Review Body on Doctors'
and Dentists' Remuneration

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Forty-Fifth Report 2017

Chair: Professor Sir Paul Curran

Cm 9441

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

Presented to the National Assembly for Wales by the First Minister
and the Cabinet Secretary for Health, Well-being and Sport

Presented to the Northern Ireland Assembly by
the First Minister, Deputy First Minister and Minister for Health[1]

by Command of Her Majesty

March 2017

Cm 9441

[1] In the absence of a Northern Ireland Executive at the time of publication, this report was presented to the Permanent Secretary of the Department of Health, Northern Ireland.

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at
Office of Manpower Economics
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2-6 Salisbury Square
London
EC4Y 8JX
www.gov.uk/government/organisations/office-of-manpower-economics

Print ISBN 9781474141338
Web ISBN 9781474141345

ID 22021705 03/17 58665

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office.

Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

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

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

> the need to recruit, retain and motivate doctors and dentists;
>
> regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
>
> the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
>
> the Government's inflation target;
>
> the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

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

The members of the Review Body are:

> Professor Sir Paul Curran *(Chair)*
> David Bingham
> Lucinda Bolton
> Mehrunnisa Lalani
> Professor Kevin Lee
> Professor James Malcomson
> Lisa Tennant
> Nigel Turner, OBE

Secretariat is provided by the Office of Manpower Economics.

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- *The maximum and minimum of the salary range for salaried GMPs be increased by 1 per cent.*
- *For independent contractor GMPs, an increase in pay, net of expenses, of 1 per cent.*
- *For independent contractor GDPs, an increase in pay, net of expenses, of 1 per cent.*

Allowances and awards

- *An increase in the GMP trainers' grant of 1 per cent.*
- *No increase in the rate for GMP appraisers which would remain at £500.*
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- *The flexible pay premia included in the new junior doctors' contract in England to increase in line with our main pay recommendation of 1 per cent.*
- *The value of the awards for consultants – Clinical Excellence Awards, Discretionary Points and Commitment Awards – to increase in line with our main pay recommendation of 1 per cent.*

Targeting

- *We recommend that better use is made of existing pay flexibilities.*
- *We recommend that the health departments, employers and workforce planners in England, Wales and Northern Ireland give serious consideration to developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing the results, in evidence next year, and would be happy to assist in developing criteria for payments if evidence is provided to us.*

Retention

- *The health departments and employers in England, Wales and Northern Ireland investigate how many doctors and dentists are taking early retirement and for what reasons, and provide us with evidence on this next year.*

Observations 2017-18

In relation to salaried GMPs:

1. *There are signs of a clear trend in the GMP workforce towards salaried employment and away from the contractor-partner model. It is not yet clear if this is a permanent trend, but broader changes in the economy, particularly with the entry of the 'Generation Y' cohort into the labour market imply that it might be. A systematic data collection exercise is needed to understand properly the profile of the GMP workforce in terms of FTE, geographic, demographic data, and career choices. Understanding FTE would shed further light on how far Generation Y desires for flexibility and a better work-life balance are translating into part-time working patterns and this in turn will be crucial for effective workforce planning.*

2. *There is a lack of data and insight into this trend by the parties. There is also a significant amount of change in the primary care landscape. This implies that there may be a lack of readiness for what may be a fundamental shift in the workforce, in terms of ensuring that the employment offer is as attractive as possible whilst maintaining value for money in primary care provision.*

3. *While there is not a great deal of evidence on this group, they are much more likely to be younger and female than GMP partners. Despite generally lower earnings than GMP partners, salaried status appears to be an increasingly popular choice for new doctors, which could be due to the greater flexibility and work-life balance this role can offer. Overall, there is insufficient evidence for us to draw firm conclusions, but we will monitor this group closely, as there could be implications for the future planning and delivery of primary care.*

Additional:

4. *We observe that a major demographic shift is taking place within our remit groups associated with the Generation Y cohort that is entering the workforce in greater numbers and the shift in gender balance of those choosing to train as doctors and dentists. We see this shift as linking closely to career choices to take salaried GMP roles and to locum, and urge the parties to consider the potential impact of this shift on workforce planning assumptions, the nature of the employment offer as well as in terms of pay, including gender pay.*

5. *We identify a number of themes looking forwards, including the need to give SAS doctors equal consideration and for them to be better reflected in the quality and quantity of evidence we receive.*

Remits and the pay round process

1. Our approach to this round was informed by our standing terms of reference and the remits submitted by England, Wales, Northern Ireland and Scotland. The UK Government previously announced its policy that it would fund public sector pay awards of 1 per cent for four years until 2019-20. HM Treasury told us that it expected that pay awards should be targeted to support the delivery of public services and to address recruitment and retention pressures, within the overall 1 per cent pay envelope. None of the parties submitted evidence to support targeting through national pay scales, although the Department of Health (England) did tell us of alternative approaches it was taking to targeting, such as flexible pay premia for those choosing to train in emergency medicine, psychiatry and general practice.

2. The Cabinet Secretary for Finance and the Constitution for the Scottish Government confirmed that Scotland would be seeking our recommendations in this pay round, but would be unable to provide evidence until after the Scottish draft budget and public sector pay policy had been published in November 2016. Therefore we consider Scotland separately with recommendations to be submitted later in a supplement to this report.

3. The headcount of our remit groups increased by 0.7 per cent compared with last year and stood at around 209,000 doctors and dentists across the United Kingdom as at September 2015. Our remit groups comprise approximately:

    - 64,300 hospital doctors;
    - 63,200 doctors and dentists in training;
    - 49,200 GMPs; and
    - 29,800 GDPs.

4. We considered written and oral evidence from: the Department of Health (England); the Welsh Government; the Northern Ireland Executive; NHS Employers; NHS England; Health Education England; NHS Improvement; the British Medical Association (BMA); the British Dental Association (BDA); and NHS Providers. We also received written evidence from the Association of Dental Groups; and Mydentist.

Context to this report

5. Our report comes at a time of change and challenge for the NHS across the UK. Developing new and innovative approaches will be required to meet the needs of an increasing and ageing population, with multiple and complex health requirements which place extra pressure on our remit groups and the wider system. Added to this are the difficulties posed by the wider financial position and the Government's public sector finance policies.

6. The policy aims in the Five Year Forward View continue to be implemented in England. As part of that, Sustainability and Transformation Plans are being developed, seeking to better integrate primary and secondary care, and shift the focus from hospital to community-based care. We also consider the impact of 'Generation Y' (those born between approximately 1980 and 2000) as a growing part of the workforce, with different work preferences and behaviours which employers and planners will need to react to in order to recruit and retain this group and ensure the effective delivery of healthcare. We have increasing concerns over the Speciality doctor and Associate Specialist (SAS) grades of hospital doctors, who play a vital role in secondary care, but appear to have slipped down the priority order.

7. Perhaps the most striking development over the last year relates to the junior doctors' contract dispute in England. Following the April 2016 first ever all-out strike by junior doctors in England in the history of the NHS, talks between NHS Employers and the BMA were restarted in May at ACAS. While a new draft contract for junior doctors in England was agreed by the parties, it was subsequently rejected at ballot. On 6 July 2016 the Secretary of State for Health announced that the contract would be implemented anyway, in a phased rollout with new terms starting to apply from October 2016 (for new appointments and as contracts of employment expire as juniors move through training). In reaction to this, at the end of August 2016, a series of four all-out five-day strikes was announced. These were called off following concerns raised over patient safety and providing cover, and all strikes were suspended in late September, although the BMA re-stated its opposition to imposition of the contract. NHS Employers produced an implementation timetable that set out when different groups in England were due to move onto the new contractual arrangements between October 2016 and October 2017.

Recruitment, retention and motivation

8. Problems remain in recruiting doctors into some specialties (such as emergency medicine, psychiatry and general practice) and into some locations. Effective workforce planning based on sound management information is essential to help mitigate this and we are pleased to note the progress being made on this in each of the three countries. It is clear to us that, as some of the issues are so stubborn and non-pay solutions have been ineffective, pay-related options should be considered.

9. Our remit groups remain motivated to deliver high quality patient care, although other pressures such as workload are having a negative effect both in primary and secondary care. Both the BMA and BDA cited low morale affecting their members and highlighted that workforce issues are tied in with the wider service aspirations in each country. The BMA said that the junior doctors' industrial action in England was likely to have a negative effect on the morale of all of our remit groups and the annual pay uplift, upon which we recommend was, in the current context, seen as an important signal of the value of our remit groups.

Economic background, pay comparability and affordability

10. Economic growth in the United Kingdom continued to be fairly strong in 2016. Gross Domestic Product (GDP) grew by an estimated 2.0 per cent in 2016 as a whole compared with 2015. Inflation increased steadily over the last year. The Consumer Prices Index (CPI) annual inflation rate rose from 0.3 per cent at the beginning of 2016 to 1.6 per cent in December 2016 and is forecast to continue to rise. The labour market continued to perform reasonably, with the employment rate increasing by 0.5 per cent over the year to 74.5 per cent.

11. Affordability (which we take from our terms of reference to mean the funds available to the health departments as set out in the government's departmental expenditure limits) was at the forefront of evidence provided to us by all three of the health departments. It is apparent that maintaining the public sector pay policy of 1 per cent until 2019-20 can offer a way of limiting increases to costs. However, the impact of ongoing pay restraint is wider than just helping to reach fiscal targets. Pay is important and the public sector pay policy could well impact adversely on recruitment, retention and motivation in our remit groups given the demands on the health services and change programmes underway.

12. We are concerned about the impact of inflation and wider wage growth upon our remit group, particularly when considering recruitment, retention and motivation. Wage growth across the economy generally at both the median and 90th percentile was well above one per cent in 2016, which eroded the relative pay of doctors and dentists. Further to this, should inflation continue to increase as it is forecast to do, it will continue to lower real wages. While some in our remit groups earn less than some in the comparator professions (law, accountancy, actuaries) that we include in our report, our data do not allow for differences in career progression. Newly qualified doctors have an almost guaranteed job upon graduation with a clearly defined career path and can access this career more or less anywhere in the country. In some of our comparator groups, reaching senior levels is more competitive, and tied to being located in London, with only a few reaching the pinnacle of their profession. However, these one-off advantages for our remit groups cannot compensate for a continuing erosion of pay relative to other professions.

Our recommendations

13. In considering the request for targeting to support recruitment and retention made by HM Treasury, we have again concluded that we should not target our recommendations for 2017-18. No proposals were put to us for targeting through national pay scales. However, we distinguish between targeting via national pay scales, targeting via differential pay premia informed by nationwide agreement (for example for particular specialties), and targeting via local pay premia or allowances.

14. We are not convinced by the general arguments that shortages are not amenable to pay. Shortages tend to persist, and no evaluation of the various non-pay approaches has been provided to us. We wait with interest to see such evaluations. Meanwhile, we consider there is scope for more targeting by nationwide agreement, building on the models that have recently been introduced, recognising that consideration would need to be given on how to fund such schemes. It is also clear to us that the issue of geographic shortages risks being ignored or at best handled piecemeal. Local premia are used rarely. We consider that non-pay measures have been given a more than reasonable time to address issues, so pay solutions should now be explored. It may be that, given current pressures on local management, some more active support and resourcing from the centre is needed to facilitate the development and testing of potential solutions, as with the recent Sustainability and Transformation Plans.

15. **We recommend:**

    - **that better use is made of existing pay flexibilities;**
    - **that the health departments, employers and workforce planners in England, Wales and Northern Ireland give serious consideration to developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing the results, in evidence next year, and would be happy to assist in developing criteria for payments if evidence is provided to us.**

16. In considering the main pay uplift, we have several concerns about the evidence we have received. Firstly, the departments and employers' organisations seem to us to have given little consideration to the possible effects of ongoing pay restraint on the recruitment, retention and motivation of our remit groups in their pay proposals. Should inflation and private sector wages continue to increase, it would be unwise to be complacent here, and we note that consultants have had a relatively larger decrease in take-home pay than others in our remit group. Linked to this, the pay proposals given to us do not demonstrate sufficient regard to the need to address severe ongoing shortages in medical staff in particular locations and specialties, and so do not help to move the situation forward. Lastly, we would welcome greater clarity from all parties on what they consider fair and appropriate pay levels would be for our remit groups in relation to any comparators that the parties thought relevant in a "steady state" environment. We will also continue to undertake our pay comparison work.

17. We note that the Consumer Prices Index (CPI) of inflation at December 2016 was 1.6 per cent, and was forecast to reach 2.5 per cent by the end of 2017. Median gross weekly earnings for full-time private sector employees increased by 3.4 per cent in the year to April 2016, according to the Annual Survey of Hours and Earnings. Whilst forecasts are subject to change and setting the contribution of annual increments aside, the obvious conclusion is that a 1 per cent award would most probably be below inflation.

18. In terms of recruitment, the annual pay award is important in supporting the attractiveness of medical and dental careers. The Department of Health (England)'s aspiration towards self-sufficiency of supply makes it even more important. On the other

hand, these are relatively highly paid groups; applications by well-qualified students for medical courses are holding up; there is not a net outflow of trained doctors from the NHS; and the supply of dentists willing to bid for NHS contracts remains solid. Workload indicators in the NHS staff survey show a high degree of dissatisfaction, but engagement measures are holding up. We note again that there is already a general expectation of a 1 per cent increase.

19. In light of wider economic forecasts, plus the increasing demands being made on the goodwill of our remit groups, we have considered whether our award should be more than 1 per cent. However, we also accept that the affordability of a settlement is weakened following the government's decision to borrow more, as set out in the Autumn Statement 2016 and given increased demands on NHS services. In view of the pressures, alleviating workload and fostering job satisfaction rather than increasing pay would still appear to be the more important priorities for improving motivation. Overall we feel there is a continuing, though diminishing, case for 1 per cent again this year, if this enables more staff to join the service to alleviate workload pressures. We understand that England, Wales and Northern Ireland have assumed 1 per cent in their funding arrangements. We again see no compelling reason for differential awards by country.

20. **We are therefore recommending a base increase of 1 per cent in 2017-18 to the national salary scales for salaried doctors and dentists in England, Wales and Northern Ireland.** Individuals on incremental pay scales who have not reached the maximum scale point will also be eligible for incremental progression according to the agreed criteria.

21. We make a separate recommendation for salaried GMPs, whose pay falls within a salary range rather than on an incremental pay scale. **We recommend that the minimum and maximum of the salary range for salaried GMPs in England, Wales and Northern Ireland be increased by 1 per cent for 2017-18.**

22. This year, we were asked to make observations, based on any evidence the parties could provide, about the factors affecting recruitment, retention and motivation of salaried GMPs in England. This followed on from our last report where we noted that there had been an expansion of the salaried model in general practice and that it would be important to gain a better understanding of this. We make the following observations:

Observation 1
There are signs of a clear trend in the GMP workforce towards salaried employment and away from the contractor-partner model. It is not yet clear if this is a permanent trend. However, broader changes in the economy, particularly with the entry of the Generation Y cohort into the labour market imply that it might be. A systematic data collection exercise is needed to understand properly the profile of the GMP workforce in terms of FTE, geographic, demographic data, and career choices. Understanding FTE would shed further light on how far Generation Y desires for flexibility and a better work-life balance are translating into part-time working patterns and this in turn will be crucial for effective workforce planning.

Observation 2
There is a lack of data on and insight into this trend by the parties. There is also a significant amount of change in the primary care landscape. This implies that there may be a lack of readiness for what may be a fundamental shift in the workforce, in terms of ensuring that the employment offer is as attractive as possible whilst maintaining value for money in primary care provision.

Observation 3
While there is not a great deal of evidence on this group, they are much more likely to be younger and female than GMP partners. Despite generally lower earnings than partners, salaried status appears to be an increasingly popular choice for new doctors, which could be due to the greater flexibility and work-life balance this role can offer. Overall, there is insufficient evidence for us to draw firm conclusions, but we will monitor this group closely, as there could be implications for the future planning and delivery of primary care.

23. Chapter 9 includes our detailed recommendations.

24. We heard from some parties that expenses discussions for GMPs and GDPs are best done by negotiation between the parties, and concluded that we should again this year make a recommendation on pay net of expenses. **For independent contractor GMPs in England, Wales and Northern Ireland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18. For independent contractor GDPs in England, Wales and Northern Ireland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.**

25. There are several topics covered in this report where we would like to receive more or improved information for our next round. We would like to develop further our understanding of areas such as salaried and locum GMPs, gender pay and retirement trends, and need robust evidence to do so.

Looking forward

26. In this final section, we draw together many of the themes in this Report, with a brief look forward at some of the challenges facing our remit groups over the next few years. We also note the potentially damaging impact on motivation, recruitment and retention if real pay levels for our remit groups continue to decline while pay in the private sector is rising.

27. It seems likely that:

- demands from patients and the NHS in general for the services of our remit groups will not decrease, and, in the short term (2-3 years), demands are much likelier to increase;
- there will continue to be some specialties, and some locations, where there is a mismatch between the availability of qualified medical or dental practitioners, and the demand for them; and
- the public finances will be tight, creating continuing affordability constraints within the NHS, and an imperative to spend resources wisely.

28. These challenges will increase pressure on our remit groups. In facing these challenges, we note that:

- our remit groups remain highly motivated by the value of their work, and the satisfaction that they obtain from practising medicine or dentistry;
- there remains a strong general desire to join the medical and dental professions; if demand by well-qualified students were the sole criterion, medical and dental schools could substantially increase the number of places they provide; and
- government relations with the medical profession suffered during the junior doctors' dispute, and trust is only gradually being rebuilt.

29. We also note that our remit groups are changing, as society is changing. Different models are emerging for the supply of health care. The growth in salaried GPs; in performer-only dentists; in qualified medical practitioners opting for locum roles; all these suggest a slow but steady shift in priorities and behaviours, especially for the younger members of our

remit groups (those we have referred to in this Report as 'Generation Y'). At the same time, changes in the NHS more generally, and in particular to pension arrangements, are affecting the retirement choices made by older members of our remit groups. This is the context in which the challenges in particular specialties and locations should be addressed.

30. We believe that some of the recruitment and retention challenges could be ameliorated by appropriate, targeted pay and reward initiatives. In principle, the pay system already offers potential for local flexibilities of this sort. In practice, trusts and health boards have found it challenging to develop and use these. Local expertise in devising and managing new pay initiatives is in short supply, and management attention focuses on maintaining day-to-day services to patients. The apparent lack of willingness to use local pay flexibilities needs to be challenged, and their use tested in practice.

31. Given the changing circumstances and aspirations within our remit groups, we think it highly desirable that different types of targeted pay and reward incentives should be explored, including some that might be radically new. A single set of nationwide solutions would be slow to develop, and risk being poorly adapted to local needs. However, at present, we see no mechanism for enabling new ideas, backed by appropriate resources, to be locally stimulated and tested rapidly. Given the costs to the whole NHS of handling shortages of key people, we believe that the leaders of the system – health departments in all three countries and the relevant other bodies such as NHS England, NHS Improvement and Health Education England – should look to fill this gap. The Sustainability and Transformation Planning process has illustrated the possible benefits of a centrally driven initiative to stimulate local thinking.

32. The key objectives should be to develop, and rapidly test, new targeted pay and reward incentives, listening carefully to what different groups in the workforce are seeking. The results should be widely shared, accepting that not all the ideas will prove successful. In our view, having this extra capacity could put the NHS in a stronger position to meet some important challenges for recruitment, retention and motivation during this Spending Review period. We will be happy to offer any help we can.

33. Meanwhile we attach great importance to motivation of our remit group, across the whole NHS, during a period when staff will continue to be under pressure; when inflation seems likely to rise; and when private sector comparators' earnings are also likely to increase. If there are affordability constraints across the public sector, our remit groups will be affected, but they should not feel singled out by government for particularly severe sacrifices. One of our important roles as a Review Body is to advise on this, ensure a fair balance and monitor the sustainability of the recruitment, retention and motivation of our remit groups. This sustainability is clearly being challenged. Consideration therefore needs to be given to planning an exit strategy at the end of the pay policy period.

PROFESSOR SIR PAUL CURRAN *(Chair)*
DAVID BINGHAM
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MEHRUNNISA LALANI
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NIGEL TURNER, OBE

OFFICE OF MANPOWER ECONOMICS
22 February 2017

CHAPTER 1: INTRODUCTION

Introduction

1.1 For 2016-17 we received remits from all four UK countries. The remits differed slightly, reflecting the public sector pay policy of each of the governments. More detail on the remits is provided later in this chapter.

1.2 We have considered the remits in relation to our standing terms of reference and set out the evidence received from the parties on these matters, together with the conclusions and recommendations we reached based on this evidence.[1] Transparency is an essential part of the independent Review Body process, which is why we ensure that the parties share evidence with one another in order to comment on and interrogate the submissions. Deliberating in private through oral evidence sessions enables us to have a free and frank exchange of views with the parties. However, again we take care to be as transparent as possible by providing details of how such sessions have informed our recommendations in this report, by explaining the rationale for our decision-making, and summarising the evidence provided.

Structure of the report

1.3 This report is divided into 10 chapters:

1. Introduction
2. Economic outlook and affordability
3. Motivation
4. Workforce Planning and Future Supply
5. Doctors and dentists in training
6. Hospital doctors
7. General Medical Practitioners
8. Dentists
9. Pay
10. Looking forward

1.4 We also include 9 appendices:

A. Remit letters from the parties
B. Detailed recommendations on remuneration
C. The number of doctors and dentists in the NHS
D. Glossary of terms
E. Earnings and expenses of General Medical Practitioners and General Dental Practitioners
F. Pay comparability
G. Total earnings distribution
H. Abbreviations and acronyms
I. Previous DDRB recommendations and the Government's response

Key context for this report

1.5 Our report comes at a time of substantial change and challenge for the NHS across the UK. New and innovative approaches will be required to meet the demands of an increasing, ageing population with multiple complex health needs placing extra pressure on the system. Added to this are the difficulties posed by the wider economic position and the constraints on public finances.

[1] The DDRB terms of reference can be found at page iii of this report.

1.6 Such pressures undoubtedly impact on our remit group. While non-pay issues such as workload are at the heart of our remit group's concerns, pay also has an important role to play in supporting motivation, and ensuring that staff feel valued and fairly treated. This has come to the fore most notably in the junior doctors' contract negotiations in England.

1.7 Other issues which have come to the fore in this round include:

- the General Practice Forward View (in England) and how the future of primary care will be remodelled to meet rising demand;
- the development and implementation of Sustainability and Transformation Plans (STPs) (in England) based on multi-disciplinary care teams which aim to better integrate primary and secondary care;
- integration of services as a key theme, including the Wellbeing of Future Generations (Wales) Act, and the Delivering Together report in Northern Ireland;
- the impact of 'Generation Y' – an increasing proportion of the medical workforce with different work preferences and behaviours; and
- the increasing concerns of speciality doctors and associate specialists (SAS doctors) who often feel undervalued and unfairly treated.

1.8 Finally we note that, at the time of writing, elections were due to take place to the Northern Ireland Assembly.

Remits for this report

1.9 The remit letters from each of the four countries are included in full at Appendix A and summarised below.

HM Treasury

1.10 The UK Government policy on public sector pay was announced by the Chancellor of the Exchequer in his summer budget on 8 July 2015.[2] The Chancellor confirmed that a pay increase of 1 per cent for four years from 2016-17 onwards would be funded for public sector workforces.

1.11 The Chief Secretary to the Treasury wrote to Review Body Chairs on 16 July 2016, reiterating that the 1 per cent public sector pay policy was to remain in place until the end of this parliament, and setting out an expectation that pay awards would be targeted in order to support the delivery of public services and to address recruitment and retention pressures, within the 1 per cent overall pay envelope.

Department of Health (England)

1.12 The Secretary of State sent his remit letter on 22 August 2016 which set out the Department's commitment to the policy of pay restraint in order to protect jobs and support 'prudent management of public finances'. It also asked us for our observations on the recruitment, retention and motivation of salaried General Medical Practitioners (GMPs) given their increasing prominence in primary care.

Welsh Government

1.13 The Cabinet Secretary for Health, Wellbeing and Sport's letter of 22 August 2016, confirmed the Welsh Government's wish to receive our recommendations in relation to the remit groups, in particular GMPs and the issues affecting their recruitment, retention and motivation.

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[2] More information on the summer budget announcements is available from: https://www.gov.uk/government/publications/summer-budget-2015/summer-budget-2015#the-uk-economy-and-public-finances

Northern Ireland Executive

1.14 The Minister for Health wrote to us on 3 August 2016 to confirm the Northern Ireland Executive's intention to participate in the pay round, and to seek our recommendations on remuneration. It also noted the Executive's adherence to the UK Government's policy of public sector pay restraint.

Scottish Government

1.15 The Cabinet Secretary for Finance and the Constitution wrote to us on 30 September 2016 to confirm that Scotland would be seeking our recommendations in this pay round, but would not be able to provide evidence until after the Scottish draft budget and public sector pay policy had been published in November.

The remit group

1.16 At September 2015, our remit groups comprised approximately 209,000 doctors and dentists, a 0.7 per cent increase on the previous year. This is broken down into the component parts of our remit group as follows:

- 63,225 doctors and dentists in training;
- 64,269 hospital doctors;
- 49,162 GMPs; and
- 29,775 dentists.

Our comment on the remits

1.17 The remits for this round once again outlined broadly similar approaches, albeit with some differences between the different countries' policies and emphasis. In terms of pay policies specifically, the UK Government set out a four-year policy, of which 2017-18 is the second year, and expected awards to be targeted to support recruitment and retention. Wales and Scotland have one-year policies to cover 2017-18, while the 2017-18 pay policy in Northern Ireland will be agreed by the Executive after the election.

1.18 We regret that it was not possible for Scotland to submit its evidence to our usual timetable as we consider the medical and dental workforce to be a UK-wide labour market. We consider Scotland separately and will be making recommendations in a supplement to this report. This report does include some pre-existing published data and evidence relating to our remit groups in Scotland. However, the Scottish supplement to this report will include our comments on the evidence submitted for this pay round.

1.19 Another focus of this year's remits was on salaried GMPs, as requested by the Department of Health (England).

Parties giving evidence

1.20 We received written evidence from the organisations listed below for this round:

Government departments and agencies

- Department of Health (England)
- NHS England
- NHS Improvement
- Health Education England
- Welsh Government
- Northern Ireland Executive
- Scottish Government (to be set out in the later supplement to this report)

Employers' Bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

- British Dental Association
- British Medical Association
- Association of Dental Groups
- Mydentist

1.21 We held oral evidence sessions during November and December 2016 with the following parties:

Government departments and agencies

- Department of Health (England)
- Health Education England
- Welsh Government
- Northern Ireland Executive
- NHS England
- NHS Improvement

Employers' Bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

- British Dental Association
- British Medical Association

We will hold additional oral evidence sessions in February relating to the Scottish remit.

Last year's recommendations

1.22 In our 44th Report 2016, our main recommendation was for an increase in basic pay of 1 per cent to the national salary scales for salaried doctors and dentists across the UK in 2016-17. We concluded that we should not target our recommendations on the basis of recruitment and retention, due to the risk of demotivating those whose pay was not uplifted.

1.23 Our main pay recommendations for 2016-17 were:

- A base increase of 1 per cent to the national salary scales for salaried doctors and dentists in the UK.
- A 1 per cent increase to the maximum and minimum of the salary range for salaried GMPs in the UK.
- For independent contractor GMPs in all countries of the UK, an increase in pay, net of expenses, of 1 per cent.
- For independent contractor GDPs in all countries of the UK, an increase in pay, net of expenses, of 1 per cent.
- An increase to the GMP trainers' grant of 1 per cent in line with our main pay recommendation for GMPs.
- No change to the rate for GMP appraisers at £500.

- No change to the supplement payable to general practice specialty registrars, which should remain at 45 per cent of basic salary.
- An increase in the value of the awards for consultants – Clinical Excellence Awards, Discretionary Points, Distinction Awards and Commitment Awards – of 1 per cent.
- Those members of our remit groups who received a 2 per cent non-consolidated payment in 2015-16 and who have not since moved on to a new pay scale point should receive a non-consolidated payment equivalent to 1 per cent of their basic earnings alongside our main pay recommendation.

1.24 In response, the **Department of Health (England)** accepted and implemented our pay recommendations in full, along with the **Welsh Government**.

1.25 The **Scottish Government** and **Northern Ireland Executive** agreed a 1 per cent uplift to basic pay for the remit groups in line with our recommendations. Neither accepted our recommendation to increase the value of distinction awards and discretionary points for consultants, so these remained unchanged in 2016-17.

CHAPTER 2: ECONOMIC OUTLOOK AND AFFORDABILITY

Introduction

2.1 In this chapter, we explore the wider economic and labour market background, public sector finances and departmental expenditure limits and consider how these relate to our terms of reference. We also take a general look at the pay and remuneration of doctors and dentists including comparisons with other professions. This chapter serves to build a picture of the range of issues relevant to our consideration of the pay for our remit groups.

General economic and wider labour market context

2.2 In this section we consider the macroeconomic picture, including inflation and employment trends that provide important context to the consideration of pay.

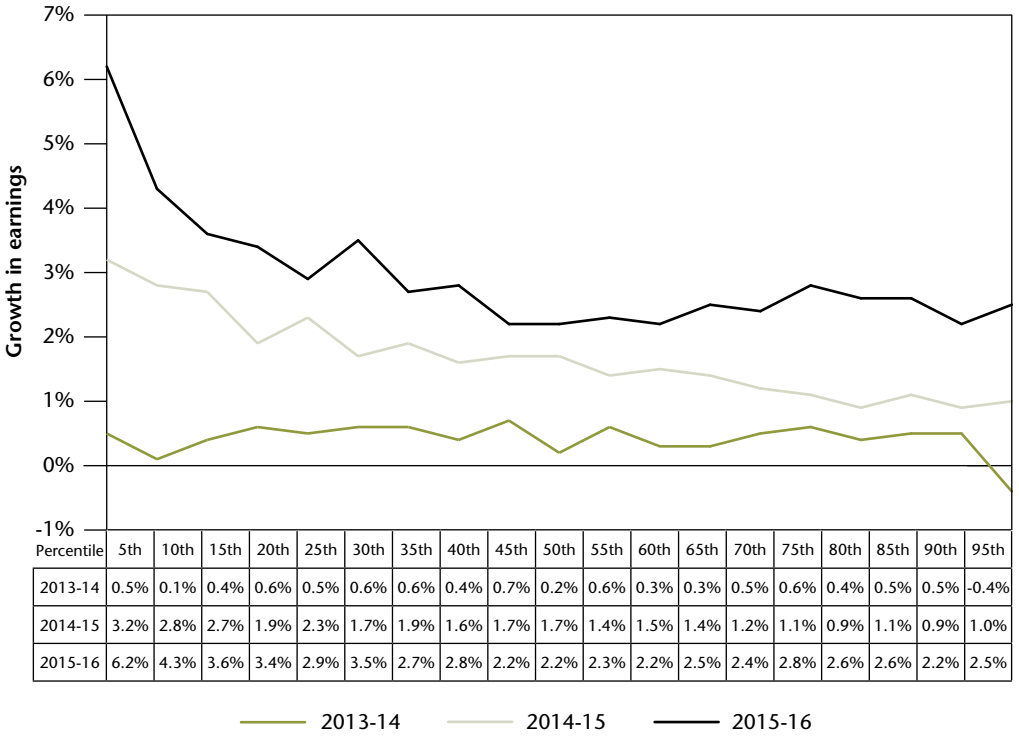
2.3 Economic growth in the United Kingdom continued to be fairly strong in 2016. Gross Domestic Product (GDP) grew by an estimated 2.0 per cent in 2016 as a whole compared with 2015, slightly weaker than forecast at the time of our last report. Both the Office for Budget Responsibility (OBR) and the Bank of England forecast slower growth in 2017, at 1.4 per cent. Much of the recent output growth was driven by an increasing population: GDP per head grew by 1.3 per cent in 2016 (compared with the 2.0 per cent for GDP overall). Since the pre-recession peak in the first quarter of 2008, the output of the economy has grown by 8.7 per cent overall, while GDP per head has increased by just 1.9 per cent.

2.4 Inflation increased steadily over the last year. The Consumer Prices Index (CPI) annual inflation rate rose from 0.3 per cent at the beginning of 2016 to 1.6 per cent in December 2016. The inflation rate is expected to continue to rise in 2017 under the influence of both higher oil prices and the weaker pound, which feeds through to higher import prices. The OBR forecast CPI inflation to rise to 2.4 per cent in the second quarter of 2017, and 2.5 per cent by the end of the year. The Retail Prices Index (RPI) inflation rate increased from 1.2 per cent in December 2015 to 2.5 per cent in December 2016 and is forecast by the OBR to end 2017 at around 3.4 per cent.

2.5 The UK labour market continued to perform robustly over the last year. The employment level grew by 294,000 in the year to November 2016, to reach 31.8 million. The employment rate rose by 0.5 per cent over the year to 74.5 per cent and the unemployment rate fell over the same period to 4.8 per cent, down from 5.1 per cent a year earlier. There were some signs of a slowing rate of improvement at the end of 2016.

2.6 There was some upward pressure on wages across the economy as a whole and average (annualised) earnings growth was 2.7 per cent in the three months to November 2016. The Annual Survey of Hours and Earnings (ASHE) provides a delayed but detailed picture of individuals' wages and shows that the median gross weekly earnings for full-time employees increased over the year to April 2016 by 2.2 per cent. There was a clear divergence between the private sector, where wages increased on average by 3.4 per cent and the public sector where wages increased by 0.7 per cent. Of most relevance to our remit groups, earnings at the top decile were up 2.2 per cent over the year to April 2016 for full-time employees (Figure 2.1).

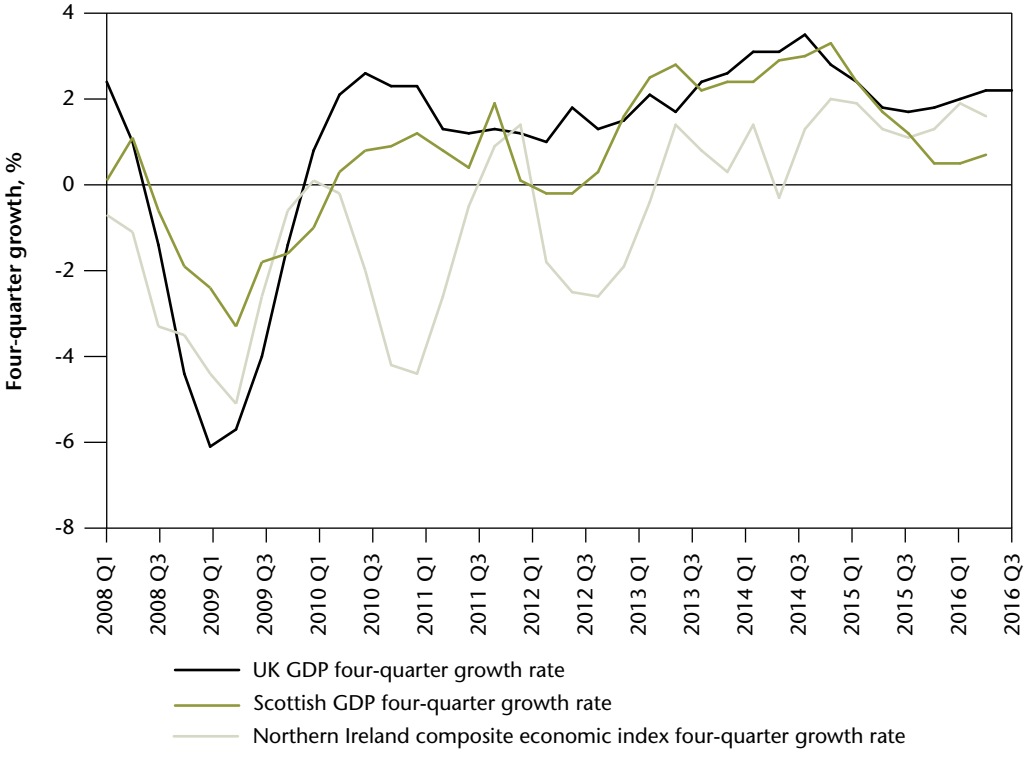
Figure 2.1: Growth of weekly full-time earnings by percentile, United Kingdom, 2013-14 to 2015-16



Percentile	5th	10th	15th	20th	25th	30th	35th	40th	45th	50th	55th	60th	65th	70th	75th	80th	85th	90th	95th
2013-14	0.5%	0.1%	0.4%	0.6%	0.5%	0.6%	0.6%	0.4%	0.7%	0.2%	0.6%	0.3%	0.3%	0.5%	0.6%	0.4%	0.5%	0.5%	-0.4%
2014-15	3.2%	2.8%	2.7%	1.9%	2.3%	1.7%	1.9%	1.6%	1.7%	1.7%	1.4%	1.5%	1.4%	1.2%	1.1%	0.9%	1.1%	0.9%	1.0%
2015-16	6.2%	4.3%	3.6%	3.4%	2.9%	3.5%	2.7%	2.8%	2.2%	2.2%	2.3%	2.2%	2.5%	2.4%	2.8%	2.6%	2.6%	2.2%	2.5%

Source: Office for National Statistics.

Figure 2.2: Annual growth in Gross Domestic Product (GDP), quarterly, United Kingdom, Scotland and Northern Ireland, 2008 to 2016

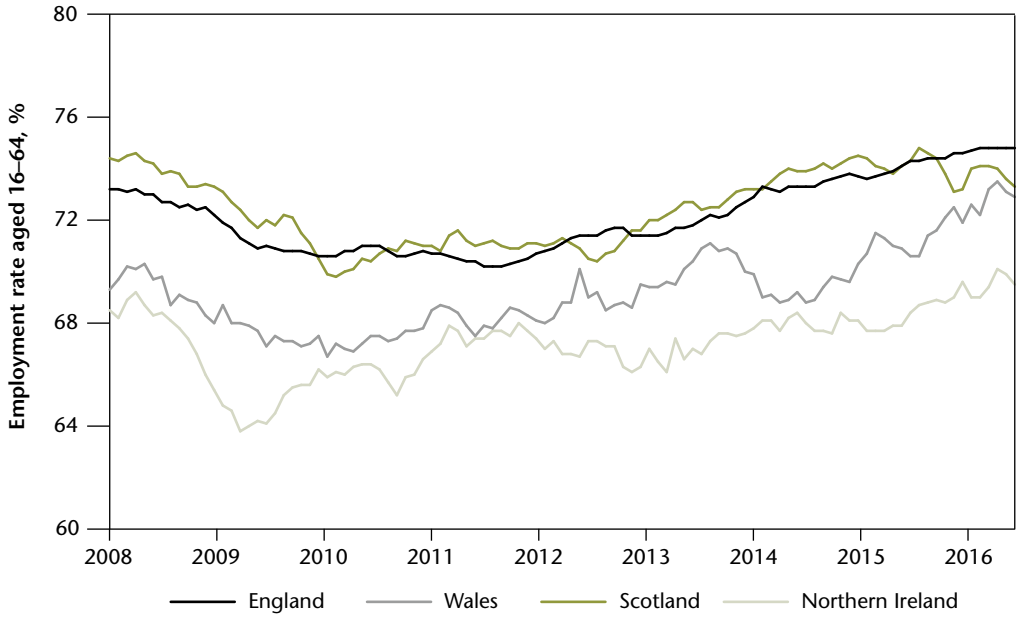


Source: Office for National Statistics, Scottish Government, DETINI.

2.7 Figure 2.2 above shows that economic growth in Scotland fell behind the UK as a whole in 2016, having kept pace over the previous three years. Northern Ireland saw a triple-dip recession with positive, relatively slow growth over the last four years. Since quarter 1 2008, just before the recession, the UK economy grew by 8.1 per cent overall (to quarter 3 2016), the Scottish economy grew by 6.0 per cent, while the Northern Ireland economy was 5.9 per cent smaller than at the start of 2008. Separate GDP data are not available for Wales.

2.8 Employment in England continued to grow in 2016, increasing by 1.2 per cent in the year to October 2016, to reach an employment rate of 74.8 per cent, the highest on record. The employment rate in Scotland had reached this peak in October 2015, but the employment level fell by 0.9 per cent over the year, to give a rate of 73.3 per cent in October 2016. Employment in Wales grew strongly over the last two years, growing by 2.8 per cent in the year to October 2016, to reach a rate of 72.9 per cent, a record high and well above the pre-recession rates. Employment in Northern Ireland also showed strong growth, of 1.9 per cent in the year to October 2016, to reach a rate of 69.5 per cent, also above the pre-recession rate.

Figure 2.3: Employment rates by country, England, Wales, Scotland and Northern Ireland, 2008 to 2016



Source: Office for National Statistics, Labour Force Survey (LF3Y, LF3Z, LF42, LF5Z).

Our comments

2.9 Since our last report several events occurred which created an uncertain economic outlook. The Prime Minister is set to trigger Article 50 at the end of March 2017, but at the time of writing the form of re-negotiation with Europe is unknown, as are the implications for the UK economy. However, the depreciation of the pound and higher oil prices look likely to increase inflation rates, affecting real wages across the UK. Despite this uncertainty, the UK economy remained strong, with GDP growing and a robust labour market. We return to the inflation forecast again later in this chapter.

Public sector finances and departmental expenditure limits

2.10 Affordability (which we take from our terms of reference to mean the funds available to the health departments as set out in the government's departmental expenditure limits) was at the forefront of the evidence provided to us by all three of the health departments.

2.11 Despite the record employment levels, the OBR noted in its November 2016 *Economic and fiscal outlook* that weaker than expected income tax receipts were the largest factor in the upward revision to the public sector budget deficit, though, as of January, its forecasts of this deficit have been reduced.

England

2.12 In October 2014, the Five Year Forward View set out how the health service should change in order to promote wellbeing and prevent ill-health. NHS England's report 'Delivering the Forward View' stressed that it believed that providers would not be able to choose to either improve care for patients or balance their books – they would be required to do both. The Five Year Forward View mentioned that the NHS would have a £30 billion per year shortfall by 2020-21 if nothing was done to address the combination of: growing demand; no further additional cost savings; and flat real-terms funding. The Department of Health (England) told us that the government would be investing £10 billion more in the NHS by 2020, with £6 billion 'frontloaded' in 2016-17. It stated that the health and social care system was facing increasing demand for its services, driven by an increasingly ageing and frail population. Meeting this demand and improving quality in an affordable way would be challenging. The Department's Shared Delivery Plan 2015-2021, informed by the Five Year Forward View, aimed to improve access to a free and high quality health service.

2.13 Between 1999-2000 and 2010-11 NHS revenue expenditure increased by an average of 5.7 per cent per year in real terms. From 2011-12 to 2015-16, it increased by an average of 1.9 per cent per year in real terms. From 2011-12 to 2015-16, increases to the Hospital and Community Health Service (HCHS) paybill accounted for 20.6 per cent (£0.7 billion out of £3.5 billion) of the increases in revenue expenditure. Of that 20.6 per cent, pay effects made up around 7.1 per cent and volume effects around 13.5 per cent. HCHS pay is the largest single cost pressure, and on average it accounted for around 38 per cent of the increases in revenue expenditure since 2001-02. As pay represents such a large proportion of NHS expenditure, the Department stated that managing the paybill was key to ensuring the NHS lived within its financial resources.

2.14 In 2015-16 the total paybill for HCHS medical staff was £10.2 billion, which is about a quarter of the expenditure on all HCHS staff. The medical HCHS pay bill increased by 2.3 per cent in 2015-16 and was 12.6 per cent higher than in 2010-11. Consultants are the largest medical paybill cost, with expenditure of £6.1 billion or 13 per cent of the total paybill in 2015-16. Since 2010-11 the percentage of total health expenditure spent on HCHS paybill declined from 43 per cent to 39 per cent.

Table 2.1: Hospital and Community Health Service staff paybill and Department of Health total health expenditure, England, 2008-09 to 2015-16

£ million	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Department of Health total health expenditure			100,418	102,844	105,221	109,774	113,345	117,248
Total HCHS paybill	39,159	41,918	43,354	43,284	43,663	44,140	45,085	46,112
All HCHS doctors (non locum)	**8,445**	**8,892**	**9,077**	**9,252**	**9,490**	**9,704**	**9,992**	**10,221**
Consultants (including Directors of public health)	4,707	5,019	5,164	5,308	5,463	5,654	5,890	6,125
Registrars	2,238	2,337	2,375	2,406	2,450	2,489	2,528	2,559
Other doctors in training	608	598	598	596	622	604	605	607
Hospital practitioners & clinical assistants	61	55	45	38	34	29	25	23
Other medical and dental staff	830	883	893	905	922	929	945	907

Source: Department of Health's Headline Hospital and Community Health Services paybill metrics (experimental).

2.15 NHS England told us that it was considered imperative that all providers in the NHS made savings and delivered efficiency gains each year. It estimated that by 2020 around £7 billion per year of efficiencies could be delivered nationally. Significantly, £3.5 billion of this was predicated on continuing to implement the government's public sector pay policy to 2019-20. NHS Employers told us that any changes in staff costs, above those already planned, would have a significant impact on the financial viability and sustainability of NHS financial plans, and that continuing to contain pay costs remained an integral part of addressing the financial challenge.

2.16 NHS Improvement acknowledged that there was a perennial mismatch between the funds available and the personnel and skills mix needed to effectively deliver services, but it considered that the NHS was as well-funded as it could be and a large proportion of public money was already spent on the NHS.

2.17 The British Medical Association (BMA) highlighted the Department of Health's annual accounts for 2015-16 which showed an overspend on the revenue DEL measure of £210 million. The BMA reported that was only achieved through a series of one-off accounting measures to avoid breaching the parliamentary limit, and despite a 3.4 per cent growth in health spending in real terms. The BMA challenged government plans on NHS spending. They acknowledged that future spending was front-loaded, saying that NHS England's budget for 2016-17 would increase by £5.4 billion (3.6 per cent). However, beyond 2017 total health spending was planned to increase only at 0.7 per cent per year in real terms. With the majority of NHS providers in England (65 per cent at the end of 2015-16) in deficit, and an overspend of £0.55 billion estimated for 2016-17, the BMA considered it to be impossible that the financial situation could improve without further new investment. The point was emphasised during oral evidence, where the BMA stated that many informed observers agreed that there were problems with funding, recruitment, and retention. The BMA argued that greater investment was needed, together with policies which empowered doctors and demonstrated that their contributions were valued.

2.18 The BMA thought that the consequence of insufficient budgets was that doctors were being asked to work increasingly longer hours and more intensively against the backdrop of continuing real-terms pay cuts. While the BMA acknowledged that the overall health service budgets were outside our control, it did ask us to consider the negative impact of a further year's pay restraint on the ability of the NHS to deliver safe care and to recruit,

retain and motivate sufficient staff to deliver the current service, let alone any aspirations to innovate to increase efficiency, and to extend access. The BMA considered that continuing pay restraint was unfair and inappropriate.

2.19 NHS Employers expressed related concerns, recognising the high-level drive for pay restraint as part of the broader financial challenge, but felt that it left little scope for motivating staff to deliver innovation and change. It told us that the system was under unprecedented pressure and staff could not be asked to do any more when the workload was already extremely demanding.

Wales

2.20 The Welsh Government said that the existing and projected context in which the NHS was operating remained challenging. The dual challenges facing the NHS in Wales from increased financial constraint alongside changing population demands for health care were outlined in the 2014 Nuffield Trust report 'A Decade of Austerity in Wales?', and its October 2016 report 'The Path to Sustainability'. The Welsh Government considered that the analysis and conclusions in both reports remained valid. In April 2016, the Wellbeing of Future Generations (Wales) Act came into force, which aims to underpin the development of the NHS workforce across Wales. Statutory guidance and 46 national indicators for Wales were published.

Northern Ireland

2.21 The Northern Ireland Executive said that the most recent pay remit approval process and guidance related to 2015-16 and included a 1 per cent pay award limit. It also told us that any public bodies with staff that were entitled to automatic time-served progression must, before submitting 2015-16 pay remit documentation, put forward proposals to end such arrangements. Later, in supplementary evidence, the Northern Ireland Executive told us that removing time-served progression was a priority area, and impacted on all public sector workers in Northern Ireland. As contracts were re-negotiated, the emphasis would be moved from time-served progression to performance-related pay, based on specific criteria being met (including the need to stay up-to-date professionally and to demonstrate the skills and attributes required) prior to progression being approved.

2.22 Northern Ireland's public sector pay policy for 2016-17 was still being considered when we received the written evidence but in oral evidence officials confirmed that 1 per cent uplifts had been factored into budget considerations for 2017-18, subject to ministerial approval. Although at an early stage in the process of assessing the budgetary requirements for 2017-18, the Department of Health (Northern Ireland) thought that there was a material and widening gap between the resources that may be available and the estimate of the costs required to maintain existing services.

Efficiency savings and measuring performance

England

2.23 In its evidence, the Department of Health (England) stated that the NHS faced a significant financial challenge in 2016-17. While NHS providers delivered an overall net deficit in 2015-16, offsetting savings throughout the rest of the system were achieved and financial balance against all spending controls was delivered. The Department also considered that with the financial controls package and help from system leads, financial balance against the overall spending controls could be expected in 2016-17. In 2017-18 trusts were expected to balance their books, but it would still be challenging due to increasing demand for health services as a consequence of the ageing and growing population, and new drugs and treatments.

2.24 The Department reported that labour productivity in the NHS in England grew by 2 per cent per annum since 1998-99. However, a broader measure of all inputs reduced the productivity figure to 0.1 per cent. In its supplementary evidence, the Department said that the quantum of output may be measured over time based on standard aggregations of activity, e.g. for day cases, elective admissions, non-elective admissions, at both organisation and national level. This would provide some insight into the volume of output for comparison with the volume of inputs. However, it was important to note that the comparison is crude. The measurement is limited by the accuracy, level of granularity, and coverage of measurement (for example, very limited data on community and mental health services activity).

2.25 The Department told us that it was working with the health service, partners and patients to develop key elements of the programme required to achieve efficiency savings. The main areas of focus were: reducing demand for NHS care by improving the public's overall health; introducing new models and places to care for patients that reduced the numbers attending hospital and reducing unwarranted variation in care; making better use of NHS providers' resources – money, technology, estates and people; reducing NHS costs by limiting pay increases, reducing NHS management costs and improving the effectiveness of purchasing and increasing income to the NHS through charges and commercial opportunities.

2.26 Staff costs were thought to represent around 70 per cent of a typical hospital's total costs according to NHS Employers, who also considered that such costs were a key factor in the declining financial position of NHS providers. Between 2011-12 and 2014-15, the share of income spent by acute trusts on staff rose by 8.1 per cent. The growth in spending on non-permanent staff in particular was significant in recent years with a 24 per cent increase, as a share of total income, between 2012-13 and 2014-15. Reports by the Health Foundation and the National Audit Office identified a strong association between spending on non-permanent staff and an organisation's financial performance. For every one per cent of a trust's staff costs accounted for by agency spend, their operating costs were likely to be 0.4 per cent higher.

2.27 On productivity, in its supplementary evidence, NHS Employers said that responding to challenges by simply making staff work harder for longer was unsustainable and would lead to more cases of burnout and other adverse effects on the health and well-being of staff. There is a long established link between staff experience and patient outcomes. The measurement of productivity was a contested area within the NHS but small changes, such as improving the quality of job planning, could lead to more things being done differently rather than simply trying to do more of the same thing. Addressing workforce challenges depended upon solutions developed as the NHS seeks to change the way that services were delivered in order to meet the wider financial challenge.

2.28 The BMA considered that there was no credible plan for the majority of the efficiency savings identified in the Five Year Forward View. It thought that the lack of investment in social care in England – with a likely funding gap of £2.8-£3.5 billion by the end of the parliament – would further add to NHS financial pressures. NHS trusts in England were behind on their cost improvement programmes by £45 million overall.

2.29 The BMA said that NHS performance should be measured against quality, equity and outcomes of patient care; and that the NHS needed to balance all three areas to deliver to the highest standards of care. Measures should be focused, evidence-based, developed with clinical input, adjusted for and appropriate to the context, and should where possible be outcome-led (noting that many outcomes will be in the future and difficult to attribute to specific interventions) and not centrally imposed.

Our comments

2.30 At a time when budget constraints often translate into difficult choices between pay and non-pay expenditure, it is important to be able to quantify productivity, not least since it provides an indirect indicator of working conditions. For example, with all other things being equal, an increased workforce reduces productivity (under existing measures), but could be reflected by improved patient care and an easing of workload pressures on staff. We urge the parties to give greater attention to productivity measurement and identify appropriate measures which will facilitate effective pay policy decisions.

Pay

2.31 In this section, we consider how doctors' and dentists' pay has changed over time, and how it compares with the distribution of pay across the whole UK economy. This is, of necessity, UK-wide due to the data sources at our disposal. We also consider how doctors' and dentists' pay compares to the private sector and to comparator groups.

Pay bill growth and pay drift

2.32 In England in 2015-16 the HCHS staff pay bill for doctors and dentists grew by 2.2 per cent. Table 2.2 below shows the change in their pay bill per full-time equivalent (FTE) doctors and dentists in England over the period 2009-10 to 2015-16. Of the 2.2 per cent increase in pay bill in 2015-16, the vast majority (1.8 per cent) was explained by an increase in staff numbers (FTE growth). The impact of the public sector pay freeze in 2014-15 and 2015-16 is shown clearly, with only non-consolidated payments being made to those on the top of the scale, which explains the 0.1 per cent increase in the headline pay award. Only the Department of Health (England) provided data on this to us.

Table 2.2: Change in costs of all Hospital and Community Health Services doctors and dentists staff pay bill, England, 2009-10 to 2015-16

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Aggregate paybill growth	**5.2%**	**1.9%**	**1.7%**	**2.4%**	**2.2%**	**3.0%**	**2.2%**
Elements of paybill growth							
Average FTE growth	3.2%	2.2%	1.6%	1.9%	1.1%	2.0%	1.8%
Headline pay award	1.5%	0.4%	0.0%	0.0%	1.0%	0.1%	0.1%
Paybill per FTE drift	0.4%	-0.7%	0.1%	0.5%	0.2%	0.9%	0.3%
Elements of paybill per FTE drift							
Basic pay per FTE drift	0.8%	0.8%	0.7%	0.7%	0.0%	0.6%	0.3%
Additional earnings per FTE drift impact	-0.4%	-1.6%	-1.2%	-0.1%	0.1%	0.4%	-0.1%
Total on-costs per FTE drift impact	0.0%	0.1%	0.6%	-0.1%	0.1%	-0.1%	0.1%

Source: Department of Health's Headline Hospital and Community Health Services pay bill metrics (experimental).
Note: All totals are derived from unrounded figures.

Trends in doctors' and dentists' pay

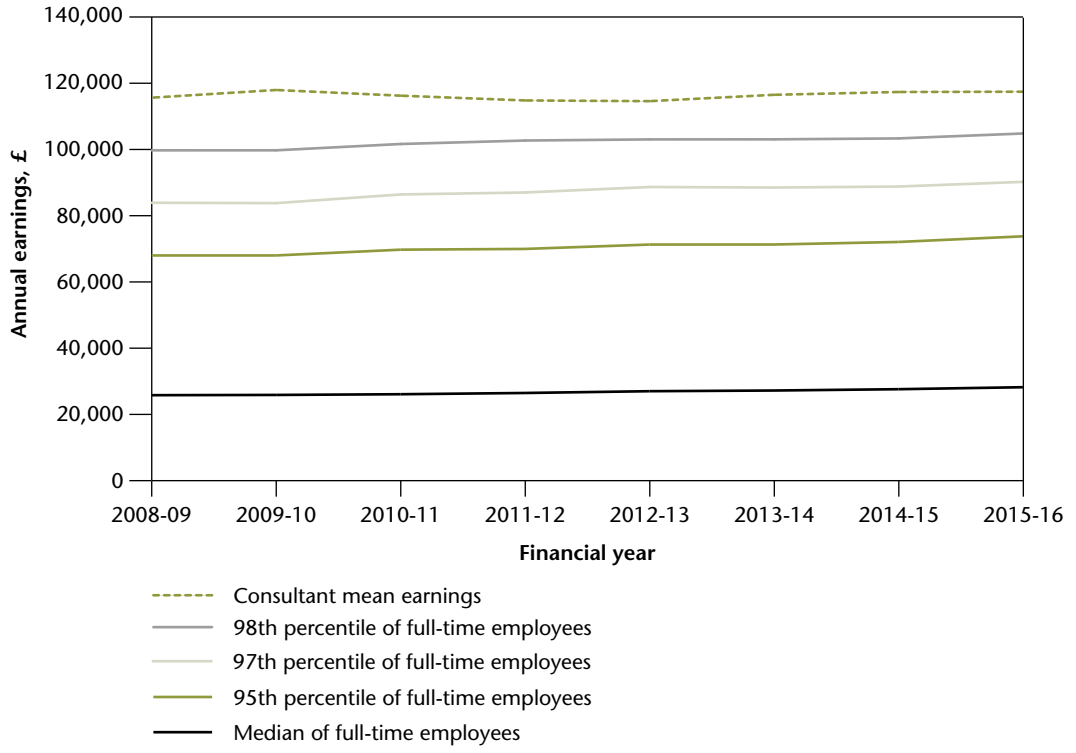
2.33 Appendix G shows the distribution of estimated total earnings for some of our hospital remit groups in the year to September 2016, with half (those between the upper and lower quartile) of registrars and consultants paid in the ranges £46,200 to £62,400 and £93,500 to £133,400 respectively. The estimated total earnings distribution for independent contractor GMPs in 2014-15 are also shown, with half paid in range £73,600 to £123,600.

2.34 Figures 2.4 to 2.8 show how the average (mean) total earnings per head of various staff groups compare to the median, 90th, 95th, 97th and 98th percentile of full-time employees' earnings in the wider economy over the last seven years, based on ASHE data.

2.35 From 2009 to 2016, while consultants' average total earnings were consistently above the 98th percentile the gap was closing. SAS doctors' average total earnings increased over the period relative to those in similar percentiles. The average total earnings of the registrar group (typically aged 25-34) fell from above the 90th percentile to just below it. For the other training grades (where staff are typically younger), their average total earnings remained relatively unchanged and are between the median and 90th percentile of full-time employees.

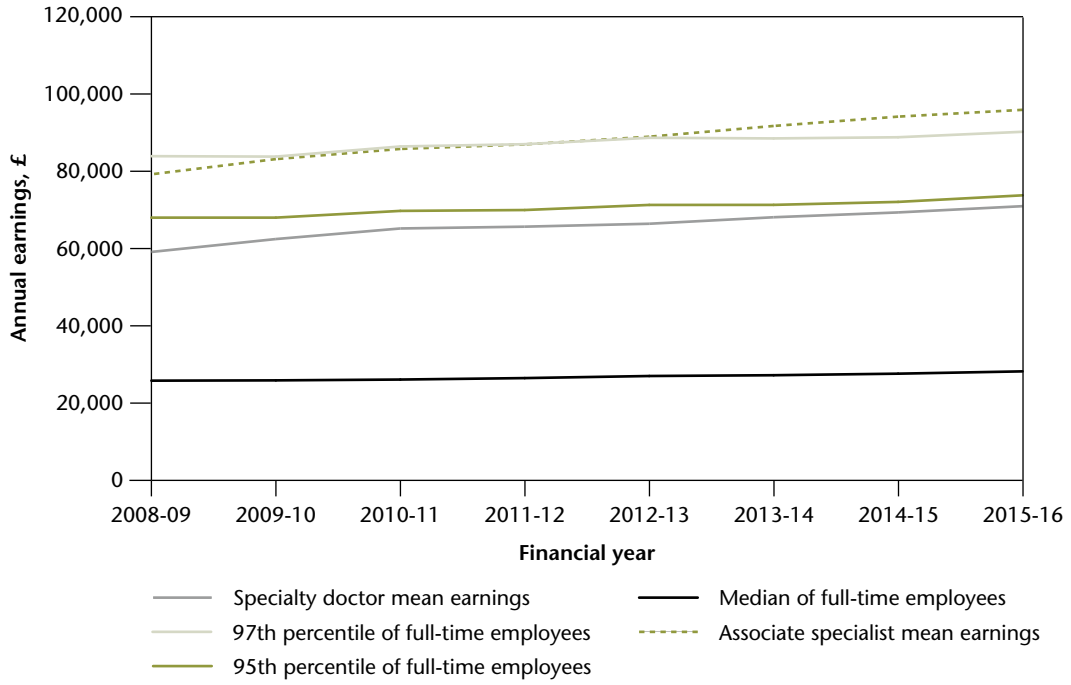
2.36 With the exception of the specialty doctor and associate specialist grades we have seen the average pay increase only slightly, whilst the national median, 90th, 95th, 97th and 98th percentiles have increased at a faster rate between 2009 and 2016.

Figure 2.4: Consultant average FTE total earnings, England, compared with full-time employees percentiles, United Kingdom, 2008-09 to 2015-16



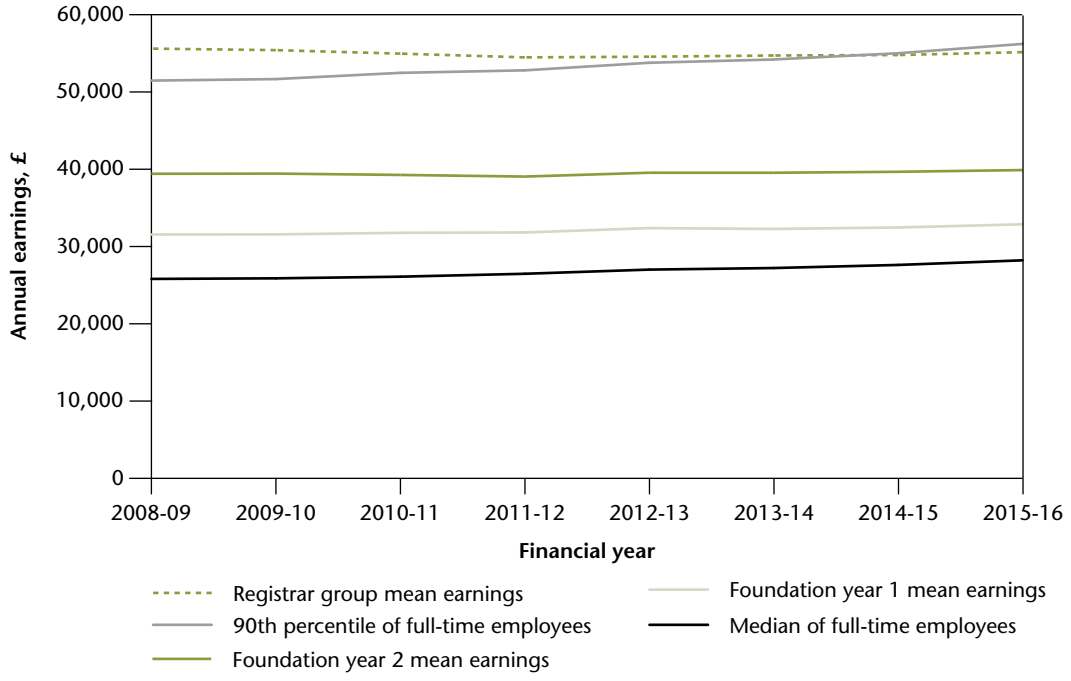
Source: NHS Digital, Office for National Statistics (ASHE).

Figure 2.5: Associate specialist and specialty doctor average FTE total earnings, England, compared with full-time employees percentiles, United Kingdom, 2008-09 to 2015-16



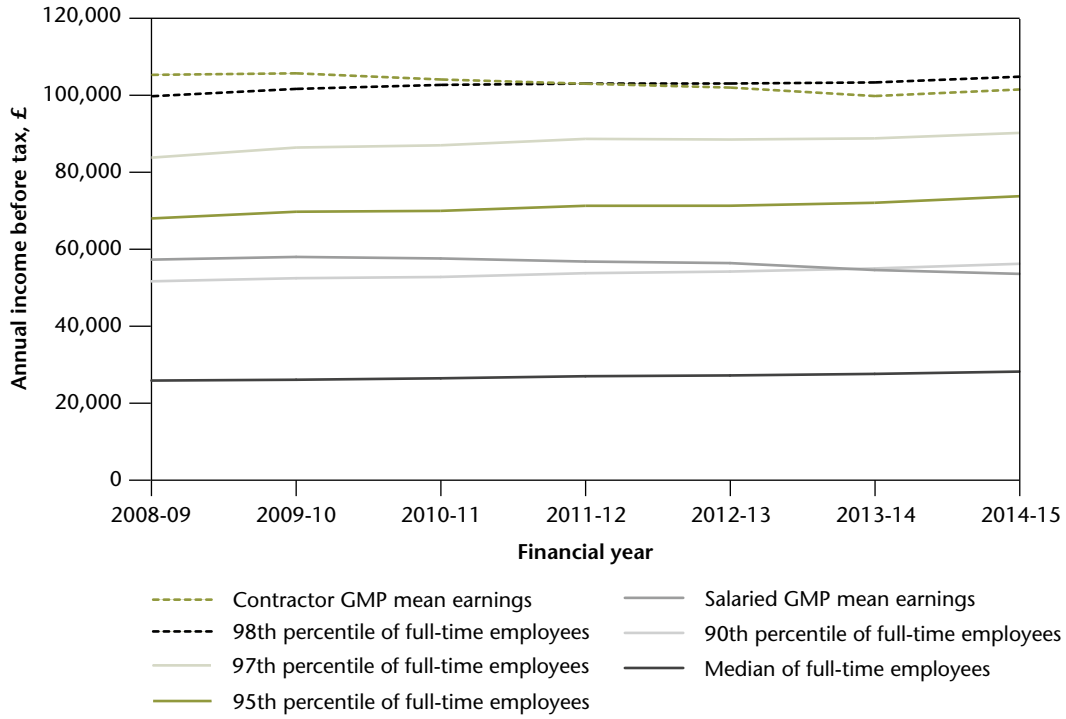
Source: NHS Digital, Office for National Statistics (ASHE).

Figure 2.6: Registrar group and other training grades average FTE total earnings, England, compared with full-time employees percentiles, United Kingdom, 2008-09 to 2015-16



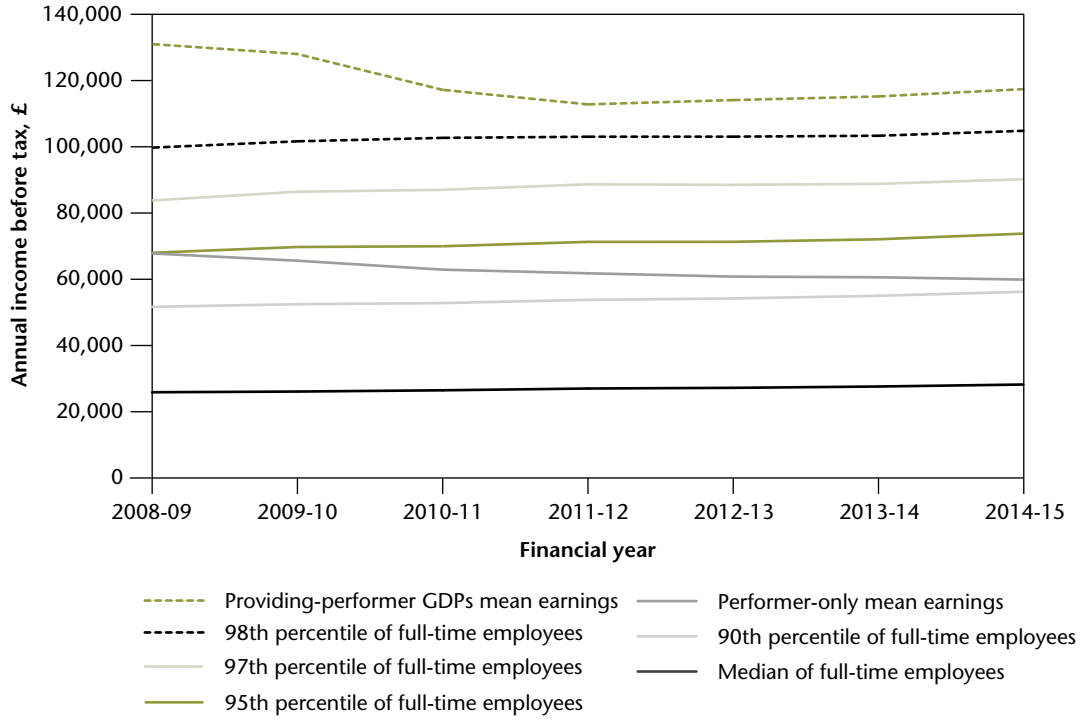
Source: NHS Digital, Office for National Statistics (ASHE).

Figure 2.7: General Medical Practitioner average income before tax by headcount, compared with full-time employees percentiles, United Kingdom, 2008-09 to 2014-15



Source: NHS Digital, Office for National Statistics (ASHE).

Figure 2.8: General Dental Practitioner average income before tax by headcount, compared with full-time employees percentiles, England and Wales, 2008-09 to 2014-15



Source: NHS Digital, Office for National Statistics (ASHE).

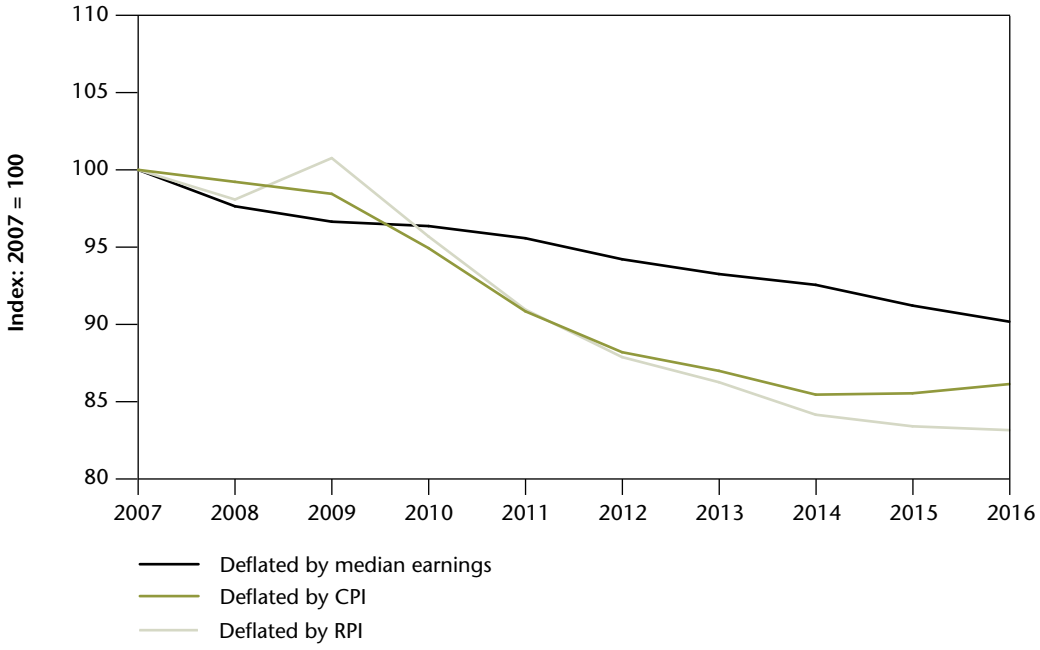
2.37 As shown in Figure 2.7, the average income before tax for contractor General Medical Practitioners (GMPs) based on headcount has been falling since 2010. The 98th percentile overtook contractor GMP earnings in 2013, although they remain above the 97th percentile for full-time employees. Similarly, salaried GMPs' average income has been decreasing since 2010 and in 2015 fell to below the 90th percentile.

2.38 Performer-only General Dental Practitioners' (GDPs) average income was in line with the 95th percentile in 2009. It has since failed to keep in line and by 2015 fell closer to the 90th percentile. While provider-performer GDPs' average earnings remained above the 98th percentile across this period, they ended the period over £10,000 lower.

2.39 The real value of consultants' pay has reduced since 2007 (Figure 2.9). The choice of inflation index affects the size of real earnings decreases as CPI is generally lower than RPI. Real earnings of a consultant with five years' experience were 13.9 or 16.8 per cent lower when deflated by CPI or RPI respectively, than in 2007. The bulk of this decrease came between 2009 and 2014 but since 2014, a low inflationary environment has caused this to slow, with real earnings deflated by CPI increasing.

2.40 These inflationary pressures reduce the real incomes of all UK workers. However, between 2007 and 2016 median pay growth for full-time employees has grown more quickly than the pay point of a consultant with five years' experience. This has reduced the value of a consultant's pay by around 10 per cent compared to the median UK worker (this is similar when repeated against a worker at the 90th percentile). Therefore, not only has the relative value of consultants' pay fallen against inflation, but it has also fallen compared with other workers in the wider economy.

Figure 2.9: Pay point of a consultant after five years' service, deflated by CPI, RPI and median annual full-time earnings growth, 2007 to 2016



Source: NHS Digital, Office for National Statistics (ASHE).

Pay comparability

2.41 Although pay comparability does not form an explicit part of our terms of reference, we believe it is important to assess the pay position of our remit groups relative to other groups that could be considered to be appropriate comparator professions, and against recent

trends in general pay and price inflation measures. Our approach looks at both pay levels and movements. We are planning to revisit the comparators we use, in time for our next report.

2.42 The data for this exercise were sourced from Hay Group in 2008 and cover comparator professions including: legal, tax and accounting, actuarial and pharmaceutical.[1] Different Hay levels were assigned to the remit group depending on a general assessment of job responsibility and experience. Table 2.3, while it does not equate to any formal job evaluation, gives a short description of each of the comparator roles.

Table 2.3: Comparison of Hay levels and comparator professions, adapted from the PA Consulting Group report (2008)

Hay Level	Remit group equivalent	Legal	Accounting	Tax
14–15	Foundation year 1 and 2.	Newly qualified with 1–2 years' experience. May also control 1–3 junior clerks or executives.	Entry for new staff with a degree in accounting.	Tasks with relatively few complex features. May help supervise a small team.
16–18	Newly qualified speciality registrar with 1–3 years of speciality training.	Ranges from newly qualified with 2–3 years' experience to practicing attorney working independently on a daily basis.	A technical lead providing supervision to a small team. Can progress to manage other managers and provide day-to-day supervision of a small group of accountants.	Works independently on assignments but receives technical guidance on unusual problems. Provides guidance and supervision to all levels below.
19	Specialist registrar with 3–7 years of speciality training.	Operational specialist but not usually a top expert in the organisation. Usually 5–8 years' experience.	Requires 8–10 years' experience including 3–4 in a supervisory position. Advises senior management and other department heads.	Manages a team. Consults with superior only on unusual problems. Participates in planning and coordination of department work.
20–21	Ranges from a newly qualified consultant to a consultant with at least 19 years' experience at the top of their pay scale.		Usually requires 8–10 years post qualification including 4 years in a major supervisory position. Advises senior management and other department heads.	Provides day to day supervision of a staff of tax accountants within a unit. Highly knowledgeable specialist analyst. Typically has a minimum of 3 years in a managerial position. Responsible for recommending and formulating company tax policies and procedures.

[1] The pay comparators were identified in the report: Review of Pay Comparability Methodology for DDRB Salaried Remit Groups, PA Consulting Group, Office of Manpower Economics, 2008.

2.43 A useful source of information on comparabilities is the Higher Education Statistics Agency (HESA) Destination of Leavers from Higher Education (DLHE) statistics. HESA publishes estimates of earnings of graduates six months after graduation. Degrees in medicine typically take longer than other subjects: as a result, medical graduates would typically be slightly (two or three years) older than the comparator groups. These figures place the first years of a career in medicine into context. Table 2.4 gives the latest estimates of earnings six months after graduation by subject, with medicine and dentistry the highest paid subject. For other comparators, see Figures 2.10 and 2.11. The figures show medical and dental graduates as the top earners. They also show that a very high proportion (93 per cent) of doctors and dentists were in work in the UK and that less than 1 per cent of respondents were unemployed at the survey point. This contrasts with those studying other subjects and subsequently working in sectors which our remit groups might consider as comparators, who earned less and for whom there is much more variability in the level of employability. We consider that the relatively high starting salary and job security offered by a career in the NHS are important considerations, although these could be seen to be counterbalanced by widespread shift and weekend working in medical careers.

Table 2.4: Graduate starting salaries by subject, 2014-15

First degree	Median salary
Medicine & dentistry	£30,000
Engineering & technology	£26,500
Mathematical sciences	£25,000
Architecture, building & planning	£25,000
Computer science	£24,000
Veterinary science	£23,500
Social studies	£23,000
Business & administrative studies	£23,000
Subjects allied to medicine	£22,000
Physical sciences	£22,000
Education	£22,000
Agriculture & related subjects	£20,000
Biological sciences	£19,000
Law	£19,000
Historical & philosophical studies	£19,000
Languages	£18,500
Creative arts & design	£17,000

Source: Higher Education Statistics Agency.

2.44 Figures 2.10 and 2.11 provide a more detailed analysis of doctors' and dentists' pay relative to the national distribution and other professional groups at different points in their careers as set out in Table 2.3. Appendix F also provides further comparisons of our remit group with other professions. Figure 2.10 considers doctors and dentists in training (foundation house officers (FHOs) and specialty registrars), staff grades and specialty

doctors. For these groups, we estimated the distribution of salaries on a per person (headcount) basis, not an FTE basis: these salaries will be lower than FTE salaries and should be interpreted with that in mind.[2] The results show that:

- Median total earnings for FHOs in their first year were £29,625, which was close to the 75th percentile of all employees aged between 22 and 29. However, median earnings for FHOs in their first year are almost £4,000 less than the nearest comparator group (legal).
- Median earnings for FHOs in their second year (£40,000) were just above the 90th percentile of all UK employees aged between 22 and 29. They are also broadly comparable with some of the comparator groups such as pharmaceutical and tax and accounting. However, the highest median earnings of a comparator group (actuarial) were £8,000 higher.
- Specialty registrars' median earnings were £53,292, a value approximately equal to the 90th percentile of all employees aged 30 to 39. The median earnings of the nearest comparator group (tax and accounting) were around £3,500 larger than speciality registrars. However, speciality registrars' median earnings were £16,000 less than matched actuarial workers.
- There is a large overlap in the earnings of staff grade and speciality doctor grades with median earnings of £63,150 and £66,185 respectively. This placed both grades into the top 10 per cent of UK earners. Relative to the comparator groups, median earnings were above the pharmaceutical and tax and accounting comparator group earnings, but below legal and actuarial group earnings.

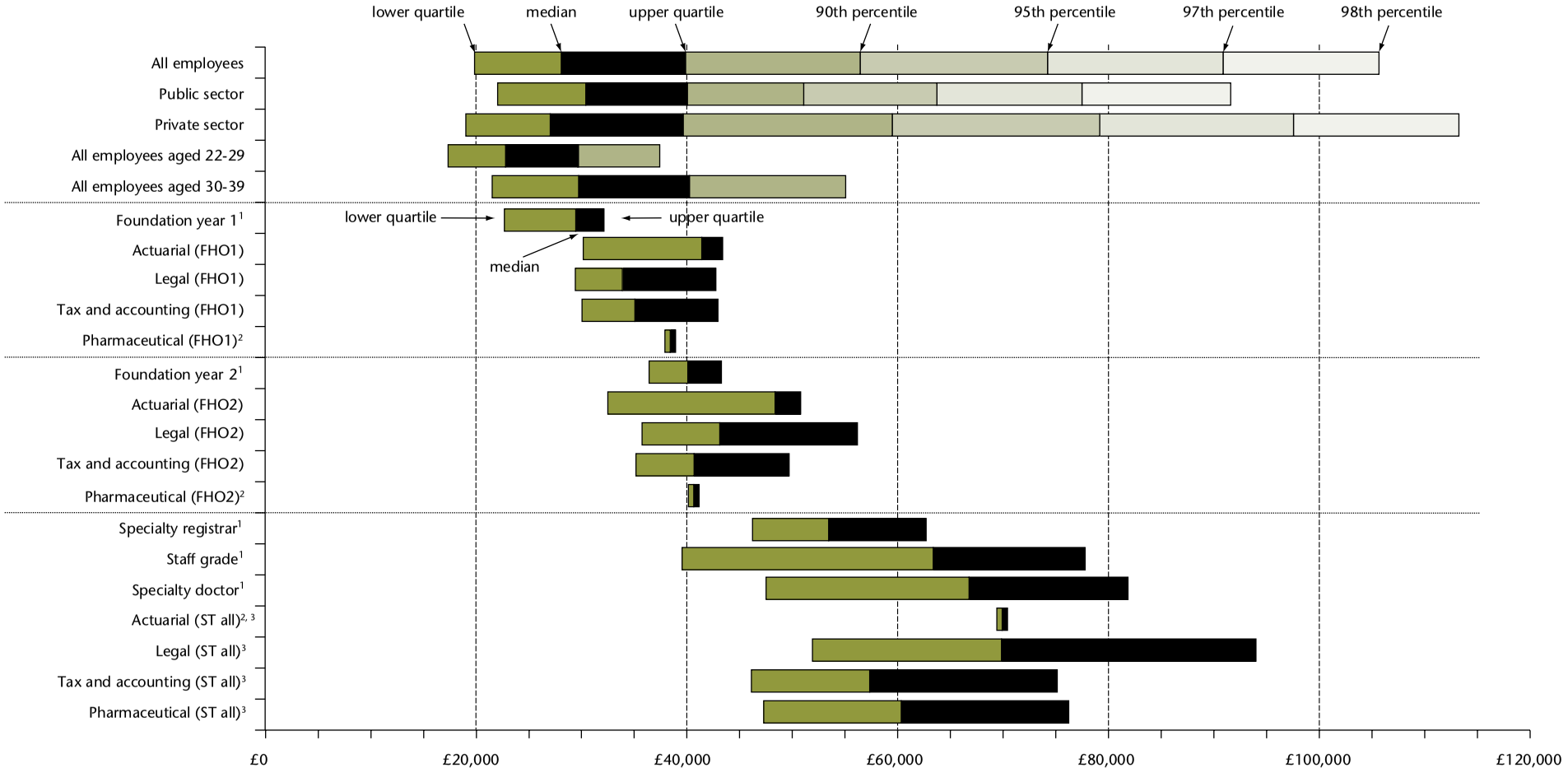
2.45 Figure 2.11 compares associate specialists, consultants, independent contractor GMPs and GDPs with the national pay distribution and other professional groups. Our analysis has again estimated the distribution of salaries on a per person basis, not an FTE basis, so we attach the same caveat to this analysis as in the previous paragraph. Our analysis shows that, compared with all full-time employees in the UK wider economy:

- Median earnings for associate specialists (£87,534) were around £2,500 less than the 97th percentile of all UK employees. Associate specialists median earnings were the lowest across the comparator groups. Tax and accounting were the closest comparator group earning £16,000 more, and actuaries, the highest paid group, have median earnings over £50,000 higher than associate specialists.
- Consultants' (including awards) median earnings (£111,519) were above the 98th percentile of all UK employees, at or above the level of the comparators for junior consultants (consultant minimum). The 75th percentile of consultants' earnings was at a similar level to legal and tax and accounting median earnings, for the level of a very senior consultant (consultant maximum).
- Contractor GMPs' median earnings of £97,600 were above the 97th percentile of all UK employees, and were over £47,000 more than salaried GMPs.
- Providing-performer GDPs' median earnings were above the 97th percentile of all employee earnings and were £44,000 larger than performer GDPs.

2.46 Chapters 7, 8 and Appendix E give more detail on the income and expenses of GMPs and GDPs.

[2] Earnings on a headcount basis will tend to be lower than FTE earnings because earnings of those working part-time are included in the estimates.

Figure 2.10: Total earnings inter-quartile ranges of DDRB training grades, staff grades and specialty doctors, compared with the national pay distribution and other professional groups, full-time rates,[1] 2015-16



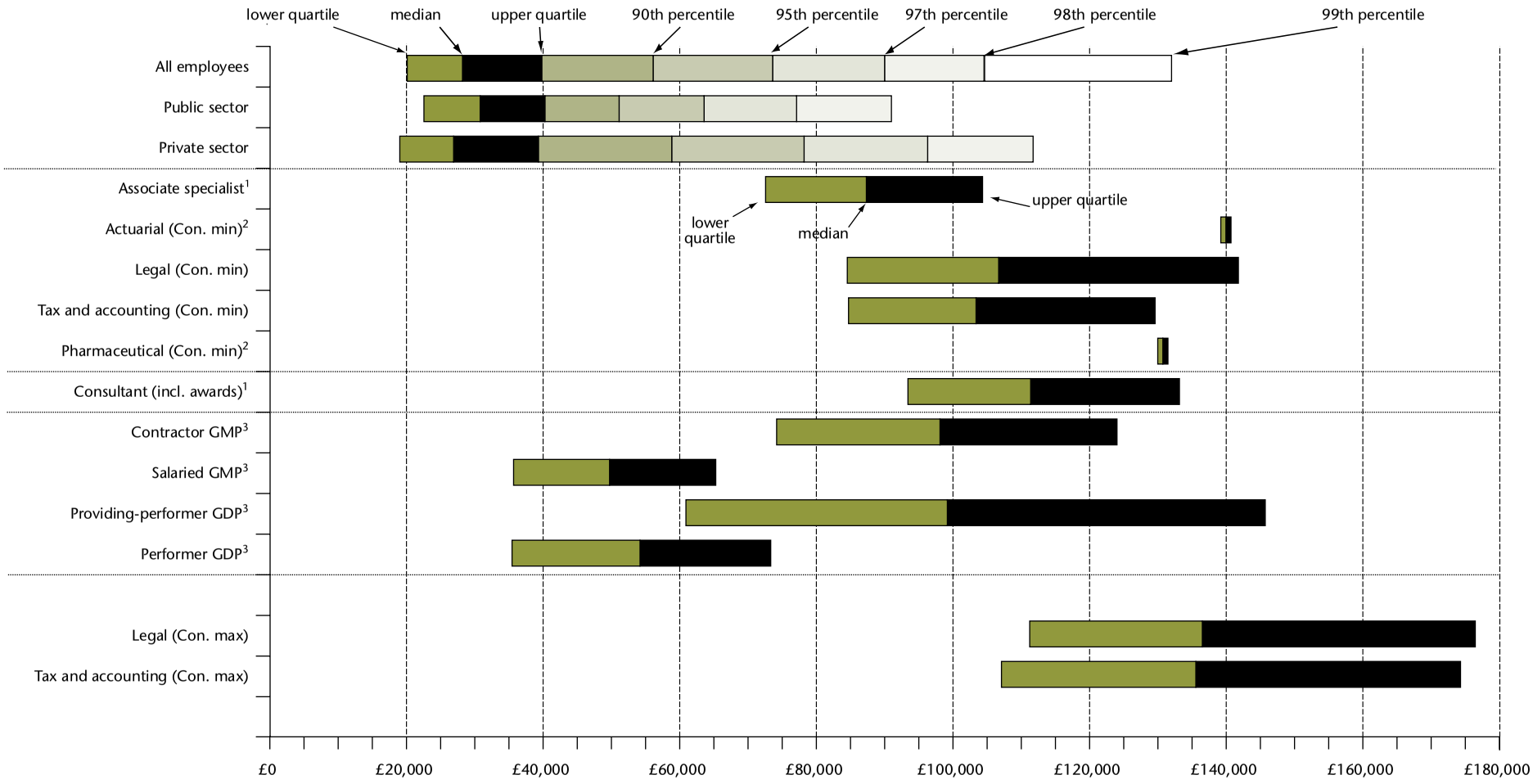
Source: The Office for National Statistics, NHS Digital, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending September 2015, by headcount not by FTE.

[2] A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median.

[3] The range for specialist training (ST all) covers four distinct reference levels/job weights and the median and quartiles presented are for these four combined.

Figure 2.11: Total earnings ranges of consultants and equivalent grades, compared with the national pay distribution and other professional groups, full-time,[1] 2015-16



Source: The Office for National Statistics, NHS Digital, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending September 2015, by headcount not by FTE.

[2] A range is not always available for these groups at this salary level. A 'notional' range of £1,500 is used in order to illustrate the median.

[3] Estimated incomes (before tax) for 2014-15 for all (both full-time and part-time) general medical practitioners and general dental practitioners (the latest available data).

[4] Due to small sample size, data are not available for these groups.

Our comments

2.47 The affordability of the NHS across the UK continues to be a key consideration and we recognise the scale of the challenges in each country. The figures in England show that in recent years the main driver of paybill growth was workforce expansion. It is apparent that maintaining the public sector pay policy of 1 per cent over the spending review period would contribute to the Department of Health's and trusts' ambitions of meeting their demanding efficiency targets. The same conclusion can be drawn for Northern Ireland and Wales. Pay restraint offers a direct means of limiting increases to costs, although all countries have other initiatives in train to support trusts and health boards as pay restraint alone would be insufficient to meet efficiency targets. However, the impact of ongoing pay restraint is wider than just helping to reach fiscal targets. Pay is important and the public sector pay policy could well impact adversely on morale, given the increasing workload, and this raises concern about the sustainability of the situation for staff.

2.48 In the context of managing the paybill, we note the focus on reforming pay progression. We referred to this in our 2012 review of Clinical Excellence Awards[3] and our view remains that progression should be linked to performance and competence in the role. We note that the new junior doctors' contract has taken significant steps to link pay progression to stages of training. In England and Northern Ireland, the negotiations on the consultant contract are likely to include reducing the number of increments and link progression to performance. We remain concerned about the lack of paybill data in the other countries.

2.49 The front-loading of investment for the NHS in England could mean that affordability will become increasingly acute in subsequent years. As we said last year, the onus of making the transformational change needed to release meaningful efficiency and productivity savings across the UK, as well as maintaining service levels, would fall largely on the NHS workforce and our remit groups as clinical leaders. We have to question whether our remit groups are being fairly rewarded for their contribution. However, there was considerable change and disruption in the private sector during the recession, with job losses and pay cuts. Our remit groups have relatively good job security and decent career prospects compared with many professions.

2.50 The success of the Sustainability and Transformation Plans in England (see Chapter 4) will be crucial in delivering more effective and efficient healthcare. However, there is uncertainty whether these will achieve the intended benefits. NHS Providers told us that 97 per cent of trust leaders did not think that they would succeed. We note the report produced by the King's Fund,[4] which expressed concerns over how the plans could be implemented within the tight financial situation, and share these concerns. Most large scale change programmes require 'pump-priming' funding to be implemented successfully.

2.51 We need comprehensive data on earnings, particularly detail by gender, country and speciality – especially if the Government continues to ask us to consider targeting. We think the detail of NHS Digital's basic and total earnings grapher tool is useful. We would also welcome sample career pathways. Our recent reports have set out our request to the parties to provide us with a greater understanding of our remit groups' earnings. We consider the position of our remit groups' pay further in Chapter 9 and set out our data requirements in Chapter 10.

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[3] Review Body on Doctors' and Dentists' Remuneration, Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants, TSO 2012.

[4] The King's Fund, Sustainability and Transformation Plans in the NHS, November 2016. Please see https://www.kingsfund.org.uk/publications/stps-in-the-nhs

2.52 We need to consider the effects of inflation on the real pay of our remit group members, particularly when considering recruitment, retention and motivation. Wage growth at both the median and 90th percentile was well above 1 per cent in 2016, which eroded the pay of doctors and dentists relative to other professions. Further to this, inflation is forecast to increase to levels not seen for several years, and this would lower the real wages of our remit group.

2.53 We recognise that our remit groups often earn less than some comparator professions. However, these comparator levels are based on job description and responsibility levels and therefore are unable to factor in career progression. Newly qualified doctors have an almost guaranteed job upon graduation with a clearly defined career path that can lead to becoming a consultant or GP partner with earnings above the 97th percentile, and can access this career anywhere in the country. In some of our comparator groups, reaching senior levels is much more competitive, with only a few reaching the pinnacle of the profession. A newly qualified law or accounting graduate is not necessarily expected to reach the most senior positions, but those that do are rewarded with large salaries. This different progression structure is not included in our current approach to pay compensation and we will seek to update this in our work on updating comparator methodology.

CHAPTER 3: MOTIVATION

Introduction

3.1 In this chapter, we consider the motivation of doctors and dentists in each UK country. This chapter serves to build up an overall picture of the issues relating to the requirement in our terms of reference to have regard to motivation. Specific issues are examined in the remit group chapters that follow later in this report. The results of the surveys of NHS staff in England, Wales and Northern Ireland for 2015-16 were provided to us in evidence, and form the bulk of this chapter. These surveys cover staff working within the hospital sector and span doctors in training, SAS doctors and consultants. The Scottish staff survey was not repeated in 2016, so for comparison we reproduce the data we used in our last report, for 2015. The evidence relating to the motivation of GMPs and GDPs is dealt with entirely in their respective chapters.

Motivation, morale and engagement

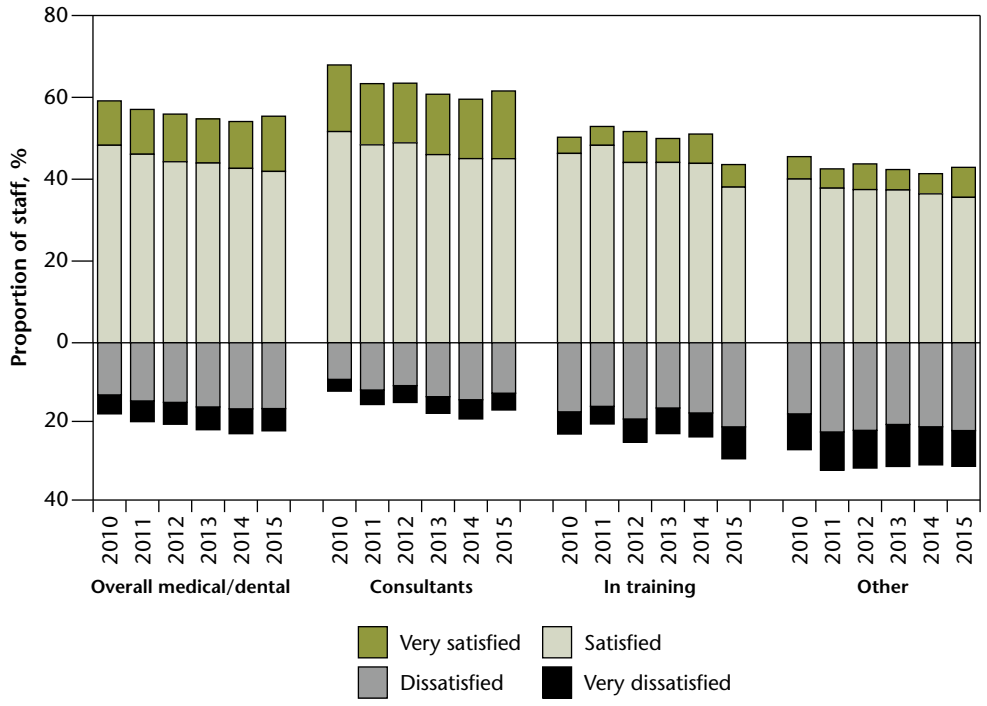
3.2 While our terms of reference require us to have regard to the need to motivate doctors and dentists, we received evidence on morale as well as on engagement and we consider these to be relevant to our understanding of motivation. Whilst there is no definitive definition of staff engagement, it brings together a range of concepts including work effort, organisational commitment, job satisfaction, shared purpose and energy with it often calculated by an index derived from staff survey responses. The engagement index is based on questions relating to the extent staff feel motivated and engaged in their work, their perceived ability to contribute to improvements and their willingness to recommend their organisation as a place to work or receive treatment.

England

3.3 We examined the results of the latest available NHS Staff Survey in England for 2015, conducted in autumn 2015 for our hospital remit groups with results published in early 2016. The survey had a 41 per cent response rate in 2015, similar to 2014 (42 per cent) but a decrease on the 2013 survey (49 per cent). This year there were substantial revisions to the wording and ordering to some of the questions, meaning that in some cases comparisons with previous years cannot be made. Figure 3.1 shows that total medical and dental staff satisfaction[1] with pay increased for the first time since 2010, rising from 54.1 per cent to 55.4 per cent between 2014 and 2015 respectively. However, satisfaction remained lower than in 2010. Continued pay restraint with increasing workloads could have an adverse impact on motivation and the situation needs to be monitored. While the data showed an overall increase in satisfaction with pay, there are variations within specific staff groups.

[1] Answering that they were satisfied or very satisfied with their level of pay.

Figure 3.1: HCHS staff satisfaction with their level of pay, England, 2010-2015



Source: National NHS Staff Survey.

Note: The percentage saying "neither satisfied nor dissatisfied" omitted throughout this chart.

3.4 Key findings from the survey:

- The staff engagement index for all medical and dental staff increased slightly from 3.82 to 3.89. There was a 3.6 percentage point increase in staff looking forward to going to work, to 68 per cent in 2015. Similarly, there was a 4.2 percentage point increase in job enthusiasm among participants, rising to 79.4 per cent in 2015.
- Workload pressures increased. Staff working unpaid hours over and above their contracted hours increased by 2.7 percentage points to 79.1 per cent in 2015. There was a further decline of 2.7 percentage points in participants indicating that they were satisfied with staffing numbers or that they had adequate materials, supplies and equipment to work.
- A common trend this year among all staff groups was an increase in satisfaction in the support received from other colleagues. However, for all staff groups, it was lower year on year in the extent to which they felt that the organisation valued their work. On average, this fell from 51.4 to 50.4 per cent between 2014 and 2015.

3.5 A summary of some of the results from the NHS Staff Survey in England over the period 2010 to 2015 is shown in Table 3.1.

Table 3.1: Summary results from the National NHS Staff Survey, hospital medical and dental staff, England, 2010 to 2015

Measure	2010	2011	2012	2013	2014	2015	Trend[1]
Engagement and job satisfaction							
I look forward to going to work	62.1	62.0	62.5	64.0	64.4	68.0	
I am enthusiastic about my job	73.3	74.0	74.3	75.4	75.2	79.4	
Time passes quickly when I am working	80.6	81.7	79.9	81.8	81.8	84.1	
The recognition I get for good work	48.5	51.9	51.9	54.3	55.3	57.4	
The support I get from my immediate manager	61.0	64.0	64.1	67.0	68.7	67.5	
The support I get from my work colleagues	79.8	81.0	82.6	82.9	83.5	86.4	
The amount of responsibility I am given	79.9	81.2	83.3	82.7	83.0	82.4	
The opportunities I have to use my skills	75.5	76.5	78.3	80.0	80.1	80.6	
The extent to which my organisation values my work	40.5	42.8	46.2	49.2	51.4	50.4	
My level of pay	59.1	57.1	55.9	54.7	54.1	55.4	
Percentage of staff appraised in the last 12 months	79.4	81.4	87.7	89.9	91.6	90.8	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months[2]			34.7	32.8	32.1	33.0	
Workload							
I am unable to meet all the conflicting demands on my time at work[2,3]	44.9	44.8	44.7	45.2	48.0		
I have adequate materials, supplies and equipment to do my work	59.2	58.1	56.0	56.9	58.9	56.2	
There are enough staff at this organisation for me to do my job properly	37.2	35.5	35.5	34.2	33.9	33.7	
During the last 12 months have you felt unwell as a result of work related stress?[2]				32.9	32.3	32.6	
Percentage of staff working PAID hours over and above their contracted hours?[2]		35.0	38.7	38.3	39.4	37.4	
Percentage of staff working UNPAID hours over and above their contracted hours?[2]		72.5	76.2	77.1	76.3	79.1	

Source: National NHS Staff Survey.

[1] Trend lines do not have a common scale; they each show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed both in the context of the data in the preceding columns and the full range of possible scores for each measure.

[2] Lower scores are better.

[3] For 2015, this question was reversed to "I am able to meet…" so direct comparisons are not possible.

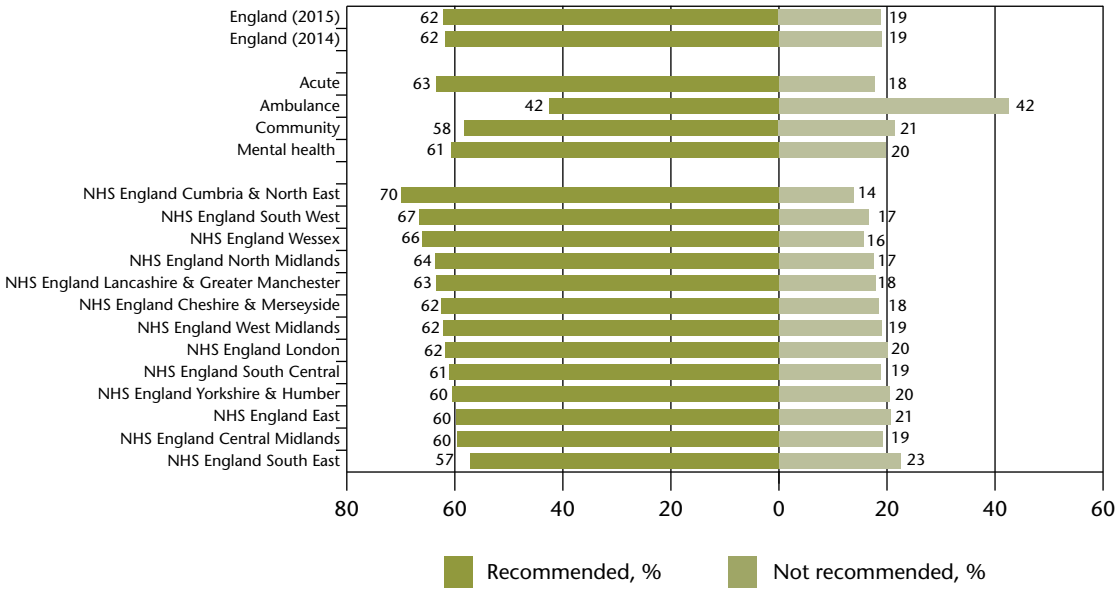
3.6 Another source of motivation, morale and engagement data in England is the NHS staff friends and family test (although the data do not separate medical from non-medical staff). Figure 3.2 shows that 62 per cent of respondents would recommend their organisation to friends and family as a place to work, similar to last year.

3.7 There is some variation by region, with NHS England Cumbria & North East being the most recommended region to work (70 per cent), while NHS England South East was the least recommended (57 per cent), but most other areas are within 1 or 2 percentage points of the average (62 per cent).

3.8 When asked to recommend their organisation as a place to receive care, a higher proportion of staff would recommend their organisation to family and friends (Figure 3.3) than those recommending it as an employer. In 2015, 79 per cent of staff would recommend the quality of care, an increase of 2 percentage points from 2014.

3.9 As before, Figure 3.3 also shows that there is some variation by region as a place to receive care, with NHS England South West scoring 84 per cent compared with 74 per cent for NHS England Central Midlands, although most locations are within 2 or 3 percentage points of the average (79 per cent). Across the 2 questions those areas that scored highly in care recommendations tended to also score highly for work recommendations.

Figure 3.2: Place to work – friends and family test (staff) by work area and location, England, Q4 2015

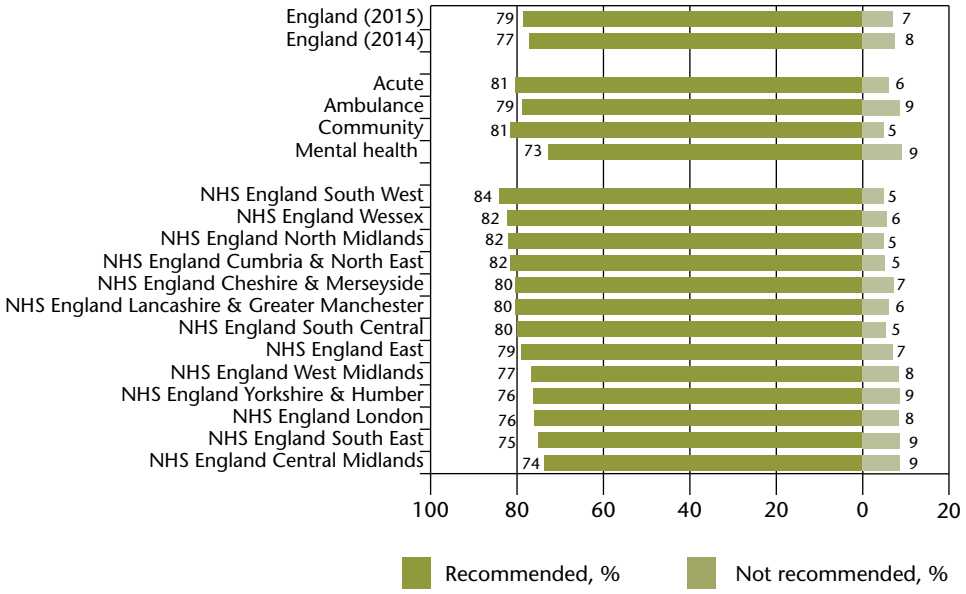


Source: NHS England, Friends and Family Test.

Note: The question asked was "We would like you to think about your recent experience of working in <the organisation>. How likely are you to recommend <this organisation> to friends and family as a place to work?"

The percentage responding "don't know" has been omitted.

Figure 3.3: Place to receive care – friends and family test (staff) by work area and location, England, Q4 2015



Source: NHS England, Friends and Family Test.

Note: The question asked was "We would like you to think about your recent experience of working in <the organisation>. How likely are you to recommend <this organisation> to friends and family if they needed care or treatment?"

The percentage responding "don't know" has been omitted.

3.10 In its written evidence, the Department of Health (England) said that the satisfaction results in the 2015 NHS staff survey were reasonably high despite the pressures on staff. It highlighted the results of the friends and family test. It said that while the results varied across the service, the overall trend was positive with 62 per cent saying they would recommend their trust as a place to work (unchanged from 2014-15), and 79 per cent recommending their trust as a place to receive treatment (up from 76 per cent in 2014-15.

3.11 The BMA told us that there had historically been the understanding that doctors would undergo extensive and lengthy training and then work hard, but be rewarded by a stable and adequately remunerated career. This was no longer the perception of junior doctors, who did not see the NHS as an employer for life, lacked confidence in the pension system and felt undervalued by their employer. We explore some of the themes emerging around younger doctors and dentists in the 'Generation Y' section of Chapter 4.

3.12 NHS Providers told us that a prolonged bearing down on pay risked breaking the 'psychological contract' and could damage the public service ethos among our remit groups. It felt there was the danger that 'goodwill would dry up' as the workload increased while resources diminished.

Wales

3.13 The latest staff survey for the NHS in Wales was carried out in 2016, building upon the findings of the previous survey in 2013. The survey results include both medical and non-medical staff as the responses are not broken down by staff groupings. The overall response rate was 38 per cent.

3.14 Overall, the results show improvement in staff engagement and motivation. Table 3.2 provides the questions that determine the overall staff engagement score and the results in 2013 and 2016. All questions received an increase in positive responses in 2016 compared with 2013.

Table 3.2: Comparison of overall engagement score, Wales, 2013 and 2016

Theme	Question	2013	2016
Intrinsic psychological engagement	I look forward to going to work	49%	55%
	I'm enthusiastic about my job	60%	66%
	I am happy to go the extra mile at work when required	86%	89%
	THEME SCORE:	**65%**	**70%**
Ability to contribute towards improvement at work	I am able to make improvements in my area of work	54%	60%
	I am involved in deciding on the changes that affect my work/area/team/department	37%	44%
	THEME SCORE:	**46%**	**52%**
Staff advocacy and recommendation	I would recommend my organisation as a place to work	48%	57%
	I am proud to tell people I work for my organisation	51%	62%
	THEME SCORE:	**49%**	**59%**
	OVERALL ENGAGEMENT INDEX SCORE:	**55%**	**62%**

Source: NHS Wales Staff Survey 2016.

3.15 Responses to questions concerning workload, resources and demand were not as positive, for example:

- 57 per cent said they did not have adequate materials and supplies to carry out their work, up from 43 per cent in 2013.
- 48 per cent of staff expressed difficulty in meeting all the conflicting demands on their time (unchanged since 2013).
- Only 30 per cent said there were enough staff to do their job properly, though up from 26 per cent in 2013.
- 15 per cent of staff said that they had experienced harassment, bullying or abuse at work from their manager, team leader or colleague.
- 28 per cent of staff said that experienced work-related stress during the past 12 months.

3.16 In an attempt to understand better how engaged and empowered doctors and dentists felt, the Welsh Government explained they had undertaken a series of events around the country. They said that pay did not tend to be raised as a major issue, however, practitioners wanted greater involvement in decision-making and a more supportive culture.

Northern Ireland

3.17 The 2015 Health and Social Care Services in Northern Ireland (HSCNI) staff survey in Northern Ireland was published in May 2016 and was the first survey carried out since 2012. The medical and dental staff group had one of the lowest staff group response rates in 2015 at 19 per cent.

3.18 The overall engagement score for medical and dental staff in Northern Ireland was 3.67 (out of a possible 5), as shown in Table 3.3. This score was slightly lower than the average for all staff at 3.72, driven by a lower recommendation of the organization as a place to work or receive treatment.

Table 3.3: Engagement scores, Northern Ireland, 2015

Theme	Question	Medical and dental	Difference from average
Staff motivation at work (KF25)	Look forward to going to work	59%	+2%
	Enthusiastic about their job	73%	+2%
	Time passes quickly when they are working	82%	+2%
	THEME SCORE:	**3.86**	**-0.04**
Staff ability to contribute towards improvements at work (KF22)	Frequent opportunities to show initiative in their role	67%	+1%
	Able to make improvements happen in their area of work	58%	+2%
	Able to make suggestions to improve the work of their team/department	73%	+6%
	THEME SCORE:	**3.42**	**+0.25**
Staff recommendation of the trust as a place to work or receive treatment (KF24)	Care of patients is the organisation's top priority	65%	-8%
	If a friend or relative needed treatment they would be happy with the standard of care provided by the organisation	68%	+1%
	Would recommend the organisation as a place to work	56%	-5%
	THEME SCORE:	**3.58**	**-0.13**
	OVERALL ENGAGEMENT INDEX SCORE:	**3.67**	**-0.05**

Source: Health and Social Care Services in Northern Ireland Staff Survey (2015).

3.19 The medical and dental staff group scores point to a positive attitude towards fairness and job roles. They also suggest that potentially harmful errors are reported.

- 93 per cent agreed that their job role makes a difference to patients and 71 per cent were satisfied with the quality of work and patient care they were able to give.
- 97 per cent believed the organisation provided equal opportunities for career progression and promotion.
- While 45 per cent of medical and dental staff said they witnessed potentially harmful errors, near misses or incidents in the last month, 79 per cent said their organisation encouraged staff to report these and 54 per cent said the organisation gave feedback about changes made in response to incidents.

3.20 Despite more of the medical and dental staff group reporting they had an appraisal than the average, only 33 per cent reported that the appraisals were well-structured. More worryingly only 28 per cent reported good communication between senior management and staff.

3.21 Harassment, bullying, abuse and physical violence levels were at concerning levels: 30 per cent reported that they had experienced harassment, bullying or abuse and 14 per cent reported that they experienced physical violence from patients, relatives or the public in the last 12 months. 20 per cent of medical and dental staff experienced harassment, bullying or abuse from staff in the last 12 months.

Scotland

3.22 The last NHS Scotland Staff Survey took place between August and September 2015: results were published in December 2015.[2] There has not been an update this year as the 'iMatter' staff engagement tool is rolled out. We have included the key findings from last year's survey and included some comparisons with the 2015 English staff survey. As set out in Chapter 1, the new evidence provided for 2017-18 relating to Scotland is included in the supplement to this report.

3.23 The 2015 survey covered all NHS staff in Scotland, including doctors, and a total of 60,681 staff responded. This was a 38 per cent response rate and a 3 per cent increase in participation from 2014. The key findings for medical and dental staff included:

- 90 per cent said they were happy to go the 'extra mile' at work when required (a decrease of 1 per cent from 2014);
- 58 per cent would recommend their workplace as a good place to work (a 3 per cent decrease from 2014);
- 76 per cent said they still intended to be working with their health board in 12 months' time (down 1 per cent from 2014); and
- 65 per cent were satisfied with the sense of achievement they got from work (down 4 per cent from 2014).

3.24 The key findings for doctors in training included:

- 92 per cent said they were happy to go the 'extra mile' at work when required (no change from 2014);
- 71 per cent would recommend their workplace as a good place to work (down 1 per cent from 2014);
- 60 per cent said they still intended to be working with their health board in 12 months' time (down 4 per cent from 2014); and
- 76 per cent were satisfied with the sense of achievement they got from work (down 1 per cent from 2014).

3.25 Table 3.4 below analyses responses to similar questions asked in the staff surveys in Scotland and England.

[2] The NHS Scotland Staff Survey 2015 National report is available from: http://www.gov.scot/nhsscotlandstaffsurvey2015nationalreport

Table 3.4: Comparison between England and Scotland survey results, 2014 to 2015

Country	2015 staff survey wording	In training		Medical/dental total	
		2014	2015	2014	2015
Scotland:	In the last 12 months, have you had a Knowledge and Skills Framework (KSF) development review, performance review, appraisal, Personal Development Plan meeting or equivalent?	89	91	88	89
England:	Percentage of staff appraised in last 12 months	82	78	92	91
Scotland:	I get the help and support I need from colleagues	90	89	84	83
England:	The support I get from my work colleagues	86	89	84	86
Scotland:	I can meet all the conflicting demands on my time at work	53	51	32	34
England:	I am able to meet all the conflicting demands on my time at work[1]	–	43	–	39
Scotland:	There are enough staff for me to do my job properly	45	47	26	25
England:	There are enough staff at my place of work for me to do my job properly	46	42	34	34
Scotland:	I am able to do my job to a standard I am personally pleased with	77	76	65	63
England:	Staff feeling satisfied with the quality of work and patient care they are able to deliver	84	78	81	77
Scotland:	I would recommend my workplace as a good place to work	74	71	61	58
England:	Staff recommendation of the trust as a place to work or receive treatment (an average score between 1 and 5 was then pro-rated to 100%)	76	77	75	76

Source: National NHS Staff Surveys (England and Scotland).

[1] This question changed in 2015 from "I cannot meet all the conflicting demands on my time at work" so direct comparisons to previous years are not possible.

Note: Red indicates a year-on-year decrease, green indicates a year-on-year increase.

Wellbeing

3.26 The BMA told us that it had a particular concern over the finding from its survey[3] that around half of doctors across the UK had felt unwell as a result of work-related stress at some point over the last year, with 1 in 10 taking time off work sick as a result. The reasons included the demand of their job, particularly in shortage specialties, with the amount of organisational change (particularly in England) offered as a secondary reason. The finding that 55 per cent of respondents (with England and Wales at a higher rate than Scotland or Northern Ireland) would no longer recommend a career in medicine gave BMA significant concern that future generations would be deterred from training as doctors, as would returners from re-entering the profession.

[3] https://www.bma.org.uk/

3.27 The Welsh Government's evidence told us that the health and wellbeing of NHS staff was identified as one of the key factors that underpinned performance at work, engagement within the workplace and sickness levels. To help improve matters, a development framework was published ('Working Differently – Working Together') for all health boards and trusts within NHS Wales which aimed to ensure that all NHS Wales staff and managers had access to the same level of health and wellbeing information, resources and guidance from accredited sources. An NHS Wales staff health and wellbeing charter was established, committing health boards and trusts to offer care services which are high quality, safe, effective and efficient.

Our comments

3.28 As last year, we note the low survey response rates which may mean that results are less representative of the population as a whole. Given that the English Staff Survey data were collected during a period of heated contract discussions and industrial action by junior doctors, it is interesting to note that satisfaction levels remained fairly static. The relationship between motivation, morale and engagement is a complex one, and the intrinsic motivation of our remit groups is evidenced by the increasing engagement index.

3.29 We are pleased that staff survey data were available for Wales and Northern Ireland, albeit limited in respect to Wales as we are unable to split out our remit groups' views. In both cases engagement appears to be strong across the NHS as a whole. However, there were concerns expressed over workload and resources, which may impact adversely on levels of stress, and harassment from colleagues.

3.30 The friends and family test results showed that NHS staff in England had a good opinion of the service they provided, as most would recommend their service as a place to receive care. However, they did not have such a good opinion of their trust as a place to work, where about one in five staff would not recommend it. This serves to further demonstrate the situation on workload pressures. We note the reliance that the Department of Health (England) places on the friends and family test. However, we also note that the results do not separate medical from non-medical staff which gives us only a limited view of what our remit groups think.

3.31 There appears to be increasing workload pressure on our remit groups (see Table 3.1) and this may be affecting motivation and morale particularly when set against the financial pressure and context of rising demand set out in Chapter 2. We heard in evidence and on our visits that there was a strong feeling that the Government did not appear to value its medical and dental staff. While on visits, we also heard that when given the choice between increased pay or increased numbers of staff, our remit group would overwhelmingly choose increased staff. This feeling seems clear to us given the junior doctors' industrial action and issues underlying it. Specific issues relating to doctors and dentists in training are highlighted in Chapter 5.

3.32 Bearing in mind the evidence on wellbeing, we conclude therefore that while intrinsic motivation is solid and engagement in the delivery of care is high, workload pressure may be causing a physical and mental strain on staff and potentially in turn on workplace relations. This is clearly an issue which employers will wish to be monitoring carefully and we urge them to do so, as we observe that this is not an ideal starting point from which to engage clinicians in the transformation of services, or in promoting medicine as an attractive career.

'Patients at the heart'

3.33 Our terms of reference require us to have regard to the overall strategy that the NHS should place 'patients at the heart' of all it does and the mechanisms by which that is to be achieved. In oral evidence, the Minister of State for the Department of Health (England) defined 'patients at the heart' as putting patient safety and outcomes first, and developing capacity to treat more patients and with better quality care. While 'patients at the heart' runs through all elements of our remit, we consider it separately here to highlight its importance.

England

3.34 NHS England said that the *General Practice Forward View*, published in April 2016, sought to address the pressures on primary care by increasing the level of support for and investment in general practice.[4] It would entail significant investment in primary care, including £2.4 billion in additional funding by 2020-21, with overall investment to include a turnaround package of £500m. In July 2016, measures announced by the NHS England Board included the £40m Practice Resilience Programme to help struggling practices; and the GP Development Programme to provide funding for learning and development opportunities in order to strengthen quality of care for patients.

3.35 NHS England noted that the *Five Year Forward View* was also aimed at improving care quality and health and wellbeing among patients. The 50 'Vanguard' sites[5] which have been developing new care models since 2015 were moving to the delivery phase in readiness for mainstreaming of new care models from 2017-18. These sites would be evaluated against national metrics and through outcome indicators to assess their effectiveness.[6]

3.36 NHS England also highlighted the piloting of new dental remuneration systems 'based on prevention and quality, and focussing more closely on patient outcomes rather than simply the number of interventions'.

3.37 In regard to the increasing reliance on use of locums within trusts, NHS England suggested there could be issues with continuity of patient care if locums were relied upon too heavily, since they would be unfamiliar with patients, local features and practices (see also the discussion of locums in Chapter 4).

3.38 The Department of Health (England) highlighted the progress made in terms of improved patient focus through the development of Vanguard sites and the policies set out in the General Practice Forward View. General Medical Practitioners (GMPs) were being encouraged to look to new care models, including through increased participation in GP federations and the use of multi-disciplinary teams which utilise the skills of all healthcare professionals to better meet patient needs.

3.39 In oral evidence, the Minister noted the intention of Sustainability and Transformation Plans (STPs) to implement the aims of the Five Year Forward View. The NHS would remain clinician-led but with greater devolution to local entities in controlling their health and social care budget to better meet the specific needs of local populations.

3.40 In terms of secondary care, the focus on 'patients at the heart' was being strengthened through changes to local Clinical Excellence Awards (CEAs) to incentivise doctors to improve patient outcomes; through the use of a Workforce Steering Group, involving

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[4] NHS England, General Practice Forward View, April 2016: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

[5] Vanguard sites are the NHS trusts and care providers that were selected to trial new and pioneering models of care which seek to break down the barriers between primary, secondary and community care, as envisaged in the Five Year Forward View.

[6] NHS England, Evaluation strategy for new care model vanguards, May 2016.

NHS bodies and the minister; and through a policy commitment to a consultant-led service which differentiated between trained doctors and senior consultant roles to make best use of the skill mix.

Wales

3.41 During oral evidence, the Welsh Government noted that the £42.6m investment in primary care health boards, and the commitment to developing multi-disciplinary teams including pharmacists, physiotherapists and other healthcare professionals in a primary care 'cluster model', would better meet individual needs in the community. GP practices were to strengthen collaborative working both within multi-disciplinary practice teams and with community services in order to improve coordination and quality of care. Recruitment of additional GPs would also help to manage patient demand.

3.42 A Welsh Development Model prototype for dental systems was launched in April 2016 with the aim of aligning with the principles of prudent healthcare and adopting a co-production approach to patient outcomes.

Northern Ireland

3.43 Officials from the Northern Ireland Executive explained that the recommendations of the Bengoa Review[7] and ambition of the Minister were to put services onto a sustainable footing for the benefit of patients. In particular, services should be reconfigured to ensure greater clinical engagement, implying a need for structural and cultural change in leadership and management so that services were clinically-led and management-supported.

Our comments

3.44 The NHS Constitution in England, Patient Rights Act 2011 in Scotland, the Core Principles of NHS Wales, and Quality 2020 strategy in Northern Ireland provide the basis for patient-centred care in each country. Each is looking to transform the way healthcare is delivered through its own initiatives and priorities. These may include new models of care, greater integration of health and social care, different skill mix, seven-day services and a generalised push to provide care in community settings close to home in order to improve patient experience and outcomes. A one-size-fits-all approach may not be appropriate and each UK country is tailoring its approach based on its own needs and resources.

3.45 While evidencing a direct link between pay and patient outcomes is difficult, we can examine the link between pay and staff engagement, since the latter is widely recognised as a factor in good patient care and patient outcomes.[8] A pay system should ideally reward both quality of care and productivity. The evolution of performance pay in the proposed consultant contract in England is an example of how this may be addressed in the health context although, as we heard, the development of performance pay systems linked to productivity remains in the early stages in most NHS organisations.

3.46 The 'patients at the heart' aspect of our terms of reference links also to the requirement for us to consider motivation, and we note the NHS staff survey results in England show an improvement in staff motivation, with increases in the number of staff looking forward to going to work and those experiencing job enthusiasm, likely to translate positively to patient care outcomes. On the other hand, there was a decline in England

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[7] Systems not Structures: Changing Health and Social Care, Expert panel Report led by Professor Rafael Bengoa, 25 October 2016 https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

[8] See for example Michael A. West and Jeremy F. Dawson, Employee Engagement and NHS Performance, King's Fund, 2012.

in the percentage of staff who felt 'satisfied with the quality of work and patient care that they are able to deliver' in 2015, to 77 per cent from 81 per cent the previous year. In Northern Ireland 71 per cent of medical and dental were satisfied with the quality of work and patient care they were able to give, compared to 78 per cent across the workforce as a whole. In Scotland, the survey carried out in 2015 showed 63 per cent of the equivalent workforce felt able to do their job to a standard they were personally pleased with, which was a small decline on the previous year. As noted earlier in the chapter, we are worried about the impact of heavy workloads on our remit groups' wellbeing and we will continue to monitor how changes in the way that our remit groups are working affect their morale, motivation and level of engagement.

3.47 Notwithstanding the Minister's comments during our oral evidence session, as some time has passed since this aspect of the remit was introduced, it would be helpful for government to define more precisely what is meant by 'patients at the heart' in the context of our deliberations. We interpret this phrase as a focus on patient safety and outcomes, rather than simply a question of staff motivation and morale. However, there is a clear link between staff engagement and outcomes and we consider that the pay and reward system should support staff engagement. We discuss the role of pay in relation to staff engagement further in Chapter 9 in consideration of our pay recommendations. It is also unclear how prevention and other forms of demand management, in which our remit groups have a role, fit into the government's vision of 'patients at the heart' in our terms of reference, and we would therefore welcome clarification.

CHAPTER 4: WORKFORCE PLANNING AND FUTURE SUPPLY

Introduction

4.1 In the face of increasing demand for healthcare, constrained budgets and the need to recruit and retain sufficient, highly-skilled doctors and dentists, coherent workforce planning is essential. This chapter considers characteristics of those in, and entering, medicine and dentistry, changes in their employment patterns, and the future delivery of healthcare. We examine the link between pay and workforce planning, particularly through the use of pay premia to incentivise potential applicants for shortage specialties, elsewhere in this report.

Workforce planning

England

4.2 The Department of Health (England) told us that it was taking action to increase the supply of trained staff available to work in the NHS and the wider health and care system. Together with Health Education England (HEE) and NHS England, it said it had taken a range of actions to increase the supply of domestically trained staff through recruiting and training new staff, and retaining productive and experienced existing staff. It also told us that it was increasing the efficiency and productivity of the workforce through better use of technology and changing the skill mix. The Department said it had accepted almost all of the recommendations made in the Public Accounts Committee's report on 'Managing the supply of NHS clinical staff in England' and was implementing measures to address the issues highlighted in the report.

4.3 There was a 10 per cent increase in the medical workforce since May 2010. In addition, the NHS Planning Guidance, issued in December 2015, made addressing the sustainability and quality of general practice one of nine 'must dos' for local areas. In particular, Sustainability and Transformation Plans (STPs) will be expected to address workload and workforce issues in general practice (see below).

4.4 HEE explained that it had established a workforce planning process that brought together decisions on: planning future medical (and non-medical) workforce; investment in training and education of existing staff; local needs and national priorities; and national workforce priorities alongside wider system and strategic goals. HEE had taken over some of the functions and resource of the Centre for Workforce Intelligence in April 2016 and aimed to produce 'short run' supply forecasts and provider-expressed demand forecasts. The Third Workforce Plan for England was published in early 2016 and increased the number of training posts in general practice, emergency medicine and clinical radiology. While HEE collected 2016 demand information, and an initial forecast of 2017 demand, changes under the STP process meant that HEE felt unable to provide us with general comment on future workforce risks. HEE provided us with a snapshot of current workforce supply 'shortfalls' and this is presented in Chapter 6.

4.5 NHS Providers felt that NHS workforce policy had been fragmented across different bodies and marginalised as an afterthought in national policy decisions. It considered that there was a need for a more strategic and coherent approach to workforce policy, including workforce planning. NHS Providers also pointed out that there had been a continuation of widely covered staffing shortages, notably in respect of some specialties such as emergency medicine. This put pressure on the quality of services and led many NHS providers to make greater use of bank and agency locum staffing, which in turn made a contribution to the deterioration of their finances.

4.6 NHS Employers agreed that a national workforce strategy was important and had previously been lacking. Any strategy would need to be agile enough to recognise that innovation often took place locally and that change could be effected by simplifying and sharing innovation.

4.7 That good workforce planning and comprehensive data were required for effective future service delivery was highlighted by the British Medical Association (BMA). The root causes of certain specialties being unattractive also had to be tackled, for example making accident and emergency medicine less intensive. It was important that if there was to be an increase in weekend working, it was accompanied by an increase in flexibility and the ability to take the full annual leave entitlement.

Wales

4.8 The Welsh Government told us that it was now focused on workforce planning and intended to establish a 'Health Education Wales' with the aim of improving planning and integration. Robust planning depended on accurate information, and assessing the needs of the service. However, ensuring the stability of the future workforce supply was challenging. Wales had the same profile of specialty shortages as the rest of the UK, but experienced additional geographical difficulties, particularly in the north and west. It acknowledged that it was reliant to a degree upon the UK-wide market for doctors, particularly from England, as well as from overseas recruitment.

Northern Ireland

4.9 In its written evidence, the Northern Ireland Executive told us that it was developing a workforce strategy to be published in May 2017. It also told us that it was undertaking a rolling, prioritised programme of workforce reviews across the range of medical specialties to assess future workforce requirements over a 5 to 10 year horizon. These reviews would inform financial bids for local training places commissioned by the Department through the Northern Ireland Medical and Dental Training Agency to assess and meet future demand.

Our comments

4.10 We note the continuing emphasis by the health departments and Health Education England on getting workforce planning right, and how challenging this is given the long lead times for medical training and the changes in service delivery being contemplated in each country. There is still a lack of transparency on the assumptions underpinning workforce planning in all countries, and for Wales and Northern Ireland on the extent to which they need to attract doctors that have trained elsewhere in the UK. We reflect further on the considerations for workforce planning throughout this chapter.

'Generation Y'

4.11 A key theme which emerged during this round was of the workforce patterns and trends associated with the so-called 'Generation Y' cohort, also known as 'millennials'. This usually refers to those born between approximately 1980 and 2000.[1] For our remit group, we have noticed that some of the millennials tend to have a different approach to their careers from their predecessors, valuing, in particular, aspects such as work-life balance, flexibility and variety in the workplace. These issues featured in the background to the junior doctors' contract dispute. While there is little specific evidence available, given the pertinence of the issue to our terms of reference, this section gives a brief overview of some of the themes and observations we have heard which relate to Generation Y.

[1] PricewaterhouseCoopers, Millennials at work: reshaping the workplace', 2012.

4.12 PwCs' survey of millennials in 2012 provided useful context.[2] It pointed out that nearly half of the global workforce will be Generation Y by 2020, and it is therefore important for employers to react accordingly. Characteristics of this group include:

- extensive use of technology and social media, and the expectation of instant access to information;
- an emphasis on personal needs as opposed to those of the broader organisation, thought to be a consequence of living through the global financial crisis;
- a dislike of rigid corporate structures and information silos;
- an expectation of rapid progression and career variety;
- a higher rate of churn and a reduction in corporate loyalty;
- the appetite for international experience;
- the need for work-life balance, flexibility and the desire to feel valued at work;
- attaching value to learning and development over financial benefit once basic pay and conditions are met; and
- a delay in personal milestones compared to previous generations, such as getting married later in life.[3]

England

4.13 We heard from Department of Health (England) officials that there were notable changes to training and workforce patterns among Generation Y doctors. These had become apparent in the junior doctors' contract negotiations, with this group left feeling distinctly undervalued and at the bottom of the pecking order as a result of the disagreements over contract provisions. The Department hoped this would be remedied by some of the provisions under the new contract, such as the use of Guardians to monitor hours and rotas, and the provision of extra support to doctors in training.

4.14 HEE also commented on the growing trend for Foundation Year doctors to take career breaks and sabbaticals. HEE was, however, unclear on the reasons behind this trend, and uncertain whether it should be attributed definitively to Generation Y characteristics or whether there were other underlying reasons. However, there was a suggestion that young doctors were increasingly seeking to diversify and broaden their experience, both by gaining wider experience working overseas and in different specialties, and by taking breaks and achieving a better work-life balance.

Wales

4.15 Welsh Government officials also commented on the Generation Y phenomenon. Generation Y doctors expected to work for longer overall, with state pension age potentially rising to age 70 and beyond. It could therefore be that young doctors were seeking to take time out before committing the rest of their lives to a career in medicine. In the NHS, this was manifest in the desire for more flexible and varied roles, moving away from the 'career for life' mentality and the traditional specialty route. Employers would need to think carefully about how to construct new roles to meet the needs of this generation.

Northern Ireland

4.16 The Northern Ireland Executive reiterated these views, adding that they were seeing around half of all Foundation Year doctors taking sabbaticals or career breaks. Part of this related to the feminisation of the workforce, with women taking time out to have

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[2] PWC survey, see above. See also PricewaterhouseCoopers, Research into Modern Pay Systems, 2016, commissioned by the Office of Manpower Economics.

[3] Office for National Statistics, Marriages in England and Wales: 2013 statistical bulletin.

and care for children, but there was also a more general desire among Generation Y to maintain a rich personal life outside of work, and seek flexibility and work-life balance as far as possible.

Views from the British Medical Association

4.17 The British Medical Association (BMA) commented that junior doctors appeared to view the NHS pension scheme, and indeed the offer as a whole, negatively and with distrust. This did not match the historical understanding that doctors would work hard in return for a stable, well-remunerated career. The BMA also highlighted the findings of a Foundation Year 2 (FY2) career destination survey in England and Scotland, noting that the 2015 UK Foundation Programme Office (UKFPO) report showed a decline in the proportion of FY2 trainees continuing straight into specialty training from 67 per cent in 2012, to 58.5 per cent in 2014 and just 52 per cent in 2015.[4]

4.18 The BMA stated that while the contract dispute for junior doctors in England was likely to affect the relative attractiveness of training in England in future, there already appeared to be an issue in the devolved nations with medical school graduates and foundation year trainees choosing to complete their specialty training outside those countries. The BMA referenced research being undertaken by both itself and the University of Edinburgh to look into this further to understand better doctors' early career choices.

Our comments

4.19 The characteristics and behaviours of Generation Y will need to be taken into account by employers and policy makers. As millennials will make up a greater proportion of the workforce, it is important that NHS employers react appropriately to ensure that they are able to recruit, retain and motivate this group. The Generation Y phenomenon, as it relates to medicine and dentistry, should not be seen in isolation from other changes, such as the shift in gender balance of those choosing to train as doctors or dentists. While there is not sufficient evidence to draw definitive conclusions at this stage, this is a theme worthy of further exploration, and one likely to affect the long-term sustainability of the workforce.

4.20 The career trajectory and preferences of Generation Y should be factored in to workforce planning, in particular regarding training, work-life balance and personal needs, but also where they want to be on pay. There appears to be a trend developing towards an increase in salaried GMPs and locum doctors. We can see the same trend towards 'performer-only' dentists. This may indicate that staff are seeking greater flexibility as well as improved work-life balance and remuneration in some cases.

4.21 We look forward to hearing more about the research by the BMA and the University of Edinburgh in next year's evidence. We will need more analysis and evidence on Generation Y behaviours to be able to make any specific recommendations or observations regarding pay and motivation. The break at FY2 seems to us to be critical and we would expect HEE (and workforce planners in the other UK countries) to be tracking this. The findings of the 2016 UKFPO report are set out in Chapter 5.

4.22 We also note that the junior doctors' dispute was the first example in living memory of age-defined industrial action in the NHS. Issues relating to work-life balance, quality of training and not feeling valued were all at play, although the dispute triggered recognition of the fact that these issues matter. We return to Generation Y issues in Chapters 5 and 7, particularly in relation to the growth in salaried GMPs and increasing use of locums.

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[4] UK Foundation Programme Office, Foundation Programme Annual Report 2015.

Retirement trends

4.23 Recent changes to pension legislation, in particular those to the lifetime and annual allowances for pension tax relief, together with changes to the NHS pension scheme, would seem to have increased early retirement rates. During our visits we heard much discontent expressed by consultants about the alterations to their pensions, and that they saw themselves subsidising the pensions of other less well-paid NHS staff as they paid a higher level of contributions. There were also concerns expressed that this will impact upon the attractiveness of the remuneration package as a whole for younger doctors and those considering a career in the field. This section examines some of the evidence we have heard on retirement trends and its potential impact on the remit group and our recommendations in regard to pay.

England

4.24 The evidence we received from the Department of Health (England) set out some key information in this area. In particular:

- Overall rates of early retirement and resignation were rising in the public sector.
- Figures suggested that the consultant retirement age was getting lower, making engagement with this part of the remit group highly important. However, the Department maintained that the NHS pension scheme remained worthwhile. It provided a guaranteed retirement income and the benefits, in terms of a good pension, outstripped the costs of extra contributions over a 25-year retirement period – even where individuals had breached the annual and/or lifetime allowance.
- Flexible options were available to enable early retirement from age 55 as part of the total reward package.
- There was a need to clamp down on 'retire and return' provisions where these were being exploited by senior staff at cost to the taxpayer; this involved staff taking full pension and lump sum, but continuing in full-time employment nonetheless. The Secretary of State's letter regarding this matter was included at Annex A of the Department's written evidence to the DDRB.[5]

4.25 The Minister outlined in oral evidence that officials were keenly aware of the increasing pressures on GPs. The General Practice Forward View was intended to address this by providing extra funding to help retain GPs and reduce the level of early retirement. Secondary care officials noted that figures suggested that the retirement age was getting lower, and were considering how to mitigate this. SAS doctors were particularly likely to consider early retirement, which was a cause for concern given that this group makes up around 20 per cent of the NHS medical workforce. Officials noted that SAS doctors were not a homogenous group, and incorporated several grades including some closed grades. The issues might well be different between the grades and also within them, and therefore a more detailed picture would be needed to 'get under the skin' of retirement patterns in this group.

4.26 NHS Employers was also mindful of retirement trends. With 46 per cent of the NHS workforce aged 45 or above, there were many staff who were at an age where they were considering retirement options. Anecdotally, there was a perception that the change in public service pensions had led to a less desirable pension scheme, and the change to pension taxation rules, together with other changes such as pay restraint, increased pension and National Insurance contributions, could lead people to choose some form of early or flexible retirement. This could potentially have an impact on supply and demand, and associated factors such as staff experience and agency/locum spend.

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[5] See Annex A to the Department of Health's written evidence to the DDRB, September 2016: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562447/DDRB_review.pdf

4.27 NHS Providers told us of the need to ensure the vertical integration of general practice, with the retirement patterns of the next 5 years critical in terms of engaging this group and ensuring better interaction between primary and secondary care. However, the contractual arrangements made it difficult to achieve due to the legal challenges involved in providing flexibility. Hospitals were therefore in some cases seeking to take direct control, for example by employing their own autonomous social care workforce.

Wales

4.28 The Welsh Government described the UK Working Group on retirement trends among doctors. Measures taken as a result included awareness-raising and the provision of information to senior staff. While retirement was a personal matter, and to a degree outside the control of policy officials, there were recruitment and retention schemes and mechanisms that would be used to incentivise staying in work. The Welsh Government was at the time of writing working on a report entitled 'Focus on Age' which the Review Body looks forward to consulting when it is available.

Our comments

4.29 We are concerned to hear that increasing numbers of experienced doctors may be seeking to retire early – especially at a time of other supply constraints and severe shortages in certain specialties. Work should be undertaken to better understand the trend and identify ways to address it. NHS Digital data suggested that about 20 per cent of GP practitioners and consultants in England were over 55 and could soon be considering their options. However, we also note that this could be a transitional problem, as those newer recruits who are only enrolled in the 2015 career-average pension scheme may not encounter the pension taxation allowances in the same way.

4.30 Given that it will take some years for any transition effects to become apparent, and the immediate need to retain experienced staff, as we commented in our last report, there is a need for greater flexibility around pensions within the NHS total reward offer. While pension taxation rules apply to everyone, many employers across the economy recognise that they have to be realistic about what this means for retention of experienced staff and offer flexible remuneration options accordingly.[6] Moreover, HM Treasury indicated to us that it would consider revisions to the NHS pension scheme if there is evidence that the number of doctors and dentists taking early retirement as a result of its inflexibility is substantial. When requested, neither Department of Health (England) nor NHS Employers provided us with quantitative evidence on this. We think it important that they do so next year. We also suggest that a full cost-benefit analysis is undertaken by government in order to establish the most effective policy both financially and in terms of retention and motivation. Please see Chapter 9 for more information and our recommendation on evidence on early retirement.

4.31 We understand that there could be broader cost implications attached to offering pension flexibilities. The savings that would follow, while beneficial for the employee and employer, may be less beneficial to the pension scheme as a whole given that the NHS pension scheme is funded via current pension contributions. Clearly the costs and savings implications, set against the costs of having to recruit more staff, all need to be fully understood.

[6] See for example remarks made by The Review Body on Senior Salaries, 38th Report, April 2016.

'Brexit' and domestically-trained staff

4.32 The implications of the result of the June 2016 EU Referendum were still being worked through as we took evidence. Following the referendum vote, the Secretary of State for Health in England publicly acknowledged the contribution made by overseas healthcare staff and made clear to those doctors who are EU nationals his desire for them to be able to stay in the UK.

4.33 The NHS has a significant proportion of medical staff who were trained overseas, outside of the EU. In 2015, 28 per cent of all NHS consultants were from 'other overseas'; for 'non-consultant non-training' staff it was 56 per cent; and for trainees it was 12 per cent. Table 4.1 shows the annual inflow by top five joiner nationalities[7] from 2012-13. India has consistently provided the most new doctors to the NHS, with between 700-800 new doctors joining each year. Similarly, Greece, Pakistan and Ireland feature in the top five for each of these years, whilst Malaysia dropped out in 2014-15, although returned the following year.

Table 4.1: Top five HCHS non-British joiners to the NHS in NHS Trusts and CCGs by nationality, 2012-13 to 2015-16

2012-13		2013-14		2014-15		2015-16	
India	797	India	703	India	729	India	751
Greece	429	Greece	468	Pakistan	468	Pakistan	517
Pakistan	359	Ireland	418	Greece	378	Ireland	426
Ireland	337	Pakistan	401	Ireland	358	Greece	399
Malaysia	219	Malaysia	265	Italy	236	Malaysia	247

Source: OME analysis of NHS Digital data.

Notes: Nationality is self-reported, and may reflect an individual's cultural heritage rather than country of birth.

Nationality of around 95,000 NHS staff records do not contain useful data, with people choosing not to specify their nationality.

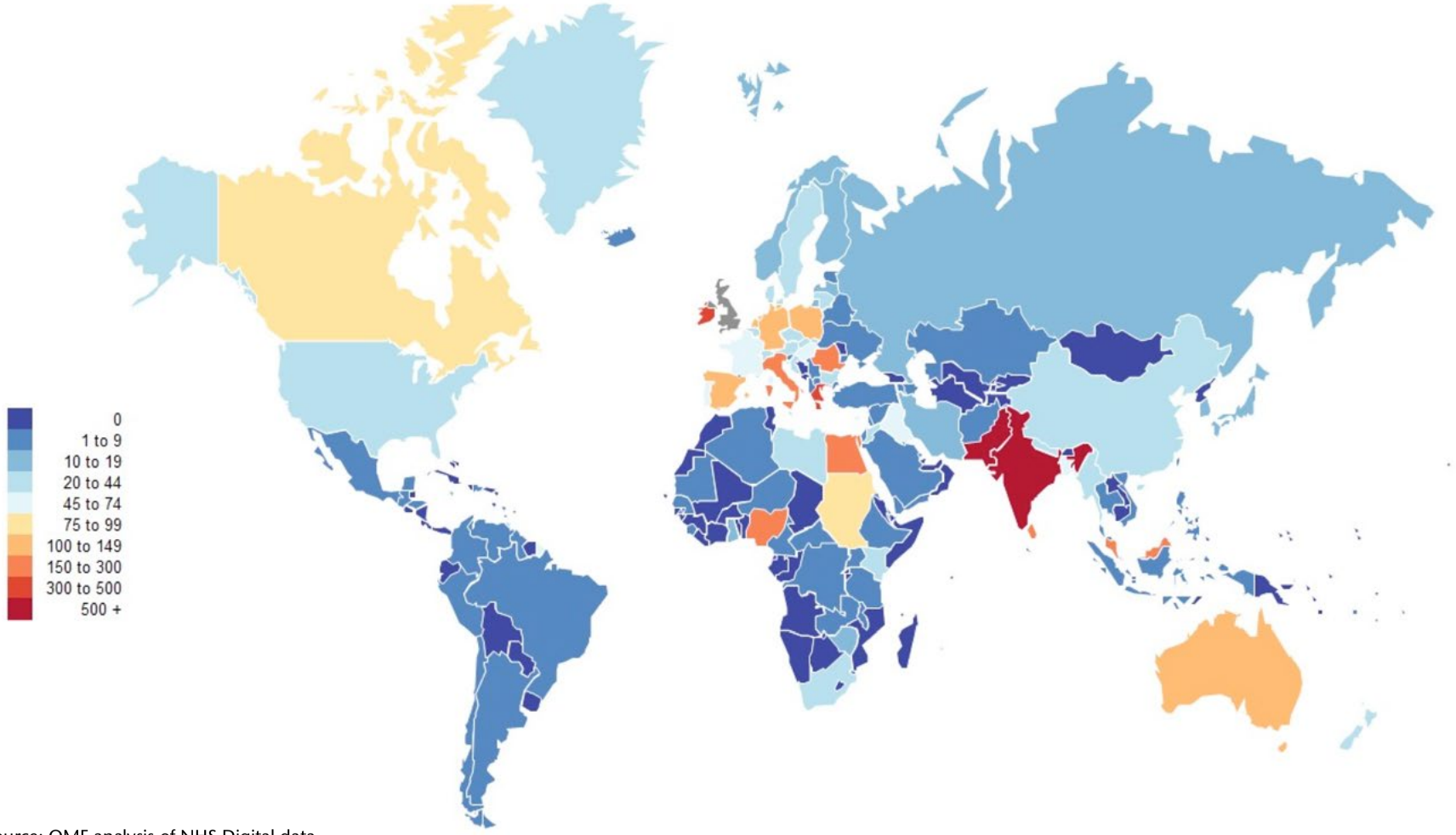
Following a public consultation in 2015, categorisation of Trusts and staff groups has changed therefore hindering comparability with previous publications.

4.34 We have mapped (Map 1) non-British medical joiners in 2015-16, which can be used to recognise the countries (nationalities) that provide the most new joiners, but also prominent regions (Map 1). In particular, most western and southern European countries have outflows of doctors to the NHS with 109, 105 and 100 new Spanish, Polish and Dutch joiners respectively. In northern Africa, Egypt, Nigeria and Sudan stand out, with 184, 184 and 93 new joiners respectively and further afield, there were 114 new Australian joiners.

4.35 Of the new medical entrants in 2015-16, 40 per cent of non-British joiners were registrars, with this proportion remaining relatively unchanged since 2012-13. This is followed by entry at the first year of foundation training and core medical/dental training, representing 18 and 12 per cent of entry respectively. The proportion of non-British joiners entering as consultants and SAS doctors were 11 and 8 per cent respectively in 2015-16.

[7] Nationality is self-reported, and may reflect an individual's heritage rather than country of birth.

Map 1: HSHC non-British joiners to the NHS in NHS trusts and CCGs, by nationality, headcount, March 2015 – March 2016



Source: OME analysis of NHS Digital data.

Notes: Countries without values have been assigned a score of 0 for mapping purposes.

Nationality is self-reported, and may reflect an individual's cultural heritage rather than country of birth.
Nationality is missing from around 95,000 NHS staff records.

4.36 HEE told us that it did not think that UK reliance on overseas doctors would reduce rapidly. It provided us with information that used the country where a doctor gained their 'primary medical qualification' as a proxy for nationality. In 2015, 8 per cent of consultants were from the EU; for 'non-consultant non-training' staff it was 18 per cent; and for trainees it was 4 per cent. The Department of Health (England) believed that it had taken steps towards self-sufficiency in doctors, with the announcement of up to 1,500 extra training places. The intention was that as part of the expansion, there would be a 'return of service' agreement of a minimum time working for the NHS. The Department confirmed that it intended to launch a consultation on the return of service proposal early in 2017 and publish a response after considering the views of all stakeholders. HEE's evidence stated that the proportion of the medical workforce from the EU and wider overseas would adjust as the existing workforce retired and the growing proportion of doctors in training with UK primary medical qualifications moved into consultant and SAS grade roles. However, this would be a long process.

4.37 HEE stated that England was aiming to be self-sufficient in terms of medical graduates by 2022. HEE does not recruit doctors directly into the service from overseas, and all training programmes, while open to overseas doctors on occasion, have rigorous recruitment processes for recruitment and retention. The Department told us that the policy intention was not to replace the current stock of doctors, but to reduce inflows from abroad, particularly from developing countries.

4.38 In the supplementary evidence it provided, the BMA told us that EU doctors, and other healthcare workers, played a critical role in both filling vacancies and in sharing knowledge and enabling diversity of workforce. It considered that these doctors should be able to stay in the UK NHS indefinitely, and that some freedom of movement should be retained to allow a flow of clinicians in both directions. The BMA did not consider it to be credible that EU staff could be replaced with UK staff in the short to medium term, given the long training times and already serious recruitment difficulties.

4.39 The BDA informed us that around 17 per cent of registered dentists qualified in the EU, and as such, the possible impact of Brexit was of major concern. It had asked the Department of Health and NHS England to help to monitor the situation.

Wales

4.40 The Welsh Government thought it too early to speculate on the potential impact of Brexit. Welsh NHS employers were part of the Cavendish Coalition, a group of health and social care organisations which was assembled to inform policy makers of the impact of Brexit on health services.[8] For doctors, 70 per cent of those who gave their nationality identified themselves as having UK nationality; 22 per cent were non-EU nationality and 8 per cent EU nationals.

Northern Ireland

4.41 Northern Ireland employers estimated that there were between 400 and 500 EU staff working within the Belfast Trust, and they were keen to, at the very least, retain existing staff. Northern Ireland employers were also involved in the Cavendish Coalition to help to understand the potential impact of Brexit. During oral evidence, officials mentioned the substantial EU funding for medical research, and how or whether this would continue after Brexit. The Western Trust in particular had a number of its staff living over the border in the Republic of Ireland, which could potentially pose problems in the future.

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[8] The Cavendish Coalition is a group of health and social care organisations whose aim is to provide those leading Brexit negotiations with the expertise, evidence and knowledge required on issues affecting the health and social care sectors. It was formed to advise and lobby on post-EU referendum issues that affect the social care and health workforce. For more information, please see: http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition

Our comments

4.42 We note that many of the parties are members of the Cavendish Coalition. There is widespread concern about the potential implications of Brexit, which we share, however it is too early to make predictions. Brexit aside, the future supply of doctors is a critical issue because more doctors are needed to alleviate the workload. We discuss the rise in the use of locums below.

4.43 The aspiration of the Department of Health (England) to be self-sufficient in terms of medical graduates by 2020 is sensible. However, we are not yet convinced that the mechanisms are in place to achieve this – particularly given changing demographic trends, such as the feminisation of the workforce and 'Generation Y' preferences for greater work-life balance and flexibility. We note the commitment made to the World Health Organisation agreement regarding those trained in developing countries. However, the existing model for training doctors and dentists imposes costs on the public purse, which is one reason why the number of domestic training places is limited. An increase in places as part of a move towards self-sufficiency of supply will have financial implications for government. Linked to that, there needs to be a more sophisticated understanding of how the UK-wide market in training doctors operates as there are common issues at play, yet it seems to us that each country is operating in isolation.

Locums and agency spending

England

4.44 In its written evidence to us, NHS Improvement said that the cost of agency staff – both locum doctors and agency nurses – had increased beyond that for staff employed substantively by the NHS over recent years. There was a fundamental mismatch between demand for doctors and nurses and supply. With activity growth outstripping demographic change across the NHS and trusts needing to increase staffing, there was a growth in demand for doctors and nurses. NHS Improvement introduced a price cap per hour for agency staff including hospital locums in November 2015, but acknowledged it had been less successful in bringing down the costs of locums than the equivalent cap for agency nurses.

4.45 NHS Employers told us that improving patient safety and outcomes were two drivers behind the work on reducing providers' dependency on agency staff, given links between use of temporary staff and quality of care. Where there is an over-reliance on non-permanent staff it may be more difficult to develop that team-based culture.

4.46 According to NHS Employers, there was no evidence that agency cap controls had affected the quality of care, or whether the agency cap alone had an impact on recruitment. There were other factors which affect the ability of some employers to recruit particular groups of staff. Employers could breach the cap where there were patient safety issues. Some employers worked in partnership with others in the locality to support internal banks and reduce reliance on agency staff.

4.47 NHS England said that the overall cost of locum allowances paid to GP practices rose by 20 per cent from £26.5 million in 2014-15 to £31.8 million in 2015. Between 18 January and 24 August 2016, significantly more GP partners became locums (632) than locums that became partners (193). Overall numbers of locums increased by 7 per cent from 11,402 to 12,203 in that period. NHS England proposed setting a maximum indicative rate based on a set of rates (which may have some degree of regional variation) for locum GPs' pay. It would then record the number of instances where a practice pays a locum doctor more than the maximum indicative rate.

Wales

4.48 The Welsh Government was unable to provide data on agency and locum spending, but did tell us that it was looking at options to capture such information better. It told us that agency and locum costs continued to increase in Wales as in the rest of the UK. Health boards in Wales were looking to better manage such costs by taking actions such as negotiating a preferred supplier agency contract, a communication campaign to encourage staff to sign up to bank and on-contract agency arrangements, a stronger focus on workforce planning to address gaps in the short/medium term, and proactive recruitment campaigns.

Northern Ireland

4.49 In Northern Ireland, Health and Social Care trusts spent approximately £44 million on agency staff in 2010-11, rising to £92 million in 2015-16. In 2015-16, £46.4 million of the total expenditure was on medical locums, up from £23.6 million in 2010-11. The health service in Northern Ireland was aiming to reduce expenditure on agency, locum and bank staff. Costs for agency and locum staff increased significantly over the last few years to a point where they were no longer financially sustainable. While trust expenditure on locum doctors was incurred to ensure that safe and effective services were sustained it was considered essential that the costs were established on a sustained, financially stable basis. The Department of Health was therefore considering the issue of the 'cap' on agency/locum costs which was introduced in England.

Evidence from the BMA

4.50 The BMA regarded the price cap on locums as unhelpful as doctors should be free to choose a locum career, for reasons such as flexibility and not being tied to particular working patterns, and around the declining attractiveness of substantive permanent posts, both in hospitals and as GMP partners. While it required further analysis, the BMA thought that better workforce planning and initiatives to fill gaps may help rebalance the relative attractiveness of substantive versus locum work. The survey of GMPs commissioned by the BMA found that 46 per cent of those working as a locum did so as a positive career choice.

Our comments

4.51 We recognise that a certain level of locum use is required, to provide operational flexibility and to respond to short-term gaps in staff levels. However, the current situation is that demand for doctors exceeds supply, and for that reason the locum expenditure caps are proving ineffective. An appropriate long-term solution is to increase supply. However, this takes time, so we suggest that the potential for flexibility within permanent contracts is explored to find ways to draw back those choosing to locum for work-life balance reasons. We note our earlier discussion of Generation Y and point to anecdotal evidence that fewer 'millennials' are home-owners servicing a mortgage; this could mean that permanent employment contracts may be less important to them. The parties need to understand better the cohort of doctors choosing to locum and we suggest that systematic research is carried out to understand their motivations and to work out how best the pay and employment package can respond. We look forward to receiving further evidence on locums in the next round.

4.52 We also link to the 'patients at the heart' aspect of our terms of reference and question whether the widespread, ongoing use of locums provides the best patient care. None of the parties were able to point to systematic evidence here; our visits highlighted that in general practice, locums can fail to develop the full skill set around patient follow-up.

However, we note also from visits that there is varied practice in the use of locums in hospitals. Some use locums only as a very last resort, which leaves remaining staff having to carry gaps in rotas.

Future delivery of healthcare

England

4.53 In recent years, much of the attention and investment in the NHS was in the secondary care area. However, NHS Employers told us that national policy in England identified the changes required to shift the focus of care from hospitals to the community, introducing new models that supported the integration of health and social care, and supported a focus on preventing illness, promoting health and wellbeing. STPs aim to bridge the gap between health and social care. Integrating care across organisations and sectors will have implications for our remit group. As set out in Chapter 2, every health and care system in England is producing a multi-year STP, showing how local services will evolve and become sustainable, with the aim of delivering the Five Year Forward View vision.

4.54 The Department of Health (England) told us that the plans were created by NHS organisations themselves, without the Department's involvement. While the STPs were high level, it was intended that they would become clinician-led. The Department considered STPs to be an important step in increasing cooperation between NHS bodies, and so reducing the risk of handover point errors. Opportunities to restructure and create new roles to meet changing needs would need to be taken to support such system integration. The consequences of getting this workforce planning wrong could be significant and could create further instability in an already pressurised environment.

4.55 NHS Employers welcomed the development of a national workforce strategy set against the Five Year Forward View and the creation of clear plans for service delivery. It stated that flexibility should be built into the new system, which could help ease the burden on high-pressure areas, for example, giving accident and emergency doctors additional leave. Pressure could be eased in some areas via capacity change, perhaps making better use of scarce resources in multi-disciplinary teams. STPs could give staff a sense that they could influence the new system, and if their buy-in was secured, they would take ownership and the changes would be more likely to succeed. Improvements should be driven by good clinical leadership.

4.56 NHS Providers considered that creating the STPs was a sensible policy move, but delivering such substantial service transformation with constrained funding was very risky. Transformation programmes generally required additional funding to double-run services and trial new models. The NHS Constitution mandated service standards which may prove impossible to meet as delivery models changed.

4.57 One interesting development that was highlighted to us by the BDA, was the devolution of the health and social care budget in Greater Manchester. In oral evidence, Department of Health officials told us that as the handover had only occurred in April it was too early to judge the impact. The objective was for NHS and local government bodies in Manchester to have greater control over health and social care in the local area, in line with the ambitions of STPs more generally.

Wales

4.58 In Wales there were changes to the wider context within which the NHS operated following the Wellbeing of Future Generations (Wales) Act coming into force in April 2016. The Act underpinned the development of the NHS workforce across Wales. Statutory guidance and 46 national indicators for Wales were published, which were laid

before the National Assembly in March 2016. This work aimed to underpin the work of the NHS and other public bodies in Wales to develop new ways of working and modes of service delivery.

Northern Ireland

4.59 The Department of Health (Northern Ireland) noted that health and social care services in Northern Ireland were entering a period of significant change, with the Minister for Health having confirmed in March 2016 that the Health and Social Care Board would close. In October 2016, an expert panel led by Professor Bengoa produced a report considering the best configuration of services in Northern Ireland.[9] The report concluded that health services needed to be reconfigured, and noted that there were low levels of clinical engagement. It said that those organisations and systems that were delivering the best care had key staff involved in the decision-making process. A structural and cultural change was needed, so that healthcare services were 'clinically-led and management-supported'. The Department responded with its 'Delivering Together' report which set out how health and social care services would be reshaped to produce better health and wellbeing outcomes.[10] The vision was for an increased focus on primary care, with patients steered away from hospital care if it was reasonable to do so.

Our comments

4.60 There are substantial changes ahead for the delivery of healthcare across the UK and the nature of the workforce. The aspiration is to move some care away from hospitals, but the achievement of such service transformation could create tensions when savings are also being demanded. Concerns have also been expressed over the STP process. We heard that the many draft plans were formulated with little clinical or patient involvement. Our remit groups will be key to making a success of these plans, and with the constraints on pay and increased workload to meet existing demand, it will take very careful leadership and management to ensure healthcare reform is implemented smoothly. We are encouraged by the various recruitment and retention initiatives in train, particularly in primary care, and the widespread recognition of the issue, but the parties will need to keep a close eye, and we see a need for more horizon-scanning. For example: in terms of generalists versus specialists; the meaning of consultant-led/delivered; the role of skill mix; and new roles; the potentially changing nature of the workforce; how they choose to work; and how medical and dental roles will fit within the future models of healthcare delivery. The pay and reward levers available need to be flexible enough to maintain recruitment, retention and motivation in reacting to the changes in both healthcare delivery and the nature of the workforce.

[9] Systems, not structures: Changing health and social care, Expert panel report led by Rafael Bengoa.

[10] Northern Ireland Executive, Health and Wellbeing 2026: Delivering Together, October 2016.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 This chapter contains our consideration of issues relating to doctors and dentists in training. We examine shortage areas, look at the career destinations of junior doctors, explore attitudes via the staff surveys and reflect on developments on the junior doctor contract. We received relatively little evidence on dentists in training.

5.2 Doctors in the UK begin their hospital training in Foundation Programmes, normally a two-year, general post-graduate medical training programme, where they are known as foundation doctors (F1 and F2). Following this training, doctors can either remain in the hospital sector as core/specialty trainees or enter general practice via the general practice specialty trainee route. Dentists undertake a vocational training programme.

5.3 A new junior doctor contract was introduced in England from October 2016. As most doctors will still be on the previous contract at the time our recommendations are made, we will make recommendations on both contracts. Junior doctors in Wales, Northern Ireland and Scotland were on the previous contract at the time of writing. We also cover many issues pertinent to doctors and dentists in training in Chapter 3 where we cover motivation, in Chapter 4 where we comment on 'Generation Y', and Chapter 6 where the characteristics of hospital doctors are presented.

Junior doctor contract reform in England

5.4 Following the first ever all-out strike by junior doctors in England, in April 2016, talks between NHS Employers and the BMA were restarted in May at ACAS, and the leadership of the BMA Junior Doctors' Committee (JDC) agreed a new draft contract for junior doctors. However, the relevant membership rejected the contract when the terms were put out to ballot. On 6 July 2016 the Secretary of State for Health announced that the contract negotiated and agreed with the leadership of the BMA Committee would be introduced anyway, in a phased rollout with new terms starting to apply from October 2016 (for new appointments, and as contracts of employment expire as juniors move through training). NHS Employers published final terms and conditions, a pay circular and associated material in July 2016, together with a timetable for implementation.

5.5 In reaction to this, at the end of August 2016, the then Chair of the BMA Junior Doctors Committee announced a series of four all-out five-day strikes for junior doctors, with the first one due to take place in mid-September. This was subsequently called off following concerns raised over patient safety and providing cover at such short notice. All strikes were suspended in late September, although the BMA restated its opposition to the imposition of the contract, saying that it planned a range of other actions to resist it.

5.6 NHS Employers produced an implementation timetable that set out when different groups were due to move onto the new contractual arrangements between October 2016 and October 2017. A summary of the timetable is below, while details of the pay elements are included in Appendix B.

Timetable:

- October 2016 – obstetrics ST3 and above.
- November-December 2016 – F1 doctors taking up next appointments; F2 doctors taking up next appointments and sharing rotas with F1 doctors.
- February-April 2017 – transitions for psychiatry, pathology, paediatrics, surgical trainees and F2 doctors and GP trainees taking up next appointments and sharing rotas with any of the above.

- August-October 2017 – all remaining trainees and new starters at all grades.

5.7 Employers will need to adapt rotas to reflect the working patterns (which include changes to limits on hours) set out in the new contract terms and conditions of service, in line with the implementation timetable. The new contract working patterns will therefore apply to all juniors, in accordance with the implementation timetable, regardless of when/whether each individual junior moves onto the new contractual arrangements.

5.8 NHS Providers told us that successfully implementing the new junior doctor contract and rebuilding junior doctor engagement and morale was a key priority for trusts. A great deal of effort was being expended locally on rebuilding relations but there was a layer of mistrust that was difficult to break down. Providers recognised that the new contract was intended to be cost-neutral, but many remained concerned that the cost of the new contract, at least in the short term, would be higher than the previous contract, which would not help trusts to meet the financial control totals set by NHS Improvement.

5.9 An important aspect of the new contract is the inclusion of the appointment of a 'Guardian of Safe Working Hours' in each trust. The Department of Health (England) told us that the role of Guardian was intended to be responsible for protecting working time limits expressed in the new contract, ensuring issues of compliance are addressed, and providing assurance to the trust board (or equivalent) that juniors' working hours are safe.

5.10 During oral evidence with the Department, the Minister said that it was important to re-establish relations with junior doctor representatives to begin rebuilding morale. Establishing the role of Guardians and providing transparency of rosters were important, although such measures would take time to have an impact. Following the announcement of the introduction of the new contract, the Secretary of State announced that additional measures would be introduced to help to rebuild the morale and engagement of doctors in training, including the potential reintroduction of the 'firm' concept, better consideration of placements for those with partners who were also doctors and better notice of rotations.

5.11 A number of non-contractual measures were also announced in July 2016. These included: a review of how best to allow couples to apply to train in the same area and to offer training placements close to home for those with caring responsibilities; a review to inform a new requirement on trusts to consider caring and other family responsibilities when designing rotas; recognition of relevant prior training when switching training path; improved rostering practices; improving the working lives of junior doctors; addressing the particular concerns of foundation year doctors who often feel most disconnected in that period of their training before they have chosen a specialty; and an independent review of the gender pay gap in the medical profession.

5.12 After suspending its mandate for industrial action, the BMA said that it was seeking to address the remaining concerns over the contract on issues such as fairness, pay and the role of the Guardian. It had been a difficult year in terms of relations, but the BMA was optimistic that the situation could improve.

Wales

5.13 The Cabinet Secretary for Health, Wellbeing and Sport confirmed that a new contract would not be imposed in Wales. While decisions had not been made on a potential new contract for junior doctors in Wales, the Department would assess the implications of the new contract in England, especially given the plentiful cross-border flows between England and Wales. Employers in Wales were in favour of having a comparable contract to facilitate cross-border movement, although pay modelling would be needed to fully cost and understand the implementation implications.

Northern Ireland

5.14 As for Wales, the Northern Ireland Executive was adopting a 'wait and see' approach and monitoring the situation. The then Health Minister was clear that there was no desire to impose the new contract in Northern Ireland. The Department was working on the other things which could be achieved without contract change. It would possibly be preferable to have a UK-wide contract, for parity of pay and ease of movement, but any solution needed to be the right one for Northern Ireland.

Our comments

5.15 Perhaps the key issue of the last year in England has been the junior doctors' dispute. While only a relatively small number of trainees transferred over to the new contract in England in October 2016, around 7,000 were due to do so in December. We look forward to receiving feedback on the experience of transition for these doctors. It will also be important for the contract to be regularly reviewed and updated. NHS Employers and the BMA agreed to commission a review by August 2018 which will consider the efficacy of the contract and identify any areas for improvement.

5.16 We welcome the signs that industrial relations in England are returning towards greater stability. We fully support the desire of the Department of Health (England) to rebuild relationships with junior doctors, and the introduction of a Guardian in each trust. General Practitioner specialty trainees are considered in Chapter 7. We reiterate the points we make in Chapter 4 about Generation Y and our view that the dispute was in part an inter-generational one; this generation of doctors may have different needs and aspirations from its predecessors.

5.17 We note that the health departments in Wales and Northern Ireland are adopting a 'wait and see' approach to junior doctor contract reform. However both expressed a desire for comparability between all four countries to facilitate movement across the UK.

5.18 We are broadly content that the pay structures incorporated into the new junior doctors' contract are in line with those we supported in our special remit report on contract reform, published in 2015.[1]

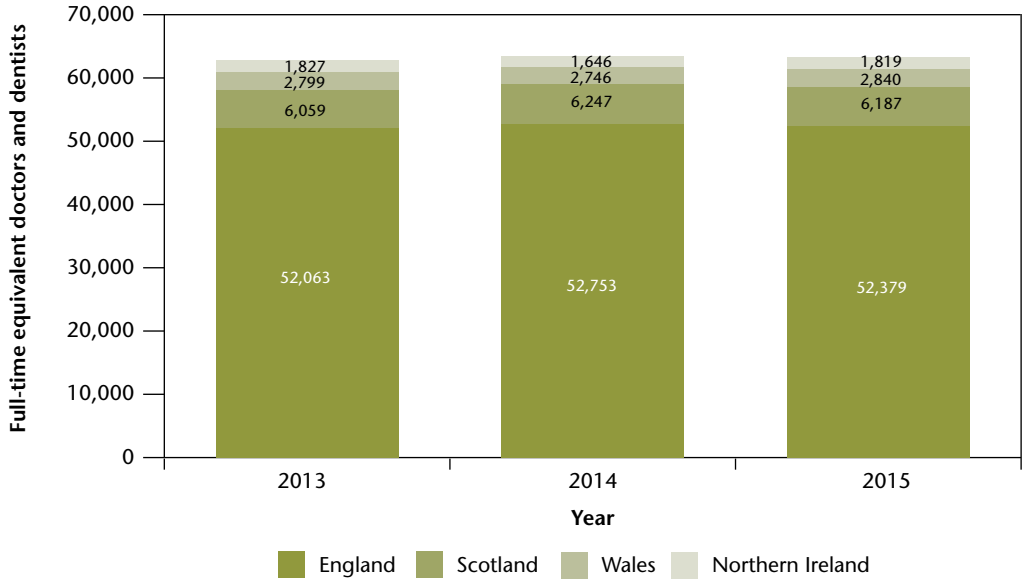
Recruitment and training choices

United Kingdom

5.19 In September 2015 there were 63,225 doctors and dentists on a full-time equivalent (FTE) basis in hospital training (Figure 5.1) in the UK, a decrease of 0.3 per cent since September 2014. As illustrated in Chapter 6, the majority of doctors and dentists in training are aged between 25 and 34, so would have been born in the 1980s or early 1990s and be part of 'Generation Y' as described in Chapter 4.

[1] Review Body on Doctors' and Dentists' Remuneration, Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week, 2015.

Figure 5.1: Number of doctors and dentists in training in the Hospital and Community Health Services, United Kingdom, 2013 to 2015



Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Northern Ireland.

Undergraduates

5.20 A typical medical student will complete a four to six year medical or dental undergraduate course before beginning their formal training. We have examined data from the Universities and Colleges Admissions Service (UCAS) and Table 5.1 provides a comparison of applications and acceptances in 2007 and 2015. Pre-clinical medicine is the most popular entry route with more applications and acceptances than other relevant subjects. Despite a rise in applications, the number of places available fell slightly since 2007. There has also been a small decrease in the number of acceptances on pre-clinical dental courses, and subsequently applications have declined compared to 2007. Other medical and dental degrees have experienced a surge in acceptances since 2007 which has led to a much larger number of applications, although this remains a relatively small proportion of medicine and dentistry places.

Table 5.1: Number of applications and acceptances to medicine and dentistry degree courses, United Kingdom, 2007 and 2015 cycle

	Applications		Acceptances	
	2007	2015	2007	2015
Pre-clinical medicine	72,275	75,665	7,845	7,660
Pre-clinical dentistry	11,160	9,875	1,200	1,095
Others in medicine and dentistry	70	1,995	20	210

Source: UCAS data.

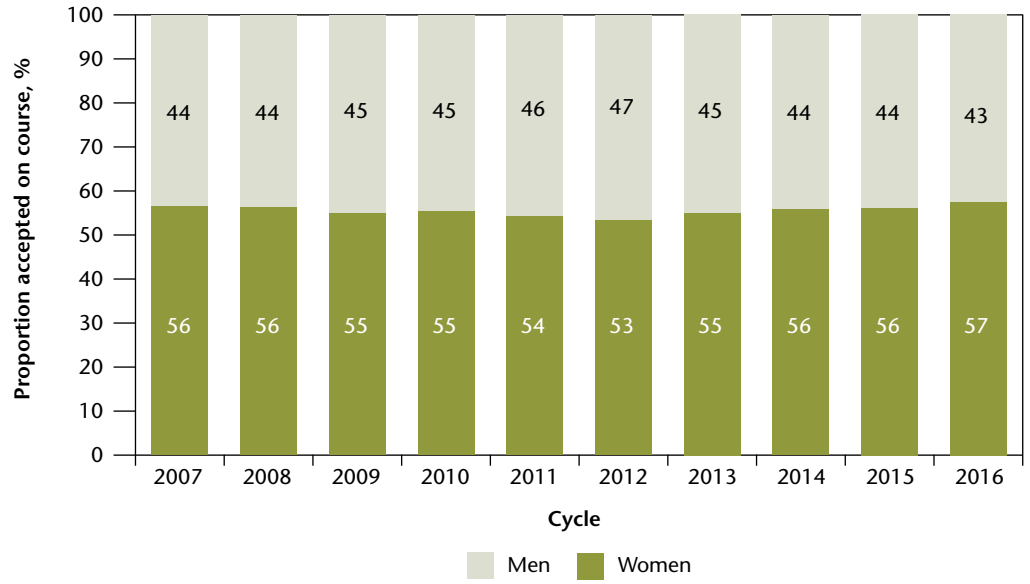
Note: Each person can make up to five different applications.

5.21 UCAS figures for the number of applicants by the January 2017 application deadline showed that the number of applicants to all degree courses in the UK decreased by 5 per cent to 469,490 compared to the same point in the cycle in 2016. The number of

applicants for medicine and dentistry courses decreased by 4 per cent overall in this period, of which the number of male applicants fell by 6 per cent and the number of female applicants fell by 2 per cent.

5.22 UCAS data can be further broken down by gender and ethnicity. The gender of accepted students on pre-clinical medicine and dentistry courses is shown in Figures 5.2 and 5.3. Both courses accepted a higher proportion of female students. On pre-clinical medicine courses, female students on average make up 55 per cent of places across this period, which has been a consistent trend. Pre-clinical dentistry courses have, on average, a slightly higher proportion of female students, averaging 60 per cent since 2007. However, more recently (from 2012 onwards) there have been a slightly higher proportion of female students.

Figure 5.2: Gender of accepted students on pre-clinical medicine courses, United Kingdom, 2007 to 2016 cycle



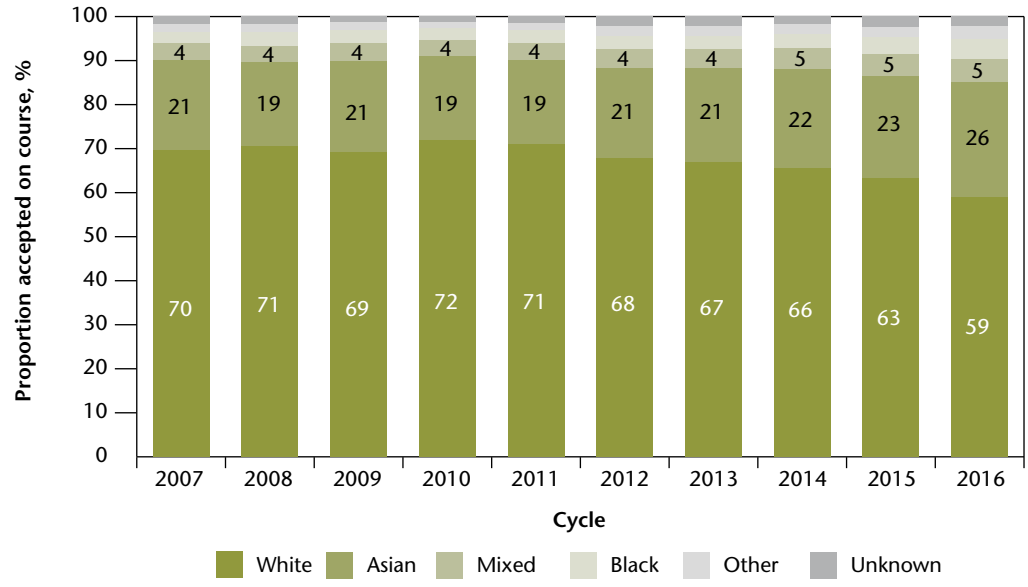
Source: OME analysis of UCAS data.

Figure 5.3: Gender of accepted students on pre-clinical dentistry courses, United Kingdom, 2007 to 2016 cycle

Source: OME analysis of UCAS data.

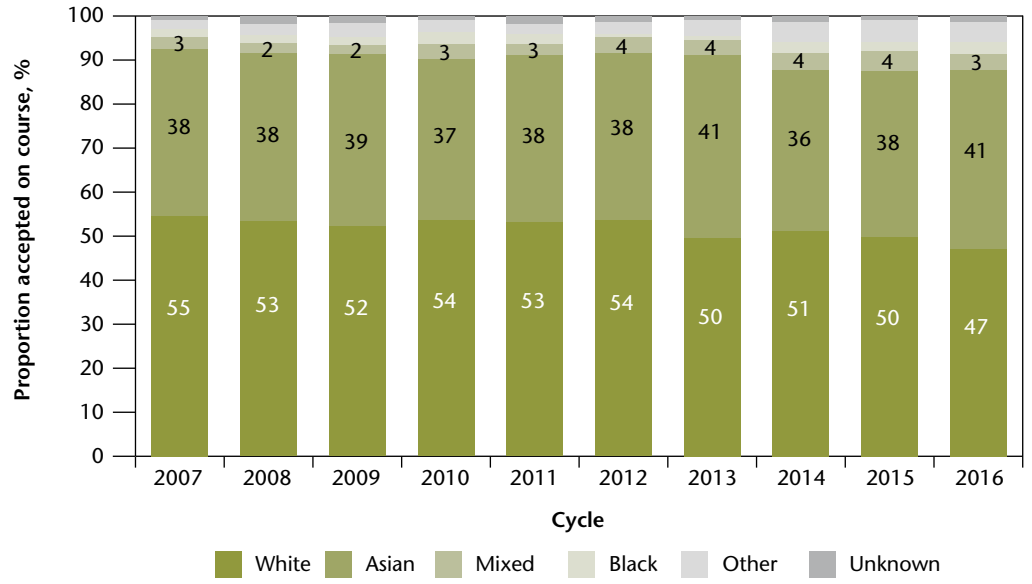
5.23 There was an increase in the proportion of Black, Asian or Minority Ethnic (BAME) students accepted on both pre-clinical medical and dental courses between 2007 and 2016 (Figures 5.4 and 5.5). The proportion of students accepted on pre-clinical medical courses who identified as BAME increased to 39 per cent in 2016, an increase of over 10 percentage points since 2007. Just over half (51 per cent) of accepted UK students on pre-clinical dentistry courses identified as BAME in 2016.

Figure 5.4: Ethnicity of acceptances for pre-clinical medicine courses, United Kingdom, 2007 to 2016 cycle



Source: OME analysis of UCAS data.

Figure 5.5: Ethnicity of acceptances for pre-clinical dentistry courses, United Kingdom, 2007 to 2016 cycle



Source: OME analysis of UCAS data.

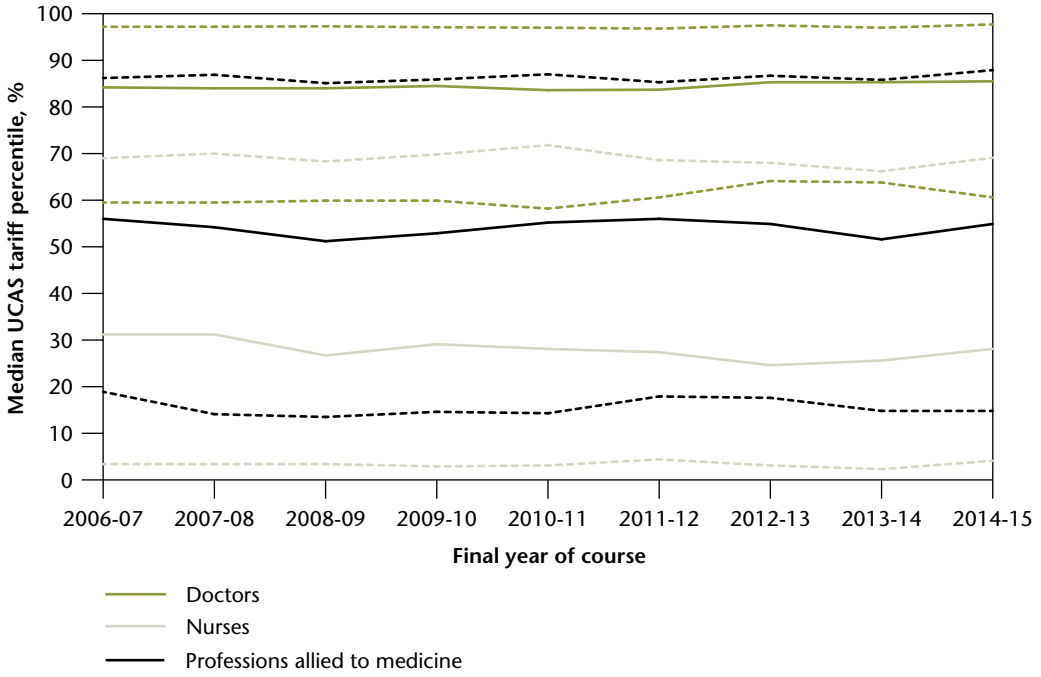
5.24 UCAS data show that in 2015 there were about 230 acceptances to pre-clinical medicine from people living in the EU outside the UK (about 3 per cent of total acceptances) and 705 from people living outside the EU (9 per cent). For pre-clinical dentistry the (rounded) figures were lower with 5 acceptances from people living in EU countries other than the UK (0.5 per cent) and 85 from non-EU countries (8 per cent). These figures are based on applicant domicile rather than nationality so, for example, the EU figures would not include EU nationals who are already living or studying in the UK when they applied.

5.25 Research from the Institute for Fiscal Studies (IFS) compares the quality of graduate recruits using educational attainment as a proxy for quality. Educational attainment is measured using UCAS tariff scores on entry to higher education. This research found that over time there has been very little change in the relative educational attainment of medical workers. The analysis did not include dentists.

5.26 New doctors have a median UCAS tariff percentile close to the 86th percentile of university graduates (which equates to a UCAS tariff score of 480[2]). At the lower end of the spectrum, the 10th percentile of educational attainment for doctors is a tariff score of 360. This score is equal to the 68th percentile of all graduates in 2014- 15, thereby illustrating the very high entry requirements to most medical degrees. At the top end, the 90th percentile of educational attainment for doctors is equivalent to the 98th percentile of all graduates in 2014-15 (Figure 5.6). The relative position of doctors is largely unchanged between 2007 and 2015.

[2] UCAS tariff scores are made up of post-16 academic qualifications, such as A Levels or Baccalaureates, but other awards or qualifications may also attract UCAS points, such as the results of music, speech and drama exams. As a guide, 480 UCAS points corresponds to four As at 'A' Level.

Figure 5.6: Relative educational attainment of new medical workers against all graduates, 2007 to 2015

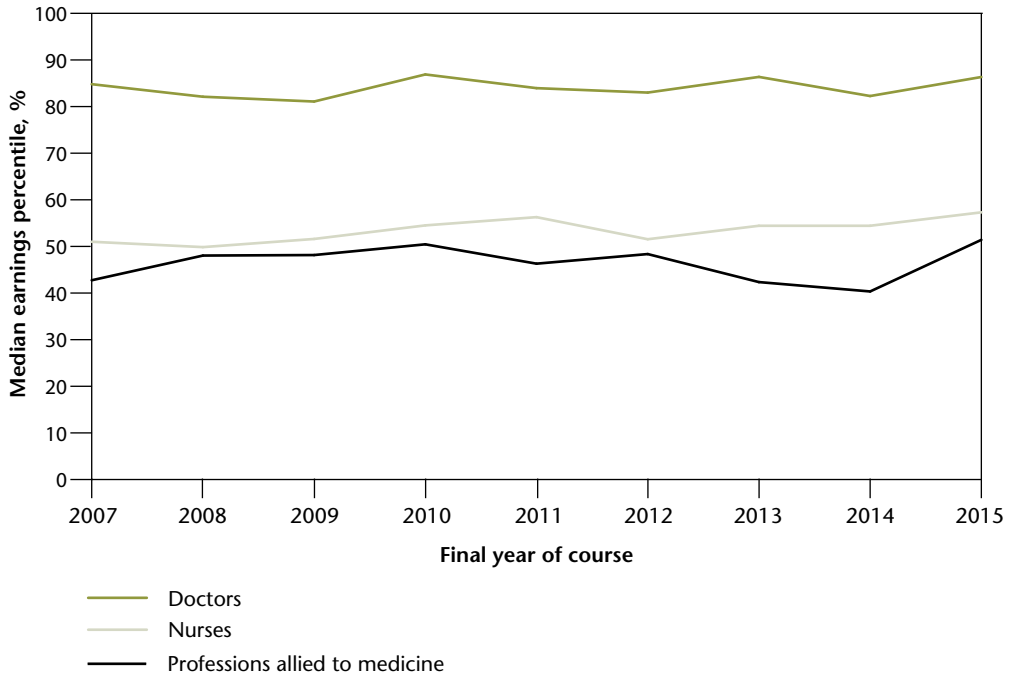


Source: Research by the IFS on behalf of the OME.

Notes: The solid line for each profession represents the median. The upper and lower dashed lines for each profession indicate the upper and lower decile respectively.

5.27 The average percentile earnings of junior doctors relative to other graduates has remained relatively stable over time, in line with most other public sector occupations. Figure 5.7 shows the average earnings percentiles for young graduate doctors (aged 22-30) over time. Doctors remain just above the 80th percentile of all young graduates (a similar position to their relative educational attainment).

Figure 5.7: Young graduates (aged 22-30) earnings percentiles, 2007 to 2015



Source: Research by the IFS on behalf of the OME.

5.28 The Higher Education Statistics Agency (HESA) Destination of Leavers of Higher Education (DLHE) surveys graduates six months after graduation, providing information on the destination of graduates. Table 5.2 shows that 99 per cent of full-time first degree medical and dental graduates were in employment or further study six months after graduation, the highest of any subject group. Furthermore 99 per cent of medical and dental graduates entering employment in the UK were working in the human health and social work activities sector in professional occupations. This indicates that there are excellent employment prospects on completion of a medicine or dentistry degree.

Table 5.2: Destination of full-time first degree leavers from medicine and dentistry degree courses, six months after graduation, 2014-15

	Medicine & dentistry
UK work	6,845
Overseas work	10
Combination of work and further study	135
Further study	345
Unemployed	15
Other	35
Total	**7,385**
Percentage in employment or further study	**99%**

Source: Higher Education Statistics Agency.

Note: All numbers are rounded to the nearest 5. Percentages are calculated on unrounded data and rounded to the nearest whole number.

Our comments

5.29 The UCAS entry data highlight that new entrants to medicine and dentistry have a different demographic profile to the current workforce, with a higher proportion of female and BAME graduates. As we discussed in Chapter 4 in relation to 'Generation Y' as these new doctors and dentists progress through the workforce we may find that priorities such as flexible working become more prominent and the job offer may have to change to reflect these. We are also pleased to see that future supply of doctors is growing in diversity.

5.30 The findings of the IFS study show that despite the recent restrictions to pay, medicine and dentistry courses are still able to recruit from a high calibre talent pool with no noticeable falls in the quality of applicants across the period 2006-07 to 2014-15. Similarly, medicine and dentistry graduates are paid at roughly the same level as their educational attainment which has again been stable between 2007 and 2015.

5.31 Medicine and dentistry are still highly sought-after careers, with oversubscription of places. We note that those studying medicine and dentistry take longer to graduate than those studying other subjects. The HESA data provided above show that almost all medical and dental graduates were in employment at the end of their studies. They also earn more than their fellow graduates, although this may partly be a factor of experience and responsibility.

Trainees

5.32 The 2016 UKFPO report shows a further decline in the number of trainees going straight into specialty training, at 50 per cent.[3] There was a slight decline in the number of trainees taking a career break compared to the previous year at 13.2 per cent (13.5 per cent in 2015), while the number of those taking another appointment within the UK, such as further study, increased from 5.4 per cent to 7 per cent in 2016, as did the number of those taking an appointment outside the UK (from 6.2 per cent in 2015 to 7.8 per cent in 2016).

Our comments

5.33 As last year we note the conclusions of the UKFPO report. We note that the trend for taking a career break at FY2 is continuing. This serves to further evidence our observations about Generation Y in Chapter 4 and the need for the parties to address how the pay and employment offer can best support this generational shift. We will continue to monitor the position.

England

5.34 In recent years, we have been monitoring fill rates as a proxy for shortages in the training grades. This year, Health Education England provided data on the fill rates for training posts by specialty and region. Table 5.3 shows that on average 90 per cent of core training year one (CT1) and specialty training year one (ST1) posts were filled in 2015 and 2016. There were clear differences by region: London was able to fill almost all of its posts, while the North was only able to fill 83 per cent, on average. The fill rates also vary by specialty, with the lowest average fill rate being in core psychiatry training and general practice. 2,628 of the 3,184 posts for general practice were filled, leaving over 500 posts unfilled. Across all other specialties, only 162 other posts were unfilled.

[3] UK Foundation Programme Office, Foundation Programme Annual Report 2016.

Table 5.3: Fill rates for Core (CT1) and Run-through (ST1) posts, England

	Fill rate, two year averages 2015 and 2016					
	England	North	E. & Mids.	South	Lon/KSS	London
Clinical Radiology	100%	100%	100%	100%	100%	100%
Ophthalmology	100%	100%	100%	100%	100%	100%
Public Health Medicine	100%	100%	100%	100%	100%	100%
Neurosurgery	100%	100%	100%	100%	100%	100%
Cardiothoracic surgery	100%	100%	100%	100%	N/A	N/A
Oral and Maxillo-facial Surgery	100%	100%	N/A	100%	N/A	N/A
Community Sexual and Reproductive Health	100%	100%	100%	100%	100%	100%
ACCS Anaesthetics/Core Anaesthetics	100%	100%	100%	99%	100%	100%
Obstetrics and Gynaecology	100%	99%	99%	100%	100%	100%
Histopathology	99%	98%	100%	100%	100%	100%
Core Surgical Training	99%	99%	99%	100%	100%	99%
Acute Care Common Stem - Emergency Medicine	99%	97%	100%	98%	100%	98%
ACCS Acute Medicine/Core Medical Training	97%	92%	98%	98%	100%	100%
Paediatrics	95%	88%	94%	100%	99%	100%
General Practice	83%	70%	78%	91%	99%	99%
Core Psychiatry Training	79%	66%	73%	78%	99%	100%
All recruited at CT/ST1	90%	83%	88%	94%	99%	100%

Source: Health Education England.

5.35 Of the 'higher' level posts (Table 5.4), psychiatry had the lowest fill rate (58.4 per cent), with surgery (97.7 per cent) and gastroenterology (98.8 per cent) having the highest fill rates. Again, London had higher fill rates than the other regions, with the North generally having the lowest. In total there were about 500 unfilled posts at the 'higher' level (out of about 2,500).

Table 5.4: Fill rates for 'higher' level posts, England

	Fill rate, two year averages 2015 and 2016					
	England	North	E. & Mids.	South	Lon/KSS	London
Anaesthetics	93%	83%	90%	98%	100%	100%
Surgery	98%	96%	98%	98%	100%	100%
Cancer Related	90%	82%	85%	95%	97%	97%
Acute Take	88%	90%	84%	82%	94%	96%
Intensive Care Medicine	88%	77%	92%	95%	97%	100%
Pathology	66%	55%	63%	63%	83%	85%
Psychiatry	58%	52%	48%	49%	79%	79%
Gastroenterology	99%	98%	100%	96%	100%	100%
Geriatric Medicine	93%	97%	87%	89%	96%	95%
Respiratory Medicine	87%	90%	78%	87%	100%	100%
Acute Internal Medicine	70%	75%	69%	61%	76%	84%
All	81%	76%	76%	82%	90%	91%

Source: Health Education England.

Note: Only doctors who have completed core or common stem training or can demonstrate equivalence can apply to these posts.

Wales

5.36 The Welsh Government provided us with data on fill rates for doctors and dentists in training. In 2016-17, the fill rate for FY1 was 97 per cent and for FY2 was 95 per cent. However, as at September 2016, of the 2,517 medical and dental trainee places in Wales, 86 per cent were filled. The vacancies covered six specialties: psychiatry, core medical training, general practice, acute medicine, higher emergency medicine and higher paediatrics.

Northern Ireland

5.37 In Northern Ireland, of the 1,753 approved medical training posts, 179 were vacant from August 2016, giving a fill rate of 90 per cent. There were continuing difficulties in recruiting to core medical and emergency medicine, with fill rates of 76 per cent and 82 per cent respectively.

Flexible pay premia

5.38 The new junior doctor contract in England includes the provision for flexible pay premia (FFP), to encourage trainees to enter into certain specialties. NHS Employers' guidance is that these can be specialty-specific FPP, payable to trainees on identified programmes only, effectively as a form of recruitment and retention payment, or payments that could, where appropriate, be paid only in certain regions or differentially between regions if supply was a local issue. The specialties identified as being eligible for FPP at the time of writing were: general practice; psychiatry; emergency medicine; and oral-maxillofacial surgery. We return to the role of pay premia in Chapter 9.

Our comments

5.39 As we noted last year, it is difficult for us to make comparisons between fill-rates from year to year. However, some specialties persist in having lower fill rates, for example psychiatry and general practice, and some locations, for example the North and East and Midlands have a harder time filling their training posts than others.

5.40 As we again noted last year, these ongoing recruitment problems are of concern to us, particularly as we continue to be told that such issues are not pay-related. For our next round, we ask the parties in the devolved countries to provide data at a similar level to HEE's evidence, which shows both the regional and specialist patterns in fill rates. We would also welcome evidence on the reasons why junior doctors are choosing particular locations or specialties (see Chapter 10).

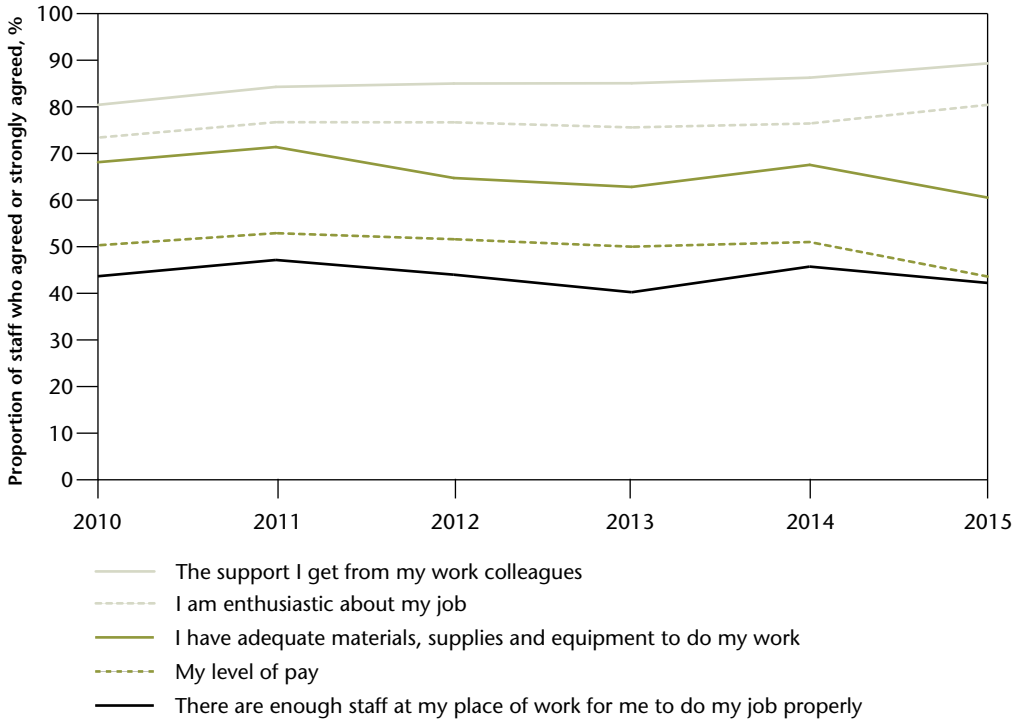
5.41 We are supportive of FPP (and their equivalent mechanism in the existing UK-wide contract) to help address recruitment into shortage specialties using pay. We understand that the intention of FPP (and RRP) is to reduce pay differences that may occur, for example, due to different shift patterns and pay rates, or in relation to training in a certain specialty, as applies to the General Practitioner Specialty Training (GPST) supplement and oral-maxillofacial surgery. Pay premia may also provide a pay *incentive* to train in demanding, under-filled specialties or small, highly specialised specialties and it is our understanding that these apply to the FPP for psychiatry and emergency medicine. We would welcome clarity on what our role will be in assessing FPP in the future. We note, however, that FPP do not appear to be utilised to address geographic shortages, yet these types of shortages persist. We discuss this further in relation to targeting in Chapter 9.

Motivation

5.42 The most recent staff survey in England for which results are available was carried out between September and December 2015. This is a key source of motivation and engagement evidence and the overall results are presented in Chapter 3 with some further data split out by grade presented in Chapter 6. Notably, the survey took place during a period of contract dispute and in November 2015 junior doctors (in England) announced they would go on strike. Figure 5.8 compares doctors and dentists in training pay satisfaction alongside other elements of their job satisfaction. Specifically:

- Despite improvements in the 2014 survey results, there was a decline in satisfaction with work materials and staffing numbers. In 2015, those satisfied with work materials decreased by 7.0 percentage points to 60.5 per cent and those satisfied with staffing levels decreased by 3.5 percentage points to 42.2 per cent.
- Continuing recent trends, doctors and dentists in training are more enthusiastic than last year about their job and the support that they are receiving from their colleagues. Those satisfied with support from colleagues increased from 86.3 per cent to 89.3 per cent between 2014 and 2015. Alongside this, job enthusiasm in 2015 peaked to its highest level over the last six years (80.4 per cent).
- Satisfaction with pay, having remained steady at around 50 per cent since 2010, decreased from 51.0 per cent in 2014 to 43.6 per cent in 2015.

Figure 5.8: Aspects of doctors' and dentists' in training job satisfaction, England, 2010 to 2015



Source: National NHS Staff Survey.

Our comments

5.43 We note that only in England is staff survey data split out by staff group, and so we do not have a picture of junior doctors' motivation in the other countries. The latest available staff survey results show that while junior doctors continued to be engaged with their work, they were dissatisfied with workload and resources as well as pay. While it is too early to see the impact of the new contract in England and its ramifications for other UK countries, we are encouraged by the actions underway to increase engagement with junior doctors. These actions will need to take account of the points we made in Chapters 3 and 4 about 'Generation Y', which suggest that this group of junior doctors may have markedly different aspirations and motivations than their predecessors.

CHAPTER 6: HOSPITAL DOCTORS

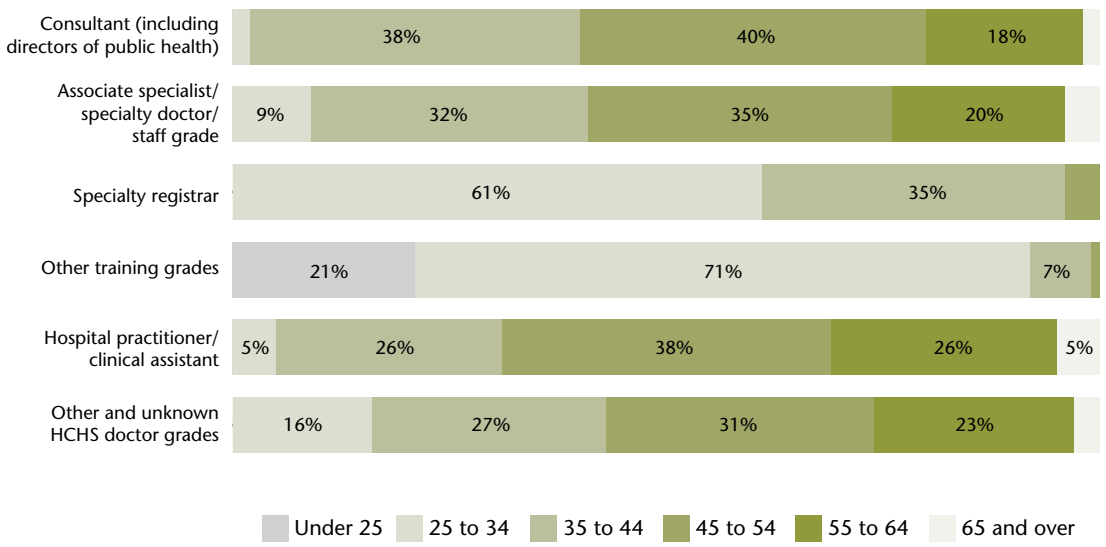
Introduction

6.1 This chapter considers the consultant group together with speciality doctors and associate specialists who together provide secondary care. It starts with data on the age, gender and ethnicity of Hospital and Community Health Service (HCHS) doctors.

Characteristics of all hospital doctors, including doctors and dentists in training

6.2 Figure 6.1 gives the age distribution of hospital doctors at different grades. As at September 2015 about two thirds of staff in the specialty registrar grade were aged between 25 and 34, with a further third aged between 35 and 44. Around 70 per cent of staff in the other training grades were aged between 25 and 34. Specialty doctors and associate specialists (SAS) doctors and consultants had a similar age profile, with about 40 per cent of staff under 45 and 20 to 25 per cent over 55.

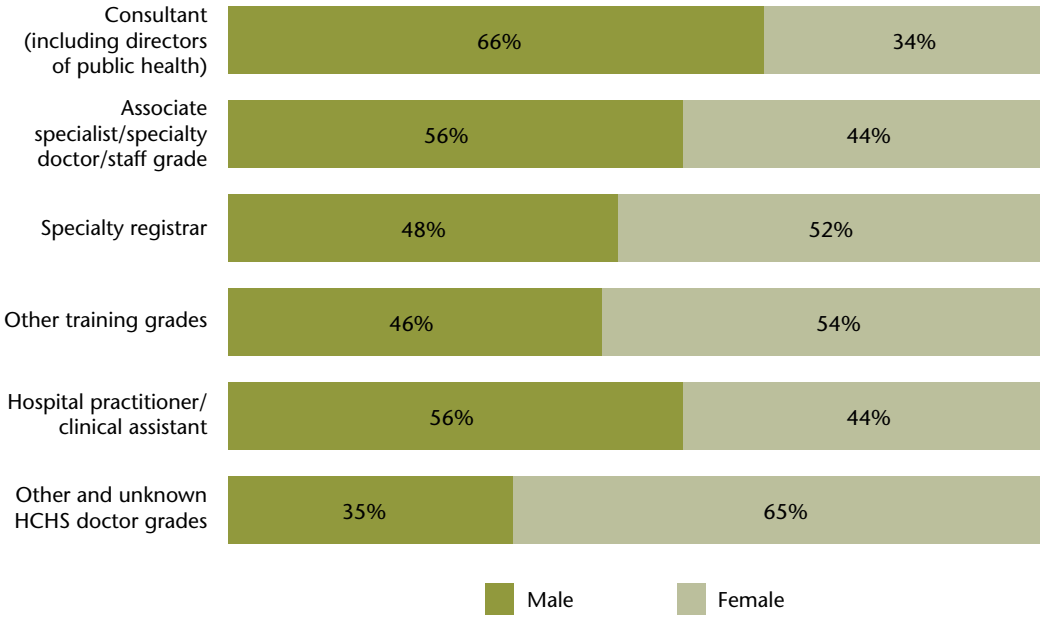
Figure 6.1: HCHS workforce by age, England, September 2015



Source: NHS Digital.

6.3 NHS Digital data (Figure 6.2) show that around a third of consultants are female. This proportion is likely to increase as the proportion of females to males in the training grades is closer to 50:50. About 45 per cent of SAS staff were female, higher than the proportion for consultants, but lower than for the training grades. As discussed in Chapters 7 and 8, this trend towards an increasing proportion of women joining the medical profession is also reflected in general practice and NHS dentistry.

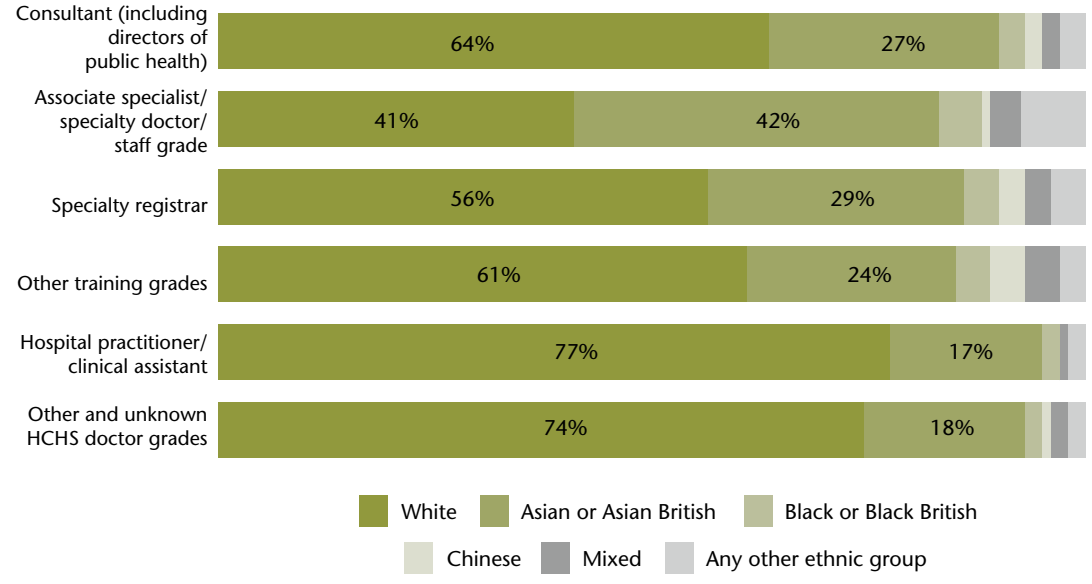
Figure 6.2: HCHS workforce by gender, England, September 2015



Source: NHS Digital.

6.4 Figure 6.3 shows that SAS doctors were the staff group with the highest proportion of Black, Asian and Minority Ethnic (BAME) staff. For consultants, specialty registrars and training grades the proportions identifying as White were closer to 6 in 10 staff. For SAS doctors, there was a higher proportion of Asian or Asian British staff than White staff.

Figure 6.3: HCHS workforce by ethnicity, England, September 2015



Source: NHS Digital.

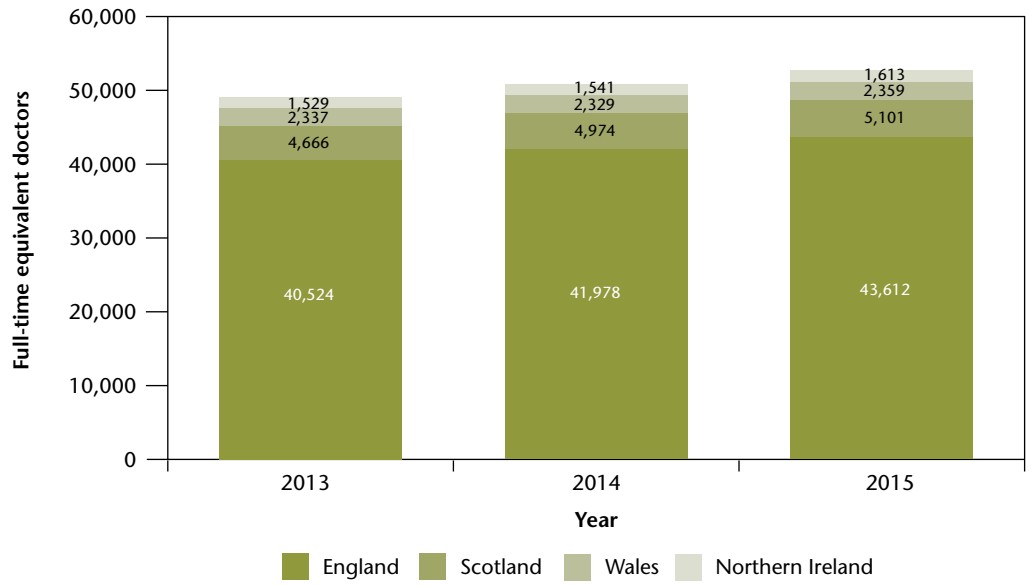
CONSULTANTS

6.5 This section considers the consultant group, which is the main career grade in hospitals. In it we observe that despite the growth of the consultant workforce in recent years, there remain some specialties and locations that continue to have significant recruitment problems. We also comment on the key findings of the staff survey for consultants, and discuss the various consultant award schemes across the UK.

Recruitment and retention

6.6 In September 2015, on a full-time equivalent (FTE) basis, there were 52,685 consultants, an increase of 3.7 per cent on the previous year (Figure 6.4). This was largely driven by an increase of 3.9 per cent in England and 4.7 per cent in Northern Ireland; Wales and Scotland increased by a more modest 1.3 and 2.8 per cent respectively.

Figure 6.4: Number of consultants in the Hospital and Community Health Services, United Kingdom, 2013 to 2015



Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health (Northern Ireland).

England

6.7 Data from Health Education England (HEE) showed that the average shortfall[1] for consultants across England was 8 per cent. Table 6.1 shows a regional variation, with higher shortfall rates in the North (9 per cent) than in the Midlands and East (7 per cent), London and the South East (6 per cent), and the South (5 per cent). The highest shortfall across England was for what HEE define as 'small specialties', followed by accident and emergency (both 13 per cent). Paediatrics and obstetrics and gynaecology (4 per cent) had the smallest shortfalls, especially in the South.

[1] Shortfall is defined as the whole-time equivalent (WTE) demand for consultants minus the number of WTE consultants in post (not including agency doctors temporarily filling substantive posts) then divided by the WTE demand for consultants.

Table 6.1: Consultant shortfall by HEE region and specialty

	Scale (Staff in Post)	England	North	East & Mids	London and SE	South
Small Specialties	508	13%	14%	9%	16%	9%
Accident and Emergency	1,509	13%	13%	15%	11%	10%
Acute Take	4,087	10%	12%	14%	8%	6%
Pathology & Lab	1,917	10%	16%	9%	6%	8%
Psychiatry	3,963	8%	13%	7%	3%	9%
Cancer Services	4,724	8%	11%	9%	6%	4%
Ophthalmology (Inc. Medical)	1,026	7%	10%	5%	10%	2%
Other Medicine	4,393	6%	8%	7%	3%	6%
Surgery	7,302	6%	8%	5%	4%	4%
Anaesthetics & ICM	6,533	5%	5%	4%	8%	1%
Obesterics & Gynaecology	2,069	4%	4%	3%	5%	1%
Paediatrics & Paed Cardio	2,977	4%	8%	4%	3%	2%
All	41,557	8%	9%	7%	6%	5%

Source: Health Education England.

Note: The shortfall rates are coloured to draw the eye. A shortfall of 6 per cent or less is coloured green, which is not to say it does not present a problem for providers. It is rather that an element of 'labour market friction' is to be expected as staff leave (for example, retire) and are recruited (from, for example, new CCT holders). Shortfalls of between over 6 and under 10 per cent are coloured amber and those of 10 per cent or more are red.

Wales

6.8 The Welsh Government was unable to supply vacancy rates, but provided information on the number of advertised vacancies in 2015-16. Between April 2015 and March 2016 there were 186.5 FTE medical and dental vacancies (these figures exclude locum and junior doctors).

Northern Ireland

6.9 The Northern Ireland Executive ceased its regular vacancy survey in 2016, instead running surveys before each recruitment campaign. In June 2016 there were 160 permanent vacancies across both consultant and SAS grades. The greatest pressure for consultants was in acute medicine and geriatric medicine.

Our comments

6.10 As we noted last year, despite the growth in consultant numbers, there are some specialties and regions with significant ongoing problems in recruiting sufficient numbers of staff. Given that we also noted last year that shortage specialties can be partly attributed to the training choices made by junior doctors, we focused on this supply in our deliberations this year and discuss this in Chapter 4. We also pick up the role of pay in addressing shortage specialties within the junior doctors' contract in Chapter 5.

6.11 However, in relation to geographic shortages, we note that the facility for local Recruitment and Retention Premia (RRP) in the consultant contract is not widely used by employers. Again, as we said last year, while we understand this when there is an overall shortage in the supply of a particular specialty, it should not preclude employers from using RRP to encourage recruitment to address local shortages that may be related to

the attractiveness of working in a particular region. We consider that RRP could be used much more widely as a route to best achieve effective targeting, with one example of a success being in the Western Health and Social Care Trust in Northern Ireland. We discuss the merits of targeting to address shortages further and make a formal recommendation in Chapter 9.

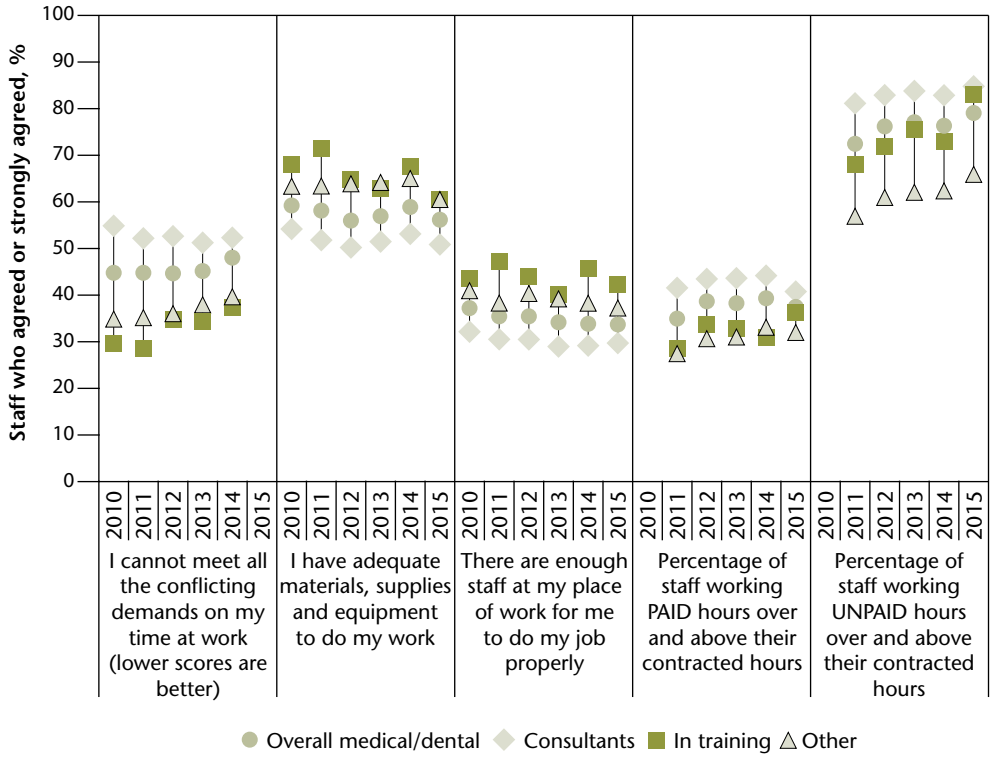
Motivation

England

6.12 As discussed in Chapter 3, total medical and dental staff satisfaction[2] with pay increased for the first time since 2010, rising from 54.1 per cent to 55.4 per cent between 2014 and 2015. The main factor behind this was greater satisfaction from consultants, which had increased by 2 percentage points. Consultants, however, remain the least satisfied group with the support received from their manager.

6.13 Consultants consistently reported the highest feelings of work pressure among hospital groups. Consultants were the least satisfied with staffing numbers and equipment, with those satisfied with adequate materials falling 2.3 percentage points to 50.9 in 2015 (Figure 6.5). Amongst medical staff, they have persistently had the highest proportion of staff working additional paid and unpaid hours since 2010. In 2015 the proportion working unpaid hours increased to 84.8 per cent.

Figure 6.5: Feelings of work pressure, 2010 to 2015



Source: NHS Staff Survey.

Note: The question "I cannot meet all the conflicting demands on my time at work" was changed in 2015 to "I am able to meet all the conflicting demands on my time at work", so direct comparisons are not possible. Responses (percentage of staff agreeing or strongly agreeing) for the new 2015 question were; consultants 33 per cent, in training 43 per cent, other 46 per cent and overall 39 per cent.

[2] In each case, satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

Wales, Northern Ireland and Scotland

6.14 Results from the staff surveys in Wales, Northern Ireland and Scotland are not published in enough detail to identify consultant level staff results.

Our comments

6.15 Our comments here echo what we say in Chapter 3, in that it is important to separate intrinsic motivation from workload and broader motivation issues for our remit groups. Consultants are clearly well-motivated, but are feeling the effects of heavy workload. It is notable that nearly 85 per cent reported working unpaid hours and that this proportion has been increasing since 2010, which appears to reflect the effects of rising demand.

Contract reform

6.16 The most recent consultant contracts were agreed in 2003 and differ somewhat in each of the devolved countries. We make recommendations on the pay uplift for consultants on all types of existing contract, although a very small and decreasing number remain on the pre-2003 contract. After a pause from October 2014, discussions recommenced on a potential new contract for consultants in England and Northern Ireland in September 2015, following publication of our special remit report on contract reform. We were advised that while negotiations continued, progress was slower than anticipated, partly in the light of the negotiations on the new junior doctors' contract and because reaching an agreement within the constraints of the government's public sector pay policy and the wider financial situation facing the NHS was challenging for all parties.

6.17 We were told during oral evidence with the Department of Health (England) that the junior doctors' contract dispute became associated with the move to deliver the seven-day service manifesto commitment. All parties accepted that junior doctors had been working shift patterns covering all seven days for very many years, so it was unfortunate that this aspect had gained such prominence. However, the Department emphasised that the existing consultant contract allowed an opt-out from some evening and weekend work, and said that it was important to find constructive ways of encouraging consultants back into hospitals at weekends. Changes to the system of pay progression were part of those negotiations.

6.18 NHS Providers stated in its written evidence that it made the case for reform of the consultant contract in 2015-16, arguing that the right to decline non-emergency work outside of core hours should be removed, that the link between pay and performance should be strengthened, and that more hours in a day and more days of the week should be defined as core hours. The contract discussions cover seven-day working, and a new pay and performance pay system linked to competency not time served. The BMA told us that it had identified some issues around equality regarding the junior doctor contract, so ensured such issues were also being considered for the consultant contract. The BMA also stated that it was not possible to know when, where and in what exact form a new contract for consultants in England and Northern Ireland might be put in place, but it was highly unlikely to be before October 2017, so it requested that we make our recommendations on the basis of the existing contracts in each respective nation of the UK.

6.19 While the Northern Ireland Executive remained actively involved with England in the consultant contract negotiations, there was no desire to impose a new contract, rather the desire to reach a negotiated agreement.

6.20 The Welsh Government told us that it continued to maintain observer status in the England and Northern Ireland consultant contract negotiations. Its preference remained for a contract that had a large degree of commonality across borders, but

any new contract would have to be right for Wales. It undertook to continue to adopt a partnership approach and had already had positive and constructive engagement with BMA Wales.

6.21 Under the 2003 contract, consultants' contracts are based on the number of programmed activities (PAs) and supporting professional activities (SPAs) they work. Total pay is comprised of five elements: basic pay on an eight-point scale; additional PAs/SPAs; on-call supplements; local and national Clinical Excellence Award (CEA)/Discretionary Point/Distinction Award payments; and other fees and allowances. The existing levels of payments are at Appendix B. The main differences for the 2003 contract in Wales are:

- a basic 37.5 hour working week (compared with 40 hours in the rest of the UK);
- a salary structure with seven incremental points; and
- a scale of Commitment Awards, increasing automatically every 3 years after reaching the maximum of the pay scale, which replaced the former Discretionary Points scheme, although consultants in Wales are also eligible for national CEAs.

Our comments

6.22 We set out our views on consultant contract reform in our 2015 Report *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week*, and continue to think that the principles we set out in that report remain valid, notwithstanding demographic changes which have come to light since publication. Pay progression should be linked to achievement of excellence, with separate payments for working unsocial hours. In our view, the current 'opt-out' clause in the consultant contract is not an appropriate provision in an NHS which aspires to continue to improve patient care with genuinely seven-day services and on that basis, we continue to endorse the case for its removal from the contract. As set out in Chapter 3, we note the increasing proportion of hospital doctors having an appraisal in England and Northern Ireland. However, only 33 per cent of medical and dental staff in Northern Ireland reported that these were well-structured, and this is no longer measured in England. High quality, meaningful performance assessment will be critical to making a new pay system, based on performance, work.

Clinical Excellence Awards

6.23 Schemes to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services have existed since the NHS was established in 1948. Since the publication of our review of incentives for consultants in December 2012[3], we have been waiting for the parties to decide how to take forward our proposals on the future of the award schemes.

6.24 The future constitution of the local award schemes in England and Northern Ireland forms part of the consultant contract negotiations. Local CEAs have been seen by some as subjective and the Department of Health (England) wanted to move to a non-recurrent model. The BMA had expressed concerns over contractual performance pay, and at the time of writing was going to court to get clarification over the status of the awards. The Department considered that CEAs should be based on appraisals of performance, but was concerned that this was not happening in many trusts. There were not proportional applications from women or BAME candidates. The Department therefore considered it to be important to move to a system were performance awards were assessed rather than applied for.

[3] Review Body on Doctors' and Dentists' Remuneration, Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants, December 2012.

6.25 The Advisory Committee on Clinical Excellence Awards (ACCEA) is responsible for the governance of the national CEA process in England and Wales. In December 2016, it announced the successful candidates in that year's review, with 300 new national awards being made in England and 18 in Wales.

6.26 ACCEA has undertaken specific analyses on the application rates and success rates of women over a number of years. These data demonstrate that while women were overall less likely to apply for an award, when they do apply they are generally as successful as men. In 2015, the last year for which data are available, about 20 per cent of applicants were female, compared with 34 per cent of the consultant workforce being female. The success rates for men and women were both around 26 per cent.

6.27 In 2015, BAME consultants were less likely to apply for an award than their white counterparts, but when BAME consultants did apply they were as successful as white consultants. In 2015 about 20 per cent of applicants were BAME, compared with 36 per cent of the consultant workforce being BAME.

Table 6.2: Success rates of applicants by ethnicity 2015

Ethnicity	Not Stated	BAME	White
Total number of applicants	18	229	940
Total number of new awards	2	66	249
Success rate of applicants	11%	29%	26%

Source: The Advisory Committee on Clinical Excellence Awards (ACCEA) annual report.

Our comments

6.28 The values of the consultant awards have mirrored basic pay increases in recent years, influenced by the overall public sector pay policy. We believe that the value of the awards should continue to increase in line with our main pay recommendation for consultants. This should apply to Clinical Excellence Awards, Discretionary Points and Commitment Awards. We continue to believe that such awards should be based on performance, as set out in our 2012 Report on this topic. Applications for awards from BAME and female candidates should be encouraged. As we note above, in addition to actually being held, appraisals need to be of good quality and assess performance fairly.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

6.29 The Specialty and Associate Specialist (SAS) doctors are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. They comprise around 20 per cent of the NHS secondary care medical workforce in England (and 13 per cent in Wales) and play a critical role in delivering continuity and quality of patient care in hospitals.

6.30 According to NHS Health Careers, SAS doctors are "non-training roles where the doctor has at least four years of postgraduate training, two of those being in a relevant specialty. SAS doctors are usually more focused on meeting NHS service requirements, compared to trainee or consultant roles. For example, they often have considerably fewer administrative functions, compared with consultants."[4]

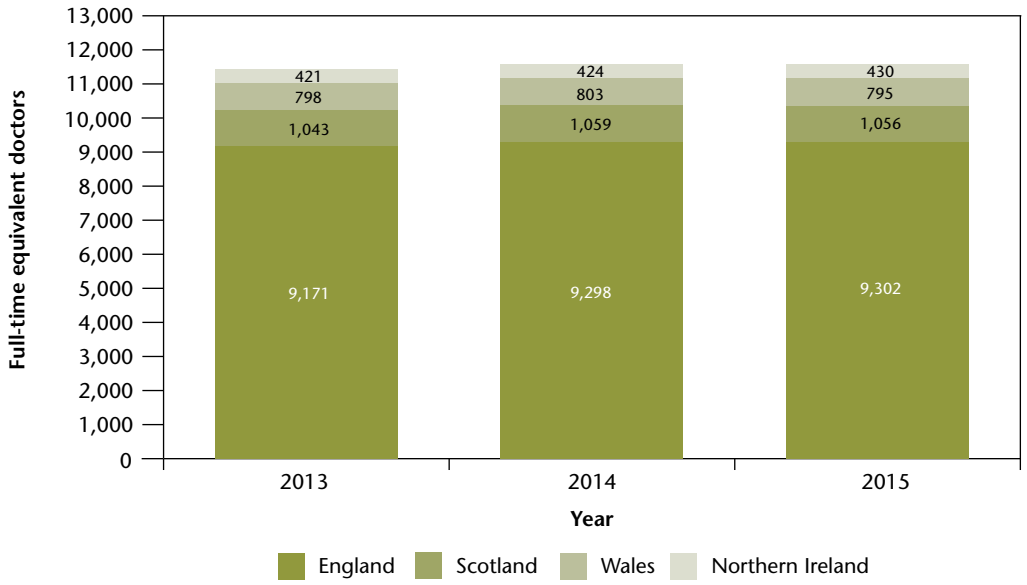
[4] See NHS Health Careers website: https://www.healthcareers.nhs.uk/i-am/working-health/information-doctors/sas-doctors

6.31 In this section, we note: limited continued growth across the UK in the SAS population; staff survey results and what they say about this group's motivation; recruitment and retention concerns; gender and equality issues in connection with this grade; and actions taken to encourage career development for this important group of doctors.

Recruitment and retention

6.32 In September 2015, on an FTE basis, there were 11,584 SAS doctors, unchanged from 2014 across the UK, although this masks underlying changes within countries with a 1.5 per cent increase in Northern Ireland and a 1.0 per cent fall in Wales (Figure 6.6).

Figure 6.6: Number of specialty doctors, associate specialists and staff grades in the Hospital and Community Health Services, United Kingdom, 2013 to 2015



Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health (Northern Ireland).

England

6.33 In written evidence, the Department of Health (England) stated that it was unaware of any specific issues, including relating to contracts, for SAS doctors – although it would wish to review current contractual arrangements, and consider any case for change, once contract reforms for consultants and doctors and dentists in training were implemented. The Department noted that in the absence of any evidence of pressing concerns or any recommendation from us that urgent contractual changes were needed it would not bring this timetable forward.

6.34 In oral evidence, it was noted that it was important that SAS doctors felt as valued as other doctors and that more could be done on that front, including through more extensive engagement with the BMA. It was noted that changes to pay implemented in 2008 had not necessarily resolved SAS concerns, and it was apparent that this group was the most dissatisfied in respect of pay and feeling valued.

6.35 HEE also told us that SAS doctors had an important role in service delivery, and it had invested around £11 million in support for this group in Continuing Professional Development funding. However, there was no formal training programme and HEE did not therefore incorporate SAS training into its workforce planning. It noted that many of

this group were older, overseas doctors who had not done specific training programmes. While HEE strongly supported the SAS Charter for Development, it had neither the funding nor the mandate to recruit to the SAS grades.

6.36 NHS Employers told us it had maintained regular contact with the BMA SAS Committee and continued to explore how SAS doctors and employers could work in partnership to support and enhance the important contribution that SAS doctors make. The new guidance for trust boards would suggest that board members consult regularly with SAS doctors to better understand the work they deliver and any necessary support they need. It would also suggest that boards could ask their medical directors to report on a range of measures to ensure that the trust was making best use of the skills and abilities of the SAS workforce. Plans should be developed and implemented at trust-level to address any issues of concern. NHS Employers reiterated that SAS doctors felt undervalued and were unhappy with pay. There was an issue with how to promote the development of SAS doctors; while some were able to progress to consultant roles, many felt they were doing most of the work of consultants without the appropriate remuneration.

6.37 NHS Providers was of the view that SAS grade contract reform was necessary, given their crucial role and the lack of adequate development opportunities for this group. Officials noted a lack of recognition of these doctors. In their opinion reopening the now closed Associate Specialist (AS) role would be one method of making SAS roles more attractive, along with better support and appreciation of SAS doctors.

Wales

6.38 In Wales, there were 795 SAS doctors, forming approximately 13 per cent of the Welsh NHS hospital workforce. Wales launched its SAS Charter in August 2016 to improve learning, development and progression opportunities at this grade.

Northern Ireland

6.39 As at June 2016, there were 160 permanent vacancies across Northern Ireland in a variety of specialties in Consultant and SAS grades. The greatest pressures for the SAS doctors were in acute medicine, anaesthetics and intensive care.

BMA comments (UK-wide)

6.40 The BMA provided evidence to us regarding SAS doctors, and oral evidence was attended by the Chair of the SAS Committee. We were told that SAS doctors were a part of the remit group that caused particular and growing concern due to low morale, and dissatisfaction with pay and terms and conditions. They were considered a complex and heterogeneous group, with a mixture of national contracts and non-standard contracts and a wide range of seniority.

6.41 The BMA was particularly concerned about trust grade doctors, who ran the risk of not getting onto their intended training route and remaining in the SAS grade in the longer term. While an active career choice for some, many SAS doctors were dissatisfied with the lack of recognition and career prospects, especially with the closure of the AS grade and lack of structured training. The BMA noted that some trusts in England were reopening the AS grade, which suggested a need for changes to remuneration and improved recognition in order to recruit and retain SAS doctors.

Our comments

6.42 In the absence of robust vacancy or turnover data, we believe, but cannot be sure, that recruitment and retention appears to be generally holding up, although there are issues with some specialties in Northern Ireland. It is notable that there has not been

an expansion in numbers of SAS doctors, as there has been for consultants in recent years. Without a clear picture of vacancies, or a sense of how SAS doctors fit into the workforce planning picture, it is difficult to comment on the suggestions from several parties that the AS grade should be reopened (although we note that it already has been in specific trusts in order to recruit). We are concerned that SAS grades do not appear to be fully integrated into workforce planning. We note the Minister's undertaking to visit SAS doctors at the next available opportunity, and believe this would be a helpful step forward in gaining an understanding of the concerns of this important group at a senior level.

6.43 While SAS doctors comprise about a fifth of the secondary care medical workforce, in general they seem to have fewer opportunities for career progression compared with other senior doctors, and the development of SAS doctors has not always been prioritised by their employers. We require more evidence in order to draw firmer observations and conclusions and outline our future data requirements in Chapter 10.

Motivation

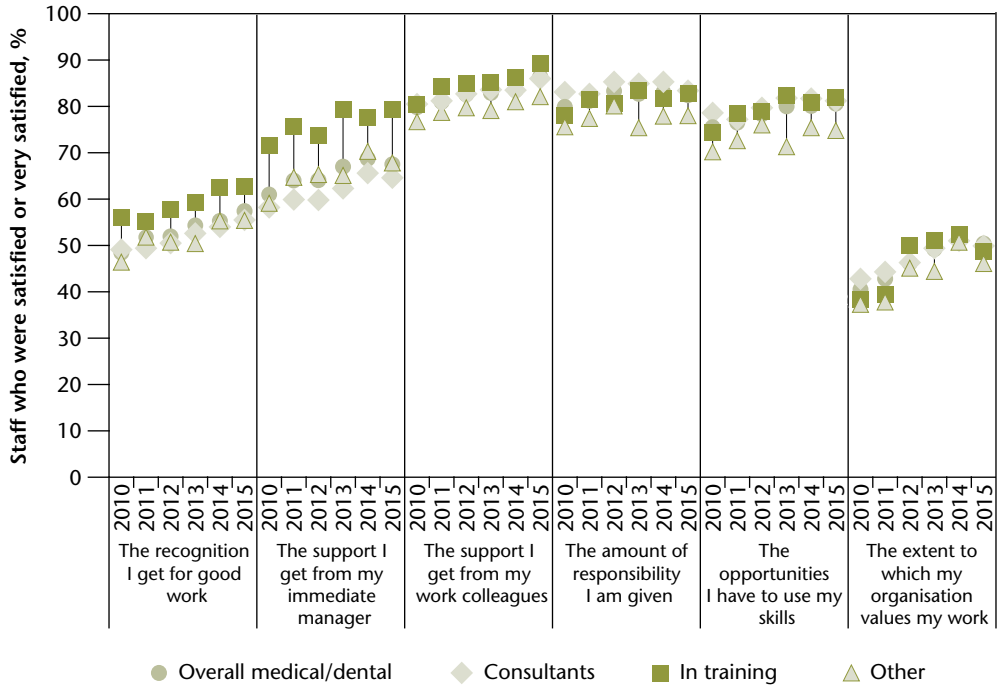
England

6.44 Further to the overall staff survey results discussed in Chapter 3, the latest available NHS staff survey results for England, from the survey conducted in autumn 2015, give an insight into the morale and motivation of SAS doctors. The so-called 'other' group of doctors referred to in the survey was composed mainly of SAS doctors. It showed stubbornly high dissatisfaction rates with pay (31 per cent) which we see as a serious cause for concern, and which substantiate the views we heard on our visits.

6.45 Staff survey results suggest workload pressures for SAS doctors are not as severe as for consultants. SAS doctors were the least likely clinical group to work paid or unpaid hours over and above their contracted hours.

6.46 SAS doctors have consistently been the least satisfied with aspects of their job as shown in Figure 6.7, in particular being the least satisfied with the value their organisation places on their work, the opportunities they have to use their skills, the amount of responsibility they have and the support they receive from their colleagues. This has been a persistent pattern since at least 2010.

Figure 6.7: Staff satisfaction with aspects of their job, England, 2010 to 2015



Source: National NHS Staff Survey.

6.47 The Department of Health (England) told us in oral evidence that it was important to differentiate between individual SAS groups which had differing motivations and different issues. Doctors in the Associate Specialty (AS) grade, for example, tended to feel let down by a lack of learning and development opportunities, and may have difficulty getting onto the consultant register, creating a sense of inequity. Specialty Doctors, many of whom were female, may have chosen that career pathway as one offering a better work-life balance, and therefore may have different concerns.

6.48 The BMA's evidence referenced its workplace experience survey from the previous round in which 53 per cent of SAS respondents stated that they wished to leave the service while 35 per cent said that they had experienced bullying.

Wales, Northern Ireland and Scotland

6.49 Results from the staff surveys in Wales, Northern Ireland and Scotland are not published in enough detail to identify SAS doctors' results.

Our comments

6.50 The evidence we received, in particular the NHS in England and BMA staff surveys, reveal a sense of disempowerment and feelings of not being valued on the part of SAS doctors. SAS doctors are the most dissatisfied group especially with their pay, and these findings, coupled with what we hear on visits, indicate this group is particularly affected by low morale. The finding of the BMA survey in relation to bullying is clearly a cause of serious concern and should be investigated further by the health departments, BMA, and other relevant NHS bodies.

6.51 There seems to us to be scope to involve SAS doctors much more as new healthcare delivery models for the NHS develop, looking at both pay issues and career structures. We would like to see SAS doctors being 'mainstreamed' in the sense of not being left behind or left out of initiatives open to other doctors – these are, after all, highly skilled, trained practitioners who deliver essential patient services.

Equal pay

6.52 NHS Providers expressed particular concern that there were gender pay issues among this group, as many SAS doctors were female, and may not have sought to progress to consultant level necessarily due to family commitments. NHS Employers also noted that while 'CESR'[5] provided an alternative route to becoming a consultant, there was a gender issue in that women may be more likely to remain as SAS doctors due to lifestyle/family choices.

6.53 We heard from the BMA that the closure of the AS grade had exacerbated matters and the organisation felt that the reopening of this grade would provide better career progression opportunities for SAS grades.

Our comments

6.54 Given the evidence of dissatisfaction and the consensus across the parties that this group provides high levels of service, we are concerned about the potential for inequalities and unfair treatment. As Figure 6.3 shows earlier in this chapter, over 42 per cent of SAS doctors are from a BAME background. These issues could also have implications for continuity of supply given the number of doctors looking for flexibility for work-life balance reasons, as discussed in earlier chapters. It may be useful for HEE and the health departments to undertake further analysis of this trend and model its potential impacts. We look forward to hearing more about how the SAS Development Fund is being used to address some of these issues.

Career development

England

6.55 HEE told us that it was considering the part played in delivering services by SAS and trust grade doctors and other Non-Consultant Non-Trainee (NCCT) staff, as well as doctors in training. At the time of writing HEE was preparing guidance on the development of SAS doctors, alongside NHS Employers, the BMA and the Academy of Medical Royal Colleges, with the intention of publishing in May 2017.

6.56 HEE stated that its review of the Annual Review of Competence Progression process, which would be launched in January 2017, would provide the forum to consider how all doctors' progress is reviewed along with their opportunities for progression, and would also explore how HEE and the wider NHS can expand opportunities outside of the traditional training route. It was a major project that would be taken forward throughout 2017 with a final report published in early 2018.

6.57 The BMA told us that funding for the SAS Charter had been reduced in some England regions and suggested that the reopening of the AS grade in some trusts implied that the Charter was not achieving the intended aim of incentivising and motivating under current structures.

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[5] For more information on this training route see the General Medical Council website: http://www.gmc-uk.org/doctors/24630.asp

Wales

6.58 Welsh evidence explained that, following a Wales-wide listening exercise undertaken in 2014, the Cabinet Secretary for Health, Well-being and Sport launched the SAS Charter for Wales in August 2016. This had been created via partnership working with BMA Cymru Wales, Wales Deanery, Welsh Government and NHS Employers Wales. The document set out both the rights and responsibilities of SAS doctors and employers to help groups to work together and enable SAS staff to realise their full potential, in turn delivering the best patient care. SAS doctors would have a right to receive support, receive suitable development opportunities, and become more involved in organisational structures. Employers would provide further job planning and activities. In oral evidence we heard from Welsh officials that the SAS Charter was in the early stages of being embedded in the NHS in Wales.

6.59 The BMA noted that in Wales, the Charter was only very recently introduced, and while the SAS Committee was broadly satisfied with the Charter, there was concern over bullying and harassment in the workplace. It was therefore too early to say if the Charter was working. The BMA view was that new SAS doctors did not have sufficient developmental tools: if they returned to training in a non-protected specialty they would lose their protected salary, while on the other hand there was a lack of recognition if no training was undertaken. This led to the BMA recommending reopening the AS grade.

Northern Ireland

6.60 The SAS Charter was adopted in Northern Ireland in 2015. However, we heard from the BMA that funding was reduced, which stalled progress. There had not been significant recruitment or retention issues, apart from in those specialities where there were shortages of all doctors, and they had a vital role to play in service delivery. The roles of SAS doctors could well evolve and more staff may choose to take such roles, rather than the traditional route to consultant.

Our comments

6.61 All four countries have signed the 'SAS Charter for Development', which intends to improve development and progression opportunities for this group. Having long championed the importance of funding for SAS doctors to support career development, we welcome the action taken in all countries via the Charter and the SAS Doctors' Development Fund.

6.62 We are concerned that SAS doctors' motivation, as measured in the surveys discussed in this chapter, is so low. While the Charters are in their early days, it is not yet clear how effective they will be in addressing SAS doctors' concerns about development and progression. We will therefore continue to monitor progress in this area and request that the parties keep us updated on the impact and results of the Charters as they bed down.

6.63 As we noted last year, SAS doctors are an important part of the NHS workforce and continue to play a key role in the provision of services. We would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive. Even the term used to refer to SAS doctors – 'Non-Consultant, Non-Training' staff – goes against the notion of an esteemed and valued part of the workforce with a vital role in delivering patient care.

6.64 We agree that the NHS is likely to continue to rely on SAS doctors, but note with concern that they appear to have dropped down the agenda as the focus has remained on other groups. SAS doctors play a leading role in healthcare delivery and should therefore be appropriately remunerated and given adequate access to training and development. Improved evidence is required from all parties to be able to draw any sound conclusions

and to fully understand if their contracts, and crucially for us their pay, are fit for purpose. We were pleased to hear that the BMA plans to undertake a substantive project on SAS doctors for next year's round, which we look forward to with great interest.

CHAPTER 7: GENERAL MEDICAL PRACTITIONERS

Introduction

7.1 This chapter considers issues relating to General Medical Practitioners (GMPs). In it, we consider plans to improve patient care in the primary sector and reduce pressure on secondary care, a move towards preventative measures, the evolution of general practice provision, recruitment and retention issues, and concerns over workload. It also gives our view on the GMP trainers' grant, the rate for GMP appraisers and the GMP specialty registrar supplement.

7.2 The core traditional role for GMPs is as the family doctor, working in the primary care sector of the NHS. There are several contracting arrangements in existence, under which primary care services are provided, and GMPs can work on an independent contractor, salaried, or locum basis. We consider contracting arrangements later in this chapter. In recent years there has been a move away from GMPs buying in to the partnership model and more towards becoming salaried or sessional GMPs (who could be employed by local primary care organisations or by independent contractor practices). In its remit letter to us, the Department of Health (England) asked us to examine the evidence regarding salaried GMPs and make observations about the factors relating to their recruitment, retention and motivation.

7.3 We also note the serious situation facing primary care in the UK. GMPs are very concerned by increasing demand and workload pressures, with many feeling the situation is unsustainable. Their strength of feeling is demonstrated by the position in Northern Ireland, where, in January 2017 the Northern Ireland General Practitioners Committee voted to proceed to gather undated resignation letters from the general practices across Northern Ireland. We are also aware of similar concerns over workload pressures expressed by hospital doctors.

Access to GMP services, *Five Year Forward View* and new care models

7.4 In October 2014, the Five Year Forward View set out how the NHS in England should change how healthcare was delivered in order to promote wellbeing and prevent ill-health. Flowing from this, in 2015, 50 'Vanguards' were selected to lead the development of new care models in England to act as the blueprints for the NHS and an inspiration to the rest of the health and social care system. During 2015-16, the programme focused on the selection, development and growth of new care models with increasing emphasis on spreading them across the country. From 2016-17, the programme moved to the next phase of systematic delivery to ensure quantifiable impact, to support wider spread and to mainstream new care models from 2017-18. The impacts of the interventions, integrated workforce models and care model changes are being evaluated nationally in the areas of: health and wellbeing; care and quality (including patient experience and staff engagement); and efficiency. Vanguards are also setting up local evaluations which look at the impact of their programmes on key local indicators and the factors driving any changes.

7.5 In April 2016, NHS England published the 'General Practice Forward View'. This describes a package of support for general practice, which aims to help improve patient care and access and invest in new ways of providing primary care. It contained measures on workload and workforce, and also reflected the changing nature of general practice. In recent years, some practices have chosen to work 'at scale' by forming networks and federations. The Department of Health told us that these were ways to both spread innovation and deliver a wider range of services to patients. The Department also told us that GP Access Fund sites were testing improved and innovative access to GP services.

There are 57 schemes covering over 2,500 practices, and over 18 million patients. The Department also said that NHS England would provide over £500 million by 2020-21 to enable Clinical Commissioning Groups to commission and fund extra capacity across England. The aim of that funding was to ensure by 2020 that all patients had access to sufficient routine appointments at evenings and weekends to meet local demand, alongside effective access to 24/7 urgent care services, with general practice being placed on a sustainable footing for the future. NHS England reported that work continued in delivering the General Practice Forward View, with the aim being to 'try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice' and support initiatives to build capacity and capability in the wider non-medical workforce. As part of this, a pilot to test the role of clinical pharmacists in general practice was introduced, with 491 clinical pharmacists supporting 648 practices in 89 pilots across England.

7.6 New care models could provide more flexible careers for GMPs. The Department of Health (England) considered it likely that recent trends would continue, with an increase in the number of larger partnerships, although the general practice landscape was complex. The move towards larger practices or federations could impact on future service delivery and perhaps increase the use of the salaried model. However, it remained an important and challenging goal to increase the number of GMPs.

7.7 In May 2016, the King's Fund published research on the pressures in general practice.[1] This found that increasing demands on general practice over the past five years – not just a heavier workload but an increasing complexity and intensity of work – had led to a feeling of crisis. It added that the NHS in England was finding it difficult to recruit and retain sufficient GMPs who wanted to do full-time, patient-facing work.

7.8 The National Audit Office (NAO) published a report in January 2017[2] setting out its findings on improving access to general practice in England. It found that the Department of Health and NHS England had a high-level vision for improving access to general practice and had increased funding, but had not evaluated the cost-effectiveness of the proposals, nor provided consistent value for money from existing services.

Our comments

7.9 The general practice landscape is undoubtedly complex and shifting, with potential impacts on how services are delivered. We mentioned in Chapter 4 the demographic changes and increasing numbers of salaried GPs. The establishment of larger practices, federations or other organisational models (such as multi-disciplinary partnerships) may further increase the use of the salaried staff model. The vision set out for healthcare delivery in England under the Five Year Forward View, with the increased emphasis on primary care would appear sensible. However, it would be fair to observe that achieving this vision will be extremely challenging in the current circumstances of increasing demand for services. The King's Fund report commented that while some activities that were previously undertaken in secondary care had moved to primary care, the funding had not followed the patient which also increased pressures on general practice. While some aspects are very similar for Wales and Northern Ireland, such as recruitment difficulties in rural areas, these countries face their own distinct challenges. The situation appears particularly worrying in Northern Ireland.

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[1] The King's Fund, Understanding Pressures in General Practice, May 2016 https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[2] National Audit Office, Improving patient access to general practice, January 2017 https://www.nao.org.uk/report/improving-patient-access-to-general-practice/

Motivation

England

7.10 The BMA commissioned a survey of GMPs in England, which considered four main areas: workload; workforce; practice finance; and working at scale. Supporting the picture set out above, the survey found that a majority of GMPs in England believed that their workload impacted negatively on the safety and quality of care that their patients received. The most commonly considered action to manage practice workload was of withdrawing wider non-contractual services that were provided voluntarily. The use of locums in GP practices is covered in Chapter 4.

7.11 The Eighth National GP Work Life Survey, the latest available, found that on a seven-point scale, overall job satisfaction was at 4.1 in 2015, down from 4.5 in 2012. Average hours worked had reduced from 41.7 hours per week to 41.4.

Wales

7.12 Workload and sustainability were key themes for GMPs in Wales. To help address workload issues, the Welsh Government had developed a primary care plan. This included allocating £42.6 million to health boards with the aim of increasing the use of multi-disciplinary teams within a primary care 'cluster' model. There were also intentions to reduce bureaucracy and to consider contract changes.

Northern Ireland

7.13 In Northern Ireland the Minister's aim was to move toward a more integrated, mixed delivery model which moved patients from secondary to primary care where appropriate, which could help to cope with the changing demographics of the population and ease workload pressures for GMPs through use of a multi-disciplinary team. Officials told us that a team had been established to explore ways of improving the morale and motivation of GMPs.

7.14 The BMA told us that ahead of the publication of the 'Delivering Together' report, 97 per cent of GMPs voted to move to collect undated resignation letters in protest at the lack of a coherent primary care strategy. The organisation noted workforce planning for GMPs in Northern Ireland had been poor, but was showing signs of improvement. The Delivering Together report set out how health and social care services would be reshaped to produce better health and wellbeing outcomes in response to the report from the expert panel led by Professor Bengoa. However, the implementation of the plans set out in the report was made uncertain by wider political issues in Northern Ireland from January 2017.

Other evidence

7.15 The King's Fund report on understanding pressures in general practice surveyed GMP trainees and found that only 11 per cent intended to be in full-time work five years after qualification. Additionally, 48 per cent of respondents reported an intention to be a salaried GMP one year after qualifying, 44 per cent intended to be a locum and just 3 per cent intended to be a partner. The NAO also reported that female and salaried doctors were increasing as a proportion of the GMP workforce.

Our comments

7.16 Information on the motivation of GMPs is relatively sparse. Therefore, we were pleased to receive the report on the survey of GMPs in England commissioned by the BMA. The report emphasised the workload pressures that GMPs in England were facing, as

highlighted in the NAO's earlier report on understanding pressures in general practice. With recruitment and retention of GMPs already an issue, health departments should be closely monitoring the impacts on motivation of the recent and forthcoming changes to primary care to ensure such issues do not exacerbate the situation. GMPs in Northern Ireland were extremely discontented, and while they had been temporarily reassured that a new primary care strategy was going to be implemented, this assurance is potentially on hold with the stalling of the political process at the time of writing. It could be potentially very serious for healthcare delivery if the resignations were submitted, and we urge the Northern Ireland Executive to take steps to ensure primary care delivery is not irrevocably damaged.

GMP trainers' grant and GMP appraisers

7.17 The BMA asked that we continue to make recommendations on the GMP trainers' grant, which it believed should increase at least in line with the overall contract recommendation. It added that a greater increase might attract new trainers, which could then enable growth in trainee numbers and foundation year placements.

Our comments

7.18 We did not hear of any further developments on the tariff-based approach to GMP trainers' pay. Our 2007 report noted the start of work on this, following an independent review of GMP trainers' pay in 2006. Given the lack of progress, we agree with the BMA that the GMP trainers' grant should be uplifted in line with our main pay recommendation for GMPs.

7.19 We received no new evidence regarding GMP appraisers again this year. Therefore, we are content for the £500 rate for GMP appraisers to stand, although we will keep the rate under review and would welcome evidence on the situation in future rounds.

Independent contractor general medical practitioners

Contracts

7.20 Most doctors working under contracts to provide primary care services are independent contractors – who are self-employed individuals or partnerships running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses or managers; some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. We have previously noted that around 95 per cent of independent contractor GMPs' earnings come from contracts for the provision of primary medical care services to NHS patients. Contractors can influence the level of taxable income that their practices generate for them by seeking to reduce costs, or looking for opportunities to increase contractual income. For example, GMPs can choose to participate in, and earn extra income by delivering enhanced services such as the Learning Disabilities Enhanced Service.

7.21 The main forms of contract are: General Medical Services (GMS), Personal Medical Services (PMS) in England, Section 17C arrangements in Scotland, Alternative Providers of Medical Services (APMS), or Primary Care Trust Medical Services (PCTMS). At the time of writing, NHS Employers was negotiating on behalf of NHS England with the General Practitioners' Committee (GPC) of the BMA over potential improvements to the GMS contract in England for 2017-18. According to NHS Digital, as at 31 March 2016, there were 7,613 GMP practices in England. Of these, around 64 per cent (accounting for 63 per cent of GMPs) operated under the national GMS contract. Contractors with PMS arrangements operate within locally agreed contracts, and any uplifts in investment for

PMS contracts are a matter for NHS England to consider. In addition, there are a small number of GMPs (437) who work under, or hold, contracts under a locally contracted APMS arrangement across some 259 practices.

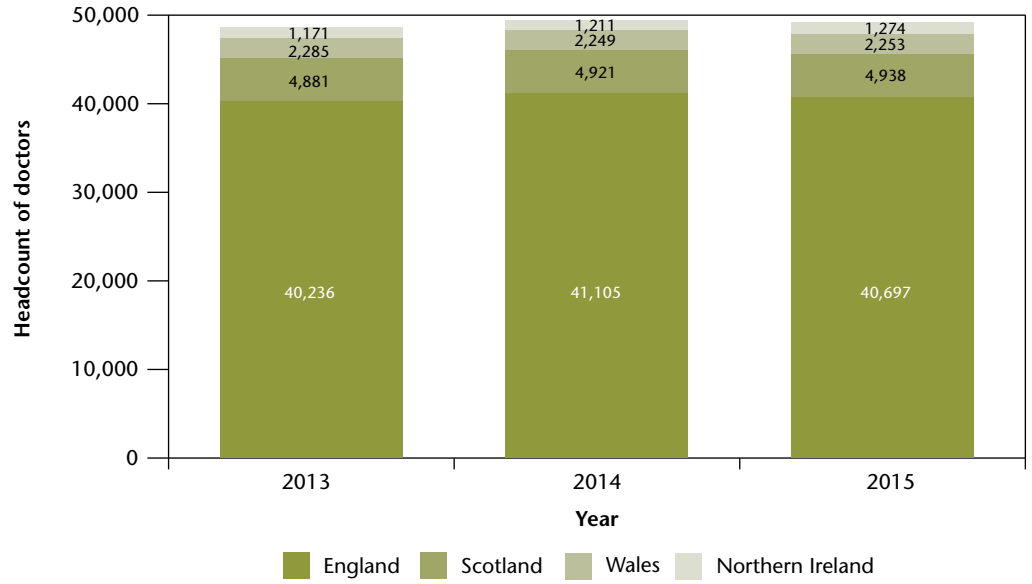
Wales

7.22 The Welsh Government told us that one of the most pressing issues in Wales was of 'last man standing'. This was where a GMP partner felt inclined to leave to avoid taking on all of a practice's liabilities. We were told during oral evidence that there had been a trend towards GMPs 'handing back the keys' in rural areas, which, coupled with recruitment difficulties could lead to difficulties in primary care delivery in the near future.

Recruitment and retention

7.23 There were 49,162 (headcount) GMPs in the UK in September[3] 2015; a decrease of 0.7 per cent compared with the same period in 2014 (Figure 7.1). Within these, in the UK, the number of GMP specialty registrars (Figure 7.2) decreased by 0.8 per cent.

Figure 7.1: Number of general medical practitioners, United Kingdom, 2013 to 2015

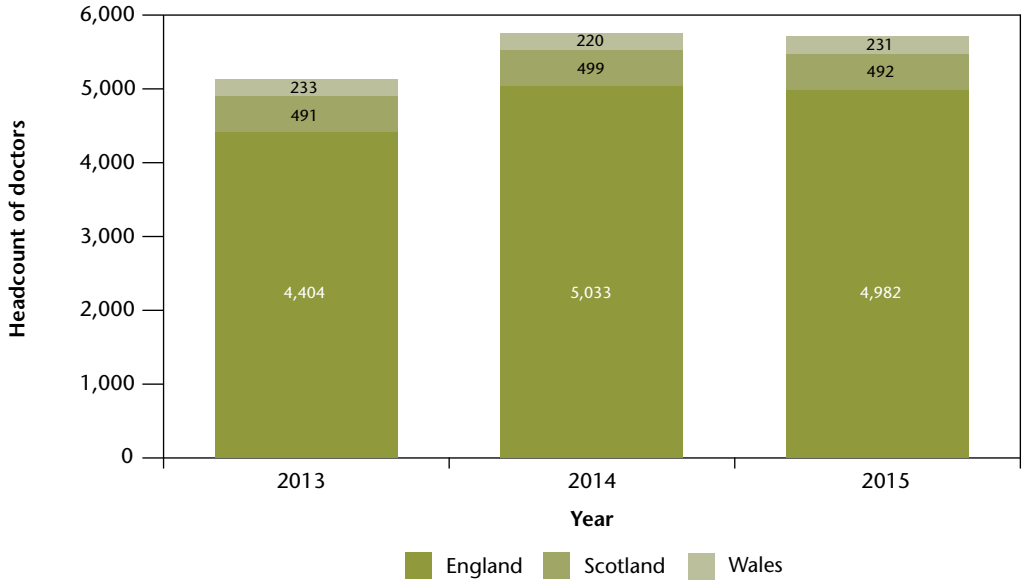


Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health (Northern Ireland).

Note: In England, prior to 2015 figures are sourced from NHAIS GP Payments (Exeter) System. From 2015 figures are sourced from the workforce Minimum Dataset (wMDS) and include estimates for missing data.

[3] As of September 2015 in England, Scotland, Wales but as of October 2015 in Northern Ireland.

Figure 7.2: Number of general practice specialty registrars, Great Britain,[1] 2013 to 2015



Sources: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland.

[1]Data for Northern Ireland were not available.

Note: In England, prior to 2015 figures are sourced from NHAIS GP Payments (Exeter) System. From 2015 figures are sourced from the workforce Minimum Dataset (wMDS) and include estimates for missing data.

United Kingdom

7.24 We have noted the *F2 Career Destination Report 2016* by The UK Foundation Programme Office. The report noted a wide variation in the percentage of survey respondents from different UK foundation schools that went on to GMP training: from 8.1 per cent in Severn in the South West; to 47.0 per cent in Leicestershire, Northamptonshire and Rutland.[4]

England

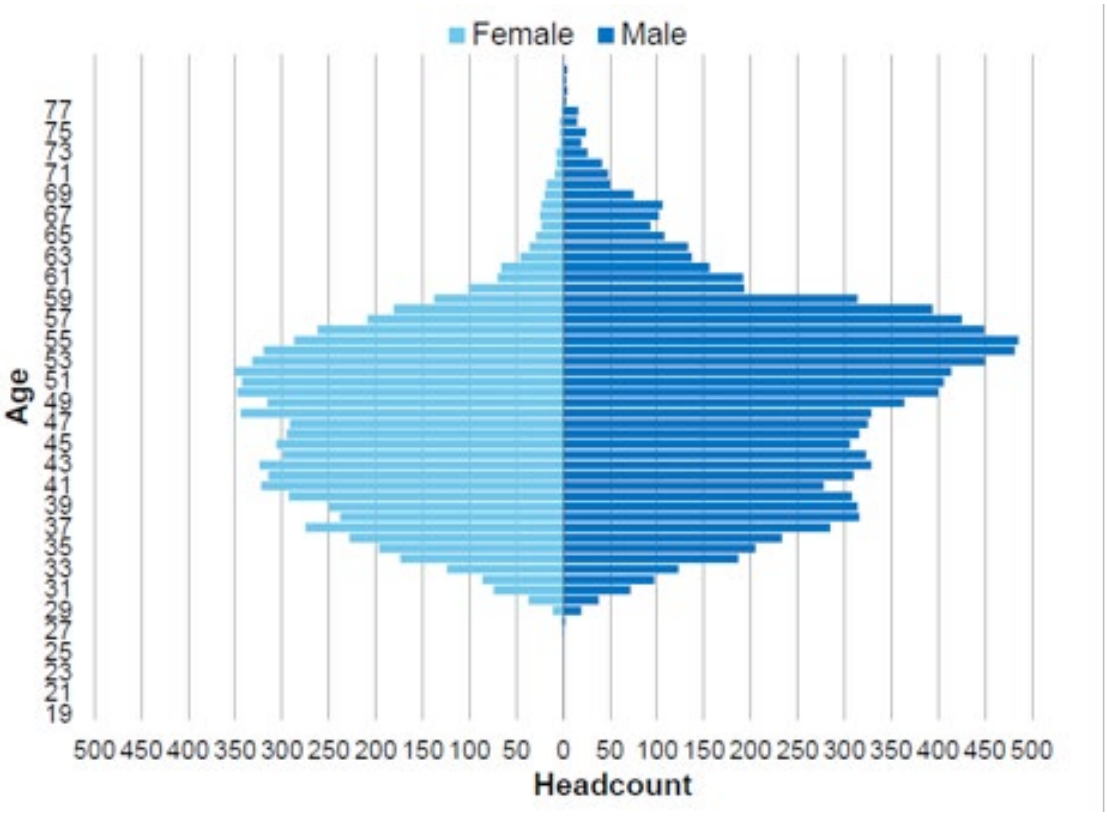
7.25 The government committed in 2015 to increase the overall number of doctors in general practice by 5,000 with a further 5,000 other practice staff by 2020-21. To help deliver this commitment, Health Education England (HEE) increased the number of GMP training places to 3,250 for 2016-17. NHS England also introduced specific schemes to make extra funding available for GMPs who choose to work in practices that have been identified as hard to recruit. The existing retained doctor scheme has been revised with increases in funding. There have been a number of improvements to the induction and refresher scheme to help doctors in England return to general practice, with further improvements planned in order to support the goal of attracting back an extra 500 doctors over the next five years.

7.26 HEE had used measures such as local radio campaigns and changes to the application process to try to encourage people into GMP training. Over 3,000 people began GMP training in the last year, the highest number to date, although below the target of 3,250.

[4] A 'foundation school' is a group of institutions bringing together medical schools, the local deanery, trusts and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments and are administered by a central local staff which is supported by the deanery. For more information see: http://www.foundationprogramme.nhs.uk/news/story/annual-report-2016

7.27 As at September 2015, women accounted for over half (54.3 per cent) of the total headcount GMP workforce in England, but only about 49 per cent of the FTE workforce. However, there are different demographics for contractor, salaried and registrar GMPs. Figure 7.3 shows that in England there were more male contractor GMPs than female, and this is particularly apparent in the older age groups. Figure 7.4 shows that GMP registrars are predominantly female, illustrating how the gender mix of the workforce has changed as GP registrars are the GMPs of the future. The salaried GMP workforce is also predominantly female and is discussed later in this chapter.

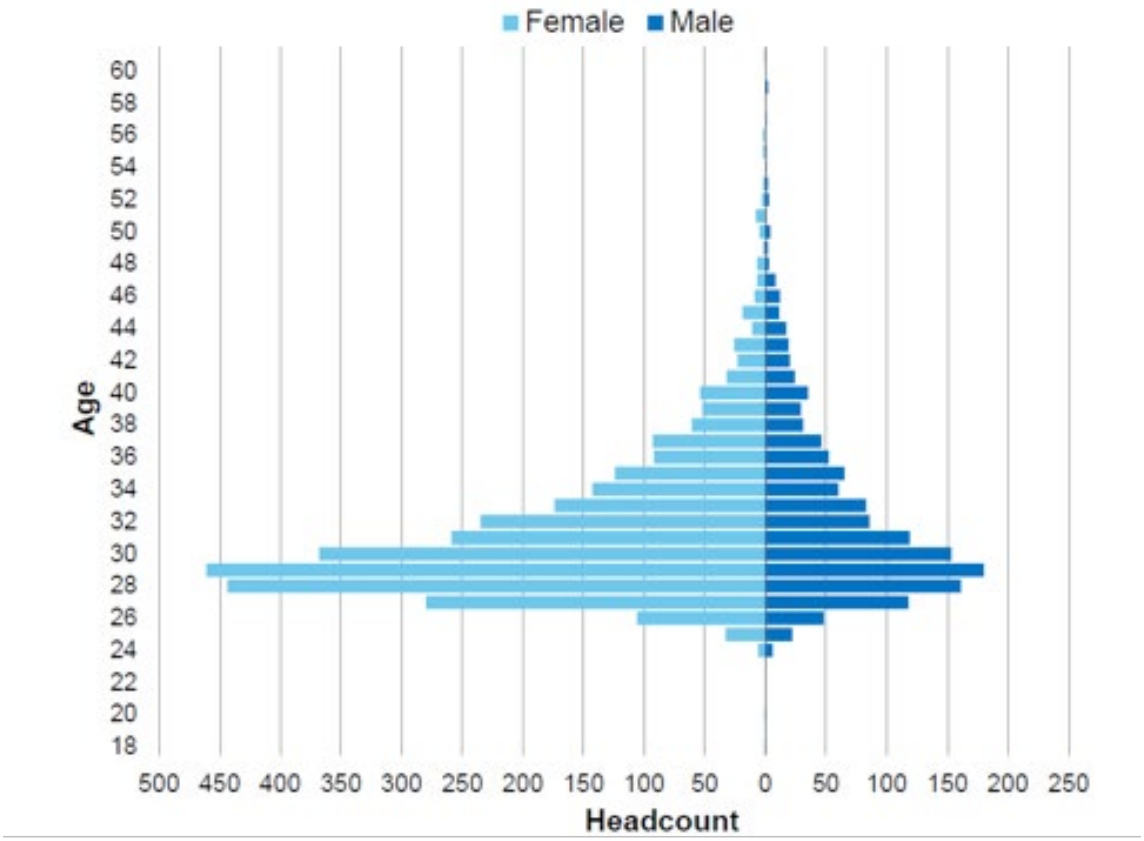
Figure 7.3: Contractor GMPs by gender and age at 31 March 2016 (headcount), England



Source: NHS Digital.

Note: Data exclude records where gender is not stated, unknown and for practices not providing a return.

Figure 7.4: GMP registrars by gender and age at 31 March 2016 (headcount), England



Source: NHS Digital.

Note: Data exclude records where gender is not stated, unknown and for practices not providing a return.

7.28 New NHS Digital statistics based on the workforce minimum data set, between April 2015 and March 2016, showed that 832 GMP contract holders joined the NHS, compared to 1,342 who left, 510 more leavers than joiners. Over the same period there were 117 GMP provider vacancies, of which 85 were ongoing and about 40 per cent were uncovered, although these figures should be treated with caution.

7.29 For GMP registrars, between April 2015 and March 2016, there were slightly more joiners than leavers, with 1,868 joiners compared to 1,773 leavers, giving a balance of 95 more joiners than leavers. Only 1 unfilled GMP registrar vacancy was recorded during this time period.

7.30 The survey of GMPs in England commissioned by the BMA in 2016 gave a mixed picture on recruitment. While 31 per cent of GMP partners had been unable to fill vacancies in the 12 months prior to the survey (excluding locum cover), 23 per cent said that they were able to fill vacancies within a reasonable time. Most (79 per cent) thought that there should be some financial incentives to encourage GMPs to work as partners or salaried GMPs within practices rather than work as locums.

Wales

7.31 The Welsh Government said that at September 2015, there were 1,997 GMPs in Wales, nine fewer than the previous year, but 148 more than in 2005. Female practitioners accounted for 50.4 per cent of the workforce (headcount); and the number of practitioners aged 55 and over had remained steady over the last five years, with around 23 per cent falling into this age band in 2015. A primary care workforce plan backed by £4.5m of new funding included actions to expand the GMP retainer scheme,

reimbursement of medical school fees when a newly-qualified doctor committed to a career in general practice, and a national recruitment campaign to promote the benefits of a career in Wales. These workforce initiatives for primary care have been supported by an additional £40m made available to health boards in 2015-16. The Welsh Government stated that much of this funding had been used to recruit additional members of the wider primary care team with 400 posts having been recruited to since the funding was made available.

Northern Ireland

7.32 GMP training places had been increased to 85 (from 65) from August 2016 and would be increased again to 111 by 2018-19. Changes outlined in the Northern Ireland Executive's response to the Bengoa report would lead to a mixed delivery model, which was intended to address the changing demographics of the population. There had been a trend towards the amalgamation of practices as GMPs in single-handed practices retired.

Our comments

7.33 As noted in Chapter 5, Table 5.3, fill rates for GMP training in England are among the lowest, with large variations by region, and difficulty filling posts outside London. Northern Ireland has consistently filled its posts and we are encouraged by the increase to 85 posts this year. In Wales, there have been consistent problems in filling General Practice training posts. However, as noted above the situation has improved this year.

7.34 The situation regarding general practice in Northern Ireland appears to us to be particularly precarious. The Department of Health (Northern Ireland) should work towards a primary care strategy that will address the issues of patients and the concerns of GMPs. We look forward to being told about the transformational actions outlined in the 'Health and Wellbeing 2026: Delivering Together' publication.

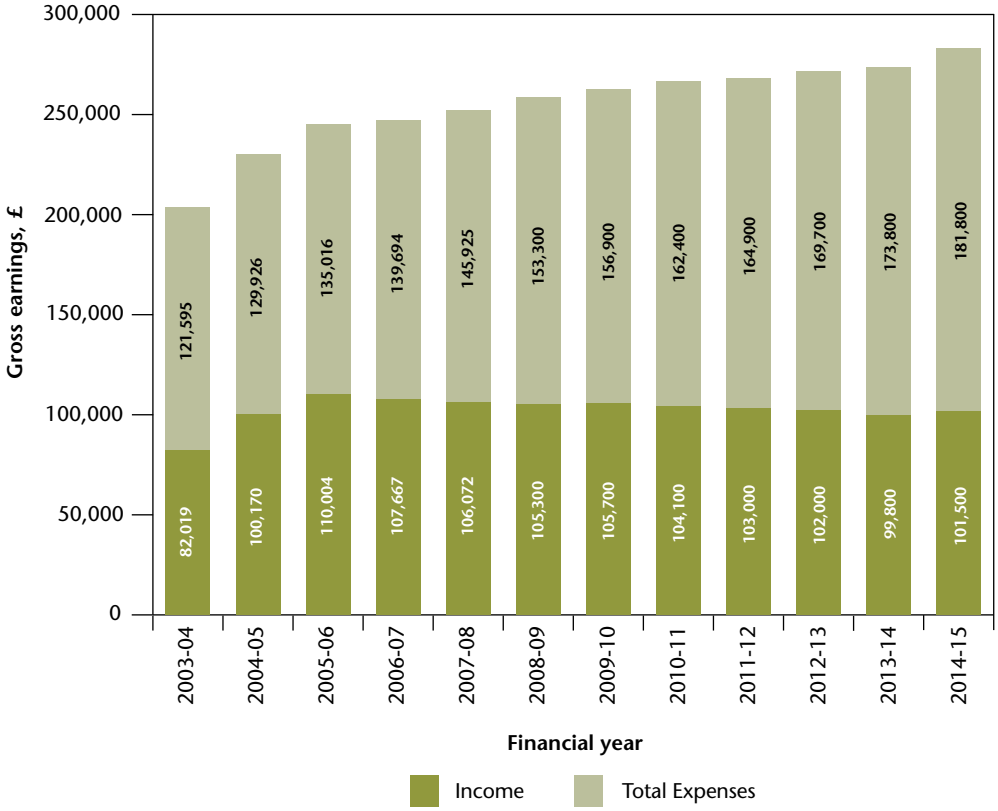
7.35 The proportion of the GMP workforce which is female is increasing and the GMP registrar data suggest this trend will continue. However, on average, female GMPs are likely to work fewer hours than male GMPs (partly due to different preference in becoming salaried rather than contractor GMPs). If this likely reduction in the amount of hours per head is not planned for, this could exacerbate the shortfall in supply of GP services. This point was also highlighted in the NAO report on improving patient access to general practice which commented that female and salaried doctors (who were less likely to work full time) were increasing as a proportion of the workforce. Data on part-time working in new GMPs suggested there may be 1,900 fewer full-time equivalent GMPs in England by 2020 than HEE had estimated there would be. This could cause serious issues for both workforce planning and the delivery of primary care.

7.36 A large number of GMPs are over 50 and may be considering retirement in the next five to ten years. Comparing this with the number of GMP registrars and the increasing numbers choosing salaried GMP work, it is unclear to us how the work will be covered – there will be fewer GMPs in total, and fewer who want to become partners.

Earnings and expenses of independent contractor GMPs

7.37 In 2014-15, average gross earnings of independent contractor GMPs were £283,300 and average expenses were £181,800 giving an expenses to earnings ratio (EER) of 64.2 per cent. Average taxable income for contractor GMPs was £101,500, an increase of 1.7 per cent, the first increase since 2009-10, as shown in Figure 7.5 and Table 7.1.

Figure 7.5: Mean GMP contractors' gross earnings, income and expenses, United Kingdom, 2003-04 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Note: Gross earnings relate to NHS and private work. Not adjusted for inflation.

Table 7.1: Mean GMP contractors' gross earnings, income and expenses, United Kingdom, 2003-04 to 2014-15

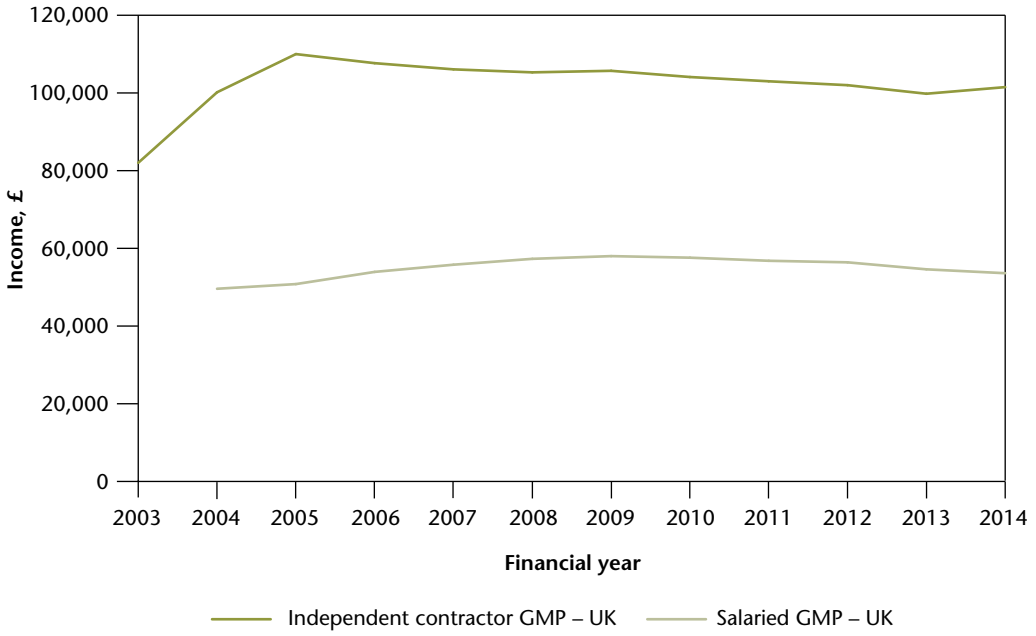
			Income			Expenses
Financial year	Gross earnings	Total expenses	£	Annual change %	Change from 2003-04 %	to earnings ratio (EER) %
2003-04	£203,613	£121,595	£82,019	–	–	59.7
2004-05	£230,097	£129,926	£100,170	22.1	22.1	56.5
2005-06	£245,020	£135,016	£110,004	9.8	34.1	55.1
2006-07	£247,362	£139,694	£107,667	-2.1	31.3	56.5
2007-08	£251,997	£145,925	£106,072	-1.5	29.3	57.9
2008-09	£258,600	£153,300	£105,300	-0.7	28.4	59.3
2009-10	£262,700	£156,900	£105,700	0.4	28.9	59.7
2010-11	£266,500	£162,400	£104,100	-1.5	26.9	60.9
2011-12	£267,900	£164,900	£103,000	-1.1	25.6	61.6
2012-13	£271,800	£169,700	£102,000	-1.0	24.4	62.4
2013-14	£273,600	£173,800	£99,800	-2.2	21.7	63.5
2014-15	£283,300	£181,800	£101,500	1.7	23.8	64.2

Source: NHS Digital using Her Majesty's Revenue and Customs data.

Note: Not adjusted for inflation.

7.38 Figure 7.6 shows that since 2005-06 the average earnings of contractor GMPs has been around £100,000–£110,000 whilst that of salaried GMPs has been around £50,000–£60,000.

Figure 7.6: Income for General/Personal Medical Services (GPMS) GMPs by type of GMP, United Kingdom, 2003-04 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

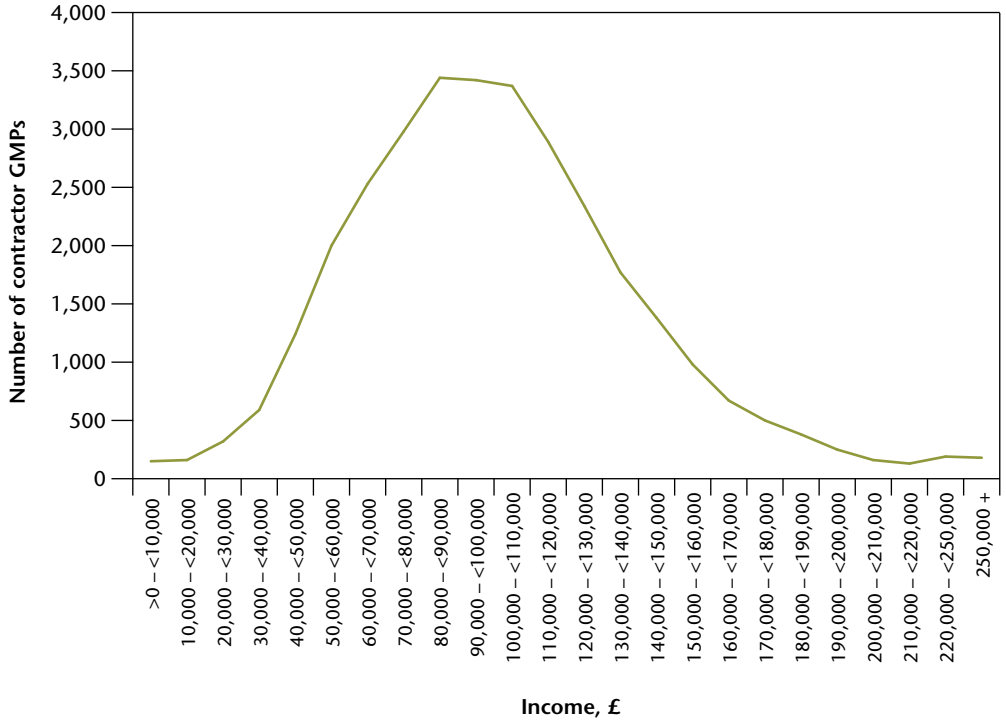
Notes: Average income is based on headcount data, not FTE.

Prior to 2006-07, the figures for salaried GMPs have been produced under different methodologies in each year.

Not adjusted for inflation.

7.39 There is a large variability in the income of contractor GMPs: Figure 7.7 shows the distribution of GMP income in the United Kingdom. About half of contractor GMPs earn between £70,000 and £120,000, with roughly a quarter earning more and roughly a quarter earning less than these amounts.

Figure 7.7: Distribution of GMP contractors' income before tax, United Kingdom, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

7.40 Further details of independent contractor GMP earnings and expenses by UK country and English region can be found in Appendix E.

Expenses and the formula

7.41 Our recent reports have rehearsed our ongoing concerns with the formula-based approach to the uplifts for independent contractor GMPs and GDPs we used until 2015.

Our concerns include:

- our intended increases in net income not being delivered by the formula;
- the limited quality of the evidence on income and expenses available to populate the formula;
- the 'cherry picking' of the coefficients used in the formula by the health departments; and
- our recommendations having only an indirect link to the actual earnings of independent contractors, given the current model where pay is an embedded element of a wider contract for services.

7.42 As a result, we took the decision in 2016 to abandon the use of the formula, and instead to make recommendations on our intended increase in *pay net of expenses*. It was therefore incumbent on the parties to discuss expenses in order for them to ascertain what gross increase was necessary in order to deliver our recommended increase in pay (assuming that the Health Departments accepted our recommendation). We did not rule out returning to a formula-based approach to the uplifts, should the data picture improve.

7.43 The BMA considered that the success of GMP expenses negotiations depended on how informed and reasonable the parties were. It believed that it would be helpful for us to recommend a methodology for calculating the uplift, to avoid politicisation of the issue.

7.44 The annual negotiations on the GMS contract are carried out separately in each country. At the time of writing, the outcome of those negotiations for 2017-18 in England had just been announced. The agreement between NHS England and the BMA was for £238.7 million to be invested in the contract to cover a general expenses uplift of 1.4 per cent and a pay uplift of 1 per cent. The agreement also included: funding to cover Care Quality Commission costs, indemnity fee increases, and Business Improvement District levies; changes in the value of a Quality and Outcomes Framework point; an increase in the payment for Learning Disabilities Health Check Scheme; changes to the GP Retention Scheme; support for costs related to covering absence; and other funding to support covering expenses on other administration arrangements. In Wales, a period of stability was agreed until March 2017, and at the time of writing, no agreement had been announced for 2017-18. At the time of writing, there had also been no announcement on an agreement for Northern Ireland for 2017-18.

Our comments

7.45 All parties agree that expenses for GMPs should be settled by negotiation. For this pay round, we therefore again make a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formula-based approach.

Salaried GMPs

Introduction

7.46 In our remit letter from the Secretary of State for Health, we were asked to make observations, based on any evidence the parties could provide, about the factors affecting recruitment, retention and motivation of salaried GMPs in England. This followed on from our last report where we noted that there had been an expansion of the salaried model in general practice and that it would be important to gain a better understanding of this trend. The remit letter from the Welsh Government asked us to make observations about recruitment and retention issues in general practice more broadly, and we hope that this chapter serves to meet this.

Evidence from the parties

7.47 The BMA told us that there was a lack of data available around sessional GMPs (salaried and locum) on which to base any firm recommendations, for example around pay ranges, and how GMPs choose to take a partnership, salaried or locum post. It asked us to consider who is able to provide what data, with a view to a more in-depth analysis in our next pay round. It told us that it was clear that the proportion of salaried GMPs was increasing with the majority of GMPs now entering the workforce on a salaried or locum basis, and that the gender split was more weighted towards female doctors than for contractor GMPs. However, there was no systematic understanding of career choice for GMPs, and crucially of how GMP trainees will view the options open to them in terms of new models of provision and salaried versus locum versus contractor status. The BMA considered that the national model contract for salaried GMPs was operating well, and protected salaried GMPs as well as providing consistency for when they chose to change jobs. It did not believe that the pay range for salaried GMPs included in our report reflected the actual pay rates needed to recruit and retain salaried GMPs. GMP contractors could recruit practice staff at any rate, and the BMA did not accept that GMP contractors should be forced to recruit against a national pay scale, given their

independent contractor status. We note that the BMA is in the potentially complex position of having some of those it represents (salaried GMPs) employed by others (partners in a practice) whom it also represents.

7.48 The survey of GMPs in England commissioned by the BMA asked salaried GMPs why they chose that role. The results are shown in Table 7.2 below.

Table 7.2: Reasons for working as a salaried GMP, England, 2016

Working in one setting/providing continuity of care	54%
Because partnership is too onerous/lacking rewards	52%
To limit my workload	43%
To suit my work pattern	42%
It provides me with job security	41%
A positive career choice	30%
Because I cannot get a job as a partner	3%
Other	13%

Source: ICMUnlimited for BMA.

Note: Subjects were asked: Which of the following best describe why you work as a salaried GP? More than one option could be chosen.

7.49 The Department of Health (England) did not have any specific concerns over the recruitment and retention of salaried GMPs. It did wish to understand better the reasons behind the expansion of the salaried model in general practice however, and told us that there were recruitment and retention problems in some areas of England, although these would not necessarily be influenced or resolved through a national uplift. During oral evidence, the Department acknowledged that there was a lack of information on this, although it was improving. Salaried GMPs had increased from around 10 per cent to around 25 per cent of all GMPs over the last ten years. It was thought that this mainly reflected lifestyle choices, for example the certainty of a regular salary, rather than the potential risk and responsibility of becoming a partner in a business. People were now tending to choose a more flexible career rather than a job for life. As greater consolidation of practices and the increase in federations continues there may be greater scope to tackle recruitment difficulties and improve accessibility.

7.50 In its evidence to us, NHS Employers told us that the GMS contract required the model contract for salaried GMPs to be offered in practices. The model terms were agreed in 2004, and as there was no negotiating machinery for salaried GMPs, they had not been updated since. The model contract was originally designed mainly for use where GMPs were directly employed by Primary Care Trusts, which have since ceased to exist. Salaried GMPs are now employed by a range of different NHS organisations providing a range of services. As a result there has often been some confusion about which terms and conditions should apply to a GMP employed by an NHS trust and whether the work they undertake meets the definition of primary care. Employers were often unsure about the status of the salaried GMP pay range and the extent of their discretion in applying the recommended pay range.

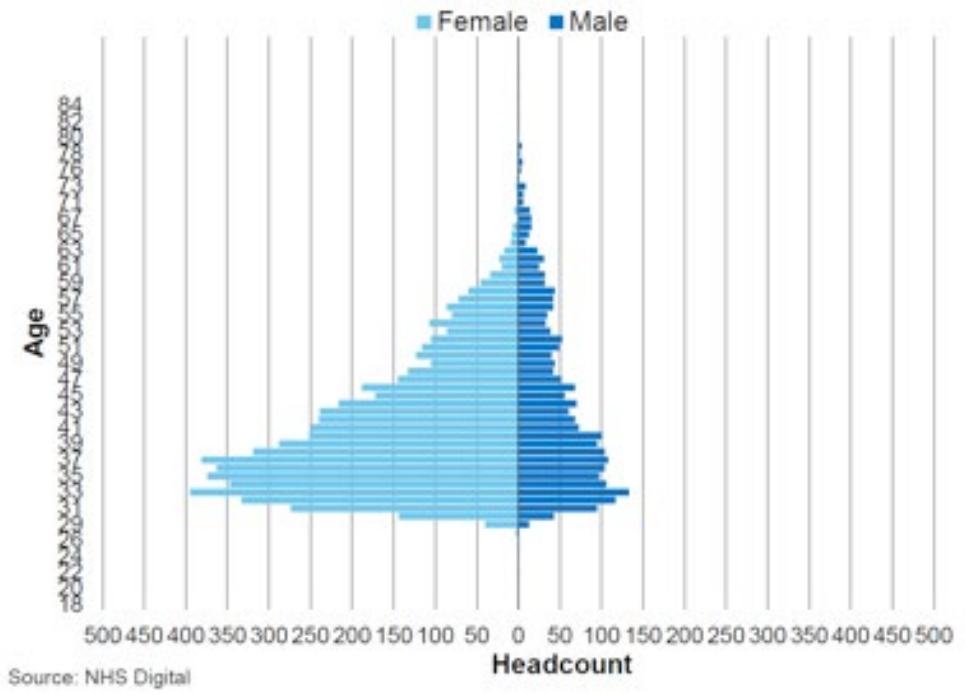
Recruitment and retention

England

7.51 In September 2016, NHS Digital published statistics of the demographic profiles of GMPs. The statistics provided a useful insight into the salaried GMP workforce. When compared with the population pyramid for contractor GMPs earlier in the chapter, Figure 7.8 shows

that salaried GMPs were predominantly younger and more likely to be female. As of March 2016, about three quarters of salaried GMPs were female, compared with about 40 per cent of contractor GMPs.

Figure 7.8: Salaried/other GMPs by gender and age at 31 March 2016 (headcount), England



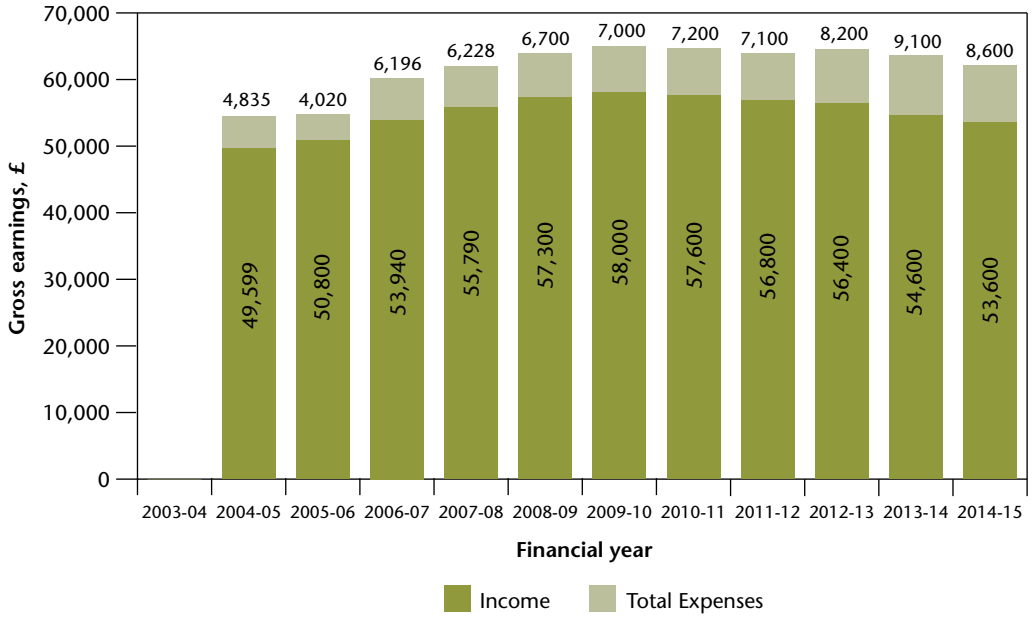
Note: Data exclude records where gender is not stated, unknown and for practices not providing a return.

7.52 Between April 2015 and March 2016, 2,888 salaried GMPs joined the NHS, compared to 2,148 who left, meaning that the headcount increased by 740. Over the same period there were 521 salaried GMP vacancies, of which 373 were ongoing and about 60 per cent were unfilled.

Earnings and expenses of independent contractor GMPs

7.53 In 2014-15, average gross earnings for salaried GMPs by headcount were £62,200 and average expenses were £8,600. Average taxable income for salaried GMPs was £53,600, a decrease of 1.7 per cent, see Figure 7.9 and Table 7.3 for further details.

Figure 7.9: Mean Salaried GMPs' gross earnings, income and expenses, United Kingdom, 2003-04 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Notes: Gross earnings relate to NHS and private work.

Not adjusted for inflation.

Table 7.3: Mean Salaried GMPs' gross earnings, income and expenses, United Kingdom, 2003-04 to 2014-15

Financial year	Gross earnings	Expenses	Income		Expenses to earnings ratio (EER)
			£	Annual change %	%
2003-04	–	–	–	–	–
2004-05	£54,434	£4,835	£49,599	–	8.9
2005-06	£54,820	£4,020	£50,800	2.4	7.3
2006-07	£60,137	£6,196	£53,940	6.2	10.3
2007-08	£62,017	£6,228	£55,790	3.4	10.0
2008-09	£64,000	£6,700	£57,300	2.7	10.5
2009-10	£65,000	£7,000	£58,000	1.2	10.8
2010-11	£64,700	£7,200	£57,600	-0.7	11.1
2011-12	£63,900	£7,100	£56,800	-1.4	11.1
2012-13	£64,600	£8,200	£56,400	-0.7	12.7
2013-14	£63,600	£9,100	£54,600	-3.2	14.3
2014-15	£62,200	£8,600	£53,600	-1.8	13.8

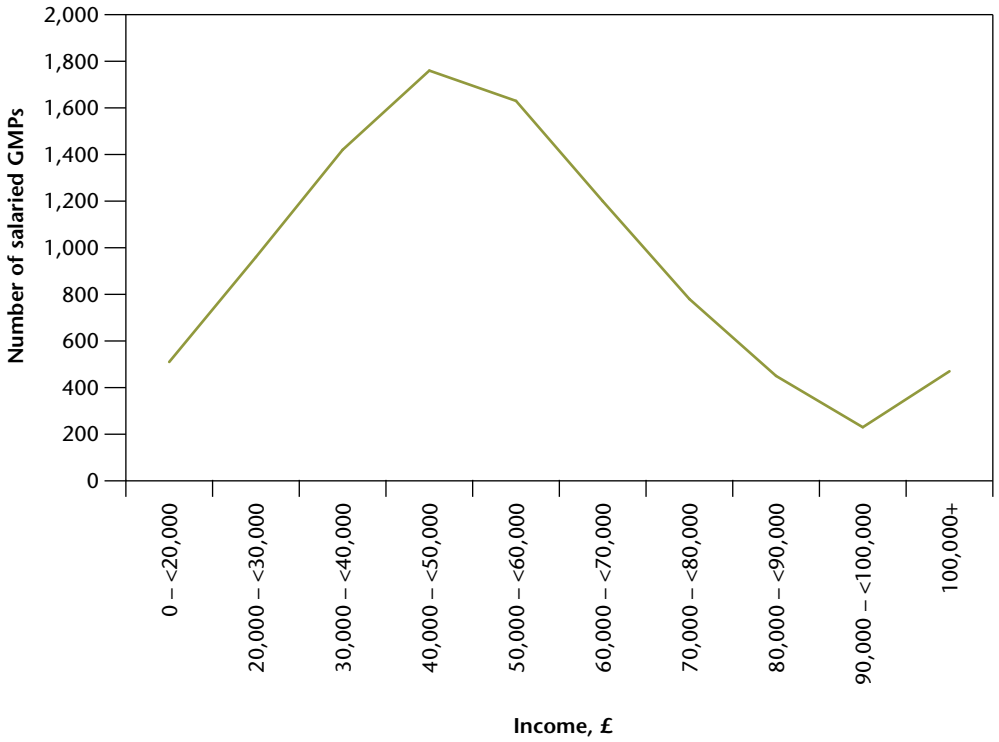
Source: NHS Digital using Her Majesty's Revenue and Customs data.

Note: Not adjusted for inflation.

7.54 There is considerable variability in the income of salaried GMPs. Figure 7.10 shows the distribution of GMP income in the United Kingdom with about half of salaried GMPs earning between £40,000 and £70,000 and 95 per cent earning less than £100,000

(about the average salary of a contractor GMP). As shown earlier in the chapter in Figure 7.10 the average earnings for salaried GMPs is about £50,000 less than independent contractor GMPs, however this does not take into account the number of hours worked.

Figure 7.10: Distribution of salaried GMP income, United Kingdom, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

7.55 Further details of salaried GMP earnings and expenses by UK country and English region can be found in Appendix E.

Our comments

7.56 We welcomed the particular opportunity to examine matters relating to salaried GMPs for this round. The Department for Health (England) considered that it would help us and it to gain a better understanding of the wider general practice picture. However, while we welcome the demographic data published by NHS Digital, it is clear that much more in-depth data are required for the situation to be fully understood.

7.57 While robust quantification of the composition of the salaried GMP workforce, in terms of FTE, geographic, demographic and ethnicity data as well as in terms of the range of salaries being paid is lacking, there is a clear trend for those becoming GMPs to choose salaried or locum positions instead of traditional partner roles. This was made clear in the BMA's survey we refer to above, and we were told on our visits that there has been a sharp drop-off in applications for GMP partnerships in recent years. This is set against the well-known recruitment and retention difficulties in general practice, which are discussed earlier in this chapter. This may have implications for the future provision of primary care at a time when it is undergoing significant change specifically for the future of the small-scale independent contractor model.

7.58 We refer back to Chapter 4 and our discussion of the Generation Y phenomenon. It seems that the focus on work-life balance, one of the key Generation Y characteristics, is a principal driver of choices to be a salaried (or locum) GMP rather than a GMP partner. At present this is not systematically evidenced and we have to rely heavily on what the parties tell us anecdotally and what we are told on our visits, although the BMA's survey (with some data presented in Table 7.2 earlier in this chapter) has been helpful.

7.59 There appears to be some confusion about the status of the existing model contract for salaried GMPs. It would be useful to understand to what extent new models of care and efforts to integrate health and social care, all of which have a primary care component, are encountering difficulties in contracting arrangements for salaried (or locum) GMPs. Again there may not be a major problem but, as above, given the significant changes and likely expansion of primary care, it is possible that the model contract may need to be revisited by departments, employers and NHS England. We would be happy to assist in this.

7.60 We only recommend on the bottom and top point of the pay range for salaried GMPs, not where individual salaried GMPs are placed within that range, or how they progress within the range, which is for local determination. We continue with that approach this year. However, on visits and anecdotally we heard that there is a very wide variation in the rates of pay available for salaried GMP roles, and this was reinforced in advertisements for salaried GMPs. We would welcome much better information on salaries from the parties for our next round, particularly given the increasing number of salaried GPs and potentially changing roles.

Observation 1: There are signs of a clear trend in the GMP workforce towards salaried employment and away from the contractor-partner model. It is not yet clear if this is a permanent trend. However, broader changes in the economy, particularly with the entry of the Generation Y cohort into the labour market imply that it might be. A systematic data collection exercise is needed to understand properly the profile of the GMP workforce in terms of FTE, geographic, demographic data, and career choices. Understanding FTE would shed further light on how far Generation Y desires for flexibility are translating into part-time working patterns, crucial for effective workforce planning.

Observation 2: There is a lack of data and insight into this trend by the parties. There is also a significant amount of change in the primary care landscape. This implies that there may be a lack of readiness for what may be a fundamental shift in the workforce, in terms of ensuring that the employment offer is as attractive as possible whilst maintaining value for money in primary care provision.

Observation 3: While there is not a great deal of evidence on this group, they are more likely younger and female than GMP partners. Despite generally lower earnings than partners, a salaried role in general practice appears to be an increasingly popular choice for new doctors, which could be due to the greater flexibility and work-life balance this role can offer over partnership. Overall, there is insufficient evidence for us to draw firm conclusions, but we will closely monitor this group, as there could be implications for the future planning and delivery of primary care.

CHAPTER 8: DENTISTS

Introduction

8.1 This chapter considers issues relating to general dental practice. It considers the recruitment and retention of General Dental Practitioners (GDPs), motivation concerns among dentists and contractual changes underway in England, Wales and Northern Ireland.

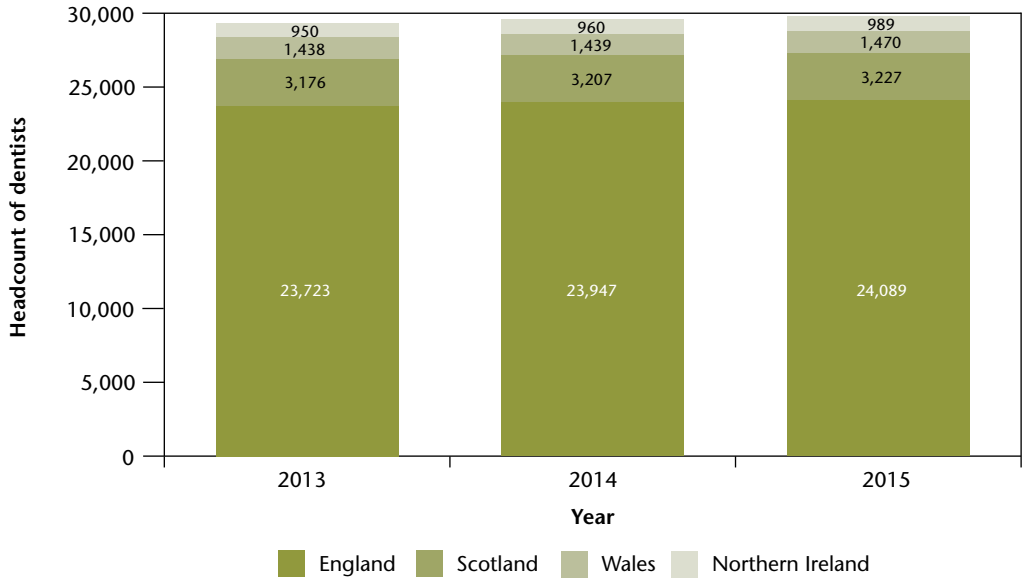
8.2 GDPs comprise 'performer-only' dentists and 'providing-performer' dentists. A 'providing-performer' dentist in England and Wales holds a contract with an NHS England Area Team or Local Health Board. The equivalent in Scotland and Northern Ireland is a 'principal dentist'. A 'performer-only' dentist delivers NHS dental services but does not hold a contract. They are employed by a provider-only or a providing-performer. The equivalent in Scotland and Northern Ireland is an 'associate dentist'.

8.3 Our remit covers all independent contractor GDPs in primary care that are contracted to provide NHS services. In England and Wales, GDPs are, in general, contracted to provide a given number of Units of Dental Activity (UDAs). In Scotland and Northern Ireland, GDPs are primarily remunerated via item-of-service fees, capitation and some continuing care payments, with some centrally funded allowances.

GENERAL DENTAL PRACTITIONERS

Workforce

Figure 8.1: Number of general dental practitioners, United Kingdom, 2013 – 2015



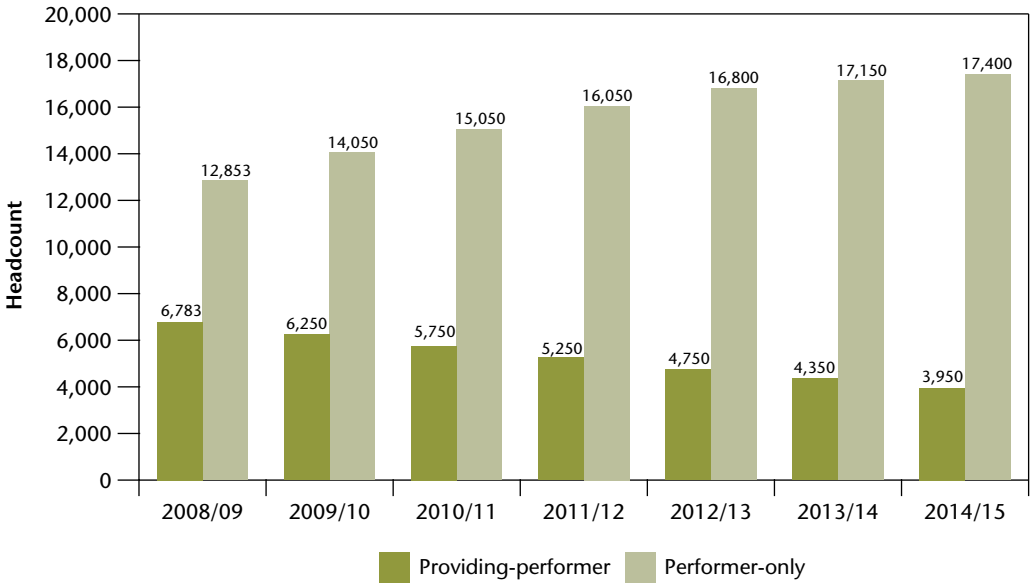
Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health (Northern Ireland).

8.4 In 2015 there were 29,775 dentists providing NHS services in the UK, which was an increase of 0.8 per cent over the previous year. The number of GDPs increased in all of the UK countries, with the largest absolute increase of 142 in England, rising to a total of 24,089. Scotland, Wales and Northern Ireland increased by 20, 31 and 29 respectively.

England and Wales

8.5 There has been a change in the employment patterns of self-employed dentists in recent years, with the number of providing-performer dentists reducing and the number of performer-only dentists increasing in England and Wales (Figure 8.2). There were similar trends in Scotland and Northern Ireland.

Figure 8.2: Number of self-employed dentists by dental type and year, England and Wales



Source: Dental Earnings & Expenses, NHS Digital.

Access to dental services

England

8.6 NHS England told us that, as of March 2016, 95 per cent of people seeking an NHS dental appointment in the last two years were successful (rising to 96 per cent in the 6 months to March 2016). 22 million adult patients (52 per cent of the population) were seen by an NHS dentist in the 24-month period ending June 2016. In the 12-month period ending June 2016, 6.7 million children accessed NHS dental services (58 per cent of the child population), while 86.4 million UDAs were carried out in 2015-16 (87.2 million in 2014-15). The proportion of dentists' time spent on NHS work fell from 71.4 per cent in 2013-14 to 70.7 per cent in 2015-16.

8.7 The Department of Health (England) reported that the decision to uplift patient charges by 5 per cent, introduced in 2016, was taken as part of the Spending Review. The Department considered that it was fair to pass the costs to patients. While the increased charges did not necessarily go back into dentistry, they were used to fund NHS services more generally. The BDA argued that the additional costs could deter patients from seeking dental treatment, and that funds raised should be hypothecated to dentistry.

8.8 The BDA also felt it was inappropriate that patients were funding more than 50 per cent of the cost of dental treatment, noting that dental services had not been 'free at the point of access' for many years and were in fact becoming more expensive. The increase in dental charges could deter people from taking care of their teeth and visiting dentists regularly. There was also a public perception that dentists were profiting from the higher

charges, while the higher charges could make it more difficult to hit patient targets, by making costs prohibitive for some people. In Wales charges were lower and charges were also lower and had been frozen in Scotland.

8.9 The BDA was also concerned that underspends seen in dentistry were being used to cover overspending on pharmaceuticals, caused by price increases. The situation varied by location: in Wales little of the national budget was spent on dentistry, resulting in some practices not getting investment; in Northern Ireland uplifts had been consistently implemented late, placing extra pressure on dentists' finances.

8.10 The Department of Health (England) also noted that it was difficult to monitor the existence and degree of private versus NHS dentistry – it was in favour of patient choice and did not wish to limit this through restrictions on private work. Its primary concern was access to NHS dental services, and the Department considered that this was fundamentally good and improving. Until this ceased to be the case there was no need to do anything to disincentivise private practice.

Wales

8.11 The number of dentists providing NHS primary dental care services increased by 31 to 1,470, equating to 4.7 dentists per 10,000 population, which was the same as last year. Use of NHS dental services in Wales has increased. A total of 1.7 million patients were recorded as having been treated in the 24 months to March 2016 amounting to 54.9 per cent of the population. This was over 5,000 higher than the year before and 104,500 more than the low point in March 2008.

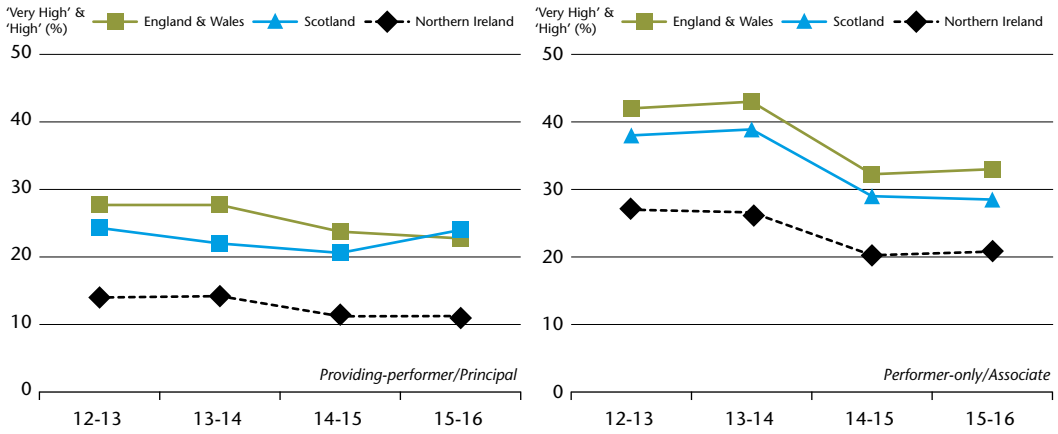
Northern Ireland

8.12 There were 1,052 GDPs working in 380 practice sites in Northern Ireland in 2016. The Northern Ireland Executive told us that access issues which had previously been a problem had been resolved, and the number of patients registered with a GDP increased to over 1.17 million.

Motivation

8.13 We are interested in the motivation of dentists across the UK. Figure 8.3 shows that dentists in England and Wales had the highest morale in the UK, followed by those in Scotland and then Northern Ireland. However, the levels of morale are generally lower than in 2013-14. Performer-only (associate) dentists had higher morale than providing-performer (principal) dentists in all four countries.

Figure 8.3: Percentage of dentists with 'very high' or 'high' morale levels, 2012-13 to 2015-16



Source: NHS Digital.

8.14 In the Dental Working Hours Motivation Analysis survey, dentists were asked six questions related to motivation:

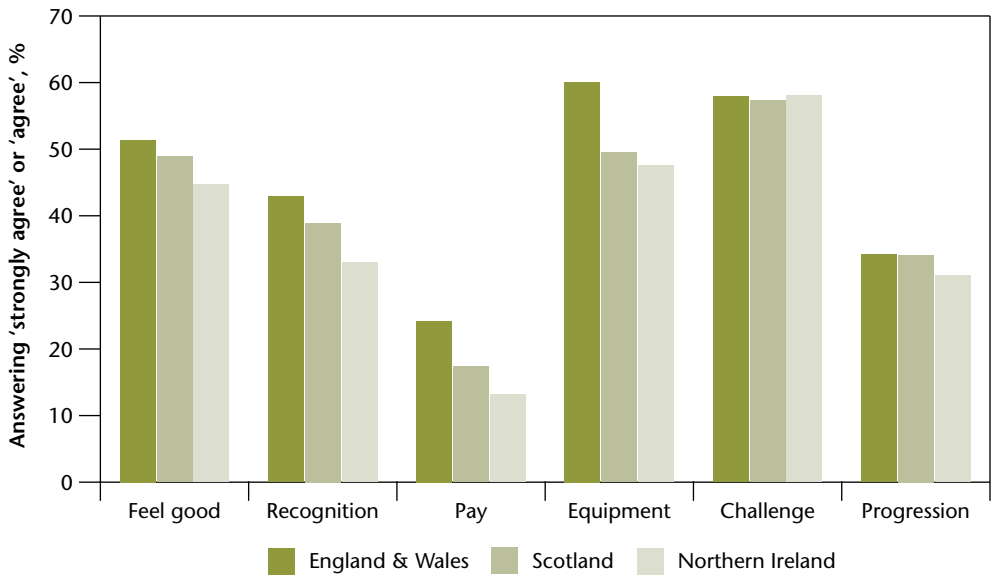
- I feel good about my job as a dentist (Feel good);
- I receive recognition for the work I do (Recognition);
- I feel my pay is fair (Pay);
- I have all the equipment and resources I need to do my job properly (Equipment);
- My job gives me the chance to do challenging and interesting work (Challenge); and
- There are opportunities for me to progress in my career (Progression).

8.15 Figure 8.4 shows that in general dentists in England and Wales were more motivated than those in Scotland and Northern Ireland in terms of how they felt. However, Figure 8.4 also shows that only a minority of dentists agreed that their pay was fair (24 per cent of providing-performer dentists in England and Wales, compared with 17 per cent in Scotland and 13 per cent in Northern Ireland). The figures for performer-only dentists (Figure 8.5) were slightly higher at 27 per cent in England and Wales, 22 per cent in Scotland and 18 per cent in Northern Ireland.

8.16 Performer-only dentists felt better about their job as a dentist and that there were opportunities to progress their career compared to providing-performer dentists. Performer-only dentists were more likely to agree that their pay was fair than providing-performer dentists. However, performer-only dentists in England were comparatively dissatisfied with the equipment and resources they had.

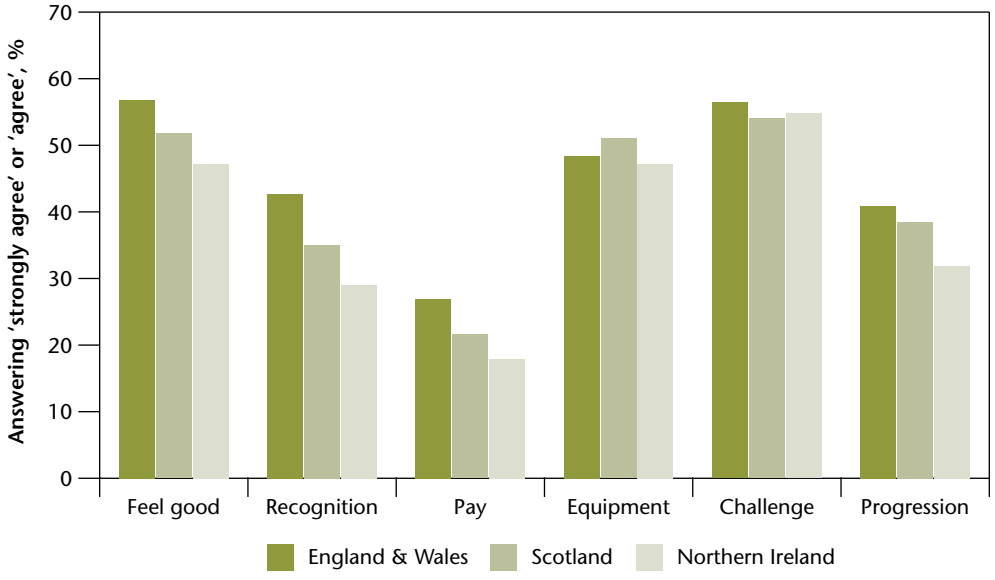
8.17 The data also suggested that the more hours per week dentists worked, the less motivated they were. Similarly, the higher the proportion of work done on NHS/Health Service work, the lower their levels of motivation. Providing-performer dentists in Northern Ireland generally worked longer average weekly hours, did more administration work and took less leave than those in England, Wales, and Scotland, which may in part explain their lower motivation scores.

Figure 8.4: Percentage of providing-performer (principal) dentists that answered 'strongly agree' or 'agree' to questions on motivation, 2015-16



Source: NHS Digital.

Figure 8.5: Percentage of performer-only (associate) dentists that answered 'strongly agree' or 'agree' to questions on motivation, 2015-16



Source: NHS Digital.

England

8.18 NHS England data indicated that performer-only dentists were more motivated and had higher morale than providing-performer dentists, but there was no explanation as to why this was so.

8.19 The BDA's view was that dentists were almost at the 'tipping point' where the balance between pay and workload would push them to leave. If a number left or retired, and Brexit had an impact, there could be a crisis. Loyalty to the NHS was also linked to age – younger dentists did not have that loyalty. The Department did not regard the morale situation as having reached crisis point, but undertook to examine further the observations of the BDA.

Wales

8.20 Regarding the reported disempowerment and disengagement of doctors and dentists, as set out in BMA and BDA evidence, the Welsh Government did not provide information on GDP morale and motivation but gave details of the NHS Wales staff survey which covered directly employed dentists (see below).

Northern Ireland

8.21 The BDA stressed that the decision by Ministers in Northern Ireland to reject our recommendation for an increase in pay of 1 per cent net of expenses for 2015-16 had created anxiety amongst dentists, leading to poor morale and motivation for the dental profession in Northern Ireland (although we note that our recommendation for a 1 per cent uplift in 2016-17 was accepted in full by the Northern Ireland Executive). It said that this could be addressed in part through remuneration and sought a clear recommendation from us for 2017-18.

Our comments

8.22 We are concerned by the BDA's findings and comments on motivation, and its assessment that NHS dentistry has reached crisis point due to pay and workload issues. There is a contrast between this assessment and that of the health departments, who reported an increase in the supply of dentists and improving access for patients and quality of care. We require more evidence on dentists' motivation in order to reconcile these differing pictures, including consideration of the impact of Brexit on staff from overseas, when this is available. We ask all parties, but in particular, health departments and NHS England, to provide further evidence and analysis on this topic for next year's round.

Recruitment and retention

England

8.23 The BDA noted that there was a discrepancy between NHS England's view that there was plenty of demand for NHS contracts, and the BDA's view that dentists were increasingly looking to leave the NHS and switch to the private sector. The BDA suggested the problem lay not with finding bidders for NHS contracts, but rather in successfully delivering those contracts. NHS contracts might be returned if they proved unprofitable, or if there were recruitment issues in the area.

8.24 The Department of Health (England) did not see the recruitment and retention crisis and diminishing investment in NHS dentistry reported by the BDA, but said that it would investigate this and look at the evidence carefully.

Wales

8.25 There are some recruitment and retention issues in the more rural areas of Wales. While individual practices may have difficulties, the Welsh Government did not agree with the BDA assessment of a looming crisis. It said that health boards continued to report little shortage of takers for new or expanded contracts when offered, noting that in general, it took longer to fill posts in the more rural areas of North and West Wales. It said that the last workforce review (in October 2012) concluded that Wales was likely to have a broad balance between supply and demand in the short and medium term. The Welsh Government said that it was working with Cardiff University to realign the ratio of dental undergraduate and dental care professional trainees over the next two to three years.

Future supply and workforce

8.26 NHS England stated that 85.7 per cent of dentists in England were now performer- only, compared with 62.4 per cent in 2006-07. The reasons for the shift toward potentially lower-paid performer-only roles is not clear, but it could be connected to the desire for work-life balance, flexibility and fewer responsibilities, similar to doctors increasingly opting for salaried GMP roles rather than partner opportunities.

8.27 In oral evidence, Department of Health (England) officials noted that the landscape for dentistry was entirely different to general practice, with oversupply rather than shortages of practitioners. Contract reform could offer more opportunities on the clinical side. The Department commented that there were a number of factors behind the rise in performer-only dentists and other labour market trends in dentistry. These included the marketability of practices and their sale/incorporation – there was a trend of contract holders selling their practices. The oversupply of dentists also acted as a downward pressure on earnings. As corporate practices achieved a larger share of the market, this would also impact on the broader picture.

BDA comments

8.28 The BDA stated that there had been a deterioration in dentists' pay since 2008, with declining real terms incomes which a 1 per cent uplift could not reverse. While dentists earned more on average as young graduates, career progression did not always materialise as expected.

8.29 According to the BDA, there had also been a fall in the number of contracts over the last decade, from around 7,500 to 3,500 in England, and a lack of funding for foundation training places. The organisation claimed that lower overall NHS spending on dentistry was combined with poor remuneration of expenses.

8.30 The BDA said that as a result, throughout dentistry, professionals were leaving the NHS in favour of the private sector. In Northern Ireland the organisation considered the situation to be particularly grave, with a new Community Dental Services contract having been proposed and accepted, but which had not yet secured financial approval from the Department of Finance. Dentists in Northern Ireland had been under particular pressure, and less than half would recommend dentistry as a career.

8.31 The BDA also asserted that anything less than 1 per cent across the board was likely to result in many dentists considering their future outside the NHS. Lastly, many BDA members said the service was no longer meeting patient needs. The BDA suggested that the current payment structure in England and Wales, based on the number of UDAs, did not incentivise preventive measures. Dentists should be paid for looking after a cohort of patients, not assessed on the number of procedures performed. There was a need to create a culture in which dentists were free to take on patients without fear of

losing money or missing activity targets. In particular, the Northern Ireland contract was highlighted as requiring reform, having been 10 years in negotiation, during which time it had not kept up with inflation.

Our comments

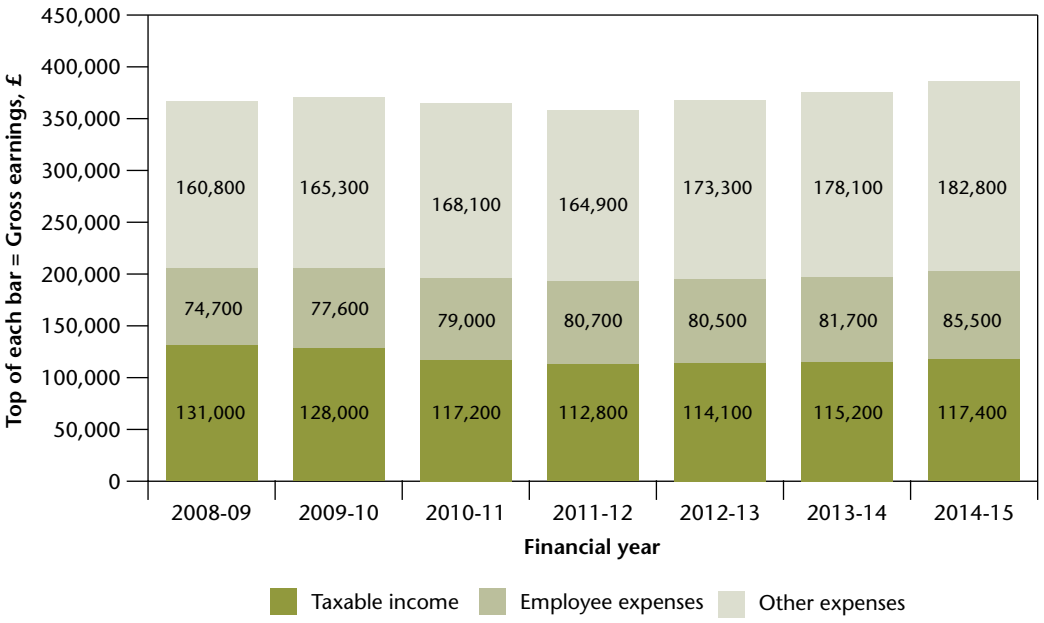
8.32 While the BDA considered that a recruitment and retention crisis was likely, it was not yet apparent in the staffing figures. As noted, the supply of dentists on the whole is steady or increasing, and patient access to care continues at around the same level, with quality of patient care generally identified as good. We have not been provided with any strong evidence to suggest that there are serious recruitment and retention problems in dentistry. We do, however, require better and more extensive data on vacancies and supply of dentists, as well as more information on the status of NHS contracts.

Earnings and expenses for providing-performer dentists

England and Wales

8.33 Table 8.1 shows that in 2014-15 providing-performer dentists in England and Wales had average taxable income of £117,400 and expenses of £268,300 (Earnings to Expenses Ratio or EER 69.6 per cent). Figure 8.6 shows that employee expenses for providing-performer dentists increased by 4.7 per cent to £85,500, while non-employee expenses increased by 2.6 per cent, continuing the trend since 2011-12 of increasing income and expenditure.

Figure 8.6: Providing-performer dentists, mean gross earnings (NHS and private), England and Wales, 2008-09 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Table 8.1: Mean income and expenses for providing-performer GDPs, England and Wales, 2008-09 to 2014-15

Dental type	Year	Estimated population[1]	Gross earnings	Employee expenses[1]	Non-employee expenses[1]	Income	EER
			(£)	(£)	(£)	(£)	(%)
Providing-performer	2008-09	6,783	366,500	74,700	160,800	131,000	64.3
	2009-10	6,250	370,900	77,600	165,300	128,000	65.5
	2010-11	5,750	364,300	79,000	168,100	117,200	67.8
	2011-12	5,250	358,400	80,700	164,900	112,800	68.5
	2012-13	4,750	368,000	80,500	173,300	114,100	69.0
	2013-14	4,350	375,000	81,700	178,100	115,200	69.3
	2014-15	3,950	385,600	85,500	182,800	117,400	69.6
	Latest % change	*-9.2%*	*2.8%*	*4.7%*	*2.6%*	*1.9%*	*0.3pp*

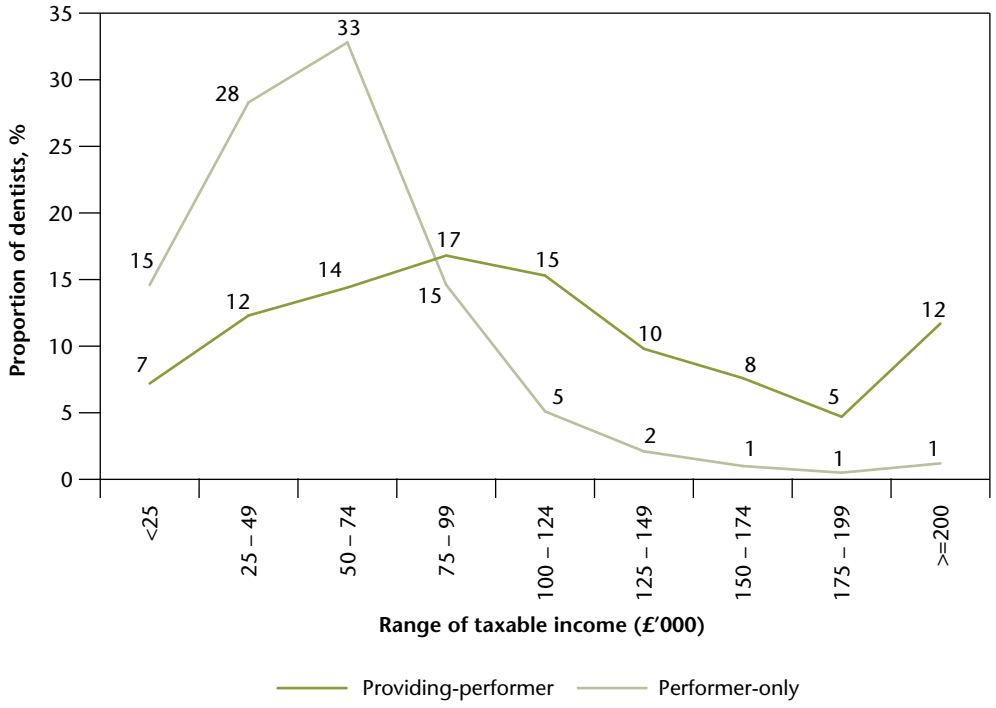
Source: NHS Digital using Her Majesty's Revenue and Customs data.

[1] Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.

pp: percentage point change.

8.34 Figure 8.7 shows the distribution of income for providing-performer dentists and performer-only dentists in England and Wales. It shows that half of providing-performer dentists had an income of over £100,000 compared with only 10 per cent of performer-only dentists.

Figure 8.7: Providing-performer and Performer-only dentists – distribution of taxable income, England and Wales, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Northern Ireland

8.35 Table 8.2 shows that in 2014-15, a principal dentist (a dentist who is a practice owner, director or partner, or who has an arrangement with an NHS trust) had an average taxable income of £111,700 and expenses of £217,000 (EER 66.0 per cent) whilst Figure 8.8 shows that incomes for principal dentists in Northern Ireland have been fairly stable for the last five years.

Table 8.2: Average income and expenses for principal GDPs, Northern Ireland, 2008-09 to 2014-15

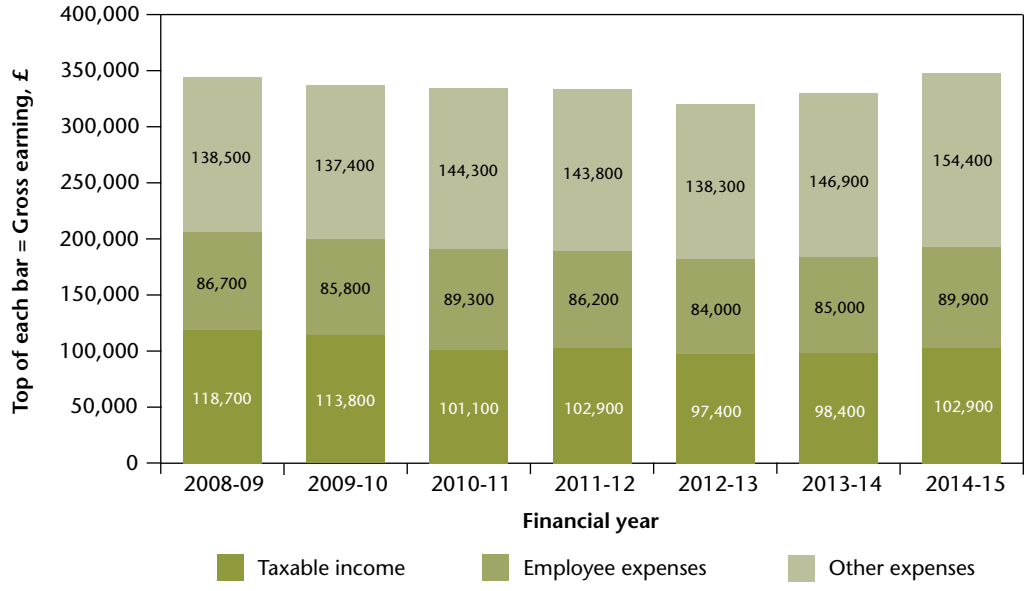
Dental type	Year	Estimated population[1]	Gross earnings	Employee expenses[1]	Non-employee expenses[1]	Income	EER
			(£)	(£)	(£)	(£)	(%)
Principal	2008-09	319	333,700	66,600	137,500	129,600	61.2
	2009-10	350	344,600	73,200	148,500	122,900	64.3
	2010-11	300	331,000	79,200	137,600	114,200	65.5
	2011-12	350	318,600	77,000	129,100	112,500	64.7
	2012-13	300	316,000	79,100	126,100	110,900	64.9
	2013-14	300	335,600	76,900	146,200	112,500	66.5
	2014-15	250	328,700	76,100	140,900	111,700	66.0
	Latest % change	*-16.7%*	*-2.1%*	*-1.0%*	*-3.6%*	*-0.7%*	*-0.5pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.

[1] Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.

pp: percentage point change.

Figure 8.8: Principal dentists, Gross earnings (NHS and private), Northern Ireland, 2008-09 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Earnings and expenses for performer-only dentists

England and Wales

8.36 Table 8.3 shows that in 2014-15 performer-only dentists[1] in England and Wales had average taxable income of £59,900 and expenses of £39,900 (Earnings to Expenses Ratio or EER 39.9 per cent). Figure 8.9 shows that the average income for performer-only dentists slowly decreased since 2008-09, on a headcount basis. Between 2013-14 and 2014-15, non-employee expenses increased by £1,200 and employee expenses by £200, whereas gross earnings increased only by £800, leading to a fall in income.

Table 8.3: Average income and expenses for Performer-only GDPs, England and Wales, 2008-09 to 2014-15

Dental type	Year	Estimated population[1]	Gross earnings	Employee expenses[1]	Non-employee expenses[1]	Income	EER
			(£)	(£)	(£)	(£)	(%)
Performer-only	2008-09	12,853	104,000	5,600	30,700	67,800	34.9
	2009-10	14,050	101,700	6,700	29,400	65,600	35.5
	2010-11	15,050	98,400	5,900	29,600	62,900	36.0
	2011-12	16,050	96,200	5,600	28,900	61,800	35.8
	2012-13	16,800	96,200	6,000	29,400	60,800	36.8
	2013-14	17,150	99,000	6,700	31,800	60,600	38.8
	2014-15	17,400	99,800	6,900	33,000	59,900	39.9
	Latest % change	*1.5%*	*0.8%*	*3.0%*	*3.8%*	*-1.2%*	*1.1pp*

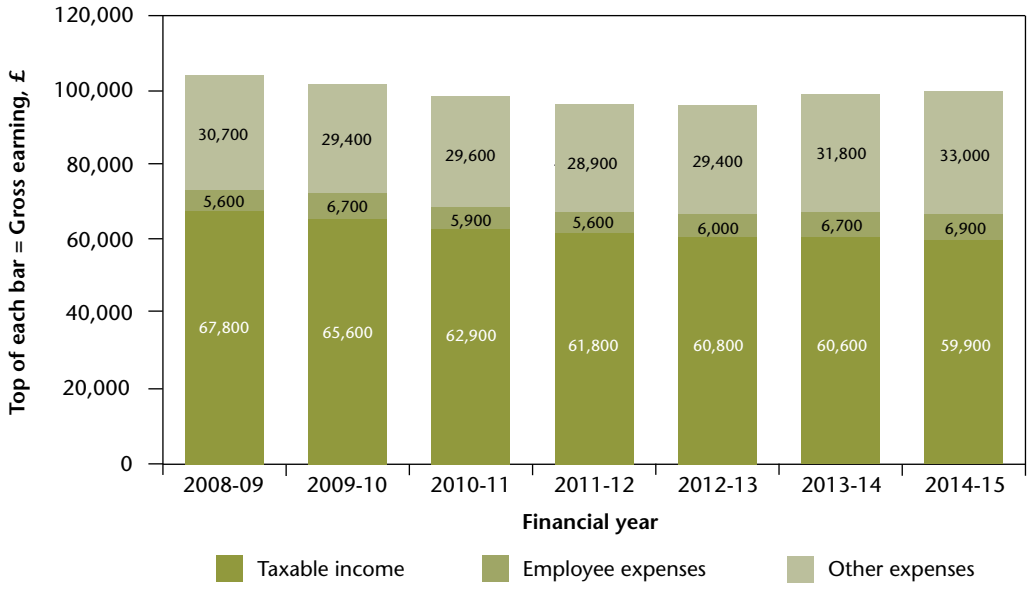
Source: NHS Digital using Her Majesty's Revenue and Customs data.

[1] Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.

pp: percentage point change.

[1] A performer-only dentist performs NHS activity on a contract, but does not hold a contract with an NHS England Area Team/Local Health Board themselves.

Figure 8.9: Performer-only, gross earnings (NHS and private), England and Wales, 2008-09 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Northern Ireland

8.37 Table 8.4 shows that in 2014-15, an associate[2] dentist had average taxable income of £54,000 and expenses of £36,100 (Earnings to Expenses Ratio or EER 40.1 per cent). Figure 8.10 shows that incomes for associate dentists have been relatively stable for the last four years, having fallen substantially between 2008-09 and 2011-12.

Table 8.4: Average income and expenses for GDPs, Northern Ireland, 2008-09 to 2014-15

Dental type	Year	Estimated population[1]	Gross earnings	Employee expenses[1]	Non-employee expenses[1]	Income	EER
			(£)	(£)	(£)	(£)	(%)
Associate	2008-09	522	105,300	2,500	36,100	66,700	36.7
	2009-10	500	97,900	1,100	34,100	62,700	36.0
	2010-11	550	96,200	500	36,400	59,400	38.3
	2011-12	600	91,600	800	35,000	55,700	39.1
	2012-13	650	86,700	200	33,500	53,000	38.9
	2013-14	700	89,700	700	34,800	54,200	39.6
	2014-15	700	90,200	500	35,600	54,000	40.1
	Latest % change	*0.0%*	*0.6%*	*-28.6%*	*2.3%*	*-0.4%*	*0.5pp*

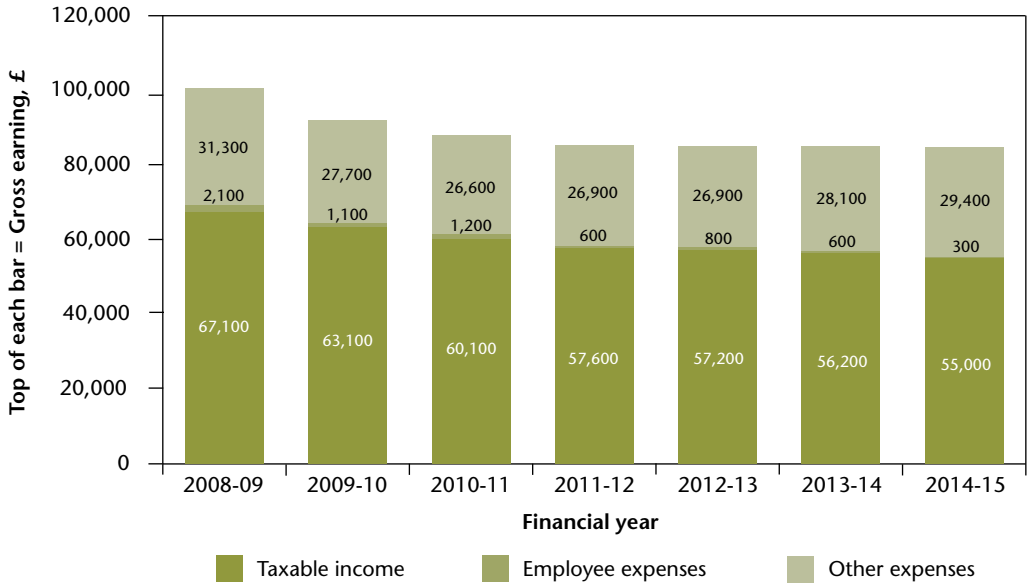
Source: NHS Digital using Her Majesty's Revenue and Customs data.

[1] Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by NHS Digital from unrounded figures.

pp: percentage point change.

[2] A dental practitioner who is self-employed and enters into an agreement with a principal dentist that is neither partnership nor employment. Holds a dental surgeon (DS) number and performs primary care dental services.

Figure 8.10: Associate dentists, gross earnings (NHS and private), Northern Ireland, 2008-09 to 2014-15

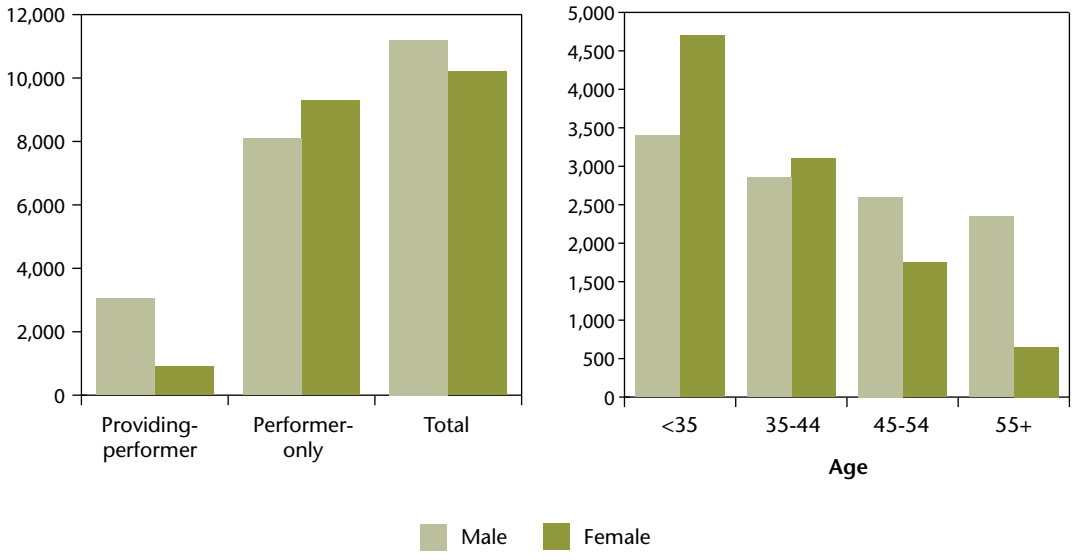


Source: NHS Digital using Her Majesty's Revenue and Customs data.

Dental demographics and earnings in England and Wales

8.38 Figure 8.11 shows that women are disproportionately more likely to be performer-only dentists than their male counterparts with over 90 per cent choosing to be performer-only, compared with 72 per cent for men. Female dentists were also more likely to be younger with almost half under 35 (46 per cent) compared with 30 per cent of men.

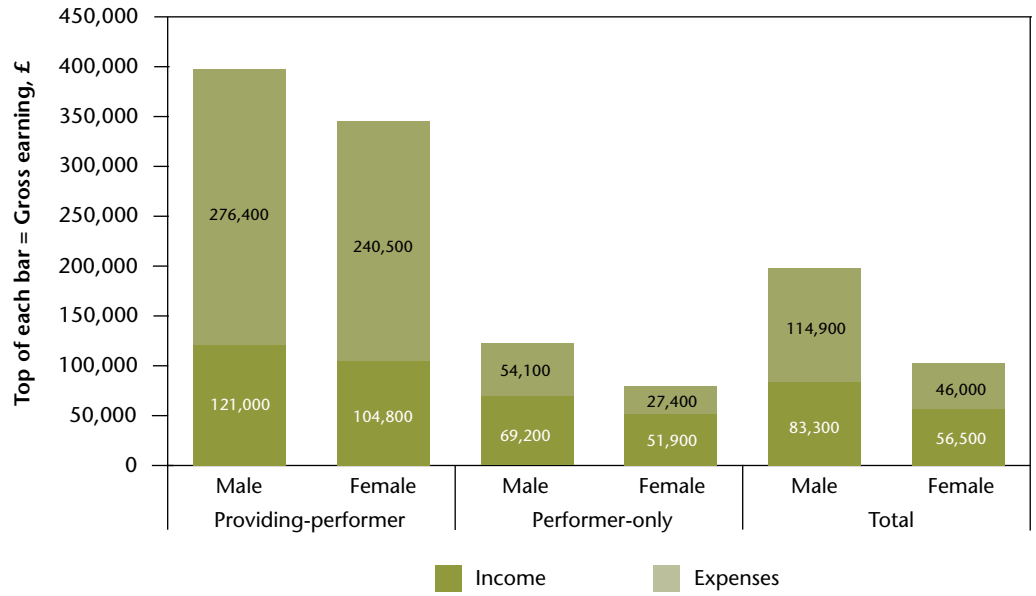
Figure 8.11: Dental population by gender, age and dental type, England and Wales, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

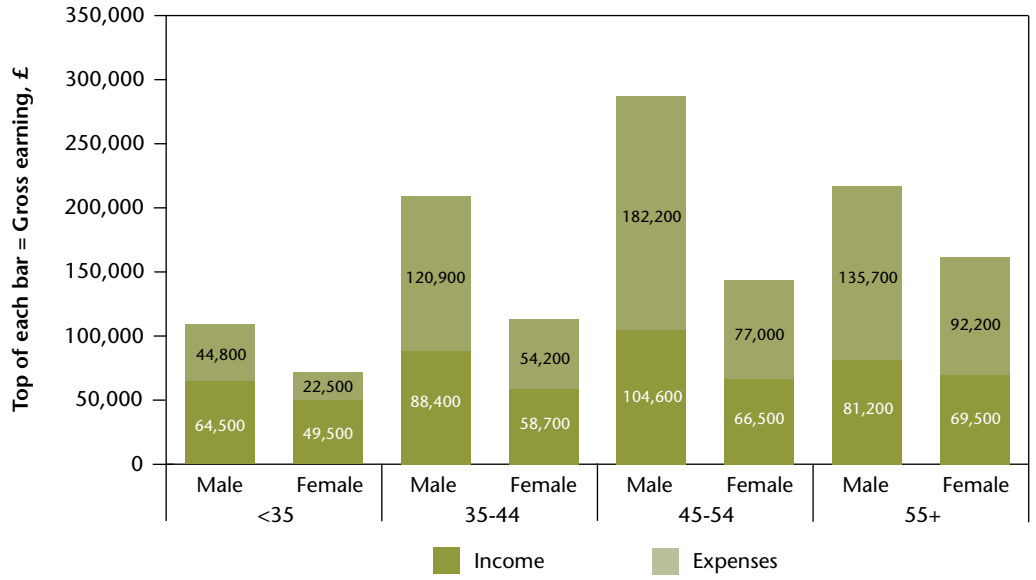
8.39 Figures 8.12 and 8.13 show that female dentists earned less than their male counterparts, although this is likely, at least in part, due to female dentists being younger, being more likely to be performer-only dentists and working fewer hours (all are correlated with lower incomes).

Figure 8.12: Dental income and expenses by gender and dental type, England and Wales, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Figure 8.13: Dental income and expenses by gender and age, providing-performer and performer-only, England and Wales, 2014-15

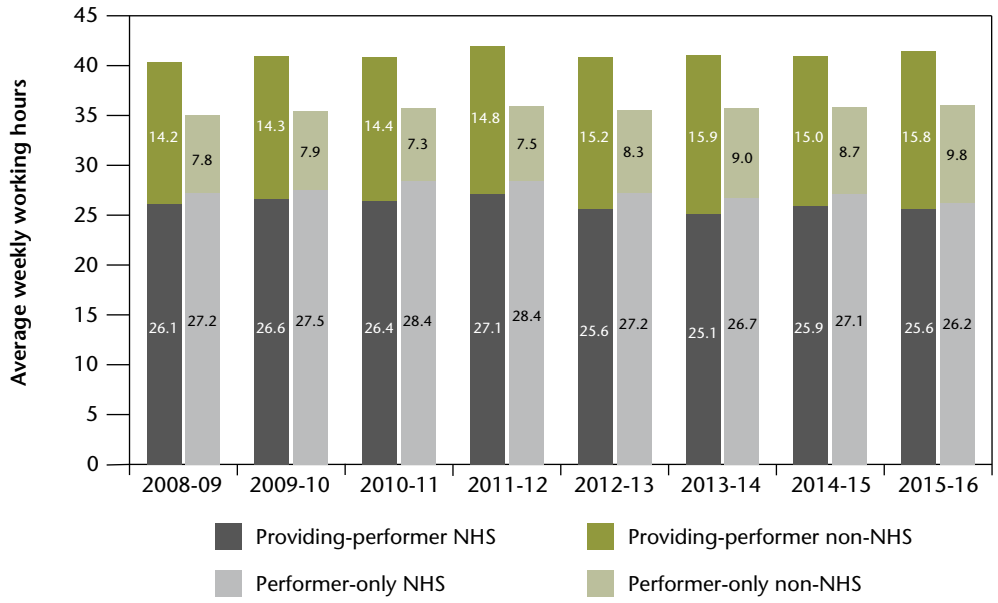


Source: NHS Digital using Her Majesty's Revenue and Customs data.

Working hours

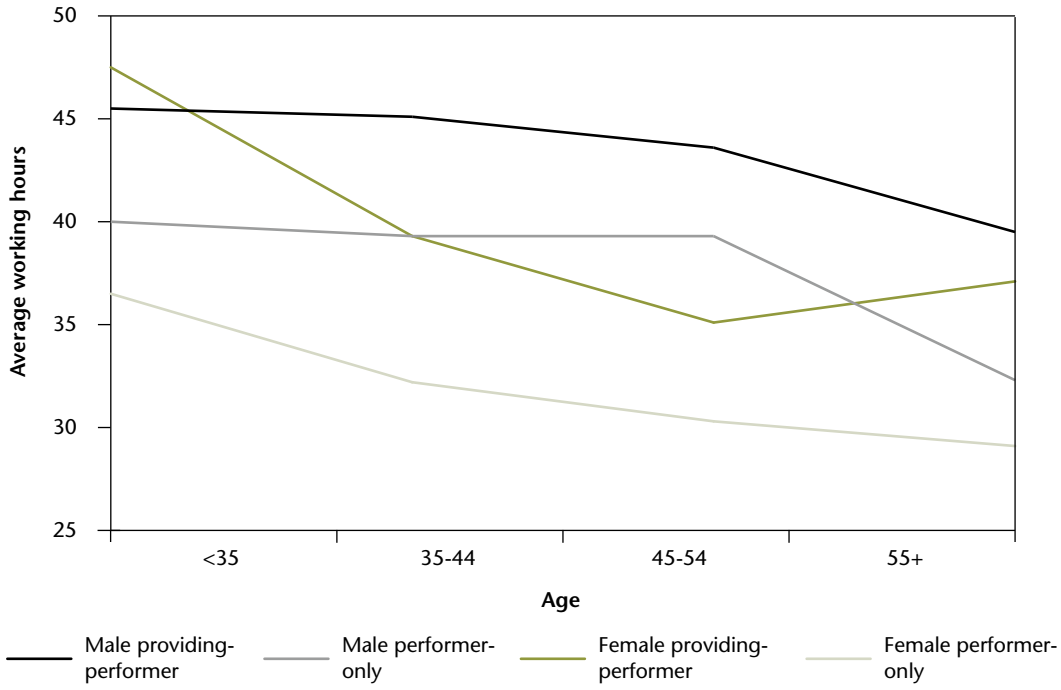
8.40 Figure 8.14 shows that average working hours for both providing-performer and performer-only dentists remained largely constant since 2008-09. However, there was a small shift away from NHS work towards private work for both providing-performers and performer-only dentists. On average, performer-only dentists did more NHS work than providing-performer dentists. Figure 8.15 shows that the average working hours for female dentists were lower and started to reduce from age 35 onwards, while for male dentists working hours reduce dramatically after age 55.

Figure 8.14: Working hours by dental type and NHS/non-NHS work, England and Wales, 2015-16



Source: NHS Digital.

Figure 8.15: Average working hours by gender and dental type, England and Wales, 2015-16



Source: NHS Digital.

Our comments

8.41 We note that these demographic and incomes data are limited to England and Wales and so are unable to comment on the picture in Northern Ireland. It is noteworthy that the trend is towards increasing numbers of performer-only dentists, despite the lower income than for providing-performer. This suggests an increasing number of dentists seek other benefits, such as flexibility and work-life balance, over and above monetary benefits.

8.42 We also note the prevalence of women among performer-only dentists, which may entail a correspondingly lower income for these individuals. This may raise issues of equal pay and the gender pay gap, but again we require more information before drawing any firm conclusions in this area and simply seek to highlight these trends. As Figure 8.15 above shows, part of any gender pay gap may be explained by factors such as the number of hours worked. There is therefore a distinction to be drawn between a 'structural' gender pay gap which can be accounted for by factors such as fewer working hours or more junior roles, and a discriminatory gap where equal work is not achieving equal pay – which the evidence presented to us does not distinguish between.

Pay recommendations: evidence from the parties

England

8.43 In the previous round for 2016-17, we recommended an uplift in income, net of expenses, of 1 per cent. The increase was accepted, and when combined with an increase for staff expenses of 1 per cent in line with the Government's public sector pay policy, and other expenses using the Consumer Prices Index (CPI), this resulted in an overall uplift of 0.7 per cent.

8.44 NHS England reported that earnings of the providing-performer dentists saw a slight increase for the third year running while the earnings of performer-only dentists continued to decrease in 2014-15.

8.45 According to NHS England, data from NHS Digital continued to be difficult to compare with previous years because of changes in the way dentists pay themselves, especially the move towards personal and practice incorporation, which takes profits out of the self-employed tax system for the individual dentist and moves them into company accounts. Although the average identifiable net income after expenses for dentists in England and Wales in 2014-15 fell to £70,500 compared with £71,700 in the previous year, this was not considered statistically significant. Income levels appear to be sufficient to recruit and retain the dental workforce. For dentists holding a contract, earnings were considerably higher at an average of £117,400 – an increase of 1.8 per cent from the previous year's £115,200. The data also showed some dentists earning considerably more; with 1 per cent earning over £300,000. Performer-only dentists had average earnings net of expenses of £59,900, down 1.1 per cent from the £60,600 of the previous year. The data showed that just over half (53.8 per cent) of gross payments to dentists was to meet their expenses.

8.46 NHS England stated that overall levels of uplift for independent contractors were best considered as part of discussions with the profession's representatives about ongoing improvements in contractual arrangements, provided that it was possible to secure appropriate improvements in quality and efficiency of services.

8.47 The Department of Health (England) considered that targeting was unlikely to be effective for GDPs, because commissioners already had the ability to target and commission new services where there is need. They have the flexibility to commission services at an appropriate contract value to reflect local circumstances including the cost of service provision, potential service availability and the level of need.

Wales

8.48 Following the recommendations in our 44th report, dentists' earnings were increased by 1 per cent, net of expenses, effective for the year beginning on 1 April 2016. After applying in full the latest data to allow for practice costs and other expenses and, using the same formula approach as previous years, the value of dental contracts increased by 1.1 per cent.

8.49 In written evidence, the Welsh Government highlighted the following in regard to dentists' pay:

- The average taxable income for all dentists in Wales in 2014-15 (average gross earnings less average expenses) was £67,000, a 2.3 per cent increase from £65,500 in 2013-14.
- For dentists holding a contract earnings were £96,200, a 10.9 per cent increase from £86,700 in 2013-14. Dentists working for others saw their earnings rise to £60,900, a 1.7 per cent increase from £59,900 in 2013-14. These increases were a reversal of the general downward trend in taxable income since 2007-08.
- The average gross earnings (self-employment income before deduction of expenses) for all dentists in Wales in 2014-15 were £143,900, a 4.3 per cent increase from £137,900 in 2013-14. For those holding contracts it was £298,400, a 19.5 per cent increase compared with £249,700 in 2013-14. For dentists working for others it was £111,300, a rise of 3.2 per cent compared with £107,900 in 2013-14.
- For dentists holding a contract, average taxable income increased with the percentage of time spent on NHS dentistry, with those dentists spending at least 75 per cent of their time on NHS dentistry earning an average taxable income of £121,000 in 2014-15 (England and Wales figure). The opposite pattern was shown

for dentists working for others, where the lowest average taxable income of £59,700 was earned by those who spent at least 75 per cent of their time on NHS dentistry, and the highest taxable income of £66,700 was earned by those who spent less than 25 per cent of their time on NHS dentistry (again England and Wales figures: there are no separate data for Wales).

8.50 In oral evidence, Welsh Government officials said that they were not concerned by the fact that for contractors, NHS work was more lucrative, while for salaried dentists, private work was more lucrative, suggesting that this was merely a function of the system for some performers. Officials suggested it could be explained by factors such as some performers charging a larger part of their expenses to private work; some practices having low expenses; and some performers earning higher wages than elsewhere in the UK.

Northern Ireland

8.51 Our recommendation for a 1 per cent pay rise for 2016-17 for staff covered by the national medical and dental terms and conditions of service was accepted by the Northern Ireland Executive, and implemented in November. It uplifted the national pay rates of hospital dental staff and dentists in public health, and salaried primary dental care, backdated to 1 April 2016. The Department of Health (Northern Ireland) also proposed that the uplift for contractor dentists should be delivered in 2016-17 through a 1.13 per cent increase to all gross remuneration figures including gross item of service fees and capitation/continuing care fees.

8.52 The Department said that it valued and recognised the contribution that dental practitioners made in terms of improving and maintaining oral health and as employers. However, it would continue to monitor and pursue measures to constrain General Dental Service (GDS) expenditure and reduce the pressure on the budget if necessary, whilst recognising the need to minimise the impact on patients, practitioners and practices.

BDA comments

8.53 The BDA was aware of the Northern Ireland Department's position in relation to the proposed implementation of a 1 per cent pay increase for GDPs in 2016-17 and its proposal to deliver this to contractor dentists through a 1.13 per cent increase to all gross remuneration figures in the Statement of Dental Remuneration (SDR). Other fees and allowances payable in the SDR would then be calculated and uprated following the normal conventions. The Department continues to engage with the BDA to monitor the impact of the recent changes made to the SDR in 2014 and the extent of any additional impacts that may still arise as a consequence of the non-implementation of increases to dental treatment fees and allowances during 2015-16.

Our comments

8.54 Employer-side parties told us that there were no serious retention and recruitment issues with dentists, therefore pay was sufficient to attract and retain an adequate workforce. The general assumption for the pay award in this round was for a maximum 1 per cent uplift across the board.

8.55 We note the uncertainty regarding the actual level of dentists' income due to the complex impact of personal and practice incorporations. It would helpful to delve deeper into this for next year's round, to ensure that net income figures are accurate. Chapter 10 provides more information on this.

8.56 The consensus on the employers' side appears to be that the split between private and NHS dentistry is not posing problems for the NHS or restricting patient access, and so there is no need for policy intervention at this stage.

Expenses and formula

8.57 As mentioned in Chapter 7, our recent reports have rehearsed our ongoing concerns with the formula-based approach to the uplifts for independent contractor GMPs and GDPs. We previously took the decision to abandon the use of the formula, and to instead make recommendations on our intended increase in *pay net of expenses*.

8.58 We conclude that we should again make a recommendation on pay net of expenses. We include (at Appendix E) the data that would have populated the formulae for both GMPs and GDPs, had we used the previous approach. It is for the parties to decide whether to use a formula and what elements they put into it. We note that discussions about expenses for dentists are progressing, but not necessarily to everyone's satisfaction.

General Dental Council Annual Retention Fee

8.59 This section considers the General Dental Council Annual Retention Fee (GDC ARF). The GDC ARF remained at £890 in 2016 despite Judicial Review and consultation responses. The BDA anticipated that the GDC would seek to retain this level in 2017. At £890, the BDA noted that dentists' ARF is over double that of the doctors' General Medical Council fee (£425).

8.60 The BDA's evidence also highlighted that the GDC ARF had increased by 55 per cent in 2015, and indemnity insurance costs had increased by 60 per cent in the previous 3 years. The ARF was not proportionate as it was the same, no matter how many hours a dentist worked. So, a limited uplift to expenses while fees were increasing would place further pressure on finances.

Contractual changes

England

8.61 NHS England became responsible for commissioning all NHS dental services in April 2013, including primary, community and hospital dental services. The overarching policy aim was to achieve a single operating model, providing an opportunity for consistency and efficiency where it was required, and enabling flexibility where necessary. The proposals for dental commissioning aimed to build on the single operating model for primary care commissioning described in the document 'Securing excellence in commissioning primary care'. New dental services being commissioned by NHS England tend to be on the basis of 08:00-20:00 access, with some weekend opening.

8.62 The Department of Health (England) affirmed the Government's commitment to reform of the dental contractual framework, including a period of prototyping a potential new contract. This aims to increase access to NHS dentistry and implement improvements in oral health. The reformed approach included: a clinical approach focussed on prevention as well as treatment; and measurement of quality through a Dental Quality and Outcomes Framework. In 2014, the Government announced the proposed new approach to remuneration reflecting activity, quality and capitation. NHS England noted that learning from pilot schemes was evaluated and a prototype scheme launched early in 2016, with 82 prototypes live at the time of writing. It highlighted the focus on quality to improve health care of patients, while a capitation system and focus on long-term care will give patients the security of continuing care.

8.63 In oral evidence, Departmental officials stated that work on contract reform was ongoing, with pay only one aspect. A full evaluation would take place toward the end of the year. An initial evaluation would be published in the spring which would give an idea of how the prototypes were performing. It was a collaborative programme, with the BDA heavily involved alongside NHS England.

8.64 The BDA said that it remained fully engaged in the contract reform process in England and stated that it would continue to monitor the impact on services and on dentists' remuneration.

8.65 The BDA also raised concerns regarding the contractual impact of the move towards devolution of health and social care services. For example, in April 2016, responsibility for the health and social care budget in Manchester was devolved to statutory organisations in Greater Manchester. BDA officials felt there were a number of potential risks for dentistry under the proposals put forward by Devolution Greater Manchester. Concerns raised included the impact of the new arrangements on the status and continued viability of businesses. There was uncertainty about what would happen to dental contracts; and whether dentists might be forced to give up their GDS/PDS contracts and therefore lose NHS contractual benefits. GMPs in Manchester will be able to take part on a voluntary basis from 2017 and it was likely that those who did so would work on a Multi-Specialty Community Provider contract. If dentistry followed suit, practices may federate to take on contracts, changes to remuneration systems and differing contractual payment methods. The BDA were monitoring the situation closely and pledged to report back in more detail next year.

Wales

8.66 Evidence from the Welsh Government stated that in order to develop a new dental contract for Wales which works for all parties, it was important that the Welsh Development Model (WDM) Prototype was monitored continuously and evaluated prior to full implementation. Collection and analysis of meaningful data and information would be vital to understand what worked well and what did not. The findings emerging from the WDM Prototype would be used to inform the future development of the dental contract. However, it was too early to consider in detail how new contractual arrangements in Wales might fit alongside future DDRB recommendations on pay.

Northern Ireland

8.67 The existing General Dental Services (GDS) arrangements were introduced in 1992 and pay dentists using a blended system of remuneration. Item of service payments account for approximately 60 per cent of GDS income; 20 per cent comes from allowances and 20 per cent comes from capitation payments for the registration of patients.

8.68 The Department of Health (Northern Ireland) remained committed to the development of a new contract which met the needs of practitioners and the service commissioner, but ultimately and most importantly will serve to protect and improve the oral health of patients in Northern Ireland.

8.69 The Department considered that it was too early to answer with any degree of certainty how our future recommendations would fit alongside any new contractual arrangements in Northern Ireland or the financial pressures being faced by the Northern Ireland Executive but it would hope to continue to engage with the BDA on the development and implementation of new contracts for GDPs, orthodontists and primary care oral surgeons.

Our comments

8.70 In light of the comments by the BDA over dissatisfaction of dentists with pay, it will remain important for the parties to continue to work closely with the profession on how new contractual developments to address these concerns.

8.71 We note that the major change proposed contractually in England is the introduction of a system of capitation payments. For next year's round, we expect to hear more on the progress of the pilot schemes implemented, and be given greater clarity on the timetable for rollout of the new contracts.

SALARIED DENTISTS

8.72 This section considers issues relating to salaried dentists who work in a range of different posts, as community dentists, primary dental services dentists, dental access centre dentists, and as salaried dental practitioners in the NHS.

England

8.73 The Department of Health (England) noted that Community Dental Services (CDS) filled an important role in dental health service provision but was not aware of any specific difficulties in filling vacancies faced by providers. Three CDS practices were testing the national contract reform programme, evaluating the new clinical approach with their specific, and usually vulnerable, patient groups. The Department and the primary NHS entities favoured the same 1 per cent increase for all NHS salaried staff.

Wales

8.74 For dentists, as for doctors, a 1 per cent consolidated increase was applied to all pay scales from 1 April 2016 in line with our recommendations. In addition, dentists who received a 2 per cent non-consolidated payment in 2015-16, and who have not since moved onto a new pay scale point, also received a non-consolidated payment, equivalent to 1 per cent of their basic earnings.

8.75 The Welsh Government informed us that the headline results of the NHS Wales staff survey 2016 were published on the 8 December 2016,[3] and that each NHS organisation would publish a more detailed analysis of local results in due course. This would involve representatives from NHS entities across Wales and would seek to identify improvement work. This survey covered NHS dentists directly employed by trusts, namely community dentists (previously referred to as Salaried Primary Care dentists), dental core trainees, dental consultants and SAS dentists in a hospital setting, but does not include GDPs.

Northern Ireland

8.76 The Northern Ireland Executive (NIE) commented that the Department of Health (Northern Ireland) and the BDA had negotiated changes to the contract and terms and conditions for Community Dental Services. Implementation of these changes would be subject to the necessary approval from the Department for Finance.

8.77 Removing time-served pay progression was part of NIE policy development, with the intention of introducing shortened payscales and performance-related criteria. New contracts gateways were planned for community dentists (as for SAS grades and consultants), with the focus on performance rather than time served. The intention was to incentivise performance by doing away with automatic pay progression, which otherwise was perceived as a right.

[3] See NHS Wales staff survey 2016: http://gov.wales/topics/health/publications/health/reports/survey/?lang=en

BDA comments

8.78 The BDA was aware that pay restraint remained the government's policy on public sector pay. It accepted that there was no willingness to consider amendments to the basic Salaried Primary Dental Care Service contract of employment in England, and recognised that the government considers formally negotiated and locally approved incremental progression to be a form of pay rise and not an appropriate reflection of increased responsibility and skills. In previous responses, the BDA highlighted its fundamental disagreement with this approach and it reiterated that it maintained those concerns.

8.79 In regard to motivation, the BDA noted that when the level of dissatisfaction was viewed alongside the future career aspirations of CDS dentists, there would seem to be a serious retention problem looming. This would be exacerbated by the fact that, according to BDA workforce data, 74 per cent of the UK workforce was at the top of their scale and hence were the most experienced members of staff, best able to handle more turbulent times and to provide guidance and mentoring to younger and less experienced colleagues.

8.80 Without a minimum 1 per cent pay increase, the BDA felt that it was likely that the 28 per cent of UK members, surveyed in the BDA Community Dentists Survey 2016, who intended to retire within five years would see no reason to postpone such a decision given that they were already likely to be at the top of their scale – and therefore experiencing a real-terms pay cut. While the Department of Health (England) and NHS England did not share this assessment, officials undertook to follow up further in this regard.

8.81 With regard to the situation in Northern Ireland, the BDA was informed in January 2016 that funding had been secured to fund a new deal and negotiations restarted. Progress on this was quick, leading to an agreement to ballot on a summary agreement on the main changes within the proposed new contract including revised pay scales and annual leave entitlement. There was an agreement that a full set of revised terms and conditions would be worked on during and indeed after the ballot period. The ballot of all community dentists in Northern Ireland on the proposed new contract closed on 14 March 2016 and an overwhelming majority voted in favour of the new contract. The new contract finally allowed CDS dentists in Northern Ireland to have modernised terms and conditions, to align with those in the rest of the UK. Once financial approval was granted by the Department of Finance, the new contract would be backdated to 2015.

Our comments

8.82 We did not receive a great deal of evidence on this part of our remit group, so it is difficult to gain an overall picture on recruitment and retention of salaried dentists. As with GDPs, the evidence suggesting low morale and motivation within this part of the remit group is of concern, and should be addressed as soon as possible, but there is a lack of definitive evidence.

CHAPTER 9: PAY RECOMMENDATIONS

Introduction

9.1 In this chapter, we set out the parties' proposals for the main uplift for our remit groups for 2017-18, along with our recommendations, and our considerations of targeting. We have, as always, carefully considered all of the written and oral evidence we received and adhered to our terms of reference. The remit letters from the parties are at Appendix A. Chapter 1 describes the remits in more detail and specific issues are addressed in the relevant chapters.

9.2 The chapter concludes by pulling together the evidence we received in relation to equal pay matters, as our terms of reference require us to have regard to these, building on the new demographic data on our remit groups presented in earlier chapters. We also set out the parties' views on total reward and pensions: while not part of our remit, these are important aspects of the overall package.

Targeting: main pay scales

9.3 The Chief Secretary to HM Treasury wrote to all pay review bodies on 13 July 2016, restating the government's public sector pay policy of funding public sector workforces for an average annual pay award of 1 per cent for 4 years from 2016-17. His letter also made clear the government's expectation that pay awards would be targeted to support the continued delivery of public services and to address recruitment and retention pressures, noting the requirement for review bodies to consider good, evidence-based propositions.

9.4 Our remit letter from the Secretary of State for Health (England) referred to the consideration of targeting and said that the Department would tell us what progress it was making in developing the measures that would enable us to assess targeting to address recruitment and retention issues. The letter also stated that the government considered that pay restraint in the public sector continued to be a crucial part of its plans for the continued prudent management of public finances to help support long-term planning and to help protect jobs.

9.5 The remit letters from the Welsh Government, Northern Ireland Executive and the Scottish Government did not ask us to address directly the issue of targeting. Both the Welsh Government and Northern Ireland Executive's remit letters stated that they adhered to the UK Government's public sector pay policy, and asked for views on how any overall uplift could be applied for GMP and GDP contractors.

9.6 The Scottish Government's public sector pay policy for 2017-18 was published on 15 December 2016, and the subsequent remit letter highlighted the features of:

- an overall 1 per cent cap on the cost of the increase in the baseline paybill for those earning over £22,000;
- flexibility to use paybill savings to consider meaningful reconstruction of pay and grading systems to address evidenced equality issues; and
- continuing the expectation to negotiate an extension to the no compulsory redundancy agreement as part of constructive, collaborative discussions between employers and their trade unions to make the most effective use of the funding available.

9.7 The letter also asked for our recommendations on GMPs' pay and contractual uplift, and told us that the Scottish Government had agreed to jointly commission with the British Medical Association's (BMA) Scottish General Practice Committee, a review of general

practice funding, pay and expenses. We regret that it was not possible for Scotland to submit its evidence to our usual timetable as we consider the medical and dental workforce to be a UK-wide labour market. We consider Scotland separately and will make recommendations later in a supplement to this report. The rest of this chapter relates to England, Wales and Northern Ireland.

The parties' views

England

9.8 In both the written and oral evidence we received this round, there was no support for any form of differential pay awards for doctors and dentists. The Department of Health (England) told us that it considered targeting as an integral part of contract reform and stated that it was 'making good progress to secure the evidence base the Review Body needs, vacancy data in particular' but that there was insufficient robust evidence on which to make recommendations that would lead to differential pay awards for doctors and dentists. In oral evidence, the Minister argued that the Spending Review had resulted in a good settlement for the health service as it gave a real terms increase in the NHS budget across this parliament. He argued that, given the recent dispute with junior doctors and the desire to reform the consultant contract, it did not appear worthwhile to exacerbate matters by targeting very limited amounts of money which may only give rise to resentment, so any increase should be across the board. He went on to state that the coming year would be seen as one of stability and embedding changes and that this year's recommendations would be crucial in helping to overcome last year's difficulties.

9.9 NHS Employers said that in the absence of an agreement on pay reform, there was consensus amongst employers in favour of the same percentage increase for all staff within the 1 per cent cap. It echoed the Department's view that there was not sufficient evidence to justify differential pay awards to our remit groups in 2017-18. The common view was that an envelope of 1 per cent would not in practice make any differentiation worthwhile and could have a negative impact on the morale of the workforce. There were no labour market challenges at national or local level that would be resolved by differentiated pay awards.

9.10 NHS Providers told us that a 1 per cent pay award should not be targeted at the national level: it may be divisive given the industrial relations climate and it may not take account of differing local recruitment challenges.

9.11 Both the British Dental Association (BDA) and BMA were firmly opposed to targeting, believing that attempts to do so within such tight funding constraints would be both demotivating and ineffective.

Wales

9.12 The Welsh Government stated that the challenge of recruiting to particular specialties should be addressed through workforce planning and recruitment initiatives as well as changing the way roles were designed. It did not wish to consider the use of targeted pay until the impact of wider measures designed to address the underlying causes of recruitment challenges were evaluated.

Northern Ireland

9.13 Targeting had been considered by the Northern Ireland Executive, but due to the nature of the configuration of the services there it was considered to be detrimental and divisive within such a small region. All health and social care trusts traditionally recruited from the same home-grown occupation categories and providing targeted awards at one group may destabilise the service provision in another trust area.

Targeting: our approach

9.14 There is a very strong consensus across all the parties against targeting, and we have been given no targeting proposals to consider for 2017-18. In reaching our conclusion, there are several factors that we consider to be important, which we assess as follows:

- Shortages of doctors in key specialties remain, and there are clear regional variations in fill rates. London tends to fill all its training posts, northern and remote and rural areas tend not to. In addition to the systemic issue of low fill rates in certain specialties in certain parts of the country, there are clear shortfalls, which all three health departments are trying to address through expansion in the consultant workforce and initiatives to recruit and retain GMPs. There are, however, no compelling arguments being made for addressing these recruitment and retention issues through targeting national pay scales. We see targeting via pay premia informed by nationwide agreement and local premia as being more appropriate here.
- The picture on workload, morale and wellbeing across our remit groups is worrying given the potential impact on patient care and the need for strong clinical engagement in transformation programmes. However, there is very little to justify targeting the award towards any one particular group on this basis.
- We remain to be convinced of the practicality of targeting pay effectively through national pay scales. By its nature, targeting is unlikely to require a nationwide response, but a coordinated menu of premia, agreed at a nationwide level, could provide a useful tool to supplement locally-determined pay premia. We also note again the lack of purchase we have on the pay of GMPs and GDPs as contractors and the salaried GPs they employ: differential pay targeting of these groups would need to feature within the contracting process over which we have little influence.
- We still consider that, given affordability constraints and the potential effect on the motivation of staff not targeted, the evidential base for national targeting needs to be high and we are glad that this has been recognised by the Department of Health (England). However, the Department has been unable to provide the data we have asked for in order to consider targeting properly – in particular, vacancy data. We therefore urge the Department, as well as Health Education England and NHS Employers, to continue making efforts here. Robust workforce data are crucial to managing the service and not just for us as a pay review body.
- We note the distinction that is drawn between the need to reduce pay differences in relation to training in certain specialties, as several of the proposed Flexible Pay Premia (FPP) appear to be designed to do, and the need to use pay incentives to attract people to particular roles and places, which are typically associated with Recruitment and Retention Premia (RRP), allowances for taking on extra responsibility and golden hellos. These all illustrate that pay does matter in order to recruit, retain and motivate our remit groups.
- We received no evidence for the targeting of dentists' pay on the basis of recruitment and retention.

9.15 For 2017-18, we have again concluded that we should not target our recommendations on the basis of recruitment and retention. While there are some stubborn shortages in certain specialties, these are more appropriately addressed by the kind of nationally-agreed flexible pay premia included in the newly introduced contract for junior doctors in England than by targeting pay scales. There are also some stubborn shortages in certain geographic locations, but again these would be more flexibly addressed by location-specific recruitment and retention premia than by targeting pay scales. While HM Treasury asked that we considered targeting within the overall pay award, none of the other parties considered that this would be appropriate or suggested how we might do it effectively in the current system.

9.16 However, we are not convinced by the arguments that shortages are not amenable to pay. They have persisted in certain geographic areas, and no evaluation of the various non-pay approaches in train has been provided to us. We continue to wait with interest for such evaluations. Meanwhile we note that local managements in practice are finding it very hard to use the pay flexibility that they have. The pressures on them to spend any available money on direct patient care are high and growing.

9.17 It is clear to us that the issue of shortages risks being ignored or at best handled piecemeal. We consider that non-pay measures have been given a more than reasonable time to address issues, so pay solutions should now be explored. However, existing local mechanisms are unlikely to be able to respond, and certainly not sufficiently speedily, or on the scale required.

Recommendation 1: We recommend that better use is made of existing pay flexibilities.

Recommendation 2: We recommend that health departments, employers, and workforce planners in England, Wales and Northern Ireland give serious consideration to developing a new mechanism for enabling targeted pay solutions, backed by extra national resources, to be locally stimulated and rapidly tested. These should aim to address persistent, above average geographic and specialty shortages. We look forward to hearing the results, in evidence next year, and would be happy to assist in developing criteria for payments if evidence is provided to us.

Targeting: pay premia

9.18 As set out in Chapter 5, the new junior doctor contract in England includes the provision for flexible pay premia (FPP), to encourage trainees to enter into certain specialties. We understand that these can be specialty-specific FPP, payable to trainees on identified programmes only effectively as a form of recruitment and retention payment, or payments that could, where appropriate, be paid only in certain regions or differentially between regions if supply was a local issue. Chapter 5 gives the details on which specialties have been selected for FPP for those coming onto the new junior doctors' contract in England in autumn 2016.

9.19 In Chapter 6 we discuss the fact that, despite the growth in consultant numbers, there are some specialties and regions with significant ongoing problems in recruiting sufficient numbers of staff. In England the shortfall is most obvious in accident and emergency, and occurs in most regions including London. However, the north also suffers from high shortfalls (of above ten per cent) in the acute take, pathology, psychiatry and cancer services. We do not have data at this level of granularity for Wales and Northern Ireland and so cannot comment on the position, although the issues appear to be similar. Our picture of the recruitment and retention issues relating to SAS doctors is only partial, and we look forward to receiving much more comprehensive evidence on this important group next year.

9.20 Chapters 7 and 8 cover General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs) respectively. Neither of these groups has a national pay system as they are contractors providing services rather than directly employed and so pay premia as such are not relevant. Chapter 7 refers to the range of separately funded initiatives in train to recruit and retain GMPs, given the extreme pressures in primary care and evidence of higher rates of leavers than joiners and some persistent vacancies. In contrast, Chapter 8 shows that recruitment and retention into dentistry remains buoyant in terms

of the availability of dentists to take on NHS contracts. The issues for GDPs are those of motivation and low morale, and we also note that there are now far more performer-only dentists than provider-performers.

9.21 We did not receive any evidence from the parties in relation to London weighting.

Our comments

9.22 We are required by our terms of reference to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists. We see the problem of shortages – both in terms of training fill rates and in consultant numbers – in this context.

9.23 We support the use of FPP to reduce pay differences in relation to training in certain specialties (see also our discussion of pay premia in Chapter 5). It is crucial that the recruitment pipeline into hospital specialties as well as into general practice is fully supported. There may well be scope to expand the use of the FPP model if national shortages are identified in certain specialties. However, we understand that the FPP identified for the first cohort entering the new junior doctors' contract in England do not include any aimed at addressing geographic supply shortages, which we see as using pay to incentivise the decision of where to locate and as equally important. In order to comment further we would like greater clarity about what our future role will be in selecting areas for FPP and the evidence that will be available to us. We would also like to understand how the RRP mechanism in the existing junior doctors' contracts in use in Wales, Northern Ireland and Scotland will continue to operate.

9.24 Our previous reports set out our view that we regard London weighting as a recruitment and retention premium issue, rather than one of cost compensation. We therefore did not intend to revisit our earlier decision that London weighting levels should remain at their existing levels, unless the parties were able to provide evidence to show that labour market conditions in London had changed. London training and consultant posts continue to be filled and we received no such evidence. We therefore believe that our earlier recommendation on London weighting should stand.

Pay proposals

9.25 The Department of Health's (England) written evidence stated that, in the absence of strong evidence to the contrary, its proposal was that a 1 per cent increase should apply to both employed doctors and independent contractors.

9.26 NHS Employers said that in the absence of an agreement on pay reform, there was consensus amongst employers in favour of the same percentage increase for all staff within the 1 per cent cap.

9.27 NHS England said that, in light of it having to deliver efficiency gains, it urged us to carefully consider what uplift, if any, was appropriate for 2017-18.

9.28 NHS Providers said that it did not oppose a 1 per cent pay award for 2017-18, on the understanding that it was fully funded through local and national contracts for 2017-18.

9.29 The Welsh Government's written evidence also did not specify a figure for 2017-18. In oral evidence, officials said that the Welsh Government had to operate within the UK Government's 1 per cent public sector pay policy until the end of the parliament and that Welsh settlements were structured around this, and more than 1 per cent would not be covered by the settlement.

9.30 Officials from the Northern Ireland Executive confirmed in oral evidence that they were factoring the 2016-17 pay policy of up to a maximum of a 1 per cent uplift into their planning for 2017-18, although the final decision on this rested with the Minister. They did not wish to see an inequitable approach in which doctors were treated differently to other NHS staff and so would wish 1 per cent for all.

9.31 The BMA did not propose a specific figure for 2017-18, but said that doctors should be treated in line with the wider economy, where pay settlements continued to run at higher than the public sector pay policy cap at around 2 per cent. It noted that if the wider economy was such that employers felt able to offer pay increases in the region of 2 per cent then it was unclear why the public sector should not be able to offer similar uplifts, from a fairness perspective as well as the likely impact on recruitment and retention as private sector jobs become relatively more attractive.

9.32 The BDA also did not cite a specific figure. However, it said that GDPs in all four countries had experienced similar reductions in taxable income and should receive the same pay uplift. It said that there was no difference in recruitment and retention issues for community dentists and salaried practitioners in each of the countries and did not wish to create any more differences in pay between the four countries.

Our comments

9.33 We have several concerns about the evidence we have received in relation to this year's pay uplift. Firstly, the departments and employer's organisations seem to us to have given little consideration to the possible effects of ongoing pay restraint on the recruitment, retention and motivation of our remit groups in their pay proposals. Should inflation and private sector wages continue to increase, it would be unwise to be complacent here, and we note that consultants, in particular, have taken a relatively larger decrease in take-home pay. Linked to this, as already discussed, the pay proposals given to us do not demonstrate sufficient regard to the need to address some severe ongoing shortages in medical staff in particular specialties and locations, and so do not help to move the situation forward. Lastly, we would welcome greater clarity from all parties on what they consider fair and appropriate pay levels would be for our different remit groups in relation to any comparators that the parties thought relevant in a 'steady state' environment. At present the focus is exclusively on the year-on-year increase, which means that the debate is tactical rather than strategic. We will also be undertaking a review of pay comparability in time for the next pay round.

Main pay recommendations

9.34 This year we are recommending on existing contracts, including the new junior doctors' contract in England. As ever, we have been guided by the evidence in formulating our pay recommendations. We continue to have in mind additionally the important concept of fairness. As we said last year, we seek to find a balance between the interests of our remit groups, of their employers, of the taxpayer, and of patients. In this context we note two factors that, while relevant throughout the public sector, apply particularly to our remit groups. First, our remit groups have a strong intrinsic motivation to practise their profession, but that does not preclude a perceived sense of unfairness adversely affecting their motivation. Second, they work in a sector where a single employer – the NHS – retains a dominant market position. Later in this chapter we discuss the evidence we received in relation to equal pay matters, which also relates to this theme of fairness. We also reiterate the importance of re-building relationships following the junior doctors' dispute in England, and wish to facilitate this where we can, in the interests of all parties.

9.35 Looking first at the wider economy, we note that the annual rate of increase in the Consumer Prices Index (CPI) of inflation at December 2016 was 1.6 per cent, and was forecast to reach 2.5 per cent by the end of 2017. The Annual Survey of Hours and Earnings showed that the median gross weekly earnings for full-time employees increased by 2.2 per cent in the year to April 2016. Earnings at the top decile (which we consider to be a more appropriate comparison for our remit groups) also increased by 2.2 per cent over the same period. We note that forecasts are subject to change. Nevertheless, the obvious conclusion is that a 1 per cent award would likely be below both inflation and wider settlements. This in turn begs the question of at what point the effects on recruitment, retention and motivation will start to make this policy unsustainable.

9.36 In relation to recruitment, the prevalence of staffing shortfalls, particularly across some hospital specialties and areas of general practice, are already a cause for concern. As we discuss in relation to targeting above, we consider that pay premia are more appropriate tools for addressing these than pay scales. However, the annual pay award is important in supporting the attractiveness of medical and dental careers. The Department of Health (England)'s aspiration towards self-sufficiency of supply makes this even more important.

9.37 In relation to motivation, the workload indicators in the NHS staff survey show a high degree of dissatisfaction, with 85 per cent of consultants working unpaid hours. SAS doctors, GMPs, GDPs and junior doctors are all under pressure and express perceptions of not being valued. There are concerns around wellbeing and stress. Yet engagement, and some satisfaction measures, are holding up, and pay levels are not yet looking hugely out of line with relevant comparators. These remain relatively highly-paid groups, and as set out in the earlier chapters, applications for undergraduate medical courses from well-qualified students are holding up, there is not a net outflow of trained doctors from the NHS and the supply of dentists willing to bid for NHS contracts remains solid.

9.38 In terms of affordability and departmental spending limits, the position has if anything got worse following the government's decision to borrow more in the Autumn Statement 2016 in order to maintain the spending plans agreed at the Comprehensive Spending Review in 2015. The scale of the efficiency challenge is set out in Chapter 2. All the health departments have, however, confirmed that they have assumed 1 per cent in their funding arrangements. We note again that there is already an expectation of a 1 per cent pay increase, and that the parties were clear that anything less would be demotivating.

9.39 The increasing demand being faced by the NHS is well-documented. We are aware of the relevance of this to affordability and we heard on our visits that staff would like to see additional staff and resources. We are also aware that the current financial settlement is front-loaded with funding increases anticipated to flatten in the next couple of years. We have had to consider all of these points in deciding on the appropriate pay uplift for this year.

9.40 In light of the wider economic forecasts, and the impact on take-home pay and hence motivation of a below-inflationary award, plus the increasing reliance on the goodwill of our remit groups, we have considered whether our award should be more than 1 per cent. However, alleviating workload and fostering job satisfaction, rather than more pay, appear to be the key immediate issues to enhance motivation. We also accept that the affordability constraint remains extremely powerful. In the light of the continuing expansion of staff numbers, we feel there is a continuing, though diminishing, case for limiting pay awards to 1 per cent again this year, if this enables more staff to continue to join the service to alleviate workload pressures.

9.41 We did consider differential recommendations by country, bearing in mind that our deliberations are for England, Wales and Northern Ireland as Scotland is considered in the supplement to this report. The BMA and BDA asked for UK-wide recommendations and gave evidence on that basis. None of the three health departments asked for anything

other than 1 per cent. We note that the affordability position is a bigger issue in Wales and Northern Ireland; however both were clear that they see themselves as part of the UK-wide market for doctors.

9.42 As noted earlier, we have concluded that targeting via national pay scales is not appropriate for 2017-18 but that targeting geographic shortages via pay premia is, and we have recommended accordingly (see recommendations 1 and 2). Our national pay recommendations are therefore for a base increase of 1 per cent in 2017-18 to the national salary scales for salaried doctors and dentists in England, Wales and Northern Ireland; an increase of 1 per cent to the top and bottom points on the pay range for salaried GMPs; and an increase in pay, net of expenses, of 1 per cent in 2017-18 for both independent contractor GMPs and GDPs in England, Wales and Northern Ireland. Individuals on incremental pay scales, who have not reached the maximum scale point, will also be eligible for incremental progression according to the agreed criteria. We note the announcement in February 2017 by NHS Employers and the BMA's General Practitioner's Committee of changes agreed to the GMS contract for 2017-18 including a pay uplift of 1 per cent.[1]

Recommendation 3: we recommend for 2017-18 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists in England, Wales and Northern Ireland.

Recommendation 4: we recommend that the maximum and minimum of the salary range for salaried GMPs in England, Wales and Northern Ireland be increased by 1 per cent for 2017-18.

Recommendation 5: for independent contractor GMPs in England, Wales and Northern Ireland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.

Recommendation 6: for independent contractor GDPs in England, Wales and Northern Ireland, we recommend an increase in pay, net of expenses, of 1 per cent for 2017-18.

9.43 Chapter 6 notes our comments on the consultant award schemes, and we also make a recommendation relating to the value of the awards. Chapter 7 includes our consideration of the GMP trainers' grant, the rate for GMP appraisers and the level of the general practice specialty registrar supplement.

Recommendation 7: for 2017-18, we recommend that the GMP trainers' grant be increased by 1 per cent in line with our main pay recommendation for GMPs.

Recommendation 8: for 2017-18, we recommend that the rate for GMP appraisers remains at £500.

[1] See 7 February 2017 announcement at http://www.nhsemployers.org/gms201718

Recommendation 9: for 2017-18, we recommend that the supplement payable to general practice specialty registrars remains at 45 per cent of basic salary for those on the existing UK-wide contract.

Recommendation 10: the value of the flexible pay premia included in the new junior doctors' contract in England should increase in line with our main pay recommendation of 1 per cent.

Recommendation 11: for 2017-18, we recommend that the value of the awards for consultants – Clinical Excellence Awards, Discretionary Points and Commitment Awards – be increased in line with our main pay recommendation of 1 per cent.

Equality and pay equality

9.44 Our terms of reference require us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

9.45 We focused in particular on gender pay and the gender pay gap, noting that the government is introducing mandatory gender pay gap reporting in the public sector from April 2017. However, we were also able to examine the overall profile of our remit groups in more detail given that new data were available to us.

Characteristics of our remit groups

9.46 This year, for the first time, NHS Digital published data on the age, gender and ethnicity profile of hospital doctors, the age and gender breakdown of GMPs and age and gender profiles of dentists.[2] These data are presented in earlier chapters, and show some interesting trends. In summary, these are:

- over half of training grade doctors and specialty registrars are female;
- around two-thirds of consultants are male;
- SAS doctors are most likely to be from Black, Asian, or Minority Ethnic (BAME) groups;
- there are more older, male GMP partners than younger, female GMP partners;
- salaried GMPs are generally younger and female; and
- performer-only dentists are generally younger and female. They also tend to work less than full-time.

9.47 In addition, as set out in more detail in Chapter 6, the level of BAME and female candidates applying for Clinical Excellence Awards (CEAs) is disproportionately low, although their percentage chance of success is similar.

9.48 The previous chapters set out the evidence we received in relation to each of our remit groups in more detail. Here we note the evidence received specific to equality issues.

[2] Health and Social Care Information Centre, General and Personal Medical Services, England September 2015 – 2016, Provisional Experimental statistics.

England

9.49 The Department of Health (England) stated that, in response to the gender equality concerns arising from the junior doctors' dispute (see also Chapter 5), they planned to introduce a series of non-contractual measures, with commitments to:

- a review of how best to offer training placements close to home for those with caring responsibilities, and couples wishing to work in close proximity;
- a review to inform a new requirement on trusts to consider caring and other family responsibilities when designing rotas;
- recognition of prior training when switching training path;
- improved rostering practices;
- addressing the particular concerns of foundation year doctors who often feel most disconnected during training as they will have yet to choose a specialty; and
- an independent review of the gender pay gap in the medical profession.

9.50 In oral evidence, the Department also stated that they recognised that junior doctors may feel better supported in their training if the concept of the 'firm' was brought back as a way of fostering team spirit and collaboration.

Our comments

9.51 We consider gender pay to be important, and note that the government is introducing of mandatory gender pay gap reporting in the public sector in 2017. We felt that, given the changing demography of the medical workforce, it was right for us to make key observations on fairness and equal pay as these issues could gain more prominence for our remit groups in the future. Research studies show that women doctors still earn less than their male colleagues and that this gap exists at all levels of responsibility. There is also an ethnicity pay gap: research shows that BAME doctors earn less than white doctors.

9.52 The demographic characteristics of our remit groups display some interesting trends that give pause for thought. While there is clear evidence of a gender pay gap (in part due to factors such as women tending to work fewer hours than men overall), we were not presented with evidence of how much of this difference was structural and how much was due to a difference in pay for equal work. Employers should be alert to such issues, given the recent and ongoing demographic shifts in the medical and dental workforces, including the higher proportion of doctors opting for locum and salaried work. We also highlight the comparatively high proportion of BAME individuals working as SAS doctors who tend to receive less pay and feel more demotivated than other NHS doctors. As we set out in Chapter 6, SAS doctors often feel undervalued and we encourage the parties to address this and their perceived lack of career progression.

9.53 In the absence of more reliable and extensive data, we are unable to comment further. We look forward to the results of the Department's independent review of gender pay in the NHS, and urge it to publish any initial findings as well as a timeline for publication.

Total reward and pensions

Total reward: pensions and other benefits

9.54 We heard a range of evidence on the total reward package offered by the NHS, and how its benefits are communicated to staff in order to convey a sense of the holistic value of NHS employment for doctors and dentists.

England

9.55 The Department of Health (England) informed us that its approach to contract reform was influenced by the interaction between pay and pensions. Increasing basic pay for junior doctors would help increase annual pension growth over previous pay arrangements. This was because under the Career Average Revalued Earnings method used by the reformed pension scheme, the level of pensionable earnings in each year of membership is taken into account. A higher proportion of pensionable pay earlier in their career would therefore lead to a larger pension.

9.56 The Department also stated that when considering changes to remuneration, it was important to consider other elements of the total reward package. These included employer pension contributions to pay and bonus. Recent HM Treasury analysis found that, on average, public sector workers benefited from a 10.4 per cent premium compared with their private sector counterparts. Public sector defined benefit pension schemes continued to be amongst the best available, with defined benefit schemes in the private sector largely replaced by less generous defined contribution schemes.

9.57 NHS Employers noted that the NHS continues to have a well-regarded package of employment benefits, including a generous pension scheme. In addition to pay and benefits, the organisation was increasingly seeing that employers in the NHS were broadening their definition of total reward to include recognition schemes, health and wellbeing initiatives and training and development programmes. Further, we heard that NHS organisations remain committed to enhancing the package of measures that they can put in place to recruit, retain, deploy and develop the NHS workforce in a way that responds to their aspirations and personal and family priorities. The largest local reward initiatives appear to remain salary sacrifice arrangements. However, as announced in the Chancellor's 2016 Autumn Statement, tax and employer National Insurance advantages of salary sacrifice schemes will be removed from April 2017, with some exceptions.[3]

9.58 NHS Employers noted that it had developed a range of reward tools and resources to support employers in developing their reward offer and reward communications, including guides, infographics, case studies and toolkits. NHS Employers noted that, in regard to pay comparability, the public sector employed a wide range of professional staff in a variety of disciplines. Many of those professions also had staff working outside the public sector on different terms and conditions, so the NHS had to make a competitive offer. However, it was difficult to draw exact comparisons, for example between the NHS and the independent sector, because of the differences in the total reward packages, including non-pay elements that those sectors provide. Therefore, we need to be confident that any comparisons beyond the public sector took all of these elements into account.

9.59 The BDA referenced an OME-commissioned report[4] which suggested that changes between 2010 and 2016 had potentially halved the value of the pension benefits built up by a GDP across their career, with this representing a reduction valued at around 10-15 per cent of NHS earnings. Significant actuarial work and expenditure would be required to confirm the actual reduction in NHS pension value for GDPs, and the figure quoted in this report carries a large margin of error. The BDA would like to commission further work to establish accurate figures for typical GDPs, to be considered in the light of the revised expenses formula which was under discussion.

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[3] Consultation outcome: Salary sacrifice for the provision of benefits-in-kind, 5 December 2016: https://www.gov.uk/government/consultations/salary-sacrifice-for-the-provision-of-benefits-in-kind

[4] Office of Manpower Economics, Research and modern pay systems, November 2016: https://www.gov.uk/government/publications/research-on-modern-pay-systems-november-2016

Wales

9.60 The Welsh Government stated that total reward approaches varied across all NHS Wales organisations. Total reward statements were available to all NHS Wales staff to access via an 'ESR' self-service system and they included financial personal details and employer benefits. A number of benefits were provided by all organisations, such as access to the NHS pension scheme, childcare vouchers, and flu vaccination programmes. However, there were some organisational variations with different benefit in kind schemes being offered.

Our comments

9.61 Total reward packages must be borne in mind when considering remuneration in order to take into account all of the benefits arising from NHS employment beyond basic pay. As we heard, total reward schemes are broadening and becoming more widespread and innovative as employers seek to find a way to reward and motivate staff within the constraints set by the 1 per cent public sector pay policy. We recognise that even following reform of pensions, the NHS pension scheme continues to provide significant benefits, although our remit groups will be contributing more than they did and, importantly, more than other staff in the future, for somewhat smaller benefits.

9.62 The reduced limit to the lifetime pension allowance represents a reduction in doctors' and dentists' total reward. We note that private sector pension schemes may well offer more flexible total reward arrangements, although locally designed benefits can also be agreed in England according to NHS Employers. Given that many of our remit group are likely at some stage to come up against either or both of the annual or lifetime allowances, it is important that appropriate support and advice is made available to help individuals manage their pensions, with further flexibility within the reward package, for example with return to work and opt-out arrangements in place, in order to reduce the number of early departures. HM Treasury indicated to us that it would consider revisions to the NHS pension scheme if there was evidence that the number of doctors and dentists taking early retirement as a result of its inflexibility was substantial. When requested, neither the Department of Health (England) nor NHS Employers provided us with quantitative evidence on this. We think it important that they do so next year. We discuss retirement trends further in Chapter 4.

Recommendation 12: We recommend that health departments and employers in England, Wales and Northern Ireland investigate how many doctors and dentists are taking early retirement and for what reasons, and provide us with evidence on this next year.

9.63 However, it is important to note that for total reward to be effective as a motivation and retention tool, it must be clearly communicated to staff, who need to be aware of its monetary as well as lifestyle value. The Welsh Government highlighted their use of 'total reward statements' which are one way of communicating the benefits to staff. We suggest that employers continue to seek new and innovative ways not only of using total reward to ease recruitment and retention pressures, but also of better communicating the value of the overall reward package on offer to NHS staff.

CHAPTER 10: LOOKING FORWARD

10.1 In this final chapter, we draw together the key themes of our report, and look ahead at some of the challenges facing our remit groups over the next few years. We also consider likely changes to the wider context and how these could impact on the recruitment, retention and motivation of doctors and dentists taking any part in the NHS.

Economic outlook and affordability

10.2 Since our last Report, several events have occurred which have contributed to an uncertain economic outlook. Most significantly, the Prime Minister is set to trigger Article 50 at the end of March 2017, but at the time of writing the form of renegotiation with Europe is unknown, as are the implications for the UK economy. However, depreciation of the pound and higher oil prices look likely to increase inflation rates, affecting real wages across the UK.

10.3 The affordability of the NHS across the UK will continue to be a key consideration and we recognise the scale of the challenges in each country. It is apparent that maintaining the public sector pay policy of 1 per cent over the spending review period would contribute markedly to the health departments' ambitions of meeting their demanding spending targets. Pay restraint offers a direct means of limiting increases to costs. However, if real pay levels for our remit group continue to decline at a time when pay in the private sector is rising, this will inevitably affect motivation, and could also damage recruitment and retention. That, in turn, would affect workloads, and a vicious circle could be created.

10.4 In the context of managing the paybill, we note the focus on reforming progression pay. We referred to this in our 2012 review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants, and our view remains that progression should be linked to performance and competence in the role. We note that the new junior doctors' contract has taken significant steps to link pay progression to stages of training. In England and Northern Ireland, we understand that the negotiations on the consultant contract include proposals to reduce the number of increments and link progression to performance.

Workforce planning and future supply

10.5 While it is too soon to judge the impact of 'Brexit' on our remit groups, all the health departments have made moves to reassure staff from overseas that they are a valued part of the NHS, and are looking to ensure security of supply. There does, however, need to be a more sophisticated understanding of how the UK-wide market in training doctors operates. There are common issues at play across all four countries, yet it seems to us that each is operating somewhat in isolation.

10.6 The characteristics and behaviours of 'Generation Y' will need to be taken into account by employers and policy makers. As millennials will make up a greater proportion of the workforce, it is important that employers react appropriately to ensure that they are able to recruit, retain and motivate this group. The Generation Y phenomenon, as it relates to medicine and dentistry, should not be seen in isolation from other changes, such as the shift in gender balance of those choosing to train as doctors or dentists and their ethnicity. While there is not sufficient evidence to draw definitive conclusions at this stage, this is a theme worthy of further exploration, and one likely to affect the long-term sustainability of the workforce.

10.7 Our Report also comes at a time of substantial change and challenge for the NHS across the UK. New and innovative approaches will be required to meet the demands of an increasing, ageing population with multiple complex health needs who are placing extra pressure on the system. Added to this are the difficulties posed by the wider economic position and the state of the public finances, including NHS finances. These pressures will undoubtedly continue to impact on our remit group.

10.8 The government's aspiration is to shift care into primary and community settings, but there are multiple tensions between major transformation and financial constraint. The success of the Sustainability and Transformation Plans in England will be crucial in delivering more effective and efficient healthcare. However, there must be uncertainty about how far, and how quickly, these will achieve the intended benefits. We heard that many of the draft plans were formulated with only limited clinical or patient involvement. Against a background of tight resources and increasing demands, it will take very careful leadership and management to ensure healthcare reform is implemented smoothly.

Doctors and Dentists in Training

10.9 While only a relatively small number of trainees transferred over to the new contract in England in October 2016, around 7,000 were due to do so in December. We look forward to receiving feedback on the experience of transition for these doctors. It will also be important for the contract to be regularly reviewed and updated. NHS Employers and the BMA agreed to commission a review by August 2018 which will consider the efficacy of the contract and identify any areas for improvement.

Hospital doctors

10.10 In relation to geographic shortages, we note that the facility to use Recruitment and Retention Premia (RRP) in the consultant contract is still not widely used by employers. While we understand this when there is an overall shortage in the supply of a particular specialty, it should not preclude employers from using RRP to encourage recruitment to address local shortages that may be related to the attractiveness of working in a particular region. We have therefore recommended that better use is made of existing pay flexibilities and recommended that serious consideration is given to developing a new mechanism for enabling targeted pay solutions.

10.11 As we noted last year, SAS doctors are an important part of the NHS workforce and continue to play a key role in the provision of services, although they appear to have slipped down the priority order in terms of the attention they are given. We would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive. We consider that the NHS is likely to continue to rely on SAS doctors and as they play a leading role in healthcare delivery should be appropriately remunerated and given adequate access to training and development. Improved evidence is required from all parties to be able to draw any sound conclusions and to fully understand if their contracts, and crucially for us their pay, are fit for purpose. We are pleased to hear that the BMA plans to undertake a substantive project on SAS doctors for next year's round, which we look forward to with great interest.

General Medical Practitioners

10.12 The general practice landscape is undoubtedly complex and shifting. The move towards larger practices or federations could impact on future service delivery and perhaps increase the use of the salaried model. The vision set out for healthcare delivery in England under the Five Year Forward View, with the increased emphasis on primary care would appear sensible. However, it would be fair to observe that achieving this vision will be extremely challenging in the current circumstances of high and increasing demand

for services. While some aspects are very similar for Wales and Northern Ireland, such as recruitment difficulties in rural areas, these countries face their own distinct challenges. The situation appears particularly serious in Northern Ireland.

10.13 While we did not receive a great deal of evidence on salaried GMPs, we note that they are much more likely to be younger and female than GMP partners. Despite generally lower annual earnings, it appears to be an increasingly popular choice for new doctors, which could be due to the greater flexibility and work-life balance this role can offer over partnership. More GMPs also seem to be opting for locum roles for similar reasons. Overall, there is insufficient evidence for us to draw firm conclusions, but we will closely monitor this group, as there could be implications for the future planning and delivery of primary care, especially given the potential decrease in full-time working. Crucially for us, if these changes become widespread, contracts and pay rates for salaried GMPs will need consideration particularly whether greater structure is required in order to gain greater predictability in pay for this group.

Dentists

10.14 We are concerned by the BDA's findings and comments on motivation among dentists, and its assessment that NHS dentistry has reached crisis point due to pay and workload issues. There is a contrast between this assessment and that of the health departments, who reported an increase in the supply of dentists and improving access for patients and quality of care. We require more evidence on dentists' motivation in order to reconcile these differing pictures, including consideration of the impact of Brexit on staff from overseas, when this is available. We ask all parties, but in particular, health departments and NHS England, to provide further evidence and analysis on this topic for next year's round.

Conclusions for pay

10.15 In summary, it seems likely that:

- demands from patients and the NHS in general for the services of our remit groups will not decrease, and, in the short term (two to three years), demands are much more likely to increase;
- there will continue to be some specialties, and some locations, where there is a mismatch between the availability of qualified medical/dental practitioners, and the demand for them; and
- public finances will be tight, creating continuing affordability constraints within the NHS, and an imperative to spend resources wisely.

10.16 These challenges will increase pressure on our remit groups. In facing these challenges, we note that:

- our remit groups remain highly motivated by the value of their work, and the satisfaction that they get from practising medicine or dentistry;
- there remains a strong general desire to join the medical and dental professions; if student demand were the sole criterion, medical and dental schools could substantially increase the number of places they provide; and
- government relations with the medical profession suffered during the junior doctors' dispute, and trust is only gradually being rebuilt.

10.17 We also note that our remit groups are changing, as society is changing. Different models are emerging for the supply of healthcare. The growth in salaried GMPs, in performer-only dentists, and in qualified medical practitioners actively opting for locum roles; all suggest a slow but steady shift in priorities and behaviours, especially for the younger members of our remit groups (those we have referred to in this Report as

'Generation Y'). At the same time, changes in the NHS more generally, and to pension taxation arrangements, are affecting the retirement choices made by the older members of our remit groups.

10.18 We believe that some of the recruitment and retention challenges could be addressed by appropriate, targeted pay and reward initiatives. In principle the pay system already offers potential for local flexibilities of this sort. In practice it has proved extremely challenging for local managements to develop and use these. Local expertise in devising and managing new pay initiatives is in short supply, and management attention focuses on maintaining services to patients day to day.

10.19 Given the changing circumstances and aspirations within our remit groups, we think it highly desirable that different types of targeted pay and reward incentives should be explored, including some that might be radically new. A single set of nationwide solutions would be slow to develop, and risk being poorly adapted to local needs. However, at present we see no mechanism for enabling new ideas, backed by appropriate resources, to be locally stimulated and tested rapidly. Given the costs to the whole NHS of handling shortages of key people, we believe that the leaders of the system – health departments in all three countries, NHS England, NHS Improvement, Health Education England – should look to fill this gap. The Sustainability and Transformation Planning process has illustrated the potential benefits of a centrally driven initiative to stimulate local thinking.

10.20 Meanwhile, we attach great importance to the motivation and morale of our remit groups, across the whole NHS, during a period when staff will continue to be under pressure; when inflation seems likely to rise; and when private sector earnings are also likely to increase. If there are affordability constraints across the public sector, our remit groups will be affected, but they should not feel singled out by government for particularly severe sacrifices. One of our important roles as a Review Body is to advise on this, ensure a fair balance and monitor sustainability of the recruitment, retention and motivation of our remit groups. Consideration therefore needs to be given to planning an exit strategy at the end of the pay policy period.

Future data requirements

10.21 We very much welcome the progress being made particularly in England on the provision of better workforce data, especially relating to the introduction of the workforce minimum data set for primary care. This is critical to good decision-making by the health system, as well as to our consideration of pay recommendations and the merits of targeting. A large number of organisations and working groups provide us with such information, for which we are grateful.

10.22 Several gaps have emerged during this round and Table 10.1 summarises these, by UK country. We are interested in these data broken down by staff group, region, gender and age where possible.

Table 10.1: Data gaps by UK country

	England	Wales	Northern Ireland
Paybill data (Chapter 2)	Continue to provide average earnings. Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Average earnings. Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Average earnings. Sample career pathways.
Staff survey results by hospital medical and dental group (Chapters 3 and 6)	Breakdown by age/ sex and staff group.	Breakdown by staff group.	Breakdown by staff group.
Workforce planning assumptions and analysis (Chapter 4)	Further details of the assumptions used to forecast supply and demand. Potential impact of Brexit and measures to mitigate the impact.	Evidence of workforce planning. Potential impact of Brexit and measures to mitigate the impact.	Evidence of workforce planning. Potential impact of Brexit and measures to mitigate the impact.
Retirement trends and Pensions (Chapter 4)	Rates of early retirement and returns. Withdrawals from pension schemes. Data on the impact of pension tax changes.	Rates of early retirement and returns. Withdrawals from pension schemes. Data on the impact of pension tax changes.	Rates of early retirement and returns. Withdrawals from pension schemes. Data on the impact of pension tax changes.
Locum use and rates (Chapter 4)	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.
Career choices for junior doctors (Chapter 5)	Career paths of junior doctors. Understanding of why they make those choices.	Career paths of junior doctors. Understanding of why they make those choices.	Career paths of junior doctors. Understanding of why they make those choices.
Vacancy rates (Chapters 4, 5, 6, 7, 8)	Dentists in training. SAS doctors. Consultants. GMPs and GDPs.	Vacancy or shortfall rates across all remit groups. Junior doctor fill rates by region and specialism.	Vacancy or shortfall rates across all remit groups. Junior doctor fill rates by region and specialism.

	England	Wales	Northern Ireland
Hospital doctors (Chapter 6)	SAS doctors recruitment and retention patterns. Use of the SAS Development Fund.	SAS doctors recruitment and retention patterns. Use of the SAS Development Fund.	SAS doctors recruitment and retention patterns. Use of the SAS Development Fund.
GMP and GDP motivation data (Chapters 7 and 8)	GMP motivation survey. Wider survey of GMPs and GDPs similar to the hospital survey. Systematic data on salaried GMPs and GDPs.	GMP and GDP motivation. Systematic data on salaried GMPs and GDPs.	GMP and GDP motivation. Systematic data on salaried GMPs and GDPs.
GMP and GDP earnings by FTE (Chapters 7 and 8)	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs. NHS and private earnings split.	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs and GDPs. NHS and private earnings split.	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs and GDPs. NHS and private earnings split.
Pay recommendations (Chapter 9)	Gender pay analysis. Department of Health independent review of gender pay in the NHS. Relevant comparator group pay.	Gender pay analysis. Relevant comparator group pay.	Gender pay analysis. Relevant comparator group pay.

APPENDIX A: REMIT LETTERS FROM THE PARTIES

OFFICIAL

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Professor Paul Curran
Chair of the DDRB
c/o Office of Manpower Economics
Fleetbank House
2-6 Salisbury House
EC4Y 8JX

17th July 2016

Dear Professor Curran,

PUBLIC SECTOR PAY 2017-18

1 Thank you for your work on the 2016-17 pay round. The Pay Review Bodies continue to play an invaluable role in making independent, evidence-based recommendations on public sector pay awards, as well as continuing to provide high-quality advice on wider reforms to pay and allowances policy. I am extremely grateful to you and your colleagues for your considered work. Over the remainder of the Parliament I look forward to the Pay Review Bodies continuing to advise the Government on how best to achieve pay reforms and deliver fair and sustainable pay awards for public sector workforces

2. As you know the fiscal context remains very challenging following the outcome of the EU referendum vote. However, the Government's public sector pay policy, announced at Summer Budget 2015 and reaffirmed in the Autumn Statement and Spending Review 2015, was intended to enable prudent long-term planning while protecting jobs, and I can confirm that this policy remains in place. We will fund public sector workforces for pay awards of an average of 1 per cent a year, up to 2019/20.

3. As I set out in my letter to you last year, I expect to see targeted pay awards, in order to support the continued delivery of public services, and to address

OFFICIAL

recruitment and retention pressures. This may mean that some workers could receive more than 1 per cent whilst others receive less, and there should be no expectation that every worker will receive a 1 per cent pay award. I am aware that this requires you to receive good, evidence-based propositions to consider.

4. Relevant Secretaries of State will write to you shortly with their remit letters, as and where needed. Relevant departments will submit their proposals covering the specific needs of their workforces in their evidence to you in the early autumn. I look forward to your 2017-18 recommendations.

Yours sincerely,

GREG HANDS

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Mb-sofs@dh.gsi.gov.uk

Professor Sir Paul Curran
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

22 August 2016

Dear Professor Curran,

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Greg Hands, on 13 July confirming the Government's approach to pay awards in the public sector for 2017-18.

I am grateful for the invaluable work you and your members carry out on behalf of all those that participate in the pay review process. The government has made it clear that pay restraint in the public sector continues to be a crucial part of its plans for the continued prudent management of public finances to help support long term planning and to help protect jobs. I appreciate that this continues to present challenges, but your expertise, and impartial and independent judgement are vital as employers and staff respond to the unprecedented challenges facing the NHS.

In his letter to you, the Chief Secretary to the Treasury asked that you consider how an award might be targeted to support recruitment and retention.

We recognise the importance of pay investment supporting recruitment and retention of staff within the NHS and independent contractors and would welcome the Review Body's recommendations. You have previously highlighted to us the importance of developing better measures that would enable you to take an evidence-based view of recruitment and retention issues

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

and assess whether there is a case for targeting pay investment. My department will set out the progress we are making towards giving you that evidence in the autumn.

The Review Body's last report noted that there has been an expansion of the salaried model in general practice and that understanding this trend would be important. The Government would welcome the Review Body's observations, based on any evidence the parties could provide, about the factors affecting recruitment, retention and motivation of this group.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/6288/16

Professor Paul Curran
Chair, Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
6th Floor
Victoria House
London
WC1B 4AD
By Email: Tony.Symmonds@bis.gsi.gov.uk

22 August 2016

Dear Paul,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION – REMIT 2017-18

I am writing to confirm that I would appreciate the Review Body providing me with pay remit recommendations for 2017-18 in relation to all staff in Wales engaged on medical and dental terms and conditions. I would also welcome your recommendations about general medical practitioners and general dental practitioners, particularly on how an overall pay uplift might be applied in Wales. In particular, for general medical practitioners, we would welcome observations about the issues affecting their recruitment, retention and motivation.

Any recommendations should take into account the UK Government's public sector pay policy as well as addressing the recruitment and retention challenges faced by all UK health departments more generally. My officials will be happy to work with your secretariat to ensure all relevant supporting information is made available to meet the Review Body's timelines.

I am copying this letter to the Secretary of State for Wales, the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland and the Minister for Health, Social Services and Public Safety in Northern Ireland.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

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FROM THE MINISTER OF HEALTH

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Our Ref: SUB/1182/2016

Date: 3 August 2016

Paul, a chara

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION REMIT 2017/18

I wish to begin by conveying my thanks to the Review Body on Doctors and Dentists Remuneration (DDRB) for its work on the 2016/17 pay round and to offer my apologies for the delay in submitting last year's remit and evidence. My Department values the work of the pay review body and its important role in making recommendations on the remuneration of doctors and dentist taking part in the NHS/HSC.

I write to confirm the approach of my Department in respect of the DDRB 2017/18 remit and would advise that it is our intention to submit evidence for the pay round before the end of September 2016 and to seek recommendations by mid February 2017 on remuneration for salaried doctors and dentists employed in Health and Social Care (HSC).

For GDP and GMP contractors, the DDRB are invited to make recommendations on remuneration and my Department would also welcome your views as to how an overall pay uplift could be applied.

The NI Executive has endorsed the principle of adherence to the UK Government's public sector pay policy and, therefore, any proposal will be constrained by calls for continued pay restraint and indeed the continuing financial challenges within HSC.

I am copying this letter to the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland and the Minister for Health, Social Services in Wales and Staff Side representatives.

Is mise le meas

Michelle O'Neill

MICHELLE O'NEILL MLA
Minister of Health

Cabinet Secretary for Health and Sport
Shona Robison MSP

T: 0300 244 4000
E: scottish.ministers@scotland.gsi.gov.uk

The Scottish Government
Riaghaltas na h-Alba

Professor Sir Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
8th Floor
Fleetbank House
2-6 Salsbury Square
LONDON EC4Y 8JX

20 December 2016

Dear Professor Curran,

Further to the letter my colleague, Derek Mackay, Cabinet Secretary for Finance and the Constitution, sent on 30 September, I am now pleased to present you with further details of our remit and the evidence for employed doctors and dentists for the 2017 pay round which we would like you to consider. I apologise that, for the reasons outlined in Mr Mackay's letter, we are later than we would have liked in sending you this information.

The Cabinet Secretary for Finance and the Constitution announced the Scottish Government's Public Sector Pay Policy for 2017-18 on 15 December 2016 as part of his draft budget announcements. This pay policy provides the basis for the remit we would like you to consider. It is a single year policy and sets out the parameters for pay increases for staff. A copy of the policy is available here.

With regard to DDRB interests, the main features of this policy are:

- An overall 1 per cent cap on the cost of the increase in the baseline paybill for those earning over £22,000.
- Flexibility to use paybill savings to consider meaningful reconstruction of pay and grading systems to address evidenced equality issues.
- Continuing the expectation to negotiate an extension to the no compulsory redundancy agreement as part of constructive, collaborative discussions between employers and their trade unions to make the most effective use of the funding available.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

You will appreciate that all consideration of staff pay by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland for 2017-18. It is important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

For General Practitioners we again seek the DDRB's recommendation in respect of GP pay and contractual uplift. The Scottish Government and the BMA's Scottish General Practitioners Committee have agreed to jointly commission a review of general practice funding, pay and expenses. This should provide better information to inform both accurate recompense of expenses and options for the long term overall development of GP pay in Scotland. This will take place in 2017, and inform options from 2018.

I would again like to take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to value the independent voice which the Review Body offers on doctors' and dentists' pay.

Copies of this letter will be sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS employers.

Yours Sincerely,

SHONA ROBISON

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www.gov.scot

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN ENGLAND

PART I: SALARY SCALES[1]

The salary scales that we recommend should apply from 1 April 2017 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	2016	2017
	£	£
Foundation house officer 1	22,862	23,091
	24,289	24,532
	25,716	25,973
Foundation house officer 2	28,357	28,640
	30,211	30,513
	32,066	32,386
Specialty registrar (full)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Specialty registrar (fixed term)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491

[1] Our recommended basic pay uplifts, to be applied from 1 April 2017, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

	2016	2017
	£	£
Specialist registrar[2]	31,614	31,931
	33,180	33,512
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Doctors in training (2016 contract)	26,350	26,614
	30,500	30,805
	36,100	36,461
	45,750	46,208
Dentists in training (2016 contract)	36,100	36,461
	45,750	46,208
Consultant (2003 contract, England for main pay thresholds)	76,001	76,761
	78,381	79,165
	80,761	81,568
	83,141	83,972
	85,514	86,369
	91,166	92,078
	96,819	97,787
	102,465	103,490
Consultant (pre-2003 contract)[3]	63,102	63,733
	67,617	68,293
	72,133	72,855
	76,649	77,415
	81,798	82,616

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

[3] Closed to new entrants.

	2016	2017
	£	£
Specialty doctor[4]	37,547	37,923
	40,758	41,165
	44,931	45,381
	47,168	47,640
	50,391	50,895
	53,602	54,138
	56,884	57,453
	60,168	60,770
	63,452	64,086
	66,734	67,402
	70,018	70,718
Associate specialist (2008)[5]	52,643	53,169
	56,875	57,444
	61,105	61,716
	66,693	67,359
	71,535	72,251
	73,544	74,280
	76,166	76,928
	78,788	79,576
	81,409	82,224
	84,031	84,871
	86,655	87,521
Associate specialist (pre-2008)	38,451	38,836
	42,524	42,950
	46,596	47,062
	50,668	51,175
	54,741	55,289
	58,813	59,402
	64,191	64,833
	68,852	69,541

[4] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

[5] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Discretionary Points	*Notional scale*	
	70,787	71,495
	73,310	74,043
	75,833	76,592
	78,357	79,140
	80,880	81,689
	83,406	84,240
Staff grade practitioner	34,786	35,133
(1997 contract, MH03/5)	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	49,082	49,573
Discretionary Points	*Notional scale*	
	51,353	51,867
	54,114	54,655
	56,876	57,444
	59,637	60,234
	62,398	63,022
	65,161	65,812
Staff grade practitioner	34,786	35,133
(pre-1997 contract, MH01)	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	48,592	49,078
	51,353	51,867
	54,114	54,655
Clinical Excellence Awards	2,986	3,016
	5,972	6,032
	8,958	9,048
	11,944	12,064
	14,930	15,080
	17,916	18,096
	23,888	24,128
	29,860	30,160
	35,832	36,192

	2016	2017
	£	£
	(Annual rate on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,699	4,746
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,598	4,644
	4,864	4,913
	5,132	5,183
	5,398	5,452
	5,664	5,721
	5,930	5,989
	6,196	6,258

B. Community health staff

	2016	2017
	£	£
Clinical medical officer	33,323	33,657
	35,128	35,479
	36,932	37,301
	38,736	39,123
	40,540	40,945
	42,344	42,767
	44,148	44,589
	45,953	46,413
Senior clinical medical officer	47,089	47,560
	49,956	50,455
	52,821	53,349
	55,686	56,243
	58,553	59,138
	61,418	62,032
	64,283	64,926
	67,150	67,821

C. Salaried primary dental care staff[6]

	2016	2017
Band A: Salaried dentist	£	£
	38,476	38,861
	42,751	43,178
	49,164	49,655
	52,370	52,894
	55,576	56,132
	57,714	58,291
Band B: Salaried dentist[7]	59,851	60,450
	61,989	62,609
	65,195	65,847
	66,798	67,466
	68,401	69,085
	70,004	70,704
Band C: Salaried dentist[8, 9, 10]	71,608	72,324
	73,745	74,483
	75,883	76,641
	78,020	78,800
	80,158	80,959
	82,295	83,118

[6] These scales also apply to salaried dentists working in Personal Dental Services.

[7] The first salary point of Band B is also the extended competency point at the top of Band A.

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

[9] The first salary point of Band C is also the extended competency point at the top of Band B.

[10] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES

1. The fee for domiciliary consultations should be increased from £84.20 to £85.04 per visit. Additional fees should be increased *pro rata*.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[11]		Per notional half day	
	2016	2017	2016	2017
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,010.79	1,020.91	91.89	92.81
Hospital practitioner appointment			103.51	104.55
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			90.11	91.01

	Per week[12]		Per standard hour	
	2016	2017	2016	2017
	£	£	£	£
Specialty registrar (higher rate) appointment	900.96	910.08	18.77	18.96
Specialty registrar (lower rate) appointment	817.92	826.08	17.04	17.21
Specialist registrar appointment	900.96	910.08	18.77	18.96
Foundation house officer 2 appointment	695.52	702.24	14.49	14.63
Dental core training appointment	780.96	788.64	16.27	16.43
Foundation house officer 1 appointment/ House officer appointment	559.20	564.96	11.65	11.77

	Per week[13]		Per session	
	2016	2017	2016	2017
	£	£	£	£
Staff grade practitioner appointment	852.50	861.00	85.25	86.10

	Per week[14]		Per programmed activity	
	2016	2017	2016	2017
	£	£	£	£
Specialty doctor appointment	861.70	870.40	86.17	87.04
Associate specialist appointment (2008)	1,171.90	1,183.60	117.19	118.36

[11] The notional half day rate multiplied by 11.

[12] The hourly rates given for junior doctors are the basic rate (the midpoint of the current salary scale) divided by 365, multiplied by 7 and divided by 40, rounded up to the nearest penny. The weekly rates are the hourly rates multiplied by 1.2 and multiplied by 40. Hourly and weekly rates have not been adjusted for banding.

[13] The per session rate multiplied by 10.

[14] The per programmed activity rate multiplied by 10.

Flexible pay premia – doctors and dentists in training (2016 contract)

	2016	2017
	£	£
General Practice	8,200	8,282
Psychiatry Core Training	3,334	3,367
Psychiatry Higher Training (3 year)	3,334	3,367
Psychiatry Higher Training (4 year)	2,500	2,525
Academia	4,000	4,040

Emergency Medicine

		2016	2017
		£	£
Emergency Medicine	3 years	6,667	6,734
	4 years	5,000	5,050
	5 years	4,000	4,040
	6 years	3,334	3,367
	7 years	2,858	2,886
	8 years	2,500	2,525

London weighting

3. The value of the London zone payment[15] is unchanged at £2,162 for non-resident staff and £602 for resident staff.

Doctors in public health medicine

4. The supplements payable to directors and regional directors of public health are:

	2016			2017		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,557	7,113	8,892	3,593	7,184	8,981
Band C	4,462	8,892	10,685	4,506	8,981	10,792
Band B	5,337	10,685	13,782	5,390	10,792	13,920
Regional director of public health: Band A	13,782	20,006		13,920	20,207	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

5. The supplement payable to general practice specialty registrars is 45 per cent[16] of basic salary.

6. The salary range for salaried general medical practitioners (GMPs) employed by primary care organisations should be increased from £55,965 – £84,453 to £56,525 – £85,298.

[15] *Thirty-Sixth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

[16] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

PART I: SALARY SCALES[17]

The salary scales that we recommend should apply from 1 April 2017 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	2016	2017
	£	£
Foundation house officer 1	22,862	23,091
	24,289	24,532
	25,716	25,973
Foundation house officer 2	28,357	28,640
	30,211	30,513
	32,066	32,386
Foundation house officer 1 (pre-2015 contract)	22,976	23,205
	24,409	24,654
	25,843	26,102
Foundation house officer 2 (pre-2015 contract)	28,497	28,782
	30,361	30,664
	32,224	32,546
Dental core training[18]	28,497	28,782
	30,361	30,664
	32,224	32,546
	34,088	34,429
	35,951	36,311
	37,815	38,193
	39,678	40,075

[17] Our recommended basic pay uplifts, to be applied from 1 April 2017, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

[18] This was formally dental trainees in hospital posts or senior house officer.

	2016	2017
	£	£
Specialty registrar (full)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Specialty registrar (fixed term)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
House officer	22,976	23,205
	24,409	24,654
	25,843	26,102
Specialist registrar[19]	31,614	31,931
	33,180	33,512
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123

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

	2016	2017
	£	£
Consultant (2003 contract, Wales)	73,656	74,393
	76,001	76,761
	79,925	80,724
	84,482	85,327
	89,686	90,582
	92,653	93,579
	95,626	96,582
Commitment Awards[20]	3,237	3,268
	6,473	6,536
	9,709	9,804
	12,945	13,072
	16,181	16,340
	19,417	19,608
	22,653	22,876
	25,889	26,144
Specialty doctor[21]	37,547	37,923
	40,758	41,165
	44,931	45,381
	47,168	47,640
	50,391	50,895
	53,602	54,138
	56,884	57,453
	60,168	60,770
	63,452	64,086
	66,734	67,402
	70,018	70,718
Associate specialist (2008)[22]	52,643	53,169
	56,875	57,444
	61,105	61,716
	66,693	67,359
	71,535	72,251
	73,544	74,280
	76,166	76,928
	78,788	79,576
	81,409	82,224
	84,031	84,871
	86,655	87,521

[20] Awarded every three years once the basic scale maximum is reached.

[21] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

[22] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Associate specialist (pre-2008)	38,451	38,836
	42,524	42,950
	46,596	47,062
	50,668	51,175
	54,741	55,289
	58,813	59,402
	64,191	64,833
	68,852	69,541
Discretionary Points	*Notional scale*	
	70,787	71,495
	73,310	74,043
	75,833	76,592
	78,357	79,140
	80,880	81,689
	83,406	84,240
Staff grade practitioner (1997 contract, MH03/5)	34,786	35,133
	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	49,082	49,573
Discretionary Points	*Notional scale*	
	51,353	51,867
	54,114	54,655
	56,876	57,444
	59,637	60,234
	62,398	63,022
	65,161	65,812
Staff grade practitioner (pre-1997 contract, MH01)	34,786	35,133
	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	48,592	49,078
	51,353	51,867
	54,114	54,665

	2016	2017
	£	£
	(Annual rate on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,699	4,746
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,598	4,644
	4,864	4,913
	5,132	5,183
	5,398	5,452
	5,664	5,721
	5,930	5,989
	6,196	6,258

B. Community health staff

	2016	2017
	£	£
Clinical medical officer	33,323	33,657
	35,128	35,479
	36,932	37,301
	38,736	39,123
	40,540	40,945
	42,334	42,767
	44,148	44,589
	45,953	46,413
Senior clinical medical officer	47,089	47,560
	49,956	50,455
	52,821	53,349
	55,686	56,243
	58,553	59,138
	61,418	62,032
	64,283	64,926
	67,150	67,821

C. Salaried primary dental care staff[23]

	2016	2017
	£	£
Band A: Salaried dentist	38,476	38,861
	42,751	43,178
	49,164	49,655
	52,370	52,894
	55,576	56,132
	57,714	58,291
Band B: Salaried dentist[24]	59,851	60,450
	61,989	62,609
	65,195	65,847
	66,798	67,466
	68,401	69,085
	70,004	70,704
Band C: Salaried dentist[25, 26, 27]	71,608	72,324
	73,745	74,483
	75,883	76,641
	78,020	78,800
	80,158	80,959
	82,295	83,118

[23] These scales also apply to salaried dentists working in Personal Dental Services.

[24] The first salary point of Band B is also the extended competency point at the top of Band A.

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

[26] The first salary point of Band C is also the extended competency point at the top of Band B.

[27] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES

1. The fee for domiciliary consultations should be increased from £84.20 to £85.04 per visit. Additional fees should be increased *pro rata*.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[28]		Per notional half day	
	2016	2017	2016	2017
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,010.79	1,020.91	91.89	92.81
Hospital practitioner appointment			103.51	104.55
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			90.11	91.01

	Per week[29]		Per standard hour	
	2016	2017	2016	2017
	£	£	£	£
Specialty registrar (higher rate) appointment	900.96	910.08	18.77	18.96
Specialty registrar (lower rate) appointment	817.92	826.08	17.04	17.21
Specialist registrar appointment	900.96	910.08	18.77	18.96
Dental core training appointment	780.96	788.96	16.27	16.43
Foundation house officer 2 appointment	695.52	702.24	14.49	14.63
Foundation house officer 1 appointment/ House officer appointment	559.20	564.96	11.65	11.77

	Per week[30]		Per session	
	2016	2017	2016	2017
	£	£	£	£
Staff grade practitioner appointment	852.50	861.00	82.25	86.10

	Per week[31]		Per programmed activity	
	2016	2017	2016	2017
	£	£	£	£
Specialty doctor appointment	861.70	870.40	86.17	87.04
Associate specialist appointment (2008)	1,171.90	1,183.60	117.19	118.36

[28] The notional half day rate multiplied by 11.

[29] The hourly rates given for junior doctors are the basic rate (the midpoint of the current salary scale) divided by 365, multiplied by 7 and divided by 40, rounded up to the nearest penny. The weekly rates are the hourly rates multiplied by 1.2 and multiplied by 40. Hourly and weekly rates have not been adjusted for banding.

[30] The per session rate multiplied by 10, except in 2016.

[31] The per programmed activity rate multiplied by 10.

Doctors in public health medicine

3. The supplements payable to directors of public and for regional directors of public health are:

	2016			2017		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,557	7,113	8,892	3,593	7,184	8,981
Band C	4,462	8,892	10,685	4,506	8,981	10,792
Band B	5,337	10,685	13,782	5,390	10,792	13,920
Regional director of public health: Band A	13,782	20,006		13,920	20,207	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[32] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,965 – £84,453 to £56,526 – £85,298.

[32] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

PART I: SALARY SCALES[33]

The salary scales that we recommend should apply from 1 April 2017 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	2016	2017
	£	£
Foundation house officer 1	22,862	23,091
	24,289	24,532
	25,716	25,973
Foundation house officer 2	28,357	28,640
	30,211	30,513
	32,066	32,386
Specialty registrar (full)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,980	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Specialty registrar (fixed term)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491

[33] Our recommended basic pay uplifts, to be applied from 1 April 2017, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

	2016	2017
	£	£
Specialist registrar[34]	31,614	31,931
	33,181	33,512
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,980	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Consultant (2003 contract, Northern Ireland for main pay thresholds)	76,001	76,761
	78,381	79,165
	80,761	81,568
	83,141	83,972
	85,514	86,369
	91,166	92,078
	96,819	97,787
	102,466	103,490
Consultant (pre-2003 contract)[35]	63,102	63,733
	67,617	68,293
	72,133	72,855
	76,649	77,415
	81,798	82,616
Specialty doctor[36]	37,548	37,923
	40,758	41,165
	44,932	45,381
	47,168	47,640
	50,391	50,895
	53,602	54,138
	56,884	57,453
	60,168	60,770
	63,451	64,086
	66,735	67,402
	70,018	70,718

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

[35] Closed to new entrants.

[36] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Associate specialist (2008)[37]	52,643	53,169
	56,875	57,444
	61,105	61,716
	66,692	67,359
	71,535	72,251
	73,544	74,280
	76,166	76,928
	78,788	79,576
	81,409	82,224
	84,031	84,871
	86,655	87,521
Associate specialist (pre-2008)	38,452	38,836
	42,524	42,950
	46,596	47,062
	50,669	51,175
	54,741	55,289
	58,813	59,402
	64,192	64,833
	68,853	69,541
Discretionary Points	*Notional scale*	
	70,787	71,495
	73,310	74,043
	75,834	76,592
	78,357	79,140
	80,880	81,689
	83,406	84,240
Staff grade practitioner (1997 contract, MH03/5)	34,785	35,133
	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	49,082	49,573
Discretionary Points	*Notional scale*	
	51,353	51,867
	54,114	54,655
	56,876	57,444
	59,637	60,234
	62,398	63,022
	65,161	65,812

[37] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements.

	2016	2017
	£	£
Staff grade practitioner (pre-1997 contract, MH01)	34,785	35,133
	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	48,592	49,078
	51,353	51,867
	54,114	54,655

	2016	2017
	£	£
	(Annual rate on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,652	4,746
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,599	4,644
	4,864	4,913
	5,132	5,183
	5,397	5,452
	5,664	5,721
	5,930	5,989
	6,196	6,258

B. Community health staff

	2016	2017
	£	£
Clinical medical officer	33,323	33,657
	35,128	35,479
	36,932	37,301
	38,736	39,123
	40,540	40,945
	42,344	42,767
	44,148	44,589
	45,953	46,413
Senior clinical medical officer	47,089	47,560
	49,956	50,455
	52,821	53,349
	55,686	56,243
	58,553	59,138
	61,418	62,032
	64,283	64,926
	67,150	67,821

C. Salaried primary dental care staff[38]

	2016	2017
	£	£
Band 1: Salaried dentist	35,314	35,667
	38,170	38,552
	41,026	41,437
	43,885	44,324
	46,742	47,209
	49,598	50,095
	52,455	52,980
	55,313	55,866
Band 2: Senior salaried dentist	50,463	50,967
	54,457	55,001
	58,450	59,035
	62,444	63,068
	66,438	67,102
	67,319	67,992
	68,199	68,880
Band 3: Assistant clinical director salaried dentist	67,056	67,726
	68,094	68,774
	69,131	69,823
	70,169	70,871
	71,207	71,919
	72,245	72,968
Band 4: Clinical director salaried dentist	67,056	67,726
	68,094	68,774
	69,131	69,823
	70,169	70,871
	71,207	71,919
	72,245	72,968
	73,283	74,016
	74,339	75,082
	75,376	76,130
	76,414	77,178

[38] These scales also apply to salaried dentists working in Personal Dental Services.

Part-time dental surgeon	Sessional fee (per hour)	
	2016	2017
	£	£
Dental surgeon	28.97	29.26
Dental surgeon holding higher registrable qualifications	38.43	38.81
Dental surgeon employed as a consultant	47.89	48.36

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES[39]

1. The fee for domiciliary consultations should be increased from £83.37 to £84.20 per visit. Additional fees should be increased *pro rata*.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[40]		Per notional half day	
	2016	2017	2016	2017
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,010.79	1,020.91	91.89	92.81
Hospital practitioner appointment			103.51	104.55
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			90.11	91.01

	Per week[41]		Per standard hour	
	2016	2017	2016	2017
	£	£	£	£
Specialty registrar (higher rate) appointment	901.24	910.08	18.78	18.96
Specialty registrar (lower rate) appointment	817.86	826.08	17.04	17.21
Specialist registrar appointment	901.24	910.08	18.78	18.96
Foundation house officer 2	695.69	702.24	14.50	14.63
Foundation house officer 1 appointment/ House officer appointment	558.97	564.96	11.65	11.77

	Per week[42]		Per session	
	2016	2017	2016	2017
	£	£	£	£
Staff grade practitioner appointment	852.54	861.00	85.25	86.10

	Per week[43]		Per programmed activity	
	2016	2017	2016	2017
	£	£	£	£
Specialty doctor appointment	861.73	870.40	86.17	87.04
Associate specialist appointment (2008)	1,171.90	1,183.60	117.19	118.36

[39] Which applied on 1 April 2017 unless otherwise specified.

[40] The notional half day rate multiplied by 11.

[41] The hourly rates given for junior doctors are the basic rate (the midpoint of the current salary scale) divided by 365, multiplied by 7 and divided by 40, rounded up to the nearest penny. The weekly rates are the hourly rates multiplied by 1.2 and multiplied by 40. Hourly and weekly rates have not been adjusted for banding.

[42] The per session rate multiplied by 10.

[43] The per programmed activity rate multiplied by 10.

Doctors in public health medicine

3. The supplements payable to directors of public and for regional directors of public health are:

	2016			2017		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,557	7,113	8,892	3,593	7,184	8,981
Band C	4,462	8,892	10,685	4,506	8,981	10,792
Band B	5,337	10,685	13,782	5,390	10,792	13,920
Regional director of public health: Band A	13,782	20,006		13,920	20,207	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[44] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,965 – £84,453 to £56,525 – £85,298.

General dental practitioners

6. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre should be increased from £88.07 to £88.95.

Community health and community dental staff (Northern Ireland)

7. The teaching supplement for assistant clinical directors in the community dental service should be increased from £2,511 to £2,536 per year.

8. The teaching supplement payable to clinical directors in the community dental service should be increased from £2,836 to £2,865 per year.

9. The supplement for clinical directors covering two districts should be increased from £1,833 to £1,852 per year and the supplement for those covering three or more districts should be increased from £2,927 to £2,956 per year.

10. The allowance for dental officers acting as trainers should be increased from £2,008 to £2,028 per year.

[44] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B4: OTHER FEES AND ALLOWANCES IN ENGLAND, WALES AND NORTHERN IRELAND

Operative date

1. The levels of remuneration set out below apply from 1 April 2017.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards (CEAs) for consultants and academic GMPs should be increased as follows:

	2016	2017
	£	£
Bronze (Level 9):	35,832	36,192
Silver (Level 10):	47,110	47,582
Gold (Level 11):	58,888	59,477
Platinum (Level 12):	76,554	77,320

3. The annual values of Distinction Awards for consultants[45] should be increased as follows:

	2016	2017
	£	£
B award:	32,278	32,601
A award:	56,483	57,048
A+ award:	76,648	77,415

4. The annual values of consultant intensity payments should be increased as follows:

	2016	2017
	£	£
Daytime supplement:	1,287	1,300

	England and Northern Ireland		Wales	
	2016	2017	2016	2017
	£	£	£	£
Band 1:	970	979	2,235	2,258
Band 2:	1,932	1,952	4,470	4,515
Band 3:	2,889	2,918	6,704	6,771

5. 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.

[45] From October 2003 in England and Wales, and from 2005 in Northern Ireland, national CEAs have replaced Distinction Awards. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA.

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%	3%
Medium Frequency: 1 in 5 to 1 in 8	5%	2%
Low Frequency: 1 in 9 or less frequent	3%	1%

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

	Multiplier
Band 2A (more than 48 hours and up to 52 hours)	1.8
Band 2B (more than 48 hours and up to 52 hours)	1.5
Band 1A (48 hours or fewer)	1.5
Band 1B (48 hours or fewer)	1.4
Band 1C (48 hours or fewer)	1.2

7. Under the contract agreed by the parties, 1.0 represented the basic salary (shown in Part I of this Appendix) and figures above 1.0 represented the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary. However, from 1 April 2010, 1.05 represented the basic salary for foundation house officer 1 trainees in posts that receive no banding supplement.

8. A 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

9. A supplement is added to the basic salary to reflect the intensity of the duties.

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

* salary = F5 to F9 calculated above.

The supplements will be applied as set out below.

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

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM[1]

ENGLAND[2]	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[3]						
Consultants	41,290	43,602	42,903	45,349	3.9%	4.0%
Associate specialists	2,626	2,967	2,416	2,727	-8.0%	-8.1%
Specialty doctors	5,920	6,985	6,064	7,156	2.4%	2.4%
Staff grades	360	449	402	478	11.5%	6.5%
Registrar group	30,050	31,237	29,458	30,569	-2.0%	-2.1%
Foundation house officers 2[4]	6,596	6,648	6,576	6,626	-0.3%	-0.3%
Foundation house officers 1[5]	6,285	6,310	6,364	6,391	1.3%	1.3%
Other doctors in training	8,756	8,873	8,910	9,047	1.8%	2.0%
Hospital practitioners/Clinical assistants	502	1,817	489	1,762	-2.6%	-3.0%
Other staff	944	1,447	917	1,407	-2.9%	-2.8%
Total	**103,330**	**109,944**	**104,498**	**111,127**	**1.1%**	**1.1%**
Hospital and Community Health Services Dental Staff						
Consultants	688		709		3.1%	
Associate specialists	101		93		-7.9%	
Specialty doctors	280		318		13.5%	
Staff grades	11		10		-5.9%	
Registrar group	474		475		0.2%	
Foundation house officers 2[4]	85		33		-60.6%	
Foundation house officers 1[5]	51		51		0.0%	
Other doctors in training	457		512		12.0%	
Hospital practitioners/Clinical assistants	29		26		-8.3%	
Other staff	34		47		39.4%	
Total	**2,208**		**2,274**		**3.0%**	

[1] An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.

[2] Data as 30 September unless otherwise indicated.

[3] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

[4] Includes senior house officers.

[5] Includes house officers.

ENGLAND	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners[6]	**34,712**	**41,105**	**34,055**	**40,697**	**-1.9%**	**-1.0%**
GMP providers	22,837	26,183	19,995	22,390	-12.4%	-14.5%
General practice specialty registrars[7]	4,348	5,033	4,719	4,982	8.5%	-1.0%
GMP retainers[8]	113	262	64	148	-43.1%	-43.5%
Other GMPs	7,413	9,885	6,826	10,063	-7.9%	1.8%
General dental practitioners[9,10,11]		**23,947**		**24,089**		**0.6%**
General Dental Services only		19,625		19,976		1.8%
Personal Dental Services only		1,799		1,709		-5.0%
Mixed		1,658		1,543		-6.9%
Trust-led		865		861		-0.5%
Ophthalmic medical practitioners[12]		**267**		**245**		**-8.2%**
Total general practitioners		**65,319**		**65,031**		**-0.4%**
Total – NHS doctors and dentists		**177,471**		**178,432**		**0.5%**

[6] Prior to 2015 figures are sourced from NHAIS GP Payments (Exeter) System. From 2015 figures are sourced from the workforce Minimum Dataset (wMDS) and include estimates for missing data.

[7] Formally known as GMP registrars.

[8] 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 four sessions of approximately half a day per week.

[9] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms at any time in the year that meet the criteria for inclusion within the annual reconciliation process.

[10] Data as at 31 March of the following year.

[11] Includes salaried dentists.

[12] Data as at 31 December of that year.

WALES[13]	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[14]						
Consultants	2,329	2,463	2,359	2,499	1.3%	1.5%
Associate specialists	306	347	282	320	-7.6%	-7.8%
Specialty doctors	492	590	508	607	3.3%	2.9%
Staff grades	6	9	4	7	-20.0%	-22.2%
Specialist registrars	1,832	1,890	1,996	2,088	8.9%	10.5%
Foundation house officers 2[15]	573	577	508	513	-11.3%	-11.1%
Foundation house officers 1[16]	341	342	336	337	-1.6%	-1.5%
Hospital practitioners	2	12	2	8	-23.1%	-33.3%
Clinical assistants	11	77	9	51	-20.7%	-33.8%
Other staff[17]	120	196	116	197	-3.3%	0.5%
Total	**6,011**	**6,503**	**6,120**	**6,627**	**1.8%**	**1.9%**
General medical practitioners		**2,249**		**2,253**		**0.2%**
GMP providers		2,006		1,997		-0.4%
General practice specialty registrars		220		231		5.0%
GMP retainers		23		25		8.7%
General dental practitioners[18]		**1,439**		**1,470**		**2.2%**
General Dental Services only		1,092		1,185		8.5%
Personal Dental Services only		126		79		-37.3%
Mixed		141		110		-22.0%
Ophthalmic medical practitioners[19]		**7**		**7**		**0.0%**
Total general practitioners		**3,695**		**3,730**		**0.9%**
Total – NHS doctors and dentists		**9,706**		**9,850**		**1.5%**

[13] Data as at 30 September unless otherwise specified.

[14] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

[15] Includes senior house officers.

[16] Includes house officers.

[17] Consists of mainly dental officers.

[18] Data as of 31 March of the following year.

[19] Data as of 31 December of that year.

SCOTLAND[20]	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff						
Consultants	4,847	5,160	4,985	5,323	2.8%	3.2%
Specialty doctors	987	1,383	989	1,369	0.2%	-1.0%
Registrar group	4,140	4,308	4,057	4,223	-2.0%	-2.0%
Foundation house officers 2[21]	856	863	760	771	-11.2%	-10.7%
Foundation house officers 1[22]	883	885	1,035	1,037	17.2%	17.2%
Other staff	301	718	334	801	10.9%	11.6%
Total	**12,014**	**13,240**	**12,160**	**13,442**	**1.2%**	**1.5%**
Hospital and Community Health Services Dental Staff						
Consultants	127	144	117	134	-8.1%	-6.9%
Registrar group	58	63	42	45	-28.4%	-28.6%
Specialty doctors	72	127	67	121	-6.3%	-4.7%
Foundation house officers 2[21]	113	134	118	144	3.9%	7.5%
Foundation house officers 1[22]	198	256	176	230	-10.9%	-10.2%
Other staff	118	140	133	160	12.9%	14.3%
Total	**685**	**850**	**652**	**811**	**-4.9%**	**-4.6%**

[20] Data as 30 September of that year.

[21] Includes senior house officers.

[22] Includes house officers.

SCOTLAND[23]	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners		**4,921**		**4,938**		**0.3%**
GMP providers		3,719		3,657		-1.7%
General practice specialty registrars[24]		499		492		-1.4%
GMP retainers[25]		115		113		-1.7%
Other GMPs		596		692		16.1%
General dental practitioners (non-hospital)[26]		**3,207**		**3,227**		**0.6%**
General Dental Service		2,870		2,910		1.4%
Public Dental Service		462		438		-5.2%
Ophthalmic medical practitioners		**35**		**30**		**-14.3%**
Total general practitioners		**8,163**		**8,195**		**0.4%**
Total – NHS doctors and dentists		**22,253**		**22,448**		**0.9%**

[23] Data as at 30 September of that year.

[24] Formally known as GMP registrars.

[25] 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 four sessions of approximately half a day per week.

[26] Includes salaried, community and public dental service dentists.

NORTHERN IRELAND[27]	2014		2015		Percentage change 2014 – 2015	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[28,29]						
Consultant	1,541	1,635	1,613	1,711	4.7%	4.6%
Associate Specialist/Specialty Doctor/Staff Grade	424	509	430	519	1.5%	2.0%
Specialty/Specialist Registrar	1,132	1,159	1,289	1,323	13.9%	14.2%
Foundation/Senior House Officer	514	514	530	533	3.2%	3.7%
Other[30]	183	321	140	292	-23.6%	-9.0%
Total	**3,793**	**4,138**	**4,002**	**4,378**	**5.5%**	**5.8%**
General medical practitioners[31]		**1,211**		**1,274**		**5.2%**
General dental practitioners[32,33]		**960**		**989**		**3.0%**
Ophthalmic medical practitioners[34]		**11**		**11**		**0.0%**
Total general practitioners		**2,182**		**2,274**		**4.2%**
Total – NHS doctors and dentists		**6,320**		**6,652**		**5.3%**

[27] As at 30 September unless otherwise specified.

[28] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic practitioners.

[29] As at March of the following year.

[30] Due to changes the collection of staff groups, the 'other' category is not consistent across year groups and should not be compared with previous years.

[31] Date as October of that year.

[32] Date as April the following year.

[33] It is possible for someone to be a dentist in one location and an assistant/Oasis, etc. at another location. The final total will not represent individual people.

[34] As at April that year.

APPENDIX D: GLOSSARY OF TERMS

ASSOCIATE DENTISTS (SCOTLAND AND NORTHERN IRELAND) – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. Associate dentists also have an arrangement with an NHS board and provide General Dental Services. The equivalent in England and Wales is performer-only dentists. See also *performer-only dentists*.

BASIC PAY – the annual rate of salary without any allowances or additional payments.

CAVENDISH COALITION – a group of health and social care organisations formed to provide those leading Brexit negotiations with the expertise, evidence and knowledge required on post-EU referendum issues affecting the health and social care sectors.

CLINICAL COMMISSIONING GROUPS – the groups of general medical practitioners and other healthcare professionals that have taken over commissioning from primary care trusts in England under NHS reforms.

CLINICAL EXCELLENCE AWARDS (CEAs) – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. All levels of Clinical Excellence Awards are pensionable. See also *Distinction Awards, Discretionary Points*.

COMMITMENT AWARDS – for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003. See also *Discretionary Points*.

COMMITMENT PAYMENTS (SCOTLAND) – paid quarterly to dentists who carry out NHS General Dental Services and who meet the criteria for payment.

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial and pharmaceutical.

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable. See also *Clinical Excellence Awards, Commitment Awards, Distinction Awards*.

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable. See also *Clinical Excellence Awards, Discretionary Points*.

EXPENSES TO EARNINGS RATIO (EER) – the percentage of earnings spent on expenses rather than income by a general medical practitioner or a general dental practitioner.

FIVE YEAR FORWARD VIEW – A 2014 NHS England policy document setting out a vision for the NHS in England based on new models of care, centre on the 'triple challenge' of achieving better health, transformed quality of care delivery, and sustainable finances.

FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a Foundation Programme, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. 'F1' refers to a trainee doctor in the first year or the programme; 'F2' refers to a doctor in the second year.

FOUNDATION SCHOOL – a group of institutions bringing together medical schools, the local deanery, trusts and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments and are administered by a central local staff which is supported by the deanery.

GENERAL DENTAL PRACTITIONER – a qualified dental practitioner, registered with the General Dental Council and on the dental list of an NHS England Region for the provision of general dental services.

GENERAL MEDICAL PRACTITIONER – more commonly known as a GP, a GMP works in primary care and specialises in family medicine.

GENERAL MEDICAL PRACTITIONER TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training a general practice specialty registrar.

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes. See also *Quality and Outcomes Framework*.

GENERAL PRACTICE FORWARD VIEW – A 2016 NHS England policy document setting out a package of support measures for primary care in England, to help improve patient care and access.

'GENERATION Y' – The term used to refer to people born between 1980 and 2000, thought to share certain characteristics and work/lifestyle preferences. Individuals from this generation are also sometimes referred to as 'millennials'.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

INCORPORATED BUSINESS – both providing-performer/principal and performer-only/associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For providing-performer/principal dentists, the business tends to be a dental practice. For performer-only/associate dentists, the business is the service they provide as a sub-contractor.

MILLENNIAL – Individual born between 1980 and 2000. See also *Generation Y* definition.

'PATIENTS AT THE HEART' – NHS England and ministerial commitment to 'put patients at the heart' of business planning to improve care and access for all. DDRB's terms of reference state that the Review Body should have reference to 'the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.'

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – performer-only delivers NHS dental services but does not hold a contract. They are employed by a provider-only or a providing-performer. The equivalent in Scotland and Northern Ireland is associate dentists. See also *associate dentists*.

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists*.

PROGRAMMED ACTIVITIES – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and 7 am during the week, or any time at weekends. A number of **SUPPORTING PROFESSIONAL ACTIVITIES** are also agreed within the job planning process to carry out training, continuing professional development, job planning, appraisal and research.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists*.

QUALITY AND OUTCOMES FRAMEWORK (QOF) – payments are made under the General Medical Services contract for achieving various government priorities such as managing chronic diseases, providing extra services including child health and maternity services, organising and managing the practice, and achieving targets for patient experience.

SALARIED CONTRACTORS (including salaried GMPs) – general medical practitioners or general dental practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract.

SALARIED DENTISTS – provide 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.

SAS GRADES – see *specialty doctors and associate specialists*.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS/SAS GRADES – doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors, associate specialists, staff grades, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. The associate specialist grade is now closed.

SUPPLEMENT – used to apply supplements to the basic salary of doctors and dentists in hospital training. They are intended to reflect the number of hours and intensity of each post.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities*.

SUSTAINABILITY AND TRANSFORMATION PLANS – local plans produced by local NHS organisations and councils in England. They aim to improve health and care by setting out practical ways for local NHS entities to improve services and health outcomes, in line with the aims of the *NHS Five Year Forward View*. See also *Five Year Forward View*.

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the NHS dental contract system regulations in England and Wales to describe weighted courses of treatment.

'VANGUARD' SITES – the NHS trusts and care providers that were selected to trial new and pioneering models of care which seek to break down the barriers between primary, secondary and community care, as envisaged in the Five Year Forward View. See also *Five Year Forward View*.

APPENDIX E: EARNINGS AND EXPENSES OF GMPs AND GDPs

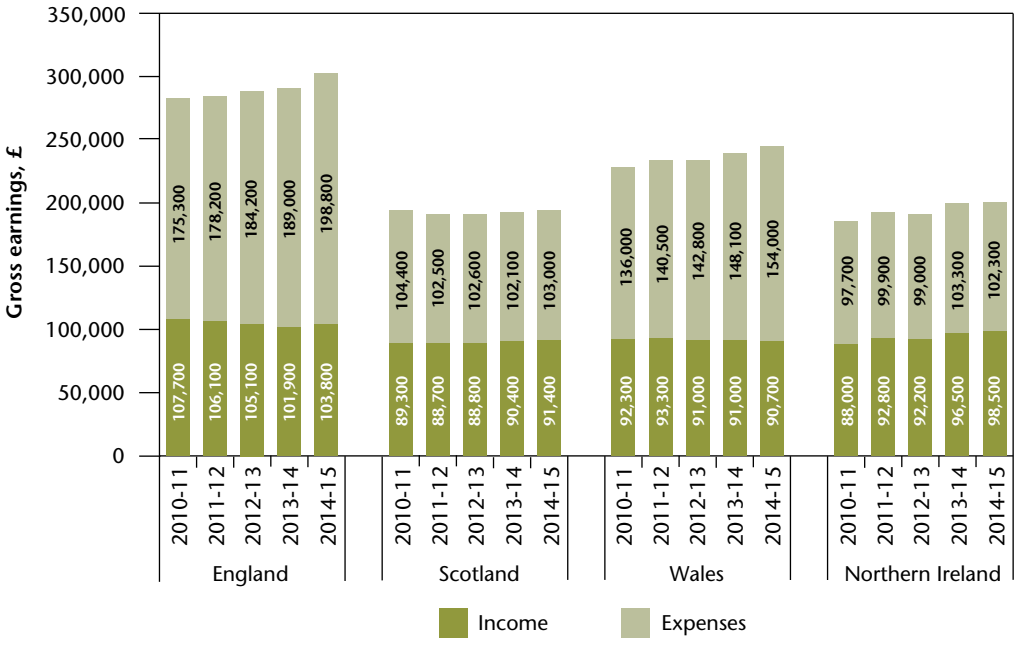
E.1 This appendix supports Chapters 7 and 8 and sets out further information on the earnings and expenses of general medical practitioners (GMPs) by UK country and English region, as reported by NHS Digital. It also gives the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach (Table E.5).

GMP earnings and expenses 2014-15 by UK country and English region

E.2 Supplementing the information provided in Chapter 7, Figure E.1 and Table E.1 show average taxable income and average expenses of contractor GMPs by UK country, while Table E.2 and Figure E.2 show these data by NHS England regions.

- In 2014-15, both average income and average expenses were highest in England, at £103,800 and £198,800 respectively, with the EER also highest at 65.7 per cent.
- Average taxable incomes in Scotland, Wales and Northern Ireland were £91,400, £90,700 and £98,500 respectively.
- Wales was the only country to see a reduction in income in 2014-15 (of £300).
- Within England, average income was highest in the East (£112,300) and lowest in the South West (£84,500) similar to 2013-14.

Figure E.1: Average GMP contractors' gross earnings, income and expenses, by United Kingdom country, 2010-11 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Note: Not adjusted for inflation.

Table E.1: Average GMP contractors' gross earnings, expenses and income by United Kingdom country, 2013-14 to 2014-15

Country	Year	Gross earnings	Expenses	Income	Expenses to earnings ratio (EER) %
England	2013-14	£290,900	£189,000	£101,900	65.0
	2014-15	£302,600	£198,800	£103,800	65.7
	% change	4.0%	5.2%	1.9%	
Scotland	2013-14	£192,400	£102,100	£90,400	53.0
	2014-15	£194,400	£103,000	£91,400	53.0
	% change	1.0%	0.9%	1.1%	
Wales	2013-14	£239,100	£148,100	£91,000	61.9
	2014-15	£244,700	£154,000	£90,700	62.9
	% change	2.3%	4.0%	-0.3%	
Northern Ireland	2013-14	£199,800	£103,300	£96,500	51.7
	2014-15	£200,900	£102,300	£98,500	50.9
	% change	0.6%	-1.0%	2.1%	
United Kingdom	2013-14	£273,600	£173,800	£99,800	63.5
	2014-15	£283,300	£181,800	£101,500	64.2
	% change	3.5%	4.6%	1.7%	

Source: NHS Digital using Her Majesty's Revenue and Customs data.

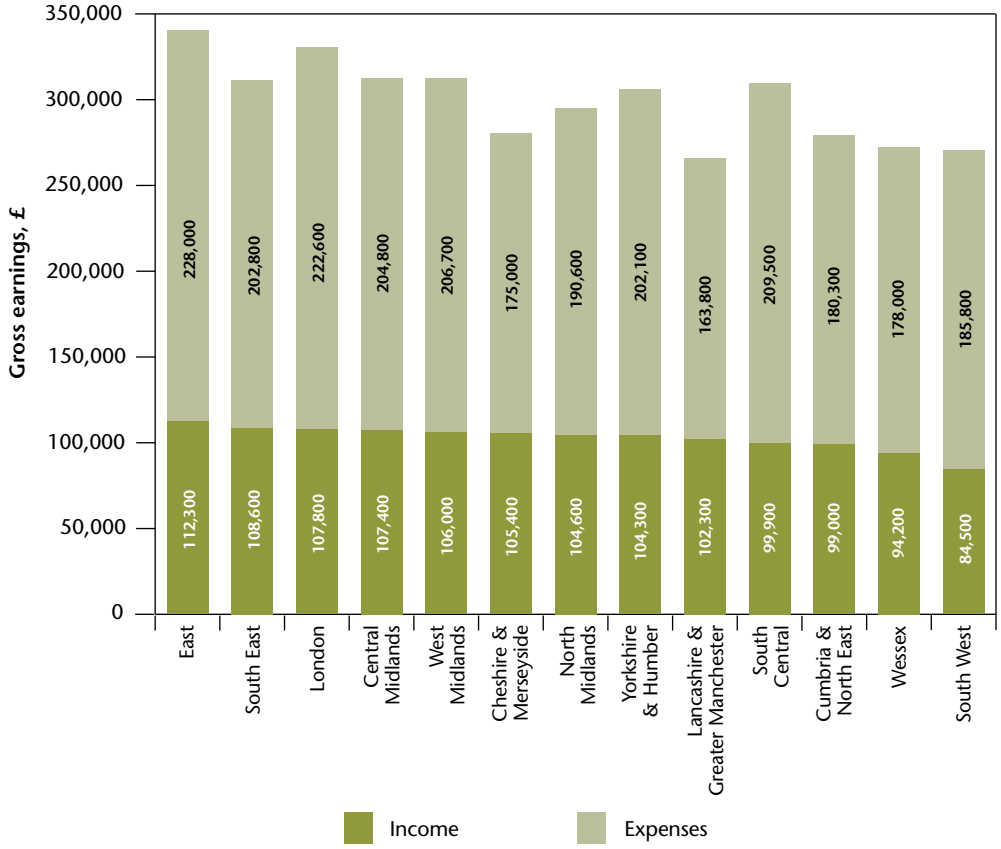
Note: Not adjusted for inflation.

Table E.2: Average expenses and income for General/Personal Medical Services (GPMS) contractor GMPs by NHS England region, 2014-15

NHS England region	Expenses £	Income £	EER %
East	228,000	112,300	67.0%
South East	202,800	108,600	65.1%
London	222,600	107,800	67.4%
Central Midlands	204,800	107,400	65.6%
West Midlands	206,700	106,000	66.1%
Cheshire & Merseyside	175,000	105,400	62.4%
North Midlands	190,600	104,600	64.6%
Yorkshire & Humber	202,100	104,300	66.0%
Lancashire & Greater Manchester	163,800	102,300	61.6%
South Central	209,500	99,900	67.7%
Cumbria & North East	180,300	99,000	64.6%
Wessex	178,000	94,200	65.4%
South West	185,800	84,500	68.7%

Source: NHS Digital using Her Majesty's Revenue and Customs data.

Figure E.2: GMP contractors' average gross earnings, income and expenses, by NHS England region, 2014-15



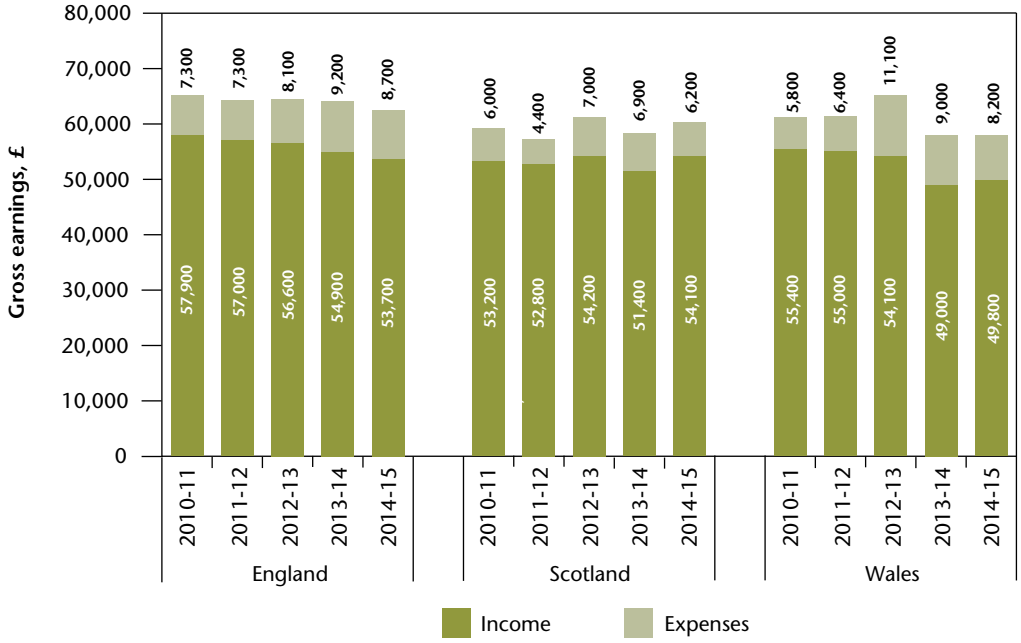
Source: NHS Digital using Her Majesty's Revenue and Customs data.

Salaried GMPs earnings and expenses by UK country and English region

E.3 Supplementing the information provided in Chapter 7, Figure E.3 and Table E.3 show average taxable income and average expenses of salaried GMPs by UK country, data for Northern Ireland is not available as it is not possible to distinguish salaried GPs from Contractor GPs. Table E.4 and Figure E.4 show these data by NHS England regions.

- In 2014-15, average salaried GP income was highest in Scotland, at £54,100.
- Average taxable incomes in England and Wales were £53,700 and £49,800 respectively.
- England was the only country to see a reduction in income in 2014-15 (of £1,200).
- Within England, average income was highest in Cheshire and Merseyside (£58,000) and lowest in Wessex (£48,000).

Figure E.3: Average salaried GMPs' gross earnings, income and expenses, by United Kingdom country, 2010-11 to 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Note: Not adjusted for inflation.

Table E.3: Average salaried GMPs' gross earnings, expenses and income by United Kingdom country, 2013-14 to 2014-15

Country	Year	Gross earnings	Expenses	Income	Expenses to earnings ratio (EER) %
England	2013-14	£64,100	£9,200	£54,900	14.4
	2014-15	£62,500	£8,700	£53,700	13.9
	% change	-2.5%	-5.4%	-2.2%	
Scotland	2013-14	£58,300	£6,900	£51,400	11.8
	2014-15	£60,300	£6,200	£54,100	10.3
	% change	3.4%	-10.1%	5.3%	
Wales	2013-14	£58,100	£9,000	£49,000	15.5
	2014-15	£58,000	£8,200	£49,800	14.1
	% change	-0.2%	-8.9%	1.6%	
Northern Ireland	2013-14	–	–	–	–
	2014-15	–	–	–	–
	% change				
United Kingdom	2013-14	£63,600	£9,100	£54,600	14.3
	2014-15	£62,200	£8,600	£53,600	13.8
	% change	-2.2%	-5.5%	-1.8%	

Source: NHS Digital using Her Majesty's Revenue and Customs data.

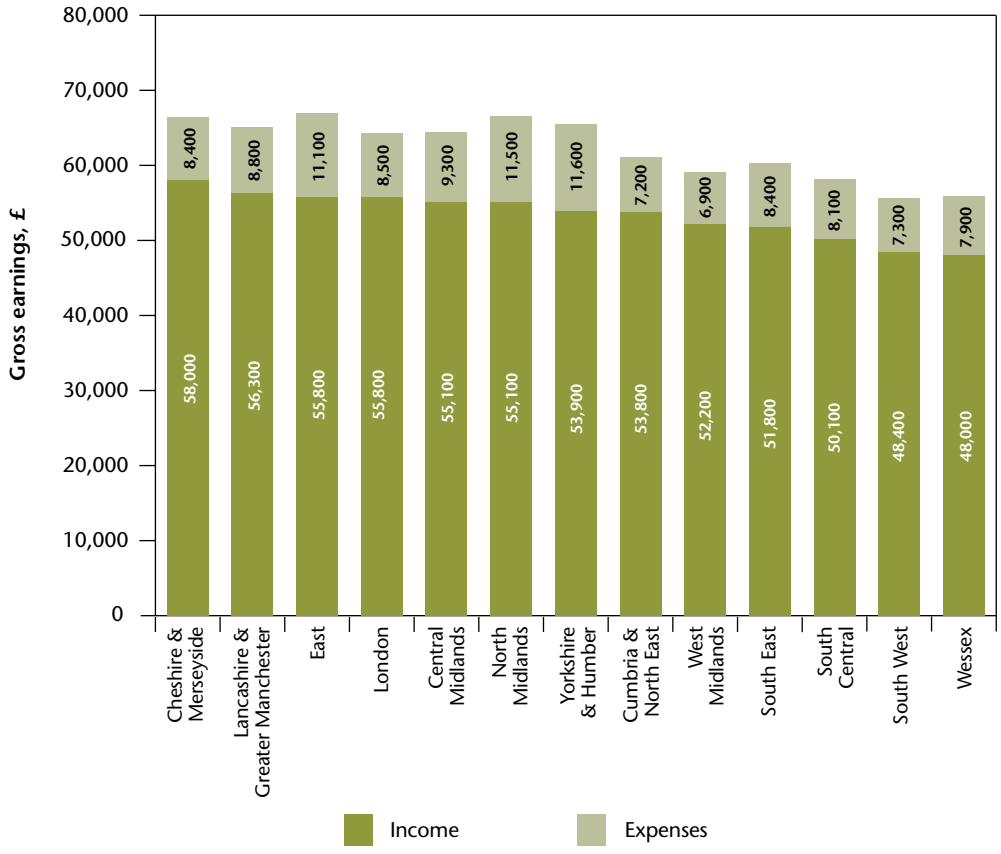
Note: Not adjusted for inflation.

Table E.4: Average expenses and income for General/Personal Medical Services (GPMS) salaried GMPs by NHS England region, 2014-15

NHS England region	Expenses £	Income £	EER %
Cheshire & Merseyside	£8,400	£58,000	12.7%
Lancashire & Greater Manchester	£8,800	£56,300	13.5%
East	£11,100	£55,800	16.6%
London	£8,500	£55,800	13.2%
Central Midlands	£9,300	£55,100	14.4%
North Midlands	£11,500	£55,100	17.3%
Yorkshire & Humber	£11,600	£53,900	17.7%
Cumbria & North East	£7,200	£53,800	11.8%
West Midlands	£6,900	£52,200	11.7%
South East	£8,400	£51,800	14.0%
South Central	£8,100	£50,100	13.9%
South West	£7,300	£48,400	13.1%
Wessex	£7,900	£48,000	14.1%

Source: NHS Digital using Her Majesty's Revenue and Customs data.

Figure E.4: Salaried GMPs' average gross earnings, income and expenses, by NHS England region, 2014-15



Source: NHS Digital using Her Majesty's Revenue and Customs data.

Multiple counting of expenses

E.4 Our recent reports have identified the issue of "double" or "multiple counting" of dental expenses. Multiple counting artificially inflates estimates of average gross earnings, expenses and the EER, but taxable income is not affected. As we are not using a formula-based approach to our uplift recommendation this year, we have not considered this issue in depth. Had we have done so, our working assumption (in the absence of evidence to the contrary) would have been to continue with our general approach whereby the weights that we use in our formula would be derived from figures on GDPs' average earnings and expenses, compiled by NHS Digital using data from self-assessment tax returns, with an adjustment made to reflect the estimated effect of the multiple counting of expenses. Since the parties have not submitted any evidence to suggest an alternative approach, our likely recommendations had we have opted to use the formula-based approach would have assumed (in line with the recommendations in our earlier reports) that an EER of 50 per cent should be used in each country of the UK.

The data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

E.5 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.5 the data that would have populated the formulae. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.5: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) *DDRB recommendation in England, Wales and Northern Ireland*	1%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2016 (general medical practice activities)*	5.1%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2016*	2.5%
Income (GDPs) *DDRB recommendation in England, Wales and Northern Ireland*	1%
Staff costs (GDPs) England, Wales and Northern Ireland *ASHE 2016 (dental practice activities)*	1.3%
Laboratory costs (GDPs) England, Wales and Northern Ireland *RPIX for Q4 2016*	2.5%
Materials (GDPs) England, Wales and Northern Ireland *RPIX for Q4 2016*	2.5%
Other costs (GDPs) England, Wales and Northern Ireland *Retail Prices Index (RPI) for Q4 2016*	2.2%

Source: Annual Survey of Hours and Earnings (Table 16.5a), Consumer Price Inflation (CDKQ, CZBH).

APPENDIX F: PAY COMPARABILITY

F.1 This appendx provides figures comparing pay levels of some of our remit groups with other professions. The pay level comparisons are made with specific professions using national data from Hay Group to match the anchor points proposed by PA Consulting Group in its 2008 report[1] (see table F.1).

Table F.1: Anchor points used for pay comparability

Anchor point	Hay reference level
Foundation house officer 1	14
Foundation house officer 2	15
Specialty registrar (years 1 and 2)	16
Specialty registrar (years 3 onwards)	17-19
Consultant on the scale minimum	20
Consultant on the scale maximum (with the upper quartile* Clinical Excellence Award)	21

Source: Office of Manpower Economics.

* In 2016 this was a level 4 local Clinical Excellence Award.

Data issues

F.2 It should be noted that, whilst PA Consulting has proposed anchor points which cover sub-sections of the specialty registrar group, mean basic salary and mean total earnings are not available for these subgroups. Consequently, Figures F.3 and F.4 provide estimates of total earnings (namely, by multiplying the pay scale value by the average banding supplement for specialty registrars, 43.7 per cent).

F.3 Hay Group has provided means for reference levels rather than for anchor points. For Figure F.4, the means of the comparator groups are the mean of three reference points (17 to 19) combined.

Pay comparability by anchor point

Foundation house officer 1

F.4 This first anchor point is for the first year of training following medical school. This is the first year of a two-year foundation course and builds upon the knowledge, skills and competences acquired in undergraduate training. Successful completion of this year will lead to registration with the General Medical Council. This anchor point aligns with graduate entry, although the undergraduate course is longer for medicine than for most other subjects. A comparison of earnings for doctors and dentists at this anchor point with external professions is given as Figure F.1.

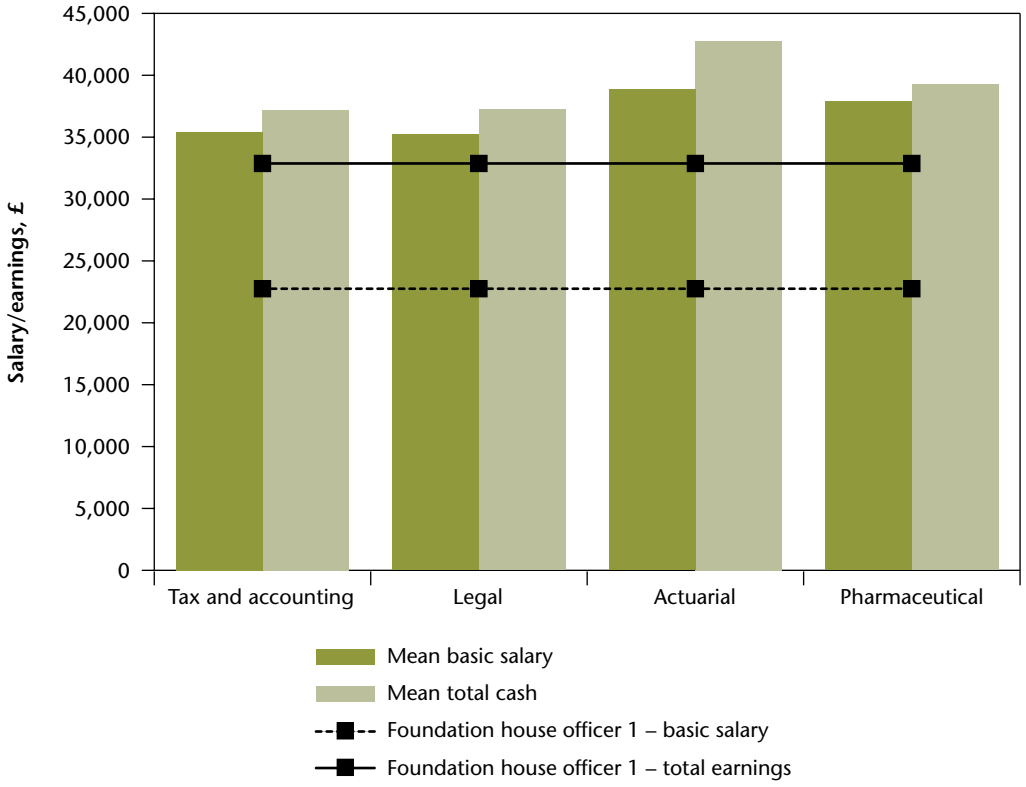
F.5 The mean basic salary[2] for foundation house officers in their first year was well below that of the mean basic salary of comparator groups, the closest comparable profession (legal) earned over £12,000 more. Mean total earnings[3] were closer but still below that of comparator professions, lagging just over £4,000 behind tax and accounting.

[1] The pay comparators were identified in the report: PA Consulting Group, *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008.

[2] Mean annual basic pay per FTE.

[3] Mean annual basic pay per FTE plus mean annual non-basic pay per person.

Figure F.1: Foundation house officer, year 1 – mean basic salary and mean total earnings against mean basic salary and mean total cash for comparator professions, 2016



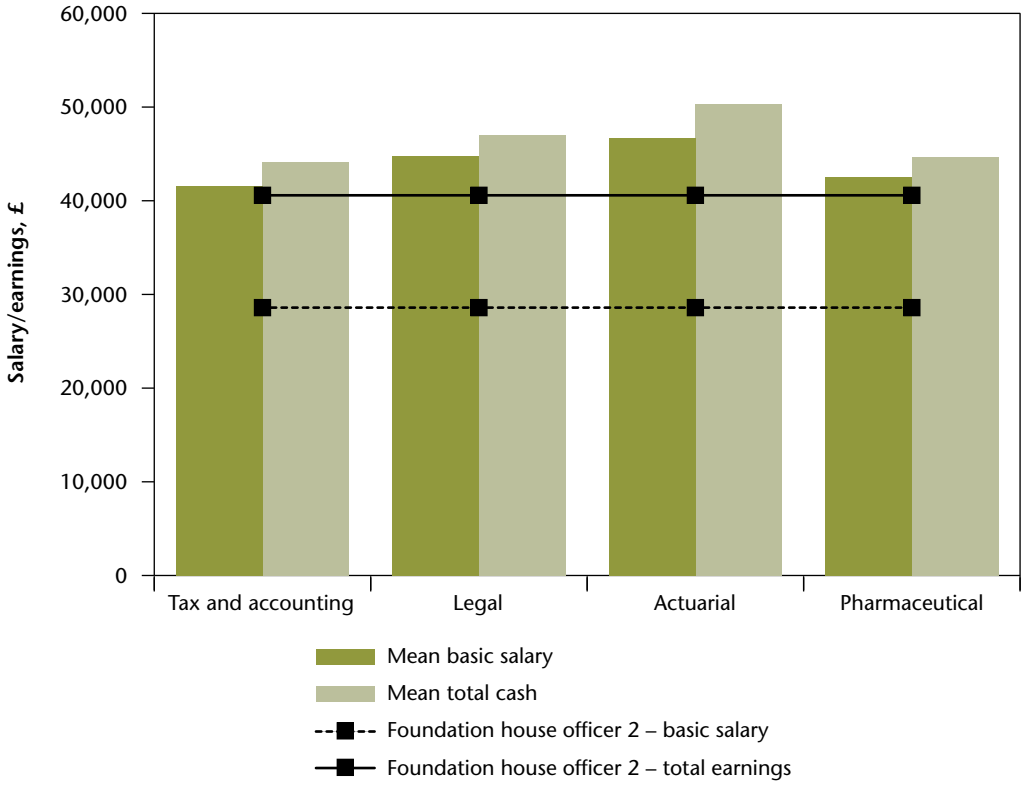
Source: NHS Digital and Hay Group.

Foundation house officer 2

F.6 This anchor point marks the second and final year of the foundation course. This year focuses on training in the assessment and management of acutely ill patients. At the end of this year, doctors and dentists in training must undergo competitive entry to obtain a place on the specialty training run-through. A comparison of the mean basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure F.2.

F.7 The basic salary for foundation house officers in their second year of training was £28,593 in 2016, which is again well below that of comparator professions. When looking at total earnings pay becomes more competitive although is still well below actuaries.

Figure F.2: Foundation house officer, year 2 – mean basic salary and mean total earnings against mean basic salary and mean total cash for comparator professions, 2016

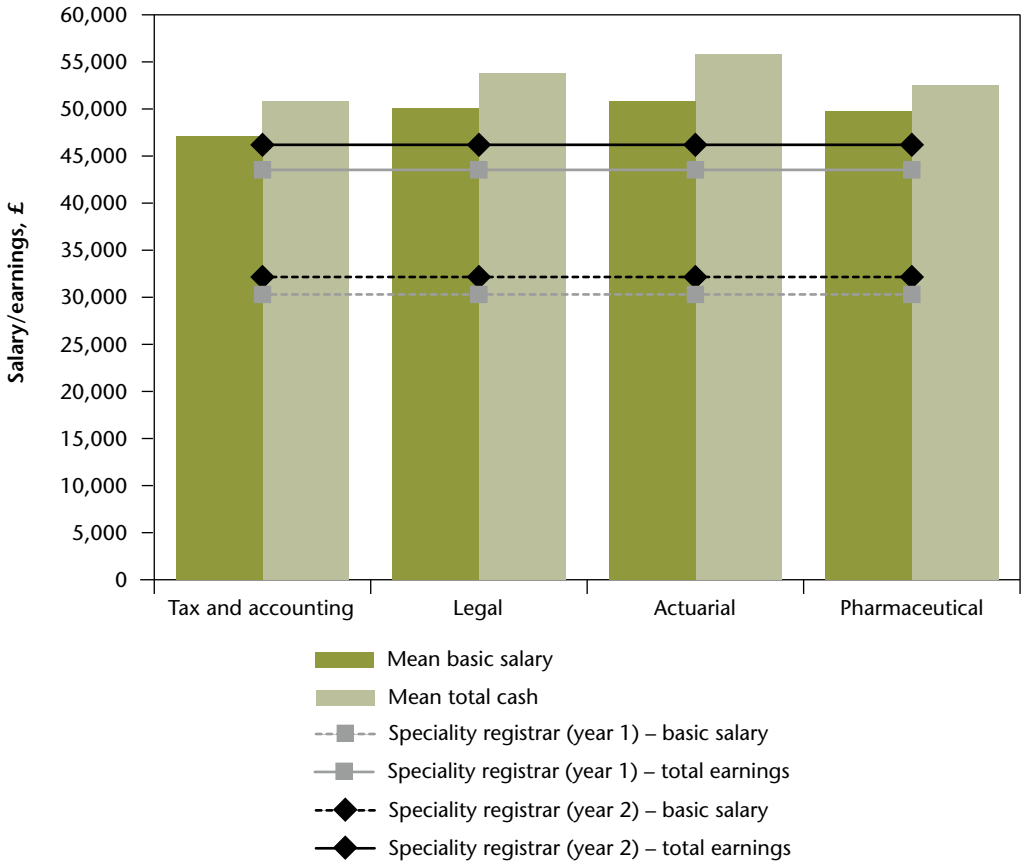


Source: NHS Digital and Hay Group.

Specialty training 1 and 2

F.8 Following foundation training, the initial stage of speciality training usually lasts for two years and is the first stage of uncoupled training. In their first and second years of speciality training, doctors' and dentists' basic salary are considerably less than the comparator professions (Figure F.3). Matched workers in tax and accounting earn almost £15,000 more than second year registrars. Total earnings are also below the comparator groups in both years of speciality training, although by second year total earnings are broadly comparable to tax and accounting. However, they remain well below other comparable professions.

Figure F.3: Specialty training years 1 and 2 – basic salary[4] and estimated total earnings[5] against mean basic salary and mean total cash for comparator professions, 2016



Source: NHS Digital and Hay Group.

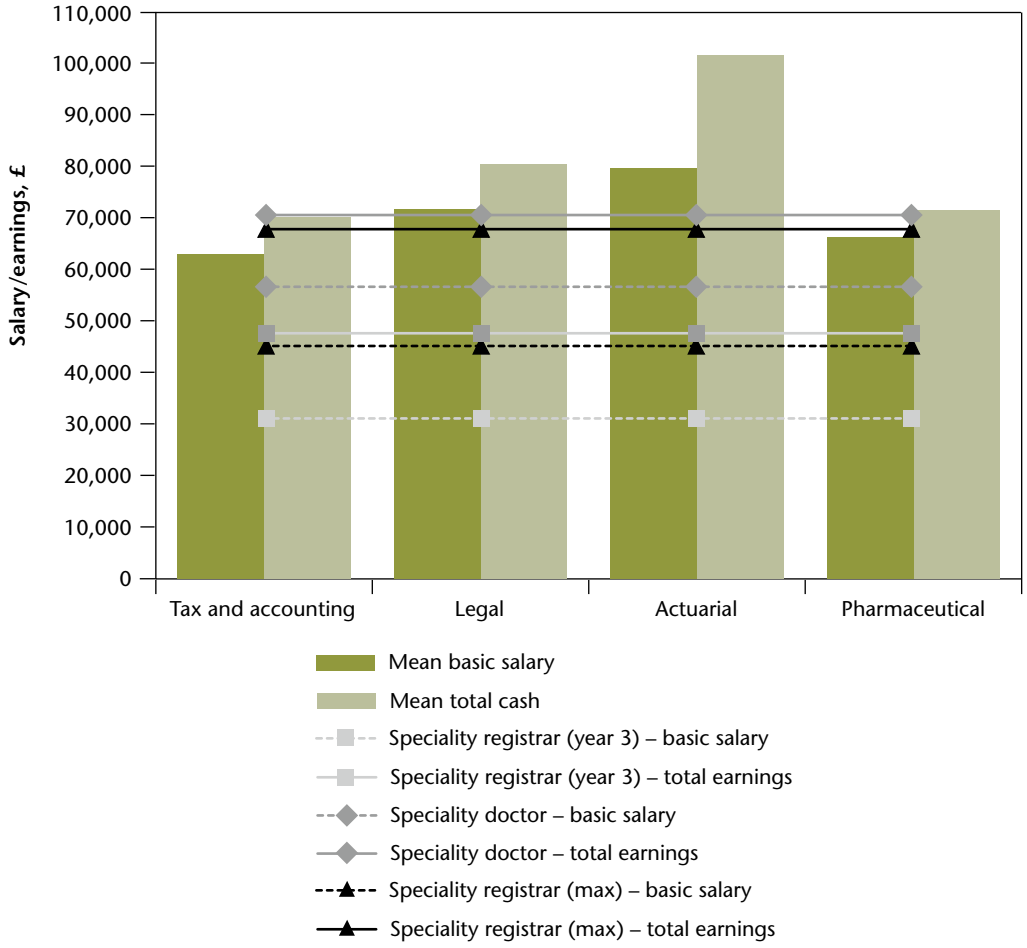
Specialty training 3 and onwards

F.9 Registrars in their third year of specialist training are required to complete Royal College membership exams; this anchor point is shared with the speciality doctor grade. Salaries and total earnings for comparator occupations cover a wide range, which is due to the anchor points spanning across three Hay reference points. Speciality doctors and speciality registrars (max) have similar total earnings which are also very competitive with legal, pharmaceutical and tax and accounting occupations although actuaries earn considerably more (Figure F.4). Third year speciality registrars had the lowest basic salary and total earnings of any of these groups.

[4] Based on salary scale minimum.

[5] Based on salary scale minimum plus estimated supplement proportions.

Figure F.4: Specialty training year 3 and onwards and specialty doctors – basic salary[6] and estimated total earnings[7] against mean basic salary and mean total cash for comparator professions, 2016



Source: NHS Digital and Hay Group.

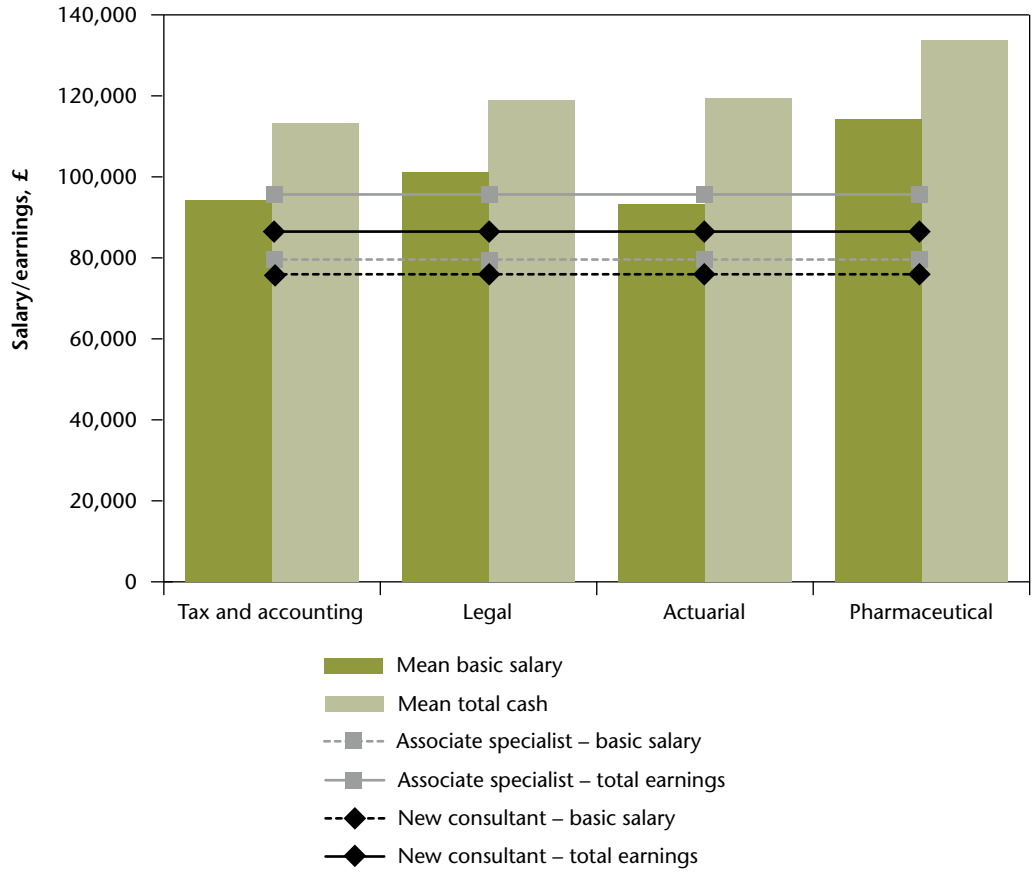
Consultant (minimum)

F.10 Entry to the consultant grade requires a formal qualification (i.e. membership of one of the Royal Colleges). Basic salary and total earnings for newly qualified consultants were lower than those generally seen in the comparator occupations. Associate specialists who are also linked at this anchor point faired a little better than new consultants in terms of comparisons in mean basic earnings and total earnings but are still behind those of their comparator groups (Figure F.5).

[6] All specialty registrar estimates are based on salary scales. The figure for specialty doctors is the estimated mean annual basic pay per FTE.

[7] All Specialty registrar estimates are based on salary scales plus estimated supplement proportions. 'Specialty doctors' is the estimated mean annual basic pay per FTE plus mean annual non-basic pay per person.

Figure F.5: Newly qualified consultant (on the minimum of the scale) and associate specialist – basic salary[8] and total earnings[9] against mean basic salary and mean total cash for comparator professions, 2016



Source: NHS Digital and Hay Group.

Consultant (maximum)

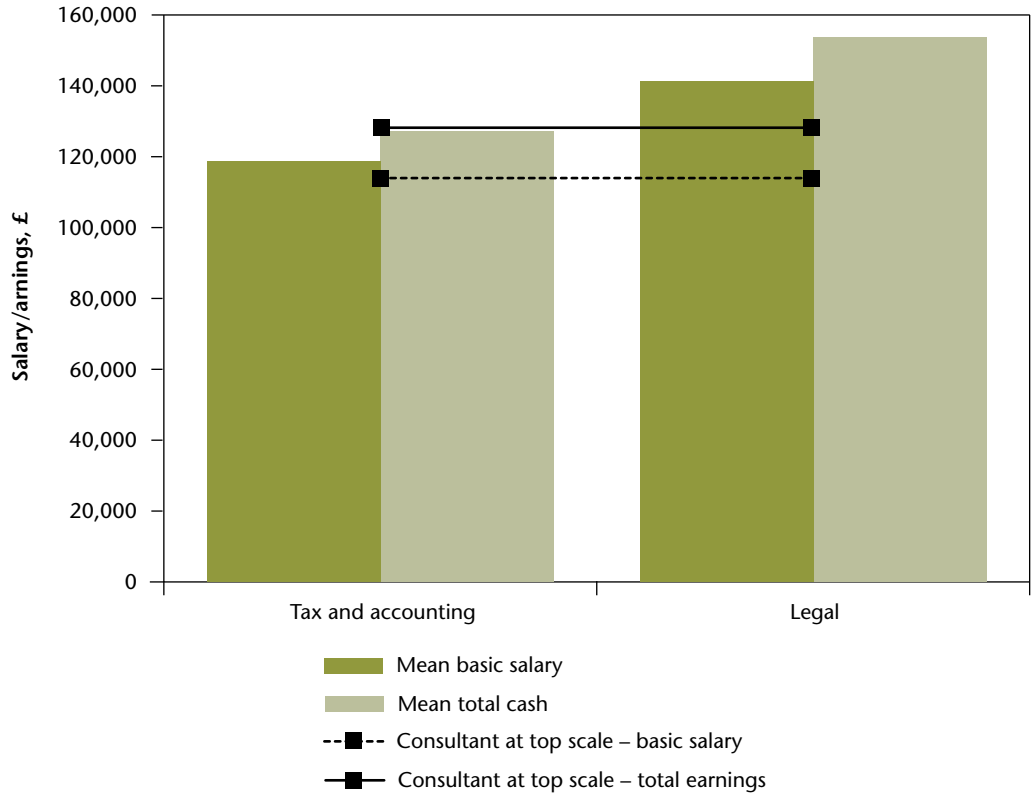
F.11 There is a (generally) accepted gap between the skills and responsibilities of newly qualified consultants and their more experienced counterparts. The final anchor point identified by PA Consulting is a consultant with at least 19 years' experience (and therefore at the scale maximum), with a level four clinical excellence award – worth £11,828 and considered to be the upper quartile[10] number of CEAs. An experienced consultant's basic salary is broadly in line with a matched worker in tax and accounting. However, consultant (max) total earnings fall behind their comparator occupations (Figure F.6).

[8] Consultant estimates are based on salary scale minimum. Associate Specialists is the estimated mean annual basic pay per FTE.

[9] Consultant estimates are based on salary scale minimum and an average of 11.4 Programmed Activities. Associate Specialists is the estimated mean annual basic pay per FTE plus mean annual non-basic pay per person.

[10] This is based on all consultants including those consultants without a CEA.

Figure F.6: Experienced consultant (at the scale maximum, with Level 4 CEA) – basic salary[11] and total earnings[12] against mean basic salary and mean total cash for comparator professions, 2016



Source: NHS Digital and Hay Group.

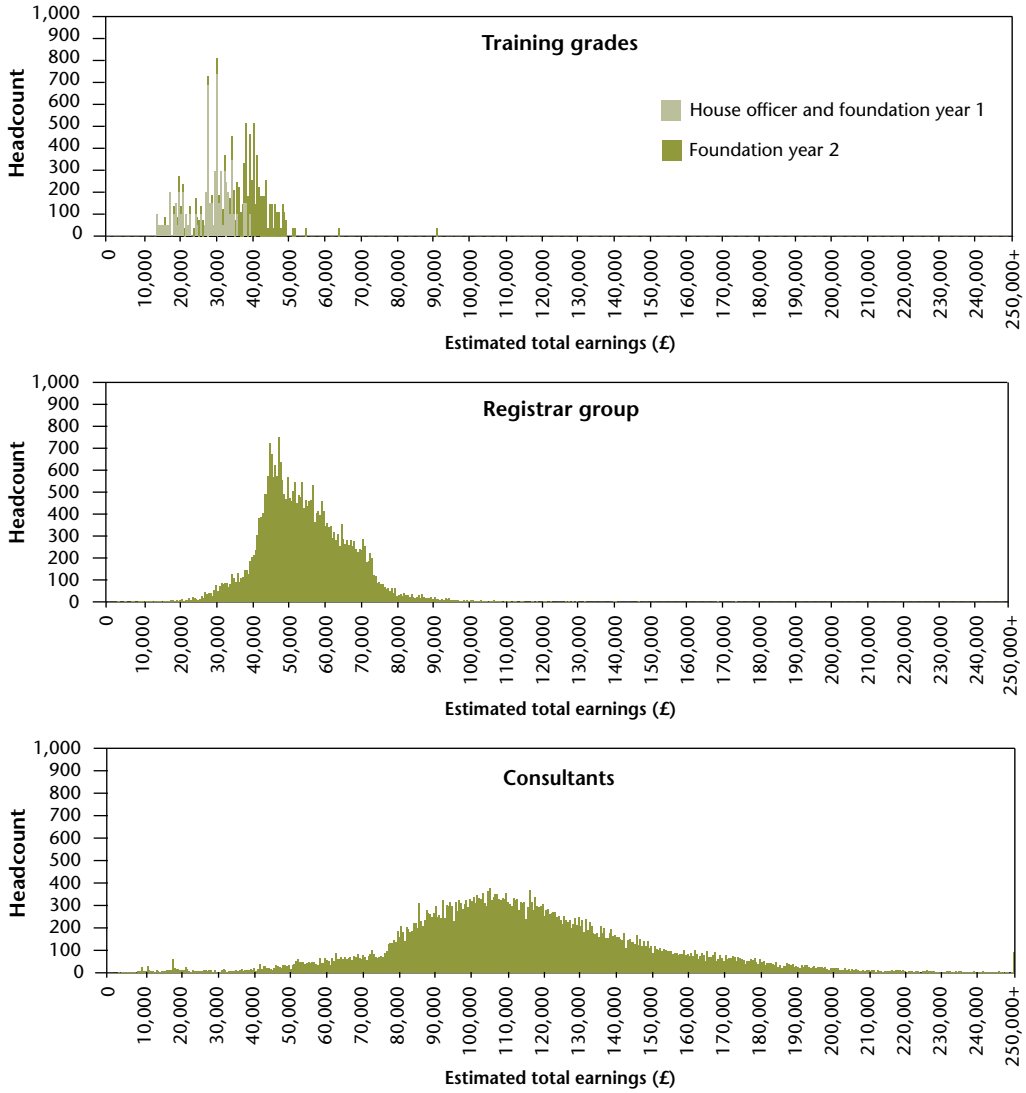
Note: Actuarial and pharmaceutical are not included due to the unavailability of data at this Hay level.

[11] Consultant estimates are based on salary scale maximum and a level 4 CEA.

[12] Consultant estimates are based on salary scale maximum and a level 4 CEA and an estimate of 11.4 Programmed Activities.

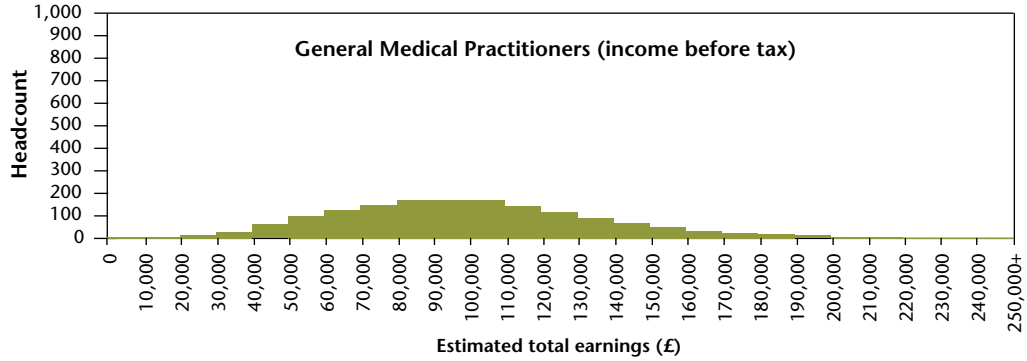
APPENDIX G: TOTAL EARNINGS DISTRIBUTION

Figure G.1: Estimated total earnings distribution for some staff groups, England, year to September 2016



Source: OME Analysis of NHS Digital.

Figure G.2: Estimated total earnings distribution for contractor GMPs, United Kingdom, 2014-15



Source: OME Analysis of NHS Digital using Her Majesty's Revenue and Customs data.

APPENDIX H: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
BAME	Black, Asian and minority ethnic
CCG	Clinical Commissioning Group
CDS	Community Dental Service
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
Con.	Consultant
CT 1-3	Junior doctor, later stages in training (core training)
DDRB	Review Body on Doctors' and Dentists' Remuneration
DETINI	Department of Enterprise, Trade and Investment in Northern Ireland
EER	Expenses to earnings ratio
F1	Foundation house officer Year 1
F2	Foundation house officer Year 2
FHO	Foundation house officer
FTE	Full Time Equivalent
GDC	General Dental Council
GDP	Gross Domestic Product
GDP	General dental practitioner
GDS	General Dental Services
GMC	General Medical Council
GMP	General medical practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General/Personal Medical Services
GPST	General Practice Specialty Training
HCHS	Hospital and Community Health Services
HSCNI	Health and Social Care Northern Ireland

HEE	Health Education England
HESA	Higher Education Statistics Agency
HSCIC	Health and Social Care Information Centre
JDC	Junior Doctors Committee
MPIG	Minimum Practice Income Guarantee
MSP	Member of the Scottish Parliament
NAO	National Audit Office
NHS	National Health Service
NI	Northern Ireland
OBR	Office of Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics
ONS	Office for National Statistics
PA	Programmed Activity
PCTMS	Primary Care Trust Medical Services
PDS	Public Dental Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SAS	Specialty doctors and associate specialists
SPA	Supporting Professional Activity
ST	Specialist training
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UK	United Kingdom
UKFPO	UK Foundation Programme Office

APPENDIX I: PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENTS RESPONSE

The main DDRB recommendations since 1990 for the general pay uplift are shown in the table below, together with the November or Quarter 4 RPI and CPI inflation figures which were usually the latest figures available at the time of publishing the Review Body's report and the Government's response to the recommendations as a whole.

Report year	Main uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
1990	9.5%	7.3	5.5	Not accepted. Rejected increases at top of consultants' scale and in the size of the A+ distinction award; staged implementation
1991	9.5% to 11%	10.9	7.8	Accepted, but staged implementation
1992	5.5% to 8.5%	3.7	7.1	Accepted
1993		3.6	2.6	No report following Government's decision to impose a 1.5% pay limit on the public sector
1994	3%	1.4	2.3	Accepted
1995	2.5% to 3%	2.4	1.8	Accepted
1996	3.8% to 6.8%	3.2	2.8	Accepted, but staged implementation
1997	3.7% to 4.1%	2.7	2.6	Accepted, but staged implementation
1998	4.2% to 5.2%	3.7	1.9	Accepted, but staged implementation
1999	3.5%	3.1	1.4	Accepted
2000	3.3%	1.2	1.2	Accepted
2001	3.9%	3.1	1.1	Accepted, but Government suspended the operation of the balancing mechanism (which recovers GMPs 'debt')
2002	3.6% to 4.6%	0.9	0.8	Accepted
2003	3.225%	2.6*	1.5	Accepted
2004	2.5% to 2.9%	2.5	1.3	Accepted
2005	3.0% to 3.4%	3.4**	1.5	Accepted
2006	2.2% to 3.0%	2.2**	2.1	Accepted, although consultants' pay award of 2.2 per cent was staged – 1.0 per cent paid from 1 April 2006 and the remaining 1.2 per cent paid from 1 November 2006
2007	£1,000 on all pay points***	3.9	2.7	Accepted, although Scottish Executive did not implement one of the smaller recommendations relating to the pot of money for distinction awards to cover newly eligible senior academic GMPs. England and Wales chose to stage awards in excess of 1.5 per cent – 1.5 per cent from 1 April 2007, the balance from 1 November 2007

[1] At November in the previous year, series CZBH.

[2] At November in the previous year, series D7G7.

Report year	Main uplift	RPI % (Nov)[1]	CPI % (Nov)[2]	Response to report
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted
2010	0% to 1.5%	0.3	1.9	Mostly accepted: DDRB recommended: 0% for consultants and independent contractor GMPs and GDPs; 1% for registrars, SAS grades, salaried GMPs and salaried dentists; and 1.5% for FHOs. England and Northern Ireland both restricted the FHO recommendation to 1%
2011	No recommendation due to public sector pay freeze	4.7	3.3	
2012	No recommendation due to public sector pay freeze	5.2	4.8	
2013	1%	3.0	2.7	Accepted
2014	1%	2.6 Q4	2.1 Q4	Accepted in Scotland. Partially accepted in England and Wales: no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales. Northern Ireland – no uplift to incremental points. 1% non-consolidated to staff at the top of pay scales.
2015	1%	1.9 Q4	0.9 Q4	Accepted. Recommendation only applied to independent contractor GMPs and GDPs in the UK and for salaried hospital staff in Scotland
2016	1%	1.0 Q4	0.1 Q4	Accepted
2017	1% (for England, Wales and Northern Ireland)	2.2 Q4	1.2 Q4	–

* Due to the late running of the round, DDRB was also able to take account of the March figures for RPI (3.1%).

** Due to a later round, November to February, DDRB was also able to take into account the December RPI figure.

*** £650 on the pay points for doctors and dentists in training. The average banding multiplier for juniors meant that this would also deliver approximately £1,000.

**** DDRB also took into account the December RPI figure (0.9%).

ISBN 978-1-4741-4133-8