Review Body on Doctors'
and Dentists' Remuneration

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Forty-Fifth Report 2017

Chair: Professor Sir Paul Curran

Executive Summary

Cm 9441

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;
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> regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists;
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> the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;
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> 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.

Executive summary

Recommendations for England, Wales and Northern Ireland 2017-18

Pay

- *A base increase of 1 per cent to the national salary scales for salaried doctors and dentists.*
- *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.*
- *The supplement payable to general practice specialty registrars to remain at 45 per cent of basic salary for those on the existing UK-wide contract.*
- *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.

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