



Review Body on Doctors' and Dentists' Remuneration

Thirty-Sixth Report 2007

Chairman: Michael Blair, QC



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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 Minister for Health and Community Care**

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

**by Command of Her Majesty
March 2007**

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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 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 Secretary of State for Scotland and the Secretary of State for Wales 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 Health Departments' output targets for the delivery of services as set out by the Government;

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

the Government's inflation target.

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.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the Secretary of State for Scotland, the Secretary of State for Wales and the Prime Minister¹.

¹ Under the Scotland Act 1998 and the Government of Wales Act 1998 responsibility for health matters, including the pay of NHS staff in Scotland and Wales, has passed to the Scottish Executive and the National Assembly for Wales respectively. In addition to our usual addresses, our recommendations are therefore addressed to the First Minister and the Minister for Health and Community Care of the Scottish Executive and to the First Minister and the Minister for Health and Social Services of the National Assembly for Wales.

The members of the Review Body are:

Michael Blair, QC (*Chairman*)
Professor Frank Burchill
Professor Peter Dolton
Katrina Easterling, Chartered FCIPD²

Professor John Beath
Dr Margaret Collingwood
Hugh Donaldson
David Grafton

The Secretariat is provided by the Office of Manpower Economics.

² Katrina Easterling was appointed to the Review Body by the Secretary of State for Health from July 2006.

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Summary of conclusions and recommendations

Our remit group now comprises some 175,000 doctors and dentists in Great Britain. Consultants, general medical practitioners (GMPs), general dental practitioners (GDPs) 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 remaining groups.

The evidence we received this year showed a generally healthy picture on recruitment and retention. The only significant problems were in recruitment of consultants to a few specialities and measures are in place to increase the supply for these. Morale and motivation are more difficult to judge. There are some grounds for concern. Some doctors appear worried that they may be affected by compulsory redundancies but the evidence suggests the risk is in fact very low.

The economic and financial background to this review is particularly difficult. The Chancellor of the Exchequer wrote to all Review Body Chairs in July 2006 urging us to have regard to the Government's inflation target of 2 per cent on the Consumer Prices Index (CPI) measure. However, since then we have seen inflation rising sharply on all measures and as we finalise our report the CPI has reached 3 per cent. We note that the Government expects inflation to come down over the coming year but it seems likely that at best CPI inflation will average around 2.5 per cent over the coming 12 months or so. We also note that the latest Retail Prices Index figure (three-month average), which includes housing costs, has reached 4.0 per cent.

The British Medical Association (BMA) urged us to recommend increases of 4 per cent or more for the different groups it represents. The British Dental Association (BDA) sought an increase of at least 4.3 per cent in the gross earnings base for 2007-08 for general dental practitioners, and that salaries and allowances for all practitioners in the Salaried Primary Dental Care Services (SPDCS) be uplifted by 4.7 per cent.

The Health Departments and NHS Employers (NHSE) told us that funding constraints and spending pressures meant that the NHS could afford only a 1.5 per cent pay increase for all doctors and dentists other than independent contractor GMPs. (They asked us to make no recommendation on the latter – see below.) Notwithstanding media reports of some NHS organisations in deficit, we found it difficult to reach a clear view on funding because of the lack of precise evidence. In the end we were persuaded that there are indeed real and growing pressures, but we do not accept that 1.5 per cent is the maximum that can be afforded.

Nevertheless, we do accept that, for both general economic and funding reasons, this year's awards for doctors and dentists should be restrained and that the overall level should be below the current rate of inflation. However, since this would lead to a pay cut in real terms for those doctors and dentists who do not benefit from an increment this year, we have considered how to minimise the adverse impact for the most vulnerable members of our remit groups.

We have also taken account of the fact that, whereas most consultants continue to benefit from their new contract's incremental scales, junior doctors' total earnings are decreasing as a consequence of the reduction in the number of hours worked in order to achieve compliance with the European Working Time Directive in 2009. We do not wish to see junior doctors' salaries fall behind those of comparable graduate-entry professions.

In all these circumstances, we believe it is right to structure our recommended award so that it gives a proportionately higher benefit to those in our remit group who earn least. **We therefore recommend that for 2007-08 a cash amount of £1,000 per annum be added to each point in the pay scale for consultants, staff and associate specialists/non-consultant career grades (SAS/NCCGs) and SPDCS dentists; and a cash amount of £650 per annum be added to each point on the pay scale for doctors and dentists in hospital training.** (When multiplied by the mean current banding multiplier of 1.56, this will mean that, on average, a doctor or dentist in training will also receive an increase of around £1,000 a year.) **We also recommend that the top and bottom points of the salary range for salaried general medical practitioners employed by a Primary Care Organisation be increased by £1,000 per annum for 2007-08.** We calculate that the effect of these recommendations will be to increase the pay bill per head of the groups concerned by 2 per cent.

It follows from our recommendations for flat cash increases that we do not believe there is scope to increase the value of **Clinical Excellence Awards, commitment awards, distinction awards and discretionary awards for consultants and we therefore recommend that they should remain at their 2006-07 rates.** However, we endorse and **recommend the Scottish Advisory Committee on Distinction Awards' proposal to distribute a further nine B awards, four A awards and two A plus awards.** We recommend that additional funding be made available for distinction awards in Scotland to cover the newly eligible senior academic GMPs, who constitute 0.7 per cent of the eligible population according to the Scottish Executive Health Department's estimate. 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, estimated by the Advisory Committee on Clinical Excellence Awards (ACCEA) at 1.5 per cent.** We also endorse and **recommend ACCEA's proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards at each level in 2007-08.**

The parties were split this year on independent contractor GMPs, with the Health Departments and NHSE arguing that we had no role to play because of the contract negotiated between the parties. The BMA, however, urged us to recommend an uplift across the whole contract. We find it unsatisfactory that we are expected to operate in parallel with negotiations, or as a fallback to them if one side is unhappy with the outcome, and we urge the parties to clarify the situation for next year. On the substance, we find that GMPs have benefited from the new contract and have received sizeable increases in their profits in recent years. A further consideration is that we have not received sufficient evidence on the structure of the GMPs' contract to be able to predict how any change would affect GMPs' earnings. **We therefore recommend a zero increase in GMPs' pay this year.**

The recruitment position for GMP registrars is strong and the banding supplements paid to hospital doctors have also fallen as their hours have reduced. GMP registrars receive a substantial supplement despite having a working pattern which is, on the whole, less intense and involves few if any additional hours compared to hospital doctors. We therefore think it appropriate that the supplement for GMP registrars be adjusted downwards, although fairness also suggests that those doctors currently receiving the higher level of the supplement should keep their existing entitlement rather than see their pay supplement reduced. **We recommend that the supplement for new GMP registrars be reduced to 55 per cent.**

While the work is taken forward 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 per cent for 2007-08.** We also **recommend that the GMP educators' pay scales should be uplifted by 2 per cent.**

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**, which we believe fits in with the trend for local commissioning of services.

For 2007-08, we **recommend that seniority payments for GMPs remain at current levels**.

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 last year's recommendation to freeze London weighting and **recommend that supplements for London weighting should remain at their existing levels for 2007-08**.

For GDPs, we **recommend that the parties work together, or commission joint independent work, looking at the issue of dental practice inflation**. With regard to the uplift, we believe it is right to recognise the inflation in dental practice costs as well as to allow for an increase in dentists' earnings of 2 per cent. We have again applied our formula which weights the different elements and in consequence we **recommend that an uplift of 3 per cent be applied to the gross earnings base under the new contract for 2007-08 for GDPs in England and Wales. In Scotland, we recommend that an uplift of 3 per cent should apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services**.

For ophthalmic medical practitioners (OMPs), we believe that a **unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both OMPs and optometrists, remains appropriate and recommend this continues for this and future years**.

For doctors and dentists in hospital training, we **recommend that the percentage values of the banding multipliers be rolled forward for another year**.

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 per cent for 2007-08, which is what we estimate to be the increase for the overall Hospital and Community Health Services medical staff pay bill.

Our main recommendations on pay levels are:

	<i>Point on scale¹</i>	<i>Recommended scales 1 April 2007 £</i>
<i>Hospital doctors and dentists – main grades (full-time salaries):</i>		
Foundation house officer 1	minimum	21,391
	maximum	24,061
Foundation house officer 2	minimum	26,532
	maximum	30,002
House officer	minimum	21,391
	maximum	24,061
Senior house officer	minimum	26,532
	maximum	36,942 ²
Specialist registrar ³	minimum	29,580
	maximum	44,581 ⁴
Staff grade practitioner	minimum	32,547
	maximum (normal)	45,924 ⁵
	maximum (discretionary)	60,968 ⁶
Associate specialist	minimum	35,977
	maximum (normal)	64,422 ⁵
	maximum (discretionary)	78,039 ⁶
Consultant (2003 contract, England and Scotland for main pay thresholds)	minimum	71,822
	maximum (normal)	96,831
	maximum (CEA ⁷)	34,200
	CEA ⁸ (bronze)	34,200
	CEA (silver)	44,965
	CEA (gold)	56,206
	CEA (platinum)	73,068
Consultant (2003 contract, Wales)	minimum	69,606
	maximum	90,368
	maximum (commitment award ⁹)	24,704

¹ Salary scales exclude additional earnings, such as those related to banding multipliers for doctors in training.

² To be awarded automatically except in cases of unsatisfactory performance, see Twenty-Eighth report, paragraph 3.21.

³ The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

⁴ Additional incremental point in 2004, to be awarded automatically except in cases of unsatisfactory performance, see paragraph 6.61 of the Thirty-Third report.

⁵ Top incremental point extended in 2004, see paragraph 8.42 of the Thirty-Third report.

⁶ Additional discretionary point in 2004, see paragraph 8.38 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. See footnotes 9 and 10 for the local award systems in Wales and Scotland respectively. 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 scale¹</i>	<i>Recommended scales 1 April 2007 £</i>
Consultant (pre-2003 contract)	minimum	59,632
	maximum (normal)	77,300
	maximum (discretionary ¹⁰)	24,704
	distinction award ¹¹ 'B'	30,808
	distinction award 'A'	53,911
	distinction award 'A plus'	73,158
<i>Community health staff – selected grades (full-time salaries):</i>		
Clinical medical officer	minimum	31,179
	maximum	42,996
Senior clinical medical officer	minimum	44,059
	maximum	62,829
<i>Salaried primary dental care staff – selected grades</i>		
Community dental officer	minimum	33,041
	maximum	51,754 ¹²
Senior dental officer	minimum	47,215
	maximum	63,810 ¹³
Clinical director	minimum	62,741
	maximum	71,497 ¹³

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OFFICE OF MANPOWER ECONOMICS
15 February 2007

¹⁰ Discretionary points are now only awarded in Scotland. Local CEAs have replaced this 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 Clinical Excellence Awards 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 Performance based increment, see paragraphs 4.21, 4.30 and 4.38 of the Thirty-First report.

¹³ Performance based increment, see paragraphs 4.21 and 4.38 of the Thirty-First report.

Part I: Overview

CHAPTER 1: INTRODUCTION AND ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

- 1.1 We have divided this, our Thirty-Sixth 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 (OMPs), 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 chapter we set out the overall context for our review, including the key facts about our remit groups, how we have collected evidence this year, and the current economic background. The chapters on each remit group discuss some of these matters in more detail. Our terms of reference are set out on page iii of this report. The main recommendations of our previous report are summarised in Appendix B.
- 1.3 Our remit groups now comprise some 175,000 doctors and dentists. The breakdown by group is given in Table 1.1. Further details are given at Appendix C.

Table 1.1: Remit staff groups for the 2007 review, at September 2005, Great Britain

	Full-time equivalents	Headcount
Consultants ¹	34,960	37,720
Associate specialists/staff grades	8,450	9,440
Registrar group	19,750	20,540
Senior house officers	25,340	25,720
House officers ²	5,670	5,690
Other staff ³	3,220	8,140
NHS contract GMPs	31,860	34,980
GMP registrars	2,810	2,970
Other GMP staff ⁴	3,160	4,640
GDPs ⁵	*	24,370
Ophthalmic medical practitioners	*	500
Total	*	174,710

Source: *Health and Social Care Information Centre, Health Departments' Medical and Dental Censuses*

* data are not available

Notes:

1. The grade of consultant also includes Directors of Public Health.
2. For England, includes Foundation Programme doctors in their first year.
3. Includes hospital practitioners, clinical assistants, and public health and community medical and dental staff not elsewhere specified.
4. Includes salaried GMPs who cannot be separately identified within this group.
5. Includes principal GDPs, assistants and vocational practitioners, GDPs working in Personal Dental Services, and salaried dentists working in General Dental Services.

- 1.4 Within our remit groups, GMPs, GDPs and consultants have all had new contract arrangements since 2000, while negotiations with the SPDCS and SAS/NCCGs appear, at the time of writing, to be entering their final stages. In addition, following the publication of *Modernising Medical Careers*¹, the way in which junior doctors are trained is undergoing a radical change. 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)
Salaried Primary Dental Care Services	Negotiations in process
Doctors and dentists in training	New contract from December 2000. Changes to training from 2004
Consultants	New contract from October 2003 – contract differs in England, Scotland and Wales. Some consultants in England and Scotland remain on the old contract
Staff and associate specialists/ non-consultant career grades	Awaiting outcome of ballot (at time of writing)

- 1.5 For many of our remit groups, the new contractual arrangements are still fairly recent and there is still some way to go before they are fully established. We have therefore approached this round on the basis of seeking to stabilise what has been agreed between the parties.

Scotland and Wales

- 1.6 Our remit currently covers Great Britain so in this report, unless we specify that remarks are relevant only to England, Scotland or Wales, we refer to the whole of Great Britain.
- 1.7 The Scottish Executive Health Department (SEHD) and the National Assembly for Wales (NAW) 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 and that it drew attention to any policies that were distinctive in Scotland or Wales.
- 1.8 The British Medical Association's (BMA) written evidence covered the whole of the United Kingdom, drawing out differences and specific issues where appropriate, and evidence from the British Dental Association (BDA) and Dental Practitioners' Association (DPA) covered Great Britain, drawing out aspects of difference as necessary. NHS Employers' evidence, however, related only to England.

The evidence

- 1.9 We received written evidence from the Health Departments, comprising the Department of Health, the NAW and the SEHD, from NHS Employers (NHSE), the Advisory Committee on Clinical Excellence Awards (ACCEA), the BMA, the BDA and the DPA. The evidence can be read in full on the parties' websites (see Appendix D). In an effort to make the report more concise, we have not paraphrased large portions of the evidence within this report, although we continue to refer to issues raised by the parties in their evidence.

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

- 1.10 The parties provided supplementary written evidence in response to other parties' evidence and requests from the Review Body. In addition we heard oral evidence from the then Minister for Health Service Reform, Lord Warner, the Health Departments, NHSE, the BMA, the BDA and the DPA.

Comments on the evidence

- 1.11 We are 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 responded to our numerous questions and requests for supplementary evidence. Nevertheless, in some respects the evidence was incomplete and we were unable to resolve some contradictions, particularly on affordability. We trust, therefore, that by identifying some shortcomings in the evidence this year we can encourage the parties to try to address the deficiencies in time for the next pay round.
- 1.12 First, it is crucial that assertions are supported by clear and concrete evidence, as we are unable to make recommendations without the substantive information to justify them. We have therefore indicated some areas in the report where the evidence we required was not available, and where we were thus prevented from looking into a matter as deeply as we should have liked.
- 1.13 Secondly, our terms of reference are printed at the front of this report and it is important that the evidence is relevant to our remit. We have noticed, over the last few years, an increasing tendency to include subjects outside our remit, on which we have no influence and which have no place in our report; we identify some of these later.

Recruitment and retention

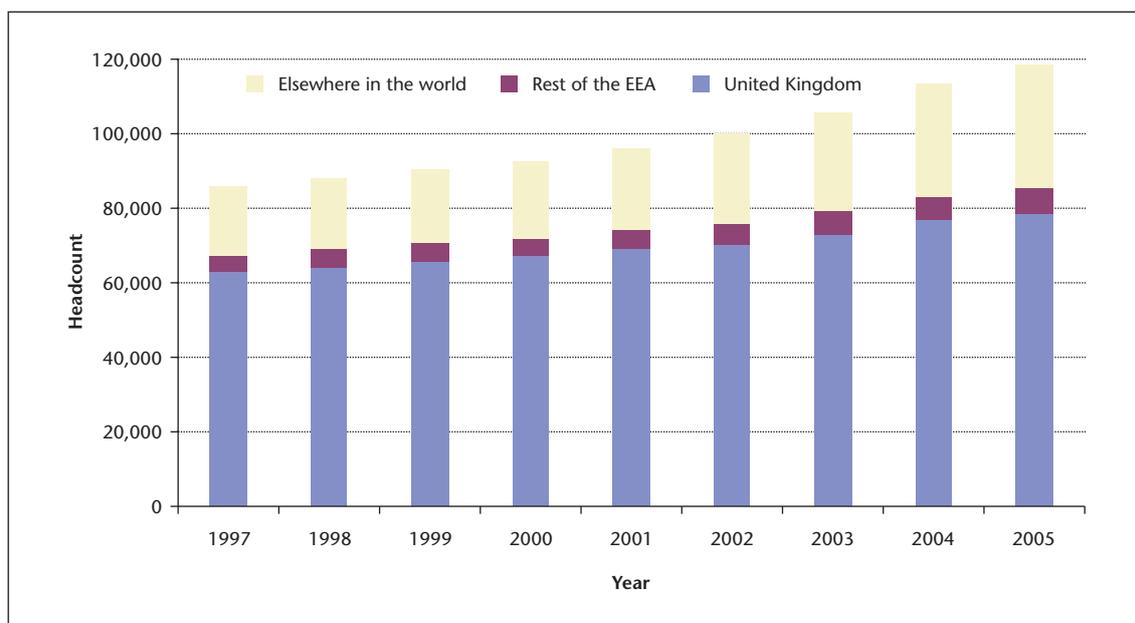
- 1.14 The BMA said that it was too early to assess the impact of the new contracts on recruitment and retention. However, the Health Departments stated that the recruitment and retention situation was "strong", and that vacancy rates were falling continuously, despite an increasing number of placements available for doctors. They believed that as doctors' pay had increased significantly in recent years pay levels were now more than adequate to attract new recruits and retain experienced staff.
- 1.15 NHSE reported that the position on recruitment and retention was, in general, healthy. There were some concerns at consultant level in particular specialities (accident and emergency, psychiatry, radiology and histopathology) where planned increases in training had yet to work through to consultant level. NHSE did not see payment of recruitment and retention premia as appropriate to address these specific shortfalls because they were attributable to the "delay" in supply. It said that few National Health Service (NHS) organisations were paying such premia. We note, however, that this may simply be because of the bureaucracy of the system and it is simpler for employers to appoint at higher scale points (see also chapter 8 on consultants). NHSE also told us that initiatives under the Improving Working Lives Standard² had been positively received and many trusts had cited non-pay measures as being as important as pay in improving recruitment and retention, for example *NHS Jobs*, the electronic recruitment service, was a major new development assisting recruitment and retention.

² <http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModelEmployer/ImprovingWorkingLives/fs/en>

Recruitment

1.16 The Health Departments told us that the domestic supply of medical and dental staff was providing sufficient recruits to meet demand and that there were now 117,000 doctors (GMPs and doctors working in hospitals) working in the NHS in England – 27,400 more than in 1997 – and record levels of students training in medical schools. Consequently there was now less need to rely on the recruitment of overseas doctors.

Figure 1.1: Numbers of doctors in the NHS by country of qualification, 1997-2005, England



Source: Health and Social Care Information Centre

1.17 The Health Departments also told us that annual growth rates of staff would fall as the workforce approached its steady state level. They believed that there would be a shift of staff from the acute sector into the primary care sector and that more could be done to improve efficiency; for example, in some cases, productivity gains might mean that fewer staff were needed to deliver the same service outcomes.

1.18 The BMA reported that the numbers of applicants for medical school places had again increased substantially in 2005. They also reported the continued growth in numbers of career grade doctors and the increase in numbers of consultant and general practitioners (both headcount and whole time equivalents). The BMA stressed the importance of starting salaries at least maintaining their value relative to competing professions, to ensure sufficient candidates of appropriate quality, and expressed concern that the recent lack of funding for the Flexible Careers Scheme³ in England seemed bound to affect recruitment.

³ The Flexible Careers Scheme (FCS) was developed in conjunction with the BMA as part of the Improving Working Lives initiative. It provides doctors with an opportunity to work flexibly within mainstream general practice while being supported in maintaining their careers.

Retention

- 1.19 We note from the Health Departments that the three-month vacancy rate for medical and dental consultants continues to fall. In March 2006 the three-month vacancy rate was 1.9 per cent (down from 3.3 per cent in March 2005 and 4.4 per cent in March 2004).
- 1.20 The BMA expressed their concern that if doctors were not appropriately rewarded for their level of skill and expertise in comparison with relevant colleagues in their own and other professions, the result might be a drain of skilled and trained doctors from the UK to other countries which currently had an under supply of doctors. However, we see no evidence that this is happening to any significant extent. Indeed, as we noted in our preceding report, the earnings of doctors in Great Britain compare well with their international counterparts.
- 1.21 We understand from the Health Departments and NHSE that there are no widespread compulsory redundancy exercises across the NHS. However, they told us that trusts were reducing posts by not filling vacancies arising from natural wastage, reducing the use of agency staff and redeploying staff. We were told that some trusts had well-reported financial problems, and would “need to make some difficult decisions”, but that compulsory redundancies would be kept to a minimum. NHSE said that most, if not all, planned reductions were in administrative, managerial and clerical roles, but that they were not collecting data on redundancies or staff at risk. The Health Departments reported that on 23 October 2006 they had announced that there had been 903 compulsory redundancies in the first six months of the financial year, across all staff groups in NHS, but of these, only 11 were medical staff. For their part, NHSE reported that there had been 167 compulsory redundancies for clinical staff (i.e. nurses and doctors) in the 2006-07 financial year, up to 30 September 2006. While this evidence is not as complete as we should wish, it does suggest that very few NHS medical staff face compulsory redundancy. Moreover, as the numbers of doctors in post have increased substantially over the last few years, it could be said that these are not significant cuts.
- 1.22 We comment in more detail on the recruitment and retention evidence provided by the parties for each remit group in the relevant chapters of the report.

Morale, motivation and workload

- 1.23 NHSE reported that the morale of medical staff was much the same as last year, though it accepted that the perceived threat of job losses might lead to some deterioration. It accepted that a pay award below inflation would be detrimental to morale and motivation, but believed that any higher pay award would cause increased financial problems for trusts and thus would only exacerbate difficulties and uncertainties for staff. Overall, therefore, it saw a low pay award as the preferable course.
- 1.24 The Health Departments reported that the Healthcare Commission staff survey (October 2005) found staff to be “generally satisfied with their jobs”, with evidence of sustained improvements in key areas such as training, learning and development, access to flexible working, support for staff with dependants and staff safety at work.

- 1.25 The University of Aberdeen carried out a second national survey of working conditions and job satisfaction among career grade doctors (consultants, GMPs and SAS/NCCGs) in Scotland⁴ as a follow up to the 2001-02 survey. Overall, the survey found substantial improvements over the last five years in the job satisfaction and attitudes to their workload of doctors working in the NHS in Scotland. It noted that the improvement had been greatest for consultants and GMPs, the two groups that had new contracts. Forty-seven per cent of consultants who reported an increase in their job satisfaction put this down to their new contract, compared to 80 per cent of GMPs. However, the majority of both groups of doctors (73 per cent of consultants and 81 per cent of GMPs) believed that some of the tasks they carried out could be done by someone less qualified, although in most cases (67 per cent of consultants and 53 per cent of GMPs) respondents said that there were insufficient staff to enable tasks to be delegated.
- 1.26 Comments received from the BMA on the morale and motivation of our remit groups are addressed in the specific chapters.

Output targets

- 1.27 The Department of Health said that the link between pay and output targets was multi-faceted and it was not possible to quantify precisely the impact of our recommendations on output targets.
- 1.28 There is clearly a relationship between output targets and the available budget. The Health Departments in their evidence repeatedly mentioned the Government's 18-week target for the maximum waiting time for treatment in a hospital, if required, after referral by a GMP. There is almost inevitably a cost involved in meeting new targets (for example, the payment of Quality and Outcomes Framework (QOF) points to GMS practices), although the cost may fall once systems are established. However, the Health Departments and NHSE have not provided evidence on the relationship between output targets and affordability. This makes it impossible for us to fulfil that element of our remit that requires us to take account of the output targets set by the Government. If the Health Departments cannot provide us with proper evidence to clarify the relationship between pay and output targets, the case for those targets remaining in our remit becomes questionable.

General economic context and the Government's inflation target

- 1.29 On 13 July 2006 the Chancellor of the Exchequer wrote to all Pay Review Body chairs⁵. He said:

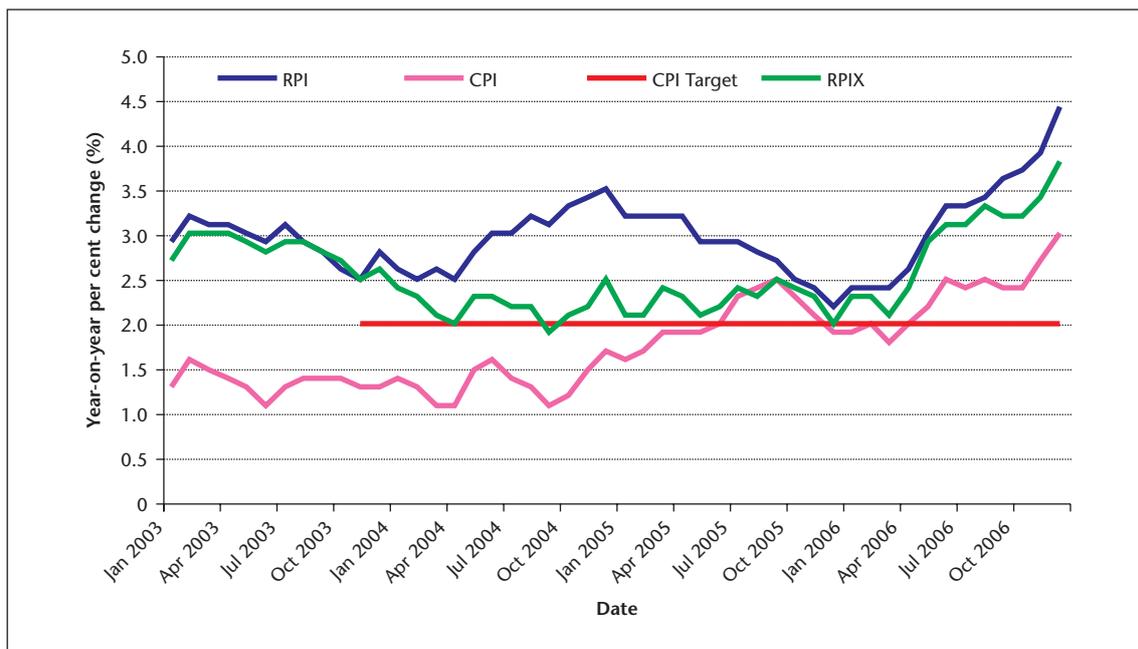
"It will be important to ensure that public sector pay increases do not contribute to inflationary pressures in the economy going forwards. To do so would risk converting a temporary increase in inflation into a permanent increase. The Pay Review Bodies should therefore continue to base their pay settlements on the achievement of the inflation target of 2 per cent."

⁴ Fiona French et al. *Second national survey of non-training grade doctors in NHS Scotland: changes in job satisfaction, work commitments and attitudes to workload following contractual reform*. University of Aberdeen, December 2006.

⁵ http://www.hm-treasury.gov.uk/documents/taxation_work_and_welfare/public_sector_pay/tax_pay_index.cfm

- 1.30 We have considered the three main general inflation measures: the Retail Prices Index (RPI); the Retail Prices Index excluding Mortgage Interest Payments (RPIX); and the Government's preferred measure, the Consumer Prices Index (CPI). The measures differ in terms of items included, what they measure, and the use to which they are put. The RPI is a general purpose measure of inflation based on average expenditure patterns and is used for, among other things, adjusting benefits, tax allowances and thresholds, and by most pay negotiators. The main use of the CPI and RPIX is to provide an inflation measure for the purpose of managing the economy; since autumn 2003 the CPI has replaced RPIX as the measure on which the Government's inflation target is based. RPIX excludes mortgage interest costs while CPI also excludes house prices and Council Tax.
- 1.31 The Chancellor's letter of 13 July 2006 asked us to have regard to the inflation target of 2 per cent (on the CPI measure) in our forthcoming deliberations. The BMA expressed concern at the Chancellor's proposal that 'core' inflation should govern pay expectations and settlements. In its view RPI was closer to 'true' inflation. It also said that the existing expenditure plans for 2007-08 incorporated growth of 9.4 per cent for the following three years, subject to the Comprehensive Spending Review. Since the Chancellor wrote, inflation on all three measures has increased. The latest figures available to us are shown in the graph below:

Figure 1.2: Inflation: CPI, RPI and RPIX, January 2003-December 2006



Source: Office for National Statistics

- 1.32 We believe it is appropriate to consider all three indices as they all measure inflation differently and none is ideal for our purpose. The most important difference between these indices for our remit groups is that the CPI excludes housing-related costs that are clearly important to almost all members of our remit groups, especially those for whom mortgage repayments are a large share of their disposable income. For technical reasons⁶ there are also small biases in the calculation of the RPI and RPIX and we therefore need to keep a watchful eye on all three trends as they have risen above the government's targets and at an increasing rate.

⁶ Technical details of the computation of the three indices are provided in *Consumer Price Indices: Technical Manual*. Office for National Statistics, 2006. Can be viewed at: http://www.statistics.gov.uk/downloads/theme_economy/CPI_Technical_Manual.pdf

- 1.33 We note that the Government and some independent forecasters predicted that inflation would come down later this year and that the decision of the Bank of England's Monetary Policy Committee to raise interest rates by 0.25 per cent in January 2007 was clearly intended to counteract the current rise in inflation, although in the short term the rise in interest rates will cause the RPI to increase. Speaking shortly after that decision, the Governor of the Bank of England said:

“... the [Monetary Policy] Committee's central view remains that inflation is likely to fall back in the second half of the year, possibly quite sharply.”⁷

He went on to say that we all need to accept:

“a temporary, but only a temporary, slowing in the growth of our real take-home pay. That adjustment – difficult but inevitable – will be helped by the fall in energy prices since last autumn. But the belief that we could avoid the adjustment by pushing up our pay would lead to a self-defeating process of higher wages offset by higher prices.”

- 1.34 In making our recommendations we have considered several factors, including the Chancellor's letter, the current level of inflation under different measures, the inflation forecasts and the average earnings index (AEI). The latest available figures for the AEI (three months to November 2006) show earnings including bonuses increasing at 4.1 per cent for the whole economy and 3.2 per cent for the public sector. The Treasury average of independent forecasts for 2007 suggests the AEI will rise by 4.3 per cent. We also note that over the last three years earnings growth in the public sector (as measured by the AEI including bonuses) was ahead of that in the private sector until spring 2006.
- 1.35 In this general economic context, the proposal from the Health Departments and NHSE for an increase of 1.5 per cent would lead both to a cut in purchasing power for our remit groups and to their pay rising more slowly in percentage terms than that of average workers. While our remit requires us to take account of inflation, it does not mean that we must necessarily protect our remit groups' purchasing power, nor their pay comparability. However, these factors become relevant to us if they impact on the recruitment, retention and motivation of doctors and dentists.
- 1.36 Other factors we have considered include the actual increases which the different groups of doctors and dentists have experienced in recent years, as well as the state of NHS finances and the question of affordability, which is discussed in more detail in paragraphs 1.37–1.49 below. It is apparent that new contracts and pay drift (also discussed below, in paragraphs 1.54–1.58) have resulted in some of our remit groups receiving increases, at least on a par with, if not above, those of some of the highest earning groups in the economy in recent years (see Figure 1.6). Our challenge as a review body is to weigh all these different factors, many of them pointing in opposite directions, and to reach an overall judgement based on the evidence received. Our overriding concern is to ensure that pay levels are adequate to recruit, retain and motivate doctors and dentists in sufficient numbers and of sufficient quality, taking into account the funds available to the Health Departments.

⁷ Speech by Mervyn King to Birmingham Chamber of Commerce, 23 January 2007: <http://www.bankofengland.co.uk/publications/speeches/2007/speech300.pdf>

Affordability and the Health Departments' expenditure limits

- 1.37 The main theme running through the evidence submitted this year by the Health Departments and NHSE has been the funding pressures facing the NHS. We have pressed the parties on the affordability evidence because affordability (i.e. the funds available) is an important element of our remit and clearly a key determinant of the level of any pay increase. We summarise below at some length the evidence we received. We do this for two reasons: first, because this is such an important part of the Health Departments' and NHSE's case this year, and secondly because, despite our efforts, we have not been able to ascertain to our own satisfaction where the increased expenditure on the NHS in 2007-08 will go and why the maximum affordable increase in pay is 1.5 per cent, as proposed by the Health Departments and NHSE.
- 1.38 In their initial evidence, the Health Departments said that expenditure on the NHS for 2007-08 was planned to increase by 6.4 per cent in England, 4.2 per cent in Wales (subject to final approval by the NAW) and 5.07 per cent in Scotland. The Department of Health said that approximately 60 per cent of a trust's budget was spent on pay. Based on figures in the evidence from the Department of Health, we therefore made the simple calculation that if the overall expenditure for a trust in England increases by 6.4 per cent and its pay costs increase by 1.5 per cent, then its remaining costs (the other 40 per cent of its expenditure) must increase by 13.75 per cent. This of course takes no account of the growth in staff numbers, nor of pay drift. The total number of full-time equivalent Hospital and Community Health Services (HCHS) medical staff increased by 32 per cent between 2000-01 and 2004-05, to 93,610. Over the same 2000-01 to 2004-05 period the total pay bill for HCHS medical staff increased by 77 per cent, while the earnings per full-time equivalent increased by 32 per cent, showing that the pay bill has been under sharp upward pressure from both the increase in numbers and pay drift. However, the trend in pay drift is downward and is forecast to be only 0.7 per cent in 2007-08.
- 1.39 The Health Departments also supplied a table setting out non-pay cost increases for 2005-06 and 2006-07, showing annual increases of 2.7 and 2.9 per cent respectively over the previous year.

Table 1.3: Non-pay cost increases – based on 2006-07 tariff uplift

	2005-06 (over 2004-05 baseline)		2006-07 (over 2005-06 baseline)	
	£m	%	£m	%
Baseline	46,162		49,806	
Increase in prices	619	1.3	898	1.8
Non-pay inflation (prices)	257	0.6	253	0.5
Clinical negligence costs	58	0.1	141	0.3
Secondary care drugs	199	0.4	287	0.6
Revenue cost of capital	105	0.2	218	0.4
Reform and quality	511	1.1	394	0.8
NICE appraisals and clinical guidelines	327	0.7	291	0.6
Investment in new capital	184	0.4	103	0.2
Connecting for Health	0	0.0	163	0.3
Technical adjustments	134	0.3	0	0.0
Revaluation of NHS estate	134	0.3	0	0.0
	Overall	2.7	Overall	2.9

Source: Department of Health

- 1.40 We found this difficult to reconcile with the proposition that pay should not increase by more than 1.5 per cent while overall funding was increasing by between 4.2 and 6.4 per cent. In supplementary evidence the Health Departments identified a number of demand-led budgets such as drugs bills, National Institute for Clinical Excellence (NICE) appraisals and guidelines, supply and services, clinical negligence claims, payments to European Economic Area countries for health care of British citizens visiting or living abroad, and training costs. The Department of Health told us that for many organisations the first call on funding would be the deficit they carried over from 2006-07. As the gross deficit would be over £1 billion, this would take a significant proportion of the £6 billion growth in Primary Care Trust (PCT) allocation in 2007-08. However, we were still not able to arrive at even an approximate breakdown of how the increased expenditure in 2007-08 was forecast to be allocated between the different elements.
- 1.41 When the Health Departments gave oral evidence, we therefore pressed them on the issue of affordability. They could not provide details of the increases in non-pay costs but suggested that there were several other cost pressures in addition to those cited in the evidence, such as the primary care drugs bill, clinical guidelines, the 18-week waiting list target, non-elective activity, improvements in health promotion work, and the NHS deficits.
- 1.42 In addition, there was also an efficiency target that would release another £1.4 billion. When other cost pressures were taken into account, the Department of Health said that no more than a 1.5 per cent increase could be afforded within this expenditure limit. To assist us in the appreciation of the financial pressures that were being faced, they provided us with the tables below, which show their forecasts of costs in the HCHS sector and other costs.

Table 1.4.1: HCHS projected cost pressures (covered by the tariff) that increase unit costs

HCHS Cost pressure	Expected baseline costs (2006-07)	Uplift (%)	Expected change (2007-08)
Pay (inc. settlement, drift & reform)	£33 billion	*	£1.4 billion
Price inflation plus NHS litigation	£7 billion	Prices: 2.7%	£0.4 billion
HCHS drugs plus NICE	£3 billion	Drugs 12.5%	£0.5 billion
Capital & IT	£2 billion	*	£0.4 billion

Source: Department of Health

* figures are not given

Table 1.4.2: Other projected costs pressures

HCHS Cost pressure	Expected baseline costs (2006-07)	Uplift (%)	Expected change (2007-08)
FHS Drugs	£7 billion	Medium term trend 8%–10%	*
Emergency activity	£11 billion	Medium term trend 4%	*
Mental Health, Community and Learning Disability	£10 billion	Expected trend underlying 1%–2%	*

Source: Department of Health

* figures are not given

- 1.43 From the first row in the upper panel, one can see that a figure of £1.4 billion has been allowed for pay growth in calculating the tariff. This is equivalent to assuming an overall increase in the NHS pay bill in England in 2007-08 of 4.24 per cent. However, this figure includes not only any settlement, but also the impact of the reform agenda and the effect of incremental pay scales, as well as any further growth in the numbers of staff. Particularly significant as components of expected increases in costs are expenditure on HCHS drugs and the implications of NICE guidelines (16 per cent) and expenditure on capital and information technology (20 per cent). These projections from the Department of Health indicate that the tariff increases have built in a figure of a 6 per cent assumed increase in HCHS pressure. Moreover, as the lower panel shows, projecting the trends in these other items of cost, suggests a figure for the increase in other costs of around 4.4 per cent. Both of these, when taken in conjunction with the Departmental Expenditure Limit figure of 6.4 per cent in paragraph 1.38, do indicate that there are genuine issues of affordability.
- 1.44 The Health Departments said that additional funding for the NHS was not available to meet cost pressures caused by high and unaffordable pay uplifts, and that pay settlements had to be the balancing item when concerns about affordability arose. They said that the Spending Review settlement required the NHS to continue to deliver productivity improvements and demonstrate value for money. However, if these savings were used to fund higher rates of pay for the same level of output, then by definition they would no longer be efficiency gains and the money would not be available for service improvements.
- 1.45 Consequently the Health Departments and NHSE were both insistent that a pay award above 1.5 per cent was unaffordable and would have an adverse impact on other aspects of the service. Initially, NHSE was seeking an increase in line with the CPI inflation target, which it had confirmed meant 2 per cent. However, it subsequently reduced the figure to 1.5 per cent after the information about the tariff became available and it had sought the opinion of the Department of Health on affordability. NHSE said that it believed that if the tariff would only accommodate a 1.5 per cent increase, then employers would not want it to be above that level and that NHSE would not want to pursue a recommendation that was unaffordable for employers and that risked jobs and service commitments.
- 1.46 The Health Departments stressed that posts could be cut or planned service investment cancelled if the pay award was higher than proposed. They told us that there would be an inevitable impact upon the cost of the patient services delivered by NHS providers and that PCT commissioners would have to consider the impact of the increased costs when deciding upon their strategies for commissioning services, meaning that PCTs might not invest in some areas. They stated that decisions about the services affected would be made locally, but that PCTs would have to consider reducing activity and changing priorities, as well as making savings. They said that savings would be found from cuts in existing services (e.g. reducing the number of elective procedures), less investment in new services (e.g. not opening a new community-based clinic) and reducing the number of staff in post (e.g. redundancies).
- 1.47 NHSE stated that, for a significant minority of employers, no pay award would be affordable, and that, whilst some employers would be making redundancies whatever the level of settlement, most indicated that an award higher than inflation would lead to further reductions in posts, possible redundancies, vacancy freezes, reduction in capacity or growth and failure to meet healthcare and financial targets. It stressed that affordable pay settlements were necessary to ensure that the current financial position in the NHS did not worsen.

- 1.48 The BMA told us in supplementary evidence that it did not believe that an above inflation pay rise would necessarily lead to redundancies. It believed that any redundancies in 2007-08 would be the consequence of poor financial management rather than increases in national pay rates and said that it would not wish the threat of redundancies to be a constraint on the review body's recommendations for 2007-08.
- 1.49 On balance, we believe the evidence shows that, despite the overall increase in funding this year, the amount available for pay increases is severely limited, not least because of increases in pay and staffing in recent years. The NHS is a very large and complex organisation. Nevertheless, we regret that, despite the importance that the Health Departments and NHSE attach to affordability, they have not been able to explain the budget (and, as we note above, the relationship between output targets and pay) in sufficiently transparent terms for us to understand why the maximum affordable increase is 1.5 per cent, as they claim. We therefore strongly urge the Health Departments and NHSE to improve the presentation of evidence on the available budget next year.

NHS deficits

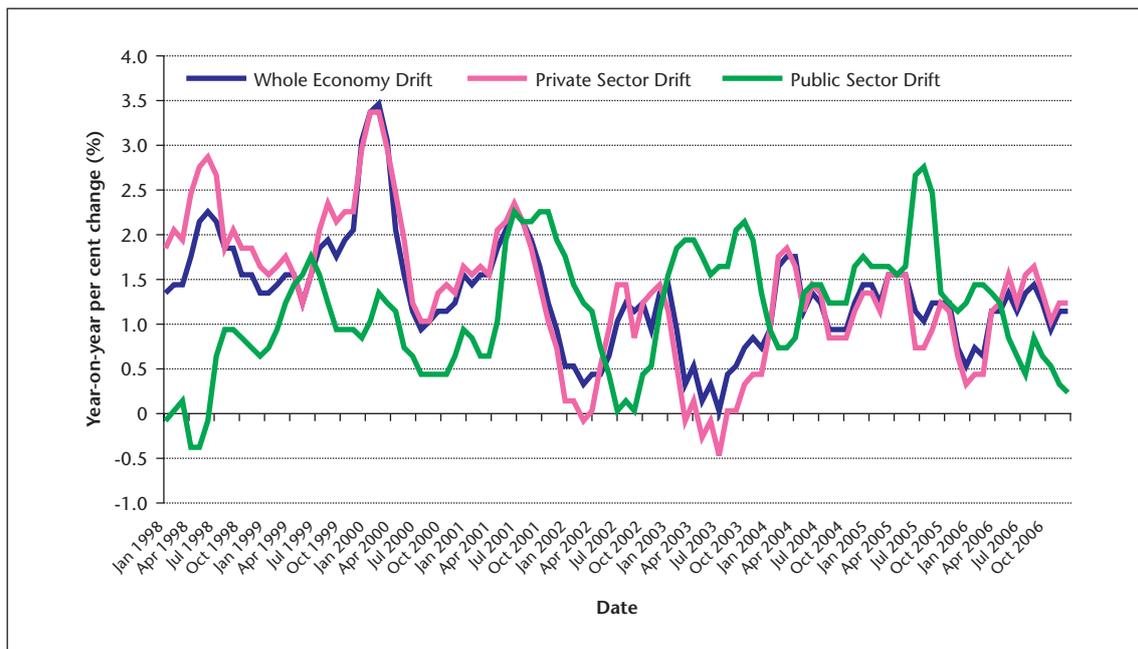
- 1.50 The Health Departments told us that the NHS had a duty to achieve financial balance overall and the effect of deficits in a minority of trusts was a national rather than a local problem, as other trusts had to run surpluses to offset trusts in deficit. We understand this to be a Government-imposed discipline, without which there would effectively be no sanction on NHS organisations that fail to keep within their budgets. The Health Departments stated that the level of the pay award would be a factor in determining whether there were more or fewer redundancies in the organisations in deficit and whether other organisations could use surpluses to drive planned service improvements. They also said that NHS reforms, e.g. payment by results and practice-based commissioning, would be helped by stability in pay rates. They said that high pay awards could result in posts being cut, or planned service investment being cancelled.
- 1.51 Giving oral evidence, the Department of Health told us that in London, PCTs were having 3 per cent top-sliced off their budgets to fund acute trusts in deficit. It said that 2007-08 would be a difficult year financially, with little prospect of loans between trusts being paid back in that year.
- 1.52 In our Thirty-Fifth report⁸ we noted the suggestion, from the research conducted by the University of Aberdeen, that doctors operated in a national labour market and that there was no evidence that greater pay differentiation would tackle recruitment and retention difficulties. With this in mind, we accept that we should not be driven in our recommendation on pay uplift by the experience of a particular subset of trusts, if this is not in fact the general experience. However, our understanding is that, for the reasons explained above, deficits in a limited number of NHS organisations have an impact across the whole of the NHS, because of the need to find offsetting savings. We are therefore satisfied that, although higher pay increases would first affect organisations in deficit adversely, there could be a knock-on effect throughout the whole of the NHS which would ultimately be likely to lead to a reduction in patient care. We must consequently be aware of the potential impact of our recommendations on organisations in deficit.

⁸ Review Body on Doctors' and Dentists' Remuneration. *Thirty-Fifth Report 2006*. Paragraph 2.24.

Pay drift

- 1.53 During this review, the Office of Manpower Economics commissioned a report on the causes of pay drift in UK organisations⁹. That report defined pay drift as “the difference between average earnings growth and basic pay settlements”. The Department of Health calculates pay drift, using financial return data, as the difference between the growth in pay bill per head (after taking into account National Insurance contributions and employers’ contributions to pension) and settlements. Earnings growth reflects the impact on pay packets from, for example, changes in overtime pay, bonuses and allowances, as well as pay progression and pay restructuring outside of the annual pay review. Although pay drift can fluctuate, the difference is normally positive with earnings increasing faster than basic pay, at a level of between 1 and 2 per cent for the whole economy. Provided that productivity is increasing at around the same rate, pay drift is not necessarily inflationary. This is why the Bank of England has indicated in the past that earnings growth of up to 4.5 per cent is consistent with an inflation target of 2 per cent.
- 1.54 From simply calculating the difference between the AEI and median settlement levels, as recorded by Industrial Relations Services, we show that the latest estimates for pay drift (to November 2006) give an annual rate of 1.1 per cent for the whole economy, 0.2 per cent in the public sector and 1.2 per cent in the private sector.

Figure 1.3: Estimated levels of Pay Drift, January 1998-November 2006



Sources: Office for National Statistics, Industrial Relations Services

⁹ An assessment of the causes of pay drift in UK organisations. Incomes Data Services, 2006. Available at <http://www.ome.uk.com/downloads/An%20assessment%20of%20the%20causes%20of%20pay%20drift%20in%20UK%20organisationsDec%202006.pdf>

- 1.55 The Health Departments argued that awards needed to take account of increases from restructuring of pay systems, recruitment and retention payments, local pay, net effect of progression payments and bonuses. They said that the expansion of the workforce meant that there were many staff at the bottom of pay scales and this would in turn lead to pressure on earnings until systems stabilised. The Department of Health forecast for pay drift for 2007-08 is 0.7 per cent on average across all hospital doctor grades, so a 1.5 per cent award would mean growth in average earnings of 2.2 per cent. For 2006-07, drift was estimated to be 3.6 per cent. No explanation was given for the substantial reduction in the forecast level of drift this year. The Health Departments stated that each 0.5 per cent increase in pay added £43 million to the pay bill. In Wales, each 1 per cent pay increase for hospital and community NHS staff would cost £23 million. They said that all elements of pay drift (except volume drift¹⁰) would impact on the average salaries of doctors and lead to increases in the overall size of the pay bill; this, in turn, could impact on the number of doctors that could be employed.
- 1.56 The BMA regarded pay drift as comprising a number of separate components, most of which it considered inappropriate for us to take into account in recommendations; i.e. incremental drift, grade drift, volume drift and variable pay (e.g. additional Programmed Activities (PAs), earnings from bandings). It said that pressure on these was in many cases downward at present.
- 1.57 Although the Health Departments told us that they were keen that we should consider the impact of the headline award on pay bill per head growth (which gives an indication of resulting changes in average earnings) and pay bill growth (which reflects the total cost to the employer), our view remains as set out in paragraphs 2.54–2.56 of our Thirty-Fifth Report. We do not believe that pay drift arising from increased overtime or other payments for higher volumes of work, nor from newly negotiated contracts, should be offset against the annual pay award. Moreover, we note that pay drift is in any case forecast to be much lower this year than last. However, we note that the existence of incremental scales means that, for most HCHS medical staff, the average increase in earnings will be significantly above the level of the uplift.

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

- 1.58 Our Thirty-Fifth Report, last year, recommended that supplements for London weighting should remain at their existing levels for 2006-07. Paragraph 2.26 of the report said: “unless the evidence in future years indicates that labour market conditions in London have changed, we do not intend to revisit this decision”. Nevertheless, NHSE and the BMA both requested an uplift in London weighting and we looked at this in connection with the evidence presented relating to junior doctors.
- 1.59 The parties continued to view London weighting from different perspectives. The Department of Health saw it as a labour market issue and considered that there was no case for an increase, while to the BMA and NHSE it was a question of cost compensation and they sought an uplift. For the BMA it also represented an equity issue in relation to other NHS staff.

¹⁰ Volume drift is the change in pay drift as a result of changes in the size of the workforce and the number of hours worked.

- 1.60 Both the Department of Health and NHSE agreed that London posts were attractive to junior doctors and the Department of Health stated that recruitment and retention were less difficult in London than elsewhere in the country, but that information on the number of applicants for junior London placements was not collected centrally. It told us that it often received letters from doctors unable to obtain training posts in their preferred specialty in London; however, it had not received any complaints about shortages of applicants for such posts in London.
- 1.61 NHSE argued that 63 per cent of respondents¹¹ to their questionnaire said that London weighting should be increased in line with the general award.
- 1.62 The BMA and NHSE both took the view that London weighting was a cost compensation issue, by which they appeared to mean that the payment was not intended to address a difficulty of recruiting in London, but simply to recognise the higher cost of living. Very few employers would take such an altruistic view. The BMA and NHSE argued that the fact that junior doctors received a reduced allowance if they had free accommodation showed that the purpose was cost compensation rather than recruitment. The BMA also argued that there was not a true labour market for junior doctors because they worked in rotations across large areas of the country and had little choice in the placements they were allocated.
- 1.63 However, we have received no evidence that there are problems with the recruitment and retention of junior doctors in London; indeed these posts are reputedly attractive to applicants for both professional and social reasons. Furthermore, for whatever reason London weighting is being paid, it would still make sense to reduce the allowance if free accommodation is provided, since the main purpose of London weighting is to offset higher accommodation or commuting costs that would otherwise deter staff from working in London. Providing free accommodation has the same effect.
- 1.64 We continue to view London weighting as a labour market issue, and as we have not received any specific evidence of problems of recruitment and retention in London, there is no reason to revise last year's recommendation to freeze London weighting. We therefore **recommend (recommendation 1) that supplements for London weighting should remain at their existing levels for 2007-08**. Unless the evidence in future years indicates that labour market conditions in London have changed, we do not intend to revisit this decision.
- 1.65 The arguments about the equity with other NHS staff raised by the BMA were also addressed last year in our Thirty-Fifth Report. Paragraph 2.27 stated:
- “The BMA raises the issue of equity with other NHS staff. As High Cost Area Supplements for other NHS staff under *Agenda for Change* have their basis in the position of the labour market, we do not consider that an equal pay issue arises for our remit groups”.

¹¹ This evidence is based on over 80 replies to a questionnaire sent to Chief Executives and HR Directors of NHS Organisations in England. If we assume that this went out to all 300+ PCTs, this represents a response rate of around 27 per cent. The type of organisation that replied is shown in the evidence but we do not know what proportion of respondents were from organisations that would be affected by London weighting. Nevertheless the low response rate means that the evidence should be treated with some caution.

- 1.66 Our position on this remains the same. The BMA chose to stay outside of *Agenda for Change* and we do not expect to see the issue of equity with *Agenda for Change* staff raised with us again in future years.

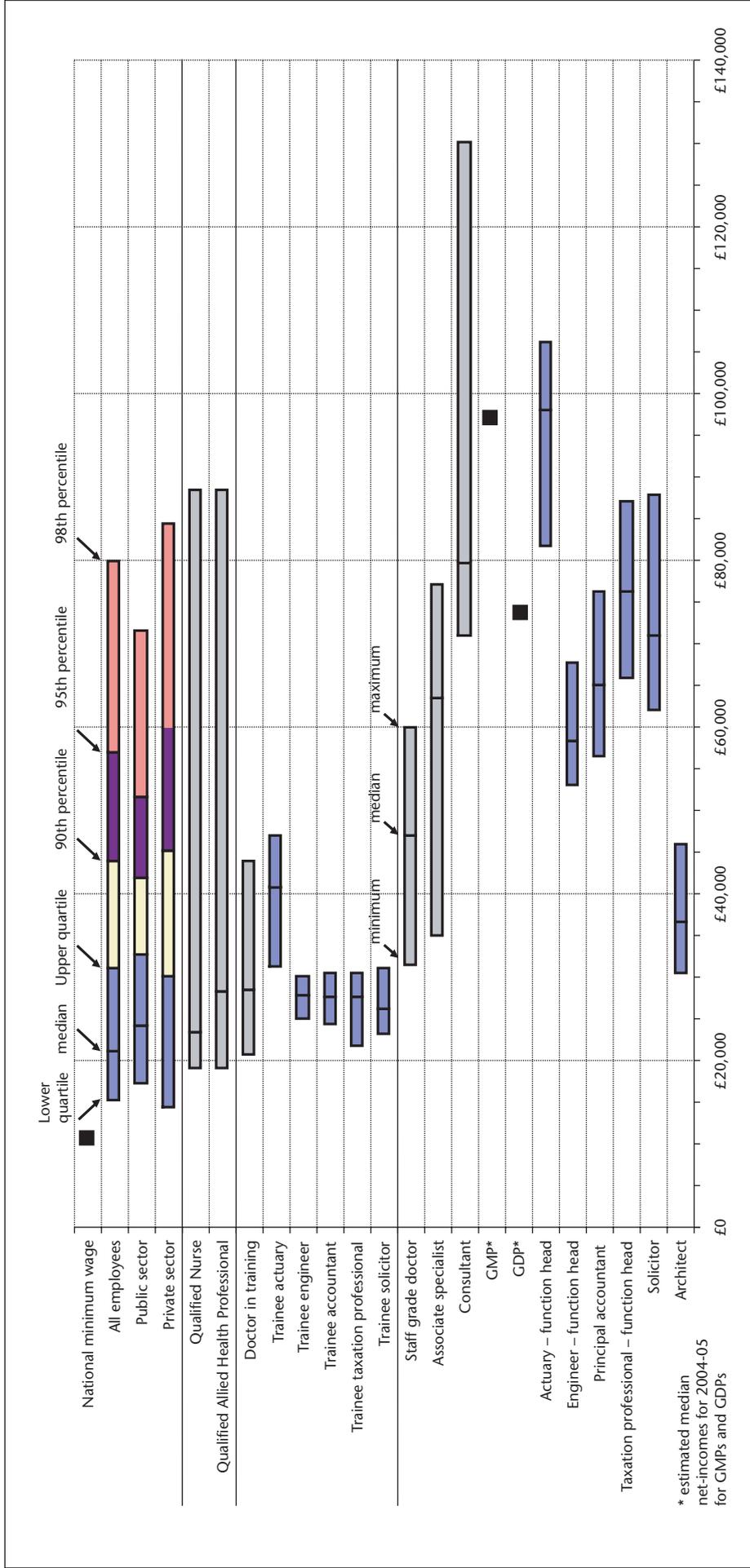
Pay comparability

- 1.67 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 to doctors, 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.

Pay levels

- 1.68 We show in Figure 1.4 the basic pay ranges of our remit groups in the HCHS sector as at November 2006, and the median basic pay levels within the ranges. For independent contractor GMPs and GDPs, we have indicated figures for median profit from NHS and non-NHS sources for 2004-05, the latest year for which actual accounts data are available from Her Majesty's Revenue & Customs. 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. Broadly we note that the pay ranges of our remit groups do not appear to be out of step with those of the comparator professions. We also note that the pay range of consultants is competitive when compared to other qualified comparator professions. While our assessment shows that there are no overall problems with pay levels, our detailed analysis indicates that there may be a problem with the starting level of basic pay for house officers, which appears low when compared to the external comparators. We return to this in more detail in chapter 7.

Figure 1.4: Basic pay ranges of DDRB's remit groups, November 2006, compared with the national pay distribution and other professional groups, full-time rates

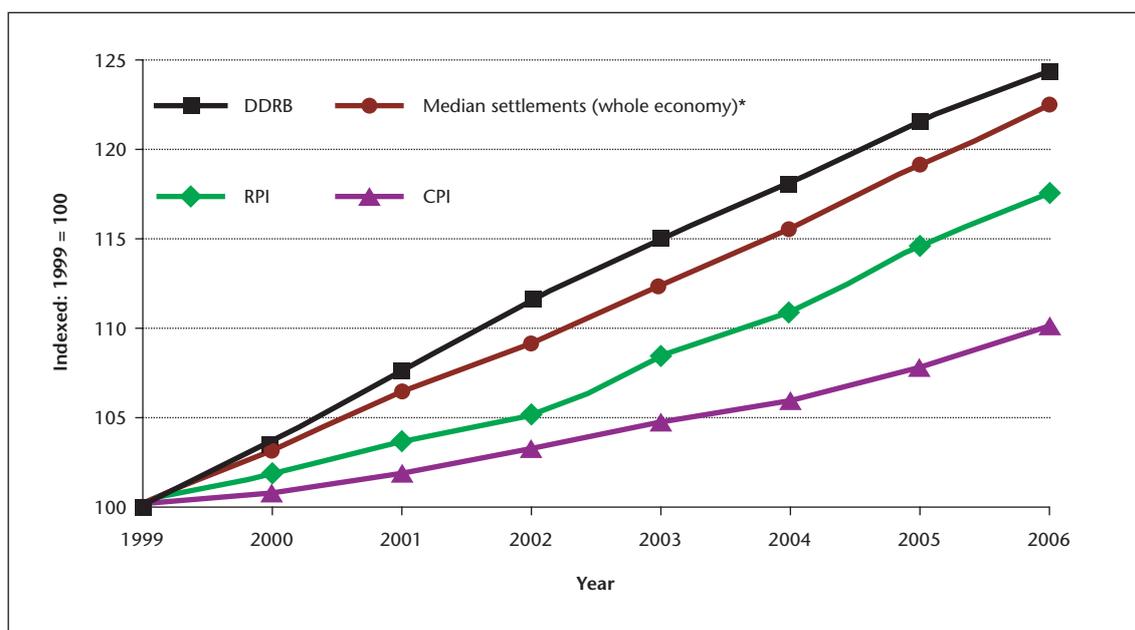


Sources: The Low Pay Commission; The Office for National Statistics, *Annual Survey of Hours and Earnings*, annualised weekly basic pay for full-time adults; Review Body for Nursing and Other Health Professions, *Twenty-First Report 2006*; Review Body on Doctors' and Dentists' Remuneration, *Thirty-Fifth Report 2006*; Remuneration Economics; The Hay Group pay database; Her Majesty's Revenue and Customs, Health and Social Care Information Centre, estimated median net incomes for 2004-05 (GDPs and GMPs).

Pay movements

- 1.69 We have also looked at how our basic awards over recent years have fared relative to settlements and earnings in the wider economy, and the main measures of inflation (CPI and RPI). However, it is worth re-emphasising that our recommendations are not linked, automatically or otherwise, to any particular macro-economic index.
- 1.70 As Figure 1.5 shows, had our main uplift been linked purely to inflation, doctors' pay would have been lower on average than it is now. Our remit requires us to take into account other factors, including information on affordability, recruitment and retention and wider general economic considerations.

Figure 1.5: DDRB main award, Settlements and Inflation¹, 1999-2006



Source: Office for National Statistics, Industrial Relations Services and DDRB reports

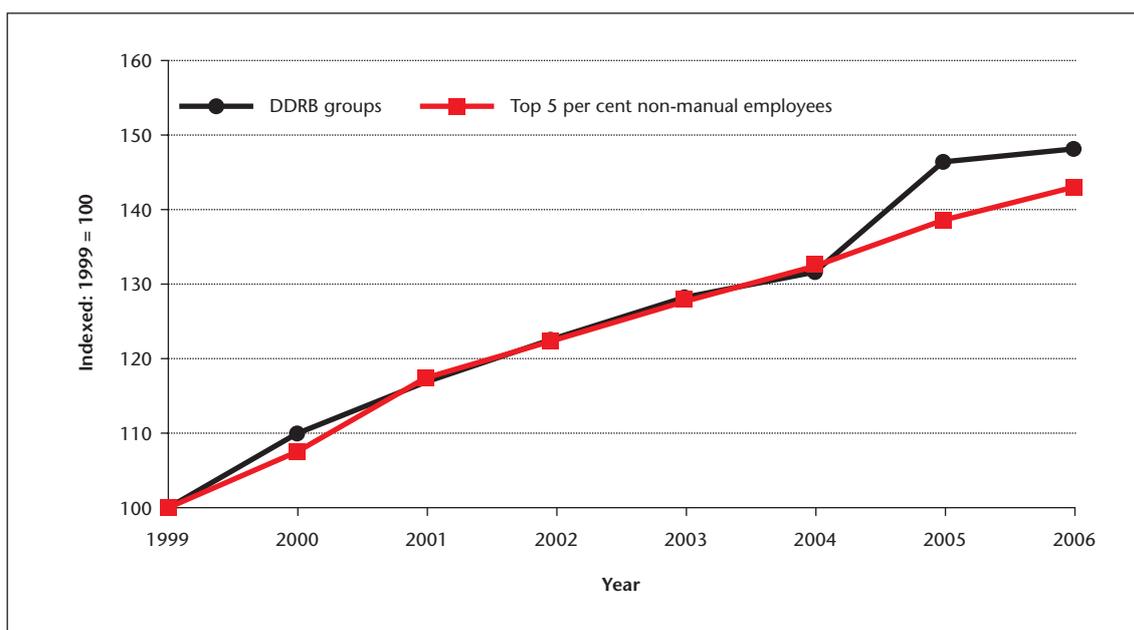
Note:

1. Annual rates for CPI, RPI and settlements at each April

* Settlements for the 3 months to April

- 1.71 As we did last year, we consider 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 1.6: Index of annual gross median earnings of DDRB's groups, 1999-2006, full-time rates



Source: Office for National Statistics, Annual Survey of Hours and Earnings

1.72 Figure 1.6 charts the earnings growth for our remit groups employed in the HCHS as a whole. With the assistance of the Office for National Statistics, we have been able to identify more precisely those employees who are specifically within our remit group, for example by excluding doctors and dentists working in the private healthcare sector. We note from this figure that the earnings growth of our remit groups has been broadly in line with that of the top 5 per cent of non-manual earners in the economy to 2004, and ahead of this group of earners since 2004. Again it is worth repeating that our recommendations are not designed to achieve broad linkage with another group of earners.

Pensions

1.73 NHSE and the NHS trade unions jointly announced the proposals for changes to the NHS pension scheme on 1 August 2006.¹² The formal consultation ran from 1 September to 30 November 2006. The key features of the change are that pension age will rise to 65 for new entrants; contributions will now be graduated according to income, ranging from 5 to 8.5 per cent of earnings; and the employer contribution will be limited to 14 per cent. It will remain a final salary scheme for employees. (Independent contractor GDPs and GMPs will continue to have a career average scheme with revalorisation.)

1.74 We received evidence from the Health Departments and NHSE on pensions, but the BMA said that it would be precipitate to take into account any perceived relative benefit of the pension scheme as the impact of the current proposals on the NHS Pension Scheme had still to be evaluated.

1.75 Our view is that pension is part of the total reward package. We have made no specific judgement on pensions this year, but think it is likely that pension provision is at least on a par with, if not better than, that for most similarly paid jobs in the public and private sector. Now that the shape of the new pension scheme is clear, we expect the parties to provide evidence to us on pensions as part of total reward.

¹² <http://www.nhsemployers.org/pay-conditions/pension-review.cfm>

Conclusions

1.76 The main conclusions we draw from our examination of the economic and general evidence are:

- there are no significant problems of recruitment, retention or motivation for our remit groups;
- we note that the Government is determined to bring inflation back down to its target of 2 per cent on the CPI measure and is concerned that higher pay settlements could lead to an upward inflationary spiral;
- notwithstanding the Government's prediction that inflation will come back down to 2.0 per cent, we are concerned that the RPI is currently at 4.0 per cent (on a three-month rolling average basis to December 2006) and on an upward trend and this will have an impact on our remit groups;
- the NHS does face serious funding constraints, despite the overall increase in funding, because of non-pay costs, accumulated deficits and new Government targets;
- pay drift has been a problem for the NHS in the past, probably mainly as a result of new contracts, but appears to be reducing. In any case it is not something we believe we should allow for, but movement up incremental scales means that HCHS medical staff will on average receive an earnings increase well above the level of the annual uplift;
- there is no case on grounds of recruitment and retention for an increase in London weighting; and
- although we are satisfied with the relative pay of doctors and dentists at senior levels, we have some concerns about the base salaries for the most junior doctors, which may be falling behind those of comparator graduate-entry professions. This could lead to problems with recruitment, retention and morale in the foreseeable future.

CHAPTER 2: MAIN PAY RECOMMENDATIONS FOR 2007-08

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. Both the Health Departments and NHS Employers (NHSE) favoured a generic pay uplift of 1.5 per cent across all staff groups, stressing that this was the maximum that could be afforded. The British Medical Association (BMA) sought a minimum of 4 per cent. For general dental practitioners (GDPs) the British Dental Association (BDA) wanted at least 4.3 per cent to be applied to their gross earnings base and 4.7 per cent for the Salaried Primary Dental Care Services (SPCDS). The Dental Practitioners' Association (DPA) believed that dentists should be at or near the top decile of earnings for hospital practitioners but gave no specific figure for an increase. The uplift proposals are covered in more detail in the relevant chapters.
- 2.2 NHSE initially requested an increase in line with the Consumer Prices Index (CPI) inflation target, which it had confirmed meant 2 per cent. However, it subsequently reduced this figure to 1.5 per cent after the information about the tariff became available and it had sought the opinion of the Department of Health on affordability.
- 2.3 NHSE also said that as all hospital doctors and salaried dentists had access to incremental pay scales, these should be factored into decisions about the uplift. It told us that for newly appointed consultants an increment was worth an average of 4 per cent of basic pay, excluding Clinical Excellence Awards (CEAs); for staff and associate specialists/non-consultant career grades (SAS/NCCGs) an increment was worth an average of 5–9 per cent of basic pay; and for doctors in training grades, 4–6 per cent of basic pay. However, we observe that not all increments are awarded every year, some are subject to satisfactory performance, and those on the maximum point of a scale receive no increments.
- 2.4 In supplementary evidence we asked the Department of Health for information on the distribution of our remit groups by grade and pay point so that we could assess what proportion of doctors would potentially receive increments. We were disappointed that the Department of Health was unable to provide us with up-to-date information on this. Instead, they said their best estimate showed that at least 50 per cent of consultants on the new contract would be entitled to an increment.
- 2.5 We do not agree that we should take incremental pay growth into account in reaching our general recommendations on the pay uplift and we uphold the view on incremental pay systems expressed in paragraph 2.55 of our Thirty-Fifth Report. We believe that if we were to offset the earnings growth arising from increments from our recommended award, it would undermine the fundamental principle on which incremental pay scales are based. Incremental scales reward increasing experience and loyalty to the employer. Effectively they mean that a worker starts on a salary below the rate for the job and with time rises to the full rate and even above it. We repeat that if Departments are concerned about pay drift caused by the incremental pay system, then they should negotiate a different pay system with the relevant parties, not ask us to hold down the level of the basic award. Nevertheless, as noted in the preceding chapter, incremental scales (and grade progression where applicable) mean that many Hospital and Community Health Services (HCHS) medical staff will receive an increase in earnings well above the level of the uplift in a given year.

- 2.6 The Health Departments have provided more information on the total reward package on offer to doctors and commented that pay is only one element of what they see as a generous total reward package that includes pensions, annual leave, flexible working, career development and access to training. They argued that if elements of the package were more generous than those provided elsewhere in the economy, or recent improvements in other elements of the total reward package, for example increased access to training or an increased relative value of pensions, then these should be offset against the level of the recommended reward.
- 2.7 We have discussed pensions in chapter 1, but the parties have not provided us with sufficient evidence on total reward, in comparison with other groups, for us to take this into account.
- 2.8 The Health Departments said that with a stable rate of inflation, on target at 2.0 per cent, and a lower rate of growth in spending, it was sensible to seek a realistic pay settlement. They believed that an affordable pay uplift was 1.5 per cent and that such an uplift would lead to an increase in average earnings for doctors of 2.2 per cent. In their view, a settlement of 1.5 per cent was appropriate given the healthy recruitment and retention position, the recent and continuing growth in average earnings and the need for an affordable uplift. The National Assembly for Wales and the Scottish Executive Health Department (SEHD) both supported the request for a generic 1.5 per cent uplift and endorsed the arguments for an affordable uplift. The SEHD also specifically said that they believed that such a rise would be fair.
- 2.9 The BMA explained that its 4 per cent figure was made up of a settlement rate for 2007-08 of 3 per cent, compounded by the extent to which the average 2.2 per cent settlement last year fell short of this figure, and then rounded up. It believed that a single rate of pay uplift across all NHS staff groups was inappropriate because medical staff were employed under different terms, with different pay scales and different ways and hours of working and training to other staff groups.
- 2.10 The parties' requests for uplifts for general dental practitioners and dentists working in Salaried Primary Dental Care Services are set out in chapters 4 and 5 respectively.

Pay recommendations for HCHS staff for 2007-08

- 2.11 In the light of all the evidence in chapter 1, we are persuaded that we should recommend a relatively low pay award this year.
- 2.12 The Health Departments and NHSE asked us to recommend the same percentage uplift, namely 1.5 per cent, for all the groups in our remit except GMPs. We disagree with this approach on two counts. First, as explained in chapter 1, we are not convinced that 1.5 per cent is the maximum affordable figure, although we do accept that this year's award should be restrained both on general economic grounds and for reasons specific to the NHS and our remit groups' recent pay history. Secondly, as shown in Figure 1.2 of chapter 1, the average rate of inflation over the period since our last report has been above 2.5 per cent, irrespective of the index that is used. In view of this, we believe that if we are to recommend an award that represents a cut in pay in real terms, certainly when measured against RPI inflation, then we should take particular account of the relative position of the lowest paid members in our remit group.

- 2.13 We have therefore this year decided to recommend a flat cash increase in basic pay of £650 for doctors in training and £1,000 for all other HCHS medical staff. According to evidence from the Health Departments, 97.5 per cent of doctors in training receive banding supplements, averaging an additional 56 per cent of their basic pay. We therefore estimate that the typical doctor in training will receive an increase of £1,014 (£650 x 1.56). We calculate that this proposed increase will increase the overall pay bill for HCHS medical staff by 2 per cent overall.
- 2.14 We believe that this recommendation weighted in favour of the lowest paid members of the remit groups will help to ensure that starting salaries for junior doctors do not fall behind those of comparable graduate-entry professions. It also recognises the need for future rebalancing of basic pay and overtime payments (banding multipliers), which will be needed in 2009 as a consequence of compliance with the European Working Time Directive. We deal with this point more fully in chapter 7.
- 2.15 We therefore **recommend (recommendation 2) that for 2007-08 a cash amount of £1,000 per annum be added to each point in the pay scale for consultants, associate specialists/non-consultant career grades (SAS/NCCGs) and Salaried Primary Dental Care Services (SPDCS) dentists; and a cash amount of £650 per annum be added to each point on the pay scale, for doctors and dentists in hospital training.**
- 2.16 It follows from our recommendation of a flat-cash award of £1,000 for all HCHS medical staff, that we do not believe there is scope to increase the value of CEAs, commitment awards, distinction awards and discretionary awards for consultants for 2007-08. We therefore **recommend (recommendation 3) that the value of CEAs, commitment awards, distinction awards and discretionary awards should remain at their 2006-07 rates.** We deal with other aspects of CEAs and similar awards in chapter 8.
- 2.17 **We recommend (recommendation 4) that the top and bottom points of the salary range for salaried general medical practitioners (GMPs) employed by Primary Care Organisations be increased by £1,000 per annum for 2007-08.**
- 2.18 We make separate recommendations for independent contractor GMPs and GDPs in chapters 3 and 4 respectively.
- 2.19 Our recommendation on London weighting is contained in chapter 1 and that on seniority payments for GMPs in chapter 3. **For the other fees and allowances on which we are required to recommend, unless they are specifically mentioned elsewhere in the report, we recommend (recommendation 5) that these be increased by the overall average percentage award of 2 per cent for 2007-08.**
- 2.20 Appendix A sets out the detailed pay scales arising from our recommendations.

Part II: Primary Care

CHAPTER 3: GENERAL MEDICAL PRACTITIONERS

Introduction

- 3.1 General medical practitioners (GMPs) can earn income from a wide variety of professional activities, but their core traditional role is the family doctor, working in General Medical Services (GMS), in the primary care sector of the National Health Service (NHS). Most GMPs are independent contractors for whom the new contract was introduced throughout the UK on 1 April 2004. It is a 'practice-based' contract, rather than a contract with each individual GMP. Money now follows the patient rather than the GMP and avoids the problem under the old contract whereby the loss of a GMP to a practice meant the loss of capitation payments for his or her patient list, unless the GMP was replaced. The contract includes the provision of essential services, additional services and enhanced services. Quality payments are an important part of the contract, with practices able to earn up to 1,000 quality points per annum under the Quality and Outcomes Framework (QOF).
- 3.2 Work outside the contract is covered by fees and allowances. These include: payments to salaried GMPs and GMP educators, and the GMP trainers' grant. The pay range for salaried GMPs is at Appendix A.
- 3.3 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, but doctors set their own fees for this work (see paragraphs 3.46–3.47).
- 3.4 The latest data shows that at the end of September 2005 there were over 42,000 GMPs in practices with NHS contracts in Great Britain.

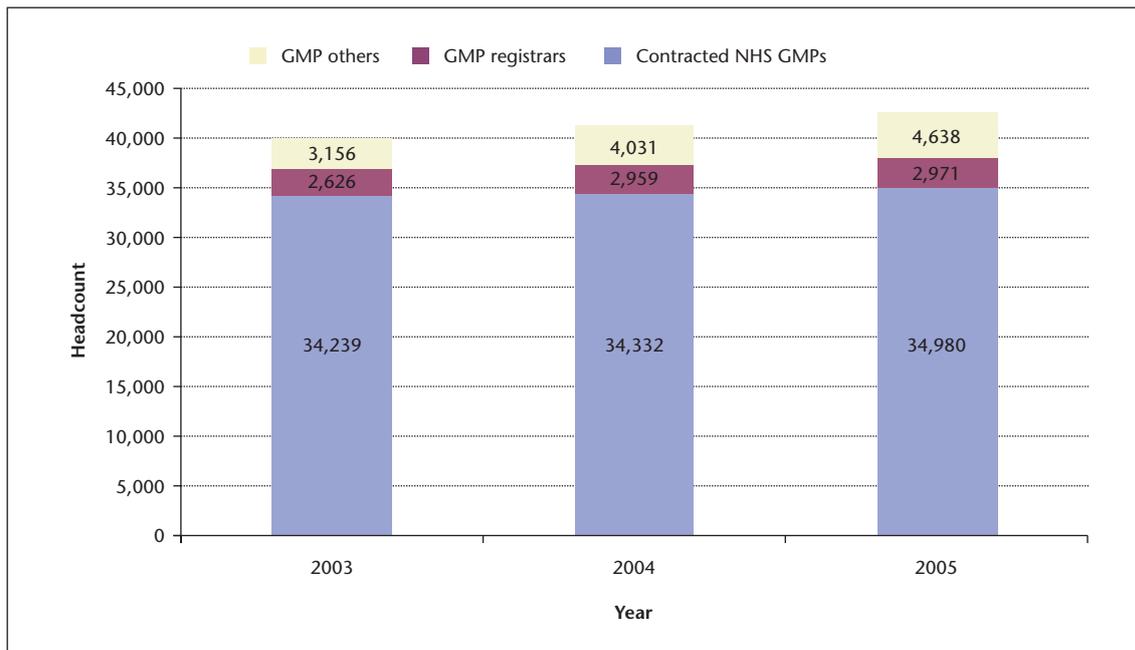
The evidence

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

Recruitment and retention

- 3.6 The Health Departments told us that there had been a strong growth in GMP numbers in the past two years, though many were flexible workers and salaried GMPs rather than partners. They said that by 2005 there were 64.9 GMPs per 100,000 population, compared to 56.8 in 1995.

Figure 3.1: Numbers of GMPs, 2003-2005, Great Britain



Source: Health and Social Care Information Centre

"GMP others" includes salaried GMPs and GMPs who work flexible arrangements

- 3.7 Figure 3.1 shows that the numbers of GMP registrars increased only marginally between 2004 and 2005. The Department of Health told us that the percentage of men choosing this career direction is now about half that of women. The Health Departments reported a strong view from recent surveys that general practice was now a more attractive career choice than hospital practice, because of the flexible arrangements, training and better pay for GMPs.
- 3.8 The National Assembly for Wales (NAW) told us that a decision had been taken to remove the 'Golden Hello' recruitment initiative scheme in Wales, as it was not encouraging doctors to work where they were needed most. However, the funding had not been removed from Local Health Board allocations, thus giving them more flexibility for other recruitment initiatives. The Scottish Executive Health Department (SEHD) reported that the Golden Hello scheme was still used to aid recruitment in Scotland, with additional payments for remote, rural and deprived areas. There had also been a television campaign to raise awareness of a career in NHS Scotland. SEHD said that it had good balanced working lives policies and 40 per cent of staff were part-time. It said that it no longer had a rigid age 65 retirement policy; instead it was looking to introduce phased retirement and step down arrangements.

Morale and motivation

- 3.9 The Health Departments reported that the National Primary Care Research and Development Centre 2005 job satisfaction survey showed that job satisfaction had increased and job pressure had reduced. GMPs had more positive views on the new contract than were indicated before its introduction, particularly in relation to pay and quality of care for patients. The BMA told us that the new contract had improved GMP pay and morale. This effect has not been quantified, but the BMA said that it had a good picture of the profession's general mood from committees, online discussion fora, road shows etc. However, the BMA said that the value and plight of GMPs working in community hospitals had been consistently disregarded by the Health Departments, and that this had had "an extremely negative impact on the morale of the workforce".

3.10 In chapter 1 (paragraph 1.25) we refer to the second national survey of working conditions and career grade doctors in Scotland, carried out by the University of Aberdeen¹. The study found that 80 per cent of GMPs who reported an increase in job satisfaction attributed this to their new contract.

Workload

3.11 The Department of Health told us in supplementary evidence that they had evidence² that GMP workload had decreased since implementation of the new contract.

3.12 The BMA told us that GMPs had worked extremely hard to implement the new contract and deliver high quality services. They claimed that the levels of workload were higher in Wales because of differences in the QOF points and the higher prevalence of disease amongst the Welsh population leading to more consultations per 1,000 patients. However, the Department of Health and the NAW both said that a differential had always existed between Welsh and English GMP remuneration, and we note that both the NAW and the Scottish Executive have devolved powers if they wish to amend the contracts in Wales or Scotland.

Independent contractor general medical practitioners

A brief history of the contract

3.13 The new contract for independent contractor GMPs came into full effect from April 2004 and the parties advised us that we were not required to make recommendations for the transitional year 2003-04, nor for 2004-05 and 2005-06. They were silent on what would happen after that.

3.14 In 2005-06 the contract delivered funding under six income streams:

Table 3.1: Income streams under the new GMS contract in 2005-06 – £billion

GMS global sum – paid to practices under national contract for essential services and basic pay, includes £334m minimum practice income guarantee	2.0
Personal Medical Services (locally negotiated contracts)	2.0
Quality and Outcomes Framework (QOF) – £125 per point up to 1000 points available	1.1
Enhanced services – incentive to shift work from secondary to primary care	0.7
Primary Care Organisations' discretionary payments e.g. seniority, premises, IT, out of hours	1.0
Dispensing doctors	0.9
Total	7.7

Source: Department of Health

¹ Fiona French et al. *Second national survey of non-training grade doctors in NHS Scotland: changes in job satisfaction, work commitments and attitudes to workload following contractual reform*. University of Aberdeen, December 2006.

² Sources included: Technical Steering Committee and National Primary Care Research and Development Centre.

- 3.15 In 2005 the BMA's General Practitioners' Committee (GPC) and NHSE agreed a number of changes to the contract including adjustments to the QOF points, reductions in payments for dispensing doctors, increased investment in Direct Enhanced Services, and an agreement to consider efficiency in future negotiations. There was no uplift in 2006-07. The parties agreed that the review of the contract package addressed the perceived value for money issues associated with the original contract³. In our Thirty-Fifth Report, we said⁴: "For our next review, we will await the parties' agreement as to whether we are required to make any remuneration recommendations for this group...".
- 3.16 The GPC and NHSE began a new round of negotiations on changes to the contract to take effect in 2007-08, but those negotiations effectively broke down on 8 January 2007. NHSE told us that the obstacle had been in obtaining agreement to deliver efficiencies across the contract in line with expectations placed nationally on all other NHS providers.

The parties' positions

- 3.17 In its evidence, the BMA argued for "an inflationary uplift across all payments in the contract ... to restore the value of the contract in 2007-08". The BMA suggested that the framework for providing an uplift to the GMP contract could be based on the formula used for the dental contract.
- 3.18 The Health Departments' position was made clear at the outset, notably in Lord Warner's letter of 30 October 2006 in which he said: "we believe that the DDRB has no role in the new contractual arrangements". However, his letter concluded: "Clearly should a negotiated agreement not be reached with the BMA all parties will need to think again about the continuing basis of the new contractual arrangements that we all agreed. That will be the time to explore any alternatives." In his letter of 15 December, following the oral evidence session, Lord Warner argued "there is no direct or sole relationship between contractual income and overall GMP remuneration". GMPs also received income from local contractual arrangements with PCTs or other trusts, and savings and incentives from practice-based commissioning. He estimated that up to 10 per cent of GMPs' income from the NHS came from sources outside the contract. He went on to argue that it was not feasible for us to undertake a comprehensive study of all the aspects necessary to make recommendations on GMP remuneration in time for the 2007 report. Instead he favoured a DDRB study in a longer timescale with recommendations that "could then play a full and appropriate part in 2008-09 contract negotiations". Copies of this correspondence are included at Appendix E.
- 3.19 The BMA rejected all these arguments in a letter of 9 January 2007 (included at Appendix E). It argued that the contract still determined at least 90 per cent of GMPs' pay. The BMA did not think it was technically difficult for us to recommend an appropriate contractual uplift for GMPs, nor did it accept that our remit was limited to contributing to contract negotiations.
- 3.20 In supplementary evidence the Department of Health told us that the Government saw no justification for uplifting GMP pay for 2007-08 because 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, job satisfaction had increased substantially and there was no evidence to suggest that there were problems with the recruitment and retention of GMPs.

³ Review Body on Doctors' and Dentists' Remuneration. *Thirty-Fifth Report 2006*. Paragraph 3.11.

⁴ Review Body on Doctors' and Dentists' Remuneration. *Thirty-Fifth Report 2006*. Paragraph 3.12.

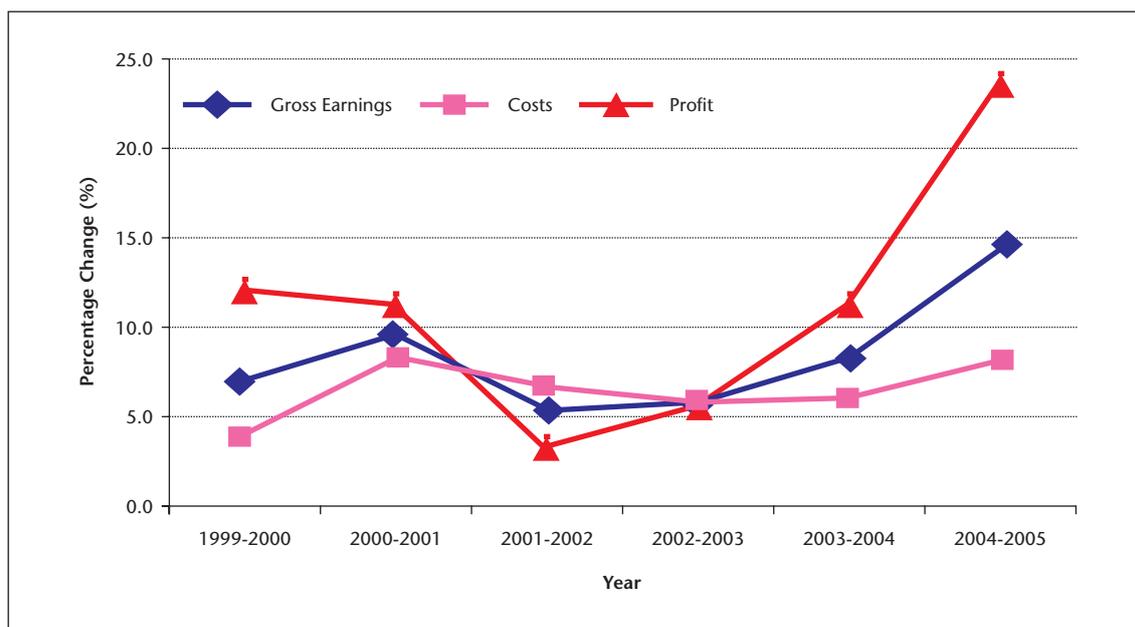
- 3.21 On workload, the Department of Health stated that the number of hours worked per week had fallen by approximately five and a half hours between 2004 and 2005; that the UK consultation rate for GMPs per patient had remained almost constant for ten years; that by 2005 there were 64.9 GMPs per 100,000 population, compared to 56.8 in 1995; and that most GMPs had exercised their right to opt out of providing some services, e.g. out-of-hours care.
- 3.22 The Department of Health told us in supplementary evidence that when considering any uplifts on GMP pay, scope should be allowed for changes to other GMP income streams, improving equity of income distribution through the Minimum Practice Income Guarantee, improvements to the QOFs and the achievement of efficiency by general practice, which must at least be consistent with Government expectations on other sectors within the NHS. The Department of Health also said that we should consider the need for “a balancing mechanism” to address the significant shift in the expenses to earnings ratio and over-delivery on the Gross Investment Guarantee.
- 3.23 NHSE also told us in supplementary evidence that it considered that a recommended uplift across the contract would be inappropriate, but suggested that we might make a recommendation concerning “indicative” levels of GMP pay. Although it did not believe that a negotiated settlement with the GPC was achievable for 2007-08, it was certain that discussions about efficiencies would have to take place. NHSE gave us three suggestions for recommendations on GMP pay: a recommendation on the outcome for the average percentage uplift to GMP net income; a recommendation on the average uplift for the global sum only (this was the recommendation that NHSE believed to be the closest to impacting on GMP pay); or a zero level uplift across the contract to allow for rebalancing of the levels of investment since the introduction of the new contract. NHSE stressed that the cost of the contract should be affordable and that our recommendation should leave flexibility for negotiations on efficiencies to resume.

Evolution of GMPs' earnings

3.24 Figure 3.2 charts the annual percentage changes in GMPs' gross earnings, expenses and profits over the years 1999-2000 to 2004-05. It shows that GMPs' profits have risen more rapidly than total gross earnings or expenses. Table 3.2 shows average levels of gross earnings, expenses and profits for GMPs under the GMS contract, as recorded in Her Majesty's Revenue and Customs tax return information and reported by the Health and Social Care Information Centre. It also shows the expenses to gross earnings ratio and this illustrates that the ratio of expenses to gross earnings has shifted from 62:38 in 1998-99 to 56:44 in 2004-05 and that profit has become a greater share of gross earnings. We initially received actual data on GMPs' gross earnings, expenses and profits to 2004-05. In later evidence the Department of Health provided us with some forecast figures for 2005-06 and 2006-07 and these showed that GMPs' profits were predicted to increase less rapidly in 2005-06 and then to fall by about 5 per cent in real terms in 2006-07. We do not know the basis for these later figures, nor whether the Department's forecasts will prove accurate. We therefore prefer to make our assessment on the current position, which we believe is as follows:

- GMPs have profited greatly from the new contract;
- the new contract has provided GMPs with workload benefits; and
- as shown in Figure 1.4 in chapter 1, GMPs' relative position in the income distribution appears to be favourable when compared with other professional groups.

Figure 3.2: Annual percentage change in GMPs' finances, 1999-2005, Great Britain



Source: Health and Social Care Information Centre, Technical Steering Committee

Table 3.2: GMP gross earnings, expenses and profit (GMS – Great Britain)

Year	Average gross earnings	Average total expenses	Expenses as % of gross earnings	Average profit	Increase in average profit on previous year
	£	£	%	£	%
1998-99	135,584	84,129	62.0	51,455	-
1999-00	144,946	87,326	60.2	57,620	12.0
2000-01	158,605	94,565	59.6	64,040	11.1
2001-02	166,965	100,851	60.4	66,114	3.2
2002-03	176,483	106,712	60.5	69,771	5.5
2003-04	190,942	113,354	59.4	77,597	11.2
2004-05*	218,394	122,514	56.1	95,880	23.6

Source: Health and Social Care Information Centre, Technical Steering Committee

* There is a discontinuity in 2004-05 because employer's pension contributions previously paid by PCTs were transferred to GMPs. The average gross earnings figure has therefore been reduced by the estimated maximum amount of employer's pension contribution so that the figures for 2004-05 remain comparable with previous years.

3.25 We recognise that the increase in GMPs' profits was at least partially intended. The new contract was negotiated at a time when there was a shortage of GMPs and, as the BMA points out in its evidence, a substantial increase in profits over the first three years of the contract was intended in return for modernisation and in particular the introduction of a large element of performance-related pay (QOF). The BMA argues that the Department of Health consistently underestimated the response of GMPs and that its own forecasts of the level of QOF points achieved by GMPs were more accurate. It seems clear that the Government believes that the contract has proved to be far more favourable to GMPs than it expected.

Independent contractor GMPs: pay recommendations for 2007-08

- 3.26 Before the parties negotiated the contract, our role was clear, as it was during the period when the parties agreed there was no need for our recommendations. There would be no problem if the parties had agreed a role for us, as they have done for the first three years of the dental contract. But the parties did not agree what would happen if negotiations on the contract failed.
- 3.27 The nature of the contract also makes it very difficult to predict what effect changes will have on GMPs' earnings. The evidence suggests that GMPs can and do adjust their behaviour to maximise their income. This is perfectly rational and understandable, but means that they tend to be high achievers in response to incentives. Moreover, they appear to be able to drive down their costs as a proportion of practice turnover, enabling them to increase profits. It is not clear how far they can continue this trend. It is therefore hard for us to know what the real impact of any recommendation will be.
- 3.28 Having considered the conflicting positions of the parties, with the BMA asking us to make a recommendation while the Government argued that we had no role, we have decided that we should make a recommendation for independent contractor GMPs. We came to this conclusion because our remit covers "the remuneration of doctors and dentists taking any part in the National Health Service". While the parties jointly can – and did – ask us not to make recommendations on remuneration when they have reached a prior agreement, we believe that, as long as independent contractor GMPs remain one of our remit groups, each side is entitled to expect that we will revert to making recommendations once the parties are no longer unanimous in asking us not to do so.
- 3.29 For next year, we look to the parties to reach agreement on our role in respect of independent contractor GMPs by the beginning of the round. If we are to make recommendations, then all parties should submit full evidence in good time to enable us to reach a well-founded decision. If, on the other hand, the parties choose to negotiate, they should agree at the outset, or at the latest, by the start of September, that no recommendations are required from us. Our role should not be to step in at the last moment when negotiations have failed, nor to make recommendations that will merely inform subsequent negotiations.
- 3.30 For 2007-08, on the basis of the available information about the considerable increase in GMP earnings in recent years and the other conclusions set out in paragraphs 3.24–3.25 above, we **recommend (recommendation 6) a zero increase in GMP pay this year.**
- 3.31 It is difficult for us to know whether our recommendation will lead to a reduction in real terms in the pay of contractor GMPs. That reflects in part the complexity of the GMS contract as well as GMPs' ability to manage, to a significant extent, their own level of pay. We urge the parties to use their best endeavours to enable a speedy resumption of negotiations on changes to the contract and ask the parties, if we are to be involved, to provide us with the fullest information to allow us to understand thoroughly all relevant matters for next year's review process.

Salaried GMPs

- 3.32 The Health Departments told us that there was no evidence to suggest that the current salary range for salaried GMPs employed by a Primary Care Organisation (PCO) was inappropriate, while NHSE sought an uplift in line with other directly employed doctors. The BMA said that many salaried GMPs did not receive regular salary increases and their pay did not always reflect their skills, experience and work. They said that the pay scale maximum was a barrier for many and asked us to recommend a significant uplift to rectify the current situation.

- 3.33 As we have said before, we should be surprised to find that contracts are being entered into which do not provide for some form of annual pay review, and we expect salaried GMPs to ensure that this aspect was covered in their contractual arrangements. As GMPs remain in demand, we consider that they should be able to negotiate appropriate arrangements when agreeing their terms and conditions. We consider that the top and bottom of the salary range for salaried GMPs employed by Primary Care Organisations should be increased by £1,000 per annum, and our recommendation is in chapter 2.

GMP registrars

- 3.34 We were told by NHSE that recruitment to GMP registrar training in England was strong, with four applicants per vacancy. There had also been no recruitment problems in Scotland since the new contract and the SEHD was confident that the Golden Hello scheme could deal with any new problems that might arise. The Health Departments and NHSE both requested that, as the average supplement paid to hospital doctors had fallen to 56 per cent in England and was 60 per cent in Scotland, the supplement for GMP registrars⁵ should be reduced to 55 per cent for new GMP registrars. The BMA said that the high level of expenses faced by GMP registrars meant that it was important to retain the supplement at a minimum of 65 per cent, requesting that the disparity in the level of hospital supplements throughout the UK be taken into account again this year.
- 3.35 The BMA gave details in its evidence of the increased costs for certification faced by GMP registrars, amounting to £2,878 during the GMP registrar year, which it believed had reduced GMP registrars' disposable income and represented a significant disincentive to general practice as a career. The BMA believed that the high level of expenses faced by GMP registrars meant that it was important to at least retain the supplement at 65 per cent. However, the Department of Health stated that General Medical Council fees had been factored into pay previously.
- 3.36 We are pleased that the Department of Health will be working with the Postgraduate Medical Education and Training Board (PMETB) on the case for the tax deductibility of PMETB fees, although we appreciate that this may not be clear cut. Nevertheless, our view is that all professions bear a cost for continuing professional development (CPD) and that it is the individual's responsibility to contribute towards these costs. The increased costs of certification are not a sufficient argument to keep the supplement at a higher level. The recruitment position for GMP registrars is strong and the banding supplements paid to hospital doctors have also fallen as their hours have reduced. GMP registrars receive a substantial supplement despite having a working pattern which is, on the whole, less intense and involves few if any additional hours compared to hospital doctors. Therefore, we think it is appropriate that the supplement for GMP registrars be adjusted downwards; although fairness also suggests that those doctors currently receiving the higher level of the supplement should keep their existing entitlement rather than see their pay supplement reduced. We **recommend (recommendation 7) that the supplement for new GMP registrars be reduced to 55 per cent.**

⁵ The supplement is paid to ensure that doctors who opt to train for a career in general practice are not financially disadvantaged in relation to hospital doctors in training. It was introduced at a time when recruitment into general practice was poor.

GMP trainers' grant

- 3.37 The Department of Health told us that an independent review of GMP trainers' pay had been completed in June 2006. The review concluded that the approach and methodology used for remunerating GMP training should be changed, but that the levels could not be proposed until the results of further research and evaluation were known. They said that they were in discussion with the Committee of General Practice Education Directors (COGPED) about further research work, though this might delay the development of the remuneration system for GMP trainers. Despite its reservations about the separate payment of £750 per annum for approved GMP trainers towards trainer-related CPD costs, the Department of Health said that it would be paid for a further year in 2006-07. It was liaising with COGPED to commission further work on trainees who required remedial training, a matter which was also raised by the BMA, but information was not available on the numbers of GMP trainees who needed such additional support, nor on the number of GMP trainers or practices involved.
- 3.38 We endorse the Department of Health's proposal to develop a new structure for the remuneration of GMP trainers and ask that when they take forward this work, they take due account of the two surveys carried out by the BMA on GMP training. In the meantime, the parties have asked us to recommend an uplift to the GMP trainers' grant. While the work is taken forward 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 (recommendation 8) that the GMP trainers' grant be increased by 2.0 per cent for 2007-08.**
- 3.39 We also note that the Department of Health are considering the BMA's proposal relating to employers' superannuation contributions and retrospective payments, and liaising with COGPED to take forward further research on funding multi-professional training.
- 3.40 The BMA also called on us to recognise the additional expenses incurred by practices in becoming and remaining training practices; these included premises costs, administration costs and lost opportunity costs in not being able to undertake additional work. It requested our support in ensuring that training practices without a GMP registrar or Foundation Year 2 trainee were still compensated for the time spent in maintaining a training practice, and we ask that this be considered as part of the study referred to above.
- 3.41 The BMA reported that few, if any, GMP trainers had received the £750 CPD payment for 2006-07, despite assurances that this would be paid. When we raised this matter with the Health Departments at oral evidence they expressed surprise and stated that they would investigate the matter. They subsequently said that when looking at their financial priorities, they expected Strategic Health Authorities to manage their commitments having full regard to our recommendation. We thank the BMA for drawing this matter to our attention and expect the Health Departments to take appropriate action to ensure that our recommendation is implemented.

GMP educators

- 3.42 'GMP educator' is a generic term for course organisers, GMP tutors and Associate GMP Directors. We commented last year when considering this group that we would like to receive evidence on the recruitment and retention position for this group. We received evidence from the Department of Health that COGPED advised that posts were being filled, although from a smaller applicant list, and that there were no significant recruitment and retention issues for this group. We therefore do not support the BMA's request for 5.9 per cent uplift for GMP educators. Last year we made a link between GMP educators and GMP trainers, since general practice is integral to the delivery of many of the Health Departments' policies. We expect the Health Departments to put a high priority on the training and development of recently qualified and existing GMPs, alongside the training of the next generation of general practitioners. **We therefore recommend (recommendation 9) that the GMP educators' pay scales should be uplifted by 2.0 per cent in line with our recommendation for the trainers' grant.**

GMPs working in community hospitals

- 3.43 As last year, the Health Departments told us that the remuneration for those working in community hospitals was determined locally. At oral evidence, NHSE told us that it was content with the arrangements for local commissioning of services, whilst recognising that there was a national variation in the level of fees. The BMA, however, called for a review of community hospital remuneration saying that there had not been a substantive review since 1979.
- 3.44 Given the potentially different roles for GMPs undertaking work in community hospitals, it seems clear to us that issues relating to the remuneration for this work are matters for local negotiation. Nevertheless, we draw the parties' attention to our comments in paragraph 3.63 of our Thirty-Fifth Report where we said:

"If the Health Departments believe that it is important for the whole of the NHS that community hospitals have an integrated role within the NHS, particularly in rural areas, then we would urge all three Departments to maintain strategic oversight of these hospitals and to look for any early warning signs that problems might be developing with service delivery because of funding issues".

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

- 3.45 Last year we recommended that doctors engaged in this work should set their own fees for 2006-07. NHSE told us that PCTs wanted fees and allowances to be centrally determined; they expressed concern that allowing doctors to set their own fees would make it difficult to monitor and manage the level of fees and amount of expenditure. At oral evidence NHSE said that doctors were bidding up the price for this work and it was becoming unaffordable. NHSE wanted a reliable fee structure, but PCTs currently had no infrastructure to negotiate fees. The BMA position was that doctors should continue to set their own rates for sessional fees.

- 3.46 We have not been provided with any evidence that would allow us to take an informed view on the level of these fees. As we have made clear in recent years, we would welcome moves by the parties to review the fees, but in the meantime, **we again recommend (recommendation 10) that doctors engaged in sessional work for community health services and work under collaborative arrangements should continue to set their own fees**, which we believe fits in with the trend for the local commissioning of services. If the parties wish us to take an alternative view, then they must demonstrate to us through evidence why and how we should make recommendations.

Seniority payments

- 3.47 The Health Departments said that there was no evidence to suggest that GMPs were less likely to continue working, or to return to general practice after drawing their pension, because of the value of seniority payments. They said that the issue was not raised during GMS contract negotiations and they proposed that seniority payments should remain at their current level.
- 3.48 We received no other evidence on seniority payments, but take this opportunity to remind the parties of the recent legislation on age discrimination and that they should consider whether seniority payments comply with the spirit of the law. **For 2007-08, we recommend (recommendation 11) that seniority payments remain at current levels.**

CHAPTER 4: GENERAL DENTAL PRACTITIONERS

Introduction

- 4.1 Our remit includes all independent general dental practitioners (GDPs) in primary care who are contracted to provide National Health Service (NHS) dental services.
- 4.2 We conduct this review in the first year of GDPs working under new arrangements for NHS dental services in England and Wales. Dental services in Scotland are changing too as a result of the implementation of the Scottish Executive's *Action Plan*¹. In last year's report we noted the emergence of different approaches to NHS dentistry in England and Wales and in Scotland. For this reason we have decided to present the evidence for Scotland later in this chapter.
- 4.3 First, we describe briefly the new arrangements for NHS dental services in England and Wales. From 1 April 2006 GDPs have 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 performers (individual GDPs) for a level of service. The level of service is measured in numbers of units of dental activity (UDAs). This is based on dental activity during the reference period October 2004-September 2005, this then being 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.
- 4.4 There is also a new system of patient charges. This has three bands and 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.
- 4.5 As at 30 September 2006, there were 20,285 dentists (performers) on open NHS contracts in England and 1,122 in Wales.

The evidence

- 4.6 This year, we received written evidence from the Health Departments, NHS Employers (NHSE), the British Dental Association (BDA) and the Dental Practitioners' Association (DPA). The evidence covers the first six months into implementation of the new arrangements and includes early evidence on contracts offered to dentists. The full 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 in paragraphs 4.47–4.58. Our responses to the other issues are set out in paragraphs 4.7–4.43.

¹ The Action Plan can be viewed at <http://www.scotland.gov.uk/library5/health/apioh-00.asp>

The dental strategy

- 4.7 As described in the Department of Health's evidence, the Government's high-level objectives for dental services and dental public health were to support the NHS and the profession to:
- deliver further improvements in oral health and reduce oral health inequalities;
 - improve access to NHS dental services; and
 - promote high-quality NHS dental services.
- 4.8 The Department of Health said that the new commissioning and contractual arrangements were designed to support all three objectives and that the abolition of the fee-per-item system should support dentists in carrying out simpler courses of treatment, with fewer interventions and would hence enable dentists to spend more time with patients and give more preventative health advice.

Change to new dental contracts in England and Wales

- 4.9 The Department of Health presented evidence on the contracts offered to dentists in the run-up to 1 April 2006, and associated service levels (UDAs). This showed the number of signed contracts, the number under discussion or rejected outright and, within the number of signed contracts, a further breakdown of those signed in dispute. 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. The Department of Health said that based on more recent information up to the end of July 2006, 41 per cent of contracts in dispute had gone through the dispute resolution process resulting in 98 per cent of those in dispute resolving to continue to provide NHS services. However, the Department of Health was aware that a number of dentists continued to question the assumptions of the new contract but it expected that practices that had been used to the fee-per-item system would adapt to the new ways of working in time and that this would free time, release capacity and lower costs. As far as the rejected contracts were concerned, the Department of Health said that the level of service associated with these providers (4 per cent of total UDAs) suggested that they had previously provided relatively low levels of NHS service. It said that in the four months from 1 April 2006, PCTs had commissioned a total of 3.5 million UDAs, which exceeded the total capacity that had been provided by those dentists who had left the NHS.
- 4.10 In Wales, 97 per cent of contract offers had been accepted, accounting for a little over 95 per cent of NHS dental services being provided prior to 1 April 2006.
- 4.11 The BDA and DPA also provided evidence on the implementation of the new contract. They collected information from surveys of their membership and this helped to put into context the statistics on contract offers which were provided by the Department of Health. The BDA told us that for the vast majority of practitioners, the new NHS contract had only been received days before implementation of the reforms and, while the Department of Health had given the profession little room to consider their options, it had in effect forced many practitioners into accepting the new NHS contract. It advanced the short time scale for the implementation of the contract as the main reason why around one-third of new NHS dental contracts had been signed in dispute.

- 4.12 Based on the BDA's survey of Local Dental Committee (LDC) Secretaries carried out in May 2006, to which 73 LDC Secretaries had responded (a response rate of 70 per cent), 9 per cent of dental practitioners were found not to have signed up to the new NHS contract. The BDA said that this was a similar proportion of rejected contract offers to that recorded in the Department of Health's statistics. The survey also found that around two-thirds of contracts signed in dispute had not been resolved at the survey date and, of those that had been resolved, 57 per cent had not been resolved to the practitioner's satisfaction. The BDA warned that, given the rate at which contracts signed in dispute were being resolved, it could be well into 2007 before all disputes were dealt with. The BDA and DPA drew our attention to two further surveys of their membership. The BDA had carried out an Omnibus Survey of 1,500 qualified dentists between July and September 2006, to which 676 dentists had responded overall (a response rate of 45 per cent). Of the dentists responding, 162 had signed the NHS contract in dispute and they had given a range of reasons for doing so including "the UDA target was too high", "full year funding not forthcoming", "additional contractual clauses added by primary care trusts" and the "loss of goodwill associated with signing the new contracts". The survey showed that although 47 per cent of those dentists with contracts in dispute had resolved these in favour of continuing to work in the NHS, the majority had done so feeling the outcome was unsatisfactory. The DPA had carried out a similar opinion survey of dentists between April and August 2006, to which 247 practices had responded overall and this showed that 42 per cent of dentists did not have the capacity to accept new NHS patients and that 74 per cent felt that they had signed the contract "under duress".
- 4.13 We note the early information on the take up of the new contract with interest and ask for an update of contract offers, including the number in dispute, and associated service levels for our next review. Overall, the percentage of GPs accepting the new contract is encouraging, and it would appear that PCTs have not faced undue difficulties in commissioning dental services to replace those dentists who have chosen not to sign the new contract, or to expand services. While the overall percentage of accepted contract offers suggests the change to the new arrangements has been successful, we are concerned by the high percentage of dentists who have signed the new contract in dispute as we must consider the motivation and morale of dentists. 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. We trust that contract disputes will be resolved to the satisfaction of both dentist and PCTs and we look forward to seeing evidence that the new ways of working are yielding measurable quality improvements, value for money, enhanced morale and better working lives for dentists, and maintaining or improving access to NHS dentistry.

Access to dental services

- 4.14 Improving access to NHS dental services is a Government priority. We consider access to dental services as there is a clear link with the recruitment and retention aspect of our remit. Now that PCTs 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.

- 4.15 The Department of Health provided us with examples of tenders recently undertaken by PCTs in areas where access to dentistry has been difficult. These suggested high levels of interest from dentists and corporate bodies and improvements in service levels and value for money. The Department of Health also drew our attention to the *NHS Dental Activity and Workforce Report* in March 2006², which showed an increase of more than half a million registrations between March 2005 and March 2006.
- 4.16 The National Assembly for Wales (NAW) said it was disappointed that 74,000 former NHS patients were now without a dentist following the reforms in April 2006. It had announced in June 2006 that £3 million was being made available to help LHBs in areas where access was still difficult.
- 4.17 NHSE pointed us to its survey of 124 PCT chief executives carried out in August 2006, which showed that half of the PCTs responding rated access to NHS dental care as either good or satisfactory and half rated access as poor.
- 4.18 We note the evidence on new tenders for dental services is encouraging. However, the evidence from the NAW, NHSE, and from our visits to PCTs last summer provides a contrasting picture concerning dental access. We believe the problem of access to dentistry is widespread and not confined to particular areas. As we indicated in 4.13 above, we trust that the new arrangements will allow more dentists to work or work more fully for the NHS across the country. The survey carried out by NHSE has been informative and we ask for the survey to be extended next year to include questions that monitor patient access to dental services in PCT areas and provide information on how PCTs are tackling access problems.
- 4.19 In oral evidence, the issue of a shortfall in planned income from patient charges arose. Through its impact on the overall funds for dentistry, it appeared that this might have an adverse effect on patient services and the commissioning of additional dentistry. While all parties agreed that the situation was still unclear and that the final position would not be known until June 2007, we are aware that a number of trusts have been reporting problems and that the Department of Health has issued a guidance memo to PCTs on the matter. In view of this, we would like the parties to monitor the situation closely and provide evidence on any problems this is creating for NHS dentistry services for our next review.

Recruitment and retention

- 4.20 The Department of Health pointed out that there were 21,111 dentists working in the NHS primary care services in England as of March 2006 and said that this number, which was 28 per cent more than the number in 1997, reflected among other factors the success of its programme to recruit an extra 1,000 full-time equivalent dentists between April 2004 and October 2005. In the Department of Health's supplementary evidence, we were provided with a more recent assessment of the dental workforce and this showed that at the end of June 2006, there were just under 19,500 dentists on open NHS contracts. Commenting on the reduction in the number of dentists during the transition to the new dental contract, the Department of Health said this was broadly consistent with its estimate that around one in ten dentists did not take up the new contract and those dentists were associated with proportionately low levels of NHS commitment (the 4 per cent figure noted in paragraph 4.9). It added that the new dental contract had demonstrated that the key measure of recruitment

² *NHS Dental Activity and Workforce Report. England: 31 March 2006.* The Information Centre, 2006. Can be viewed at: <http://www.ic.nhs.uk/pubs/dwfactivity>

and retention was not the number of dentists with NHS contracts, but rather the level of dental services that dentists provided. It said that the new contract now enabled it to have a consistent contractual currency (UDAs) for tracking changes in NHS dental workforce capacity. As at the end of September 2006, the Health and Social Care Information Centre reported that there were 20,285 dentists on open NHS contracts in England.

- 4.21 Our attention was also drawn to the measures begun in October 2005 to increase the number of undergraduate training places by 25 per cent and to the fourfold increase in training places for dental therapists, as set out in the Department of Health's evidence last year. The NAW commented that there had been a 13 per cent increase in the number of dental undergraduates in Cardiff since 2004 and there were 1,087 dentists in general dental practice/pilot Personal Dental Services in Wales (at 31 March 2006) compared to 975 (at 30 June 1999) when it was established.
- 4.22 The BDA said it continued to believe that there was an under-supply of full-time equivalent (*fte*) dentists across the United Kingdom of at least double the 1,850 *fte* dentists stated in the Department of Health's *Report of the Primary Care Dental Workforce Review* in 2003. It remained doubtful as to whether the recent recruitment drive had addressed the undersupply, and said that the overseas GDPs recruited to the workforce were only a short-term solution and they would begin to move towards private practice.
- 4.23 The BDA also highlighted to us some difficulties that vocational dental practitioners (VDPs) were having securing training places in dental practices under the new arrangements in England and Wales. The results of its Post-Vocational Training Employment Survey carried out in June 2006 showed that 18 per cent of VDPs had not yet found employment. It said that, while many of the overseas dentists who had recently entered the workforce had been placed in specific dental positions, home-grown VDPs did not have the assistance of the Department of Health to help them identify and secure employment. In Wales, the BDA found that LHBs were refusing to offer 'year two' contracts that would allow VDPs to stay in their training practices as practice performers.
- 4.24 In response to these difficulties, the Department of Health said that under the new arrangements the opportunities available to dentists at the end of their vocational training year would depend on where new vacancies were opening up. It said this represented a significant change for younger dentists who would now need to look more widely for service posts. It was not, however, aware of evidence of suitably qualified dentists being unable to find work because of overseas recruitment. The NAW replied that recruitment into dental vocational training was good.
- 4.25 We note that in less than a year there has been a marked change in the number of dentists with NHS contracts. Between the beginning of April and the end of June 2006, the number of GDPs in England fell by 8 per cent to 19,500, and between July and the end of September, it rose by 4 per cent to 20,285. The Department of Health attributes the initial fall in numbers in the workforce to those dentists who did not take up the new contract and it says that these dentists accounted for a small fraction of the overall provision, which it has since re-commissioned. We have not been provided with any information about why GDPs chose not to sign the contract and the type of practices affected. We do not know whether it has been mainly small practices that have, for one reason or another, left the NHS as the Department of Health claims. We note that the lost capacity varies across the country and, since we have not been provided with any information on where services have been replaced across the country, our concern is that there may be areas where there are insufficient numbers of providers of dentistry working in the NHS. The Department of Health says

that the key measure of recruitment and retention is now the level of dental services that dentists provide, as measured by UDAs. We do not necessarily agree with this view. 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 the size of 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 GDPs. We ask for greater clarity about the resources needed or the scale of patient demand from the Department of Health so that we can use this as a basis for assessing the issue of recruitment and retention. Since June 2006 the number of dentists in England with NHS contracts has grown. We hope this marks the start of an upward trend. The commitment of those GDPs operating within the NHS is a valuable resource that we are required to support, within the other constraints of our remit. We make our recommendations for 2007-08 with this in mind.

Capital support

- 4.26 The Department of Health reported to us that £100 million of capital funding had been made available over 2006-07 and 2007-08 for infrastructure improvements to NHS primary care dental services, following the announcement made by the Health Minister, Rosie Winterton, in May 2006. It said that this amount was on top of the £80 million capital funding it had already announced going towards modernising dental education establishments and supporting the 25 per cent expansion in dental training places.
- 4.27 We welcome the Government's decision to put £100 million into dental practices' capital costs over the next two years. We request for our next review a report on how and where the money is being spent. We will also be gathering feedback on this from GDPs in our next round of visits.

Practice cost allowance

- 4.28 The BDA has raised again the issue of a practice cost allowance. Its argument is that there are a number of factors that have raised or will shortly raise the cost base of dental practices: the new registration and training requirements of dental care professionals (DCPs), additional and stricter infection control guidelines and the move towards single-use items. The claim is that since this was not built in to the contract value, some adjustment is required. It has proposed that this be done via the introduction of a practice cost allowance and cites as evidence the Scottish Dental Practice Allowance, drawing our attention to what it believes has been its positive impact on recruitment, retention and morale of GDPs in Scotland. The BDA has asked us to support the introduction of a practice allowance for practitioners in England, as part of a package of recommendations. It has proposed that a figure of £97 million be made available for a practice cost allowance to be introduced in 2007-08.
- 4.29 In later evidence, the BDA provided us with an illustration of how our dental uplift formula could be adapted to include an element for practice costs and suggested some specific figures. It showed that, by making an adjustment to allow for the higher costs as a proportion of total gross earnings of practice owners, the weights that applied to the different components of the formula would be changed, and the cost base would be greater than 100 per cent. In response, the Department of Health said an additional increase in recompense for expenses could not be justified, particularly on top of the £100 million capital funding that had been made available.

- 4.30 The Scottish Executive Health Department (SEHD) provides dentists in Scotland with specific funding, the practice allowance, to help in the provision of high quality premises, health and safety requirements, staffing support and information collection and provision. There is a basic amount provided to each practice equivalent to 6 per cent of gross practice earnings. There is also an additional 6 per cent, payable quarterly, to practices that satisfy a criterion of NHS commitment. That it is the way that the health authorities in Scotland, which have freedom to set their own policies under devolved powers, have chosen to allow for these specific elements of dental costs. As the enhanced allowance is available only to those with enhanced commitment to NHS dentistry, it can be argued that SEHD implicitly sees this as a device to help maintain NHS commitment, even though this is not its explicit aim. However, the Department of Health in its evidence has pointed out that special funding of £40 million in 2006-07 and £60 million in 2007-08 has been allocated via Strategic Health Authorities to PCTs to give additional financial support to dentists. In its guidance notes³ it gives examples of how such funding may be used and these include support for capital costs for establishing new or expanding existing premises, modernisation of practice facilities, assisting in the provision of high-quality local decontamination facilities, and improvements in IT infrastructure. Among the criteria recommended to PCTs for use in their allocation of these funds is the degree of NHS commitment. While this scheme does not have the ongoing commitment of the Scottish scheme, it does appear to address the same issues.
- 4.31 We have considered the BDA's submission on how the formula might be adapted to take into account practice costs. Our comment is as follows. There are actually two quite separate arguments. The first is that new cost items have arisen since the contract was negotiated but no allowance has been made for these. Given the contract value, this would increase the ratio of expenses to gross earnings (the expense ratio) and so, other things remaining equal, reduce the practitioner's own income. If such new costs arise for practitioners, this would eventually be reflected in the existing formula by an increased expense ratio. However, to provide this in advance through an arbitrary scaling of the coefficients in the formula could not be justified on the basis of proper accounting evidence and would hence be open to criticism. Moreover, as the claim has to do with levels of costs and returns, adjustments to a formula that has to do with rates of change would not be the appropriate way to deal with such a problem. The second argument is that a practice cost allowance will act as a sort of 'loyalty bonus' that will cement commitment to the NHS contract. Even if one were to accept the logic of this argument, there remains the critical issue of the level of allowance that would be sufficient to maintain NHS commitment. Moreover, in the context of our formula and the Scottish model, such an allowance would be proportional to NHS commitment and so the gross contract value. This would scale up the computed uplift beyond that justified by increases in practice expenses and the target for GDP income. This raises potential implications for affordability. In view of this and our comments in 4.30, we have concluded that it is not appropriate for the general uplift formula (which applies to the contract values of a range of dental providers, including individual GDPs, partnerships, practices or corporate bodies) to be changed in the way suggested by the BDA.

³ *Guidance: Arrangements for Allocating Capital Funding for Primary Care NHS Dentistry*. Gateway Reference 6844. Department of Health, 2006.

Practice goodwill

- 4.32 The BDA has raised the issue of practice goodwill this year, saying that under the new arrangements there is no guarantee that PCTs will commission NHS dental services from a dental practice if a new owner takes control. However, the Department of Health told us that in the case 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. It also said it was advisable that contractors considering selling their practices involved PCTs in the discussions as soon as possible.
- 4.33 We accept that there is a legitimate issue that needs to be considered here. While the Department of Health say that PCTs would typically seek to commission dentistry from whoever took over the practice, it was our understanding from oral evidence from the Department of Health that this is not guaranteed under the existing rules. An implication of this is that an additional business risk has emerged that would reduce the asset value of an existing practice. Consequently, existing practice owners may face an unanticipated capital loss because they are no longer certain to be able to sell on part of the asset base – the NHS practice list and UDAs. In view of this we would ask that both parties carefully monitor the position and we would like to see them submit what evidence is available on this for our next review.

Seniority payments

- 4.34 Seniority payments are additional sums that are paid to GDPs who have practised in the NHS for at least ten years and have practised for five years within the last ten years, and who have reached the age of 55. They are designed to reward GDPs for staying within the NHS and to compensate them for the perceived reduction in their ability to perform NHS dentistry at the same pace as younger colleagues. Under the new dental arrangements, there is an interim seniority payment scheme in operation, which disappears from 1 April 2008. The BDA raised the issue of an experience related payment scheme to replace seniority payments in 2008-09 and the Department of Health told us that it had not yet taken a decision on whether there will be a longer-term replacement for seniority payments. We remind the parties that if they decide that an additional experience-based allowance is necessary, they should also consider its compliance with age discrimination legislation.

Practice expenses

- 4.35 In making our judgement on the uplift to GDPs' contract values we take into account both dentists' own remuneration and their practice expenses. In the absence of any specific comprehensive index of dental expenses, we have used a formula to derive the expenses element and combined expenses with dentists' take home pay. Our formula is set out in paragraph 4.52.
- 4.36 Concerning practice expenses, the parties have offered opposite views on the likely movement of dental expense inflation under the new arrangements, with neither side being able to support their claim with detailed data. We have received actual data on dentists' earnings and expenses for 2004-05 based on Her Majesty's Revenue & Customs tax return information and reported by the Health and Social Care Information Centre (HSCIC). These data cover dentists who worked under the old General Dental Services (GDS) contract and their earnings and expenses from NHS and private sources.

- 4.37 The Department of Health said it believed that under the new contract dentists would be carrying out simpler courses of treatment and this would mean reduced use of consumables and appliances, lower expenses and higher net incomes. It also argued that as consumables and laboratory costs formed around 30 per cent of expenses and there was a 5 per cent reduction already built into dentists' baseline activity, as measured by UDAs, this should lead to an expense saving of 0.75 percentage points.
- 4.38 Commenting on the formula, the Department of Health noted that in our 2005 report we had based the increase in staff costs on the change in dental nurses' earnings while in our 2006 report we had used the change in earnings of staff employed in the Healthcare and Related Personal Services sector. It said there would be year-to-year variations in whatever pay indicators that were chosen and urged us to take a consistent approach when determining this component of the formula. We address this issue in paragraph 4.55 below.
- 4.39 The BDA said that it continued to believe that there would be upward pressure on dental practice overheads. First, it pointed to the upward pressure on the wages and salaries of DCPs coming from two sources: the shortage of available staff and the need to recruit more highly-qualified staff. Second, it pointed out that there would be additional costs to be borne by practices because of dental nurses needing (from July 2006) to undergo training and acquire qualifications in order to meet the registration requirements of the General Dental Council. Third, it said that it expected compliance with best practice guidelines on infection control and clinical governance would impact on practices' capital, training and revenue costs. The BDA said it remained concerned at our retrospective approach when assessing the movements in dental expenses. It urged us to adopt a more forward-looking approach in determining our recommendations.
- 4.40 The data on dentists' earnings and expenses revealed that:
- dentists earned more from private work than from the NHS during 2004-05. Overall, dentists working under the GDS earned 48 per cent of their gross income from NHS work compared with 54 per cent in the previous year;
 - average income, after expenses have been deducted, was highest for 2004-05 among dentists who were practice owners. They received an average annual income of £105,000. Dentists who used the facilities within another dentist's practice earned less; on average £57,000. Dentists who practised alone earned an average of £86,000, with those that were most committed to the NHS earning £84,000 and those that were less committed earning £89,000 on average; and
 - for dentists who practised alone, average expenses for their NHS and private work combined were shown to be £120,000 in 2004-05 (accounting for 58 per cent of their overall income). In the previous year, expenses had accounted for 56 per cent of overall income. Average expenses incurred by practice owners were £224,000 in 2004-05 (accounting for 68 per cent of their overall income), and for users of other dentists' facilities it was £29,000 (34 per cent of their overall income).

- 4.41 The detailed breakdown of expenses for 2004-05 for dentists who practised alone was: business⁴ (9 per cent), premises (8 per cent), salary and wages (31 per cent), car and travel (2 per cent), interest and depreciation (6 per cent), net capital allowances (4 per cent) and other items⁵ (39 per cent).
- 4.42 We are disappointed that once again there is no agreement on dental practice inflation. Both the Department of Health and the BDA ask us to take a forward look when assessing the movements of dental expenses, but neither side has yet been able to provide us with actual data on expenses under the new arrangements to allow us to do so. For example, had we been presented with a definitive and quantified view of the costs of compulsory dental nurse registration requirements then we could have factored this into our thinking on the uplift. Furthermore, if we had received actual data that showed under the new arrangements there had been, so far, a reduction in laboratory costs and the use of consumable goods, we then could have taken this into account in our consideration on expenses. Since we do not have these data, we base our recommendation for dental expense inflation on the most recent pay and price measures and we continue to believe a formula-based approach provides an appropriate framework for considering our uplift. 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. As such, an agreement is in the interests of both parties and we believe they must have a shared interest in reaching 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. We therefore **recommend (recommendation 12) that the parties work together, or commission joint independent work, on dental expenses** and look forward to receiving agreed evidence on this next year.
- 4.43 We note from the HSCIC data this year the inclusion of expenses and earnings information for different types of GDPs, although the data cover GDPs working under the old GDS contract for 2004-05. 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. These are set out in more detail in paragraph 4.52.

Dentistry in Scotland

- 4.44 As in paragraph 4.3, we begin by describing briefly arrangements for NHS dentistry in Scotland. 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 available to dentists a number of allowances funded centrally.
- 4.45 As at 31 March 2006, there were 2,301 GDPs registered to provide NHS treatment in Scotland.

⁴ 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.

⁵ Includes cost of sales, i.e. the cost of purchasing raw materials/items sold.

4.46 SEHD said that after the first year of the *Action Plan*⁶, 18 out of 19 milestones had been met or were on schedule to be completed. It said that it was committed to investing an additional £150 million by 2007-08 in order to achieve the goals of the *Action Plan*. It reminded us of a number of allowances for GDPs that were designed to assist recruitment and retention. There had been an increase in the number of vocational dental trainees who had taken up the vocational trainee allowance. There had also been a rise from 86 per cent in 2004 to 91.5 per cent in 2006 in the percentage of dental graduates from Scottish dental schools taking up training posts in Scotland. It said the practice allowance could be claimed by a practice and was based on the gross NHS practice earnings. This allowance was intended to help practices with providing high quality premises, meeting health and safety standards, supporting staff and collecting and providing information.

Pay recommendations for 2007-08

4.47 The Department of Health said as PCTs were currently facing no significant difficulties in expanding services and could commission additional services at improved levels of value for money, this suggested that dentists and corporate bodies were attracted by the contractual and remuneration packages available for NHS work. It said it considered that an increase of gross remuneration of 1.5 per cent would fairly reflect the likely reduction in expenses flowing from the new contract arrangements. It asked us to recommend a simple uplift of 1.5 per cent to be applied to the GDS dental contract values. The NAW requested an uplift of no more than 1.5 per cent and the SEHD said it would welcome an uplift of 1.5 per cent on dentists' fees.

4.48 In the light of the issues raised in its evidence, the BDA asked us to recommend at least a 4.3 per cent uplift on gross earnings for GDPs for 2007-08. Its calculation for the uplift was based on our formula approach from last year and took account of published HM Treasury forecasts⁷ for average earnings growth (of 4.7 per cent) and the Retail Prices Index (RPI) (3.7 per cent). It said that the percentage uplift of 4.3 per cent, together with its requests for the introduction of a practice cost allowance and seniority payments, would stabilise the current workforce and retain the current levels of NHS commitment.

4.49 The DPA said it was its opinion that the level of remuneration sufficient to recruit, maintain and motivate dental practitioners was at or near the top decile of earnings – the top decile for health professionals started at £111,668, according to the Office for National Statistics' 2006 Annual Survey of Hours and Earnings.

4.50 As we noted in paragraph 4.44, there are now two dental systems operating in parallel within Great Britain. Scotland has retained the fee per item system. 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 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/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 thus amenable to analysis and a formula-based approach to the uplift.

⁶ Can be viewed at <http://www.scotland.gov.uk/library5/health/apioh-00.asp>

⁷ www.hm-treasury.gov.uk/forecasts as at September 2006.

4.51 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.⁸ While the HSCIC analysis of Revenue and Customs' returns might allow one to infer 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.

4.52 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 suggestions for its improvement or even replacement. The formula involves weighting together the increase in the practitioner's personal remuneration and the increase in GDPs' expenses. The weights that were used last year were derived from the HSCIC's survey of dental earnings and expenses, based on Revenue and Customs 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 HSCIC data, the weights are 31 per cent and 69 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 own remuneration, 17.05 per cent (31 per cent of 55 per cent) to the appropriate indicator of staff costs and 37.95 per cent (69 per cent of 55 per cent) to our indicator of other practice expenses. The formula is set out as follows:

$$\text{Uplift}_{2007-08} = 0.45*x + 0.1705*y + 0.3795*z;$$

where:

x = increase in GDP remuneration;

y = increase in staff costs;

z = increase in other costs.

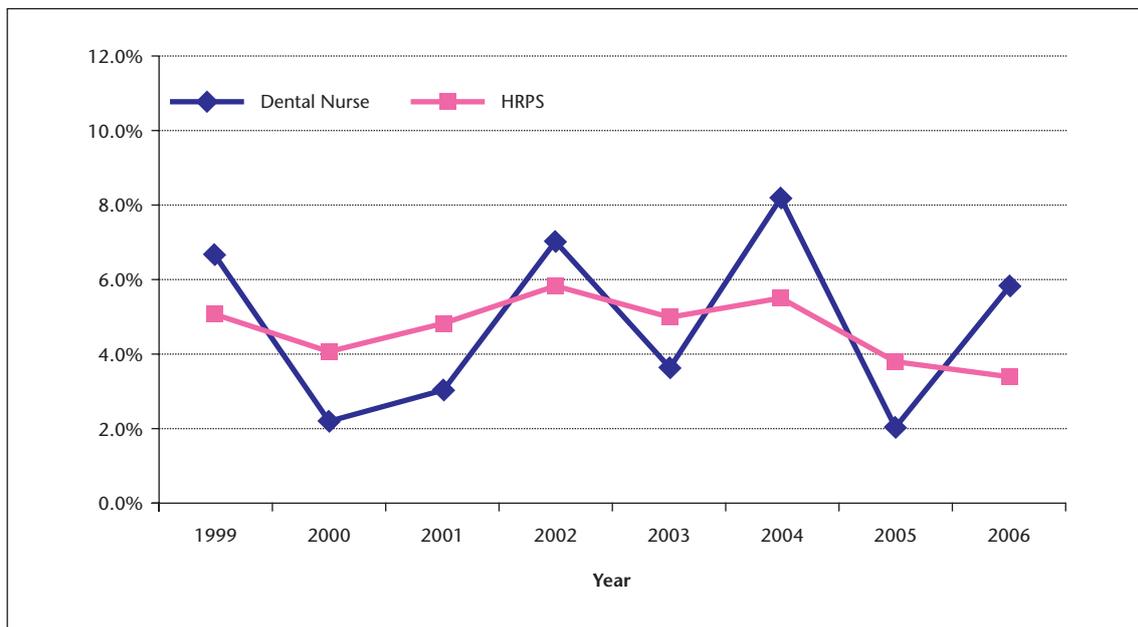
4.53 In looking for an appropriate indicator for the increase in GDPs' personal remuneration (x), we believe this year that they should share the average uplift that we have recommended for our remit groups working in the Hospital and Community Health Service (HCHS) sector. We calculate the average increase to be 2.0 per cent.

⁸ Though we should note that staff may be a fixed cost for many practices. Thus a practice may have a dental nurse, and over a range of levels of output, that nurse will be sufficient and so the fixed cost (salary) is given and the average cost falls as output rises until at some point the practice has so increased in size as to require the employment of a second nurse.

4.54 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. Two points have been put to us in evidence. The dental profession has urged us to take a more prospective view. However to do so would involve us in making forecasts for one year ahead on the specific elements and we do not think that it is appropriate for us to do so. On the other hand, the Department of Health has argued that the straight cost pass-through feature of our formula means that practitioners will have no incentive to bargain with their suppliers so that expense inflation becomes institutionalised. While it is true that the formula does pass through costs into contract values, this argument fails to take into account timing. The point about our retrospective approach to the expenses component is that cost increases are only passed on with a one-year lag. This gives dentists a financial incentive to drive a bargain with the suppliers of their inputs in the current round of negotiations⁹. The formula therefore has appropriate incentive properties built in to it.

4.55 The Department of Health has also commented on the appropriateness of the indicator used to represent staff costs. Last year, we used the change in the hourly rate of pay for those employed in the Healthcare and Related Personal Services (HRPS) sector as recorded by the Annual Survey of Hours and Earnings. We continue to think that this measure is more appropriate than the measure that monitors changes in the earnings of a specific group of dental nurses. Our analysis of the HRPS and the dental nurse data is given below.

Figure 4.1: Annual percentage change in gross median hourly pay of dental nurses and employees in the Healthcare and Related Personal Service Sector, 1999-2006

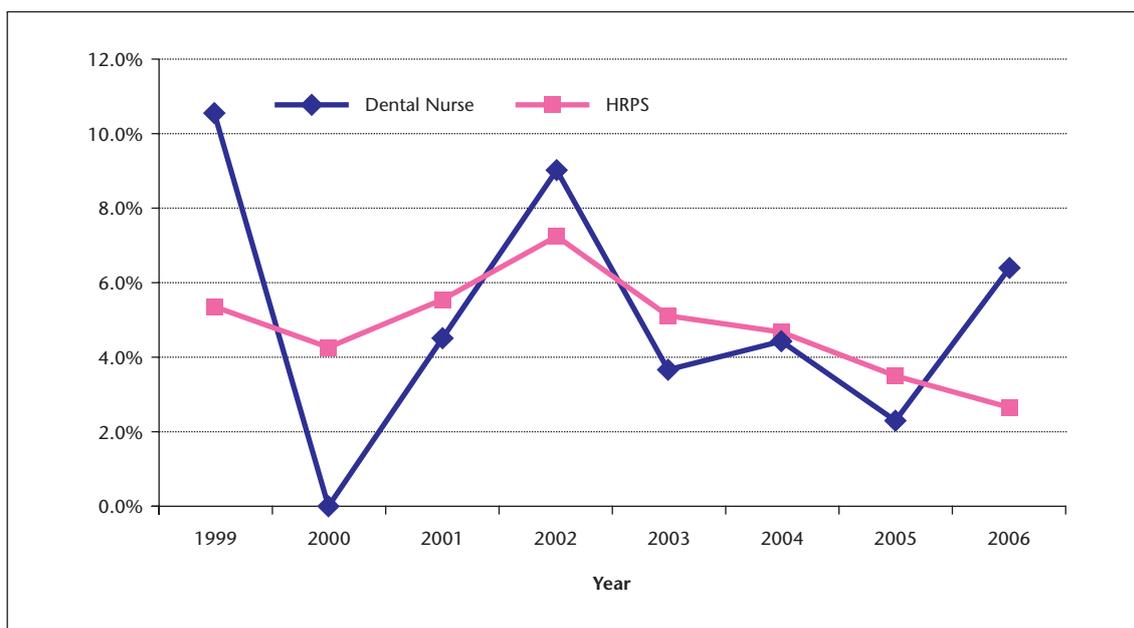


Source: ASHE, ONS

HRPS – employees in the Healthcare and Related Personal Services sector

⁹ In passing, we would point out that the formula can be readily adapted to allow for (a) incomplete cost pass through and (b) a target for efficiency savings (productivity growth).

Figure 4.2: Annual percentage change in gross mean hourly pay of dental nurses and employees in the Healthcare and Related Personal Service Sector, 1999-2006



Source: ASHE, ONS

HRPS – employees in the Healthcare and Related Personal Services sector

- 4.56 As Figures 4.1 and 4.2 show, the data for dental nurses are rather erratic. This may indicate that the labour market for dental nurses is volatile, or may reflect the small sample size underlying the data. However, what is clear from these figures is that the HRPS data track the trend in the dental nurse data closely and can thus also act as a proxy for a smoothed series for dental nurse pay. The other feature of the HRPS series is that the median and mean have been declining over the last three years, with the latter falling more rapidly than the former. This suggests that the underlying pay distribution of those employed in the HRPS sector is skewed and that the median (HRPS) figure, rather than the mean figure, is the appropriate measure for staff cost inflation. For the year to April 2006, the annual percentage change in the median hourly rate of HRPS employees was 3.3 per cent and this is the figure that we have used this year to represent staff cost inflation (y).
- 4.57 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 4.0 per cent, the average change in the RPI for the last quarter of 2006.
- 4.58 Using our recommended uplift for GDPs' personal remuneration and our recommended increase for expenses in the uplift formula gives an overall percentage rise of 3.0 per cent. We therefore **recommend (recommendation 13) that an uplift of 3.0 per cent be applied to the gross earnings base under the new contract for 2007-08 for GDPs in England and Wales.** This year we are **recommending (recommendation 14) that the uplift of 3.0 per cent also apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland.** However, as we have indicated in paragraph 4.50 above, the two dental systems continue to diverge and it may be that in future years we shall find it necessary to consider Scottish dentistry separately and to make a separate recommendation.

CHAPTER 5: SALARIED PRIMARY DENTAL CARE SERVICES

Introduction

5.1 Salaried primary care dentists work as community dentists, salaried Personal Dental Service dentists, Dental Access Centre dentists and salaried general dental practitioners in the National Health Service (NHS). These NHS dentists, employed in the main by Primary Care Trusts, represent about 10 per cent of the primary dental care workforce. 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. Salaried dentists 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 and they are often referred to as the 'safety net'. For future rounds, we would be interested in receiving data on the number of SPDCS dentists with a breakdown and analysis of the various types of dentists, as the data provided by the Health and Social Care Information Centre (and reproduced in our report at Appendix C) does not appear to clarify the total number of SPDCS dentists.

The evidence

5.2 Evidence on the SPDCS was provided to us this year by the Health Departments, the British Dental Association (BDA) and NHS Employers (NHSE). The full 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 review of the SPDCS and the subsequent negotiations on new pay, terms and conditions for salaried dentists.

The review of the SPDCS

5.3 Following consideration of the responses to the *Creating the Future*¹ consultation, the Department of Health asked NHSE to negotiate directly with the BDA on new pay, terms and conditions for salaried dentists in England. The aim of the new arrangements would be to support the modernisation of careers, support high quality patient care, and would allow an increase of up to 10 per cent in the pay budget for salaried dentists. NHSE and the BDA provided us with a joint letter that told us that negotiations were proceeding, and progress had been made in obtaining detailed information about the current workforce, appraisal and job planning and identification of competencies to underpin a single pay spine for all salaried dentists. The parties were aiming to complete negotiations to allow implementation of the new arrangements for 1 April 2007.

5.4 The Scottish Executive Health Department told us that it had also undertaken a review of the salaried services², and that it was with Ministers for consideration. The National Assembly for Wales was following up its own consultation *Bridges to the Future*³. It said it had observer status on the English negotiations and that the outcomes would be assessed for their suitability for introduction in Wales.

¹ *Creating the Future: Modernising Careers for Salaried Dentists in Primary Care*. Department of Health, December 2004.

² *Review of Primary Care Salaried Dental Services in Scotland*. NHSScotland, October 2006.

³ *Bridges to the Future: a consultation on the future of Salaried Primary Dental Care Services in Wales*. Welsh Assembly, August 2005.

The pay uplift

- 5.5 The BDA asked us to recommend that salaries and allowances for SPDCS dentists be increased by 4.7 per cent, which it said was in line with its requested uplift for general dental practitioners. This uplift request was on top of the increase that would be delivered by the current review of up to 10 per cent. The BDA said it firmly believed that those involved in the provision of primary care dentistry should be equally rewarded. The Health Departments also sought an increase for salaried dentists equal to that of general dental practitioners, albeit a lower increase of 1.5 per cent. NHS Employers' original request for an uplift in line with the inflation target was amended to a request for a 1.5 per cent uplift, as this was considered the most that was affordable without risk to jobs and service commitments.
- 5.6 Our pay recommendation for SPDCS dentists is contained in chapter 2.

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 National Health Service (NHS) sight tests had decreased from 592 to 477, while the number of optometrists had increased from 8,328 to 8,522. It said that the General Ophthalmic Services 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 said that 46 per cent of practising OMPs also held appointments as hospital doctors. Only one issue was brought to our attention this year: the sight test fee.

The sight test fee

- 6.2 The Department of Health said it was currently negotiating the 2006-07 sight test fee with the Optometric Fees Review Committee, which represents optometrists and OMPs. As we have not been provided with any evidence that demonstrates the requirement for differentiated fees for sight tests conducted by OMPs and by optometrists, we believe that **a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both OMPs and optometrists, remains appropriate and recommend (recommendation 15) this continues for this and future years.**

Part III: Secondary Care

CHAPTER 7: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction and reform of training

7.1 Following the publication of *Modernising Medical Careers*¹, the way in which junior doctors are trained is undergoing a radical change. Previously, 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). With the reform of training, juniors now enter Foundation Programmes, covering the previous HO year and the first year of SHO training but with a new unified curriculum. Doctors will then enter a 'run-through' grade that will complete their training. The SpR grade will be closed to new entrants from the end of 2006 and the SHO grade from August 2007, but both scales will be used in parallel for some time. Details of all the pay scales are in Appendix A. The latest data at 30 September 2005 shows there were 5,687 HOs, 25,718 SHOs and 20,537 registrars (headcounts) working in the hospital and community health services, an overall increase of 5.7 per cent since September 2004.

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 (NHSE). The full evidence can be read at the parties' websites (see Appendix D). In addition to the basic uplift (which we address in paragraphs 7.24–7.26 and in chapter 2), the parties asked us to address a number of other issues. Our responses to these other issues are set out in paragraphs 7.3–7.23.

Recruitment and retention

7.3 Once again we are pleased to note the growth in the number of good quality applicants to study medicine. As the BMA has pointed out, this year saw a return to the historic levels of applicants per place prior to the expansion of medical school places in 1997. The Health Departments told us that in 2005 there were 2.4 applicants for every medical school place in the United Kingdom (UK). This is strong evidence that medicine is seen as an attractive career. Following the pattern of recent years, we note that most entrants (58 per cent) are women, and we therefore again make the point that it will be 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.

Student debt

- 7.4 The BMA returned to the issue of student debt, telling us that average fifth year debt had fallen by 0.4 per cent to £20,097. It also welcomed our interest in the recommendations of the *Gateway to the Professions*² report, particularly as it related to student debt. The Department of Health told us that it was a member of the Inter-Departmental Group that has been set up to implement recommendations from the *Gateway* report. It said that there was a good financial package in place to support medical students and that research showed that those that qualified significantly increased their earning potential. It said that officials would keep in touch with our secretariat to determine how to take forward any outcomes from the Inter-Departmental Group.
- 7.5 The BMA acknowledged our earlier comments that student debt was beyond our remit, but asked us to recognise the unavoidable effect of student debt on the financial situation of new doctors, and to recommend a substantial rise in basic salary accordingly. We can only repeat that student debt does fall outside of our remit, and that it would therefore be inappropriate for us to recommend an increase in basic salary for this reason. Student debt might be an issue if it could be shown to be affecting levels of recruitment or retention, but we see no evidence that this is the case. On the contrary, as we have already noted, applications are running at historically high levels. We do not propose to say anything about this issue in future unless there is evidence that it is having a serious effect on the recruitment of trainee doctors and dentists.

Availability of training places and future career progression

- 7.6 Early in the round, the BMA voiced its concerns to us about the availability of training posts. Subsequently, we noted that the Department of Health announced there would be between 22,000 and 23,000 training opportunities for doctors, with approximately 17,000–18,000 providing access to run-through training – that is, continuous training subject to satisfactory progress to become a consultant or a GMP. The BMA asked us to support its proposition that doctors should not get ‘stuck’ in non-training grades or fixed-term posts for years. We offer no comment here, as this is clearly a workforce planning issue. In a similar vein, we note the BMA’s concerns about the uncertainty surrounding the future career structure for specialists, but again this is not a matter for us.

Working Time Directive and the junior doctors’ contract

- 7.7 The Department of Health told us that, in relation to the Working Time Directive (WTD), it was continuing to press for changes to the directive in the light of the SiMAP and Jaeger judgements (which ruled that all time spent on-call in hospital counted as work and reduced the flexibility in the timing of rest breaks), but that there was no guarantee that a deal could be reached. It said that the National Health Service (NHS) was therefore planning for full implementation of the WTD based on current interpretations. We were pleased to note the work being carried out by various parts of the NHS, looking at ways of improving WTD compliance and sharing best practice. We hope that this will be of help in further reducing junior doctors’ hours, particularly as we near the 2009 target of 48 hours per week. The BMA told us that, once junior doctors’ weekly hours fell below 48, it would be in favour of a system of remuneration which better remunerated a basic 40 hour week and where most of the overall salary came from basic pay. We accept that the current pay system, which is designed to make long hours proportionately more expensive in order to encourage a reduction in hours, will need to be revised once working hours are reduced and we say more about this in paragraph 7.10 below.

² Sir Alan Langlands. *The Gateways to the Professions Report*. Department for Education and Skills, July 2005.

- 7.8 The parties told us that compliance with the new contract was now in excess of 95 per cent. The BMA voiced its disappointment that this was a slight increase on the previous six months by 75 posts, but NHSE said that it was inevitable that some posts were Band 3 on occasion, but only for transient reasons. It said that if compliance remained at its current level, then there was no reason to pay specific attention to it. We accept this, but ask that the parties continue to work together to eliminate Band 3 posts as far as possible. We hope that the high level of Band 3 payments will encourage employers to ensure that Band 3 posts are kept to a minimum, and as NHSE said, are used only for transient reasons.

Banding multipliers and pay protection

- 7.9 The parties offered slightly different views of the value of the average banding multiplier, but all were in agreement that there had been a slight reduction over the last year. NHSE said that the average supplement was 56 per cent, and that they expected the average supplement to reduce slowly as we approached 2009, but did not expect it to fall significantly below 50 per cent. The Health Departments said they were pleased that working hours and average multipliers were falling, and that they did not want to see any adjustment made to a system that was working as intended. They made the comment that the banding multipliers fully reflected the relativities that were agreed with the BMA to reward work intensity and out-of-hours commitment. When the parties negotiated the banding multipliers, they asked that we give consideration to them on an annual basis. The parties think the current banding multipliers are working well, rewarding the junior doctors in the posts with the most unsocial hours and highest intensity, and simultaneously encouraging employers to reduce hours and intensity as they work towards full compliance with the WTD in 2009. We see no reason to propose any change to the banding multipliers which the parties negotiated and we therefore **recommend (recommendation 16) that the percentage values of the banding multipliers be rolled forward for another year.** The detail of our recommendation is at Appendix A.
- 7.10 However, it is a foreseen consequence of the reduction in hours and intensity that pay will also drop. Once all junior doctors are working 48 hours a week or fewer, it will be appropriate to shift the balance away from the banding multipliers towards base pay. This will also have the benefit of ensuring that junior doctors' starting salaries do not fall behind those of other graduate-entry professions. We therefore invite the parties to start giving consideration to restructuring junior doctors' pay from 2009, including the banding multipliers, since we shall wish to address this issue in our next report and look forward to receiving evidence on it. Our recommendation on pay this year for junior doctors (see chapter 2) is partly intended as a first step towards managing this problem.
- 7.11 In supplementary evidence, the BMA told us about the results of its survey of antisocial working patterns. It said that it demonstrated that in a number of cases antisocial working was not adequately accounted for or rewarded in the current banding system. Although the BMA believed that some doctors were inappropriately rewarded by the banding system, we note that the banding system that was jointly negotiated between the parties is capable of, and has always been used for, determining pay for all types of working patterns. We appreciate that it is becoming increasingly difficult for employers to draw up rotas that address the need for total hours to reduce while at the same time ensuring there is sufficient coverage. Nevertheless, we would urge employers to try to take account of the adverse effects on juniors that antisocial working might have when drawing up rotas.

7.12 The BMA commented that many employers declined to provide written confirmation of banding for future posts, and so the rules of pay protection did not apply. NHSE told us last year that it was important that those trainees who had firm commitments for their future work should have their pay protected even if the banding of a post reduced before a trainee took it up. Pay protection was based on the banding and pay scale in place at the time the doctor was offered and accepted the post. We noted last year that we were unable to comment on this issue, as the interpretation of the original agreement between the parties and of doctors' individual contracts of employment was ultimately a matter for Employment Tribunals or the courts to rule on. The BMA told us that it was now seeking a legal ruling on this issue as it could not reach agreement with NHSE on how the pay protection provisions should be interpreted. We ask the parties to keep us informed of developments for our next review.

Recruitment into specialties where most posts attract no supplement

7.13 The BMA told us about difficulties in recruiting to histopathology. It suggested that one reason for this could be the level of pay, since these posts often attracted no banding supplement. It noted other specialties that typically did not attract a banding multiplier, such as radiology and microbiology. It was also concerned about the plans to extend general practice placements to 80 per cent of foundation programme trainees, as it made the point that such posts were unlikely to have an out-of-hours component, and would therefore only attract basic salary. The BMA said that this was evidence that the level of basic pay needed to be increased significantly.

7.14 We have already made our recommendation on the level of the banding multipliers. These are the levels that the parties negotiated as fully reflecting the out-of-hours commitment and intensity of posts. A more intensive post involving more hours should attract higher pay than one less heavily loaded. Our concern would be if recruitment were to fall below demand. The Department of Health told us that there were historical recruitment problems in radiology and histopathology, but that this had been addressed through creating centrally-funded training schools and academies. It said that it was not aware of other specialty training programmes that had shortages of applicants. We therefore see no role for us here, but ask the Department to keep alert to the need for further action targeted at particular specialties should recruitment difficulties arise.

7.15 The BMA also said that many junior doctors had concerns that their basic salary was too low to allow them to buy their own home. It is not, of course, the responsibility of the Review Body to ensure that doctors are able to buy their own homes and doctors are not alone in finding the housing market difficult to enter.

Flexible training and Flexible Careers Scheme

7.16 The BMA told us that the number of UK flexible trainees declined by 11.2 per cent in the six months to April 2006, despite the introduction of new arrangements for flexible training, which as NHSE said, they expected would lead to a large uptake. The BMA asked us to recommend additional, protected funding for flexible training. In supplementary evidence, NHSE told us that one possible reason for the decline in take-up of the scheme was that, under the new arrangements agreed last year, pay was less attractive but more appropriate, as it brought the cost of a flexible trainee into line with that of an equivalent full-time trainee. The BMA's evidence supported this view as it noted that many flexible trainees returned to full-time training for financial reasons. During oral evidence, NHSE told us that 40 per cent of flexible trainees were in London, a slight decrease on the previous year. It said that there was no waiting list to enter flexible training.

7.17 The BMA also told us that funding for the Flexible Careers Scheme had been devolved to Strategic Health Authorities (SHAs). While the Department of Health said that this would empower employers to target the use of the scheme and would ensure cost effective use of funding, the BMA said that applicants were now in competition for funding from the general SHA budget, and that as a result, there were difficulties in accessing the scheme. Decisions on the funding for flexible working must rest, of course, with the Health Departments and NHSE, but we think that it will be increasingly important for flexible work opportunities to be available to aid recruitment and retention, particularly given the large proportion of women in the workforce.

Free accommodation

7.18 The parties updated us on the issue of free accommodation for house officers/foundation year 1 doctors. The BMA said that a problem still existed with NHS Glasgow, which did not accept that there was a contractual obligation to provide free accommodation to pre-registration doctors. In response, NHS Glasgow said that it had secured legal advice supporting its view that it was not required to provide free accommodation to junior medical staff. Despite this, the Scottish Executive Health Department (SEHD) told us that at all times the supply of accommodation in Glasgow had been sufficient to meet demand. Given the recourse by the parties to legal advice, we do not think it appropriate for us to comment on this particular issue. We understand that the parties are in discussions to try and resolve this matter, and we hope that agreement can be reached to the satisfaction of all concerned.

Agreement on pay scales

7.19 We were pleased to note that the parties had agreed new titles for foundation programme grades – foundation house officer (FHO) 1 and 2 – along with pay scales for such doctors, based on the existing house officer and senior house officer pay scales. The pay scales are reproduced in Appendix A. We look forward to receiving further evidence setting out the agreed titles and pay scales for the run through training grades.

Comparator groups

7.20 Last year, the BMA conducted research into pay comparability for junior doctors; its conclusion was that medical graduates' earnings were in line with comparable professions. In this year's evidence, the Department of Health said that for graduates entering HO posts, salaries remained very competitive, with average earnings at £32,563 and 26 per cent earning £37,334 or more. Our own research undertaken for this round indicates that total earnings do indeed appear to be good, but that the level of basic pay appears lower than for comparator groups. The starting salary for house officers/FHO 1 doctors of £20,741 is below the median graduate basic starting salary reported by both Incomes Data Services³ (£22,000) and the Association of Graduate Recruiters⁴ (£23,100). In addition, we note that medical students' courses are typically longer than those of comparators, so it could be argued that the correct comparator would be graduates one to three years into their profession. Despite all this, it does not appear to be acting as a deterrent to recruitment, with NHSE telling us that there was no shortage of qualified applicants at all levels of training. Nevertheless, we have already commented, in paragraph 7.10 above, that the current pay system will need to be revised as working hours are reduced in line with the 2009 target of 48 hours per week and expect the parties to give full consideration to these issues at that time.

³ *Pay and Progression for Graduates*. Incomes Data Services, 2006.

⁴ *The AGR Graduate Recruitment Survey 2006: Summer Review*. Association of Graduate Recruiters, 2006.

Costs of being a doctor

- 7.21 The BMA provided us with evidence showing that on average, for each year of training, having taken account of tax deductions and any deanery allowances, doctors were required to fund £546 per year themselves to cover a number of costs, including certification fees and General Medical Council (GMC) charges. Consequently, it asked that we recommend that all pay scales for junior doctors be uplifted by a minimum of £546, before this year's uplift. The Department of Health told us that fees for GMC registration, Postgraduate Medical Education and Training Board (PMETB) certification, Royal College examinations and medical defence coverage were not determined by government, but by the appropriate independent body. It said it recognised that all trainee doctors did, and expected to, incur such fees. It argued that doctors would over a lifetime earn significantly more than the average, and it was therefore right that they should shoulder part of the cost of the examinations and subsequent regulatory requirements which enabled them to do so. It said that the government already contributed significantly to undergraduate and postgraduate education. If the government were to meet these fees, there would be a risk that the medical bodies would feel able to increase them disproportionately.
- 7.22 We accept the points put forward by the Health Departments on this issue. We expect the existence of such costs to form part of the decision making process for students when deciding which career path they might follow. Having said that, we note from the Department of Health's evidence that fees for the GMC have been factored into pay previously. We have therefore considered this issue by working from the assumption that account of such costs must have been taken when the pay scales were negotiated between the parties. This issue might carry more weight if it could be demonstrated that such costs had risen significantly in excess of the increases that had been delivered by the uplifts to the pay scales.
- 7.23 We asked the BMA if it could show how costs had changed since December 2000 (when the new junior doctors' contract was put in place) for a variety of doctors in different specialties, so that a meaningful average cost could be shown. In supplementary evidence the BMA told us that not all expenses could be tracked back to 2000, and that PMETB had not existed then. Although it provided us with information on some of the more common expenses, it was unable to provide us with detailed information of the kind we requested. We are therefore unable to come to any meaningful conclusion, or to make any sort of recommendation on this issue. If the BMA would like us to consider this issue for the next round, we will need more detailed evidence. In its proposal for this year, we note that the BMA's request for all incremental points to be increased by £546 did not take account of the effect of the banding multipliers, which would have resulted in a higher increase for the vast majority of junior doctors. If the BMA returns to this issue in future rounds, we ask them to take this into account in any proposals. In the meantime, we welcome the action that the Department of Health has told us it is taking, looking at the case for the tax-deductibility of PMETB fees.

The pay uplift

- 7.24 Turning to the pay uplift, the parties have again sought to bring us to widely different conclusions. The BMA suggested that the general level of settlement necessary to protect the value of existing contracts relative to settlements elsewhere was 4 per cent. The Department of Health said it believed that an affordable pay uplift (given the financial pressures on the NHS) was 1.5 per cent, a view that was supported by both the National Assembly for Wales and the SEHD. Although NHSE initially told us that it would support an inflation uplift, it subsequently told us that following the publication of the tariff, it had sought the views of the Department of Health as to the affordability of a pay uplift and was advised that, given the cost of other factors, such as pay modernisation, the most that could be afforded was 1.5 per cent. It said it did not wish to pursue a recommendation that ultimately became unaffordable for employers, risking the viability of jobs and service commitments.
- 7.25 The Department of Health also drew our attention to the effect of incremental scales, which it said for an SpR not yet at the top of the scale would deliver an increase of 4.2–5.3 per cent before the pay award. NHSE said that annual increments added around 4–6 per cent to basic pay. The BMA, however, said that incremental scales were to recognise increasing experience, skill and worth to the service. NHSE agreed, saying that the purpose of incremental scales was to allow people to progress to higher pay points through achieving an increased level of competency or acquiring a greater level of experience. They said that pay scales encouraged motivation by providing clear expectations of the reward available in the future.
- 7.26 Our views on the use of incremental scales, along with our recommendation on pay, are set out in chapter 2.

CHAPTER 8: CONSULTANTS

Introduction

- 8.1 The consultant grade is the main career grade in the hospital and public health service. New contracts were agreed in October 2003 and included a three-year pay deal: 2003-04 to 2005-06. The contract differs in England, Scotland and Wales. It was optional in England and Scotland, although all new appointments or moves to a new trust are under the new contract. All consultants in Wales were required to transfer. A decreasing number of consultants remain on the pre-October 2003 contract and we make recommendations on the pay uplift for consultants on both types of contract. All consultants, regardless of their type of contract, are now meant 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 four-hourly programmed activities (PAs) they will work. In England and Scotland ten PAs are intended to represent a full time post. 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, replacing the former discretionary points scheme, although consultants in Wales will also be eligible for the new national level CEAs; and a new salary structure with two extra incremental points.
- 8.3 Last year our recommendation for an uplift for consultants was staged by the Government. Although consultants were the only one of our remit group to have their award staged, awards were also staged for the Senior Civil Service, the Judiciary, Members of Parliament and Ministers.

The evidence

- 8.4 We have received evidence relating to consultants from the Health Departments, NHS Employers (NHSE), the Advisory Committee on Clinical Excellence Awards (ACCEA), the British Medical Association (BMA) and the British Dental Association (BDA). The evidence, which can be read in full on the parties' websites (see Appendix D), covered a range of issues affecting consultants, in addition to the general pay uplift. These issues are addressed in the following paragraphs.

Pay aspects of the new consultant contract

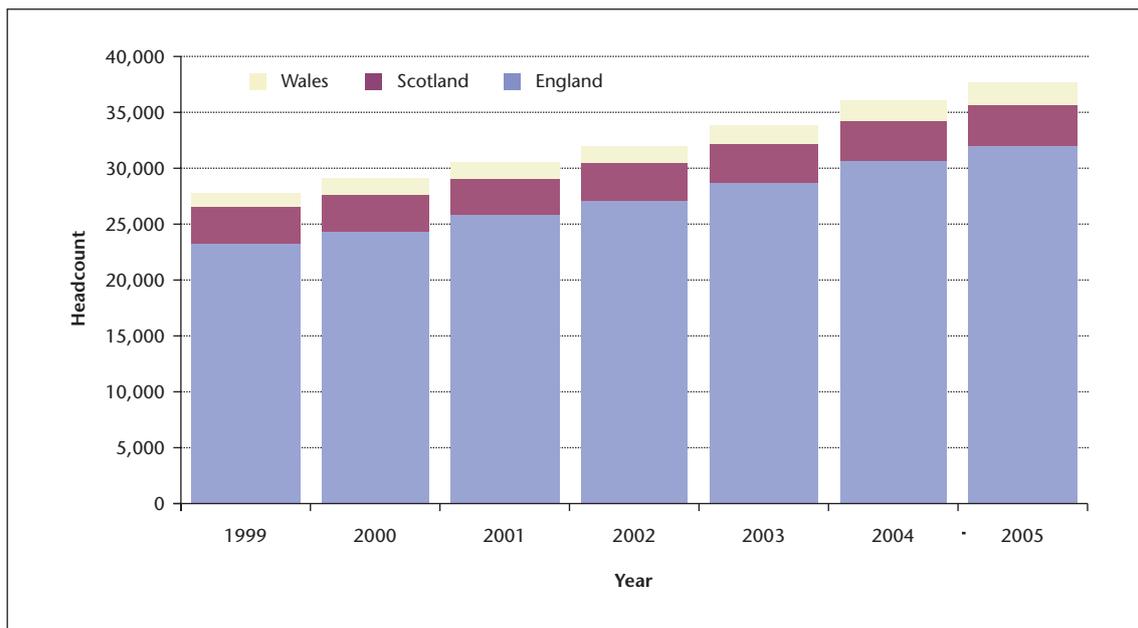
- 8.5 The Health Departments told us that overall 87 per cent of consultants in England were on the new contract and 97 per cent of consultants in Scotland, but that the cost of pay reform for consultants had been £90 million more than expected. NHSE stated more specifically that uptake of the new contract varied by type of NHS organisation, geographical location and specialty; 98.1 per cent of consultants employed by Strategic Health Authorities (SHAs) had moved to the new contract compared with 74.8 per cent to 97.5 per cent of consultants in other NHS organisations. NHSE said that the number of consultants on the old contract would continue to reduce, mainly because of retirements, although the old contract would be maintained for the immediate future.

- 8.6 The BMA's concerns relate to its belief that most consultants have had a pay reduction in the past year through decreased PAs, plus additional losses from the staged award. It also reported that salary at the top end of the scale was £8,000 less for Welsh consultants, where the incremental scale was shorter and more compressed. However, the National Assembly of Wales (NAW) explained that the agreements and pay scales were different, and although it might be that a small number of consultants in England could end up with a maximum salary higher than the maximum in Wales, consultants in Wales could achieve the top salary within a clearly defined period, whereas few in England would ever be likely to achieve the potential top salary. It said that most consultants in Wales enjoyed a better salary (as opposed to earnings) than their peers in England, because Wales consciously put more of its share of available monies into the basic salary scale, and less into on-call and out-of-hours premium payments etc.
- 8.7 We note that studies show pay rates of consultants in Great Britain to be favourable when compared with similar professions. This can be seen in Figure 1.4 in chapter 1.

Recruitment and retention

- 8.8 The numbers of consultants in each part of Great Britain have again increased. The smallest percentage growth was in Scotland.

Figure 8.1: Numbers of consultants in the Hospital and Community Health Services, 1999-2005, Great Britain



Source: Health and Social Care Information Centre, Medical and Dental Workforce Censuses

- 8.9 The Health Departments told us that, while vacancies continued to increase in Scotland, £2.5 million has been allocated to Health Boards to target vacancies; meanwhile vacancies have reduced in Wales.
- 8.10 The BMA expressed concern that consultant vacancy rates remained higher in Wales than England but the NAW viewed this as misleading. It said that vacancies might well be higher than in England, but they had reduced considerably and progressively since the amended contract was introduced. Anecdotally, trusts in Wales were also reporting greater responses to adverts, better ranges of candidates, and they were now filling many long-standing vacancies in previously hard to fill specialties, particularly in those parts of Wales where recruitment had traditionally been more difficult. BMA Scotland

believed more work needed to be done to address the rising vacancy rate and to provide consultants with 'step down' arrangements to enable them to continue working but less intensively.

- 8.11 NHSE told us that whilst provision existed within the contract for payment of recruitment and retention premia, employers overwhelmingly reported that they were not used, with the exception of a few specialties with acknowledged shortages such as psychiatry, paediatrics, radiology and histopathology; even here premia were mostly time limited (as intended) and in some cases soon to be discontinued. Referring to the Department of Health implementation survey,¹ NHSE reported that SHAs and trusts in London had taken a strategic decision not to pay recruitment and retention premia, although this arrangement was reviewable at least annually. In view of the comparatively low vacancy rates in London, we understand this reasoning. NHSE told us that employers regarded the current provisions for local level design and payment of premia as satisfactory and not in need of change. The Scottish Executive Health Department (SEHD) said that the approach in Scotland, however, was that for consistency and fairness, recruitment and retention premia should be applied only on a collective basis across the country. To date, there had been no applications to apply the premia.

Morale and workload

- 8.12 The BMA said that although it had no new data on consultants' morale, it believed that the staging of last year's pay award and increased job insecurity, together with unpaid working hours, were all likely to have had a negative impact on morale.
- 8.13 The new contract seems to have had a positive impact on morale. We refer, in chapter 1 (paragraph 1.25) to the second national survey of working conditions and career grade doctors in Scotland, carried out by the University of Aberdeen². The study found that the 47 per cent of consultants who reported an increase in their job satisfaction attributed this to the new contract.
- 8.14 NHSE told us that for consultants in England the average weekly number of contracted PAs had decreased from 11.17 (October 2004) to 10.83 (October 2005). It observed that this reduction was not unexpected as the number of additional PAs contracted for was subject to change, at least annually, when job plans were reviewed and as the job planning process became more effective. It also reported that the proportion of PAs allocated to direct clinical care decreased from an average of 8.27 (October 2004) to 7.93 (October 2005). Again this was to be expected as additional contractual consultant work reduced towards an average working week of 10 PAs. The NAW said that in Wales, virtually all trusts had seen a reduction in the level of additional sessions being paid. The remaining sessions, which currently attracted an escalator premium payment, were expected to reduce substantially by autumn 2006. The average number of sessions worked had reduced by 0.5 per week, although the potential loss of activity was compensated by the increase in consultant numbers. The average weekly hours worked were 44.3, which represented a reduction of two hours since the introduction of the contract. However, some consultants worked considerably in excess of this, in part to cover vacancies. The SEHD said that in Scotland, the average weekly number of PAs contracted stood at 11.5 in September/October 2005.

¹ Department of Health. *New consultant contract implementation survey*. (HSCIC, July 2006).

² Fiona French et al. *Second national survey of non-training grade doctors in NHS Scotland: changes in job satisfaction, work commitments and attitudes to workload following contractual reform*. University of Aberdeen, December 2006.

- 8.15 The BMA reported that many consultants were working long hours, often unpaid, and that some felt increased pressure to work unpaid PAs. It considered that it was vital that work undertaken by consultants was recognised and paid, as this would support service redesign and workforce planning. It also commented that as additional PAs were non-pensionable, they were a cheap way of increasing activity but not consultant numbers.
- 8.16 We note that PAs are being reduced in the move towards consultants working a 10 PA week, and that the job planning process is becoming more effective. Clearly it is fair that if less work is being done, there will be less remuneration, but if consultants are being pressurised to work additional hours without additional pay their job plans should be adjusted accordingly.

Clinical Excellence Awards, discretionary points, distinction awards

- 8.17 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. Discretionary points and distinction awards 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. In England and Wales, the national awards are made by the Advisory Committee on Clinical Excellence Awards (ACCEA); in Scotland they are awarded by the Scottish Advisory Committee on Distinction Awards (SACDA).
- 8.18 ACCEA stated that CEAs were 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”³ while SACDA said that distinction awards were made for “outstanding professional work”⁴.
- 8.19 SACDA completed its seventh awards round in September 2006. It told us that at 30 September 2005 there were 494 award holders in Scotland, that is 13.5 per cent of all consultants; 63 awards were approved in the 2006 round.

Table 8.1: Distinction awards made by SACDA in 2006

B award	40
A award	18
A plus award	5
Total awards	63

Source: SACDA

- 8.20 For 2007, SACDA proposed to distribute a further nine B awards, four A awards and two A plus awards and noted that there had been a 2.7 per cent increase in the consultant population in Scotland. **We endorse and recommend (recommendation 17) SACDA’s proposal to distribute a further nine B awards, four A awards and two A plus awards.**
- 8.21 NHSE reported that a review of the CEA scheme had taken place and that its report had been agreed with the BMA and submitted to the Department of Health. The SEHD hoped to complete its review by the end of 2006. We await the results of these reviews with interest.

³ <http://www.advisorybodies.doh.gov.uk/accea/index.htm>

⁴ <http://www.sacda.scot.nhs.uk/home.htm>

- 8.22 The BMA said that pending the review of distinction awards in Scotland, the number of awards should be increased in line with consultant expansion in Scotland and the value increased by the same percentage as the general pay award for consultants; the value of discretionary points should be increased by the same percentage. The SEHD stated that, pending the outcome of the review of the distinction award and discretionary points scheme, it would not contest the BMA's view.
- 8.23 The BMA also said that in Scotland it was planned to add approximately 20 senior academic GMPs to the group of consultants eligible for distinction awards in 2007, but without extra funding. It said that this would mean that consultants were automatically disadvantaged in the coming round and that when English senior academic GMPs were made eligible for CEAs, additional funding had been allocated. It sought our support for separate, additional funding for awards for senior academic GMPs or alternatively for a retrospective offsetting process, whereby the actual sum spent on distinction awards for senior academic GMPs in 2007 would be compensated for in funding for the 2008 award round.
- 8.24 However, the SEHD view was that no additional funding should be provided, nor any retrospective offsetting process introduced for senior academic GMPs. It said that the number of academic GMPs who would stand to gain an award was so small as to dilute the amount of funding available for consultants only to a negligible extent. It said there were currently just over 3,500 consultants and clinical academics in Scotland and around 25 senior academic GMPs to be added to the number; this was a 0.7 per cent dilution. It also said that as the distinction awards scheme was under review in Scotland, it was not appropriate to make a change until the review was completed.
- 8.25 Our view is that, notwithstanding the review of distinction awards in Scotland, additional funding should be made available to recognise the increase in the population arising from the newly eligible senior academic GMPs. Not to do so would undermine the scheme and potentially disadvantage consultants who might otherwise be eligible for an award. We therefore **recommend (recommendation 18) that additional funding be made available for distinction awards in Scotland, to cover the newly eligible senior academic GMPs, who constitute 0.7 per cent of the eligible population according to SEHD's estimate.**
- 8.26 ACCEA told us 2007 would be the fourth year of the new CEA scheme. It said that at 1 October 2006, 58.5 per cent of consultants were in receipt of a CEA, distinction award or discretionary points and it expected that, as the scheme bedded down, a pattern would emerge whereby half of the consultants in each band would, over time, progress to the next level. ACCEA did not believe that the pattern was yet sufficiently settled to enable it to request specific numbers of awards at each level, and it reported that the transition between schemes remained unpredictable.
- 8.27 ACCEA reported that there were 2,400 applications for new awards in 2006, resulting in 572 awards.

Table 8.2: Clinical Excellence Awards made by ACCEA in 2006

Bronze awards	330
Silver awards	157
Gold awards	47
Platinum awards	38
Total awards	572

Source: ACCEA

- 8.28 As in 2005, there were fewer gold awards than ACCEA had expected, but more bronze and silver. ACCEA believed that this was due to the transition between schemes and expected that gold awards would pick up from 2009, as consultants given silver awards in 2004 demonstrated further enhancement. It reported that 2,345 consultants continued to hold distinction awards, but that over time some would move to the new scheme and some would retire.
- 8.29 ACCEA proposed that the value of CEAs (both locally and nationally awarded) should be increased in line with our general uplift recommendation for consultants. It said that provision for new awards should be funded at the cost of the 2006 awards (valued at 1 April 2007) increased by 1.5 per cent, which it said represented the estimated increase in the consultant population. It said this would maintain the ratio of awards to eligible consultants. It said that this would need to be uprated by any inflation increase in consultant remuneration, which would in turn enable a budget for new awards to be created while retaining the flexibility for it to determine the precise number of awards to be made at each level.
- 8.30 The BMA also asked for the total sum invested in national CEAs to be uprated in line with the increased number of consultants and the pay award, and for the value of local awards to be uprated in line with the pay award.
- 8.31 The Department of Health told us that while it accepted the current position on CEAs, they represented about 4.5 per cent of the consultant pay bill and were another cost pressure on the overall affordability of any pay uplift for consultants. ACCEA said it had anecdotal evidence of employers being reluctant to invest in CEAs at lower levels because of the financial pressures on NHS budgets. The BMA sought a statement from us requiring employers to award a minimum 0.35 CEAs per eligible consultant per year – in line with the CEA framework document.
- 8.32 We therefore welcome ACCEA issuing guidance on its website reminding employers of the investment commitment made when the CEA scheme was established⁵. The guidance said that the only acceptable reason for not making the full investment in new awards would be that a properly constituted committee found insufficient excellence demonstrated by applicants. In such circumstances, employers would be expected to hold the investment over to the following year so that the full investment could be made over the two-year period.
- 8.33 With regard to the recommendations for CEAs this year, we are happy to **endorse and recommend (recommendation 19) the proposal that the budget for higher awards should be increased in line with the increase in the number of consultants eligible for an award, estimated by ACCEA at 1.5 per cent.**
- 8.34 In chapter 1 we have outlined the background to this year's pay recommendations and in chapter 2 we explained why we believed this year's award should take the form of a flat-rate increase of £1,000 for all salaried doctors and dentists. All salaried members of our remit group will thus receive the same cash award, although the effect will be a higher percentage increase for the lower paid. We do not believe that there is scope to increase the value of CEAs, commitment awards, distinction awards and discretionary awards for consultants for 2007-08 and our recommendation is included in chapter 2. However, we **endorse and recommend (recommendation 20) ACCEA's proposal that it should continue to retain the flexibility to determine the number of CEAs to be made at each level in 2007-08.**

⁵ <http://www.advisorybodies.doh.gov.uk/accea/2007-guidetoscheme.pdf>

- 8.35 The BMA said that awards should be used to encourage teaching and research activity, and sought our support for its position that the use of CEAs as a means of remuneration for management work by medical managers was inappropriate, although ACCEA subsequently told us that it had no evidence that CEAs were being used in this way. We were concerned at the possibility that CEAs might be being used improperly as a means of financial compensation for management work, but have been unable to find clear evidence that this is happening. Nevertheless, we emphasise that we expect the awards to be made for professional excellence, as outlined on the ACCEA and SACDA websites and in paragraph 8.18 above.
- 8.36 The BMA also expressed concern that senior consultants in Wales were potentially being disadvantaged by the value of commitment awards in comparison with CEAs. They gave the example of the maximum commitment award level (point 8) being worth £3,796 less than the equivalent CEA (point 8) in the rest of the UK. We note that this disparity forms part of the consultant contract that was separately negotiated in Wales, and that consultants in that country voted to accept these alternative arrangements.

Clinical Academic GMPs

- 8.37 In our Thirty-Fifth Report, we recommended that local awards for academic GMPs should be made by the relevant local ACCEA committee and moderated centrally. This led the BMA to express concern to us that the £200,000 allocated to local CEAs for senior academic GMPs might be insufficient. ACCEA told us that the figure was based on 0.35 of a CEA per eligible academic GMP, but that it had only been able to estimate the number of such consultants and would welcome assistance in determining the number of eligible academic GMPs. We agree the necessity for accurate figures on the number of eligible academic GMPs and ask that the parties provide this data for the next pay round so that the basis of the CEA scheme is not undermined.

Medical managers

- 8.38 The BMA told us that it believed that the additional work and extra responsibility from medical management duties justified the continued existence of responsibility allowances. It sought set minimum rates for clinical and medical directors, dependent on level of responsibility and whether they had separate management contracts, but regardless of where they worked. It wanted the rates to be uprated in line with awards for NHS consultants and said that it would welcome the opportunity to work with us on this. As an interim measure, it sought to reinstate previous responsibility allowances as minima and for them to be uprated since last set.
- 8.39 We are in agreement with the Health Departments, however, that there is no need to reinstate the responsibility allowances, as we believe that there is adequate flexibility in the new consultant contract. This allows responsibilities as a Medical Director or Clinical Director to be reflected by substituting whole or part PAs, or through additional remuneration, agreed locally.

Clinical academics

- 8.40 We have commented in our previous reports that clinical academic staff are outside our remit and a matter for the universities rather than the NHS. Nevertheless, we do take an interest in the effect that any shortfall in numbers may have on the ability of the NHS to train sufficient numbers of medical and dental staff. The BMA and the BDA both raised issues relating to clinical academics with us this year. We repeat our comments from previous years: 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 BMA said that it was concerned about the impact of NHS reorganisations on public health capacity and claimed that the number of consultants and specialists in this area had fallen by 17 per cent since 2003, and that 17.6 per cent of public health consultants had indicated that they might leave the specialty in the next five years.
- 8.42 The BDA had similar concerns and gave anecdotal evidence that some dental public health staff were considering alternative careers within the dental profession. It stated that an increase in part-time working had resulted in an overall reduction in the dental public health workforce and that almost half of the current dental public health consultants in England would retire in the next ten years. The Department of Health told us that it was undertaking several projects to ensure the retention and strengthening of the public health workforce and that it wished to incorporate dental public health staff in the main hospital medical and dental/public health medicine terms and conditions of service, although this was still not fully agreed with the BDA.
- 8.43 As last year, we remind the parties that the organisational structure of the NHS and the size of the workforce are outside our remit, though as always we ask that the Health Departments consider the impact of any changes on the recruitment and retention, morale and motivation of our remit groups.

Pay recommendations for 2007-08

- 8.44 As has been the case in previous years, the parties have urged us to very different conclusions. The Health Departments favoured a generic pay uplift of 1.5 per cent across all staff groups, stressing that this was the maximum that could be afforded. NHSE had originally proposed an increase in line with the Consumer Prices Index inflation target of 2 per cent, but subsequently revised this to 1.5 per cent in the belief that that was the maximum affordable uplift. It sought the same increase for those on pre and post 2003 contracts. The BMA sought a minimum of 4 per cent with a further 0.7 per cent to compensate for the loss of salary caused by the staging of last year's award, to be made up through an enhanced pay increase or back pay.
- 8.45 The Health Departments said that they expected average earnings per head to continue to grow at a high rate as consultants progressed through the thresholds towards the new maximum. They calculated that a 1.5 per cent increase this year would deliver average increased earnings per head for consultants of 4.3 per cent. The NAW noted that those consultants who had been aged between 51 and 56 at the time of introduction of the new contract would automatically receive a consultant award of £3,088 in December 2006; those aged between 43 and 50 would receive a similar increase in December 2007. The Health Departments also made specific mention of dental public health staff, who they said should receive the same uplift to pay as their hospital medical and dental staff and public health counterparts.
- 8.46 The BMA said that consultants should be rewarded appropriately as professionals working at the top of their chosen fields. It also sought a flat rate pay supplement for all doctors who did not wish to work voluntarily beyond whole time (i.e. 10 PAs) but who were not offered the opportunity to reduce to 10 PAs. However, the Health Departments said that they did not wish to introduce financial disincentives that would constrain the flexibility of the new contract, a view that we endorse.
- 8.47 The recommended pay uplift for consultants for 2007-08 is in chapter 2.

CHAPTER 9: STAFF AND ASSOCIATE SPECIALISTS/ NON-CONSULTANT CAREER GRADE DOCTORS AND DENTISTS

Introduction

- 9.1 We have continued to use 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. A wide and disparate group of doctors and dentists come under the umbrella of SAS/NCCGs, 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 2007-08 will apply to all these groups. However, clinical assistants, hospital practitioners and doctors working in community hospitals can be qualified as general medical practitioners and our recommendations for these doctors, where appropriate, are contained in chapter 3 of the report.
- 9.2 The numbers of SAS/NCCGs working in the Hospital and Community Health Services (HCHS) have risen sharply over recent years, from 6,380 in 1999 to 9,440 in 2005. As a proportion of all HCHS doctors, SAS/NCCGs represent about 8.8 per cent. However, these figures do not include the significant numbers of trust grade doctors employed under local terms and conditions, so the true proportion of SAS/NCCG doctors as part of the HCHS is certain to be higher.

The evidence

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

Recruitment and retention, morale and motivation

- 9.4 Because of the uncertainty surrounding the actual number of SAS/NCCGs, it is not easy to reach a firm conclusion on recruitment and retention for this group of doctors. We ask again for some clarification from the parties as to the total numbers in this group. The Department of Health said that it believed there was no evidence of any general recruitment and retention problems. The BMA reported that the future remained unclear for this group of doctors while the outcome of the contract negotiations was awaited. In their evidence and anecdotally in our visits in recent years, SAS/NCCG doctors have expressed their frustrations stemming from the ambiguity in their role, where they could be treated as senior or junior doctors. They did not believe that they received the recognition they deserved and felt that they had a poor training route. We hope that these issues will be addressed by the negotiations for the new contractual arrangements.

Education, training, opportunities for career progression

- 9.5 The Health Departments told us that *Modernising Medical Careers* would provide more opportunities to progress careers and that opportunities for SAS/NCCG doctors have increased as a result of them being able to apply to the Postgraduate Medical Education and Training Board (PMETB) to have their qualifications, training and experience recognised as sufficient to be placed on the Specialist or General Practitioner Register, or be prescribed 'top up' training. The BMA seemed less clear how this would work, however. The BMA also said that the proposed closure of the associate specialist grade had closed an opportunity for career progression for staff grade doctors. It stated that apart from in Scotland, no funding had been allocated for top up training for Article 14 applicants¹ and no provision had been made to describe how this might be accessed if funding were to be available. It told us that issues of career progression, professional development and training remained areas of great anxiety for SAS/NCCG doctors. We offer no comment here while we await the outcome of the new contractual arrangements.

New contractual arrangements

- 9.6 Last year, we reported that the parties were continuing their negotiations and hoped to introduce new contractual arrangements for the main grades in the SAS/NCCG group by 1 April 2006. This did not happen. Negotiations continued throughout 2006 and at the time of writing, we understand that proposals were being put to ballot. The BMA emphasised that it had been negotiating at a time of financial difficulties for the NHS and that SAS/NCCG doctors were the last group to be reviewed and benefit from a new national contract. It is our hope that the new contract will provide benefits for all parties and we will be following progress closely.

The pay uplift

- 9.7 The parties have tried to lead us to different conclusions on the appropriate level of the uplift. The BMA argued for all groups of doctors that the general level of settlement necessary to protect the value of existing contracts relative to settlements elsewhere needed to be 4 per cent. The Health Departments were in agreement that given the financial pressures on the NHS, an affordable pay uplift was 1.5 per cent. Although NHSE originally suggested an uplift in line with inflation, it later told us that following the publication of the tariff, it had consulted with the Department of Health on the affordability of a pay uplift and was advised that, given the cost of other factors, the most that could be afforded was 1.5 per cent.
- 9.8 The recommendation on pay for SAS/NCCGs for 2007-08 can be found in chapter 2.

¹ Article 14 is part of the General and Specialist Medical Practice (Medical Education, Training and Qualifications) Order 2003 that established PMETB. Article 14 explains how doctors who have not completed a UK specialist training programme for award of a Certificate of Completion of Training may apply for a statement that they are eligible for the Specialist Register. For further information see: <http://www.pmetb.org.uk/index.php?id=609>

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 2007 ¹ £
	<i>(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>	
Foundation house officer 1	20,741	21,391
	22,076	22,726
	23,411	24,061
Foundation house officer 2	25,882	26,532
	27,617	28,267
	29,352	30,002
House officer	20,741	21,391
	22,076	22,726
	23,411	24,061
Senior house officer	25,882	26,532
	27,617	28,267
	29,352	30,002
	31,087	31,737
	32,822	33,472
	34,557	35,207 ²
	36,292	36,942 ²
Registrar	28,930	29,580
	30,395	31,045
	31,860	32,510
	33,325	33,975
	35,092	35,742
Senior registrar	33,325	33,975
	35,092	35,742
	36,860	37,510
	38,628	39,278
	40,395	41,045
	42,163	42,813
	43,931	44,581 ³

¹ Our recommended basic pay uplifts to be applied from April 2007 are based on the current scales, with the final result being rounded up usually to the nearest pound.

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.

	Current scales £	Recommended scales payable from 1 April 2007 ¹ £
Specialist registrar ⁴	28,930	29,580
	30,395	31,045
	31,860	32,510
	33,325	33,975
	35,092	35,742
	36,860	37,510
	38,628	39,278
	40,395	41,045 ⁵
	42,163	42,813 ⁵
	43,931	44,581 ⁶
Consultant (2003 contract, England and Scotland for main pay thresholds) ⁷	70,822	71,822
	73,071	74,071
	75,320	76,320
	77,569	78,569
	79,812	80,812
	85,153	86,153
	90,495	91,495
	95,831	96,831
<i>Clinical Excellence Awards</i> ⁸		<i>Value</i>
	2,850	2,850
	5,700	5,700
	8,550	8,550
	11,400	11,400
	14,250	14,250
	17,100	17,100
	22,800	22,800
	28,500	28,500
	34,200	34,200
Consultant (2003 contract, Wales)	68,606	69,606
	70,822	71,822
	74,530	75,530
	78,837	79,837
	83,754	84,754
	86,558	87,558
	89,368	90,368
<i>Commitment awards</i> ⁹		<i>Value</i>
	3,088	3,088
	6,176	6,176
	9,264	9,264
	12,352	12,352
	15,440	15,440
	18,528	18,528
	21,616	21,616
24,704	24,704	

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.

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

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

	Current scales £	Recommended scales payable from 1 April 2007 ¹ £
Consultant (pre-2003 contract) ¹⁰	58,632	59,632
	62,899	63,899
	67,167	68,167
	71,434	72,434
	76,300	77,300
<i>Discretionary points</i> ¹¹		<i>Value</i>
	3,088	3,088
	6,176	6,176
	9,264	9,264
	12,352	12,352
	15,440	15,440
	18,528	18,528
	21,616	21,616
	24,704	24,704
Associate specialist	34,977	35,977
	38,788	39,788
	42,598	43,598
	46,408	47,408
	50,219	51,219
	54,029	55,029
	59,061	60,061
	63,422	64,422
<i>Discretionary points</i>		<i>Notional scale</i>
	65,232	66,232
	67,593	68,593
	69,954	70,954
	72,315	73,315
	74,676	75,676
	77,039	78,039
Staff grade practitioner (1997 contract, MH03/5)	31,547	32,547
	34,131	35,131
	36,714	37,714
	39,298	40,298
	41,882	42,882
	44,924	45,924
<i>Discretionary points</i> ¹²		<i>Notional scale</i>
	47,049	48,049
	49,632	50,632
	52,216	53,216
	54,800	55,800
	57,383	58,383
	59,968	60,968

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.

¹² See Twenty-Seventh Report, paragraph 2.34.

	Current scales £	Recommended scales payable from 1 April 2007 ¹ £
Staff grade practitioner (pre-1997 contract, MH01)	31,547	32,547
	34,131	35,131
	36,714	37,714
	39,298	40,298
	41,882	42,882
	44,465	45,465
	47,049	48,049
	49,632	50,632
<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)	4,310	4,396
Hospital practitioner (limited to a maximum of 5 half day weekly sessions)	4,218	4,302
	4,462	4,551
	4,706	4,801
	4,951	5,050
	5,195	5,299
	5,439	5,548
	5,683	5,797

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

B. Community health staff

*(Salary scales excluding earnings from
additional sources, such as out-of-hours
payments for training grades)*

Clinical medical officer	30,179	31,179
	31,867	32,867
	33,555	34,555
	35,243	36,243
	36,931	37,931
	38,619	39,619
	40,307	41,307
	41,996	42,996
Senior clinical medical officer	43,059	44,059
	45,741	46,741
	48,422	49,422
	51,103	52,103
	53,785	54,785
	56,466	57,466
	59,147	60,147
61,829	62,829	

C. Salaried primary dental care staff¹³

	Current scales £	Recommended scales payable from 1 April 2007 ¹ £
<i>(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)</i>		
Band 1: Community dental officer	32,041	33,041
	34,714	35,714
	37,387	38,387
	40,061	41,061
	42,734	43,734
	45,407	46,407
	48,080	49,080 ¹⁴
	50,754	51,754 ¹⁴
Band 2: Senior dental officer	46,215	47,215
	49,952	50,952
	53,689	54,689
	57,426	58,426
	61,163	62,163
	61,987	62,987 ¹⁵
	62,810	63,810 ¹⁵
Band 3: Assistant clinical director	61,741	62,741
	62,712	63,712
	63,683	64,683
	64,654	65,654
	65,625	66,625 ¹⁵
	66,597	67,597 ¹⁵
Band 3: Clinical director	61,741	62,741
	62,712	63,712
	63,683	64,683
	64,654	65,654
	65,625	66,625
	66,597	67,597
	67,568	68,568
	68,555	69,555
	69,526	70,526 ¹⁵
70,497	71,497 ¹⁵	

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

¹⁴ 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).

¹⁵ 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 2007 ¹⁶ £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	54,103 57,529 60,956 64,382 68,555 69,526 70,497	55,103 58,529 61,956 65,382 69,555 70,526 ¹⁶ 71,497 ¹⁶
Part-time dental surgeon	Sessional fee (per hour)	
Dental surgeon	26.57	27.10
Dental surgeon holding higher registrable qualifications	35.25	35.95
Dental surgeon employed as a consultant	43.92	44.80

Details of the supplements payable to salaried dental staff in primary care are set out in Part II of this Appendix.

¹⁶ 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 2007. 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 plus distinction awards should be increased by two, the number of A awards should be increased by four, and the number of B awards should be increased by nine.
3. The annual values of national Clinical Excellence Awards for consultants and academic GMPs are as follows:

Bronze (Level 9):	£34,200
Silver (Level 10):	£44,965
Gold (Level 11):	£56,206
Platinum (Level 12):	£73,068

4. The annual values of distinction awards for consultants¹ are as follows:

B award:	£30,808
A award:	£53,911
A plus award:	£73,158

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

Daytime supplement:	from £1,204 to £1,228	
Out-of-hours supplement	(England and Scotland)	(Wales)
Band 1:	from £907 to £925	from £2,091 to £2,133
Band 2:	from £1,808 to £1,844	from £4,182 to £4,266
Band 3:	from £2,703 to £2,757	from £6,273 to £6,398

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.

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

* 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 8 am to 7 pm Monday to Friday	20%

11. The fee for domiciliary consultations should be increased from £77.21 to £78.76 a visit. Additional fees should be increased *pro rata*.

12. Weekly and sessional rates for locum appointments² in the hospital service should be increased as follows:

Associate specialist, senior hospital medical or dental officer appointment	from £926.64 to £945.78 per week; from £84.24 to £85.98 per notional half day.
Specialist registrar LAS appointment	from £690.00 to £702.80 per week; from £17.25 to £17.57 per standard hour.
Senior house officer appointment	from £596.40 to £608.80 per week; from £14.91 to £15.22 per standard hour.
House officer appointment	from £423.60 to £436.00 per week; from £10.59 to £10.90 per standard hour.
Hospital practitioner appointment	from £94.96 to £96.85 per notional half day.
Staff grade practitioner appointment	from £778.50 to £797.70 per week; from £77.85 to £79.77 per session.
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)	from £82.66 to £84.31 per 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 the London zone payment³ 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 be set in negotiations between the parties.

² For locum rates under the 2003 consultant contract, refer to Schedule 22 of the contract's Terms and Conditions of Service.

³ See paragraph 1.64 of this report.

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 follows⁴:

	Current range of supplements £	Recommended range or supplements payable from 1 April 2007 £
Island Health Boards: Band E (under 50,000 population)	1,661 – 3,295	1,694 – 3,361
District director of public health (director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,295 – 6,589 (Bar); 8,239	3,361 – 6,721 (Bar); 8,403
Band C (District of 250,000 – 449,999 population)	4,133 – 8,239 (Bar); 9,899	4,216 – 8,403 (Bar); 10,097
Band B (District of 450,000 and over population)	4,944 – 9,899 (Bar); 12,769	5,043 – 10,097 (Bar); 13,024
Regional director of public health: Band A:	12,769 – 18,535	13,024 – 18,906

General medical practitioners

17. The supplement payable to GMP registrars is 55 per cent⁵ of basic salary for 2007-08.
18. The salary range for salaried GMPs⁶ employed by Primary Care Organisations should be £51,332 to £77,462 for 2007-08.

General dental practitioners

19. The contract values for providers of NHS dental services in England and Wales should be increased by 3.0 per cent from 1 April 2007. An uplift of 3.0 per cent also applies to gross fees from 1 April 2007 in Scotland.
20. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £112.01 to £115.37.
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 £79.29 to £81.67.

⁴ Population size is not the sole determinant for placing posts within a particular band.

⁵ See paragraph 3.36 of this report. For those in post on 1 April 2007, the supplement remains at 65 per cent.

⁶ See paragraph 3.33 of this report.

22. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £61.10 to £62.93.
23. The quarterly payments under the Commitment Payments scheme⁷ should be increased as follows:

Level 1 payment	from £42 to £44 per quarter
Level 2 payment	from £347 to £358 per quarter
Level 3 payment	from £448 to £462 per quarter
Level 4 payment	from £537 to £554 per quarter
Level 5 payment	from £626 to £645 per quarter
Level 6 payment	from £713 to £735 per quarter
Level 7 payment	from £804 to £829 per quarter
Level 8 payment	from £894 to £921 per quarter
Level 9 payment	from £982 to £1,012 per quarter
Level 10 payment	from £1,071 to £1,104 per quarter

Salaried dentists in primary care

24. The teaching supplement for assistant clinical directors in the CDS should be increased from £2,280 to £2,326 per year.
25. The teaching supplement payable to clinical directors in the CDS should be increased from £2,575 to £2,627 per year.
26. The supplement for clinical directors covering two districts should be increased from £1,664 to £1,698 per year and the supplement for those covering three or more districts should be increased from £2,657 to £2,711 per year.
27. The allowance for dental officers acting as trainers should be increased from £1,823 to £1,860 per year.
28. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

⁷ GDPs in Scotland are eligible for these payments. In England and Wales, commitment payments are subsumed in contract values. To calculate 2007-08 payments, an uplift of 3.0 per cent has been applied to 2006-07 payments and the result is then rounded up to the nearest pound.

APPENDIX B

THE 2006-07 SETTLEMENT

In our Thirty-Fifth Report we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2006. Our main recommendations were:

- an increase of 2.2 per cent for all grades of doctors and dentists in training;
- an increase of 2.4 per cent for associate specialists, staff grade practitioners, hospital practitioners and clinical assistants;
- an increase of 2.2 per cent for consultants;
- 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); and
- an increase of 2.4 per cent for salaried primary dental care services dentists.

The Government accepted in full our recommendations relating to 2006-07, although it staged the award for consultants, paying 1.0 per cent from 1 April 2006, and the remaining 1.2 per cent from 1 November 2006.

APPENDIX C

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE¹ IN GREAT BRITAIN

	2003		2004		Percentage change 2004-2005	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff²						
Consultant	32,630	35130	34,190	36,800	4.8	4.8
Associate specialist	2,280	2540	2,510	2,820	10.1	11.1
Staff Grade	5,700	6200	5,650	6,240	-0.8	0.7
Registrar group ²	18,180	18910	19,310	20,080	6.2	6.2
Senior House Officer	23,570	23880	24,720	25,080	4.9	5.0
House Officer	5,270	5280	5,640	5,660	7.0	7.1
Hospital Practitioner	320	1160	240	1,130	-23.5	-2.8
Clinical Assistant	1,280	3920	890	3,360	-30.5	-14.3
Other Staff	600	1090	450	990	-25.6	-8.9
Total	89,830	98,110	93,610	102,160	4.2	4.1
Hospital and Community Health Services Dental Staff²						
Consultant	760	910	760	920	1.2	1.2
Associate specialist	100	130	100	130	2.5	2.3
Staff Grade	170	230	180	250	6.4	6.5
Registrar group	390	410	440	460	12.2	12.5
Senior House Officer	600	610	620	640	3.1	5.8
House Officer	30	30	30	30	-9.5	-6.5
Hospital Practitioner	30	90	20	90	-31.8	-6.5
Clinical Assistant	120	520	100	510	-17.2	-1.0
Other staff	1,480	1930	1,520	2,060	2.9	6.9
Total	3,670	4,850	3,770	5,080	2.7	4.8

NUMBERS OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE¹ IN GREAT BRITAIN (*continued*)

	2003		2004		Percentage change 2004-2005	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General practitioners^{3,4}						
General medical practitioners:	36,810	41,320	37,840	42,590	2.8	3.1
Contracted GPs	31,320	34,330	31,860	34,980	1.7	1.9
<i>GMS Contracted GPs</i>	21,750	23,810	22,590	24,770	3.9	4.0
<i>PMS Contracted GPs</i>	9,580	10,530	9,220	10,160	-3.8	-3.5
2C GPs, Contracted GPs			50	60	-	-
GMS GP registrars ⁵	1,920	2,010	1,980	2,090	3.1	4.1
PMS GP registrars ⁵	910	950	830	880	-8.3	-7.5
2C GPs, GP registrars ⁵	-	-	0	0	-	-
GP retainers ⁶	360	1,050	310	910	-12.0	-13.0
GMS Other	1,160	1,510	1,690	2,200	44.9	45.5
PMS Other	1,130	1,470	1,130	1,490	-0.4	1.4
2C GPs, Other	-	-	20	40	-	-
General dental practitioners:		23,240		24,370	-	4.9
principals		18,820		16,310	-	-13.4
assistants and vocational practitioners		2,000		1,670	-	-16.7
Personal Dental Services ⁷		2,170		6,100	-	180.8
salaried dentists ⁸		240		300	-	22.5
Ophthalmic medical practitioners⁹		610		500	-	-17.8
Total		65,180		67,460	-	3.5
Total – NHS doctors and dentists		168,140		174,710	-	3.9

¹ Data as at 30 September. Numbers have been rounded to the nearest 10. Percentages calculated from unrounded numbers.

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 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 for 1994-2004. In Scotland, Non-principals do not have FTE so factors of 0.65 are applied to all except GP Registrars where a factor of 0.96 is applied.

⁴ Data as at 30 September for England and Wales; as at 1 October for Scotland.

⁵ GMP Registrars were formerly known as GMP trainees.

⁶ 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.

⁷ In 2003, 390 dentists worked in Personal Dental Services (PDS) but also had a General Dental Services (GDS) contract. The corresponding figure for 2004 was 701 dentists and 982 dentists for 2005. Most of these dentists would appear in the general dental practitioner principals' row. These are excluded from PDS figures to avoid double counting. There are no PDS schemes in Scotland.

⁸ Data as at September except in Scotland where data is at March. As a result of improved data, salaried posts in Scotland not previously recognised as active have now been classified as active. Data includes dentists who hold both salaried and non-salaried list numbers in the GDS.

⁹ Data as at 31 December for England and Wales, and as at 31 March for Scotland.

APPENDIX D

THE EVIDENCE

We received written evidence from the Health Departments, comprising the Department of Health, the National Assembly of Wales and the Scottish Executive Health Department, from HM Treasury, from NHS Employers, the Advisory Committee on Clinical Excellence 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/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4120838&chk=8fBRmx

Evidence from HM Treasury

http://www.hm-treasury.gov.uk/documents/taxation_work_and_welfare/public_sector_pay/tax_pay_index.cfm

Evidence from NHS Employers

<http://www.nhsememployers.org/pay-conditions/pay-conditions-1447.cfm>

Evidence from the Advisory Committee on Clinical Excellence Awards

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

Evidence from the British Medical Association

<http://www.bma.org.uk/ap.nsf/Content/DDRBevidence2006?OpenDocument&Highlight=2,evidence,remuneration>

Evidence from the British Dental Association

<http://www.bda.org/index.cfm>

Evidence from the Dental Practitioners' Association

<http://www.uk-dentistry.org/library/documents/DPA%20Evidence%200929.pdf>

<http://uk-dentistry.org/library/documents/DPA%20Supplementary.pdf>

APPENDIX E

THE PARTIES' LETTERS ON INDEPENDENT CONTRACTOR GENERAL MEDICAL PRACTITIONERS

*From the RT Hon the Lord Warner
Minister of State NHS Reform*

MS(R)102006



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30 October 06

Dear Michael

We understand that the BMA has included in its written evidence to the Doctors' and Dentists' Review Body submissions from its General Practitioners' Committee asking the Review Body to recommend an appropriate inflationary uplift to the present contractual arrangements for primary medical care contractors.

Following discussions with the Devolved Administrations in Wales, Scotland and Northern Ireland, we believe that the DDRB has no role in the new contractual arrangements.

In contrast to the previous arrangements, the new contract is now clearly agreed and accepted as a contract for services with practices, rather than one concerned with GP remuneration. Previously DDRB was concerned with ensuring that GP remuneration was fair and appropriate in comparison to other health professions. Then the Review Body made a recommendation of IANI – intended net income of the average GP. However, the concept of average GP pay disappeared with the introduction of a practice-based service contract. This clearly links investment to a practice, and therefore GP remunerations, with the range, scale and quality of services provided to patients. The concept of IANI has ended.

Should the Review Body decide they are able to make recommendations on an intended average net increase to GP pay; it would bring into question the whole basis of an individually determined practice-based contract that links levels of payment to practices for services. Furthermore, the complexity of the new contractual arrangements is governed by a significant legislative and IT infrastructure such that it would not be possible for the necessary technical changes to be implemented through the contract for 2007.

As such, we see no way, in which the comprehensive negotiations operated jointly by NHS Employers and the GPC can, or should, be bypassed. I fear that during this tough round of negotiations, that takes into account the NHS' financial position as well as the need for this very significant contract to deliver similar efficiencies as other NHS contracts, GPC have considered that it is more convenient to abandon negotiations in favour of seeking a DDRB review.

They may believe it might result in a more favourable settlement for them or because it may be easier to justify to their members a settlement determined elsewhere. We remain committed to making further investment in primary medical care for delivery of new services and improvements in quality of care and therefore to increase investment delivered through the contract. For these reasons, we see no role for DDRB in considering GP pay issues for 2007. Clearly should a negotiated agreement not be reached with the BMA all parties will need to think again about the continuing basis of the new contractual arrangements that we all agreed. That will be the time to explore any alternatives.

I hope this clarifies our views.

Yours sincerely,
Norman Warner

NORMAN WARNER

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15 December 2006

Dear Michael

Thank you for affording me the opportunity to address the Doctor's and Dentist's Review Body at your recent oral evidence hearing.

You will recall that I undertook to write to you covering two aspects, relating to the remuneration of general medical practitioners (GMPs), in a little more detail. Those areas were:-

- the legal advice received by the Department on the case for resisting the BMA's request that the DDRB should make a recommendation in its 2007 report on "a fair inflationary increase across the entire contract";
- the issues that we believe the Review Body would need to take into account in reaching any recommendations in relation to GMP remuneration.

I should start by being clear that, of course, it is for the Review Body to decide if it will accept the BMA's invitation to include recommendations on GMP remuneration in their 2007 report, and the way it would approach making any recommendation. We accept that the Review Body's terms of reference are broad and general, and would potentially appear to cover all matters affecting remuneration of GMPs. The basic rationale for having an independent review body identified by the Pilkington Royal Commission (namely, that GMPs in effect had a monopoly client – the state - and no strong means of protecting their livelihoods if that client did not pay them fairly) still have force in relation to GMPs even in the new contractual environment.

However, a crucial question is the relationship between contract pricing as determined nationally and the actual take home pay of GMPs from their work for the NHS.

I would contend that there is no direct or sole relationship between contractual income and overall GMP remuneration. GMP pay is no longer solely about the investment derived from national determinations on the contract. That is only one element of GMP pay - albeit at this time a significant element. However, this is a declining proportion of the contribution to GMPs' pay and will increasingly become a smaller element as PCTs and practices determine where and what services are commissioned.

In considering any intended increase in GMP remuneration, you would need to take account of other NHS sources of income: those arising from local contractual arrangements as well as other payments from PCTs or NHS Trusts, and from Practice-Based Commissioning savings and incentives. This other NHS income constitutes an increasingly large proportion of GMP income - we estimate up to 10% of GMPs' income is now determined outside the nationally negotiated GMS contract. This will accelerate as PCTs and local practice-based commissioners increasingly move services out of hospitals and into the community. In addition, other groups (and by definition their remuneration) are now parties to the primary medical service contracts (nurses, managers etc.) and, additionally, contract income provides the pay of those employed by the contract holders. It is these areas, as well as other issues such as the operation of a balancing mechanism, that we believe the Review Body would need to consider if it is to establish how it can make appropriate recommendations on GMP take home pay in the future rather than the limited inflationary increase on the pricing of services within the contract that the BMA seeks.

Taking account of the breadth of work that is required, I believe that it would not be feasible for the Review Body to undertake a comprehensive study of all these aspects to a timetable that would allow recommendations to be included in the 2007 Report. Without that work, the Review Body cannot properly understand the relationship between the different elements that comprise:

- nationally or locally determined prices for services under the contract,
- other NHS payments made to GPs for other work, advice or contributions made to the NHS and patients, and,
- the take home pay of GPs (which is what your terms of reference are directed to).

My view is that if the Review Body undertook such a study its recommendations could then play a full and appropriate part in 2008/2009 contract negotiations.

As I made clear at the oral evidence, we have carefully considered the legal position (and taken advice). We are satisfied that in urging the Review Body not to accede to the request of the BMA (i.e. that it make a recommendation in its 2007 Report on "a fair inflationary increase across the entire contract")

we are not inviting the Review Body to act improperly or in a way that is incompatible with its terms of reference. We would be happy to discuss our view, and the reasons for our taking it, with your legal advisers if they wished so that your legal advisers could give the Review Body the clear advice you seek on the arguments we have presented to you. If, notwithstanding these considerations, the Review Body decides to proceed, we could not agree that it should be on the basis of the "general uplift" approach suggested by the BMA. In our view, that is too crude and would represent a departure from the objective served by the Review Body (in recommending on actual rates of GMP remuneration) under its terms of reference.

Finally, you asked me to comment on the opportunities still for reaching a negotiated settlement with the BMA. We remain committed to such an approach and wish to continue to invest in delivering more services and better care for patients within primary care. Investment is not the issue but the level of profit is. General practice is in a unique position within the NHS. It is largely able to determine the level of pay that can be earned by contract holders through the way they chose to deliver those services and reinvest income to extend the range of services offered and number of patients served, therefore in turn further increasing NHS investment into the practice.

We believe that given the huge increase in profits being experienced by GPs, outstripping the level of investment into practices, that it is reasonable to expect these organisations to deliver a level of efficiency and improvement in services provided to patients under their contract as part of any consideration of any increase to existing service provision resulting from inflationary pressures.

If there is further information or clarification required on any points made at the oral evidence given on the 11 December, I or my officials, would be happy to provide it.

Approved by the Minister and signed in his absence

P.P. 

NORMAN WARNER



BRITISH MEDICAL ASSOCIATION

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From the Chairman of Council:
Mr J N Johnson MD FRCS FRCP FDSRCS

Mr Michael Blair QC
Chairman
Doctors and Dentists Review Body
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Our Ref: JNJ/FC

09 January 2007

Dear Michael

Thank you for copying the BMA into the response you sent to Lord Warner on 21 December 2006. We have now seen a copy of his letter to you dated 15 December.

We are glad to see that the Department recognises that a monopsonistic market still exists in the new contractual environment and, consequently, that the basic rationale for the Review Body still has force in relation to GMPs. It is, therefore, disappointing that the Department continues to argue that the DDRB should not include recommendations on GMP remuneration in its 2007 report.

As I initially outlined in my letter to you dated 6 November 2006, we do not accept the Department of Health's arguments for excluding GMPs from the DDRB's consideration. While it is true that GPs have access to non-contractual income streams, a direct relationship clearly remains between the contract price and GMP remuneration. In many ways the new contract has made very little difference in this respect. As you know, the DDRB has always taken into account GPs' access to non-contractual income. Furthermore, as the Department acknowledges in its letter, even under the new arrangements at least 90 percent of GMPs' income is still determined by the GMS contract. Therefore, as in previous years, while the DDRB is unable to determine GMPs' exact remuneration, it has a critical role to play in ensuring that payments made for the bulk of GPs' work, which have a fundamental effect on their income, are fair and appropriate.

We do not accept that it would be technically difficult for the Review Body to recommend an appropriate contractual uplift for GMPs. It has become clear that we will not be able to reach a negotiated agreement with NHS Employers this year but it has been obvious throughout our discussions that uplifts could, in theory, be applied across the contract. As a result, we are not persuaded by the Department's argument that the Review Body needs to undertake a

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Chief Executive/Secretary: Tony Bourne

study into the relationship between different elements of GMP income. Moreover, we do not accept that the Review Body's remit is limited purely to contributing to direct contract negotiations, as Lord Warner's letter suggests.

Finally, Lord Warner commented on his commitment to reaching a negotiated settlement. I am afraid the prospect of doing so is virtually non-existent since, despite Lord Warner's statement that investment is not the issue, it is the level of any such investment that is the fundamental matter between the parties. As we stated earlier, we believe that you cannot disaggregate investment and profit and it is precisely for these reasons that we believe the DDRB continues to have a crucial role in determining GP income.

I hope that the Review Body will share our interpretation of the current situation.

If you require any more detail on methods of calculating a contractual uplift for GMPs, Jon Ford of our Health Policy and Economic Research Unit would be happy to discuss this with you.

Happy New Year

Best wishes



APPENDIX F

THE POLICY FRAMEWORK

1. The evidence we have received from the three **Health Departments** was set in the context of the following policy documents:
 - The *NHS Plan*¹, *HR in the NHS Plan*², *Our health, our care, our say: a new direction for community services*³ and *The NHS in England: the operating framework for 2007/08*⁴, all covering England;
 - *Our National Health, A Plan for Action, A Plan for Change*⁵, *A Partnership for a Better Scotland: Partnership Agreement*⁶, *Building A Health Service Fit For The Future*⁷, *Fair to All, Personal to Each – The Next Steps for NHS Scotland*⁸, the *National Workforce Plan 2006*⁹ and *Healthy Working Lives*¹⁰ covering Scotland;
 - *Improving Health in Wales – A Plan for the NHS with its partners*¹¹, *Delivering for Patients*¹², the *Wanless Report Implementation Plan*¹³, *Building for the Future*¹⁴ and *Designed for Life*¹⁵ in Wales; and
 - *Modernising Medical Careers*¹⁶.
2. The objective of the *NHS Plan* was to modernise the NHS in England through a combination of investment and reform. It committed the Government to increases in key staff groups over the period to 2004 alongside a range of Human Resource (HR) initiatives designed to complement the increases in numbers and improve working lives. The key targets in the *NHS Plan* affecting our remit groups were for:
 - 1,000 more medical school places;
 - 1,000 more specialist registrars;
 - 7,500 more consultants; and
 - 2,000 more general medical practitioners.

¹ *The NHS Plan*. Department of Health, 27 July 2000.

² *HR in the NHS Plan*. Department of Health, July 2002.

³ *Our health, our care, our say: a new direction for community services*. Department of Health, January 2006.

⁴ *The NHS in England: the operating framework for 2007/08*. Department of Health, December 2006.

⁵ *Our National Health, A Plan for Action, A Plan for Change*. Scottish Executive on 14 December 2000.

⁶ *A Partnership For A Better Scotland: Partnership Agreement*. Labour/Liberal Democrat coalition following the Scottish Parliament elections, May 2003.

⁷ *Building A Health Service Fit For The Future*. Scottish Executive, May 2005.

⁸ *Fair to All, Personal to Each – The Next Steps for NHS Scotland*. Scottish Executive, December 2004.

⁹ *National Workforce Plan 2006*. Scottish Executive, December 2006.

¹⁰ *Healthy Working Lives, A Plan for Action*. Scottish Executive, August 2004.

¹¹ *Improving Health in Wales – A Plan for the NHS with its partners*. National Assembly for Wales, 2 February 2001.

¹² *Delivering for Patients*. NHS Wales, June 2000.

¹³ *Wanless Report Implementation Plan*. National Assembly for Wales, November 2003.

¹⁴ *Building for the Future*. Welsh Assembly, March 1999.

¹⁵ *Designed for Life*. Welsh Assembly, May 2005.

¹⁶ *Modernising Medical Careers: the next steps*. Department of Health, 15 April 2004.

3. By 2008, the **Department of Health** expects the NHS to have net increases of 15,000 doctors (consultants and GMPs) over the September 2001 baseline. The HR initiatives in the *NHS Plan* have now been strengthened by *HR in the NHS Plan* which outlined a five-year strategy aimed at delivering increased numbers of staff with jobs designed around the needs of patients.
4. In January 2006, the Department published a White Paper, *Our health, our care, our say: a new direction for community services*. It set out proposals for providing people with good quality social care and NHS services in the communities where they live.
5. In December 2006, the Department published its operating framework for 2007-08, which was intended to provide consistency of purpose for the NHS, set out the key targets that staff needed to focus on in order to improve patient experience, reduce health inequalities and achieve financial health. The framework built on the programme of reform set out in the *NHS Plan* and the proposals from *Our Health, our care, our say*.
6. In Scotland, *Building A Health Service Fit For The Future* set out a framework for service change over the next 20 years, with a health service anchored in communities, built on fully integrated services, more responsive to the healthcare needs of an ageing population. *Fair to All, Personal to Each – The Next Steps for NHS Scotland* outlined enhanced targets for access to health services in Scotland, such as no patient waiting more than 18 weeks from GP referral to outpatient appointment. The *National Workforce Plan 2006* built on the 2004 and 2005 reports, supporting workforce planning at NHS Board and regional level. *A Partnership for a Better Scotland: Partnership Agreement* contained a number of targets relating to the medical and dental workforce. Details of staff governance documents were provided, such as *Healthy Working Lives* which presented an action plan to make NHS Scotland the employer of choice.
7. In Wales, *Designed for Life* set out the vision for the next ten years, continuing along the path set out in *Improving Health in Wales* and *Building for the Future*. It recognised that health services in Wales would in the coming years be more explicitly organised around three regional networks, and required a restructuring of the workforce, new ways of working, changes in practice and improved efficiency, as well as greater support for carers and for supporting service users to do more for themselves.
8. *Modernising Medical Careers*, prepared under the auspices of all four UK home countries, looked at the future shape of Foundation, Specialist and General Practice Training Programmes, and examined opportunities for streamlining the training of doctors and dentists, and ways of providing greater flexibility.

APPENDIX G

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

APPENDIX H

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
AEI	Average Earnings Index
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
COGPED	Committee of General Practice Education Directors
CPI	Consumer Prices Index
DCP	dental care professional
DDRB	Review Body on Doctors' and Dentists' Remuneration
DEL	Departmental Expenditure Limit
DPA	Dental Practitioners' Association
FHO	foundation house officer
GDP	general dental practitioner
GDS	General Dental Services
GMC	General Medical Council
GMP	general medical practitioner
GMS	General Medical Services
GPC	General Practitioners' Committee
HCHS	Hospital and Community Health Services
HMRC	Her Majesty's Revenue & Customs
HO	(pre-registration) house officer
HRPS	Healthcare and Related Personal Services
HSCIC	Health and Social Care Information Centre
LDC	Local Dental Committee
LHB	Local Health Board
NAW	National Assembly for Wales
NCCG	non-consultant career grade
NHS	National Health Service
NHSE	NHS Employers
NICE	National Institute for Clinical Excellence
OMP	ophthalmic medical practitioner
ONS	Office for National Statistics
PA	programmed activity
PCO	Primary Care Organisation
PCT	Primary Care Trust
PMETB	Postgraduate Medical Education and Training Board
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
SHA	Strategic Health Authority
SHO	senior house officer
SPDCS	Salaried Primary Dental Care Services
SpR	specialist registrar
UDA	unit of dental activity
UK	United Kingdom
VDP	vocational dental practitioner
WTD	Working Time Directive