. It believed that this award would significantly slow the shift into private dentistry and send a clear message that dentistry remained a valued and essential NHS service.

- 4.57 The DPA said that it was seeking an uplift sufficient to recruit, retain and motivate dentists to work within the NHS in sufficient numbers to secure and improve the oral health of the public which either paid, or would be liable to pay, taxes towards this end. It commented that it regarded this as a multi-factorial problem and believed any formulaic approach which fully accounted for all of the variables would be too large to be useful. It added that the formula originally suggested by us was already growing and while 'plugging in' various figures gave an illusion of a deterministic process, only a retrospective analysis of compliance with the objectives could be a measure of success or failure. In carrying out this analysis, the DPA believed that we must disregard the majority of measurements on which the Department of Health chose to rely, such as the number of NHS dentists or the number of UDAs re-commissioned. It stated there was currently no relationship between either the number of dentists in contract or the number of UDAs commissioned or re-commissioned, and the amount of NHS dentistry provided measured by any clinical standard relevant to the prevention or treatment of dental disease.
- 4.58 As we noted earlier, there are now effectively two dental systems operating in parallel within the United Kingdom. Scotland and Northern Ireland have retained the fee-per-item system, although this may change in Northern Ireland with the new contract. The relationship between the fee and the underlying 'cost' is unclear, although it has no doubt a historical basis. It is therefore very hard to know how appropriate the fee/cost relationship implied by the fee is, and we have no data to assist. However, that notwithstanding, it is the case that the SEHD has chosen to support dentists' costs by means of a practice allowance whose scale is related both to NHS income and to NHS commitment. In England and Wales, on the other hand, there is a contract whose value is designed to deliver a specified output, cover the full costs of doing so and provide a fair income to the practice owner and his or her associates. Here the link between cost and income is much clearer. Since gross income is guaranteed under the terms of the contract, the dentist's own income is simply the residual between that and expenses. It is therefore amenable to analysis and a formula-based approach to the uplift.

The formula

- 4.59 For the last two years we have used a particular formula to calculate the recommended uplift for dentistry. The approach is an accounting-based one that was designed to recognise that GDPs, as independent contractors, need to generate gross revenues that cover the opportunity cost of the practitioner's time, the return on capital invested (capital costs) and the costs of service delivery. Practice costs are of two sorts: fixed (those that are invariant to the level of activity) and variable (those that vary with the level of activity). Moreover, variable costs themselves have a range of elements: staff, materials, laboratory costs etc. While the IC analysis of HMRC's returns might allow inference of the division of expenses into these two categories, as in previous years we have simply dealt with their aggregate and sub-divided that into two elements: staff costs and other costs. To the extent that the movements in the underlying items of cost have been diverging, and depending on the inflation indicator we use, it is of course the case that our approach may underestimate or overestimate what has actually been happening to the true level of expenses.
- 4.60 We continue to think that this transparent, formula-based approach is the appropriate one to use in framing our recommendations for the uplift in NHS dentistry in England and Wales, although we would be happy to receive from the parties further suggestions for its improvement or even replacement. The formula involves weighting together the increase in the practitioners' personal remuneration and the increase in GDPs' expenses. The weights that were used last year were derived from the IC's

survey of dental earnings and expenses, based on HMRC data, and we continue to derive the weights in the formula using these data. As we did last year, we have set the weight for the personal remuneration figure at 45 per cent and weight for the dental expense figure at 55 per cent. Dental expenses themselves involve weighting together staff costs and other costs and, using the latest IC data, the weights are 30 per cent and 70 per cent respectively. Hence, once we have decided on the appropriate indicators to use for these elements, our uplift is calculated by applying a weight of 45 per cent to the figure for the GDPs' own remuneration, 16.5 per cent (30 per cent of 55 per cent) to the appropriate indicator of staff costs and 38.5 per cent (70 per cent of 55 per cent) to our indicator of other practice expenses. The formula is set out as follows:

$$\text{Uplift}_{2008-09} = 0.45*x + 0.165*y + 0.385*z;$$

where:

x = increase in GDP remuneration;

y = increase in staff costs;

z = increase in other costs.

- 4.61 In looking for an appropriate indicator for the increase in GDPs' personal remuneration (x), we believe this year that they should share the uplift recommended for our remit groups working in the Hospital and Community Health Services. This increase is 2.2 per cent.
- 4.62 For the pay and price measures for the expenses elements in the formula (staff costs and other costs), we continue to use the most recent pay and price data. Both the Department of Health and the BDA raised specific potential changes to the formula.
- 4.63 The Department of Health suggested dividing the 'other costs' category used in previous years into consumables costs, laboratory costs and other costs. Each of consumables costs and laboratory costs is about 15 per cent of dental expenses as reported in early income and expenses surveys and in BDA surveys. The Department said that it believed, under the new contract, that the volume of consumables had fallen by about 15 per cent. It based this on the UDA requirement being 5 per cent less and activity within the banded courses, as reported by the IC, being down about 11 per cent between 2003-04 and 2007. The Department said that the volume of laboratory costs had fallen by 40 per cent. This estimate came from the recent report on activity published by the IC and was based on a combination of a 35 per cent reduction in advanced treatments and 5 per cent reduction in weighted courses of treatment between 2003-04 and 2007. Under these changes, the consumables share would fall by 15 per cent from 8.25 per cent to 7 per cent and the laboratory costs share would fall from 8.25 per cent to 5 per cent. The Department also suggested taking the price increases made by the *Dental Directory*, which it regarded as being the main supplier, and applying these to consumables. This would result in an increase for consumables of 0.75 per cent. We propose not using these figures or making the split of laboratory costs, consumables and other costs this year as we feel we would first like to see these trends reflected in other data sources and over a longer time frame. Instead we urge the parties to use them as a basis for joint further investigation.
- 4.64 The BDA proposed using forecasts for average earnings increases across 2008 to uplift staff costs within our dental formula. However, as in previous years we do not think it is appropriate for us to make forecasts due to their uncertain nature.

- 4.65 For the year to April 2007, the annual percentage change in the median hourly rate of HRPS employees was 5.1 per cent and this is the figure that we have used this year to represent staff cost inflation (y). We did consider other sources, such as the dental nurse earnings increase which is also recorded in the Annual Survey of Hours and Earnings. However, because this series of earnings data is now based on a far smaller sample it is erratic, and we do not believe we can have regard to it this year.
- 4.66 For costs other than staff (z), we recognise that there are no specific measures for the different categories of expenses in this component and we therefore use, as last year, the RPI as the appropriate measure. The RPI uses a more general bundle of goods and services than the Consumer Prices Index, which we also considered. Thus the figure for the third component of the formula is 4.2 per cent, the average change in the RPI for the last quarter of 2007.
- 4.67 **We recommend that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 2.2 per cent after allowing for an increase in expenses.** Using this uplift for GDPs' personal remuneration along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 3.4 per cent. Therefore, **we recommend that an uplift of 3.4 per cent be applied to the gross earnings base under the new contract for 2008-09 for GDPs in England and Wales. We recommend uplifting gross fees, commitment payments and sessional fees so that this will also result in an increase in GDPs' income of 2.2 per cent in Scotland and Northern Ireland after allowing for an increase in expenses. Therefore, this year we are recommending that the uplift of 3.4 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland.** However, as we have already indicated, the two dental systems continue to diverge and it may be that in future years we shall find it necessary to consider Scottish dentistry and Northern Ireland dentistry separately and to make a separate recommendation.

CHAPTER 5: SALARIED PRIMARY DENTAL CARE SERVICES

Introduction

5.1 Salaried primary care dentists work in a range of different posts, as community dentists, salaried Personal Dental Service dentists, Dental Access Centre dentists and as salaried general dental practitioners in the NHS. The salaried primary dental care services (SPDCS) developed predominantly in response to the need for services which could complement the independent contractor general dental service. They are an important part of primary care dentistry, providing generalist and specialist care largely for vulnerable groups. They often provide specialist care outside the hospital setting, to many who might not otherwise receive NHS dental care. Although information on the number of salaried dentists in England is not regularly collected, data from a survey undertaken by NHS Employers suggests that there are 1,471 SPDCS dentists (1,034 whole-time equivalent (WTE)). In Wales, the number of Community Dental Services (CDS) dentists accounts for around 1 in 9 of all dentists: in 2005-06, there were 124 dentists (97 WTE). Scotland has 401 community dentists, 308 hospital dentists and 324 salaried dentists. Northern Ireland has 94 community dentists.

The evidence

5.2 Evidence on the SPDCS was provided us to us this year by the Health Departments, the British Dental Association (BDA) and NHS Employers. The main evidence can be read at the parties' websites (see Appendix D). Apart from the pay uplift, the main issue to be brought to our attention this year was the ongoing negotiations on new pay, terms and conditions for salaried dentists in England, together with the plans of the other three administrations for pay reform. The BDA also raised the issues of increased workload pressure and problems with recruitment, retention and morale.

Recruitment, retention, motivation, morale and workload

5.3 The BDA said its Survey of Clinical Directors¹ indicated problems with the recruitment and retention of dentists in the SPDCS/CDS. It said that 28 per cent of respondents to the survey confirmed that posts had been frozen, and 68 per cent of Clinical Directors had experienced difficulties in recruiting, with the major reason cited being relatively poor pay compared with dentists in general practice. Supplementary survey work by the BDA looking at recruitment in Scotland suggested a vacancy rate of 20 per cent, coupled with a shortage of applicants for advertised posts. Workload had increased, partly to help tackle local access problems and partly because of increased referrals, particularly of more complex work. The BDA suggested that low job satisfaction and increasing workload had contributed to decreasing morale within the profession. Morale had been undermined by the commissioning process which had begun to see traditional SPDCS/CDS services being put out to tender: the process had resulted in greater uncertainty about the future.

¹ *Survey of Clinical Directors*. BDA, 2007

New pay, terms and conditions and the devolved administrations

- 5.4 Last year, we were told that NHS Employers had been asked to negotiate with the BDA on new pay, terms and conditions for salaried dentists in England, and would allow an increase of up to 10 per cent in the pay budget for salaried dentists. This year, NHS Employers told us that they had completed negotiations with the BDA and that authorisation had been received to proceed to a ballot of dentists. They said there were two key elements to the agreement: a new single pay spine underpinned with defined competencies; and enhanced career development structures. The BDA said that working with NHS Employers on the negotiations had been a positive process, and that all parties had worked in partnership to ensure that the new contract was fit for purpose and met the aims of all parties. We subsequently learned that the ballot that took place in November 2007 resulted in 86 per cent of votes cast in favour of the new contract.
- 5.5 The Welsh Assembly Government said that similar proposals to those accepted in England would be put to Ministers for approval. The Scottish Executive Health Department told us that its review of the salaried services had concluded that the current Community Dental Service and the Salaried General Dental Service should be combined to form a new Scottish Public Dental Service. A Project Implementation Board was taking forward the recommendations of the report that came from the review² and the Board was due to submit its report to the Chief Dental Officer by the end of 2007. The BDA said it was meeting regularly with members of the Project Board and any future negotiations on pay, terms and conditions would be likely to take place via the Scottish Joint Negotiating Forum. In Northern Ireland, the BDA said a new salaried service was being introduced, managed through the existing CDS. It said that the strategy for moving forward with reforms to the CDS appeared to be to observe the outcomes of the negotiations in England, and then to consider the potential suitability of introducing something similar in Northern Ireland. The BDA said that the uncertainty and absence of direction for CDS dentists in Scotland, Wales and Northern Ireland was causing considerable anxiety.
- 5.6 We are pleased to note the successful outcome to the ballot in England on new terms and conditions for these dentists, and note the comments made by the BDA in support of the negotiation process. We look forward to receiving evidence in future rounds on the implementation of the new arrangements and the benefits for both patients and dentists. We hope that the new contract will deliver stability for the workforce and that there will be corresponding improvements in the morale of dentists. We welcome the scope for dentists to increase their remuneration linked to defined competencies and the improved career development structures offered by the new terms and conditions, both of which we expect to address any recruitment issues for this group of dentists. The BDA suggests that the workload of salaried dentists has partly been affected by increased referrals from the general dental service, particularly of more complex cases. Any abnormalities in the number of referrals from the general dental service should be picked up by commissioners as part of their ongoing relationship with practitioners, and we expect commissioners to take up any concerns they might have directly with practitioners. In any case, job planning is an important part of the new contract, and we expect workload issues to be addressed as part of that process.

² *Review of Primary Care Salaried Dental Services in Scotland*. Scottish Executive, February 2007. Available from: <http://www.scotland.gov.uk/Publications/2007/01/10103940/0>

- 5.7 Now that the outcome of the ballot in England is known, we hope that both Wales and Northern Ireland will give urgent consideration as to what action they wish to take in those countries. In Scotland, we look forward to receiving evidence for our next round on how the Project Implementation Board is taking forward its work on the new Scottish Public Dental Service. The existence of different arrangements for salaried dentists in the different countries may have an unwelcome effect on recruitment and retention, particularly in areas that are near to the borders between countries. We also note that SPDCS/CDS dentists are among the last NHS staff to receive modernised terms and conditions and associated pay, and we therefore urge the devolved countries to provide some stability for this important group of dentists by giving priority to the consideration of the future for the SPDCS/CDS.

Pay recommendation for 2008-09

- 5.8 As part of the agreement on new terms and conditions for SPDCS dentists in England, pay will be backdated to 1 June 2007. In addition to this, the BDA said that in the light of all the issues raised in its evidence, it was seeking a 7 per cent increase for all dentists (in all countries). NHS Employers said that it wanted a fair and reasonable national pay award that took account of cost of living pressures and the impact on staff morale. It concluded that an affordable pay award was up to 2 per cent. The Health Departments said that the balance between the interests of staff and those of patients would best be served if basic pay were to be increased by 1.5 per cent.
- 5.9 For 2008-09, we **recommend increases of 2.2 per cent for all grades in the salaried primary dental care services**. The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrive at our recommended increase.

CHAPTER 6: OPHTHALMIC MEDICAL PRACTITIONERS

Introduction

- 6.1 The Department of Health told us that the number of ophthalmic medical practitioners (OMPs) with contracts in England and Wales to carry out NHS sight tests had decreased from 479 to 406, while the number of optometrists had increased from 8,692 to 9,102. It said that the General Ophthalmic Services (GOS) continued to attract adequate numbers of good quality practitioners with appropriate training and qualifications. Surveys conducted into the working patterns of optometrists and OMPs showed that most OMPs practised part-time. The Department of Health reported back to us on the findings of a review of the GOS and, as in previous years, brought the issue of the sight test fee to our attention.

The review of the GOS and the sight test fee

- 6.2 The Department of Health said that it had published the findings of a review of GOS¹ in January 2007. The main focus of the review was to assess how to support the NHS in making greater use of community-based services to improve patient experience and patient choice. It said that the review had concluded that there was clear potential to develop more accessible, tailored eye care services for patients by making greater use of the skills that exist among eye care professionals in both primary and secondary care. It said that the review also confirmed the case for maintaining the present system for sight testing services with no fundamental changes to the system of demand-led sight testing with fees continuing to be set nationally after negotiation with the Optometric Fees Review Committee. Our recommendation last year was for a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and the representatives of both OMPs and optometrists to continue for future years. We note that the outcomes of the review of the GOS support our conclusions from last year, and we are therefore content not to revisit our recommendation.

¹ *General Ophthalmic Services Review*. Department of Health, January 2007. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063984

Part III: Secondary Care

CHAPTER 7: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction and reform of training

7.1 Since the publication of *Modernising Medical Careers*,¹ the way in which junior doctors are trained has undergone a radical change. Under the old system, trainees (following medical school) would have entered as pre-registration house officers (HO), and once registered would enter the senior house officer (SHO) grade before becoming a registrar (either a specialist registrar (SpR) if choosing to remain within the hospital sector, or a general medical practitioner (GMP) registrar if deciding to enter general practice). Following the reform of training, juniors now enter Foundation Programmes (foundation house officers Years 1 and 2 – FHO1 and FHO2), covering the previous HO year and the first year of SHO training but with a new unified curriculum. Doctors then enter a ‘run-through’ grade known as a specialty registrar that will complete their training. The SHO and SpR grades are now both closed to new entrants, but both scales will be used in parallel with the new scales for some time. Details of all the pay scales are in Appendix A. The latest data² at 30 September 2006 show that there were 33,906 FHOs (years 1 and 2) and 21,997 registrars (both headcounts) working in the Hospital and Community Health Services, an overall increase of 4.1 per cent since September 2005.

The evidence

7.2 This year, the parties have provided evidence on a number of issues concerning doctors and dentists in training. We received evidence from the Health Departments, the British Medical Association (BMA) and NHS Employers. The main evidence can be read at the parties’ websites (see Appendix D). In addition to the basic uplift, the parties asked us to address a number of other issues, including the unavoidable costs of being a doctor and the removal of free accommodation. Our responses to these other issues are set out in the following paragraphs.

Recruitment and retention

7.3 This year, we note that the ratio of applicants to medical school places has dropped slightly, from 2.4 to 2.3. Nevertheless, we are pleased to note that there continues to be a more than adequate number of good quality applicants to study medicine, which as we have previously commented, is strong evidence that medicine is seen as an attractive career. The trend of recent years of most entrants being women continues, with the number of female entrants now being 59 per cent, an increase of 1 per cent on last year. It will therefore remain important for the Health Departments to consider the possible implications that this might have for future workforce planning and policies that support the retention of staff.

¹ *Modernising medical careers: the next steps*. Department of Health, April 2004. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4079530

² The latest data for doctors and dentists in hospital training in Wales are September 2005.

Motivation and morale

- 7.4 The main issue affecting junior doctors' morale brought to our attention in evidence this year was the difficulties surrounding the introduction of the new training arrangements, particularly relating to the Medical Training Application Service (MTAS), the new electronic recruitment and selection tool. The BMA said that MTAS had proved little short of disastrous and would affect the traditional view of job security within the medical profession. NHS Employers said that the longer-term effect on doctors' morale had yet to be assessed and it would be monitoring the situation closely. They acknowledged that the last year had been a difficult year, but drew attention to the huge commitment and effort put into supporting junior doctors from others within the medical profession, medical staffing teams and Human Resources departments. NHS Employers undertook to improve the morale of junior doctors in the longer term, and to focus on the priorities of ensuring that training and service posts were filled from August 2007 and the development of a package of careers' support.
- 7.5 We agree with NHS Employers that the last year has been a difficult one for junior doctors and do not underestimate the stress caused by the apparent failings in MTAS. However, workforce planning is not within our remit and we therefore offer no comment here. Nevertheless, we wish to acknowledge the work of the teams surrounding junior doctors highlighted by NHS Employers in their evidence. We welcome the commitment made by NHS Employers to bring about improvements in the morale of junior doctors and to ensure that training places are filled in the future alongside general support for future careers.

Pay scales for junior doctors

- 7.6 NHS Employers told us that they had reached agreement with the BMA on pay scales and grade names for doctors in post-Foundation training. They said that trainees appointed to a full programme of training leading to entry onto the Specialist Register would be known as Specialty Registrars (StRs); and those appointed to one-year appointments would be known as Specialty Registrars (Fixed Term) (StR(FT)). The agreed pay scales for junior doctors are set out in Appendix A of this report.

Flexible training

- 7.7 The BMA told us that it remained concerned about the availability of, and access to, flexible training. NHS Employers said that the uptake of flexible training had changed very little since last year, despite the introduction of changes to the arrangements that it anticipated would lead to an increase. They maintained that in the majority of cases, those wishing to train flexibly were able to do so. They said that a joint review would be undertaken with the BMA to give a further understanding of the factors affecting take-up of flexible training. We welcome this review by NHS Employers and the BMA and ask the parties to update us on progress for next year. We have long championed the benefits of flexible work opportunities to help aid recruitment and retention, particularly given the increasingly female proportion of the workforce.

New Deal and Working Time Directive

- 7.8 England, Wales and Scotland reported that New Deal compliance³ was at 98 per cent, 99 per cent and 96.8 per cent respectively. The Scottish Executive Health Department said that some of its non-compliance was in small specialties where national service redesign was planned. NHS Employers told us that, in agreement with the Department of Health and the BMA, no monitoring of working arrangements and pay bands had taken place during March 2007. However, they said that they saw no reason to suggest that working arrangements had changed since the last monitoring had occurred in September 2006. The Department of Health referred to the need to implement the Working Time Directive's 48-hour week from August 2009, and drew attention to the emerging findings of the University of Sheffield's research project to assess the impact of changing working patterns and reduced working hours on medical training. Wales reported Working Time Directive compliance as being at 98 per cent and Scotland at over 99 per cent. Wales told us that trusts were planning for the 48-hour target and Scotland said it was working to help design rotas now wherever possible so that efforts could be concentrated on the smaller units and specialties which would have the greatest difficulty in meeting the 2009 target.
- 7.9 We are pleased to note the continuing improvements in New Deal compliance and note with interest the work being carried out by the Department of Health, the Welsh Assembly Government and Scottish Executive Health Department to help the NHS meet the 2009 48-hour week target set by the Working Time Directive. Clearly, meeting this target will prove very challenging and we hope that the parties can learn from each others' experience and knowledge. We note that Northern Ireland has not provided us with any data to enable us to take a view on this issue in that country and ask it to let us have evidence for our next review.

Basic pay and the banding multipliers

- 7.10 Last year, we invited the parties to begin giving consideration to restructuring junior doctors' pay from 2009, when the Working Time Directive 48-hour week will come into force. In evidence this year, the Health Departments said that they felt it was too early to restructure pay, and that they wanted to see the full effects of the Working Time Directive and Modernising Medical Careers before changes were made. In particular, they wished to consider the final recommendations of the Tooke Inquiry into Modernising Medical Careers⁴ and the forthcoming NHS Next Stage Review. Nevertheless, the Health Departments did confirm to us during oral evidence that they were committed to reviewing juniors' pay at an appropriate time. The BMA, on the other hand, said that it could be a long time before the full effects of the Working Time Directive are known, and wanted a commitment from the Department of Health that discussions in earnest should begin by August 2009. It said that any future debate on a new contract needed to be on the basis of at least the current overall levels of funding.
- 7.11 We offer no comment on the level of funding needed for new contractual arrangements, as this is a matter that is properly left for negotiation between the parties. However, we think that the target proposed by the BMA for talks to begin in earnest by August 2009 is a reasonable one, and we hope that the Health Departments will give priority to their examination of the recommendations of the

³ New Deal compliance refers to the limits on working hours that formed part of the new contract for junior doctors introduced in 2000.

⁴ Professor Sir John Tooke. *Aspiring to excellence: final report of the independent inquiry into modernising medical careers*. MMC Inquiry, January 2008. Available from: http://www.mmcinquiry.org.uk/MMC_FINAL_REPORT_REVD_4jan.pdf

Tooke Inquiry into Modernising Medical Careers and the NHS Next Stage Review so that they can begin to address this issue with the BMA. We noted last year that once all junior doctors are working 48 hours a week or less, it would be necessary to shift the balance away from the banding multipliers towards base pay in order to ensure pay comparability, and we continue to believe this to be the case. We ask the parties to update us on any developments for our next review.

- 7.12 In the meantime, we are again required to recommend on the levels of the banding multipliers for junior hospital doctors. The current levels of the multipliers are those that were negotiated between the parties to fully recognise work intensity and out-of-hours commitment, and the parties have not provided us with any evidence to suggest that those levels need adjustment. We therefore **recommend that the percentage values of the banding multipliers be maintained at current rates for another year**. The detail of our recommendation is at Appendix A.

Comparator groups

- 7.13 The BMA said that the starting salary for FHO1s of £21,391 was less than the average graduate starting salary reported by Incomes Data Services⁵ in 2007 of £22,426. It also said that the correct comparator was graduates one to three years into their careers and suggested that the appropriate level for comparison was £29,378. The Health Departments believed that total pay was competitive and medical graduates could reasonably expect to obtain an NHS training post. NHS Employers said that overall pay on graduation remained competitive and attractive with no shortage of qualified applicants to vacancies at all levels of training. Our own study of pay comparability notes that the starting salary for FHO1s is below the levels reported by Incomes Data Services and the Association of Graduate Recruiters 2007 Summer Review⁶, although no data are available to compare with the considerable uplift received by FHO1s through the banding multipliers. Similarly, basic pay for SHOs and SpRs appears to be uncompetitive, but total earnings are more competitive. The way that junior doctors are currently paid, with pay split between basic pay and the banding multiplier, makes it very difficult for us to come to a conclusion about pay when comparing with other graduates. We have already commented that we would like the parties to begin thinking about how to address the issue of the balance between basic pay and the banding multipliers, and will expect the outcome of any such discussions to enable comparisons with the pay of other graduates to be much simpler. When making comparisons, we will also wish to take account of the levels of recruitment to medical school so see whether the total pay on offer is acting as a disincentive. Certainly at present, this does not appear to be the case.

Unavoidable costs

- 7.14 Last year the BMA asked us to consider the issue of the costs of being a doctor. At that time, we asked for more detailed evidence as to how costs have changed since 2000, when the new junior doctors' contract was introduced. The BMA has returned to this issue again this year, this time focusing on what it describes as core costs that are essential to training and progression: examination fees and membership of the key professional bodies.
- 7.15 We have examined the data provided by the BMA, and our analysis shows that across the specialties that they have quoted, the average increase for what it describes as 'core costs' that must be met by trainees since 2000 amounts to £279 per year. Part

⁵ *Pay and progression for graduates 2007*. Incomes Data Services, 2007.

⁶ *Graduate recruitment survey 2007: summer review*. Association of Graduate Recruiters, 2007.

of this £279 will have been delivered by our own recommendations since 2000 and will also be boosted by the effect of the banding multipliers. Stripping out the effect of our recommendations and the banding multipliers, we estimate that just £157 per year has to be met by junior doctors for these increased 'core costs'.

- 7.16 While it appears that pay has not kept pace with the increased 'core costs' quoted by the BMA, we note that the sums involved represent a very small percentage of total pay. We think it is important to look at the bigger picture here: recent changes to pay for doctors mean that the potential for future earnings has been greatly enhanced. Payment of these 'core costs' seems to be a very small investment in the light of future career earnings. Furthermore, if the BMA believes the costs to be increasing at an unacceptable rate, then it should take the issue up directly with the professional bodies involved. We commented last year that if the government were to meet these fees, then there would be a real risk that the professional bodies would feel able to increase them disproportionately, and we continue to believe that to be the case. It is not our role to micro-manage the pay system and we do not intend to revisit this issue in future years.

Free accommodation

- 7.17 NHS Employers told us that in the past, doctors in training were required to be contractually resident during their first year of hospital training (the HO/FHO1 year) in order to satisfy the requirements of the Medical Act for full registration. This regulation dated from the days when trainees were required to live in hospital and be available at all hours of the day and night. The introduction of more family-friendly working practices, a recognition of the need to reduce hours of work for safety reasons, and the impracticalities of requiring people to live at their workplace in today's NHS where there was no service need, had made the residential criterion redundant. In 2006, amendments to the Medical Act made provision for the removal of this requirement, and this aspect of the legislation was enacted in August 2007.
- 7.18 The BMA said it believed that it was essential for there to be a substantial uplift in basic pay levels for FHO1s to counter the additional costs of private rented accommodation. It believed that the earlier provision of free accommodation was a benefit in kind that formed part of the assessment of total remuneration for comparative purposes in the past. It said that the average amount that non-resident junior doctors paid in rent was £400 per month, and the BMA also took the view that the required uplift in FHO1 basic pay would also need to preserve the existing differential between FHO1 and higher pay scales in order to continue to recognise properly the achievements of full registration and progression through the grades.
- 7.19 The Health Departments said they believed that the removal of the residency requirement was an improvement in doctors' conditions of service and reflected the improvements in working hours. NHS Employers said that where accommodation was necessary to meet statutory or contractual requirements, it was provided at no charge, but that where it was not necessary, it was not provided. They said that this practice was in line with the provisions for all other NHS staff groups. An adjustment to FHO1 pay would affect the remainder of the scale where adjustment was unnecessary and unwarranted. An alternative, the payment of a housing allowance, was also considered unacceptable as it would provide FHO1s with a benefit not available to other staff groups and could lead to equal pay claims, given that the other staff group likely to want to use hospital accommodation were nurses and predominantly female. NHS Employers said that if we felt some adjustment was necessary, that we should not make any recommendation but suggested that the matter be left to negotiation.

- 7.20 Our view on free accommodation for junior doctors is that its provision was linked to the statutory requirement under the Medical Act for such doctors to be contractually resident. Changes to the working patterns of junior doctors and new rotas making it unnecessary for them to be 'on call' have allowed the government to amend the Medical Act so as to remove the residency requirement. It is therefore the case that free accommodation for junior doctors has not been a necessity for some time and we consider it entirely appropriate that junior doctors are treated in exactly the same way as other NHS staff.
- 7.21 The BMA believed that the removal of free accommodation was the removal of a benefit in kind. As with our comments on unavoidable costs above, while we acknowledge that the removal of free accommodation may in the short term increase costs for some junior doctors, the potential for future earnings has been greatly enhanced by recent contractual changes. We do not intend to revisit this issue in future years.

Pay recommendation for 2008-09

- 7.22 The BMA's arguments on the pay increase for junior doctors are part of its overall argument on the general level of settlement set out in Chapter 2. It suggested that a settlement of between 3.6 and 4.3 per cent was necessary to protect the value of existing contracts relative to Retail Prices Index inflation and reflected NHS productivity. The Health Departments were united in their call for an increase of 1.5 per cent. NHS Employers suggested an increase of up to 2 per cent was affordable. They also said that the incremental increases for junior doctors should be factored into decisions about the increase and we comment on the use of incremental pay scales in Chapter 1 of this report.
- 7.23 For 2008-09, we **recommend an increase of 2.2 per cent on the salary scales of all grades of doctors and dentists in training**. The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrive at our recommendation.

CHAPTER 8: CONSULTANTS

Introduction

- 8.1 The consultant grade is the main career grade in the hospital and public health service. In October 2003 new contracts were agreed and included a three-year pay deal from 2003-04 to 2005-06. The contract differs in England, Wales, Scotland and Northern Ireland. It was optional in England, Scotland and Northern Ireland, although all new appointments or moves to a new trust are under the new contract. All consultants in Wales were obliged to transfer to the new contract. We make recommendations on the pay uplift for consultants on both types of contract although a decreasing number of consultants remain on the pre-October 2003 contract. All consultants, whatever their type of contract, are now expected to have agreed job plans scheduling both their clinical and non-clinical activity.
- 8.2 Under the new contract, consultants have to agree the number of programmed activities (PAs) they will work. Each PA is four hours, or three hours in 'premium time', which is defined as between 7 p.m. and 7 a.m. during the week, or any time at weekends. In England, Scotland and Northern Ireland, ten PAs represents a full-time post, but the contract refers only to minimum commitments and does not define a maximum. On average, 7.5 PAs are for direct clinical care, although different patterns can be agreed through the job planning process. Total pay is composed of five elements: basic pay; additional PAs; on-call supplements; Clinical Excellence Award (CEA)/discretionary points/distinction award payments; and other fees and allowances. The current levels of payments are at Appendix A. The main differences for the new contract in Wales are: a basic 37.5 hour working week; a system of commitment awards to be paid every three years after reaching the new maximum of the pay scale, which replaces the former discretionary points scheme, although consultants in Wales are also eligible for national level CEAs; and a new salary structure with two extra incremental points.

The evidence

- 8.3 We have received evidence relating to consultants from the Health Departments, NHS Employers, the Advisory Committee on Clinical Excellence Awards (ACCEA), the Scottish Advisory Committee on Distinction Awards (SACDA), the British Medical Association (BMA) and the British Dental Association (BDA). The main evidence can be read in full on the parties' websites (see Appendix D); it covered a range of issues affecting consultants, in addition to the general pay uplift. These issues are addressed in the following paragraphs.
- 8.4 For this chapter of the report we have also drawn on the National Audit Office (NAO) report¹ on the new consultants' contract, which we found particularly useful and impartial.

¹ National Audit Office. *Pay modernisation: a new contract for NHS consultants in England*. Report by the Comptroller and Auditor General. HC 335 Session 2006-07. 19 April 2007. TSO, 2007. Available from: http://www.nao.org.uk/publications/nao_reports/06-07/0607335.pdf

Pay aspects of the new consultant contract

- 8.5 The Health Departments told us that at October 2005, there were fewer than 13 per cent of consultants still on the old contract. They said that the new contract was designed to provide, over time, a 15 per cent increase in career earnings and a 24 per cent increase in maximum basic salary. In the first three years of the contract, consultants' earnings increased by 24 per cent and they expected to see continued growth in average earnings per head, at the rate of about 1 per cent above the headline pay settlement, as consultants progressed through the thresholds towards the new maximum. The Health Departments forecast that if, for example, consultants were awarded a 1.5 per cent uplift in 2008-09, average earnings per head for consultants would rise by 2.5 per cent.
- 8.6 NHS Employers said that there were still some residual cost pressures from the continuing review of PAs within consultants' job plans. However, they had introduced cost neutral modifications to the on-call availability supplements, and revised and reissued earlier guidance on best practice in contracting with consultants for Additional Programmed Activities (APAs). They believed that the 2003 contract continued to work well and saw no need at present to revise it further.
- 8.7 The BMA noted that reports from the Kings Fund², NAO³ and Audit Scotland⁴ had been critical of the Department's failure to properly recognise consultants' working hours and the apparent lack of benefits resulting from the changes.⁵ The BMA thought that the lack of clarity over pay levels had been particularly unhelpful. However, emerging data suggested that benefits were beginning to be realised although consultants continued to work unpaid hours. The BMA said that the intention of the new contract had been to improve lifetime earnings by around 15 per cent. The Information Centre survey into NHS pay⁶ (January – March 2007) had concluded that average earnings per full-time equivalent consultant working under the new contract were £111,800 in March 2007; the BMA said that average earnings under the old contract were approximately £93,900. It said that it believed that the Health Departments' estimates were consistently higher than the incomes actually being received by consultants and that this had contributed to the negative climate surrounding consultant pay. It expressed concern that these data may also have contributed to our decision to recommend increases for consultants that it considered to be well below the rate of inflation.
- 8.8 As before, we note that when compared to similar professions, the pay rates of consultants in the United Kingdom continue to be favourable and Chapter 1 considers pay comparability in more depth. The NAO found that NHS consultants are paid at a higher rate than in many other countries, although it said that the United Kingdom had fewer consultants per head of population and international comparisons were

² Sally Williams and James Buchan. *Assessing the new NHS consultant contract: a something for something deal?* Kings Fund, May 2006. Available from: http://www.kingsfund.org.uk/publications/kings_fund_publications/assessing_the.html

³ National Audit Office. *Pay modernisation: a new contract for NHS consultants in England*. Report by the Comptroller and Auditor General. HC 335 Session 2006-07. 19 April 2007. TSO, 2007. Available from: http://www.nao.org.uk/publications/nao_reports/06-07/0607335.pdf

⁴ *Implementing the NHS consultant contract in Scotland*. For the Auditor General. Audit Scotland, 9 March 2006. Available from: http://www.audit-scotland.gov.uk/docs/health/2005/nr_060309_consultant_contract.pdf

⁵ We have drawn on the NAO report within this report, but offer no further comment on the Kings Fund and Audit Scotland Reports as they were published in 2006.

⁶ *NHS staff earnings: January – March 2007*. Information Centre, 11 July 2007. Table 5: Basic pay and earnings for medical staff groups. Available from: http://www.ic.nhs.uk/webfiles/publications/esr_earnings_2007-7/july%202007%20Earnings%20Estimates%20Tables.pdf

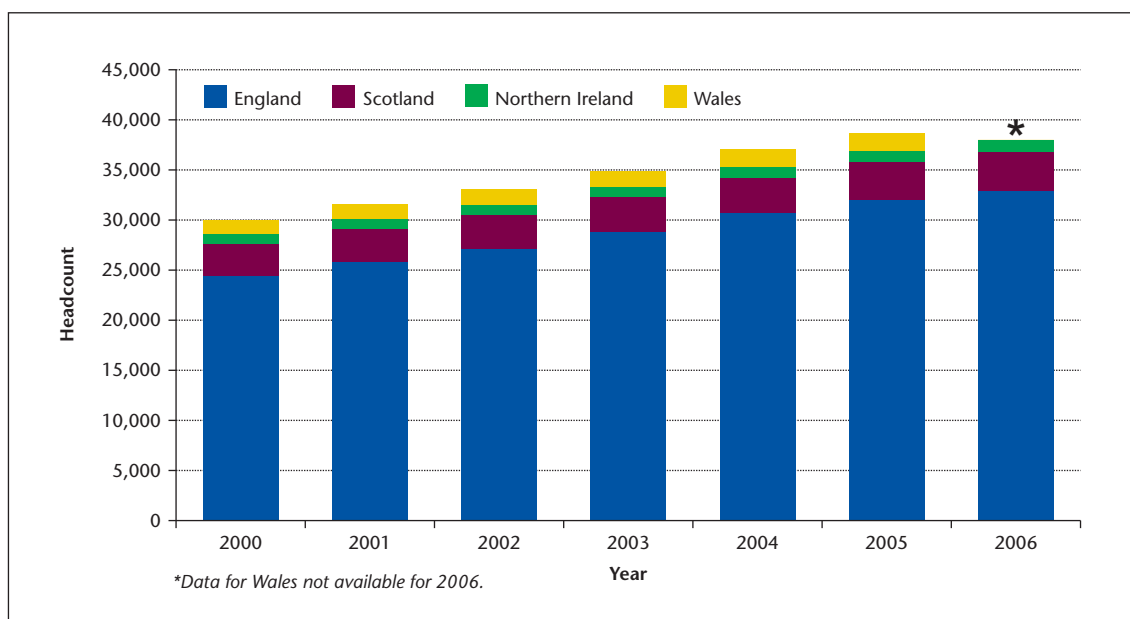
difficult because of the differences in their roles, including volume of work and level of training. It reported a correlation between the number of specialists per head of population and their average pay and said that the trend reflected a combination of market forces, increased pay and the increased seniority of specialist doctors in countries with fewer specialists per head. However, it found that the United Kingdom was above this trend and still appeared to pay at a higher level than the other countries with salaried specialists.

- 8.9 The NAO found that the costs of the consultant contract were higher than originally estimated and by the end of 2005-06, the Department of Health had allocated an additional £150 million above the £715 million expected to fund the contract. Even so, 84 per cent of trusts surveyed by the NAO did not believe that the contract had been fully funded. It stated that the main benefit of the new contract was that it had increased the transparency for managing the work of a consultant. This was seen as an important precondition for improving the value of consultants to the NHS. Overall the NAO found that the new contract had met the Department's expected benefits for the management of consultants' time, achieving a small reduction in the amount of private practice, extra PAs being bought at plain-time rates, and increasing the number of consultants. It was less clear whether the expected benefits had been achieved for patient waiting times, and it was too early to tell the full effect on productivity and whether the decrease in pay drift for 2005-06 was sustainable. The contract had not achieved the expected benefits for extending patient services or time spent on direct clinical care. The NAO concluded that the contract was not yet delivering the full value for money to the NHS and patients that had been expected, although it said that the Department felt that it was still too early to judge. Nevertheless, the contract had helped to align consultants' pay with their contribution to the NHS and some were even working the same or fewer hours for more money, which the NAO believed was in line with the Department's objective to reward consultants more appropriately.

Recruitment and retention

- 8.10 The number of consultants continues to increase steadily, as can be seen in Figure 8.1.
- 8.11 The Health Departments reported that the vacancy rates for consultants in England, Wales and Scotland had all reduced, with the greatest percentage reduction being shown in Wales where vacancies have fallen from 5.4 per cent to 3.0 per cent (March 2007). In Scotland, work with the Health Boards was continuing, to reduce vacancies and increase the number of consultants in post. Northern Ireland data were only available for the whole medical and dental group (which includes all Hospital and Community Health Services staff) and the vacancy rate had dropped across the latest year from 1.2 per cent to 0.9 per cent (March 2007).

Figure 8.1: Number of consultants in the Hospital and Community Health Services, 1999 – 2006, United Kingdom



Sources: The Information Centre, Welsh Assembly Government, Information Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

8.12 NHS Employers told us that, in general, there were few recruitment and retention difficulties but specialties where there were difficulties in recruitment and retention for consultants included: accident and emergency, anaesthetics, radiology, haematology, histopathology, radiology, paediatrics and psychiatry. They said that non-pay solutions to any localised recruitment and retention challenges remained as effective or more effective than increases in pay and payment of recruitment and retention premia was still used only infrequently and for limited periods, with exceptions in specialties with known shortages, for example, psychiatry and paediatrics. The current provisions for local level design and use of recruitment and retention premia continued to be deemed satisfactory by employers and no change was sought to these arrangements. We were told by the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) that it had been unnecessary to pay recruitment and retention premia to consultants in Northern Ireland.

8.13 The new contract was expected to lead to an improvement in recruitment and retention. However, the NAO found that although vacancy rates had shown an overall improvement, most trusts believed that there had been no change in recruitment and retention.

Motivation and morale

8.14 Most of the evidence we received on motivation and morale related to general observations on our remit group. However, the BMA provided us with some evidence specific to consultants. It said that the recommendation in our last report represented a failure to protect the value of the new contract and failed to recognise the demotivating impact of such reductions in real pay. It told us that there was a widespread view that morale was not as high as it should be given the aims of the newly introduced contract for consultants and the investment made in it. Reasons for reduced morale included the negative publicity that continued to surround the new contract, fuelled by government attacks on consultants' levels of income. However, in a BMA survey of consultants in England,⁷ carried out in May 2007, 78 per cent were

satisfied or very satisfied with the contract. The BMA also told us that 40 per cent of respondents said that they would encourage their child about to enter university to study medicine, although 56 per cent would not. In addition, the NAO found that consultants' morale had been reduced in the process of implementing the new contract.

Workload

- 8.15 The BMA said that some trusts had sought to reduce supporting professional activity (SPAs) in consultants' job plans. In its view this was short sighted, as the development and improvement of consultants and the service they could offer patients was dependent on SPA time. We did not receive figures from either the Health Departments or NHS Employers on the number of PAs contracted. However, a BMA survey of member opinion had shown that between November 2006 and May 2007 the average hours of work for whole time consultants were 48 per week (47.1 hours, excluding on-call in Scotland⁸) and that the average number of PAs contracted was 11.2. The BMA observed that this suggested that an average of four hours per week was unrewarded. It said that where PAs had decreased, this was because of financial reasons in the trust, personal reasons, or additional consultants being appointed by the trust with a consequent reduction in pressure in workload; where PAs had increased, the most common reason was workload.
- 8.16 The BMA asked us to take into account the reluctance of many trusts to comply with the spirit of the contract. However, NHS Employers said that it had seen no evidence to underpin the BMA's assertion that 'many trusts' were reluctant to comply with the spirit of the new consultant contract. They said that it was a positive and intended aspect of the contract that the numbers and types of PAs contracted for would change periodically to reflect the evolving needs of employers, patients and consultants.
- 8.17 The NAO found that many consultants saw the high numbers of PAs negotiated in the first year of the contract as a reward for the actual hours they worked. However, many trusts had subsequently reduced the number of PAs, so that many consultants no longer believed that their current contract reflected their working hours and they had reluctantly developed a 'clockwatching attitude' to their work. It said that one of the expected benefits of the new contract had been that it would improve the link between pay and performance, but appraisals and job plans were not being carried out in a coordinated way. The NAO report included recommendations that job plans should reflect the needs of the local NHS and should be applied with a suitable level of rigour.
- 8.18 As last year, we remain of the view that it is only fair that if PAs are reduced and less work is done, then there will be less remuneration. However, if consultants are under pressure to work additional hours their job plans and remuneration should be adjusted to reflect this. We are also of the opinion that a real effort by both parties to improve the job planning processes, without pre-determined outcomes, would generate both efficiency and morale benefits.

⁷ *Survey of consultants on the implementation of the new contract in England, May 2007: report*. Health Policy and Economic Research Unit, June 2007.

⁸ Data provided by the BMA; source: Health Economics Research Unit, University of Aberdeen.

Clinical Excellence Awards, discretionary points, distinction awards

- 8.19 Schemes to provide consultants with some form of financial reward for exceptional achievements and contributions to patient care have been in existence since the beginning of the NHS in 1948. In England and Wales, the national awards are made by ACCEA; in Scotland they are awarded by SACDA; and in Northern Ireland awards are made by the Northern Ireland Clinical Excellence Awards Committee (NICEAC). From October 2003, local CEAs in England, and commitment awards in Wales, have replaced discretionary points; national CEAs have also replaced distinction awards in England and Wales. The new CEA scheme was introduced in Northern Ireland in 2005 replacing discretionary points and distinction awards. Discretionary points and distinction awards continue to be awarded in Scotland and remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA or commitment award. All levels of CEAs, discretionary awards and discretionary points are pensionable.
- 8.20 ACCEA's website states that CEAs are given "to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care";⁹ SACDA says that distinction awards are made for "outstanding professional work";¹⁰ and NICEAC states that "the scheme aims to ensure recognition of exceptional personal contributions made by individual consultants who show a commitment to achieving the delivery of high quality care to patients and to the continuous improvement of health and social care".¹¹
- 8.21 The BMA expressed concern that we had not made a recommendation to increase the value of CEAs in our last report. It said that it believed that these should continue to maintain their value relative to consultants' basic salaries and urged us to restore the relationship as a failure to maintain the value of the awards sent out the wrong message to consultants, i.e. that quality and excellence were not as highly valued as they had been in the past and subverted the original scheme's intention to motivate excellence.

England and Wales

- 8.22 The Department of Health told us that at June 2007, 59 per cent of eligible consultants held an award (CEA, discretionary award or discretionary point) and 13 per cent of consultants held a CEA at or above level 9 or a distinction award (representing between £34,200 and £73,068 each). It said that for 2008-09, it believed that the numbers of new bronze, silver, gold and platinum awards should again be determined by ACCEA having regard to the available funding and the number of awards released at each level through retirements, resignations, withdrawals and progression through the scheme. It proposed that the value of CEAs, distinction awards and discretionary points should be increased in line with the award that the Health Departments proposed for all salaried medical grades (i.e. 1.5 per cent). We also note that NHS Employers, in partnership with the BMA, had submitted a report to the Department of Health on the operation of the first two years of the CEA scheme in England, and that the recommendations did not set out to address any pay related matters.

⁹ <http://www.advisorybodies.doh.gov.uk/accea/index.htm>

¹⁰ <http://www.sacda.scot.nhs.uk/>

¹¹ http://www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme.htm

- 8.23 ACCEA reported that 2008 would be the fifth year of the CEA scheme and that 2007 had seen the first example of a consultant moving from a silver to a gold award. It told us that for the national awards (bronze to platinum awards, levels 9 – 12) it seemed likely that a pattern would emerge whereby half of the consultants in each band would, over time, progress to the next level. However, this pattern was not yet sufficiently established to enable ACCEA to request specific numbers of awards at each level. It also noted that the transition between the schemes was still unpredictable. With these factors in mind, ACCEA sought an increase in the overall budget, in line with the number of consultants now eligible for an award, together with any general uplift awarded by us. It believed that this would give it the flexibility to manage the final stages of the transition between the schemes. For the local awards funded by employers (levels 1 – 8 and some level 9 awards) it reported that approximately two-thirds of organisations appeared to have met or exceeded the minimum investment requirement. It sought an uplift to the value of the lower level CEAs by the same rate as remuneration under the consultant contract.
- 8.24 ACCEA reported that there had been 2,243 applications in 2007, resulting in 576 new awards. It observed that there were fewer gold, but more silver awards than might have been expected. However, it expected that the number of gold awards would increase in 2008 as consultants given silver awards in 2004 demonstrated that they had enhanced their contribution. It told us that 2,740 consultants now held CEAs and a further 1,613 continued to hold distinction awards. In time, the holders of distinction awards would either move to the new scheme or retire.

Table 8.1: Clinical Excellence Awards made by ACCEA in 2007

Bronze awards	338
Silver awards	178
Gold awards	28
Platinum awards	32
Total awards	576

Source: ACCEA

- 8.25 ACCEA asked that the value of employer-based CEAs (levels 1 – 8 and 9 when awarded by employers) should be increased in line with the general uplift recommended for consultants; also that the value of higher awards should be increased in line with the general uplift recommended for consultants; and that provision for new awards should be funded at the cost of the 2007 awards (valued at 1 April 2008) increased by 2.8 per cent, which represented the estimated increase in the consultant population. It said that this would maintain the ratio of awards to eligible consultants, but sought a further uplift in line with any increase in remuneration for consultants. ACCEA said that this would enable the creation of a budget for new awards, but would retain the flexibility for it to determine the precise number of awards to be made at each level.
- 8.26 We recognise the value of the CEA schemes as a reward for excellence and **endorse and recommend the proposal that the budget for higher CEAs should be increased in line with the increase in the number of consultants eligible for an award.** We also recognise the need for flexibility while the system continues to settle down and we therefore **endorse and recommend ACCEA's proposal that it should continue to retain the flexibility to determine the number of CEAs to be made at each level in 2008-09.**

Scotland

- 8.27 The BMA told us that the long-delayed review was unlikely to be completed for 2008 and asked us to make recommendations for distinction awards and discretionary points. It believed the number of A+, A and B awards should be increased to match consultant expansion in Scotland and their value should be increased by the same percentage as the general pay award for consultants. It also requested that the value of discretionary points was increased by the same percentage. The BMA did not seek any change to the basis of the Scottish schemes until the parties had reached agreement on the new arrangements.
- 8.28 We heard from SACDA that at 30 September 2006 there were 509 award holders in Scotland, comprising 13.7 per cent of all consultants. It told us that 2007 was the eighth round of the scheme and that 69 awards had been approved, including 15 additional awards.

Table 8.2: Distinction awards made by SACDA in 2007

B award	42
A award	21
A+ award	6
Total awards	69

Source: SACDA

- 8.29 For 2008, SACDA proposed to distribute a further three A+ awards; eight A awards; and 16 B awards. It noted that there had been an increase of approximately 4.8 per cent in the consultant population in Scotland. We therefore **endorse and recommend SACDA's proposal to distribute a further three A+ awards; eight A awards; and 16 B awards.**
- 8.30 We are concerned about the ongoing delays in the review of the distinction awards scheme in Scotland. Last year we were told that the Scottish Executive Health Department (SEHD) hoped to complete the review by the end of 2006 but this review is not yet complete. We do not believe that these delays in the review should be allowed to cause a detriment to eligible consultants in Scotland.

Northern Ireland

- 8.31 Northern Ireland is new to our remit this year and the DHSSPSNI told us that the new CEA scheme had been introduced in 2005 with 12 levels of award. The scheme was open to consultants with at least three years' experience. At the end of the 2006-07 awards round, there were 109 consultants in receipt of a higher award (out of a consultant population of 1,126 at 1 April 2006) and 523 consultants were in receipt of at least one lower CEA or discretionary point. Concerns about the potential for costs to increase in the new scheme, due to a wider eligibility pool, had led the Department to advise trusts that they should no longer apply the eligibility formula and that awards should instead be recycled as existing award holders left or retired. However, trusts had also been advised that they had discretion to allocate more awards within existing budgets. A review of the scheme was due to commence shortly with the aim of putting any new arrangements in place for the start of the next awards round in April 2008. The Department did not propose making any recommendation on the number of new awards that should be made at the higher level for 2008-09 as it wished to await the outcome of the internal review.

- 8.32 The BMA expressed concern that the CEA scheme in Northern Ireland had a number of important differences relating to eligibility to apply and funding allocation for CEA points and asked us to recommend an end to these anomalies. It said that the scheme discriminated against new consultants and that the money for CEAs was only released when a consultant holding points retired or died, which it believed prevented new consultants attaining CEA points and current holders from progressing up the CEA scale. An increase in consultant numbers meant that points/funding were spread ever more thinly. It said that in 2005-06, nine of the 16 trusts in Northern Ireland were unable to make any lower CEA awards citing insufficient funds and no released CEA points; in 2006-07, five of the same 16 trusts were unable to make any lower CEA awards, for the same reasons. It was expected that only 15 consultants currently holding lower CEA points would retire in 2007-08, thus releasing 76 lower CEA points. These would be redistributed among an increasing number of consultants (844) eligible for lower CEAs.
- 8.33 Asked about this apparent non-conformance with the scheme, the DHSSPSNI said that the BMA (Northern Ireland) had been consulted about the new CEA scheme prior to the formal consultation and during the formal consultation period; there had been widespread support for a three-year eligibility period. The changes to the eligibility criteria had the potential to increase the cost of the overall scheme, so the eligibility formula had been revised and restrictions placed on any 'new' higher awards. These changes had been agreed on the basis that there would be a formal review of the scheme after three years. This review would shortly be undertaken.
- 8.34 We did not receive any evidence from NICEAC, the body responsible for making awards in Northern Ireland; however, we are concerned at the possible inequalities between the awards scheme in Northern Ireland and elsewhere in the United Kingdom, and thus the potential disadvantages for eligible consultants. We would prefer to see greater equity throughout the United Kingdom and hope that the review of the scheme will have been completed in time for our next review and that we will also receive evidence from NICEAC.

Our recommendations

- 8.35 Last year we recommended that the value of CEAs, commitment awards, distinction awards and discretionary awards should remain at their 2006-07 rates. This was because in the light of financial constraints on the NHS, we limited the overall award to hospital doctors in order to maximise the limited benefits to the lower end of the salary scales. Nevertheless, we recognise that all of the different merit awards form part of the consultant pay structure and that we have traditionally recommended the same percentage uplift for these payments as we recommend for basic pay. We therefore **recommend that for 2008-09 the value of CEAs, commitment awards, distinction awards and discretionary points should be increased by 2.2 per cent**, in line with our main pay uplift recommendation.

Clinical academic general medical practitioners (GMPs)

- 8.36 The BMA said that it assumed that SACDA's request for an increase in the number of distinction awards would include the numbers of senior academic GMPs who were now part of the eligible pool. It also said that as the SEHD did not accept last year's recommendation for newly eligible senior academic GMPs in Scotland it was seeking our support for a retrospective offsetting process, similar to that proposed by ACCEA when these GMPs were included in England, with the actual sum spent on distinction awards for these doctors in 2007 being compensated for in the funding for the 2008 round of awards.

- 8.37 We have already commented in Chapter 1 on the rejection of last year's recommendation that additional funding be made available for distinction awards in Scotland, to cover the newly eligible senior academic GMPs. Our view remains that, notwithstanding the review of distinction awards in Scotland, additional funding should be made available by the SEHD to recognise the increase in the population arising from the newly eligible senior academic GMPs since 2007-08, and to ensure that consultants who might otherwise be eligible for an award are not disadvantaged by this small increase in numbers.

Medical managers

- 8.38 The BMA told us that it would be opening negotiations with the Health Departments to establish a proper career and remuneration structure for medical managers. In the interim, it wanted these doctors to continue to benefit from any uplift to consultant remuneration. It also sought encouragement from us that locally negotiated remuneration schemes for medical managers should be uplifted by at least our recommendations each year.
- 8.39 Medical managers are outside our remit, a view that the BMA confirmed during oral evidence. As such, we do not consider it appropriate to offer comment on how the remuneration of such staff should be uplifted. Locally negotiated remuneration schemes will, by their very nature, reflect local circumstances. Nevertheless, many medical or clinical directors will be covered by the consultant contract and therefore eligible for the uplift recommended for consultants.

Clinical academics

- 8.40 Again, we must emphasise that clinical academic staff are outside our remit and a matter for the universities rather than the NHS. However, we do take an interest because any shortfall in numbers could affect the ability to train sufficient medical and dental staff. Both the BMA and BDA drew our attention to issues relating to clinical academics this year. We reiterate our comments from previous reports: we support the principle of pay parity between clinical academic staff and NHS clinicians, and we place importance on there being sufficient incentives for doctors and dentists to enter this field.

Public health medicine

- 8.41 The Health Departments asked that dental public health consultants and training grade staff should receive exactly the same uplift to pay and allowances as their hospital medical and dental staff/public health medicine counterparts in order to maintain parity. The BMA also said that it was important that supplements for directors of public health kept pace with increases to salaries elsewhere in the profession. However, the BDA told us that the less than inflationary pay increase last year had contributed to the diminishing level of morale of consultants in dental public health and put additional strain on loyal employees who were subject to ever increasing workloads. It said that although the number of consultants in dental public health working in England had remained relatively stable in the last five years, it would fall in the near future. The BDA said that consultants in dental public health and other public health colleagues had faced difficult and uncertain times this year when a number had either been made compulsorily redundant or had their sessions reduced by primary care trusts. In some cases where there was the risk of, or imminent redundancy, cost savings had been given as the main rationale; in others, those who had retired had not been replaced.

- 8.42 We support the principle of pay parity for consultants in medical and dental public health and expect them to receive the same uplift to pay and allowances as hospital medical and dental consultants.

Pay recommendation for 2008-09

- 8.43 We received no evidence seeking a differential uplift for consultants. The different proposals from the parties are set out in Chapter 2 along with our main pay recommendations. The Health Departments sought an increase of 1.5 per cent. NHS Employers said that 2 per cent would be affordable and requested no difference in the increase awarded to those on the pre and post-2003 consultant contracts. The BMA asked for a settlement of between 3.6 and 4.3 per cent and for all other fees and allowances to be increased to maintain or restore their relationship with basic salaries.
- 8.44 For 2008-09, we **recommend an increase of 2.2 per cent on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts.** The recommended pay scales and pay thresholds are set out at Appendix A. Chapter 2 gives more detail as to how we arrive at our recommendation.

CHAPTER 9: STAFF AND ASSOCIATE SPECIALISTS/NON-CONSULTANT CAREER GRADES

Introduction

- 9.1 As before, we have used the titles *staff and associate specialists/non-consultant career grades (SAS/NCCGs)* for this chapter, while we await the outcome of the discussions between the parties on a new generic title. SAS/NCCGs are comprised of a diverse group of doctors¹ and dentists including: associate specialists, staff grades, senior clinical medical officers, clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. Our recommendations for 2008-09 will apply to all these groups. However, clinical assistants, hospital practitioners and doctors working in community hospitals can be qualified as general medical practitioners (GMPs) and our recommendations for these doctors, where appropriate, are contained in Chapter 3 of this report.
- 9.2 The numbers of SAS/NCCGs centrally recorded as working in the Hospital and Community Health Services (HCHS) have remained largely unchanged over recent years, from 19,175 in 2000 to 18,064 in 2006.² As a proportion of all HCHS doctors, SAS/NCCGs represent about 16 per cent of the total headcount.³ However, the significant numbers of trust grade doctors employed under local terms and conditions are not included in these figures, so the true proportion of SAS/NCCG doctors as part of the HCHS is higher. The Welsh Assembly Government (WAG) advised that SAS doctors were a particularly important part of the Welsh medical workforce, stating that they comprised 22 per cent of employed doctors and dentists (as opposed to 15 per cent in England, 14 per cent in Scotland). Similarly this group is 18 per cent of employed doctors and dentists in Northern Ireland. This group therefore makes an important contribution to overall service delivery.

The evidence

- 9.3 We have received evidence relating to SAS/NCCG doctors and dentists from the Health Departments, NHS Employers and the British Medical Association (BMA). The main evidence, which can be read on the parties' websites (see Appendix D), covered a number of issues in addition to the basic pay uplift, in particular the new contract arrangements. These issues are addressed in the following paragraphs.

¹ The BMA website provides the following definitions:

SAS grade doctors are neither junior nor senior doctors. They are hospital doctors who will normally have spent some time as a junior doctor but will not have formally completed training in the United Kingdom or have not yet been judged to have acquired an equivalent level of experience to be registered on the General Medical Council's specialist register.

An **associate specialist** is a doctor who will have trained and gained experience in a medical specialty but has not yet attained the status of a consultant. They will often work without direct supervision, but will be attached to a clinical team led by a consultant in their specialty.

Staff or trust grades are doctors who work in a specialist area and undertake clinics and perform procedures under the supervision of a consultant. They are not trainees but will have done some training and are likely to have a professional qualification, or part of, from the relevant medical royal college or faculty.

Source: BMA Glossary of doctors. Available from:
<http://www.bma.org.uk/ap.nsf/Content/glossdoctors#associate%20specialist>

² This may not include all locally employed SAS/NCCGs and anecdotal evidence suggests that this local group has grown over the years.

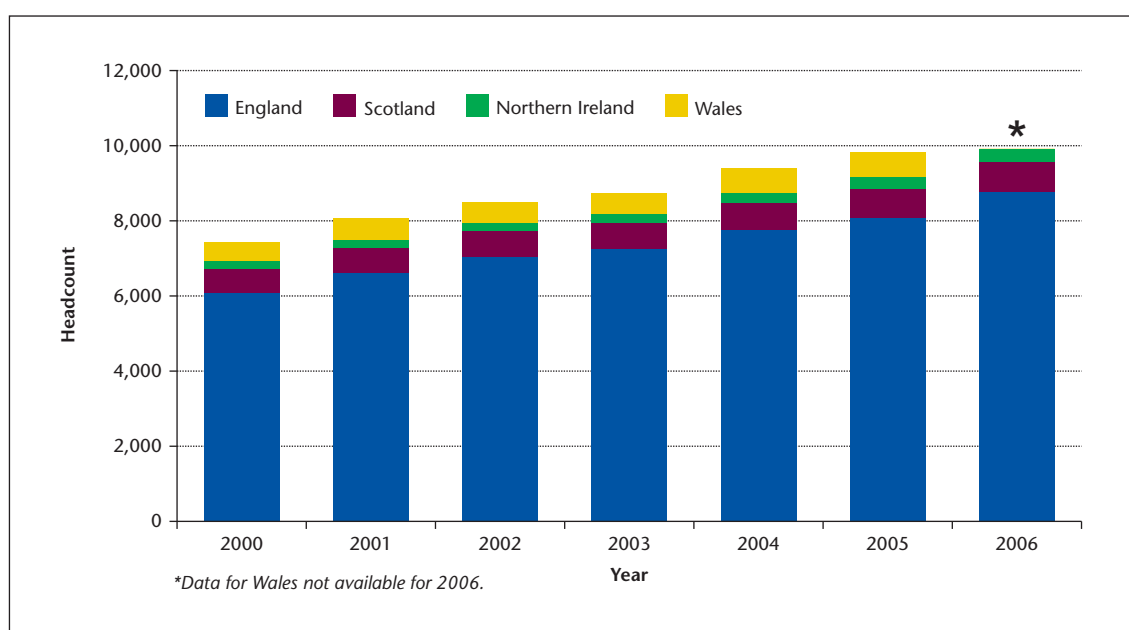
³ The combined group of associate specialists and staff grades is 9 per cent of all HCHS staff.

Recruitment and retention

9.4 NHS Employers told us that despite the protracted process for the new contract, there were no recruitment and retention problems for this group of doctors. The Health Departments reported evidence of healthy recruitment and retention in these grades and said that in England the number of associate specialists had increased by 276 (10.8 per cent) in 2005-06 and the number of staff grade doctors by 410 (7.4 per cent) (2005-06); in Wales, associate specialists had increased by 25 per cent (149 – 187) in 2005-06 and in Scotland, SAS grade numbers had increased by five whole-time equivalents (0.8 per cent) in 2006. In Northern Ireland SAS grade headcount had increased by 36 (11.1 per cent) in 2005-06. The BMA reported that the United Kingdom medical workforce growth had been 10 per cent for associate specialists and 7 per cent for staff grades, which it said was consistent with an increasing reliance on these grades.

9.5 Figures for SAS/NCCGs are difficult to obtain, because of the wide range of doctors and dentists who make up this group. Figure 9.1 shows the numbers of staff grades and associate specialists in the United Kingdom; as these make up the largest part of this group, this gives an indication of total numbers.

Figure 9.1: Number of staff grades and associate specialists in the Hospital and Community Health Services, 2000 – 2006, United Kingdom



Sources: The Information Centre, Welsh Assembly Government, Information Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

Motivation and morale

- 9.6 NHS Employers told us that motivation and morale among SAS/NCCGs had remained the same in most cases, but that they recognised that the new contract would be a positive step forward in bringing these doctors into line with other medical contracts. However, the BMA noted that morale had been adversely affected by the perplexing failure of the Treasury to permit the proposed SAS grade doctors' contract to proceed to the next phase. This group of doctors is among the last to move towards a new contract. A negative effect on morale may have resulted from the lengthy process, which formally commenced in May 2004 when the Secretary of State for Health announced that the government had accepted in full the recommendations⁴ for the modernisation of this grade. We hope that the new contractual arrangements will have a positive effect on motivation and morale and, if accepted at ballot, will be implemented as a matter of priority. All parties have discussed an implementation date of 1 April 2008.

Workload and career progression

- 9.7 The BMA commissioned a survey on SAS doctors' workload and career progression⁵ to inform its evidence and determine the contribution of SAS doctors to patient care and the NHS. The BMA particularly drew our attention to the fact that on average, full-time associate specialist doctors worked two to three hours per week above their contracted hours and full-time staff grade doctors worked one hour longer; additionally, that their contracted hours were over the basic 40 per week. We also noted from the survey that these doctors spent approximately two-thirds of their time on direct clinical care, 12 to 17 per cent of their time on out-of-hours work, 5 to 6 per cent on continuing professional development, and the remainder on administration and management. The survey had found that almost two-thirds of associate specialist respondents and just under half of staff grade respondents currently received optional/discretionary salary points. For many, their current grade was their career goal, but for those who aspired to becoming consultants, they were most likely to describe the probability of achieving this as low. For staff grades, one means of progression was to apply for regrading to associate specialist grade; two-thirds of respondents had been successful and lack of funding seemed to be the most common reason for refusal. Clinical workload and funding issues were given as the most frequent reasons why respondents were unable to utilise fully their protected study time.
- 9.8 We hope that the new contractual arrangements will bring benefits to these doctors and understand that it will address career progression and workload issues. The other parties offered little evidence on workload and career progression, although the Health Departments commented that the introduction of *Modernising Medical Careers* would offer these doctors more opportunities to undertake further training and progress their careers.

⁴ *Choice and opportunity: modernising medical careers for non-consultant career grade doctors*. Department of Health, July 2003. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4050441

⁵ *Survey of SAS grade doctors' workload and career progression: final report*. Health Policy and Economic Research Unit, November 2007

New contractual arrangements

- 9.9 The negotiations for the new contractual arrangements have been protracted and as we have commented above, SAS/NCCGs will be among the last group of doctors to benefit from a new contract. At the start of negotiations we understood that it was intended to introduce a new contract from 1 April 2006, but this has not happened. However, NHS Employers told us that the new contract should lead to benefits in job planning, the working week, a new pay structure and career development and that the Tooke report⁶ had suggested that the new contract might lead to a parallel attractive career route.
- 9.10 Following oral evidence, the Department of Health gave us further information regarding the government's response to the contract proposals submitted jointly by the BMA and NHS Employers. It said that the average pay increases for staff grades would be 5.2 per cent on 1 April 2008 and 5 per cent on 1 April 2009; for associate specialists it would be 1.8 per cent on each of these two dates. It told us that the government was keen to secure the benefits of the contract as soon as possible and had therefore included sufficient additional funding in the 2008-09 tariff to support transitional implementation from April 2008. The Department was not aware of any reason why the proposed new contract should not be implemented to this timescale; however, implementation was dependent on the timing and outcome of the BMA's ballot.
- 9.11 The parties have provided us with a wealth of information and opinions on the new contract, but we do not offer further comment at this stage as it is not the role of the Review Body to be a party to the negotiations. At time of writing, the BMA is conducting a ballot of its members in this remit group. We will make recommendations that apply to the existing contracts as well as the new contract, should it be accepted.

Pay recommendation for 2008-09

- 9.12 Regarding our role in any uplift to the pay for SAS/NCCGs for 2008-09, the Department made it clear that although it believed that the proposed contract represented a generous offer in return for improved working practices, it was content for us to consider, as part of our normal deliberations, the need to increase the proposed rates of pay for this group of doctors, for both the existing and proposed pay scales. However, the government asked us to pay regard to what it described as the "buoyant recruitment and retention" among these grades and to ensure that any recommendation on the existing scales did not act as a disincentive to the implementation of the new contract.
- 9.13 NHS Employers told us that if implemented, the new contract would result in a pay rise of 6 to 13 per cent of basic pay and that any substantial uplift for this group of doctors would undermine the current position. They asked that while the outcome of the negotiations and ballot was awaited, the pay uplift for this group of doctors should be in line with that of other healthcare workers.

⁶ *Aspiring to excellence: findings and recommendations of the independent inquiry into modernising medical careers*. Led by Professor Sir John Tooke. Aldridge Press, 2007. Available from: http://www.mmcinquiry.org.uk/MMC_InquiryReportREVD3.pdf

- 9.14 The BMA emphasised that this group of doctors was the only one without modernised pay arrangements and said that its pay had declined relative to that of other career grades in the interim. It sought an uplift on the existing contracts and recognition of the disadvantage of this group of doctors relative to other branches of practice. It expressed concern over the resources (equal to 10 per cent of the total pay bill for the number of whole-time equivalent SAS doctors in England and equivalent amounts for the devolved administrations) which it said had been made available for the new contract; it believed that this represented a potential source for a differential award that would not generate affordability issues. The BMA summarised the uplift it was seeking for 2008-09. It sought a differential award for SAS grade doctors; it said that the refusal of the government to countenance full backdating of the contract, as if it had been introduced in 2006-07, suggested that this resource would be lost; it asked us to consider incorporating some of the optional and discretionary points into the automatic scale to address lack of progression; and requested the introduction of new pay points on the SAS grade scales which would allow SAS doctors an increase that was not part of a percentage uplift.
- 9.15 We asked the other parties about the original 10 per cent funding envelope for the modernisation of this particular group, that the BMA was anxious should not be lost. We were told by the Health Departments that the resource was in primary care trust (PCT) allocations and had not been lost as the PCTs would use their allocations to secure services for patients. In oral evidence, the Health Departments stressed that the money to pay for the new contract was in the tariff, but that there was no additional 10 per cent funding envelope. Similarly, NHS Employers confirmed in supplementary evidence that no money had been 'lost' as it had not been 'set aside'. They said that the contract proposals had been negotiated within a funding envelope set by the Health Departments, which represented 10 per cent of the SAS group pay bill at 2005-06 prices, with the intention of implementing it from April 2006. We conclude from this that there is no additional money set aside, which could be used for any additional uplift for SAS/NCCGs.
- 9.16 With regard to our recommendation for SAS/NCCGs for 2008-09, we believe that it is important that any recommendation we make does not influence the outcome of the forthcoming ballot. Therefore, our recommendation will apply to SAS/NCCGs regardless of which contract they are working under. We also take the view that any new contractual arrangements for these doctors will deal with any historic problems associated with the grade, and that it would therefore be inappropriate to recommend any form of compensation for the delays which this group of doctors have seen in reaching agreement on the new contractual arrangements. Furthermore, we see no reason for the uplift to differ from that awarded to other salaried doctors and dentists within the HCHS.
- 9.17 For 2008-09, we **recommend an increase of 2.2 per cent on the national salary scales of SAS/NCCGs**. Chapter 2 gives more detail as to how we arrive at our recommendation. Our recommendation applies to both the existing salary scales (set out at Appendix A) and the new scales upon which SAS/NCCGs are currently being balloted. In the usual way, our recommendation of a 2.2 per cent increase will also apply to the pay scales for non-GMP clinical assistants and hospital practitioners.

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* those of equivalent full-time staff.

A. Hospital medical and dental, public health medicine and dental public health staff

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
	<i>(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Foundation house officer 1	21,391 22,726 24,061	21,862 23,226 24,591
Foundation house officer 2	26,532 28,267 30,002	27,116 28,889 30,663
Specialty registrar (full)	28,352 30,087 32,510 33,975 35,742 37,510 39,278 41,045 42,813 44,581	28,976 30,749 33,226 34,723 36,529 38,336 40,143 41,948 43,755 45,562
Specialty registrar (fixed term)	28,352 30,087 32,510 33,975 35,742 37,510	28,976 30,749 33,226 34,723 36,529 38,336
House officer	21,391 22,726 24,061	21,862 23,226 24,591

¹ Our recommended basic pay uplifts to be applied from April 2008 are based on the current scales, with the final result being rounded up to the nearest unit.

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
Senior house officer	26,532	27,116
	28,267	28,889
	30,002	30,663
	31,737	32,436
	33,472	34,209
	35,207	35,982 ²
	36,942	37,755 ²
Registrar	29,580	30,231
	31,045	31,728
	32,510	33,226
	33,975	34,723
	35,742	36,529
Senior registrar	33,975	34,723
	35,742	36,529
	37,510	38,336
	39,278	40,143
	41,045	41,948
	42,813	43,755
Specialist registrar ⁴	44,581	45,562 ³
	29,580	30,231
	31,045	31,728
	32,510	33,226
	33,975	34,723
	35,742	36,529
	37,510	38,336
	39,278	40,143
	41,045	41,948 ⁵
	42,813	43,755 ⁵
44,581	45,562 ⁶	
Consultant (2003 contract, England and Scotland for main pay thresholds) ⁷	71,822	73,403
	74,071	75,701
	76,320	78,000
	78,569	80,298
	80,812	82,590
	86,153	88,049
	91,495	93,508
	96,831	98,962

² To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21, and Thirty-First Report, paragraph 6.46.

³ To be awarded automatically except in cases of unsatisfactory performance, see Thirty-Third Report, paragraph 6.61.

⁴ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁵ To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth Report, paragraph 3.21.

⁶ To be awarded automatically except in cases of unsatisfactory performance, see Thirty-Third Report, paragraph 6.61.

⁷ Pay thresholds and transitional arrangements apply.

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
<i>Clinical Excellence Awards⁸</i>		<i>Value</i>
	2,850	2,913
	5,700	5,826
	8,550	8,739
	11,400	11,652
	14,250	14,565
	17,100	17,478
	22,800	23,304
	28,500	29,130
	34,200	34,956
Consultant (2003 contract, Wales)	69,606	71,138
	71,822	73,403
	75,530	77,192
	79,837	81,594
	84,754	86,619
	87,558	89,485
	90,368	92,357
<i>Commitment awards⁹</i>		<i>Value</i>
	3,088	3,156
	6,176	6,312
	9,264	9,468
	12,352	12,624
	15,440	15,780
	18,528	18,936
	21,616	22,092
	24,704	25,248
Consultant (pre-2003 contract) ¹⁰	59,632	60,944
	63,899	65,305
	68,167	69,667
	72,434	74,028
	77,300	79,001
<i>Discretionary points¹¹</i>		<i>Value</i>
	3,088	3,156
	6,176	6,312
	9,264	9,468
	12,352	12,624
	15,440	15,780
	18,528	18,936
	21,616	22,092
	24,704	25,248

⁸ Local level CEAs in England. For national CEAs, see Part II below.

⁹ Awarded every 3 years once the basic scale maximum is reached.

¹⁰ Closed to new entrants.

¹¹ From October 2003, local Clinical Excellence Awards (CEAs) in England and Commitment awards in Wales have replaced discretionary points. Discretionary points continue to be awarded in Scotland and remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA or Commitment award.

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
Associate specialist	35,977	36,769
	39,788	40,664
	43,598	44,558
	47,408	48,451
	51,219	52,346
	55,029	56,240
	60,061	61,383
	64,422	65,840
<i>Discretionary points</i>		<i>Notional scale</i>
	66,232	67,690
	68,593	70,103
	70,954	72,515
	73,315	74,928
	75,676	77,341
	78,039	79,756
Staff grade practitioner (1997 contract, MH03/5)	32,547	33,264
	35,131	35,904
	37,714	38,544
	40,298	41,185
	42,882	43,826
	45,924	46,935
<i>Discretionary points¹²</i>		<i>Notional scale</i>
	48,049	49,107
	50,632	51,746
	53,216	54,387
	55,800	57,028
	58,383	59,668
	60,968	62,310
Staff grade practitioner (pre-1997 contract, MH01)	32,547	33,264
	35,131	35,904
	37,714	38,544
	40,298	41,185
	42,882	43,826
	45,465	46,466
	48,049	49,107
	50,632	51,746
	<i>(Annual rates on the basis of a notional half day per week)</i>	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,396	4,493
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	4,302	4,397
	4,551	4,652
	4,801	4,907
	5,050	5,162
	5,299	5,416
	5,548	5,671
	5,797	5,925

Details of the supplements payable to public health medicine staff are set out in Part II of this Appendix.

¹² See Twenty-Seventh Report, paragraph 2.34.

B. Community health staff

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
	<i>(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Clinical medical officer	31,179	31,865
	32,867	33,591
	34,555	35,316
	36,243	37,041
	37,931	38,766
	39,619	40,491
	41,307	42,216
Senior clinical medical officer	42,996	43,942
	44,059	45,029
	46,741	47,770
	49,422	50,510
	52,103	53,250
	54,785	55,991
	57,466	58,731
	60,147	61,471
	62,829	64,212

C. Salaried primary dental care staff¹³

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
	<i>(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Band A: Salaried dentist	36,000	36,792
	40,000	40,880
	46,000	47,012
	49,000	50,078
	52,000	53,144
	54,000	55,188
Band B: Salaried dentist	56,000	57,232 ¹⁴
	58,000	59,276
	61,000	62,342
	62,500	63,875
	64,000	65,408
	65,500	66,941

¹³ These scales also apply to salaried dentists working in Personal Dental Services.

¹⁴ Salary point is the entry level to band B but is also the extended competency point at the top of band A.

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
Band C: Salaried dentist ¹⁵	67,000	68,474 ^{16, 17}
	69,000	70,518
	71,000	72,562
	73,000	74,606
	75,000	76,650
	77,000	78,694
Band 1: Community dental officer	33,041	33,768
	35,714	36,500
	38,387	39,232
	41,061	41,965
	43,734	44,697
	46,407	47,428
	49,080	50,160 ¹⁸
	51,754	52,893 ¹⁸
Band 2: Senior dental officer	47,215	48,254
	50,952	52,073
	54,689	55,893
	58,426	59,712
	62,163	63,531
	62,987	64,373 ¹⁹
	63,810	65,214 ¹⁹
Band 3: Assistant clinical director	62,741	64,122
	63,712	65,114
	64,683	66,107
	65,654	67,099
	66,625	68,091 ¹⁹
	67,597	69,085 ¹⁹
Band 3: Clinical director	62,741	64,122
	63,712	65,114
	64,683	66,107
	65,654	67,099
	66,625	68,091
	67,597	69,085
	68,568	70,077
	69,555	71,086
	70,526	72,078 ¹⁹
71,497	73,070 ¹⁹	

¹⁵ Managerial dentist posts with standard service complexity are represented by the first four points in the band C range, those with medium service complexity are represented by points two to five of the range and those with high complexity by the highest four points of the band C range.

¹⁶ Salary point is the entry level to band C but is also the extended competency point at the top of band B.

¹⁷ The first three points on the band C range represent those available to current assistant clinical directors under the new pay spine.

¹⁸ Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First Report. See also Twenty-Eighth Report, paragraph 8.9 (community dental officers) and Twenty-Ninth Report, paragraph 7.61 (salaried general dental practitioners).

¹⁹ Performance based increment, see paragraph 4.21 and 4.38 of the Thirty-First Report. See also Thirtieth Report, paragraph 8.15.

	Current scales £	Recommended scales payable from 1 April 2008 ¹ £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	55,103	56,316
	58,529	59,817
	61,956	63,320
	65,382	66,821
	69,555	71,086
	70,526	72,078 ²⁰
	71,497	73,070 ²⁰
Part-time dental surgeon	Sessional fee (per hour)	
Dental surgeon	27.10	27.70
Dental surgeon holding higher registrable qualifications	35.95	36.75
Dental surgeon employed as a consultant	44.80	45.79

²⁰ Performance based increment, see paragraph 4.48 of the Thirty-First Report.

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2008. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The budget for national Clinical Excellence Awards should be increased in line with the increase in the number of consultants now eligible for an award (including academic GMPs) in England and Wales. In Scotland, the number of A+ awards should be increased by three, the number of A awards should be increased by eight, and the number of B awards should be increased by 16.
3. The annual values of national Clinical Excellence Awards for consultants and academic GMPs should be increased as follows.

Bronze (Level 9): from £34,200 to £34,956

Silver (Level 10): from £44,965 to £45,955

Gold (Level 11): from £56,206 to £57,443

Platinum (Level 12): from £73,068 to £74,676

4. The annual values of distinction awards for consultants¹ should be increased as follows.

B award: from £30,808 to £31,486

A award: from £53,911 to £55,098

A+ award: from £73,158 to £74,768

5. The annual values of consultant intensity payments should be increased to the following amounts:

Daytime supplement: from £1,228 to £1,256

Out-of-hours supplement (England and Scotland) (Wales)

Band 1: from £925 to £946 from £2,133 to £2,180

Band 2: from £1,844 to £1,885 from £4,266 to £4,360

Band 3: from £2,757 to £2,818 from £6,398 to £6,539

¹ From October 2003, national Clinical Excellence Awards (CEAs) replaced distinction awards in England and Wales. Distinction awards continue to be awarded to eligible consultants in Scotland and remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA.

6. A consultant on the 2003 Terms and Conditions of Service working on an on-call rota will be paid a supplement in addition to basic salary in respect of his or her availability to work during on-call periods. This is determined by the frequency of the rota they are working and which category they come under. To determine the category the employing organisation should establish whether typically a consultant is required to return to site to undertake interventions in which case they should come under category A. If they can typically respond by giving telephone advice they would come under category B.

The rates are set out in the table below.

Frequency of Rota Commitment	Value of supplement as a percentage of full-time basic salary	
	Category A	Category B
High Frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium Frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low Frequency: 1 in 9 or less frequent	3.0%	1.0%

7. The following non-pensionable multipliers apply to the basic pay of whole-time doctors and dentists in training grades:

	December 2002 onwards
Band 3	2.00
Band 2A	1.80
Band 2B	1.50
Band 1A	1.50
Band 1B	1.40
Band 1C	1.20

8. Under the contract agreed by the parties, 1.0 represents the basic salary (shown in Part I of this Appendix) and figures above 1.0 represent the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary.

Doctors in flexible medical training

9. A new payment system was introduced in Summer 2005 for flexible trainees working less than 40 hours of actual work per week, where basic pay is calculated as follows:

	Proportion of full time basic pay
F5 (20 or more and less than 24 hours of actual work)	0.5
F6 (24 or more and less than 28 hours of actual work)	0.6
F7 (28 or more and less than 32 hours of actual work)	0.7
F8 (32 or more and less than 36 hours of actual work)	0.8
F9 (36 or more and less than 40 hours of actual work)	0.9

10. Added to the basic salary identified above in paragraph 9 is a supplement to reflect the intensity of the duties.

$$\text{Total salary} = \text{salary}^* + \text{salary}^* \times \begin{cases} 0.5 \\ 0.4 \\ 0.2 \end{cases}$$

* salary = F5 to F9 calculated above.

The supplements will be applied on the basis as set out below

Band	Supplement payable as a percentage of calculated basic salary
FA – trainees working at high intensity and at the most unsocial times	50%
FB – trainees working at less intensity at less unsocial times	40%
FC – all other trainees with duties outside the period 8am to 7pm Monday to Friday	20%

11. The fee for domiciliary consultations should be increased from £78.76 to £80.50 a visit. Additional fees should be increased *pro rata*.
12. Weekly² and sessional rates for locum appointments³ in the hospital service should be increased as follows:

Associate specialist, senior hospital medical or dental officer appointment	from £945.78 to £966.57 a week; from £85.98 to £87.87 a notional half day.
Specialty registrar (higher rate) appointment	from £842.90 a week to £861.60; from £17.57 to £17.95 per standard hour.
Specialty registrar (lower rate) appointment	from £765.02 a week to £781.92; from £15.94 to £16.29 per standard hour.
Specialist registrar LAS appointment	from £842.90 a week to £861.60; from £17.57 to £17.95 per standard hour.

² The weekly rates given for junior doctors are the basic rate (the midpoint of the current salary scale multiplied by 1.2, divided by 365 and multiplied by 7) and have not been adjusted for banding. The rates in paragraph 7 should apply; rounded up to the nearest penny.

³ For locum rates under the 2003 consultant contract, refer to Schedule 22 of the contract's Terms and Conditions of Service.

Foundation house officer 2 appointment	from £650.52 a week to £665.28; from £13.56 to £13.86 per standard hour.
Senior house officer appointment	from £730.38 a week to £746.88; from £15.22 to £15.56 per standard hour.
Foundation house officer 1 appointment/ House officer appointment	from £523.01 a week to £534.72; from £10.90 to £11.14 per standard hour.
Hospital practitioner appointment	from £96.85 to £98.98 a notional half day.
Staff grade practitioner appointment	from £797.70 to £815.20 a week; from £79.77 to £81.52 a session.
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)	from £84.31 to £86.17 a notional half day.

13. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

London Weighting

14. The value of London zone payment⁴ is £2,162 for non-resident staff and £602 for resident staff.

Ophthalmic medical practitioners

15. The ophthalmic medical practitioners' gross fee for sight testing should continue to be negotiated between the parties.

Doctors in public health medicine

16. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows⁵:

	Current range of supplements £	Recommended range of supplements payable from 1 April 2008 £
Island Health Boards: Band E (under 50,000 population)	1,694 – 3,361	1,732 – 3,435
District director of public health (director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,361 – 6,721 (Bar); 8,403	3,435 – 6,869 (Bar); 8,588
Band C (District of 250,000 – 449,999 population)	4,216 – 8,403 (Bar); 10,097	4,309 – 8,588 (Bar); 10,320
Band B (District of 450,000 and over population)	5,043 – 10,097 (Bar); 13,024	5,154 – 10,320 (Bar); 13,311
Regional director of public health: Band A:	13,024 – 18,906	13,311 – 19,322

⁴ See paragraph 1.64 of the Thirty-Sixth Report.

⁵ Population size is not the sole determinant for placing posts within a particular band.

General medical practitioners

17. The supplement payable to GMP registrars is 50 per cent⁶ of basic salary for 2008-09.
18. The salary range for salaried GMPs⁷ employed by primary care organisations should be £52,462 to £79,167 for 2008-09.

General dental practitioners

19. The contract value for providers of NHS dental services in England and Wales should be increased by 3.4 per cent from 1 April 2008. An uplift of 3.4 per cent also applies to gross fees from 1 April 2008 in Scotland and Northern Ireland.
20. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £115.37 to £119.30.
21. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £81.67 to £84.45.
22. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £62.93 to £65.07.
23. The quarterly payments under the Commitment Payments scheme⁸ should be increased as follows:

Level 1 payment	from £44 to £46 a quarter
Level 2 payment	from £358 to £371 a quarter
Level 3 payment	from £462 to £478 a quarter
Level 4 payment	from £554 to £573 a quarter
Level 5 payment	from £645 to £667 a quarter
Level 6 payment	from £735 to £760 a quarter
Level 7 payment	from £829 to £858 a quarter
Level 8 payment	from £921 to £953 a quarter
Level 9 payment	from £1,012 to £1,047 a quarter
Level 10 payment	from £1,104 to £1,142 a quarter

⁶ See Chapter 3 of this report. For those already in post on 1 April 2008, the supplement remains unchanged.

⁷ See Chapter 3 of this report.

⁸ GDPs in Scotland are eligible for these payments. In England and Wales, commitment payments are subsumed in contract values. To calculate 2008-09 payments, an uplift of 3.4 per cent has been applied to 2007-08 payments and the result is rounded up to the nearest pound.

Community health and community dental staff

24. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,326 to £2,378 a year.
25. The teaching supplement payable to clinical directors in the CDS should be increased from £2,627 to £2,685 a year.
26. The supplement for clinical directors covering two districts should be increased from £1,698 to £1,736 a year and the supplement for those covering three or more districts should be increased from £2,711 to £2,771 a year.
27. The allowance for dental officers acting as trainers should be increased from £1,860 to £1,901 a year.
28. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

APPENDIX B

THE 2007-08 SETTLEMENT

In our Thirty-Sixth Report we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2007. Our main recommendations were:

- an increase of £650 per annum be added to each point on the pay scale for all grades of doctors and dentists in training;
- an increase of £1,000 be added to each point on the pay scale for consultants, staff and associate specialists/non-consultant career grades and dentists in the salaried primary dental care services;
- a zero increase in general medical practitioners' pay; and
- an increase of 3.0 per cent for general dental practitioners (on the gross earnings base) under the new contract in England and Wales, and an increase of 3.0 per cent for general dental practitioners in Scotland (on gross fees).

The government accepted in full our main recommendations relating to 2007-08. However, in England and Wales, the awards were staged with 1.5 per cent being paid from 1 April 2007 and the balance paid from 1 November 2007, although the award for community dentists in Wales was not staged. Scotland paid the awards in full from 1 April 2007.

APPENDIX C

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM

ENGLAND ¹	2005		2006		Percentage change 2005-2006	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff²						
Consultants	28,990	31,250	29,990	32,110	3.4	2.8
Associate specialists	2,190	2,450	2,410	2,710	10.3	10.7
Staff grades	4,820	5,330	5,160	5,720	7.2	7.4
Registrar group	16,980	17,660	17,840	18,450	5.1	4.5
Foundation house officer 2 ³	20,820	21,110	21,870	22,070	5.1	4.5
Foundation house officer 1 ⁴	4,620	4,640	4,870	4,880	5.4	5.3
Hospital practitioner	200	950	180	860	-10.3	-8.8
Clinical assistant	710	2,640	580	2,220	-19.0	-16.2
Other staff	330	650	170	400	-46.9	-39.0
Total	79,650	86,660	83,070	89,410	4.3	3.2
Hospital and Community Health Services Dental Staff²						
Consultants	620	750	620	760	1.1	1.9
Associate specialists	80	100	80	120	10.8	13.5
Staff grades	150	200	160	220	8.1	9.0
Registrar group	330	350	340	360	2.6	2.9
Foundation house officer 2 ³	520	530	480	490	-7.3	-8.1
Foundation house officer 1 ⁴	30	30	20	30	-8.8	-7.1
Hospital practitioner	20	70	20	70	-6.7	-6.9
Clinical assistant	80	410	80	380	-5.1	-6.7
Other staff	1,100	1,530	1,090	1,490	-0.6	-2.6
Total	2,920	3,970	2,910	3,910	-0.6	-1.5
General practitioners						
General medical practitioners⁵	31,900	35,940	33,380	36,010	4.6	0.2
GP providers	26,630	29,340	26,360	27,690	-1.0	-5.6
GP registrars ⁶	2,430	2,560	2,190	2,280	-10.0	-11.2
GP retainers ⁷	220	640	260	640	20.2	-0.5
Other GPs	2,620	3,400	4,570	5,400	74.6	58.9

¹ Data as at 30 September unless otherwise specified.

² The table contains full-time equivalent (FTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

³ This includes Senior House Officers.

⁴ This includes House Officers.

⁵ For 2004 onwards, all GPs: Full-time 1.0 fte; Part-time =0.6 fte, and therefore this may not be fully comparable with previous years. FTE GP Retainers have been estimated using a factor of 0.12 per session.

⁶ GMP registrars were formerly known as GMP trainees.

⁷ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (*continued*)

ENGLAND ¹	2005		2006		Percentage change 2005-2006	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners^{8,9}		19,800		21,110		6.6
GDS only		15,210		13,590		-10.7
PDS only		3,670		6,220		69.7
GDS and PDS		920		1,310		41.5
Ophthalmic medical practitioners¹⁰		440		380		-13.7
Total		56,190		57,500		2.3
Total – NHS doctors and dentists		146,820		150,820		2.7

⁸ Data as at 31 March.

⁹ Data include salaried dentists.

¹⁰ Data as at 31 December.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (*continued*)

WALES ¹¹	2004		2005		Percentage change 2004-2005	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff¹²						
Consultants	1,540	1,710	1,620	1,800	5.3	4.9
Associate specialists	130	160	140	160	2.6	0.0
Staff grades	450	480	430	470	-3.7	-2.1
Registrar group	790	820	810	840	3.7	2.4
Foundation house officer ² ¹³	1,150	1,160	1,220	1,230	6.3	6.5
Foundation house officer ¹ ¹⁴	250	250	260	260	4.5	4.0
Hospital practitioner	20	50	10	60	-18.5	5.8
Clinical assistant	70	370	50	250	-30.9	-30.9
Other staff	60	90	70	100	11.9	7.8
Total	4,460	5,080	4,620	5,160	3.6	1.5
Hospital and Community Health Services Dental Staff¹²						
Consultants	50	60	50	60	-4.7	-6.3
Associate specialists	10	10	10	20	7.5	14.3
Staff grades	10	20	10	20	-0.7	4.8
Registrar group	20	20	30	30	47.9	38.9
Foundation house officer ² ¹³	40	40	40	40	-15.9	-15.9
Foundation house officer ¹ ¹⁴	0	0	0	0	0.0	0.0
Hospital practitioner	0	0	0	0	-50.9	-66.7
Clinical assistant	10	60	10	50	-15.5	-1.8
Other staff	110	130	90	120	-17.0	-9.9
Total	260	350	240	330	-8.2	-4.9
General practitioners						
General medical practitioners	2,000		2,020		1.0	
GP providers	1,770		1,820		2.9	
GP registrars ¹⁵	120		100		-10.4	
GP retainers ¹⁶	70		70		0.0	
Other GPs	50		30		-38.8	

¹¹ Data for Wales are from an earlier period than data for the other countries as Wales Hospital and Community Health Service data are not available for 2006 due to collection problems (see Chapter 1 for further details). Data as at 30 September unless otherwise specified.

¹² The table contains full-time equivalent (FTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

¹³ This includes Senior House Officers.

¹⁴ This includes House Officers.

¹⁵ GMP registrars were formerly known as GMP trainees.

¹⁶ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (*continued*)

WALES ¹¹	2004		2005		Percentage change 2004-2005	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners¹⁷		1,020		1,070		4.5
General dental practitioner		930		970		4.3
Vocational dental practitioner		50		60		3.8
Assistant dental practitioner		40		50		9.1
Ophthalmic medical practitioners¹⁸		30		30		-2.9
Total		3,060		3,130		0.9
Total – NHS doctors and dentists		8,490		8,620		1.1

¹⁷ Data include salaried dentists.

¹⁸ Data as at 31 December.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (continued)

SCOTLAND ¹⁹						
	2005		2006		Percentage change 2005-2006	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff²⁰						
Consultants	3,420	3,630	3,540	3,750	3.8	3.3
Associate specialists	180	220	190	230	4.6	4.1
Staff grades	420	500	420	510	0.8	2.0
Registrar group	1,590	1,660	1,550	1,610	-2.7	-3.0
Foundation house officer ²¹	2,670	2,700	2,900	2,930	8.5	8.4
Foundation house officer ¹²²	760	770	790	790	3.7	3.5
Hospital practitioner	40	150	30	120	-23.8	-19.3
Clinical assistant	130	490	120	460	-6.4	-5.1
Other staff	50	130	50	120	4.9	-6.9
Total	9,260	10,210	9,600	10,500	3.7	2.8
Hospital and Community Health Services Dental Staff²⁰						
Consultants	80	90	80	100	7.3	7.9
Associate specialists	10	10	10	10	-5.8	8.3
Staff grades	20	20	20	20	-3.3	-4.3
Registrar group	30	30	30	40	3.3	2.9
Foundation house officer ²¹	60	60	60	60	4.3	6.8
Foundation house officer ¹²²	0	0	0	0	-100.0	-100.0
Hospital practitioner	0	10	0	10	0.0	0.0
Clinical assistant	10	60	10	60	-3.5	-4.9
Other staff	320	380	350	410	10.6	9.0
Total	520	660	560	700	7.6	6.7
General practitioners						
General medical practitioners		4,590		4,640		1.2
GP providers		3,810		3,810		0.2
GP registrars ²³		310		310		0.3
GP retainers ²⁴		190		180		-4.2
Other GPs		280		340		20.7

¹⁹ Data as at 30 September.

²⁰ The table contains full-time equivalent (FTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

²¹ This includes Senior House Officers.

²² This includes House Officers.

²³ GMP registrars were formerly known as GMP trainees.

²⁴ GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (*continued*)

SCOTLAND ¹⁹	2005		2006		Percentage change 2005-2006	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners²⁵	2,280		2,440		7.1	
General dental practitioner	2,100		2,260		7.5	
Vocational dental practitioner	140		150		8.1	
Assistant dental practitioner	50		40		-13.0	
Ophthalmic medical practitioners	20		30		37.5	
Total	6,890		7,120		3.3	
Total – NHS doctors and dentists	17,760		18,320		3.2	

²⁵ Data include salaried dentists.

NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM (continued)

NORTHERN IRELAND ²⁶						
	2005		2006		Percentage change 2005-2006	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff²⁷						
Consultants	1,080	1,140	1,160	1,230	8.1	7.9
Associate specialists	50	70	60	70	9.2	1.4
Staff grades	210	250	250	290	16.8	13.8
Registrar group	620	630	670	680	8.1	8.0
Foundation house officer 1 & 2 ²⁸	1,130	1,140	1,130	1,130	-0.4	-0.4
Hospital practitioner	20	60	20	70	0.8	9.7
Other staff	130	230	150	250	18.2	8.8
Total	3,230	3,510	3,430	3,710	6.1	5.6
General practitioners						
General medical practitioners²⁹		1,080		1,110		2.4
General dental practitioners^{29, 30}		760		780		2.9
Ophthalmic medical practitioners³¹		20		20		15.8
Total		1,860		1,910		2.7
Total – NHS doctors and dentists		5,370		5,620		4.6

²⁶ Data as at 30 September unless otherwise specified.

²⁷ The table contains full-time equivalent (FTE) and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

²⁸ This includes House Officers and Senior House Officers.

²⁹ Data as at 31 October.

³⁰ Data include salaried dentists.

³¹ Data as at 30 April.

APPENDIX D

THE EVIDENCE

We received written evidence from the Health Departments, comprising the Department of Health, the Welsh Assembly Government, the Scottish Executive Health Department and the Department of Health, Social Services and Public Safety in Northern Ireland, from NHS Employers, the Advisory Committee on Clinical Excellence Awards, the Scottish Advisory Committee on Distinction Awards, the British Medical Association, the British Dental Association and the Dental Practitioners' Association. The main evidence can be read in full on the parties' websites.

Evidence from the Health Departments

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080117

Evidence from NHS Employers

<http://www.nhsemployers.org/pay-conditions/pay-conditions-3077.cfm>

Evidence from the Advisory Committee on Clinical Excellence Awards

<http://www.advisorybodies.doh.gov.uk/accea/DDRB%20evidence%202008.pdf>

Evidence from the Scottish Advisory Committee on Distinction Awards

<http://www.sacda.scot.nhs.uk/>

Evidence from the British Medical Association

<http://www.bma.org.uk/ap.nsf/Content/DDRBvidence2007>

Evidence from the British Dental Association

http://www.bda.org/about/quicknav_about.cfm?PID=policy-template1.cfm&CONTENTID=1940

Evidence from the Dental Practitioners' Association

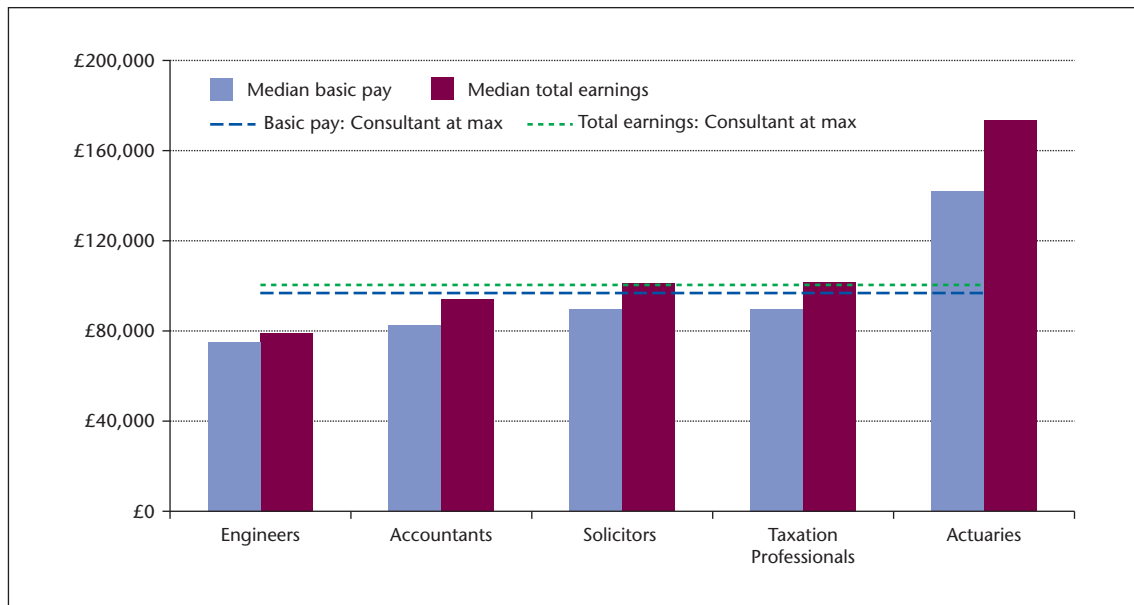
[http://www.uk-dentistry.org/downloads/DPA%20Evidence%20\(37\).pdf](http://www.uk-dentistry.org/downloads/DPA%20Evidence%20(37).pdf)

APPENDIX E

PAY COMPARABILITY: LEVELS

This appendix provides figures comparing pay levels of some of our remit groups with other professions. The pay level comparisons are made with specific professions using national data from Computer Economics Limited and Remuneration Economics (Celre), Hay Group, the Association of Graduate Recruiters (AGR) and Incomes Data Services (IDS) in accordance with criteria suggested by Towers Perrin in 1997 (see Annex A of this appendix) for a guide to the job matching methodology.

Figure E1: Consultant at the top of the scale: basic pay and total NHS earnings against comparator median basic pay and median total earnings, 2007-08



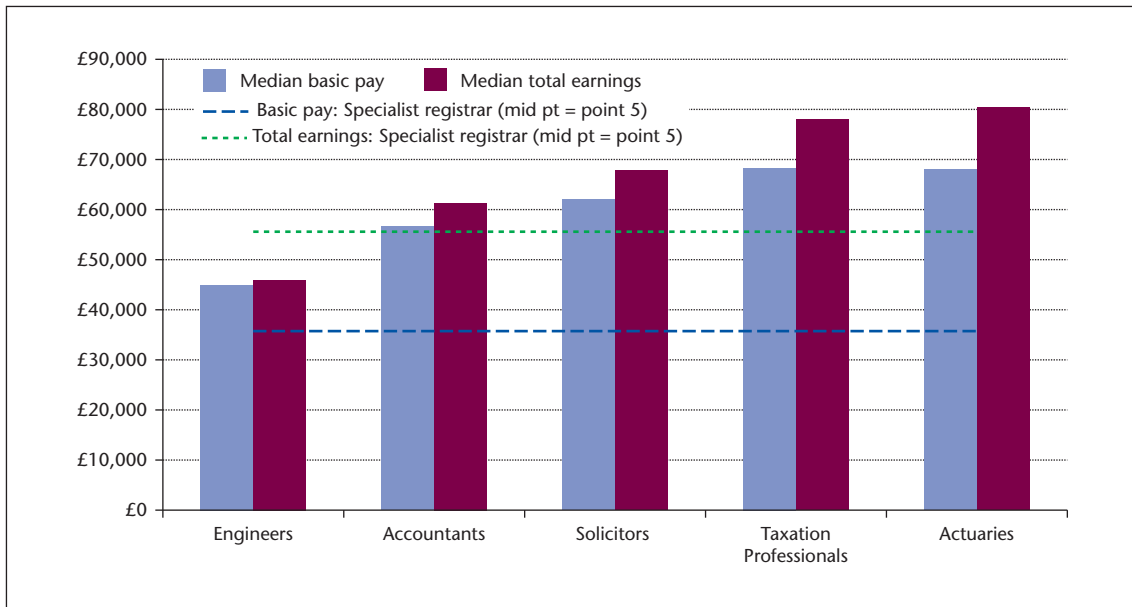
Sources:

NHS Employers

Hay Group, Accountants, Solicitors & Legal executives and Taxation professionals

Celre, Actuaries and Engineers

Figure E2: Specialist registrar (mid-point = point 5): basic pay and total earnings against comparator median basic pay and median total earnings, 2007-08



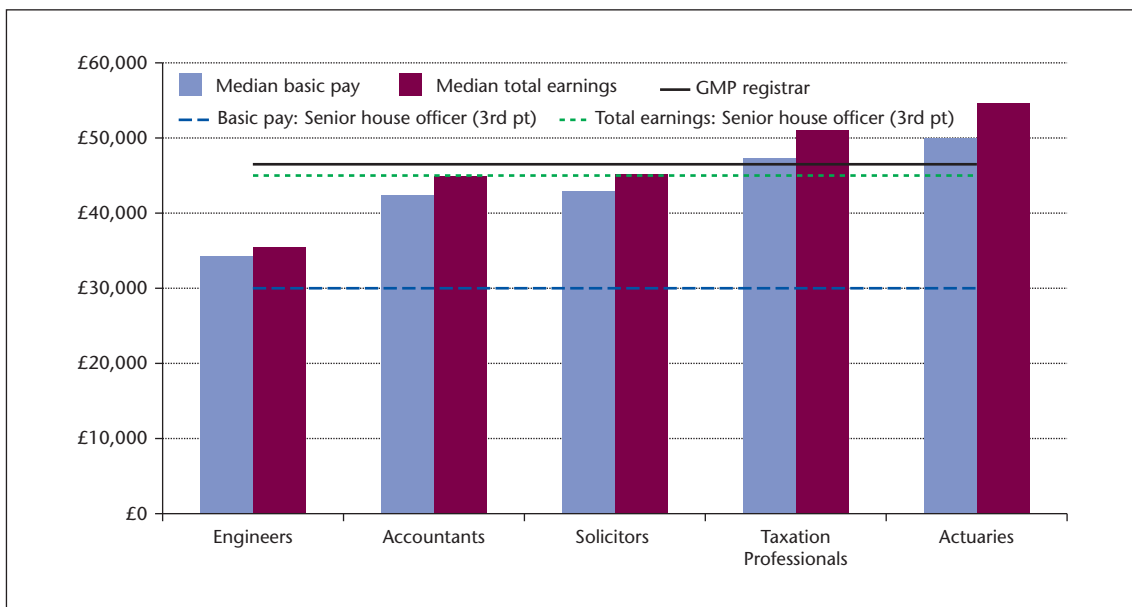
Sources:

NHS Employers

Hay Group, for Accountants, Solicitors & Legal executives and Taxation professionals

Celre, for Actuaries and Engineers

Figure E3: Senior house officer (3rd point): basic pay and total earnings against comparator median basic pay and median total earnings, 2007-08

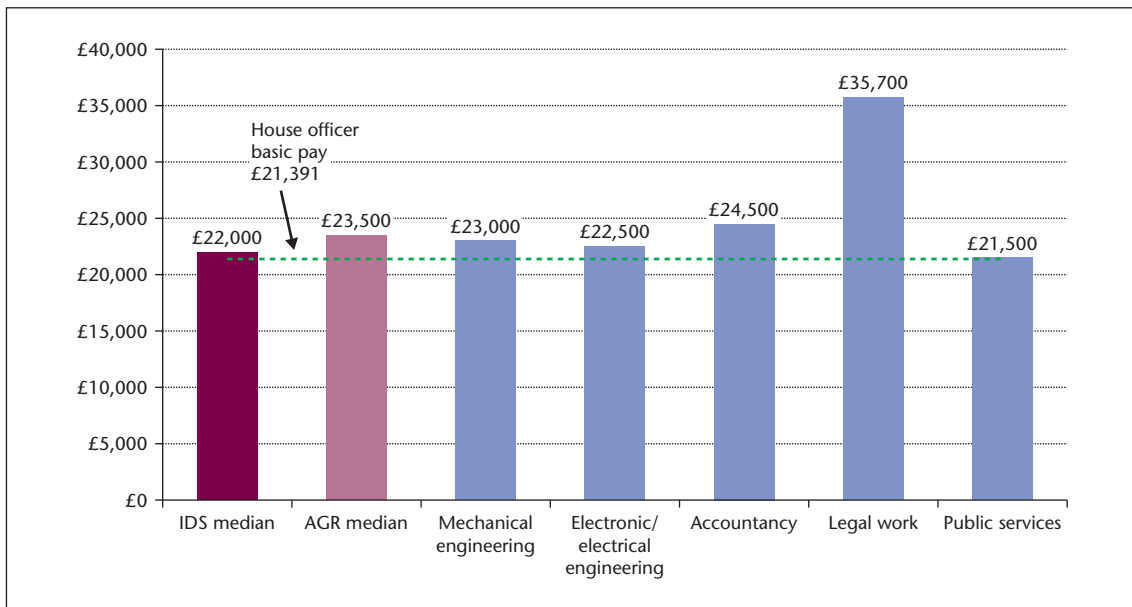


Sources: NHS Employers

Hay Group, for Accountants, Solicitors & Legal executives and Taxation professionals

Celre, for Actuaries and Engineers

Figure E4: Basic starting salary for house officers compared with median basic starting salaries in IDS and AGR reports, 2007-08



Sources:

AGR Graduate Recruitment Survey 2005, Summer Review

IDS Graduate pay and progression for 2006.

ANNEX A TO APPENDIX E

INDICATIVE HAY REFERENCE LEVELS FOR MEDICAL GRADES: SUMMARY

Hospital grade	Remuneration Economics responsibility levels	Hay Group responsibility levels*	Notes
Very experienced senior consultant (at the top of the scale with five Clinical Excellence Awards)	Level 12: Other Director (other than Chief Executive and Deputy Chief Executive). Overall responsible for a function, region or defined activity with boardroom membership a pre-requisite. Always full-time executives.	Level 22	A very senior consultant at this level will be recognised as having national or international level of knowledge and skills, leading research and working on wider developments for the speciality possibly through the Royal Colleges or other bodies. Senior consultants at this level will need to be able to think within broad policy areas and at a creative level to address new, arising challenges that may not have been faced before. Very senior consultants are likely to carry the accountability for leading senior teams, research programmes and other projects.
Consultant at scale maximum	Level 13: Senior Functioning Head. Fully responsible for a complete function or activity reporting directly to the Chief Executive.	Level 21: Senior Manager Tax Compliance, Tax Manager	This level of role is based upon a number of years experience as a consultant (7 – 10) with growing expertise, knowledge and some corresponding increase in responsibilities (such as for leading training or research). These consultants may be leading the design and organisation of advanced care packages for patients – often across multiple teams or specialities and possibly across organisations. They may also be testing and delivering complex new procedures and involved in national work via Royal Colleges or other bodies as well as being involved in supervising/training juniors and leading multi-disciplinary teams. At this level they will require the ability to think within broad policy areas and accepted policies and procedures for their speciality practice whilst also applying creativity to resolving patients' diagnoses and on-going care in addition to other problems relating to service delivery. They will be accountable for the on-going care and treatment of patients with potentially complex needs, and the leadership of teams of juniors and other staff.

Hospital grade	Remuneration Economics responsibility levels	Hay Group responsibility levels*	Notes
Consultant on scale minimum	Level 14: Function head. Full managerial responsibility for one or more activities, reporting to a director at level 11 or 12. Normally involved in policy formulation.	Level 20: Chief Accountant; Divisional Finance Manager; Manager Tax Compliance; Tax Supervisor II. Senior Managing Solicitor.	This is a standard or newly appointed consultant role with responsibilities for managing a patient caseload, organising and supervising some juniors and also directing other multi-disciplinary staff within the speciality or area of expertise as required. The role will require thinking within the generally accepted and laid down policies and procedures of the speciality and the ability to work through patient diagnoses to determine appropriate care and interventions. The role will carry accountability for the long term care and outcomes of their patients and some direction of others to deliver this care.
Specialist registrar (SpR)	Level 16: Section Manager. Normally responsible to a Departmental manager (Level 15) for the day-to-day management of a section or activity and might deputise for them. Top ranking specialists, where the emphasis is on individual contribution rather than control of others may well be found here.	Level 19: Operating Unit Manager; Finance Officer. Senior Tax Adviser; Tax Supervisor I. Managing Solicitor; Company Solicitor; Legal Adviser.	SpRs have 5 years undergraduate study plus 1 year PRHO** or a 2 year Foundation programme (new system) followed by 2 or 3 years as an SHO before making this grade. They are likely to be an SpR for between 4-7 years before gaining a Certificate of Completion of Specialist Training to become a consultant. Levels of SpR role may therefore vary both in terms of experience but also according to speciality where differing complexities of patient case-mix and required interventions may arise. Newly appointed SpRs are likely to be Hay Level 18 rising to Level 19 when acting at the generally fully expected level of competence after an appropriate period of experience at this level. The SpR role carries out day-to-day clinical care, making admission /discharge, prescribing and diagnostic/treatment decisions but does not carry complete accountability for the on-going care of the patient. Responsibility levels for experienced SpRs can be high – being the on-call clinicians for medical teams and for whole departments for some shifts. The level of thinking in an SpR role will vary but broadly will require the ability to resolve issues within defined, clear policies and procedures within their speciality and under varying degrees of supervision from consultants. They will need to be able to assess and resolve many patient diagnoses and issues for themselves, referring on to consultants when appropriate. The level of accountability relates largely to the appropriate delivery of day-to-day care to patients and some on-going advice and support to other team members as required.

Hospital grade	Remuneration Economics responsibility levels	Hay Group responsibility levels*	Notes
Foundation house officer year 2/Senior house officer	Level 21 Senior staff (in earlier years this was Level 18). Less experience and seniority than those in the level above. They will have others reporting to them who may be first line managers or foremen. Qualified professional staff, working within a minimum of supervision will be found at this level.	Level 17: Senior Financial/Management Accountant. Tax Adviser I; Tax Accountant III. Assistant Solicitor; Principal Legal Executive.	These roles require appropriate undergraduate qualification (5 years) with 1 or 2 years experience before taking up post (either PRHO year or new 2 year foundation programme). Newly appointed SHOs post Foundation programme are more likely to be Hay Level 17 than previously under the old training regime where roles would most likely to have been a Hay Level 16 moving to a Level 17 when acting at the fully expected level of competence after at least a year's experience. These roles deliver day-to-day clinical care under the direct supervision of consultants and other team members. They will undertake certain procedures and interventions but are unlikely to make significant or complex admission/discharge, prescribing and treatment decisions. The role will require the ability to solve problems within the detailed procedures given to it and the supervision available. The accountability of the role is focussed on the day-to-day delivery of care at the appropriate level for their experience.

NOTE: Hay Group Levels may vary for some roles by specialities depending on the complexity of the work/case-mix of the role.

* For accountants and solicitors in the Hay column, only private sector job titles are shown.

** PRHO – Pre Registration House Officer training (now being replaced by foundation house officer training)

APPENDIX F

PREVIOUS REPORTS BY THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

1971.....	Cmnd. 4825, December 1971
1972.....	Cmnd. 5010, June 1972
Third Report (1973).....	Cmnd. 5353, July 1973
Supplement to Third Report (1973).....	Cmnd. 5377, July 1973
Second Supplement to Third Report (1973).....	Cmnd. 5517, December 1973
Fourth Report (1974).....	Cmnd. 5644, June 1974
Supplement to Fourth Report (1974).....	Cmnd. 5849, December 1974
Fifth Report (1975).....	Cmnd. 6032, April 1975
Supplement to Fifth Report (1975).....	Cmnd. 6243, September 1975
Second Supplement to Fifth Report (1975).....	Cmnd. 6306, January 1976
Third Supplement to Fifth Report (1975).....	Cmnd. 6406, February 1976
Sixth Report (1976).....	Cmnd. 6473, May 1976
Seventh Report (1977).....	Cmnd. 6800, May 1977
Eighth Report (1978).....	Cmnd. 7176, May 1978
Ninth Report (1979).....	Cmnd. 7574, June 1979
Supplement to Ninth Report (1979).....	Cmnd. 7723, October 1979
Second Supplement to Ninth Report (1979).....	Cmnd. 7790, December 1979
Tenth Report (1980).....	Cmnd. 7903, May 1980
Eleventh Report (1981).....	Cmnd. 8239, May 1981
Twelfth Report (1982).....	Cmnd. 8550, May 1982
Thirteenth Report (1983).....	Cmnd. 8878, May 1983
Fourteenth Report (1984).....	Cmnd. 9256, June 1984
Fifteenth Report (1985).....	Cmnd. 9527, June 1985
Sixteenth Report (1986).....	Cmnd. 9788, May 1986
Seventeenth Report (1987).....	Cm 127, April 1987
Supplement to Seventeenth Report (1987).....	Cm 309, February 1988
Eighteenth Report (1988).....	Cm 358, April 1988
Nineteenth Report (1989).....	Cm 580, February 1989
Twentieth Report (1990).....	Cm 937, February 1990
Twenty-First Report (1991).....	Cm 1412, January 1991
Supplement to Twenty-First Report (1991).....	Cm 1632, September 1991
Second Supplement to Twenty-First Report (1991).....	Cm 1759, December 1991
Twenty-Second Report (1992).....	Cm 1813, February 1992
Twenty-Third Report (1994).....	Cm 2460, February 1994
Twenty-Fourth Report (1995).....	Cm 2760, February 1995
Supplement to Twenty-Fourth Report (1995).....	Cm 2831, April 1995
Twenty-Fifth Report (1996).....	Cm 3090, February 1996
Twenty-Sixth Report (1997).....	Cm 3535, February 1997
Twenty-Seventh Report (1998).....	Cm 3835, January 1998
Twenty-Eighth Report (1999).....	Cm 4243, February 1999
Twenty-Ninth Report (2000).....	Cm 4562, January 2000
Thirtieth Report (2001).....	Cm 4998, December 2000
Supplement to Thirtieth Report (2001).....	Cm 4999, February 2001
Thirty-First Report (2002)*.....	Cm 5340, December 2001
Supplement to Thirty-First Report (2002)*.....	Cm 5341, December 2001

Thirty-Second Report (2003)*	Cm 5721, May 2003
Supplement to the Thirty-Second Report (2003)*	Cm 5722, June 2003
Thirty-Third Report (2004)*	Cm 6127, March 2004
Thirty-Fourth Report (2005)*	Cm 6463, February 2005
Thirty-Fifth Report (2006)*	Cm 6733, March 2006
Thirty-Sixth Report (2007)*	Cm 7025, March 2007

* These reports are also available at <http://www.ome.uk.com/review.cfm?body=5&page=1&all#documents>

APPENDIX G

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
AEI	Average Earnings Index
APA	additional programmed activity
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CDS	Community Dental Services
CEA	Clinical Excellence Award
CNST	Clinical Negligence Scheme for Trusts
COGPED	Committee of General Practice Education Directors
CoT	courses of treatment
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSSPSNI	Department of Health, Social Services and Public Safety in Northern Ireland
DPA	Dental Practitioners' Association
ERINI	Economic Research Institute of Northern Ireland
FHO1/2	foundation house officer year 1/year 2
GDP	general dental practitioner
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
GOS	General Ophthalmic Services
GP	general (medical) practitioner
HCHS	Hospital and Community Health Services
HMRC	Her Majesty's Revenue & Customs
HO	(pre-registration) house officer
HRPS	Healthcare and Related Personal Services
IC	Information Centre
IDS	Incomes Data Services
ISD	Information Services Division
IT	Information Technology
LHB	Local Health Board
MPIG	minimum practice income guarantee
MTAS	Medical Training Application Service
NAO	National Audit Office
NCCG	non-consultant career grade
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NICEAC	Northern Ireland Clinical Excellence Awards Committee
OMP	ophthalmic medical practitioner
ONS	Office for National Statistics
PA	programmed activity
PCO	primary care organisation
PCT	primary care trust
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework

RPI	Retail Prices Index
RPIX	Retail Prices Index excluding Mortgage Interest Payments
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	staff and associate specialists
SEHD	Scottish Executive Health Department
SHO	senior house officer
SPA	supporting professional activity
SPDCS	salaries primary dental care services
SpR	specialist registrar
StR	specialty registrar
StR(FT)	specialty registrar (Fixed Term)
UDA	unit of dental activity
VDP	vocational dental practitioner
VT	vocational training
WAG	Welsh Assembly Government
WTE	whole-time equivalent



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