Review Body on Doctors' and Dentists' Remuneration

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Forty-Sixth Report 2018

Chair: Professor Sir Paul Curran

Cm 9670

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

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

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

Presented to the Permanent Secretary of the Department of Health,
Northern Ireland

by Command of Her Majesty

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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 and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Cabinet Secretary for Health and Social Services in the Welsh Government and the First Minister, Deputy First Minister and Minister for Health 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 and Social Care, the First Minister and the Cabinet Secretary for Health and Sport of the Scottish Parliament, the First Minister and the Cabinet Secretary for Health and Social Services of the Welsh Government, the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive and the Prime Minister.

The members of the Review Body are:

> Professor Sir Paul Curran *(Chair)*
> David Bingham
> Mehrunnisa Lalani
> Professor Kevin Lee
> Professor James Malcomson
> John Matheson, CBE
> Nigel Turner, OBE
> Jane Williams

The Secretariat is provided by the Office of Manpower Economics.

Contents

Executive Summary

The DDRB's remit group

1. Across the United Kingdom (UK) the National Health Service (NHS) spends around £120 billion per annum and is the country's largest employer, with around 1.4 million staff. Our terms of reference cover over 215,000 doctors and dentists providing NHS services. These include 70,000 hospital doctors, 65,000 doctors and dentists in training, around 50,000 General Medical Practitioners (GMPs), and around 30,000 General Dental Practitioners (GDPs).

2. The remit group is complex: some of its members are salaried employees of the NHS, such as those who work in hospitals. Others, such as GMPs or GDPs, may work in the primary care sector as independent contractors, as salaried employees of practices, or locums.

Context

3. The position of the wider economy remains an important backdrop to our work (see Chapter 2).

    - The economy grew by 1.8 per cent in 2017, following growth of 1.9 per cent in 2016. The prospects for economic growth appear relatively muted across the UK, both over the next year and coming few years.
    - Inflation peaked towards the end of 2017. CPI inflation was broadly stable at around 3 per cent over the second half of 2017 and fell sharply to 2½ per cent in the early part of 2018. Over the period of the settlement it is generally expected to be close to 2 per cent and to fall towards the 2 per cent target by 2019.
    - Growth in average earnings had picked up through 2017, and at the time of making our recommendations was just over 2½ per cent. Pay settlements in the wider economy have also started to increase.

4. Over the course of previous reports, we have noted other background trends which continue to concern us. These include:

    - The level of motivation across our remit group, and their expectations about pay, as the country emerges from a period of tight public sector pay restraint into an era of more flexibility;
    - The challenges of addressing the flexibility and work-life balance sought by some in the modern medical workforce;
    - The negative impact on retention of changes to the taxation of pension benefits;
    - Recent restrictions in the availability of visas for overseas doctors and dentists seeking to work in the UK, which increase the challenge of recruitment and retention;
    - Uncertainties about the impact of Brexit.

5. We noted that, whilst we were engaged in our work, all four countries in the UK published strategy documents relating to their respective health sectors:

    - In England, a draft workforce strategy for the NHS in England went out to consultation in December 2017, with the final strategy to be published in July 2018.
    - In Wales, a review of health and social care in the country was published in January 2018. One of the goals was *enriching the wellbeing, capability and engagement, of the health and social care workforce.*
    - In Scotland, the Government published its National Health and Social Care Workforce plan in three parts between June 2017 and May 2018.
    - In Northern Ireland, the Department of Health published in May 2108 its own Workforce Strategy, building on the work of the Bengoa report.

6. There were further significant developments. In March 2018, the NHS Staff Council reached a framework agreement on the proposed reform of the NHS pay structure for Agenda for Change (AfC) staff. In June 2018 the majority of NHS Trades Unions announced that they had accepted the proposed pay deal for England. In Scotland on 9 June 2018 the First Minister announced that AfC staff in the NHS earning up to £80,000 would receive at least a 3 per cent pay uplift and those earning £80,000 and over would receive a flat rate increase of £1,600. The delivery of medical care is a collaborative effort between those in our remit group and staff in the AfC grades.

7. The past year has also seen:

    - Agreement between the NHS Employers and the BMA on reform to the current system of local Clinical Excellence Awards (CEAs).
    - The roll-out of the new junior doctors' contract in England.
    - In Scotland, from April 2018 the introduction, with BMA agreement, of a new contract for the provision of General Medical Services.

Our remits and our process

8. We received remits this year from each of the four countries of the UK.

9. The Chief Secretary to the Treasury (CST) wrote to us to say that the last Spending Review budgeted for 1 per cent average basic pay awards, but that the Government recognised that in some parts of the public sector, particularly in areas of skill shortage, more flexibility may be required.

10. In Scotland, the new public sector pay policy explicitly set out a guaranteed minimum increase of 3 per cent for those earning £36,500 or less, up to 2 per cent for those earning below £80,000 and a maximum increase of £1,600 for those earning £80,000 or more.

11. In the same letter referred to in paragraph 9 the CST went on to say that the move to a single fiscal event in the autumn of 2017 would mean that the round would run to a later timetable this year. We asked the evidence-providers to make written submissions by 18 December 2017. However, written evidence from the Department of Health and Social Care (DHSC) was not received until 19 January 2018 and evidence from the Scottish and Welsh Governments was not received until 7 February 2018 and 19 February 2018 respectively. The BMA and BDA, both raised concerns about the late delivery of written evidence by other parties.

12. We received written and oral evidence from the Department of Health and Social Care (England); the Welsh Government; the Scottish Government; the Department of Health (Northern Ireland); NHS England; NHS Improvement; Health Education England; NHS Employers; NHS Providers; the British Medical Association (BMA); the British Dental Association (BDA); and the Hospital Consultants and Specialists Association (HCSA).

The case for a pay award

13. We understand that pressure on health services remains severe, given the current financial settlement. Over recent years we have felt that the evidence supported pay increases for our remit group that have been in line with the government's pay policy, but we noted last year that the case for continued pay restraint was diminishing. We have not seen sufficient evidence to persuade us of the case for a settlement that would undo the effects of this period of pay restraint, but we have heard evidence that employers are facing increasing difficulties recruiting and retaining the medical and dental workforce they need, and that the motivation and morale of doctors and dentists and their satisfaction with their pay have declined.

14. On recruitment, this year we have seen a continuing decline in the numbers of university applications for pre-clinical medicine and, pre-clinical dentistry, but we have been presented with no evidence that quality problems are starting to emerge.

15. We have heard that overseas recruitment may be affected by uncertainty around Brexit, by the ability of candidates to obtain visas to enter the UK, and by the time taken to procure such visas. Moreover, the relative fall in the value of the pound since the middle of 2016, particularly against the Euro, will have reduced for overseas applicants the financial value of medical posts paid in sterling.

16. An increasing proportion of junior doctors are stepping out of training after Foundation Year 2. This phenomenon may be a reflection of the choices doctors and dentists are now making early in their career about work-life balance. We referred to this in our 45th Report 2017, and employers in the NHS may have to accommodate such demands. However, the data we have seen suggests that the vast majority are returning within a year or two and are not being permanently lost to the NHS.

17. We have seen an increase in the number of doctors choosing to retire at an earlier age. One cause may be the impact of lowering the thresholds of the pensions annual and lifetime allowances.

18. On motivation and morale, Staff Survey data for 2017 in England were generally less positive than in 2016. The results showed a decrease in engagement scores, a fall in satisfaction with pay, and a fall in job satisfaction in general. Meanwhile, workforce pressures remained high and showed little sign of easing.

19. We considered the extent to which it was appropriate to target some or all of our recommendations on specific areas. We had to balance this against the possible demotivating and divisive effect on those who would have lost out with an approach based solely on targeting.

20. We are convinced by the evidence we have seen that we have reached a point at which, if we are properly to balance the different factors listed in our terms of reference, a pay recommendation, with a general uplift greater than the 1 per cent which the UK Government states has been funded, now becomes necessary. We believe the workforce represented by our remit group should not now be expected to see their pay decline significantly further in real terms.

21. Both price inflation (as measured by CPI) and average earnings growth are an important part of this year's context. At the time of reporting both are at or around 2½ per cent, although CPI over the period of the settlement is generally expected to be close to 2 per cent.

22. Taking account of all these circumstances, we conclude that the appropriate level for a general increase, should be 2 per cent, which broadly maintains pay in real-terms. In making our recommendations we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs and GDPs net of expenses.

We recommend:

- **A minimum 2 per cent increase to the national salary scales for salaried doctors and dentists across the UK;**
- **For independent contractor GMPs and GDPs across the UK a minimum increase in pay, net of expenses, of 2 per cent;**
- **The maximum and minimum of the salary range for salaried GMPs be increased by 2 per cent;**
- **An increase in the GMPs trainers' grant and rate for GMP appraisers of 2 per cent;**
- **That the flexible pay premia included in the junior doctors' contract in England increase by 2 per cent.**

Targeting

23. As invited to do so by some of our evidence providers, we considered the case for targeting in some specific areas. We have focused on areas where the needs seem greatest. That has led us to focus our recommendations on GMPs and specialty doctors and associate specialists (SAS) this year.

General Medical Practitioners (GMPs)

24. Health providers are looking to increase the emphasis on primary care and to do so, increase the number of GMPs. This will require a combination of increasing the number of training places, overseas recruitment, and encouraging suitably qualified doctors to remain in, or return to, the workforce. Expanding the number of trainees will take a considerable number of years to have an impact, but overseas recruitment could have an impact more quickly. The ambition to expand the GMP workforces may be affected by uncertainty around Brexit and by the recent limited ability of candidates to obtain visas to enter the UK.

25. We observed that for GMPs in particular there were several specific issues potentially impacting on retention. These include:

- The extent to which the role of the GMP will change and the demands increase as a result of the greater integration of healthcare with social care;
- The increasing regulatory and administrative burden of running practices;
- The increasing demands posed by a rising and an ageing population with more complex needs;
- A decreasing willingness on the part of younger GMPs to work the number of sessions their predecessors worked;
- The data show an increase in the number of GMPs taking voluntary early retirement which may be linked to lowering the thresholds of the pensions annual and lifetime allowances;
- The increasing tendency for GMPs to prefer salaried employment to practice ownership;
- The fact that average gross earnings for GMPs, both contracted and salaried, were lower in nominal terms in 2015-16 than in 2006-07.

26. These concerns were underlined by results from the University of Manchester National GP Work Life Survey, published in May 2018. The survey reported an increase in the number of GMPs in England saying they were likely to leave direct patient care in the next five years, and the vast majority reporting considerable or high pressure from increasing workloads. Those conducting the survey found that low satisfaction and high pressure reported by GMPs in 2015 had been repeated in 2017, and said that this may have implications for recruitment, retention and patient care.

27. These factors all appear to have combined to make it less attractive to pursue the traditional GMP career path, which leads ultimately to practice ownership. This concerns us, particularly given the renewed emphasis being placed on the role of the GP in addressing demand for health services and hence delivering the productivity improvements sought from this. We believe that a pay response can help achieve this goal. We recognise that many of the problems facing this part of our remit group are not necessarily resolved through pay alone. However, we believe that if sufficient number of GMPs are either to be recruited from overseas or encouraged to remain in the service longer than they otherwise would have done, a pay response is required now. Such a response needs to be significant and go beyond our recommended base increase for the pay remit group as a whole.

- **We recommend for independent contractor GMPs an additional increase in pay, net of expenses, of 2 per cent above our minimum pay recommendation[1];**
- **We make a similar additional 2 per cent recommendation to the maximum and minimum of the salary range for salaried GMPs and to the GMP trainers' grant and the rate for GMP appraisers.**

Specialty doctors and associate specialists (SAS)

28. SAS doctors are the specialty doctors and associate specialists in the hospital system, of whom there are about 11,000 working across the UK, or around 1 in 10 of the hospital doctor workforce. In England, compared with other groups within our remit, SAS doctors contained the highest proportion of BAME staff, with only about 4 in 10 staff identifying as white. SAS grades also contained a higher proportion of women, at 45 per cent, when compared to consultants, where the figure was 35 per cent. Health Education England (HEE) data suggested that three-quarters of SAS doctors in England had obtained their primary medical qualification abroad.

29. We have drawn attention over several years to the pivotal role that SAS doctors play in the provision of hospital services. We were pleased to see this acknowledged by HEE who said that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas'.

30. We believe that SAS doctors are a significant element of the wider medical team that, through their front-line roles, make an important contribution to productivity. We would further observe that the role of an SAS doctor, if properly structured and managed in career terms, could be attractive to those whose commitments might otherwise deter them from following the path to consultant.

31. Results from the NHS Employers and BMA surveys highlighted problems with recruitment and retention to SAS posts, and pay, morale, workload, career progression and development were cited as factors. We noted that the 2017 Staff Survey results in England showed this group had the highest dissatisfaction with pay of the medical groups and felt least valued for their work.

32. Some steps have been taken to try to address these issues, such as through the introduction of the SAS Charters and the establishment of SAS doctors' development funds, but we were not encouraged to hear that a majority of the doctors concerned were unaware of the existence of a Charter and had not accessed the development funds.

33. The lack of any substantial progress in this area tends to reinforce the impression that the needs of this group are not being treated with what we feel should be the appropriate level of priority. A review covering the roles, career structure, salary structure and developmental support available to SAS doctors appears to us to be urgently needed. In the meantime, and in the interests of addressing the motivation of this group, and HEE's view that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas', we believe that a pay solution is required, and therefore,

    - **We recommend for SAS doctors an additional increase in pay, of 1.5 per cent, above our minimum pay recommendation.**

[1] In making our recommendation we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs net of expenses.

Doctors and dentists in training

34. In 2016 a new contract for doctors and dentists in training was introduced in England, with new trainees moving on to it from October of that year. The BMA said that the contract was being introduced without its agreement. Those working in Scotland, Wales and Northern Ireland are still on the previous contract.

35. Competition for places on pre-clinical medicine and pre-clinical dentistry courses remained strong, with roughly nine applications per acceptance in 2017. The number of applications for these courses has declined in recent years but we have seen no evidence to suggest this is leading to a reduction in quality.

36. Generally, between 2011 and 2016, for Foundation Years 1 and 2 (F1 and F2), the average total earnings for both doctors and dentists in training in England have remained significantly higher than median earnings of full-time employees but have nonetheless fallen back towards the median. However, we also observe that between September 2016 and September 2017, F1 and F2 monthly average total earnings for doctors in training in England has increased, following the introduction of the new contract, increasing by 5.4 per cent for F1, 2.4 per cent for F2, 4.3 per cent for core training, and 2.8 per cent for Registrars.

37. On this basis we do not believe that any further uplifts are required for doctors and dentists in training, beyond the minimum base increase which we have recommended above across the whole of our remit group.

38. The 2016 contract in England includes flexible pay premia for those undertaking general practice training, emergency medicine and psychiatry. HEE told us it had a key role in making recommendations on the targeting of flexible pay for hard to recruit specialties, and that it was now recommending the application of a premium for histopathology.

39. We heard some anecdotal evidence to suggest that the geographical distribution of both doctors and dentists may be influenced by where they finished their training.

40. As a matter of general principle, it seems right to us that any geographically-targeted pay premia should be designed so that they provide an incentive to doctors and dentists at the points in their careers where they will have the greatest impact. HEE said that the Targeted Enhanced Recruitment Scheme (TERS) for GMPs which targets this group early in their career, has been effective in encouraging trainees to take up posts in hard-to-fill areas. There are also a range of incentives in Scotland for doctors and dentists in remote and rural areas, and relocation packages for GMPs. We noted however that the Welsh government said in its evidence that it was opposed to targeting pay to specific staff groups. In general, TERS seem to us to be a potentially helpful way to address specialism and geographical shortages.

41. On implementation of either specialty or geographic premia, we observe that the DDRB was not asked to make a recommendation on specific proposals before it was decided to introduce the existing premia in England. We would support strongly the introduction of specialty premia in appropriate circumstances, particularly that proposed for histopathology. We would also support strongly the parties in their efforts to move forward the application of appropriately targeted geographic premia.

42. We would find it helpful in the evidence next year to receive reports on the impact of those premia already in place as the nature and the size of any such specialty or geographical premia should be kept under regular review to ensure that they do not outlive their usefulness. There may well be scope to expand existing premia further, but decisions on extension should be subject to the same careful review as decisions on continuation of the current schemes.

Consultants

43. In England the consultant workforce has doubled in size between 2000 and 2017. Some of this increase is the result of a conscious decision to change from a consultant-led service to a consultant-delivered service. We also observe that NHS output has grown, but at a slower rate than growth in consultant numbers.

44. Despite the long-term increase in consultant numbers, the evidence demonstrates that there continue to be persistent vacancies at consultant level. One issue that has been raised with us is the taxation of pensions. We have heard some evidence that lowering the thresholds of the pensions annual and lifetime allowances are leading to some more experienced members of the workforce choosing to retire earlier than they would otherwise have done. We observe that while anecdotal evidence is readily available, the numerical evidence in support of this assertion is not currently strong and more work needs to be done to better understand the situation.

45. Overall, we see no case at this stage for an uplift in the basic salary scales for consultants beyond our recommended minimum base increase of 2 per cent. Additional increases may become appropriate in the future if negotiations over a new contract for consultants deliver substantial productivity increases.

46. We are pleased to see that NHS Employers and the BMA have now been able to make progress towards implementing our 2012 recommendations in England, on the reform of local Clinical Excellence Awards (CEAs), though there is still further to go. We recognise the merits of the changes that have been agreed to local CEAs by NHS Employers and the BMA as part of the wider on-going consultant contract negotiations, including changes that make new awards non-pensionable, and the increased investment ratio. We recognise that these arrangements, which have only recently been negotiated, need to be given time to bed down in order to deliver the productivity outcomes which they are designed to support, before further changes are made to implement our 2012 recommendations more fully.

47. In recent years we have recommended increasing the value of consultant awards in line with our main pay recommendation for consultants and have done so again this year.

    - **We recommend that the value of Clinical Excellence Awards, Distinction Awards and Discretionary Points increase in line with our recommendation for the basic consultant pay scales.**

Dentists

48. Dentist numbers are steady, while figures showing access to and satisfaction with dental services are generally positive, although the BDA told us that increased pressures in the NHS and a reduction in dental incomes mean there is a looming crisis in general dental practice. Despite this, we were told in oral evidence from NHS England that they were able to let contracts for NHS dentistry and that some practices were being bought on the open market for good prices. However, the BDA challenged whether the prices paid represented the true earnings potential and that dental contracts were being handed back.

49. Although the headline income statistics show a reduction in dental incomes it is difficult to draw firm conclusions as the figures are based on headcount rather than full-time equivalents (FTE), so may reflect changes in working patterns rather than income.

50. We have heard that reform of dental contracts is an issue across the UK as a whole. We were told that new models of service provision had been piloted, some as far back as 2011, but we were given little evidence to help determine whether they were providing a suitable role model for the way(s) ahead. We expect to be kept informed of developments in this area and hope that at least in some parts of the UK the parties are able to reach agreement on the introduction of new arrangements.

51. On this occasion, as in previous years, we were struck by the relative absence of evidence or data to underpin any argument for recommendations going beyond the basic minimum increase we are recommending for the remit group in general. We will continue to monitor the situation, but we would ask the parties to consider what further data might be available. In the meantime, we have concluded that pay net of expenses should be increased by the same basic increase as for the rest of our remit group, namely 2 per cent.

Pay policy and affordability

52. All four countries in the UK have asked for recommendations, which we have made on the basis of the evidence we have received, and it is for each of them to decide how they respond. They will each face their own local challenges.

53. We regard the market for doctors and dentists as, for the most part, a UK-wide one. We have not seen any evidence to suggest that our remit group faces fundamentally different issues in different national markets, so our pay recommendations have not distinguished between the constituent countries within the UK.

54. We have noted in this respect the Welsh Government's view that considerations of fairness dictate that pay should align across the UK for the individuals fulfilling equivalent roles across the UK NHS and to avoid unhelpful internal competition for staff within the NHS workforce.

55. We have also noted that pay policy in Scotland, devised for the public sector as a whole, would relate to our remit group differentially. We have not sought to adjust our recommendations to take account of this. We have however noted that this different treatment may result in different outcomes for individual groups.

56. The Department of Health in Northern Ireland said that the 2016-17 pay policy as set by the previous Finance Minister continued to apply in 2017-18. In practical terms this may affect how quickly a response can be made to our recommendations. We recognise the political circumstances in Northern Ireland currently present challenges to moving ahead in the development of policy in this area, as in others.

57. Clearly, proposals for pay increases imply spending money which would not then be available for other health service priorities. However, the overall effectiveness of the NHS depends on recruiting, retaining and motivating adequate numbers of qualified staff, who can focus on caring for patients and on improving productivity. In that context, after nine years of pay awards no greater than 1 per cent, we are clear that increases of the order that we recommend this year are appropriate under the terms of our remit.

Looking ahead

58. The final part of our report looks forward to the pay round for the future year, and the areas on which we would expect to hear further about developments.

59. If the review body process is to work effectively, it is important that all the parties strive to work to an agreed timetable. Much of the Government evidence was delayed this year and both the BMA and the BDA were concerned that the process was delayed to such an extent this year that they gave evidence to DDRB after the date on which any award was due. For our 2019 Report we are seeking an early indication of when we can expect to receive evidence so that we can say when we would be able to submit our report.

60. Subject to this we set out in Chapter 11 the areas on which it would be helpful to have more evidence for the next round, which we have set out in tabular form.

CHAPTER 1: INTRODUCTION

Introduction

1.1 For this pay round we received remits from all four UK countries. The remits differed slightly, reflecting the different priorities and public sector pay policies of each Government. More detail on the remits is provided later in this chapter.

Structure of the report

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.

1.3 This report is divided into eleven chapters:

1. Introduction
2. Economic outlook
3. Affordability, productivity and workforce demand
4. Pay, motivation and workforce supply
5. Doctors and dentists in training
6. Specialty doctors and associate specialists (SAS)
7. Consultants
8. General Medical Practitioners
9. Dentists
10. Pay recommendations and observations
11. Looking forward

1.4 We also include seven appendices:

A. Remit letters from the parties
B. Detailed recommendations on remuneration
C. The number of doctors and dentists in the NHS in the UK
D. Glossary of terms
E. The data historically used in our formula-based decisions for independent contractor GMPs and GDPs
F. Abbreviations and acronyms
G. Previous DDRB recommendations and the Government's response

Key context for this report

1.5 In September 2017 the Chief Secretary to the Treasury (CST) wrote to us to say that the move to a single fiscal event in the autumn of 2017 would delay the submission of departmental evidence, and acknowledged that the round would run to a later timetable this year.

1.6 The Westminster and Holyrood Governments both announced changes to their policies for public sector pay.

1.7 Since January 2017 there has been no functioning Northern Ireland Executive. This has meant a lack of budget certainty and ministerial direction, which has had an impact on the ability of public services to plan effectively.

1.8 There has been a move towards greater integration of health and social care services across the UK.

1.9 A new junior doctors' contract was introduced in England in October 2016, without the agreement of the BMA. Discussions are underway in England about changes to the contract arrangements for consultants.

1.10 A new General Medical Services contract in Scotland was agreed between the Scottish Government and the Scottish GP Committee of the BMA, with effect from 1 April 2018. The new contract aims to reduce GMP workload through the expansion of primary care multidisciplinary teams, increase support for GMPs, and provide financial stability for GMPs.

1.11 In March 2018 the NHS Staff Council reached a framework agreement on the proposed reform of the NHS pay structure for Agenda for Change (AfC) staff. In June 2018 the majority of NHS Trades Unions announced that they had accepted the proposed pay deal for England.

Remits for this report

1.12 The remit letters from each of the four countries are included in full at Appendix A.

HM Treasury

1.13 The CST wrote to Pay Review Body Chairs on 21 September 2017, to say that the last Spending Review had budgeted for 1 per cent average basic pay awards and that there would still be a need for pay discipline over the coming years but that the Government recognised that in some parts of the public sector, particularly in areas of skill shortage, more flexibility might be required.

Department of Health and Social Care (England)

1.14 The Secretary of State sent his remit letter on 7 December 2017 which invited us to make recommendations in relation to the employed medical workforce, targeting funding to support productivity and recruitment and retention. We were also asked to consider how resources might be targeted: through existing flexible pay premia in the contract for doctors and dentists in training; and as a response to discussions between NHS Employers and the BMA on reform of the consultant contract.

Welsh Government

1.15 The Cabinet Secretary for Health and Social Services wrote to us on 21 December 2017, asking for recommendations that would enable him to determine a fair pay award for medical and dental staff in Wales and what level of pay award could be afforded by the NHS in Wales in the absence of further funding from the HM Treasury.

Scottish Government

1.16 The Cabinet Secretary for Health and Sport wrote to us on 7 February 2018 to ask us to make recommendations in this pay round for employed doctors and dentists, and to make recommendations for GMPs pay and the contractual uplift and pay of GDPs.

Northern Ireland Department of Health

1.17 The Permanent Secretary of the Department of Health wrote to us on 18 December 2017, and submitted evidence to assist us in the task of providing recommendations for Northern Ireland for the 2018-19 pay round.

Our comments on the remits

1.18 Remits for England and Scotland were informed by developments in the public sector pay policies in each country. In England the Government pay policy recognised that in some parts of the public sector, particularly in areas of skill shortage, more flexibility might be required to deliver world class public services, including improvements to public sector productivity.

1.19 In Scotland the new public sector pay policy explicitly set out a guaranteed minimum increase of 3 per cent for those earning £36,500 or less, up to 2 per cent for those earning above £36,500 and below £80,000 and a maximum increase of £1,600 for those earning £80,000 or more. On 9 June 2018 the First Minister announced that AfC staff in the NHS earning up to £80,000 would receive at least a 3 per cent uplift and those earning £80,000 and over would receive a flat rate increase of £1,600.

1.20 The Welsh Government asked us to recommend what level of pay award could be afforded by the NHS in Wales in the absence of further funding from the HM Treasury. Affordability is one of the factors we take into account when making our recommendations. However, our main role is to advise on pay, and it is not part of our remit to advise Governments on how much financial resource they should devote to the NHS in general.

1.21 In Northern Ireland, the absence of an Executive and a Minister for Health meant that our remit was given by the Permanent Secretary of the Department of Health.

The remit group

1.22 At September 2016 our remit group comprised approximately 217,000 doctors and dentists across the UK, a 1.1 per cent increase from the previous year. A breakdown of this figure is available at Appendix C.

Parties giving evidence

1.23 We received written and oral evidence from the organisations listed below:

Government departments and agencies

- Department of Health and Social Care (England)
- NHS England
- NHS Improvement
- Health Education England
- Welsh Government
- Scottish Government
- Department of Health (Northern Ireland)

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing doctors and dentists

- British Dental Association (BDA)
- British Medical Association (BMA)
- Hospital Consultants and Specialists Association

1.24 We asked the evidence providers to make written submissions by 18 December 2017. However, written evidence from the Department of Health and Social Care (DHSC) was not received until 19 January 2018 and evidence from the Scottish and Welsh Governments was not received until 7 February 2018 and 19 February 2018 respectively.

1.25 The BMA and BDA, both of whom submitted their evidence by the December deadline, raised concerns about the late delivery of written evidence by other parties. The BMA said that if any parties were unable to make the agreed timescale, then steps should be taken either to revise the timescale, or to ensure that no evidence was shared by the DDRB until all parties had submitted their evidence. The BDA wrote to us in January 2018 describing the delay as an unsatisfactory state of affairs, and that giving oral evidence after 1 April 2018, the date to which any award should apply, should not be considered acceptable. The BDA also asked that we comment about the process this year, and that we call on Government to make sure remit letters are issued in good time, as this would allow evidence timetables to be maintained. This is an issue to which we return in Chapter 11.

Last year's recommendations

1.26 In our 45th Report 2017, 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 2017-18. We were comfortable for that year with a pay recommendation that was in line with the Government's pay policy, but noted that the case for continued pay restraint was diminishing.

1.27 We considered whether we should target our recommendations on the basis of recruitment and retention. We made the general point, which we repeat here, that we are unconvinced by arguments that shortages are not amenable to pay. We recognised that there are non-pay approaches, but we had not seen any evaluation which suggested they could provide a substitute for pay-based solutions. We considered that non-pay measures had been given a more than reasonable time to address issues, and so pay solutions should now be explored.

1.28 We also noted our concerns that geographic shortages risked being ignored or at best handled piecemeal. We considered there was more scope for national targeting by agreement: we felt that it was highly desirable that different types of targeted pay and reward incentives should be explored, including some that might be radically new. However, we recognised the practical difficulties: a nationwide system would be slow to develop, and that we could see no mechanism for enabling new ideas, backed by appropriate resources, to be locally stimulated and tested rapidly.

1.29 We concluded that we should not target our recommendations on the basis of recruitment and retention, as the overall pay uplift was modest and there was a risk of demotivating those whose pay was uplifted least.

1.30 Our main pay recommendations for 2017-18 were:

- 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 and GDPs, an increase in pay, net of expenses, of 1 per cent;
- 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, Distinction Awards, Discretionary Points and Commitment Awards – to increase in line with our main pay recommendation of 1 per cent.

1.31 In response, the Department of Health (England) accepted and implemented our pay recommendations in full, as did the Welsh Government.

1.32 The Scottish Government and the Department of Health in Northern Ireland 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 2017-18.

CHAPTER 2: ECONOMIC OUTLOOK

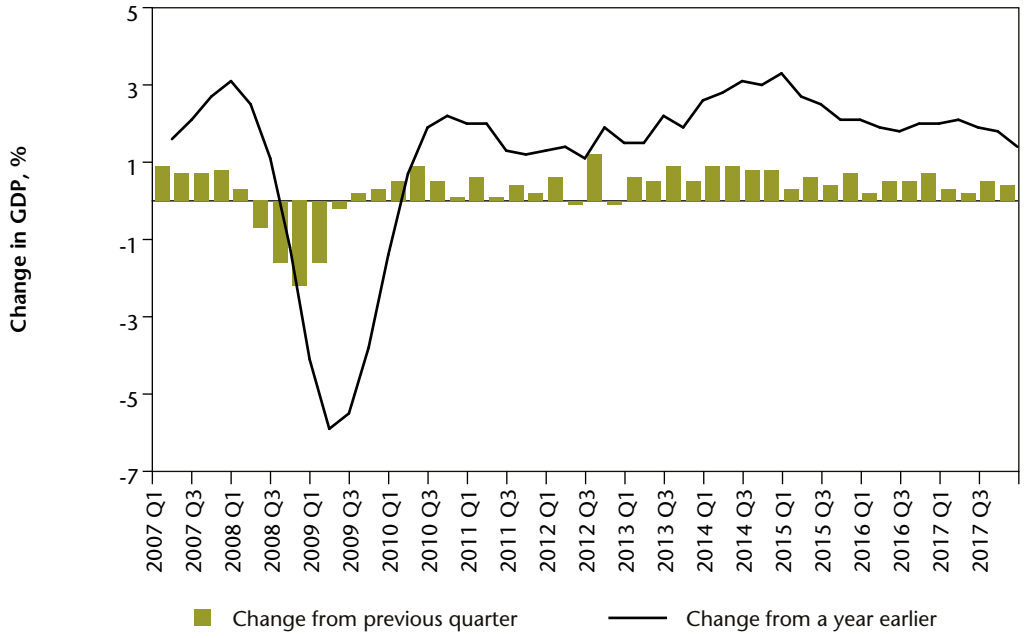
Introduction

2.1 In this chapter we look at the wider economic context, taking account of economic growth, price inflation and the state of the labour market, including average earnings growth and recent pay settlements.

Economic growth

2.2 Gross domestic product (GDP) in the UK grew by 1.8 per cent in 2017, following growth of 1.9 per cent in 2016.

Figure 2.1: Gross domestic product (GDP) growth, United Kingdom, 2007 to 2017



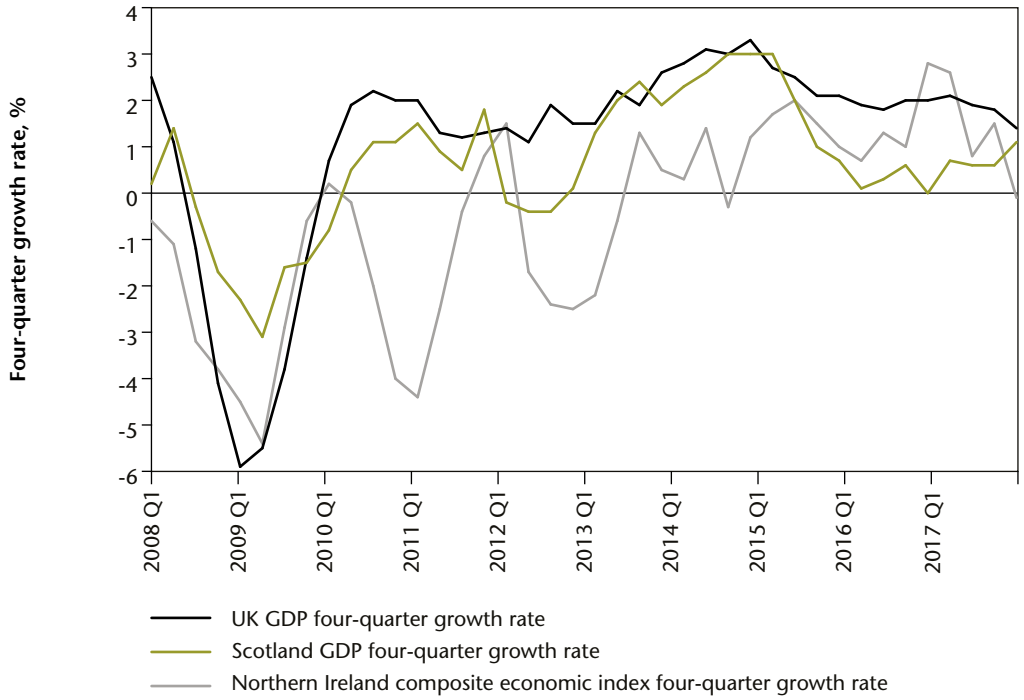
Source: ONS, gross domestic product, quarter-on-quarter growth (IHYQ); four-quarter growth (IHYR), seasonally adjusted, UK, Q1 2008-Q1 2018.

2.3 The overall growth rate in 2017 obscures some important differences across different parts of the economy. For example, while the service sector grew by 1.5 per cent in 2017, manufacturing output grew by 2.5 per cent and the construction sector grew by 5.7 per cent.

2.4 Figure 2.2 compares economic growth in Scotland and Northern Ireland with that in the UK as a whole. Economic growth in Scotland was similar to that for the UK as a whole in 2013 and 2014, but the Scottish economy has not kept pace since 2015, and grew by just 1.1 per cent in 2017. The Northern Ireland economy has also grown more slowly than the UK as a whole since 2010, and in 2017 economic activity in Northern Ireland grew by 1.2 per cent.

2.5 Separate GDP data are not available for Wales, but the index of market services for Wales, which accounts for 45 per cent of the market economy, grew by 1.7 per cent in 2017 and 2.0 per cent in 2016 (compared to 2.0 and 3.1 per cent growth across the UK as a whole). Since the third quarter of 2009, growth in the index has been 14.6 per cent for Wales, and 23.5 per cent for the UK as a whole.

Figure 2.2: Annual gross domestic product (GDP) growth rate, United Kingdom, Scotland and Northern Ireland, 2008 to 2017



Source: ONS, gross domestic product, four-quarter growth (IHYR), seasonally adjusted, UK.
Scottish Government, gross domestic product. DETINI: Northern Ireland Composite Economic Index.

2.6 The Office for Budget Responsibility (OBR) in its March 2018 economic forecast said that the UK economy had slightly more momentum in the near term, due to the unexpected strength of the world economy, but there was little reason to change the view of its medium-term growth potential. It expected growth of 1.5 per cent in 2018, slowing to 1.3 per cent in 2019 and 2020, before picking up modestly over the subsequent two years. In its May 2018 Inflation Report, the Bank of England revised down its forecast for 2018 GDP growth from 1.8 per cent to 1.4 per cent, in the light of the weak figures for the first quarter of 2018. It then expected GDP growth of 1.7 per cent in 2019 and 2020.

Table 2.1: GDP forecasts, year on year growth, United Kingdom

	Office for Budget Responsibility (OBR) %	Bank of England central projection %	Treasury independent median %
	March 2018	May 2018	May 2018
2018	1.5	1.4	1.4
2019	1.3	1.7	1.6
2020	1.3	1.7	1.7
2021	1.4	-	1.8
2022	1.5	-	1.8

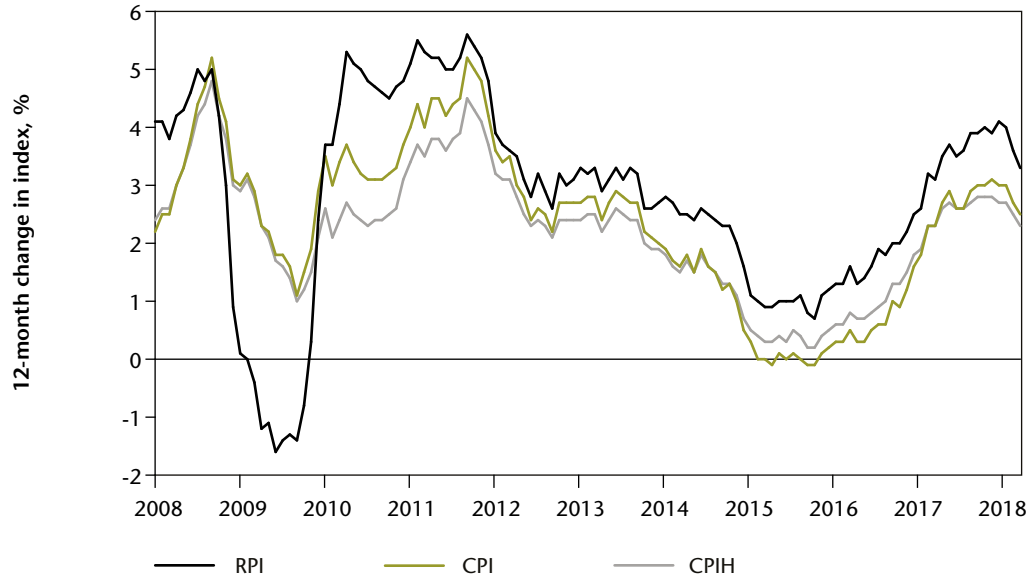
2.7 The Scottish Government said that independent forecasters expected growth of between 0.7 per cent and 1.4 per cent in 2018, below the long-run trend of 2.0 per cent. The Welsh Government noted that it did not publish growth forecasts for the Welsh economy, but considered that the performance of the Welsh economy would be driven largely by the performance of the wider UK economy.

2.8 Taken together, prospects for economic growth appear relatively muted across the UK, both over the next year and coming few years.

Inflation

2.9 Figures for March 2018, as measured by the Consumer Prices Index (CPI), show inflation at 2.5 per cent. CPI inflation has fallen sharply over the last two months, having been broadly stable at around 3 per cent over the second half of 2017. The RPI rate of inflation was at 3.3 per cent in March 2018, down from a peak of 4.2 per cent in December 2017. CPIH inflation was at 2.3 per cent in March 2018.

Figure 2.3: Price inflation, United Kingdom, 2008 to 2018



Source: ONS.

2.10 The rate of inflation, as measured by CPI over the period of the settlement, is generally expected to be close to 2 per cent. CPI inflation was forecast by the Bank of England and by independent forecasters to fall gradually towards the 2 per cent target by 2019. The OBR assumed that the unwinding of the 2017 sterling-driven rise in import prices would bring inflation down to around 2 per cent relatively quickly and that it would remain close to that level, with the effects of slightly more cyclical momentum in the economy and higher wage growth in future offset by a stronger pound and a sharper fall in oil prices.

Table 2.2: Inflation forecasts, United Kingdom

	Office for Budget Responsibility (OBR) %		Bank of England central projection %	Treasury independent median* %	
	March 2018		May 2018	May 2018	
Q4	CPI	RPI	CPI	CPI	RPI
2018	2.1	3.3	2.2	2.2	3.1
2019	1.8	2.9	2.1	2.0	3.0
2020	2.0	2.9	2.0	2.0	3.0
2021	2.0	2.9	-	2.0	3.2
2022	2.0	3.0	-	2.0	3.3

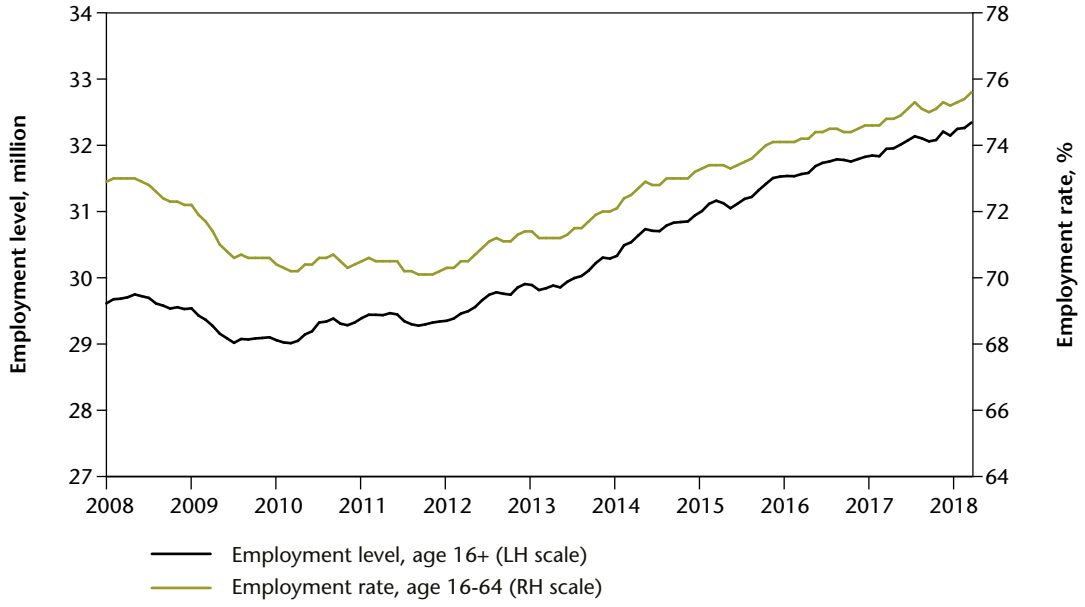
*2020 to 2022 are annual averages (rather than Q4).

Employment and the labour market

2.11 In the UK, employment continued to rise, by 396,000 (1.2 per cent) over the year to March 2018, and the employment rate reached 75.6 per cent in the three months to March 2018, its highest ever.

2.12 The number of full-time employees rose by 2.0 per cent (406,000) over the year to March 2018, while the number of part-time employees rose by 1.1 per cent (73,000). Self-employment fell by 0.8 per cent (38,000), consisting of a rise in part-time self-employment of 6.4 per cent (87,000), and a fall in full-time self-employment of 3.7 per cent (126,000). Private sector employment grew by 502,000 (1.9 per cent) in the year to December 2017, public sector employment fell by 100,000 (1.8 per cent).

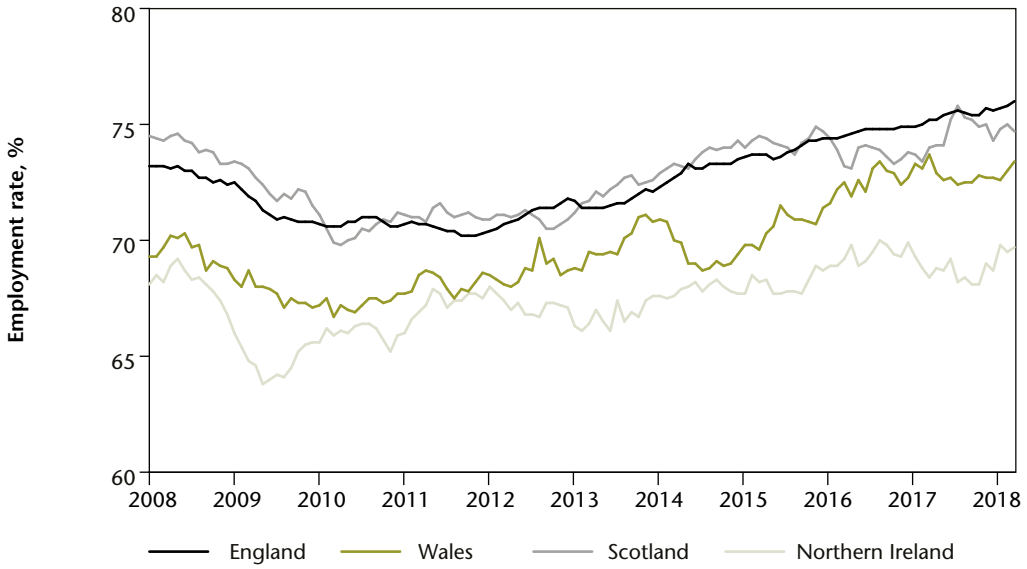
Figure 2.4: Total employment, level and rate, United Kingdom, 2008 to 2018



Source: ONS (MGRZ and LF24).

2.13 Differences were also experienced across the four countries of the UK. Figure 2.5 shows that the employment rate in England has experienced almost continuous growth over the last six years, reaching 76.0 per cent in the three months to March 2018. Scotland's experience has been broadly similar, albeit with falls in employment recorded in 2015 and 2016, while Wales has had a lower employment rate throughout, rising to 73.4 per cent in the three months to March 2018. The employment rate in Northern Ireland was also lower than in other parts of the UK but picked up in the second half of 2017, reaching 69.7 per cent in the three months to March 2018.

Figure 2.5: Employment, rates by country, England, Wales, Scotland and Northern Ireland, 2008 to 2018



Source: ONS.

2.14 In March 2018, the OBR expected employment growth in the UK to slow over the next five years from the strong rates seen in much of the post-crisis period. This reflected its view that unemployment was just below its sustainable rate, and that the ageing of the population would place downward pressure on the overall participation rate. Table 2.3 describes these forecast outcomes, measuring employment rates as a percentage of those aged 16 and above (as opposed to the percentage of those aged 16-64 as in Figures 2.4 and 2.5).

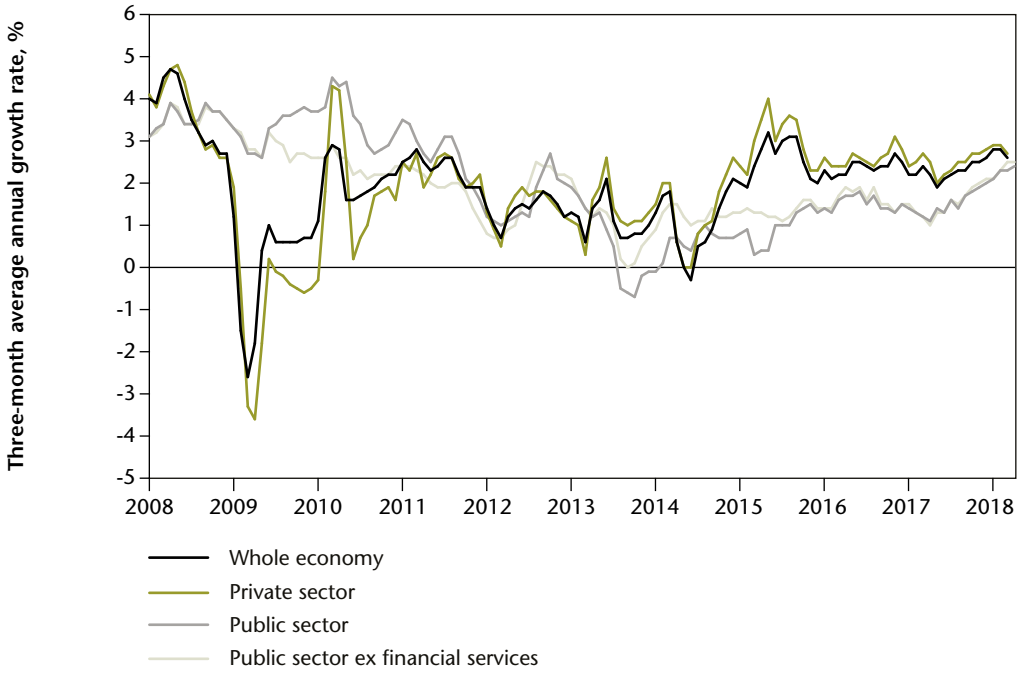
Table 2.3: Labour market forecasts, United Kingdom

	Office for Budget Responsibility (OBR) (March 2018)				Bank of England (May 2018)	Treasury independent median (May 2018)
	Employment		Unemployment		Unemployment	
Q4	(million)	rate age 16+ (%)	(million)	rate (%)	rate (%)	
2018	32.3	60.8	1.5	4.5	4.1	4.4
2019	32.4	60.7	1.5	4.5	4.0	4.4
2020	32.5	60.6	1.6	4.6	4.0	4.4
2021	32.6	60.4	1.6	4.6	-	4.4
2022	32.7	60.3	1.6	4.6	-	4.6

Earnings growth

2.15 Whole economy average earnings growth was 2.6 per cent in the three months to March 2018 (see Figure 2.6), compared with the 2.3 per cent seen on average in 2017. In the three months to March 2018, regular average earnings (i.e., excluding bonus payments) grew by 2.9 per cent, the highest growth rate recorded since July 2015. Private sector average earnings growth was 2.6 per cent and public sector average earnings growth (excluding financial services) was at 2.5 per cent, its highest since August 2012. The higher average earnings growth meant that real average earnings growth (based on CPIH at least) was flat in the three months to March 2018.

Figure 2.6: Average weekly earnings growth (total pay), three-month average, Great Britain, 2008 to 2018



Source: ONS, average weekly earnings annual three-month average change in total pay for: the whole economy (KAC3); private sector (KAC6); public sector (KAC9); private sector excluding financial services (KAE2); monthly, seasonally adjusted, GB, 2008-2018.

2.16 According to the Annual Survey of Hours and Earnings (ASHE), earnings growth at the top end of the distribution was slightly higher than at the middle in 2017. Earnings growth for full-time employees was 2.2 per cent at the median, 3.2 per cent at the 90th percentile, and 2.6 per cent at the 95th percentile in the year to April 2017. There was a difference in growth between the private and public sector, with gross weekly earnings for full-time employees at the median increasing by 2.8 per cent in the private sector, and 0.9 per cent in the public sector.

2.17 The OBR expected overall wage growth of around 2.7 per cent in 2018, partly on the basis of early indications (from the Bank of England's agents' survey) of stronger growth in pay settlements. Real earnings growth over the next five years was expected to remain subdued however, averaging just 0.7 per cent a year.

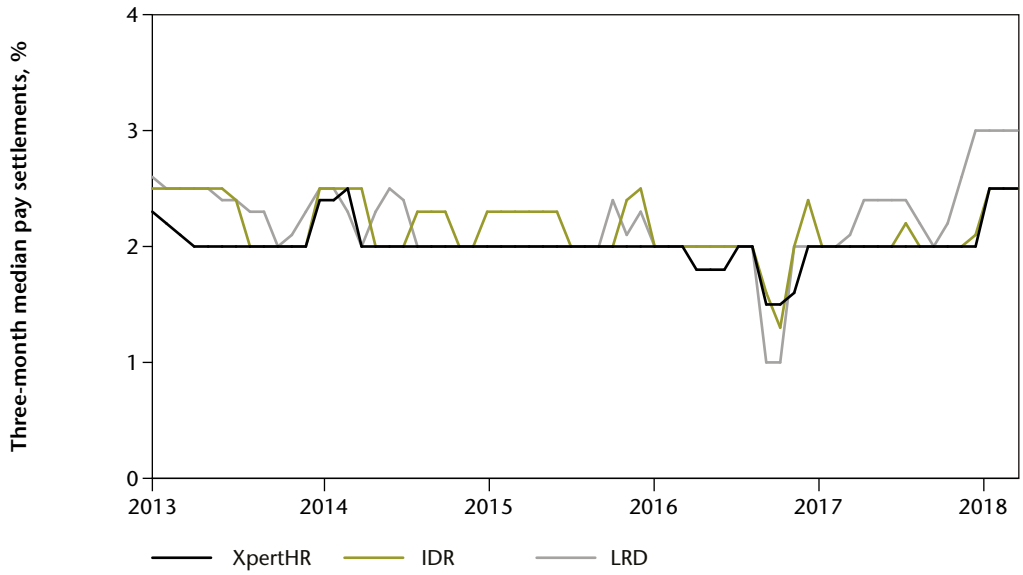
Pay settlements

2.18 Pay settlements picked up at the start of 2018, having recorded a median of 2.0 per cent across 2017. XpertHR and IDR both recorded a median settlement of 2.5 per cent in the three months to March 2018, while LRD saw a median pay award of 3.0 per cent.

2.19 A survey from XpertHR, published in March 2018, indicated that the median predicted private sector pay award, over the 12 months to February 2019, was 2.5 per cent. A survey of the Bank of England's agents, published in February 2018, indicated that companies expected average pay settlements of 3.1 per cent in 2018, up from 2.6 per cent in 2017. The increases in pay settlements in 2018 are expected to be broad-based, with only the construction sector expecting pay settlements in 2018 to be the same as in 2017. Companies in consumer services were expecting to pay higher increases to meet the National Living Wage, which increased to £7.83 an hour from 1 April 2018.

2.20 Taken together, the earnings forecasts and settlements figures suggest that overall pay will rise by a little more than price inflation over the coming year, with private sector wages pushing ahead of public sector pay, despite relatively buoyant demand for labour and low unemployment.

Figure 2.7: Pay settlements, United Kingdom, 2013 to 2018 (three-month average)



Source: XpertHR, IDR, LRD, pay databank records, three-month medians, UK, 2013-2018.

Our comments

2.21 Since our last report, public sector pay policy has relaxed to some extent, but growth in the economy as a whole remains relatively low by historical standards, so Government debt levels, and affordability, remain important considerations for public sector pay settlements. Given expected rates of economic growth, there is limited scope for real wage growth in the economy as a whole, despite high rates of employment and low rates of unemployment. The full impact of Brexit is still unknown, but it has already impacted on the exchange rate, and prices through 2017. This has led to relatively high inflation in general, and specifically to higher materials costs for the NHS, and a relative reduction in pay for overseas staff looking to work in the NHS. It is expected that these price effects will drop out of the inflation figures during the coming year, but the future economic situation is always uncertain, and with major changes such as Brexit, there is added uncertainty to any forecasts for the years ahead.

CHAPTER 3: AFFORDABILITY, PRODUCTIVITY AND WORKFORCE DEMAND

Introduction

3.1 This chapter covers public sector finances, departmental expenditure limits, productivity and workforce demand across the UK.

Public sector finances and departmental expenditure limits

England

3.2 The Department of Health and Social Care (DHSC) said that the 2014 NHS *Five Year Forward View (FYFV)* anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020-21, if the NHS received flat real terms funding increases and no further efficiencies were delivered. To fill this gap, the DHSC said it was investing the additional £10 billion that the FYFV said the NHS needed to implement its plan, alongside the NHS delivering the £22 billion of efficiency savings that it has committed to. The department said that meeting this efficiency challenge was likely to require shifting the focus from centrally driven savings to transformational changes, which would reduce long-term cost pressures on NHS services.

3.3 In its written evidence, NHS Improvement said that recent financial pressures resulted in NHS providers recording financial deficits of £2.4 billion in 2015-16, £790 million in 2016-17 and an expected £620 million for 2017-18. It went on to say that the November 2017 Budget delivered an additional £1.6 billion of NHS revenue and £350 million of public capital, and that real terms NHS revenue growth for 2018-19 would therefore be 1.9 per cent, compared with growth of 2.0 per cent in 2017-18, and 3.1 per cent in 2016-17.

3.4 NHS Employers said that the increase in funding was substantially less than the increase in demand for services, and other cost pressures. NHS organisations were having to manage growing disparities between rising demand for services and the amount of funding available, while continuing to meet public and patient expectations. Although the overall financial deficit in trusts had fallen, the persistent level of structural debt had limited the financial resources available to local leaders for delivering current services, and for transforming how these services would be delivered in future.

3.5 The DHSC said that in 2016-17 spend on permanently employed staff was £47.6 billion, 44.9 per cent of total spend, compared with 2013-14, when staff expenditure was £43.0 billion, or 45.3 per cent of total spend.

Wales

3.6 The Welsh Government said that between 2010-11 and 2019-20 its revenue budget had reduced by 6 per cent in real-terms, and its capital budget was 10 per cent lower. In 2018-19 the total health budget was £7.7 billion, the single largest area of expenditure for the Welsh Government. It said that the NHS in Wales faces growing demand and pressure on services as the service adapts to the changing health needs of the population, which was projected to see growth between 2014 and 2039 of 44 per cent in the number of people aged 65 and over.

Scotland

3.7 The Scottish Government said that its overall budget had been reduced by 8 per cent in real-terms between 2010-11 and 2019-20. However, it was giving an above inflation increase for Health and Sport in 2018-19. It said that this additional funding was being provided to support frontline services and continued reform.

3.8 NHS Territorial Boards would receive a cash uplift of 1.5 per cent, while the patient-facing National Boards (Scottish Ambulance Service, NHS24, Golden Jubilee and The State Hospital) would each receive a 1 per cent budget increase. NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education for Scotland and NHS Health Scotland would receive a flat cash settlement. In addition to this, a further £175 million had been made available for investment in reform, and those Boards furthest from National Resource Allocation Committee (NRAC) parity would receive a share of £30 million. Overall, this would take total additional funding for frontline NHS Boards to £354 million (3.7 per cent), or a real-terms increase of £208 million (2.2 per cent).

3.9 The Government said that issues such as the ageing population, new technology and the cost of drugs meant that the NHS in Scotland would continue to face considerable budget pressures. The Scottish Government said that it expected all Boards to take all reasonable steps to live within their means, and to make best use of the available resources as part of a balanced approach to finance and performance. Within this context it said it would be essential to shift the balance of care to community health services.

Northern Ireland

3.10 We were told by the Department of Health (Northern Ireland) that the 2016-17 public sector pay policy, set by the previous Finance Minister, would continue to apply in 2017-18.

Efficiency and productivity

England

3.11 In February 2016, a report[1] looking at variations in productivity in English NHS acute hospitals was published. The report, following a review conducted by Lord Carter of Coles, said that if all hospitals brought their productivity up to that of the current average, there was the potential to achieve £5 billion of efficiency savings by 2020-21. Areas identified included increased use of generic medicines in hospital pharmacies, reducing the stock of medicines, and improving efficiencies and patient outcomes in trauma and orthopaedics through the Getting It Right First Time (GIRFT) programme. NHS Improvement said that it viewed the potential efficiency savings as achievable, providing the scope for improvements in the quality and consistency of patient care rather than financial savings.

3.12 The potential gains identified by Lord Carter of Coles do not require transformative behaviour across the system, merely that less efficient trusts work to a level already achieved by their peers. Long-term productivity improvements rely on more fundamental, system-wide clinical, technical or managerial innovations made over time. However, the efficiency gains identified by the Carter report showed that, taking current technical and managerial best-practice as given, substantial improvements could be made by reducing the variation in practice across the system.

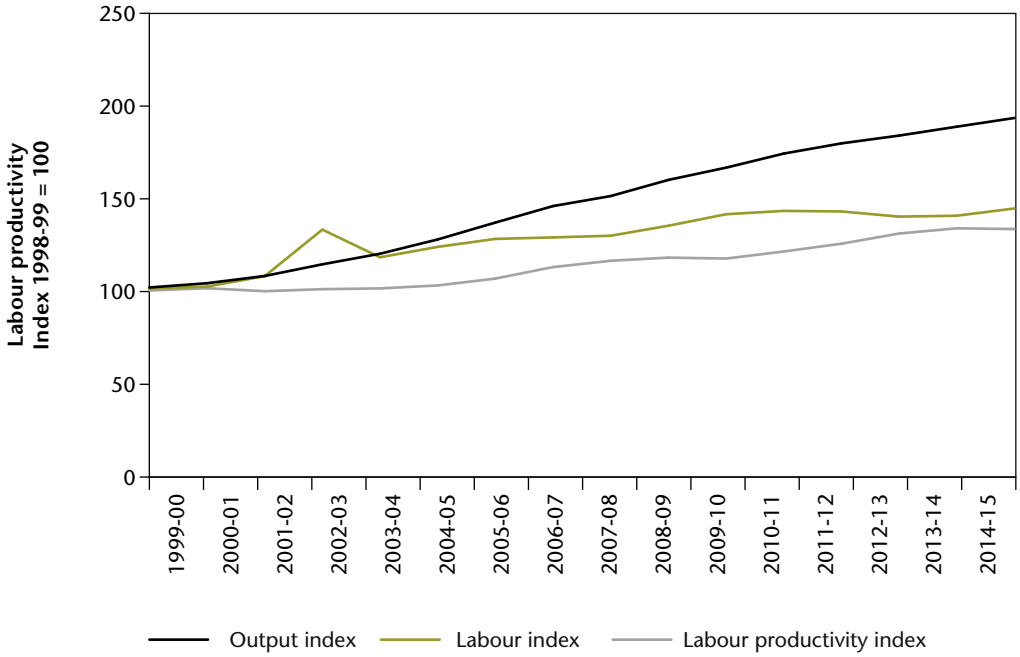
[1] https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

Long-term productivity: output and employment trends

England

3.13 The DHSC said that the measure of labour productivity it used for the NHS was developed by the University of York, and adjusted for quality change, death rates and changes in waiting times. Their data, in Figure 3.1, showed that between 1998-99 and 2014-15 NHS outputs in England had grown by 94 per cent while the volume of labour input, taking into account all those employed by the NHS, had grown by 45 per cent. This suggests average annual growth in labour productivity of 1.8 per cent per annum, broadly in line with the UK economy's performance as a whole.

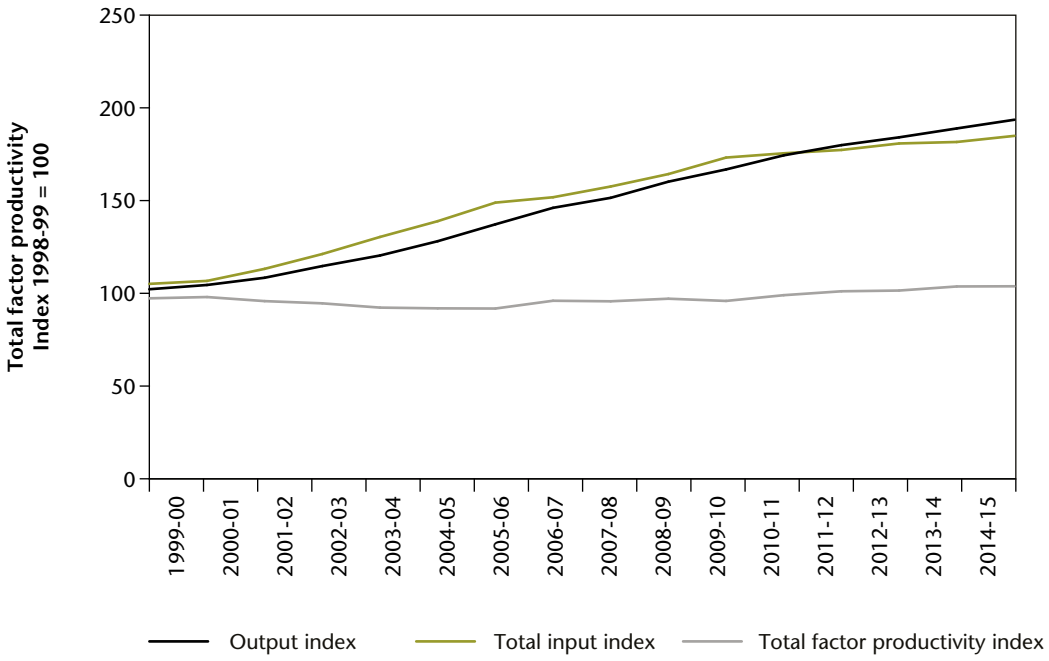
Figure 3.1: Labour productivity in the NHS, England, 1998-99 to 2014-15



Source: DHSC.

3.14 Figure 3.2 shows a broader measure of productivity, also developed by the University of York. This considers output growth, but takes into account the growth of all the inputs into the NHS, including the composition of the workforce, and derives overall productivity growth of 0.3 per cent a year.

Figure 3.2: Total factor productivity in the NHS, England, 1998-99 to 2014-15

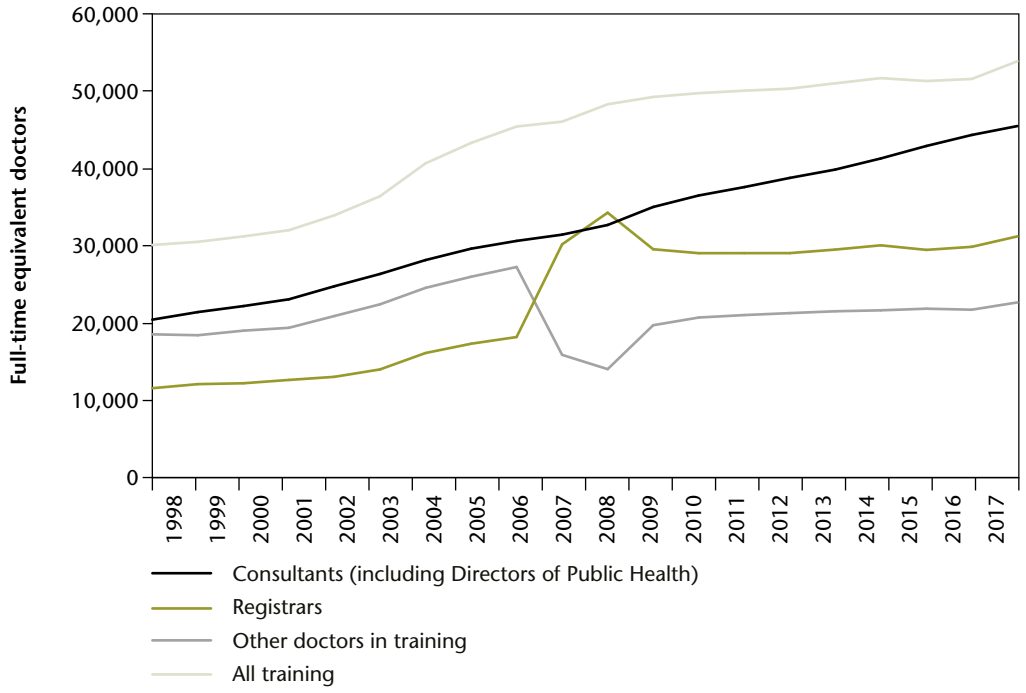


Source: DHSC.

3.15 Figure 3.3 shows the numbers of Hospital and Community Health Service (HCHS) doctors in England between 1998 and 2017. The number of doctors in training (including F1, F2 and Registrars) rose by almost 60 per cent between 2000 and 2010 and has remained at this higher level since that time. Over the last decade the consultant workforce has increased by almost 50 per cent and has more than doubled since 2001.

3.16 The size of the consultant workforce has grown more quickly than the sector output, so that output per consultant has fallen over the last twenty years. Health outcomes are the result of a complex team effort, and it would be inappropriate to relate these figures directly to pay. However, from a demand perspective, in the absence of strong productivity performance, this increase in the number of consultants, relatively highly paid compared to the rest of the remit group, puts pressure on budgets and impacts on the affordability of pay settlements.

Figure 3.3: Hospital and Community Health Service (HCHS) medical workforce, England, 1998-2017



Source: NHS Digital.

Note: Progress in the Modernising Medical Careers programme brought grade changes in 2007 and these changes are reflected in the data. The Registrar count for 2008 represents an improvement in data collection processes, and comparisons with previous years should be treated with caution.

3.17 The BMA noted that it was challenging to measure productivity in the NHS, and that any attempt to do so should take into account the quality of care, equity of resources and patient care outcomes. We were also told by NHS Improvement that, as the consultant workforce had grown because of the move towards a consultant-delivered service, consultants would have taken on some roles that were previously filled by less senior colleagues. It was noted that while this might have contributed to more muted growth in measured productivity, it was argued that it had led to better and safer outcomes for patients, including additional weekend cover by consultants, which were not easily represented in the output figures.

Long-term demand pressures: workforce configuration and skills mix

3.18 We have heard from across the UK about the need to better integrate social care and both primary and secondary healthcare, at a time when demands for health and social care continue to increase. This will need an assessment of the skills and configuration of the workforce required to meet those demands. Changes of this kind represent one element of the more fundamental system-wide clinical, technical or managerial innovations that can be made over time to achieve long-term productivity gains.

3.19 In England, the DHSC said that it was working with the health service, partners and patients to deliver key elements of the programme required to achieve the efficiency savings recently reinforced in the *Next Steps on the Five Year Forward View*, by: reducing demand for NHS care by improving the public's overall health; introducing new models and places to care for patients that mean reduced hospital attendances; and improving purchasing, making more effective use of resources, and reducing management costs.

3.20 In Scotland we have seen the introduction of a new General Medical Services (GMS) contract - which we discuss in more detail in Chapter 8 - which requires GMPs to be expert medical generalists within a wider primary care multi-disciplinary team, with some tasks previously carried out by GMPs being carried out by members of this wider team, and allowing GMPs to focus on the job they train to do.

Workforce planning

England

3.21 In December 2017 Health Education England, with support from a range of other NHS organisations including NHS England, NHS Improvement, Public Health England and the DHSC, published a draft health and care workforce strategy, *Facing the Facts, Shaping the Future*[2]. The draft strategy reviewed the growth in the NHS workforce in the last five years, and set out the challenges for the next decade. Consultation responses were sought by March 2018 and at the time of completing this report we were expecting the final strategy to be published in July 2018.

3.22 Overall, the draft strategy concluded that more needed to be done to keep up with increased demand for NHS staff as the population expanded and grew older. A set of six shared principles were proposed in order to underpin future workforce decisions. The draft strategy then focused on a range of measures to improve productivity, boost training and retention, open up new routes into nursing, and prepare the future workforce for advances in technology. Actions proposed included:

- Increasing the workforce through education and training by increasing the number of GMP trainees and expanding the number of undergraduate medical places;
- Recruiting experienced staff, by attracting 2,000 GMPs from overseas and launching a return to practice campaign for GMPs;
- Improving retention by building on the 'Improving Junior Doctors Lives' programme;
- Reviewing the distribution of postgraduate medical training places by specialty and geography;
- A far-reaching technology review looking at how advances in genomics, pharmaceuticals, artificial intelligence and robotics would change roles, functions and skills/training needs of clinical staff;
- Making the NHS a more inclusive, "family-friendly" employer – acknowledging the changing shape and expectations of the workforce, demands for flexible working practices and developing an attractive employment offer.

3.23 The draft strategy acknowledged that reducing staff turnover improved working conditions, patient outcomes and productivity. Reducing staff turnover was a high workforce priority, and pay was seen as a significant factor in recruitment and retention. The strategy also commented on the need for a good employment package to be sufficiently flexible to be able to respond to the needs of employees at different stages of a career.

3.24 The strategy noted: a seven per cent rise in clinicians substantively employed since 2012; an unprecedented programme of expansion in training over the past three years; medical and nursing undergraduate places to rise by 25 per cent; the highest-ever number of people entering GMP training; NHS workforce vacancies reduced by up to 15 per cent during 2016-17; and successful measures to control agency spending releasing £700 million in savings.

[2] https://hee.nhs.uk/our-work/workforce-strategy

3.25 The strategy concluded that the current gap between workforce demand and supply has occurred partly from a historic disconnect between service and financial and workforce planning. Drawing on the NHS Five Year Forward View, the strategy included service specific workforce plans for priority areas in cancer, mental health, urgent and emergency care, maternity and primary care, and the impacts for specific professional groups. Looking forward to workforce requirements beyond 2021-22 showed that, with no action on productivity or service redesign, the NHS would need 190,000 additional posts by 2027, and supply trends indicated that 72,000 were expected to join the NHS by then.

Wales

3.26 In January 2018 *The Parliamentary Review of Health and Social Care in Wales* was published[3]. One of the goals was 'enriching the wellbeing, capability and engagement, of the health and social care workforce' and to make the NHS in Wales a great place to work. Actions required included joint workforce planning at regional level, support for recruitment in rural areas, learning from campaigns such as *Train, Work, Live* to address short-term recruitment issues, and having a senior executive responsible for staff well-being. In oral evidence the Welsh Government said that it was too early to measure the impact of any changes brought about by the review.

Scotland

3.27 The Scottish Government told us that the NHS was Scotland's largest single workforce, and planning it is a complex activity. It told us of a National Health and Social Care Workforce Plan[4], which had three parts.

3.28 Part 1 of the plan was published in June 2017 and included the establishment of a National Workforce Planning Group and increased the number of medical training places. Part 2 was published in December 2017 focusing on social care, and Part 3 was published in May 2018 and focused on primary care.

3.29 The Government said that actions taken to increase medical supply had included:

- Adding 55 undergraduate medical places through the new Scottish Graduate Medical School, from September 2018;
- Further undergraduate increases of up to 100 over the lifetime of the current Parliament;
- Creating 130 additional specialty training posts in response to service demand;
- Adding 100 GMP training posts;
- Introducing two pre-medical entry programmes for medicine, with up to 40 places, which commenced in September 2017.

Northern Ireland

3.30 In May 2018 the Department of Health in Northern Ireland produced its *Health and Social Care Workforce Strategy 2026*[5]. It assessed that demand for services would continue to rise as the population grew, people lived longer, and increasing numbers of people lived with more than one health condition. It believed that funding levels could not keep pace with the system as currently configured, therefore transformation of service provision was required, of which the workforce strategy was one element. The strategy had three high level objectives:

[3] https://beta.gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf
[4] http://www.gov.scot/Publications/2017/06/1354
[5] https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

- By 2026 the reconfigured health and social care system would have the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise;
- By 2021, health and social care would be a fulfilling and rewarding place to work, and staff would feel valued and supported;
- By 2019 the Department and health and social care providers would be able to monitor workforce trends and issues effectively, and be able to take proactive action to address these problems before they become acute.

Locums and agency spending

England

3.31 An important element in controlling costs in the NHS is through managing agency and locum spend. In response to our request for data on GMP locums NHS England said that:

- The cost of locum allowances paid to practices rose by 3 per cent in 2016, to £32.7 million;
- This figure did not reflect the full costs of locum cover to practices, as practices would also incur costs employing locums that were not covered by allowances;
- Overall numbers of GMPs describing themselves principally as locums increased by 801 (7 per cent) to 12,203 in the period between January and August 2016.

3.32 NHS Improvement said that agency costs had continued to decrease significantly following the initiatives it had undertaken, and action taken by providers, over the last two years. In aggregate, agency spend as a percentage of the total NHS provider pay bill was 4.6 per cent in the first half of 2017-18 and was expected to fall to 4.4 per cent by year end. Overall, providers were forecasting to underspend by £249 million in 2017-18. Agency costs for medical and dental staff in the first half of 2017-18 were £471 million, a reduction of 11.3 per cent from the first half of 2016-17.

Wales

3.33 The Welsh Government said that agency and locum spend on medical and dental staff in Wales had risen sharply over recent years, from £28.8 million in 2013-14 to £77.3 million in 2016-17. From November 2017 caps were introduced on the rates to be paid for both external agency staff and internal additional duties hours. Although it was too early to properly evaluate the effect of these controls, the Welsh Government said that it expected a fall in agency and locum spend in 2017-18.

Scotland

3.34 The Scottish Government said that, in the year ending August 2015, the input from locums was worth the equivalent of 350 FTE GMPs, an increase from 290 in 2013.

Northern Ireland

3.35 Data from the Department of Health (Northern Ireland) showed agency spending, in 2016-17, on medical and dental staff, of £68.7 million. This was a sharp increase, from £38.5 million in 2014-15 and £46.0 million in 2015-16. The BMA said that this increase in expenditure was an indicator of worsening vacancy rates within secondary care in Northern Ireland.

Our comments

3.36 All the evidence we received made it clear that financial pressures remain severe. The Scottish and Welsh Governments both said that their overall budgets had reduced between 2010-11 and 2019-20. In England NHS Employers reported that, while funding had been broadly in line with plans from the *Five Year Forward View*, increases in funding did not match demand for services and other cost pressures. The BMA pointed out that the value of resources allocated to health is a political choice, and it called on Governments across the UK to match or exceed the average spend of other comparable European countries on health and social care.

3.37 Health productivity data are available only for England, and show that since 1999-2000 labour productivity in the NHS has grown by 1.8 per cent per annum, broadly in line with that of the wider economy. However, taking into account all inputs and their composition, productivity growth is closer to 0.3 per cent per year. Over the same period the size of the consultant workforce has grown considerably, resulting in a fall in output per consultant (discussed in Paragraph 3.16), pressures on budgets and impacts on the affordability of pay settlements. We question whether continually looking to increase the size and relative proportion of the consultant workforce is necessarily the best way to manage workforce demand, or to increase productivity.

3.38 We note the importance that health departments are attaching to workforce planning and the development of strategies to help them meet the demands of the future. We do not underestimate the difficulty of forecasting health and social care needs, and putting in place the workforce strategies to meet those needs. However, we believe it is vital that there are clear lines of accountability, and that there is no ambiguity about who is responsible for delivering each element of these strategies.

3.39 For several years we have seen the reliance on locums and agency staff increasing across all parts of the UK although data from NHS Improvement, for England, and the Welsh Government, showed expected reductions in agency and locum spend in 2017-18. We support the increased use of medical bank staff across Trusts, as these should encourage staff to offer extra hours within their own trusts, and may help provide competition to the agencies. However, the official rates, including in the new junior doctors' contract, may have to be reviewed and adjusted.

CHAPTER 4: PAY, MOTIVATION AND WORKFORCE SUPPLY

Introduction

4.1 In this chapter, we consider how doctors' and dentists' pay has changed over time in England (equivalent data are not available for the other countries in the UK). We also consider how doctors' and dentists' pay compares with the distribution of pay across the whole UK economy, and how it compares to the private sector and to comparator groups. We also comment on doctors' and dentists' motivation, and their labour supply choices.

The pay position

4.2 Figures 4.1 to 4.5 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, since 2010-11, based on data from the Annual Survey of Hours and Earnings (ASHE). However, comparisons are not straightforward, as the data for doctors takes no account of hours worked, whereas the figures from ASHE are for full-time employees.

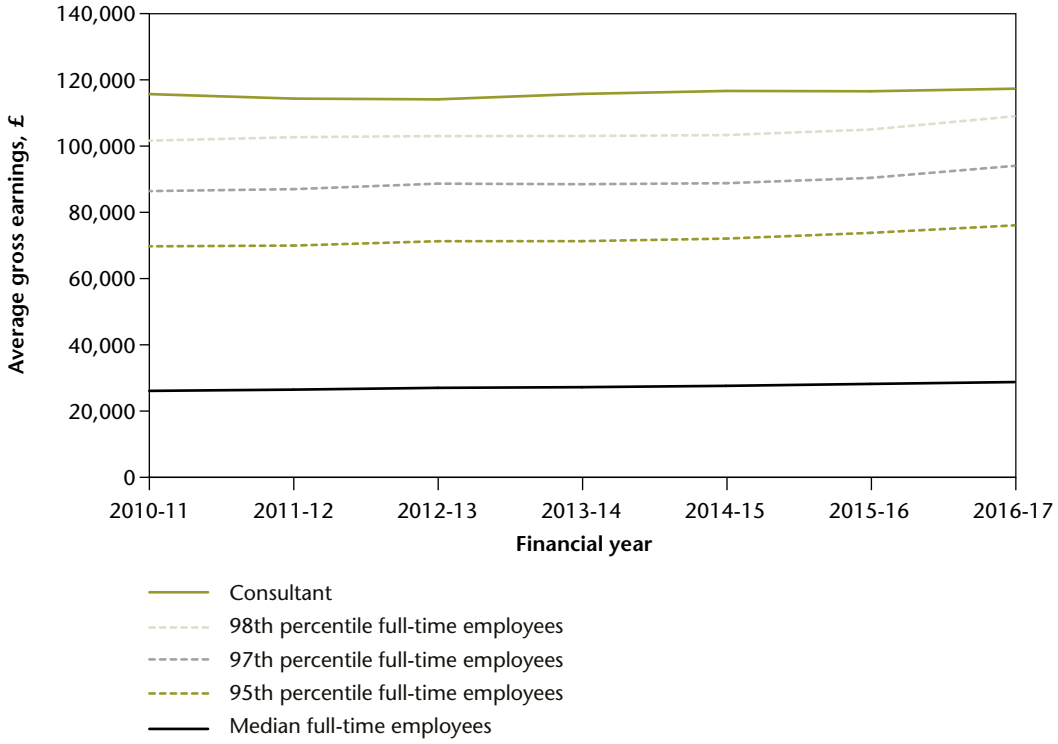
4.3 From 2010-11 to 2016-17, while consultants' average total earnings were consistently above the 98th percentile, the gap was closing, notably between 2015-16 and 2016-17 (Figure 4.1). However, care needs to be taken as the figures take no account of the changing composition of the workforce. The size of the consultant workforce has increased over recent years as consultant recruitment has grown. This in turn, will have led to an increasing proportion of the consultant workforce being paid towards the lower end of the pay scale, depressing the average gross earnings figures.

4.4 Figure 4.2 shows that associate specialists' average total earnings increased over the period relative to those at the 97th percentile, while the average total earnings of specialty doctors almost kept pace with the 95th percentile.

4.5 The average total earnings of the registrar group were above the 90th percentile in 2010-11 by approximately £4,500. However, the gap has closed over time, so that by 2016-17 total earnings for registrars were close to the 90th percentile (Figure 4.3). For training grades in their first years as doctors (Foundation Year 1 & 2), the average total earnings for both grew over the period, but by less than median earnings of full-time employees (Figure 4.3).

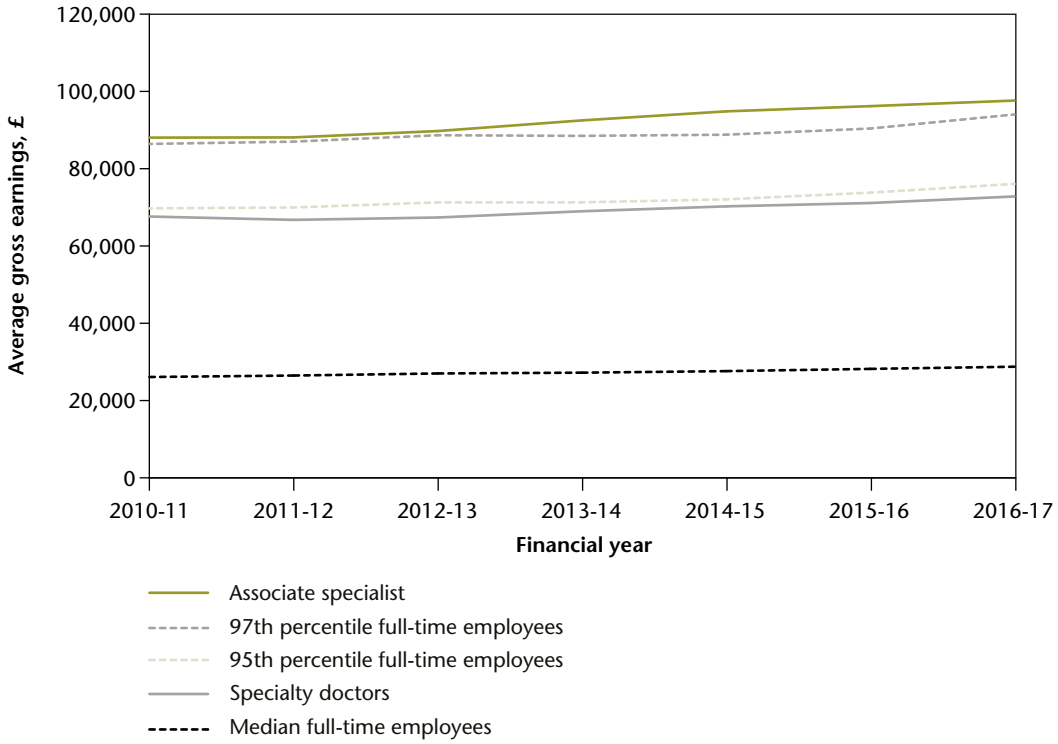
4.6 Between 2010-11 and 2016-17, the average earnings of each group of hospital doctors grew, with the exception of associate specialists, less quickly than the UK median, 90th, 95th, 97th and 98th percentiles.

Figure 4.1: Average gross earnings of consultants in England, compared with the distribution of earnings for full-time UK employees, 2010-11 to 2016-17



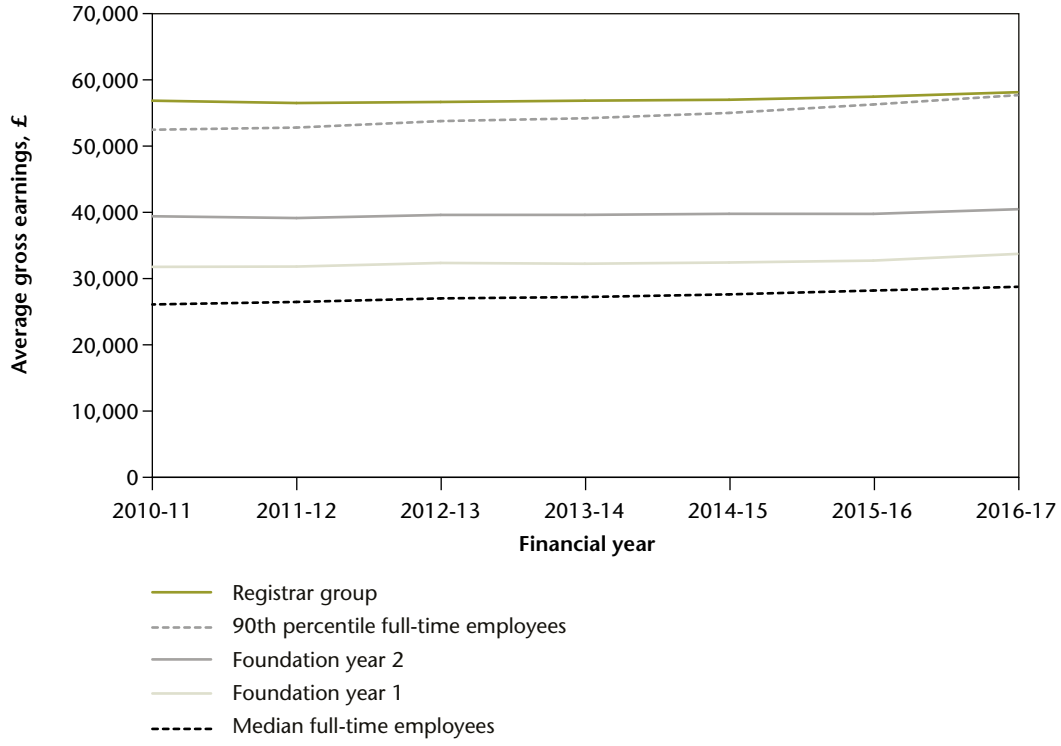
Source: NHS Digital, ONS.

Figure 4.2: Average gross earnings of specialty doctors and associate specialists in England, compared with the distribution of earnings of full-time UK employees, 2010-11 to 2016-17



Source: NHS Digital, ONS.

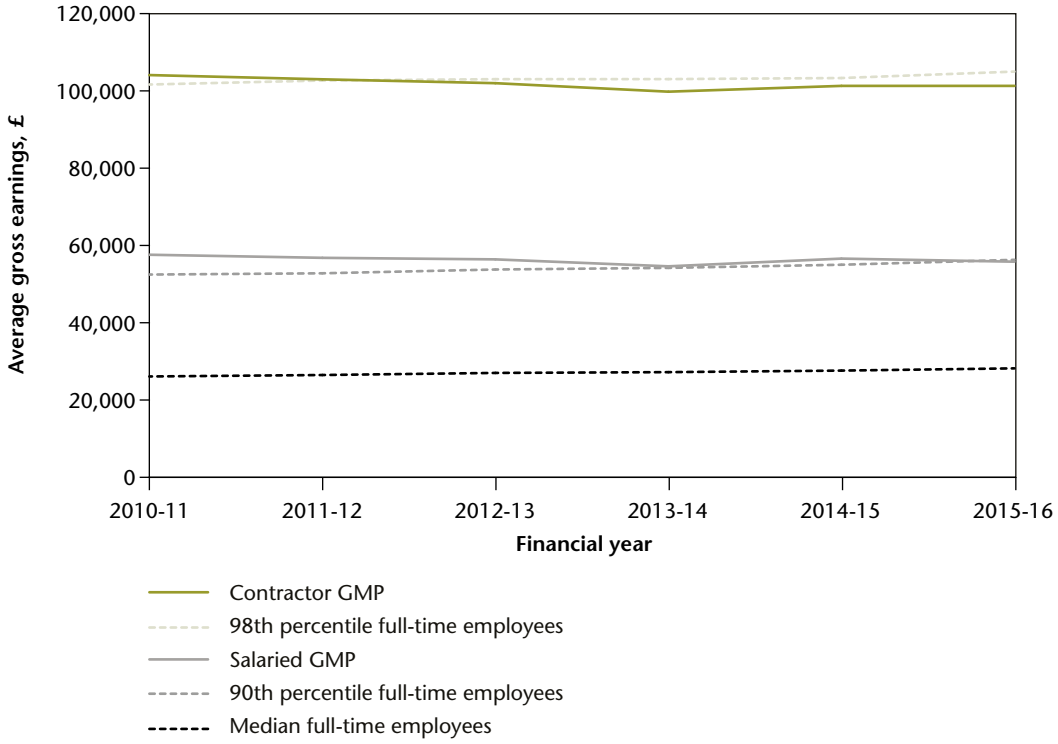
Figure 4.3: Average gross earnings of doctors in training in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2016-17



Source: NHS Digital, ONS.

4.7 As shown in Figure 4.4, the average income before tax for contractor General Medical Practitioners (GMPs) based on headcount has fallen since 2010-11. Contractor GMP earnings are around the 98th percentile of earnings of full-time employees, falling just below this level in 2012-13. Earnings in 2015-16 remained in excess of the 97th percentile but continued to fall behind the 98th percentile. Similarly, salaried GMPs' average income is around the 90th percentile of full-time employees, although it has decreased overall since 2010-11 and in 2015-16 fell to below the 90th percentile. We believe the figures are reliable, being based on tax returns, but are based on headcount, and do not take into account hours worked and how these hours have changed over time.

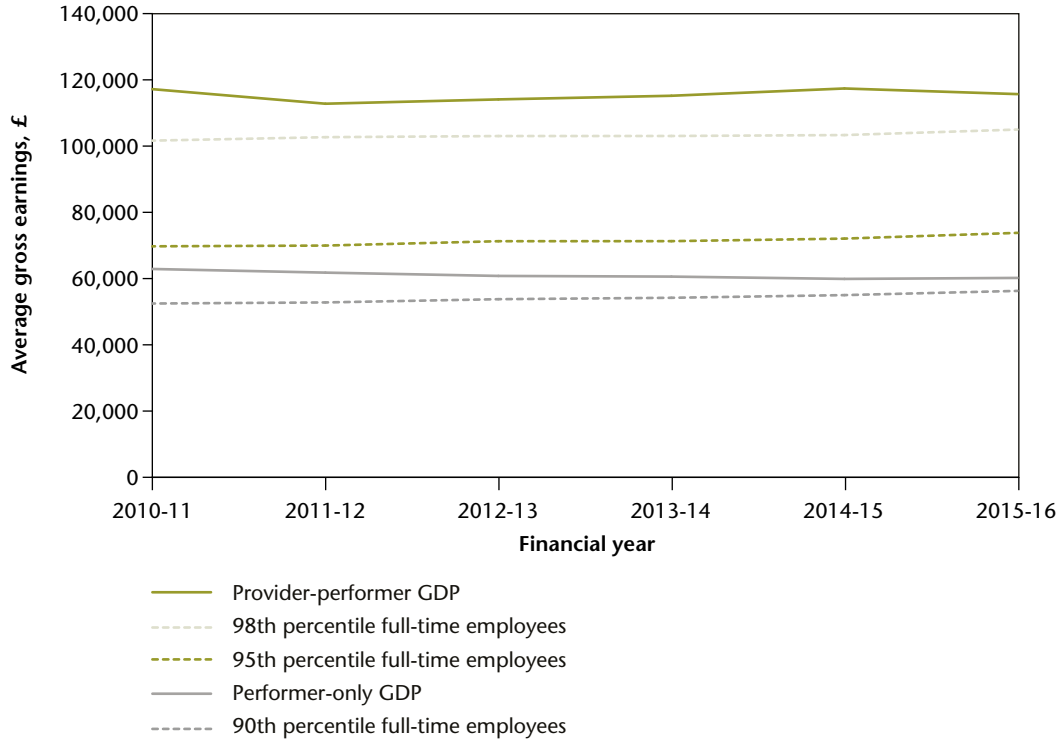
Figure 4.4: Average gross earnings of GMPs in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2015-16



Source: NHS Digital, ONS.

4.8 Providing-performer General Dental Practitioners (GDPs) average income remained above the 98th percentile across this period (Figure 4.5), again based on headcount data. Performer-only GDPs average income has been between the 95th and the 90th percentiles but has fallen relative to those benchmarks and, by 2015-16 it was closer to the 90th percentile. These figures are not adjusted to take account of changes in part-time working.

Figure 4.5: Average gross earnings of GDPs in England, compared with the distribution of earnings of all full-time UK employees, 2010-11 to 2015-16

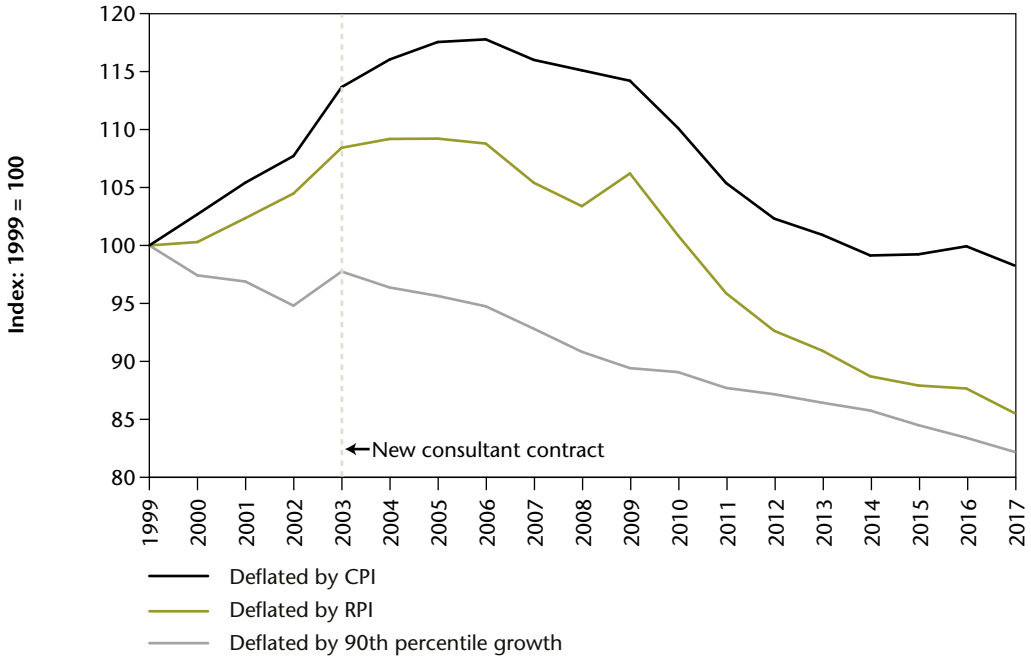


Source: NHS Digital, ONS.

4.9 Figure 4.6 shows the real-terms change from 1999 to 2017 in the 5th point of the consultants' pay scale. This is a useful figure because, unlike the average earnings figures, it is not affected by the changing composition of the consultant workforce, but relates only to basic (not total) pay. The choice of inflation index affects the size of real earnings changes, as CPI is generally lower than RPI. Compared to CPI inflation, the consultants' pay point increased until 2006 and then decreased until 2017, where it reached roughly the same level as in 1999. Compared to RPI, the pay point increased until 2005 after which it decreased, but ended up at a lower level when compared to 1999.

4.10 These inflationary pressures change the real income of all UK workers. However, between 1999 and 2017, pay for full-time employees in the 90th percentile has grown more quickly than the pay point of a consultant with five years' experience. Compared to the 90th percentile of UK workers, the consultants' pay point has fallen every year since 1999, except in 2003 when the new consultant contract was brought in.

Figure 4.6: Real terms change in the 5th point on the consultants' pay scale, England, 1999 to 2017



Source: ONS.

4.11 The BMA said that all groups of doctors had experienced a significant fall in real income since 2008 of around 20 per cent. It also referenced a report by University College London (UCL), *Wage Growth in Pay Review Body Occupations*[1], which said that, between 2005 and 2015, review body occupations as a whole had experienced a 5.8 per cent decline in median real gross hourly earnings, compared with a 22.5 per cent fall for doctors, the largest fall for a single review body group. However, if the UCL results are adjusted for changes in the composition of the workforce the real-terms decline falls to a smaller 3.5 per cent.

Pay comparability

4.12 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 appropriate comparator professions, and against recent trends in general pay and price inflation measures. Our approach looks at both pay levels and movements.

4.13 This year the Institute of Employment Studies reviewed the DDRB pay comparability methodology[2]. They recommended that we continue to use the same anchor points (i.e., job weights) as identified and used in previous reports, and to add in some new comparability professions. In this report we have included data for vets and higher education roles, as well as our previously used comparators (actuaries, legal professions, tax and accounting and pharmaceutical roles).

[1] https://www.gov.uk/government/publications/wage-growth-in-pay-review-body-occupations
[2] Review of DDRB Pay Comparability Methodology, 2017, https://www.gov.uk/government/publications/review-of-ddrb-pay-comparability-methodology-2017

4.14 Figure 4.7 compares the pay distributions for doctors in training (foundation house officers and specialty registrars), staff grades and specialty doctors in England, to comparator professions. It is important to note that, in this and subsequent tables, the pay for other professions is on a full-time equivalent (FTE) basis, whereas that for doctors and dentists is the average for both full- and part-time, and so lower than it would be on an FTE basis.

- Median total earnings for Foundation doctors in their first year was £31,550. This is almost 10 per cent more than the median earnings of all employees, and 35 per cent higher than median earnings of all employees ages 22 - 29. Median earnings were similar to those for vets who had just qualified, and for trainee lecturers. However, they were lower than for the other comparator groups, and over £10,000 lower than the highest group (pharmaceutical).
- Median earnings for Foundation doctors in their second year (£43,150), were 6 per cent higher than the 75th percentile of all UK employees. Median earnings were higher than those for lecturers, vets, tax and accounting and legal, but lower than those for pharmaceutical and actuarial. The median earnings of the highest paid comparator group (actuarial) were £6,300 higher than for Foundation doctors in their second year.
- The Registrar group's median earnings were £59,100, which was 2.5 per cent higher than the 90th percentile of all UK employees (£57,700) and 6 per cent higher than the 90th percentile of all UK employees ages 30-39. Median earnings were lower than for actuarial, legal and pharmaceutical groups but higher than for the other comparators.
- There was an overlap in the earnings of staff grade and specialty doctor grades, with median earnings of £66,800 and £67,500 respectively. This placed both grades into the top 10 per cent of UK earners. Relative to the comparator groups, median earnings were above those of senior lecturers, vets, pharmaceutical, and tax and accounting comparator groups, but below actuarial earnings. Median legal earnings (£66,900) fell in between median earnings of staff grades and specialty doctors.

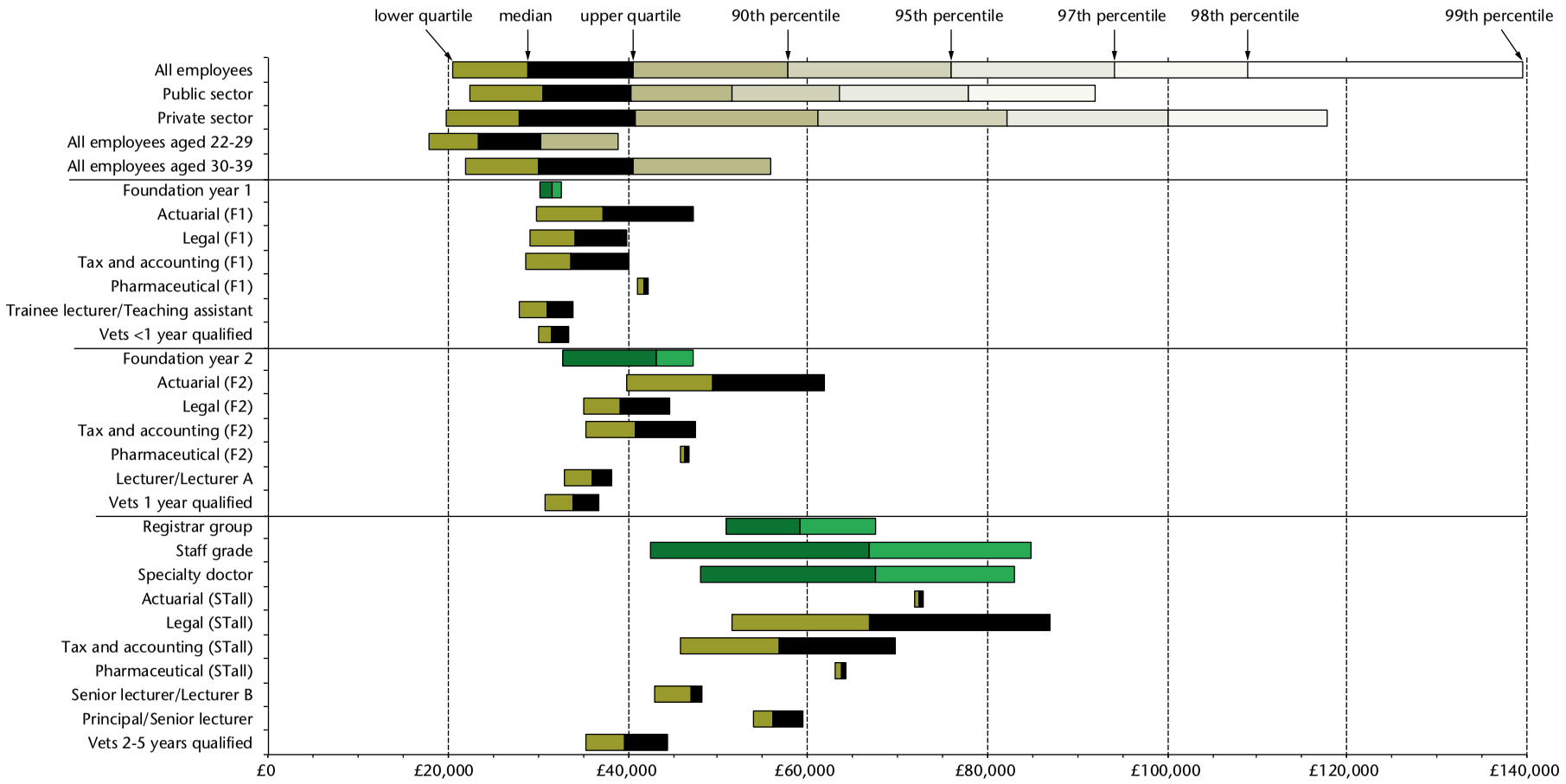
4.15 Figure 4.8 shows comparisons for associate specialists and consultants with the national pay distribution and other professional groups.

- Median earnings for associate specialists (£89,400) were £4,700 less than the 97th percentile of all UK employees. Although considerably higher than for the head or director of a major academic area, and for vets, median earnings were much lower than those for actuarial, legal, tax and accounting, and pharmaceutical groups.
- Consultants median earnings (£111,200) were above the 98th percentile of all UK employees. Median earners were above the highest paid vets and higher education academics, but lower than for pharmaceutical, tax and accounting, legal and actuarial groups. The highest (pharmaceutical) had median earnings almost £100,000 higher.

4.16 Figure 4.9 shows comparisons for GMPs and GDPs.

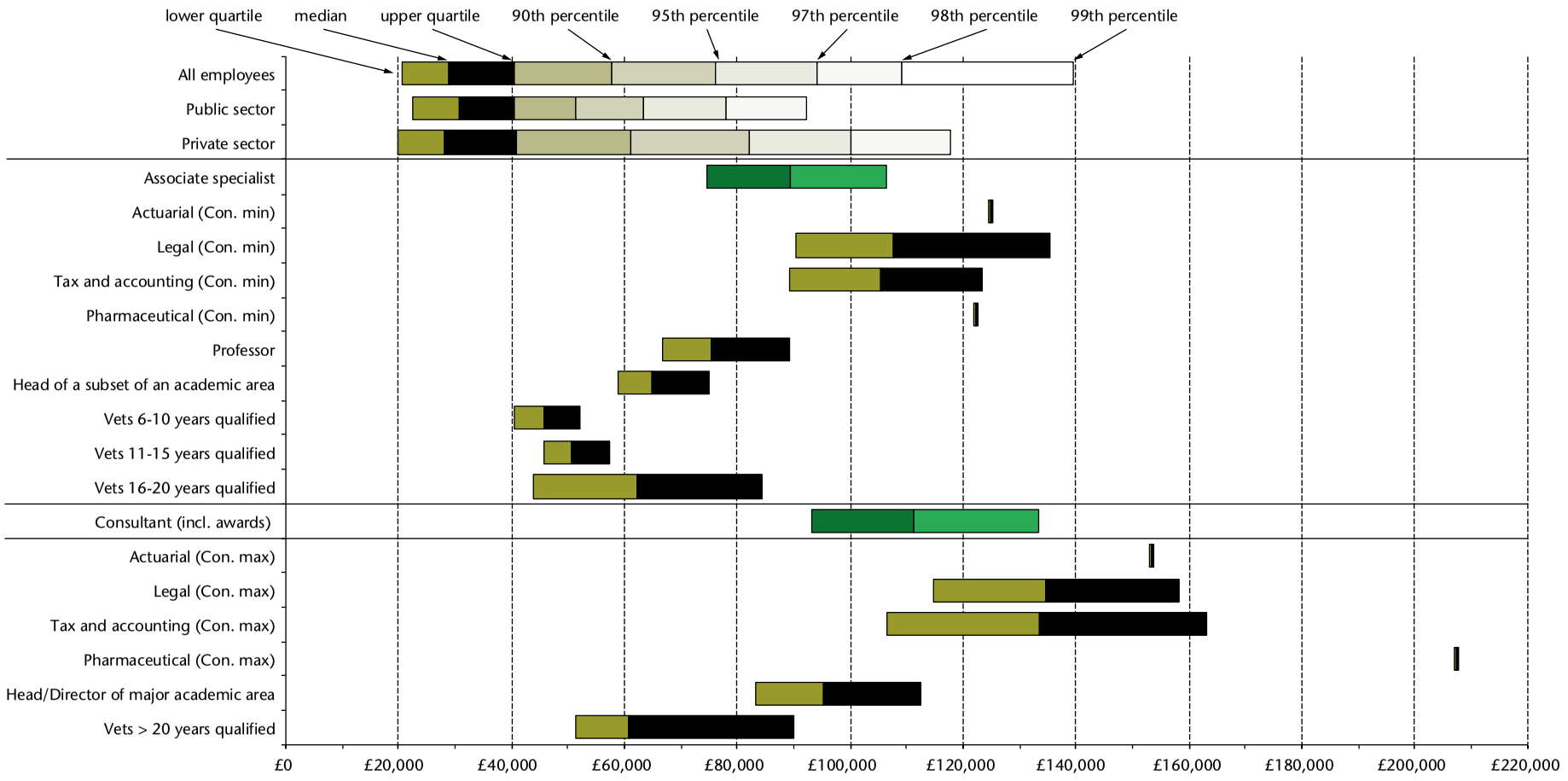
- Salaried GMPs median earnings (£52,600) were 9 per cent less than the 90th percentile of all UK employees. Performer GDPs (£54,500) were 6 per cent less than the 90th percentile. Both had earnings higher than vets qualified for 6-10 and 11-15 years, but lower earnings than actuarial, legal, tax and accounting and pharmaceutical groups.
- Contractor GMPs had median earnings of £96,600, which was 3 per cent higher than the 97th percentile of all UK employees. Providing-performer GDPs had median earnings of £98,900, which was 5 per cent higher than the 97th percentile. Median earnings for both groups were higher than median earnings for vets qualified for 20 years or more, but less than for actuarial, legal, tax and accounting and pharmaceutical groups.

Figure 4.7: Total earnings inter-quartile ranges of DDRB training grades, staff grades and specialty doctors (England), compared with the national pay distribution and other professional groups, full-time rates, 2017



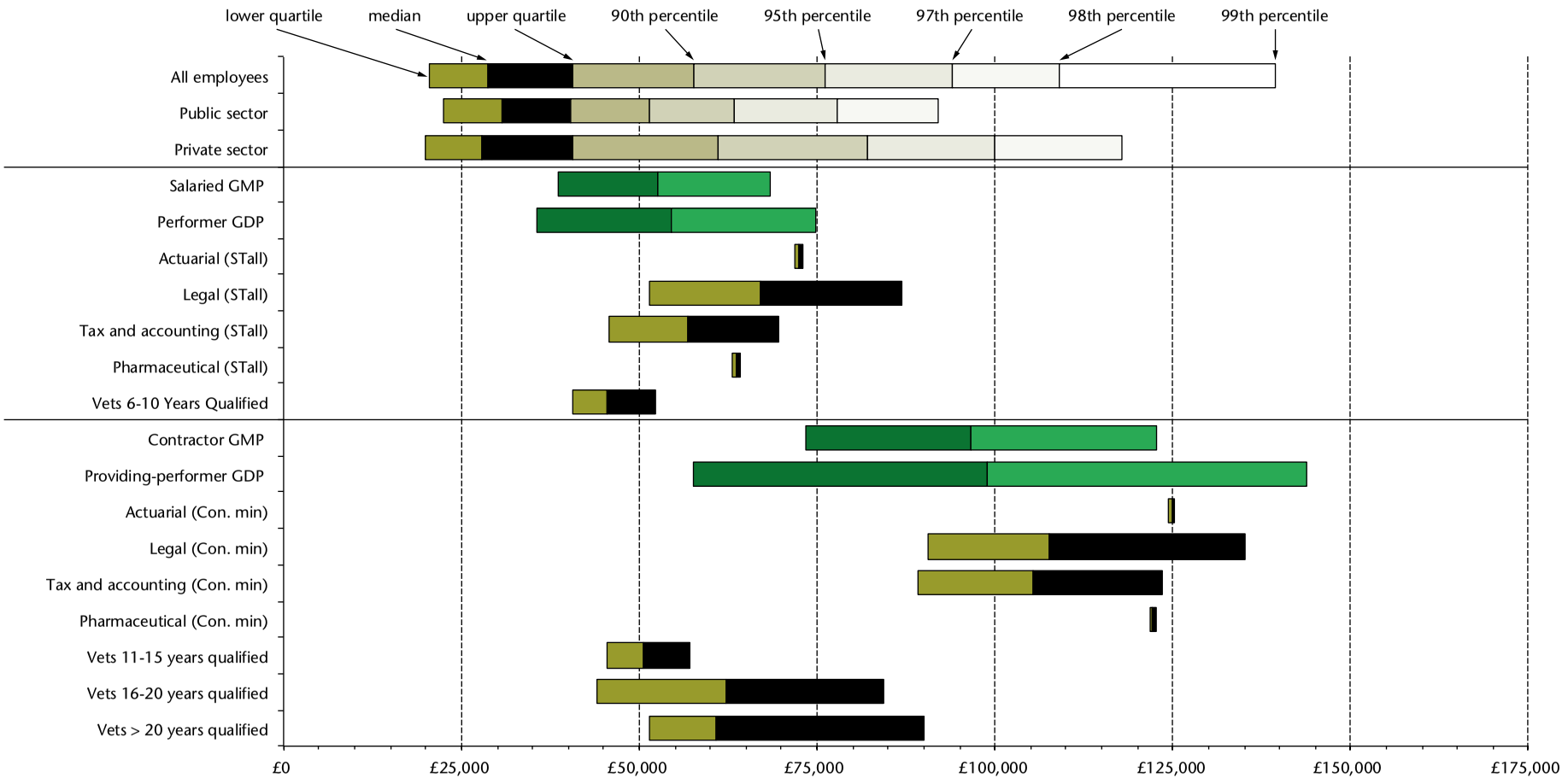
Source: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part-time in the year ending June 2017, by headcount.
(2) A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median.

Figure 4.8: Total earnings inter-quartile ranges of consultants and equivalent grades, and associate specialists (England), compared with the national pay distribution and other professional groups, full-time rates, 2017



Source: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part-time in the year ending June 2017, by headcount.
(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.

Figure 4.9: Total earnings inter-quartile ranges of GMPs and GDPs (United Kingdom), compared with the national pay distribution and other professional groups, full-time rates, 2017



Source: ONS, NHS Digital, NHS Employers, Hay group, UCEA and SPVS.
(1) Figures for hospital medical grades are average total earnings for full and part-time in the year ending June 2017, by headcount.
(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.

Turnover

England

4.17 In 2016-17, joining rates for hospital medical and dental staff in England were higher than the leaving rates by 2.4 percentage points. This is the widest gap between rates in the period from 2010-11 to 2016-17. Whilst the joining and leaving rates are large across the time period, implying that turnover is high, they are fairly balanced, with a higher percentage of joiners than leavers each year between 2011-12 and 2016-17 (Figure 4.10).

Wales

4.18 Time series data for Wales were not available.

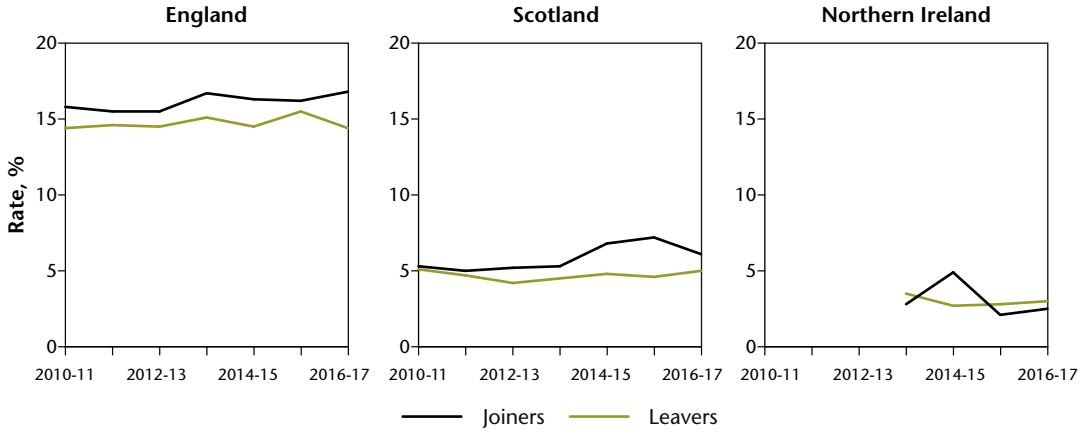
Scotland

4.19 In Scotland, joining rates have also been consistently higher than leaving rates, although the gap closed in 2016-17, due to a combination of falling joining rates and increased leaving rates.

Northern Ireland

4.20 In Northern Ireland, leaving rates have been higher than joining rates for three out of the four years shown. In 2016-17, the leaving rate was above the joining rate by 0.5 percentage points. This gap has decreased from 2015-16 when it was 0.7 percentage points.

Figure 4.10: Joining and leaving rates over time by country



Source: NHS Digital, Information Services Division Scotland, DHSC, Social Services and Public Safety Northern Ireland (HSC).

International recruitment

England

4.21 In 2016-17 just under 10 per cent of joiners to medical core training were from EU countries other than the UK, a decrease of about a third since 2012-13 (Table 4.1). For consultant level staff the figure has remained at around 12 per cent between 2012-13 and 2016-17. For SAS staff, the proportion has halved between 2012-13 and 2016-17, down to about 5 per cent. The top five EU nationalities of joiners into the NHS in England were the Republic of Ireland, Greece, Italy, Romania and Germany.

Table 4.1: Nationality of joiners to NHS in England by grade, 2012-13 to 2016-17

	Joiners of EU nationality (%)				
	2012-13	2013-14	2014-15	2015-16	2016-17
Core training	15.1	14.5	14.1	12.4	9.9
Consultant	11.8	12.2	11.9	12.6	12.2
Other and local HCHS doctor grades	11.8	11.3	9.8	8.1	5.2

Source: NHS Digital

4.22 In its written evidence NHS Employers said that, in collaboration with NHS Providers and the Shelford Group, it had commenced a quarterly survey of NHS organisations, looking at the implications of the UK's decision to leave the EU on the recruitment and retention of staff from the EU. NHS Employers said that, a year after the referendum vote, a greater number of employers felt that the decision to leave the EU would have a negative impact on their workforce, and that there were fewer employers with plans to recruit from the European Economic Area (EEA), because of the uncertainty.

Wales

4.23 The Welsh Government said that it was developing an international recruitment campaign to market Wales and NHS Wales as an attractive place for doctors to work. It said that the campaign built on a 2015 junior doctor recruitment campaign that had marketed Wales as a place to *Train, Work, Live*.

Scotland

4.24 The Scottish Government said that the impact of Brexit on the NHS Scotland workforce would depend on the precise form of withdrawal from the EU. It said that, without the free movement of people from the EU/EEA which allowed skilled and experienced professionals to work in the NHS, there would be an adverse impact on the provision of health and social care services. The Government said it was important to retain access to this market, given the continuing recruitment challenges in health and social care. It added that the fact that EU students enjoyed free tuition fees in Scotland had made Scottish medical and dental schools more attractive to such students. The introduction of tuition fees for EU students could deter students from applying to study medicine and dentistry in Scotland.

4.25 The Scottish Government said that Brexit was a big challenge, as 1 in 10 of all Scottish dentists and almost half of those in Dumfries and Galloway were from elsewhere in the EU. The Government said that those who arrived, settled, put down roots and invested in their practices were likely to remain, but that it was concerned about its ability to attract newcomers from elsewhere in the EU.

United Kingdom

4.26 The BMA said that around 10,000 doctors (6.6 per cent of the workforce) were from the EEA. It had conducted a survey of EEA doctors working in the UK, and found that more than 40 per cent said they were considering leaving the NHS following the EU referendum result. The BMA also cited a General Medical Council survey which said that 60 per cent of respondents said they intended to leave as a direct result of Brexit.

4.27 The BDA estimated that 16 per cent of registered dentists in the UK qualified in an EEA country, and that the devaluation of the pound and the effects of Brexit had seen the cost of materials and equipment in dental practices increasing. It said that Brexit posed a unique set of challenges for Northern Ireland, and that it was important to establish how reliant Northern Ireland was on dentists and dental care professionals from the Republic of Ireland and other parts of the EU.

4.28 NHS Employers were clear that the immigration system that would be in place after the UK left the EU, alongside the strategy to increase domestic workforce supply, would need to be flexible enough to allow employers to recruit appropriately from outside the UK to fill workforce shortages and maintain services.

4.29 Across the UK, the number of Tier 2 visas issued for the Human Health and Social Work Activities industry had increased by about 5,000 between 2011 and 2017, from around 1,500 to 6,500. However, NHS Employers said that the demand for restricted certificates of sponsorship (employers wishing to recruit a worker currently outside the UK need to make an application for a certificate from the Home Office) across the economy as a whole, was significantly higher than the number available, leading to many organisations having their applications refused. NHS Employers said it was working very closely with the DHSC, the Home Office and other national bodies to explore potential solutions to the problem.

Retirement trends

4.30 We have heard evidence from several of the parties that changes to the NHS pension scheme, and the lowering of the thresholds of the pensions annual and lifetime allowances, have led to an increase in the numbers retiring at an earlier age.

England

4.31 The DHSC provided data on numbers in England who had taken voluntary early retirement (VER) since 2011-12 (Table 4.2). It showed for both hospital doctors and GMPs an increase in the numbers choosing VER, and that the percentage of retirements they accounted for was increasing. This is particularly the case for GMPs where over 60 per cent of retirements are on a VER basis. For dental practitioners the numbers choosing VER have declined since 2012-13, but still account for just over a third of all retirements.

Table 4.2: Numbers claiming their NHS pension on a voluntary early retirement (VER) basis, England, 2011-12 to 2016-17

	Hospital doctors		General medical practitioners		General dental practitioners	
	VER	% of all retirements	VER	% of all retirements	VER	% of all retirements
2011-12	-	-	513	33	-	-
2012-13	201	17	591	42	186	35
2013-14	187	14	746	50	175	39
2014-15	222	17	738	51	190	39
2015-16	226	18	677	54	175	38
2016-17	241	19	721	62	158	35

Source: DHSC Evidence

4.32 The HCSA said that health departments needed to investigate why doctors were taking early retirement, and that in a survey of its members, over 85 per cent of respondents had said they had considered leaving the profession early.

4.33 The BMA said that doctors were being asked to work longer and harder, without recognition or an increase in pay, which had had a negative impact on their wellbeing, morale and motivation, all of which could lead to early retirement.

4.34 The BDA said that there were a considerable number of dentists planning to retire. It said that the proportion of associates stating that they intended to retire in the next five years had increased from 13 per cent to 20 per cent. For practice owners the proportion intending to retire in the next five years had increased to 36 per cent from 30 per cent. The BDA also said that the NHS pension scheme should allow greater flexibility for dentists to determine the level of earnings which were pensionable.

4.35 NHS Digital statistics show that, between April 2016 and March 2017, of those doctors and dentists who reported their reasons for leaving, retirement age was the third most likely reason (736 people), behind end of fixed term contract (7,324), and voluntary resignation for unknown reasons (1,477).

Wales

4.36 Evidence from the Welsh Government showed that between April 2016 and March 2017 84 medical and dental staff had retired, of which fifteen were voluntary early retirements.

Scotland

4.37 The Scottish Government included data from the Scottish Public Pensions Agency on the retirements of GMP and GDPs in Scotland. For GMPs, 81 were identified as retiring early in 2016-17, compared with 80 in 2015-16. For GDPs there were 31 identified early retirements in 2016-17 (from a total of 67 retirements), compared with 36 in 2015-16 (from a total of 81 retirements).

Northern Ireland

4.38 Data from the Northern Ireland Department of Health identified the number of medical and dental staff leaving the system (133, 5.2 per cent), but did not identify the reasons for leaving.

Generation 'Y'

4.39 In our 45th Report 2017, we focused on 'Generation Y', the cohort born approximately between 1980 and 2000. We were informed that this group had a different approach to their careers from their predecessors, valuing in particular aspects such as work-life balance, and flexibility and variety in the workplace. This can be seen in our remit group through an increase in those wanting to be salaried GMPs or locums, or performer only dentists, or the increase in the percentage of trainee doctors delaying their transition to post-foundation training. We said that the behaviours of this group would need to be taken into account by employers and policy makers.

4.40 In its evidence for this round the BMA said that focusing on 'Generation Y' diverted attention away from issues such as gender equality and the unequal distribution of caring responsibilities. It went on to say that the increase in women's participation in the workforce had led to a position where women now make up 57 per cent of junior doctors, and that this in turn had led to consideration of how medical training patterns could be made more flexible to allow trainees to combine work with caring responsibilities. The BMA said that its cohort study showed that women trainees were more likely to train on a less than full-time basis because of caring responsibilities, and were more likely to switch into the specialties which were most amenable to flexible and part-time working.

4.41 In addition to generational changes the BDA also highlighted demographic changes. It said that considerably more women and ethnic minorities were entering dentistry, and structural factors within the dental market, such as corporatisation, were having a greater

impact. The BDA did say that surveys of dental medical students indicated a significant proportion were looking to work on a part-time basis in the future, and that compared with a medical career, the relative flexibility of working hours in the dental profession was viewed positively.

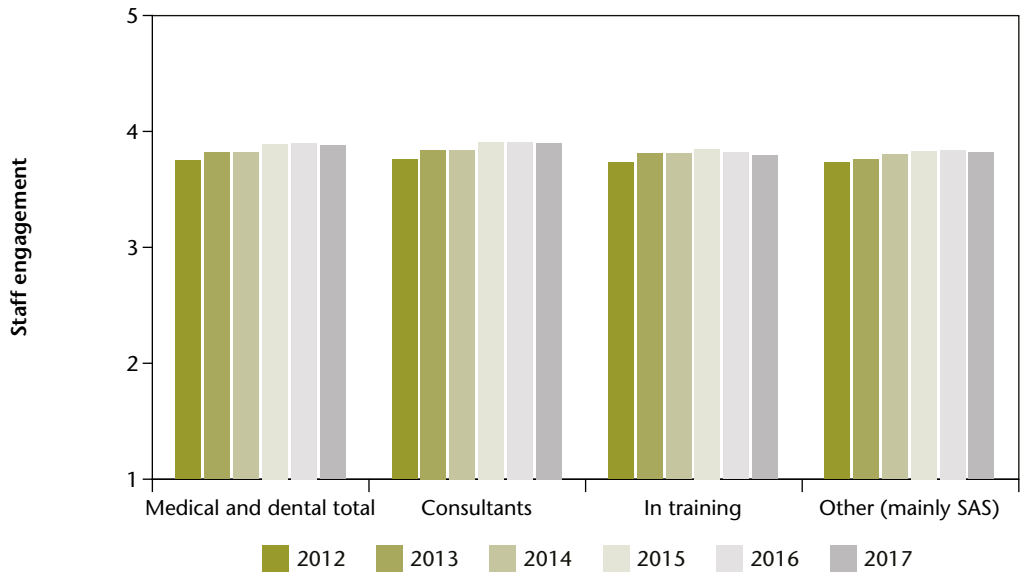
Motivation, morale and engagement

4.42 Since our 45th Report 2017, the fourteenth and fifteenth annual NHS Staff Surveys in England have been published. The surveys were conducted in autumn 2016 and 2017, with a response rate of 45 per cent, and with almost 500,000 respondents in 2017. Wales and Northern Ireland run surveys every three to five years, and last ran them in 2016 and 2015 respectively. Scotland is currently transitioning to a new survey system (iMatters) with the first set of new survey results having been published in March 2018.

England

4.43 In England, total medical staff engagement decreased by 0.02 points in 2017, a small decline, reversing the increase from previous years. The largest decrease came from junior doctors, where engagement decreased by 0.03 points, with a smaller decrease of 0.02 from consultants and SAS doctors (Figure 4.11).

Figure 4.11: HCHS medical staff engagement scores, England, 2012 to 2017



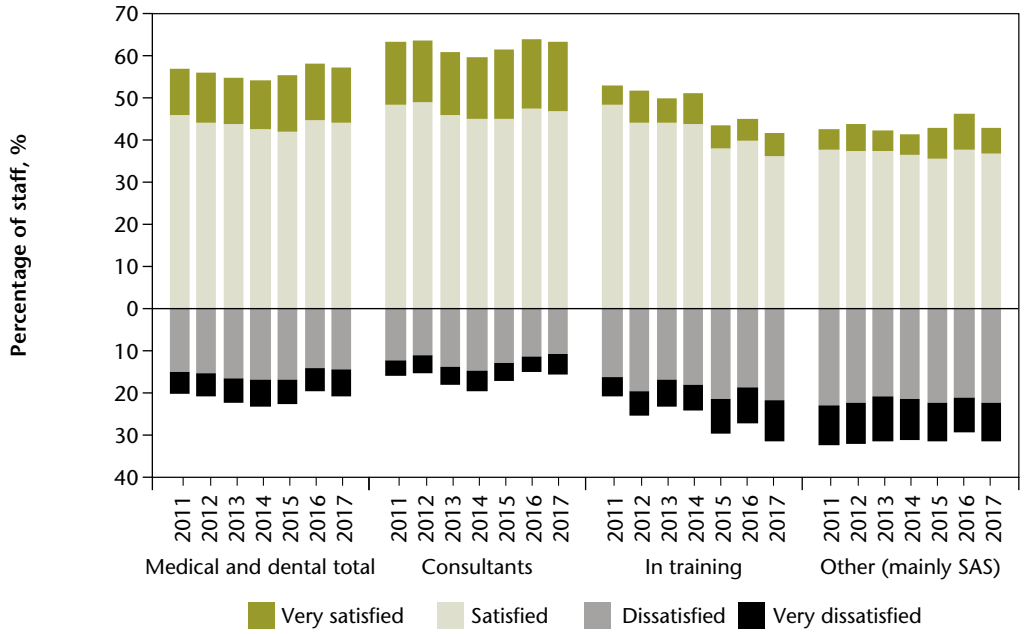
Source: National NHS Staff Survey (England).

4.44 In 2017, 57.1 per cent of medical and dental staff responding said they were satisfied[3] with their pay, a fall from 58.0 per cent in 2016 (Figure 4.12).

- A larger proportion of consultants said they were satisfied with their pay than other groups. In 2017, 63.2 per cent said they were satisfied, a fall of 0.6 percentage points from 2016.
- For doctors and dentists in training, in 2017, 41.6 per cent said they were satisfied with pay, a fall of 3.6 percentage points compared to 2016, the largest fall of the medical groups.
- For the "other" group (comprising mainly specialty doctors and associate specialists (SAS)), 42.9 per cent said they were satisfied with pay, a fall of 3.3 percentage points from 2016.

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

Figure 4.12: HCHS medical staff satisfaction with level of pay, England, 2011 to 2017



Source: National NHS Staff Survey (England).
Note: The percentage saying "neither satisfied nor dissatisfied" omitted throughout this chart.

4.45 Job satisfaction generally declined for medical and dental staff in 2017 compared to 2016 (Table 4.3).

- There was a decrease of 1.7 percentage points of staff saying they looked forward to going to work, and a decrease of 1.3 percentage points of staff saying they were enthusiastic about their job.
- Respondents said they were more positive about the amount of responsibility they were given, with figures increasing by 0.7 percentage points.
- The percentage of respondents saying they experienced harassment, bullying or abuse from patients, relatives or the public, increased for the third year in a row, to 33.5 per cent in 2017.

Table 4.3: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2017

Engagement and job satisfaction	2011	2012	2013	2014	2015	2016	2017	Trend[1]
I look forward to going to work	62.0	62.5	64.0	64.4	68.0	68.9	67.2	
I am enthusiastic about my job	74.0	74.3	75.4	75.2	79.4	78.7	77.4	
Time passes quickly when I am working	81.7	79.9	81.8	81.8	84.1	83.2	83.0	
The recognition I get for good work	51.9	51.9	54.3	55.3	57.4	58.3	57.8	
The support I get from my immediate manager	64.0	64.1	67.0	68.7	67.5	69.2	68.3	
The support I get from my work colleagues	81.0	82.6	82.9	83.5	86.4	85.8	85.6	
The amount of responsibility I am given	81.2	83.3	82.7	83.0	82.4	82.2	83.0	
The opportunities I have to use my skills	76.5	78.3	80.0	80.1	80.6	79.6	79.4	
The extent to which my organisation values my work	42.8	46.2	49.2	51.4	50.4	52.3	52.1	
My level of pay	57.1	55.9	54.7	54.1	55.4	58.0	57.1	
Percentage of staff appraised in the last 12 months	81.9	87.7	89.9	91.5	90.8	91.1	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	33.4	33.5	

Source: National NHS Staff Survey (England).

Notes: Data rounded to 1 decimal place.

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

[2] Lower scores are better in these cases, however, in all other cases, higher scores are better.

4.46 Workload pressures generally remained high and showed little sign of easing (Table 4.4). In 2017, compared with 2016:

- There was a large decline in the numbers of staff agreeing that there were enough staff at their organisation (falling 1.6 percentage points to 30.8 per cent in 2017);
- There was a 0.6 percentage point increase in the percentage of staff who said they felt unwell as a result of work related stress;
- There was an increase in the percentage of staff saying they worked paid hours over and above their contracted hours of 0.4 percentage points. Meanwhile there was a reduction of 0.8 percentage points of staff saying they worked unpaid hours, although the overall percentage is still around 80 percent;
- There was a large increase, of 2.0 percentage points, in staff agreeing they could meet all the conflicting demands on their work.

Table 4.4: Selected results from the National Staff Survey, medical and dental staff, England, 2011 to 2017

Workload	2011	2012	2013	2014	2015	2016	2017	Trend[1]
I am unable to meet all the conflicting demands on my time at work[2,3]	44.8	44.7	45.2	48.0				
I am able to meet all the conflicting demands on my time at work[4]					38.7	37.2	39.3	
I have adequate materials, supplies and equipment to do my work	58.1	56.0	56.9	58.9	56.2	56.3	55.9	
There are enough staff at this organisation for me to do my job properly	35.5	35.5	34.2	33.9	33.7	32.4	30.8	
During the last 12 months have you felt unwell as a result of work related stress		32.0	32.9	32.3	32.6	31.1	31.7	
Percentage of staff working PAID hours over and above their contracted hours[2]	35.0	38.7	38.3	39.4	37.4	35.9	36.3	
Percentage of staff working UNPAID hours over and above their contracted hours[2]	72.5	76.2	77.1	76.3	79.1	80.5	79.6	

Source: National NHS Staff Survey (England).

Notes: Data rounded to 1 decimal place.

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

[2] Lower scores are better in these cases, however, in all other cases, higher scores are better.

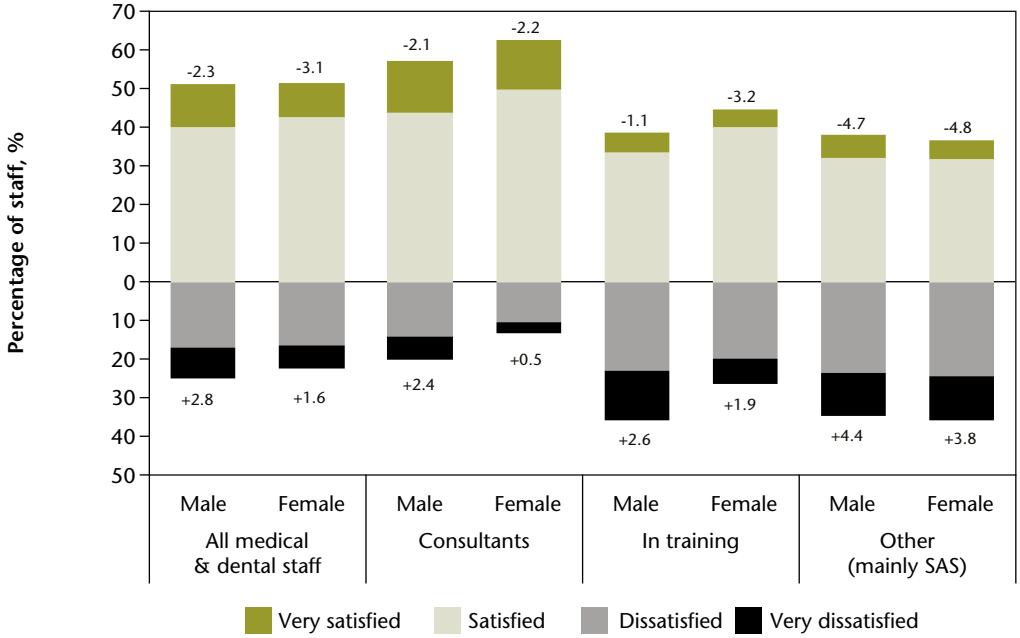
[3] For 2015, this question was reversed to "I am able to meet…"

[4] This question was introduced in 2015.

4.47 We have conducted some additional analysis of the medical and dental Staff Survey results by gender for 2016 and 2017. When looking across all medical and dental staff, similar proportions of female and male staff expressed satisfaction with pay (Figure 4.13). The increase in the proportion of male doctors reporting dissatisfaction with pay was greater that that for female doctors. However, within medical groups there were much larger differences between the genders.

- Female consultants (62.6 per cent) were more likely to express satisfaction with their pay than male counterparts (57.4 per cent). Similarly, male consultants were more likely to express dissatisfaction with their pay than female counterparts;
- There was a 5.9 percentage point gap between the proportion of male and female doctors and dentists in training expressing satisfaction with pay. 44.7 per cent of females expressed satisfaction with pay in 2017, compared to 38.8 per cent among males. Compared with 2016, there was a much larger fall in the proportion of female doctors and dentists in training (3.2 percentage points) expressing satisfaction with pay than for males (1.1 percentage points);
- The SAS doctor (other) group was the only medical group where male doctors (38.2 per cent) were more likely than female doctors (36.8 per cent) to express satisfaction with pay.

Figure 4.13: HCHS staff satisfaction with level of pay by grade and gender, England, 2017



Source: NHS Staff Survey data (England).
Note: *Those answering 'neither satisfied nor dissatisfied' have been excluded from this chart*
Those answering 'prefer to self-identify' or 'prefer not to say' are not shown.
Figures above and below the bars are the change in satisfaction/dissatisfaction compared to 2016.

Scotland

4.48 In November 2017 all staff across NHS Scotland and 23 Health & Social Care Partnerships were asked to participate in iMatters and the Dignity at Work survey, which replaced the Scottish Staff Survey last run in 2015. iMatters achieved a 63 per cent response rate, with over 100,000 responses. As this is the first set of results using this new approach, it is not possible to make comparisons with previous Staff Survey results, or results in other countries.

4.49 The Scottish iMatters results cover the whole of the workforce and are not solely for medical and dental staff. The Scottish Engagement Index stood at 75 per cent, which took into account responses to 28 questions. In general staff said that they were satisfied that they had sufficient support to do their job well (77 per cent), that their work gave them a sense of achievement (81 per cent), and that they felt appreciated for the work they do (73 per cent). In terms of their organisation, 70 per cent agreed that their organisation cared about their health and wellbeing, and 71 per cent that they had the help and support they need from other teams and services within the organisation. However, only 64 per cent said that performance was managed well within their organisation.

4.50 The Dignity at Work Survey achieved a 36 per cent response rate, and focused on experiences of discrimination, bullying, harassment, abuse and violence, as well as questions about whistleblowing and resourcing. Staff felt that nothing would happen as a result of reporting an incident, and were often fearful of what would happen if they did report it, including concerns about confidentiality. Sixty-nine per cent of staff reported that they could meet all the conflicting demands on their time, however only about half of staff (54 per cent) said that there were enough staff for them to be able to do their job properly.

Our comments

4.51 Pay for consultants, associate specialists, contractor GMPs, and providing-performer GDPs lies broadly in the region of the 97th percentile of full-time employees or above, while pay for registrars, salaried GMPs and performer only GDPs lies closer to the 90th percentile. The figures are not straightforward to interpret due to changes in the composition of the workforce, and/or limitations on information on hours worked. But there is evidence that the value of the points on the consultant pay scale has fallen relative to that of UK employees generally over the last twenty years.

4.52 In paragraphs 4.12 to 4.16 we described the pay comparability work undertaken by the Institute of Employment Studies. It showed that, despite the prolonged period of pay restraint, the levels of pay for members of our remit group were not out of line with the pay of the comparator professional groups.

4.53 The EU remains an important market for the recruitment of doctors, with 12 per cent of consultants, 10 per cent of trainees, and 5 per cent of other doctors who joined the NHS in England coming from the EU. However, NHS Employers reported that fewer employers were looking to recruit in the EEA because of uncertainty. This means there is increased importance on recruitment from the rest of the world, and we agree with NHS Employers that the immigration system that is in place after the UK leaves the EU must be flexible enough to allow employers to recruit from outside the UK to fill workforce shortages and maintain services. However, we were concerned to hear that the demand for certificates of sponsorship, which are required to recruit a worker currently outside the UK, exceeded supply, and that this might impact on employers' ability to recruit the doctors and dentists they need.

4.54 Data from DHSC show an increase in the number of doctors retiring early, with a particularly sharp increase in the proportion of retiring GMPs taking early retirement. It is not clear from the evidence why doctors are behaving in this way, but we remain concerned that changes to the ways in which benefits accrued as part of the NHS pension scheme are taxed may be having some impact.

4.55 In our 45th Report 2017 we focused on the Generation 'Y' cohort, which we were told placed greater value on work-life balance and flexibility, and variety in the workplace, than their predecessors. This year both the BMA and the BDA highlighted demographic changes, with women and BAME doctors and dentists accounting for a growing share of the medical and dental workforce. These are further factors that employers will need to consider when looking to develop and structure careers in the future.

4.56 The Staff Survey results in England for 2017 were generally less positive than in 2016. We noted particularly that the percentage of respondents saying that there were enough staff at their organisation for them to be able to do their job properly had fallen for the fifth consecutive year, and that the percentage of respondents saying they had experienced harassment, bullying or abuse was over a third. Satisfaction with pay in 2017 was lower than in 2016, but was still greater than in each of the years between 2012 and 2015.

4.57 We are pleased that the results of the new surveys covering staff in the Scottish NHS were made available before we submitted our report. However, we were unable to attach much weight to them, as they do not separately identify those staff members in our remit group. In addition, as a new survey approach is being used, we cannot compare the results to those for previous years.

4.58 There have been no new staff survey results for Wales and Northern Ireland since our 45th Report 2017.

CHAPTER 5: DOCTORS AND DENTISTS IN TRAINING

Introduction

5.1 This chapter examines doctors and dentists in training. 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 continue in the hospital sector or enter general practice training. Dentists undertake a vocational training programme.

5.2 A new junior doctors' contract was introduced in England from October 2016. Although most juniors in England are working to the new contract, those working in Scotland, Wales and Northern Ireland are still working to the previous contract. Therefore, we make recommendations for changes to the national salary scales that will apply to both contracts.

5.3 In September 2016 there were almost 62,500 doctors and dentists on a full-time equivalent (FTE) basis in hospital training in the UK, an increase of 0.4 per cent from 2015. Within this group, registrars rose by 1.3 per cent and foundation doctors fell by 0.8 per cent. Comparing September 2016 with 2015 there was an increase in the numbers in hospital training in England (0.5 per cent), Wales (1.5 per cent) and Northern Ireland (1.8 per cent[1]) but a decrease in Scotland (1.3 per cent).

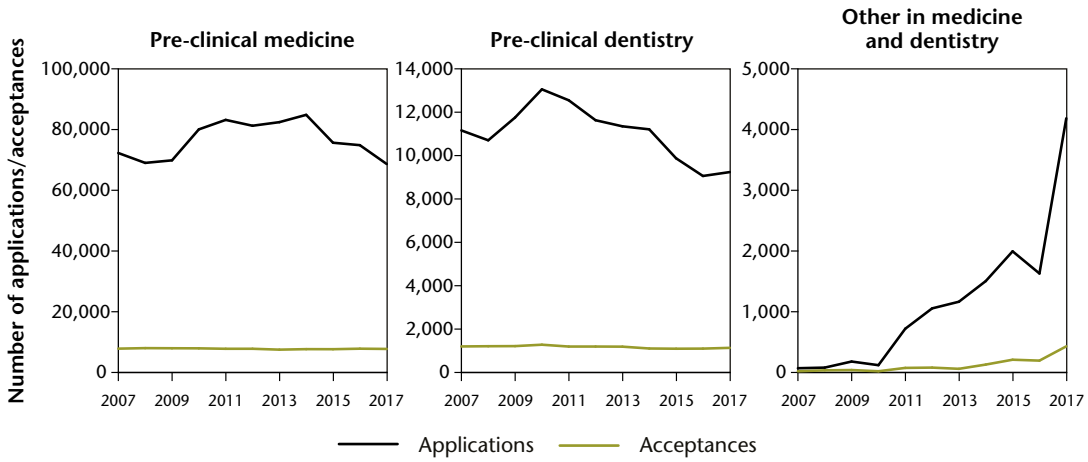
Undergraduates

5.4 Graduation from one of the medical or dental schools in the UK is the main entry route to the NHS for doctors and dentists. A typical medical student will complete a 4 to 6-year medical undergraduate course, before beginning two years of hospital training in Foundation Programmes.

5.5 Figure 5.1 shows time series from 2007 to 2017 for the numbers of applications and acceptances on pre-clinical medicine, pre-clinical dentistry, and other subjects in medicine and dentistry.[2] Applications for these courses are highly competitive; there were roughly nine applications per acceptance in all three courses leading to a medical or dental career in 2017[3] (9,300 acceptances from 82,000 applications). Pre-clinical medicine is the most popular entry route with more applications and acceptances than other subjects.

[1] The figures for Northern Ireland are for March 2017 compared to March 2016.
[2] The year refers to the year students start their studies, so 2017 refers to students who applied in 2016.
[3] One person can make up to five applications.

Figure 5.1: Number of applications and acceptances for medicine and dentistry courses in the United Kingdom, 2007 to 2017



Source: UCAS.

5.6 The number of applications for pre-clinical medicine rose between 2010 and 2014, but has fallen back in each of the last three years. Between 2007 and 2017, both pre-clinical medicine and pre-clinical dentistry have seen an overall fall in the number of applications (by 5.0 per cent and 17.2 per cent respectively) and in the number of acceptances of offers by applicants (by 1.2 per cent and 5.2 per cent respectively). The BMA highlighted that the number of applicants to UK medical schools to study medicine had fallen by 13 per cent between 2013 and 2017. Other medical and dental degrees[4] still account for a relatively small proportion of medicine and dentistry places but have become more popular since 2007, when there were far fewer applications for places on courses of this type.

5.7 Table 5.1 shows the ten undergraduate subjects with the largest ratio of applications to acceptances in 2017. This shows that, despite the reduction in applications and applicants over the past three years, there is still a higher ratio of applications to acceptances to study medicine and dentistry than for any other subject.

Table 5.1: Subjects[5] with the highest ratio of applications to acceptances, United Kingdom, 2017

Subject	Ratio of applications to acceptances 2017
Others in medicine and dentistry	9.7
Pre-clinical medicine	8.9
Pre-clinical dentistry	8.1
Artificial intelligence	7.9
Anatomy, physiology and pathology	7.1
Biotechnology	6.6
Nursing	6.6
Medical technology	6.5
Japanese studies	6.4
Economics	6.3

Source: UCAS

[4] UCAS definition for this group of degrees is: "Miscellaneous grouping for related subjects which do not fit into the other Medicine and Dentistry categories. To be used sparingly." Example courses include: foundation year for Medicine and Surgery Certificate of Higher Education, Oral Health Sciences, Dental Hygiene and Dental Therapy.

[5] This table only looks at subjects that had at least 100 acceptances in 2017.

5.8 UCAS data can be further broken down by gender, ethnicity and location. The percentage of students accepted each year that are female is given in Table 5.2. Since 2007 there have consistently been more female students than male students on medical and dental courses. All medical and dental courses have seen the proportion of female students increase across the period, with the biggest increase seen in pre-clinical dentistry.

Table 5.2[6]: Gender of accepted students on medical and dental courses, United Kingdom, 2007 to 2017

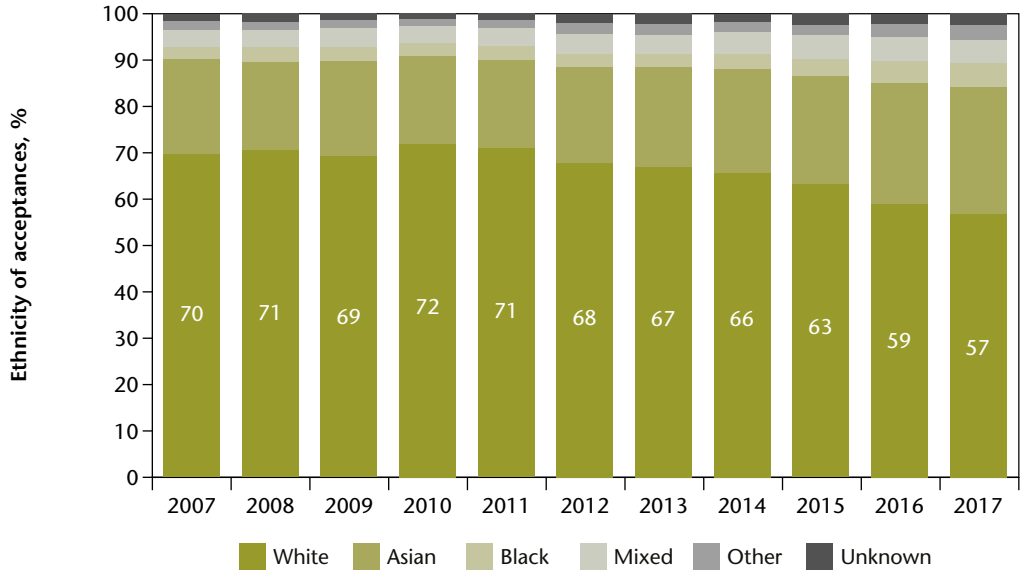
	Percentage female		
	Pre-clinical medicine	Pre-clinical dentistry	Others in medicine & dentistry
2007	56.5	57.5	60.0
2008	56.3	57.4	57.1
2009	54.9	58.8	62.5
2010	55.4	59.0	75.0
2011	54.1	57.3	73.3
2012	53.3	60.7	68.8
2013	55.0	61.2	75.0
2014	55.7	64.1	65.4
2015	56.1	62.6	68.3
2016	57.5	60.9	76.9
2017	59.0	63.4	64.7

Source: UCAS

5.9 Between 2007 and 2017 there have been increases in the proportion of students accepted on both pre-clinical medical and dental courses that were BAME. The percentage of students accepted on pre-clinical medical courses (out of the total number of students accepted each year) who were from BAME backgrounds increased from 29 per cent in 2007, to 42 per cent in 2017. For pre-clinical dental courses there was an increase from 42 per cent to 54 per cent[7].

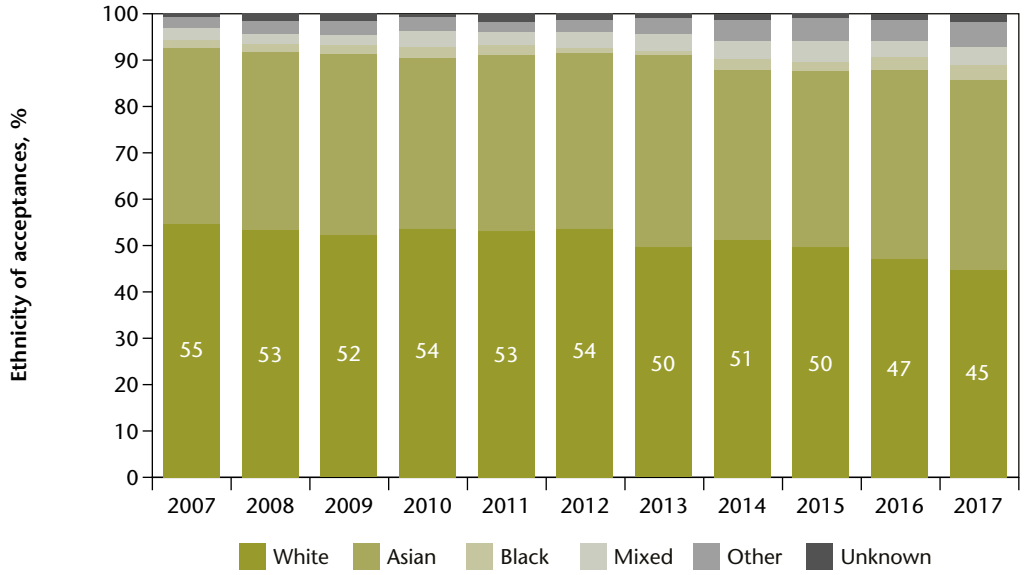
[6] Currently in UCAS data a student can only be recorded as either male or female gender.
[7] These percentages exclude those with ethnicity recorded as 'other'.

Figure 5.2: Ethnicity of acceptances for pre-clinical medicine courses, United Kingdom, 2007 to 2017



Source: UCAS.

Figure 5.3: Ethnicity of acceptances for pre-clinical dental courses, United Kingdom, 2007 to 2017



Source: UCAS.

5.10 UCAS data show that in 2017 there were 255 acceptances to pre-clinical medicine from people living in the EU but from outside the UK (just over 3 per cent of total acceptances), and 725 acceptances from people living outside the EU (9 per cent of total acceptances). For pre-clinical dentistry the figures were 15 acceptances from people living in EU countries other than the UK (1 per cent), and 75 from non-EU countries (4 per cent). Since 2007 there has been an increase in the number of accepted students applying from EU and non-EU countries for pre-clinical medicine, and an increase from non-EU countries for pre-clinical dentistry, but little change from EU countries for pre-clinical dentistry.

5.11 The Destination of Leavers of Higher Education (DLHE) survey, carried out by the Higher Education Statistics Agency (HESA), surveys graduates six months after graduation, providing information on their destinations. Table 5.3 shows the destination of graduates from medicine and dentistry courses. The majority of students studying pre-clinical or clinical medicine go into the hospital sector (61.1 per cent and 77.1 per cent respectively). Similarly, the majority of students studying pre-clinical or clinical dentistry go into the dental sector (73.0 per cent and 80.6 per cent respectively).

5.12 Small percentages of students go into other areas (approximately 14.0 per cent in total). This percentage is higher for those who studied other courses in medicine and dentistry. Examples of other sectors that graduates went into include: research and development in biotechnology; natural sciences or engineering; social work; regulators of activities providing health care, education & cultural activities; defence activities; manufacture of pharmaceutical products; and secondary education. 10.2 per cent of graduates did not give a job destination. The highest percentage of students with unknown destinations were for those who had studied pre-clinical medicine (27.9 per cent).

Table 5.3: Destination of graduates from medical and dentistry degree courses, by degree course, United Kingdom, 2015-16 graduates (%)

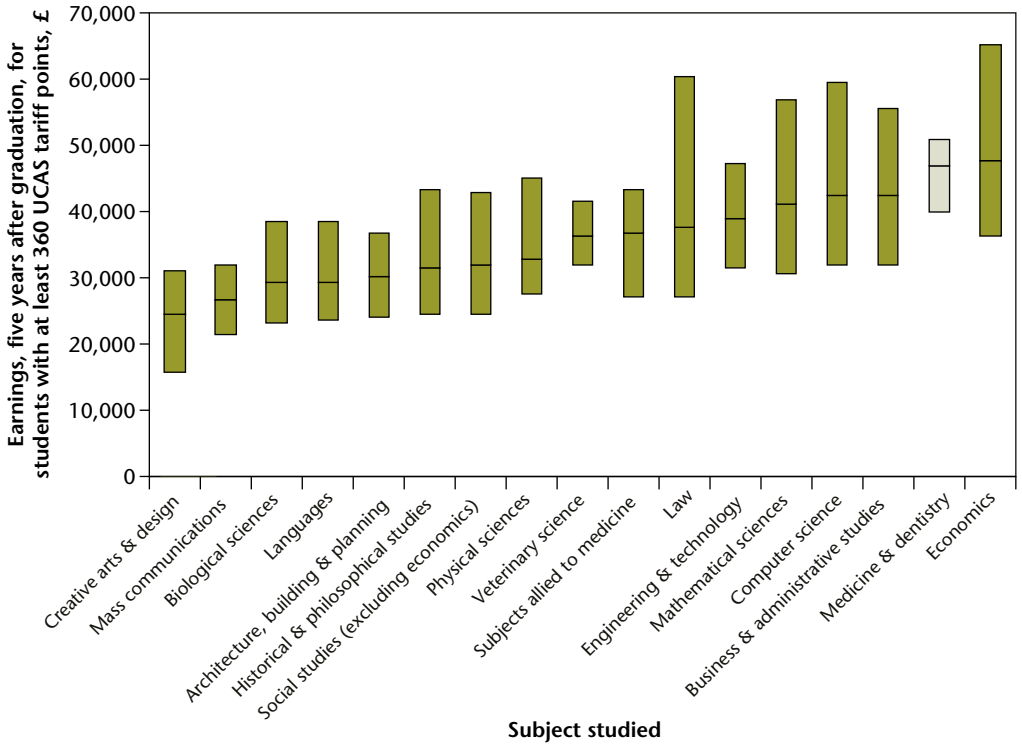
Degree course	Hospital sector	Dental sector	GMP sector	Specialist medical activity	Tertiary education	Other	Not known	Total
Pre-clinical medicine	61.1	0.1	0.8	0.2	0.3	9.7	27.9	**1,694**
Pre-clinical dentistry	9.9	73.0	0.9	0.0	1.2	9.5	5.5	**116**
Clinical medicine	77.1	0.0	1.4	0.1	1.1	13.5	6.7	**6,958**
Clinical dentistry	9.6	80.6	0.4	0.1	1.7	4.0	3.5	**1,120**
Others in medicine & dentistry	40.5	10.9	6.8	0.1	0.8	27.8	13.1	**796**
Total	**64.0**	**10.1**	**1.6**	**0.1**	**1.0**	**13.0**	**10.2**	**10,685**

Source: OME analysis of HESA data

5.13 The Department for Education's Longitudinal Educational Outcomes (LEO) data brings together higher education data with Her Majesty's Revenue and Customs and Department for Work and Pensions earnings and employment data. This provides a comparison of graduate earnings five years after graduation by subject studied and prior attainment before university.

5.14 Figure 5.4 shows the distribution of earnings for students with at least 360 UCAS tariff points in each subject area five years after graduation. Those studying medicine and dentistry have the second highest median annualised earnings (£47,000) out of all the degree subjects listed, just behind those studying economics (£48,000). While five other subjects had higher upper quartiles than medicine and dentistry (economics, law, computer science, mathematical sciences and business and administrative studies), earnings at the lower quartile for those who studied medicine and dentistry are above the lower quartile for all other subjects. The interquartile range for medicine and dentistry is small, reflecting the fact that the vast majority who study those degrees go on to become a doctor or dentist in training on pay close to this relatively high median figure. This combination of relatively high salary with low variance is unlike most other degree subjects, where graduates will go on to do a wide range of different types of work with more varied salaries, and is one of the features that makes a medical or dental career attractive.

Figure 5.4: Earnings, five years after graduation, by subject studied, for students with a prior attainment of at least 360 UCAS tariff points (2008-09 graduates from English Higher Education Institutions)



Source: OME Analysis of Department for Education data.

Junior doctors contract reform in England

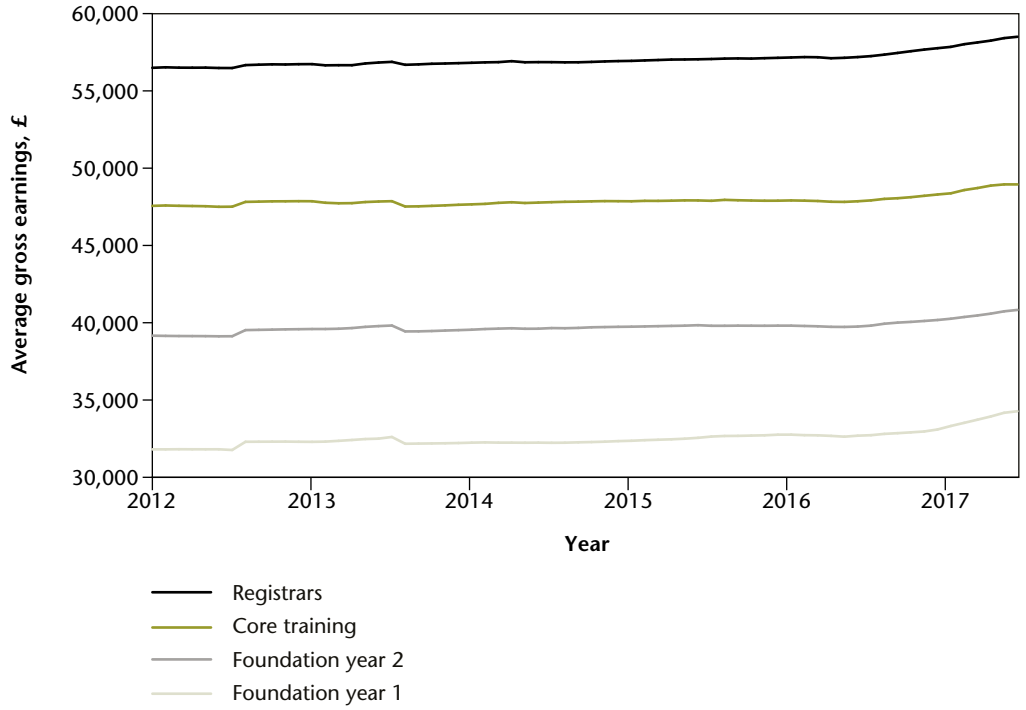
5.15 In 2016 a new contract for junior doctors was introduced in England, with new trainees starting on the new arrangements from October of that year. NHS Employers said that all eligible trainees in England are now on the new contract (some, who are on longer-term contracts, and have not changed lead employer since 2016, remain on the old contract), and that employers generally feel that the underlying principle of the new contract is the right one. In the long run, employers believe the long-term benefits will be worthwhile.

5.16 The BMA said that the new contract was being introduced for the majority of trainees between October 2016 and October 2017, as their existing contracts expired, and with a staggered approach. The BMA said it had not accepted this contract, because many of its members' concerns remain.

5.17 NHS Employers said that good progress had been made in implementing the new contract, and that it was supporting work to improve the overall training experience for doctors. It also said that it was in discussions with stakeholders on a review of the contract in line with an agreement reached at the Advisory, Conciliation and Arbitration Service (ACAS).

5.18 Between September 2016 and September 2017, junior doctors' monthly average total earnings have increased at a faster rate than over the preceding five years, coinciding with the introduction of the new contract (Figure 5.5). Total earnings increased by 5.4 per cent for F1, 2.4 per cent for F2, 4.3 per cent for Core Training, and 2.8 per cent for Registrars. Previously between 2011 and 2016, for both Foundation Years, the average total earnings for both years have moved slightly down, away from the 90th percentile and towards the median.

Figure 5.5: Monthly average gross earnings of doctors in training in England, 2012 to 2017



Source: NHS Digital.

Flexible pay premia

5.19 The 2016 junior doctor contract in England includes flexible pay premia for:

- general practice training, payable only during the practice-based period of GMP specialty training;
- hard to fill training programmes, initially emergency medicine and psychiatry;
- oral-maxillofacial surgery;
- clinical academic trainees;
- those taking time out for training for recognised activities deemed to be of benefit to the wider NHS.

5.20 The 2017 values of these flexible pay premia are set out in Table 5.4.

Table 5.4: Flexible pay premia in England, 2017

	Full-time annual value (£)
General practice	8,282
Psychiatry core training	3,367
Psychiatry higher training (3 year)	3,367
Psychiatry higher training (4 year)	2,525
Academia	4,040
Emergency medicine/Oral & maxillofacial surgery: (Length of training programme)	
3 years	6,734
4 years	5,050
5 years	4,040
6 years	3,367
7 years	2,886
8 years	2,525

Source: NHS Employers, Pay and Conditions Circular (M&D) 1/2017

5.21 The DHSC said that in 2017-18 the combined cost of these premia was £47 million, with most of the payments being on general practice training. This was equivalent to 0.1 per cent of the HCHS paybill or 1.4 per cent of the junior doctor paybill. For 2018-19, as juniors continued to move on to the new contract, DHSC said they expected the costs of the premia, based on their existing value, to increase to £56 million in 2018-19.

5.22 In its evidence Health Education England (HEE) said that:

- It had agreed with NHS England funding to expand the Targeted Enhanced Recruitment (TER) scheme to 200 places. This provided a £20,000 'Golden Hello' for new general practice trainees filling places in specific parts of the country that were experiencing difficulties filling training places. HEE said that the scheme had been effective;
- The pay premium for psychiatry was vital, but that it was also exploring with NHS England and the Royal College of Psychiatrists the development of a TER in some areas;
- Although it was currently able to fill 100 per cent of emergency medicine places, HEE said that the premium should be retained;
- Recent work on the Cancer Workforce plan showed a risk of under-filling histopathology training programmes, and it would now recommend the national application of a premium for this specialty. The data for 2017 showed a 71 per cent fill rate for histopathology posts, the lowest fill rate for any specialty.

5.23 NHS Employers said that there was some emerging anecdotal evidence to suggest that the flexible pay premia introduced for emergency medicine and psychiatry had had an impact.

5.24 HEE, NHS Employers and DHSC said that recruitment and retention premia should be focused on junior doctors, with a focus on recruitment into both the specialties and geographies where the NHS most needs doctors to train. Rather than focusing on consultants, where in their view it was too late to have the required impact, targeting pay premia at junior doctors provided the opportunity to influence doctors' training choices at the appropriate point in their careers.

5.25 The BMA said that any increase in pay rates which the DDRB recommended should also apply to the various flexible pay premia for trainees in shortage specialties, or who had lost out disproportionately as a result of the new contract, so that these were not degraded by inflation. However, the BMA also said that it did not support further targeted recommendations to address location or specialty recruitment issues, and that the existing premia were stop-gap solutions that did not address the underlying issue of a cut in pay for those specialties.

5.26 The HCSA said that it did not support targeted recommendations to address location or specialty recruitment issues that were outside standard national pay scales and terms. However, it acknowledged the introduction of additional pay premia for trainee doctors choosing to undertake hard-to-fill training programmes, and cautiously supported its continuation.

Recruitment and training choices

England

5.27 HEE supplied data showing the fill rates for various training programmes between 2015 and 2017 (Table 5.5). Between 92 and 93 per cent of post-foundation years' training posts were filled in each year: in 2017 this represented over 500 unfilled posts. The fill rates varied by specialty, with the lowest fill rates in 2017 being in histopathology (71 per cent), cardiothoracic surgery (75 per cent) and core psychiatry training (78 per cent). Fill rates in 2017 also varied by geography, from 99 per cent in the South, 98 per cent in London and the South East, 91 per cent in the Midlands and East, to 79 per cent in the North.

Table 5.5: Fill rates for post-foundation years' training posts, England

Training programme	Posts	Fill rates (%)		
	2017	2017	2016	2015
Clinical Radiology	226	100	100	100
Community Sexual and Reproductive Health	4	100	100	100
Neurosurgery	27	100	100	100
Ophthalmology	55	100	100	100
Oral and Maxillo-facial Surgery	7	100	100	100
Core Surgical Training	501	100	100	98
Obstetrics and Gynaecology	238	100	99	100
Public Health Medicine	70	99	100	100
ACCS/Core Anaesthetics	552	96	97	98
General Practice	3,250	95	90	86
ACCS – Emergency Medicine	308	91	98	99
ACCS Acute Medicine/Core Medical Training	1,423	90	95	98
Paediatrics	381	88	93	96
Core Psychiatry Training	419	78	73	86
Cardiothoracic Surgery	8	75	100	100
Histopathology	85	71	99	103
Total	7,554	93	92	93

ACCS – Acute Care Common Stem
Source: HEE analysis of recruitment data recorded by HEE local teams

5.28 HEE provided the DDRB with analysis of the flow of trainee doctors in England from foundation to further training. Figure 5.6 shows the percentage of trainee doctors identified in training one to three years after finishing their second foundation year.

5.29 It confirms the continuation of the established trend for trainees to delay transition to further PGME (Post-Graduate Medical Education) training. The proportion of doctors that had returned to training had recovered substantially by the second year, but there had been a decline in the rate of this recovery from 81 per cent (2012 cohort) to 75 per cent (2015 cohort). Rates in the third-year post-foundation were slightly lower than those in the second year.

Figure 5.6: The proportion of trainee doctors identified in training 1, 2 and 3 years after finishing their second foundation year, England

Cohort	After 1 year	After 2 years	After 3 years
2012	68%	81%	79%
2013	62%	79%	79%
2014	59%	79%	76%
2015	52%	75%	
2016	47%		

Source: HEE.

Wales

5.30 The Welsh Government told us that in 2017-18, compared with a total number of posts of 339 at each level, there were 327 F1 and 325 F2 doctors in Wales. These figures represent fill rates of 96 per cent at both F1 and F2. Overall, in September 2017 there were 2,157 medical and dental trainee places in Wales, of which 13 per cent were vacant. The vacancies covered the following specialties: psychiatry, core medical training, general practice, higher medical specialties and higher paediatrics. The Welsh Government said that there were no adjustments to pay in Wales for specialties or areas with low fill rates.

Scotland

5.31 The Scottish Government described fill rates in specialties and areas as challenging. It said that specialties that did not fill well included acute internal medicine, and general surgery. The evidence said that general surgery had historically filled well, but that this was the second year where this had not been the case, and that the data would be carefully observed to monitor any new trend as a result of the *Improving Surgical Training* initiative for 2018 recruitment.

5.32 The Scottish Government said that the number of general practice specialty training places advertised in Scotland had been increased to 430, resulting in an increase in fill rates to 90 per cent, against an establishment of 1,082.

Northern Ireland

5.33 The Department of Health (Northern Ireland) said that as at August 2017 it had been able to fill 380 of the 498 training posts it was looking to fill during the year. It said that, at that time, there had been 179 vacancies overall, giving a fill rate of 90 per cent.

5.34 The Department told us that the commissioning of GMP training is provided through the Northern Ireland Medical and Dental Training Agency (NIMDTA), and was being informed by a workforce review of training in general practice undertaken in 2014. Following that review, the number of GMP training places increased from 65 to 85 in 2016-17, and in 2018-19 there would be an intake of 111 GMP trainees.

Motivation

England

5.35 The 2017 Staff Survey data discussed in Chapter 4 showed that, of the medical staff groups, the group with the largest reduction in numbers saying they were satisfied with pay was doctors and dentists in training, who showed a reduction of 3.6 percentage points from 2016. This group also reported the largest fall in engagement scores.

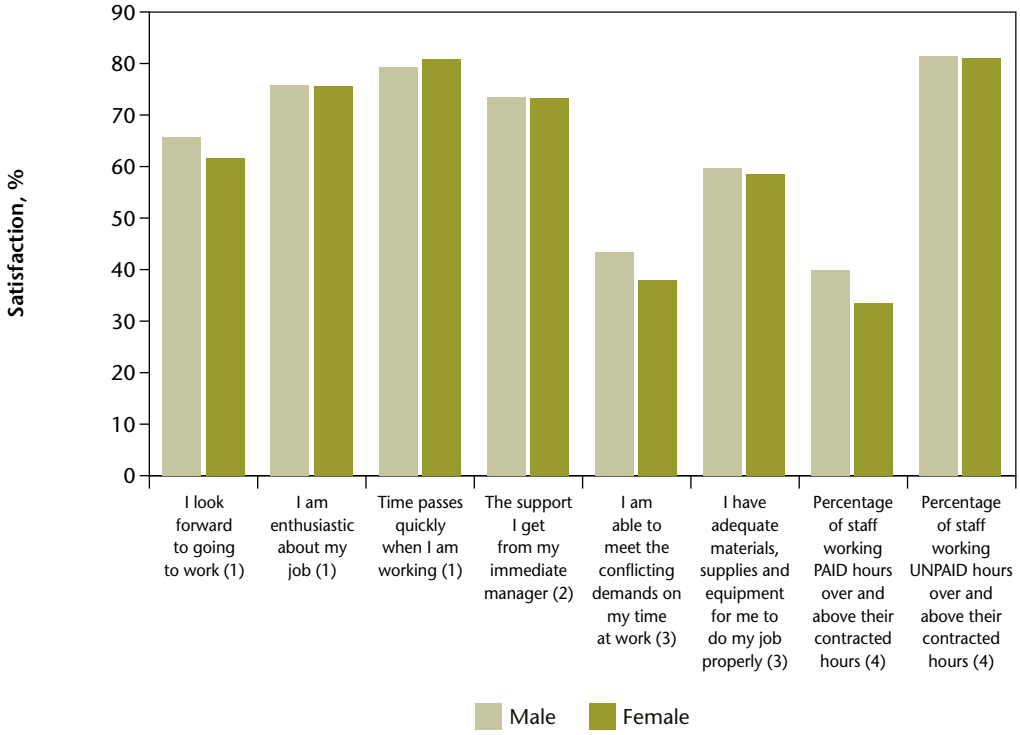
5.36 In terms of job satisfaction, a greater proportion of doctors and dentists in training than in 2016 felt they were satisfied with the support they received from their immediate managers, an increase of 0.8 percentage points. However, most of the other responses were worse, with a decrease of 5.8 percentage points in those saying they were satisfied with the recognition they received for good work, and a fall of 2.8 percentage points in the proportion saying they were satisfied with the amount of responsibility they were given.

5.37 Junior doctors were generally more negative about work pressures than in 2016. A greater proportion than in 2016 said they were working more paid hours than their contracted hours (an increase of 4.1 percentage points), but there was a reduction in the proportion saying that they were working unpaid hours (a reduction of 1.9 percentage points). The proportion who felt there were not enough staff had increased by 4.2 percentage points.

5.38 When looking at the differences by gender (Figure 5.7), the largest difference was between the proportion of males and females who said that they were working additional paid hours. 39.8 per cent of male junior doctors said they worked additional paid hours compared to 33.5 per cent of female junior doctors (an increase of about 5-6 percentage points for both genders since 2016).

5.39 43.4 per cent of male junior doctors felt that they were able to meet all of the demands on their time at work, 5.5 percentage points higher than for females, at 37.9 per cent.

Figure 5.7: HCHS doctors and dentists in training, satisfaction with aspects of the job and work pressures by gender, England, 2017



Source: NHS Staff Survey data.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

5.40 In its evidence for our 2017 report, NHS Providers said that rebuilding junior doctor engagement and morale was a key priority for Trusts following the introduction of the new contract. NHS Providers also said that in October 2017, with NHS Improvement and the Faculty of Medical Leadership and Management, it had published *Eight high impact actions to improve the working environment for junior doctors*[8]. These actions included tackling work pressures, promoting rest breaks, clearer communication between trainees and managers, rotas that promoted work-life balance, and offering support and mentoring. NHS Providers said that it expected these and other initiatives to support the rebuilding of junior doctor engagement and morale.

5.41 NHS Employers said that it had received mixed reports about the experience of junior doctors. It reported that many employers said that, as the contract had been implemented, they were receiving far fewer complaints about it. However, it added that there had been issues which had affected morale in some locations, including:

- difficulties in accessing flexible working and training patterns;
- rota gaps and rota uncertainty when trainees join a new employer;
- the administrative burden when rotating to new training placements;
- cultures that do not encourage exception reporting.

[8] https://improvement.nhs.uk/resources/eight-high-impact-actions-to-improve-the-working-environment-for-junior-doctors/

5.42 HEE said that it had published a document in March 2017, *Enhancing Junior Doctors Working Lives*, which set out a commitment to improving the quality of education and training of junior doctors. In a progress report[9] HEE said that it was aware of reports of low morale across the junior doctor workforce, and that ten training issues had been identified which needed to be addressed. These included: late rota notifications; the impact on relationships and family life; the rising costs of training; the need to improve induction and mandatory training; and the need to move home repeatedly.

Scotland

5.43 The Scottish Government said that it had taken action to improve the working lives of junior doctors. Actions included maintaining compliance with the Working Time Regulation average 48 hour working week, changing rotas to make them safe, and abolishing junior doctors working seven nights in a row. The Government said that, in partnership with the BMA and employers, it was looking to implement a minimum rest period of 46 hours after a period of night shift working, improved rest and catering facilities for those working out of hours, improved rota design and planning, and exploring flexibilities around the use of fixed annual leave.

Our comments

5.44 Although many juniors in England are employed on the new contract those working in Scotland, Wales and Northern Ireland are still on the previous contract. The contract in England was implemented without the BMA's agreement, and we hope that there is still scope for the BMA and NHS Employers to reach some accommodation on the outstanding issues. NHS Employers, NHS Providers and HEE have all recognised that the morale of juniors has suffered, and that work is needed to address this. However, while in many cases the results from the 2017 Staff Survey were more negative for juniors than other groups, HEE have acknowledged that this is about more than just the contract.

5.45 We note that that the earnings of doctors in training in England have increased since the introduction of the new contract. We had been told that the introduction of the contract was cost neutral in the longer-term, although in the short-term, transitional pay protection arrangements designed to ensure that no junior lost out as a result of the new contract may have had an effect on the data. Despite this increase in earnings, the proportion of junior doctors reporting that they were satisfied with pay, as part of the 2017 Staff Survey, fell by more than that of any other group.

5.46 Junior doctors in other parts of the UK are still on the previous contract. We heard no evidence that the introduction of the contract in England had had any impact on the ability of those employers in Scotland, Wales and Northern Ireland to fill their training places.

5.47 Despite falls in the number of applicants and applications to study medicine and dentistry, the ratio of applications to acceptances for these subjects remains higher than that for any other. We have yet to see any evidence that the fall in the number of applications has had a negative effect on the quality of those studying medicine and dentistry. Since 2007 there has been an increase in the percentage of students accepted onto pre-clinical medical and dental courses in the UK that were women or BAME. Over the same period there has also been an increase in the number of students accepted to study from outside the UK.

[9] https://hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%20working%20lives%20-%20a%20progress%20report.pdf

5.48 The earnings, five years after graduation, of those who studied medicine and dentistry (£47,000 at the median) compares favourably with those who studied other subjects. This is still likely to be a positive factor when considering whether to study medicine or dentistry.

5.49 Data for England for between 2015 and 2017 showed a failure to fill 7-8 per cent (over 500 posts) of posts for those continuing training after completion of their foundation training. At the same time, HEE data showed an increasing proportion, over half in 2016, of those completing their foundation training chose not to continue their training immediately. One way of filling the unfilled posts in the future would be to encourage trainees to continue their post foundation training without a lengthy break, although the trends show this may be difficult to achieve as a result of a generational change in young people's attitudes to work.

5.50 Scotland, Wales and England all reported that they had had problems filling posts for particular specialties. In England, as part of the new contract, a series of flexible pay premia were introduced for those training in emergency medicine, psychiatry, and general practice, with the greatest focus on filling general practice training positions. These premia have only been in place for a short time, but NHS Employers told us that there was anecdotal evidence that the payments for emergency medicine and psychiatry had had an impact, while the fill rate for the general practice training programme had increased from 86 per cent in 2015 to 95 per cent in 2017. HEE recommended that a pay premium be introduced for those training in histopathology and we support this strongly.

5.51 Currently, these pay premia are attached to specialties as a whole, with no variation by geography. We note that there is a significant difference in fill rates by region, with fill rates of almost 100 per cent in London and the South, around 90 per cent in the East Midlands, East of England and the North West, and around 80 per cent in the North East. We have also heard on our visits that some rural and coastal areas have particular difficulties attracting sufficient numbers, even in regions where overall fill rates may otherwise be relatively high. Where there are problems recruiting to particular specialties or locations we believe it is desirable to look to develop solutions that target those particular areas, a subject we return to in Chapter 10.

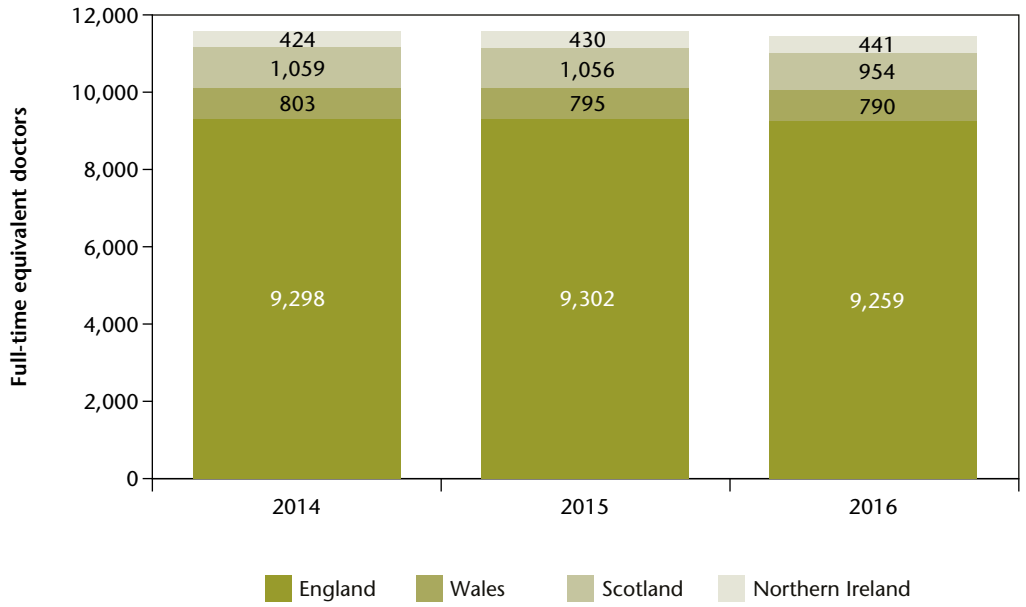
CHAPTER 6: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS (SAS)

Introduction

6.1 This chapter covers specialty doctors and associate specialists (SAS). This is 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.

6.2 In September 2016 there were just over 11,000 full-time equivalent (FTE) specialty doctors, associate specialists and staff grades in the UK, around 1 in 10 of the hospital doctor workforce. In 2016, compared with 2015, the number of SAS doctors fell by 1.3 per cent, with reductions in all parts of the UK except Northern Ireland.

Figure 6.1: Number of specialty doctors, associate specialists and staff grades in the Hospital and Community Health Services, United Kingdom, 2014 to 2016



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

6.3 Data from NHS Digital, for England only, gives a breakdown of the remit group by gender and ethnicity. The data show that SAS doctors contained the highest proportion of BAME staff, with only about 4 in 10 staff identifying as white. For consultants, specialty registrars and training grades, the proportions were closer to 6 in 10 staff. The SAS grades also contained a higher proportion of women, at 45 per cent, than the equivalent figure for consultants, 35 per cent.

6.4 Health Education England (HEE) data suggests that over 70 per cent of SAS doctors in England obtained their primary medical qualification abroad, about 60 per cent from a non-EU country, with a further 12 per cent from EU countries.

6.5 In our 45th Report 2017, we said that improved evidence was required from all parties about the SAS staff group. We are pleased that the BMA provided evidence, which included the results of a survey of SAS doctors[1], and that NHS Employers provided a summary of its findings, from a survey of its members about SAS doctors in England.

Recruitment and retention

6.6 In the survey conducted by NHS Employers in England, 77 per cent of respondents said they had experienced some difficulty recruiting to SAS posts. Employers reported the most difficulty filling positions in emergency medicine, psychiatry, and paediatrics. The most common reasons given for experiencing difficulties were the general supply position and national shortages (82 per cent), pay and conditions (57 per cent), and location (39 per cent).

6.7 Just over 30 per cent of respondents to the NHS Employers' survey in England reported difficulties with retention of SAS doctors. The most common reasons given for leaving were career progression (78 per cent), pay (57 per cent), morale (48 per cent), career development (43 per cent) and workload (26 per cent).

6.8 The BMA carried out a survey of SAS doctors in September 2017. It highlighted that the results included 71 per cent of respondents saying there were SAS doctor vacancies where they worked, and that of those reporting such vacancies, 90 per cent said that there was at least one vacancy that had been unfilled for more than six months.

6.9 The Northern Ireland Department of Health said that there were 67 SAS doctor vacancies at the end of June 2017, an increase from 65 at the end of March 2017. Between April 2016 and March 2017, 33 new doctors joined at these grades, while 23 doctors at these grades left the Health and Social Care system.

Career development

6.10 In December 2017 HEE published its draft health and care workforce strategy for England[2], to cover the period to 2027. In the draft strategy HEE said that it was investing £12 million a year in the education and training of SAS doctors and that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas'. HEE said that there was a need for more discussions and ideas about what could be done to support and value the SAS workforce.

6.11 NHS Improvement said that the SAS doctor career pathway should be recognised as a valid career path, and that this group could be expanded and used more efficiently and effectively. NHS Improvement said that, as was the case for other groups, the aim for SAS doctors was that they should practise at the top of their licence.

6.12 On our visits during 2017 we heard from SAS doctors across the UK. SAS doctors reported feeling 'stuck' and 'disheartened' due to a lack of progression opportunities. They wanted to see the reopening of the associate specialist grade, since they felt that there was now no pathway to recognise SAS seniority in either pay or name. SAS doctors wanted recognition and adequate remuneration in their existing grade, rather than being asked to retrain as consultants, which they felt would add substantially to already heavy workloads, and would often be incompatible with family commitments.

[1] https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/sas-doctor-survey
[2] https://hee.nhs.uk/our-work/workforce-strategy

6.13 Each of the four countries in the UK has published its own Charter for SAS doctors[3]. These set out what SAS doctors and their employers can expect from each other. However, the BMA told us that only 22 per cent of respondents to its survey of SAS doctors said that the Charter had been implemented where they worked, and 53 per cent said they were unaware of the existence of an SAS Charter where they worked.

6.14 The Welsh Government said that in 2016 an SAS Charter for Wales was published, which highlighted the commitment of employers in NHS Wales to providing an appropriate agreed job plan relevant to their role within the service and individual specialised skills. An SAS reference group for Wales was reviewing the numbers of SAS staff with job plans.

6.15 The Scottish Government said that it had an SAS Doctors Development Fund, to which it had allocated £500,000. The aim was to direct national funding to SAS doctors and dentists whose teams were seeking to develop new or improved clinical services, or to enhance their role within the clinical team. Funding was available to support the costs of training, salary backfill, or completion of training to apply for a Certificate of Eligibility for Specialist Registration (CESR). The Scottish Government said that it had received positive feedback from those who had benefited from the fund, and from clinical directors whose doctors had used it.

6.16 The DHSC said that the aspirations of today's junior doctors may lead to greater demand for different career pathways, and wider consideration of the availability and suitability of career grade options as an alternative to the consultant pathway.

6.17 In the 2017 Staff Survey in England, 84 per cent of SAS doctors said they believed that their organisation provided equal opportunities for career progression or promotion. This was lower than the equivalent figures for consultants (91 per cent), or for junior doctors (95 per cent).

Motivation

England

6.18 In Chapter 4 we reported on the results of the 2017 Staff Survey. It showed that, of the medical staff groups, more of the SAS doctors had said they were dissatisfied with their pay than other groups. This has been the case in six of the last seven surveys. In the 2017 Staff Survey, the engagement score for SAS doctors fell for the first time in the last seven surveys, by 0.02 points, from 3.84 to 3.82.

6.19 Fewer SAS doctors than other medical staff groups expressed satisfaction with the opportunity to use their skills (74.1 per cent), and with the support they received from their immediate manager (67.0 per cent), and the extent to which the organisation valued their work (48.8 per cent). Compared with the 2016 results, a greater proportion of SAS doctors felt there were not enough staff, and that they were not able to meet the demands on their time.

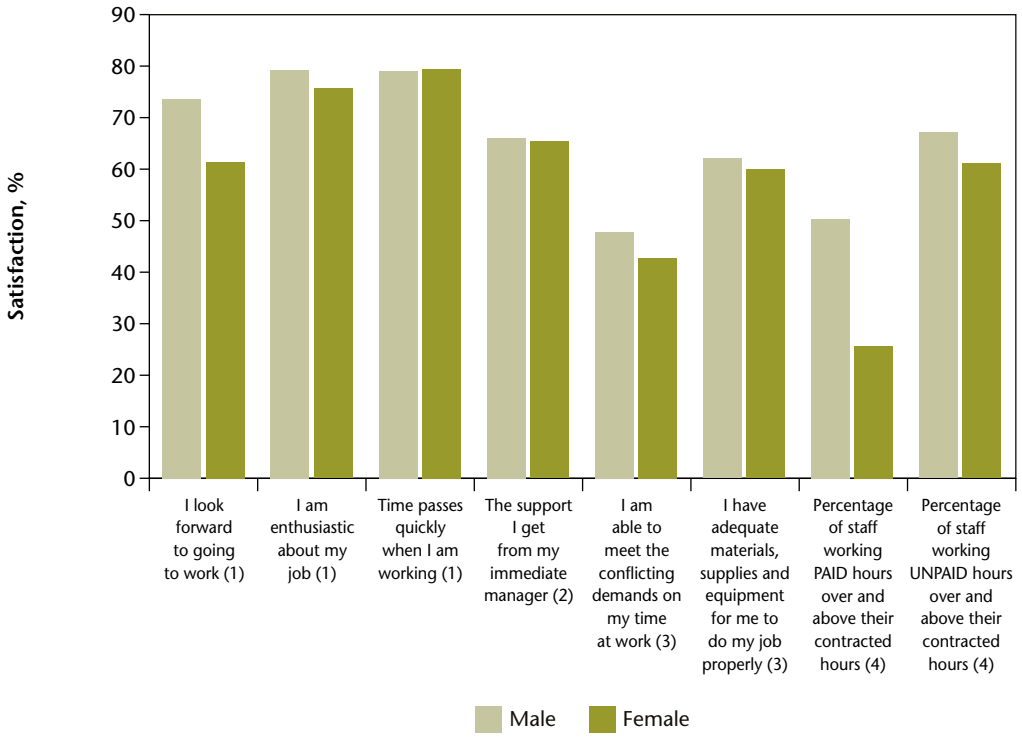
6.20 SAS doctor satisfaction with pay was similar across the two genders. However, this was the only medical group where a slightly higher percentage of male doctors (38 per cent) expressed satisfaction than female doctors (37 per cent). Further details, in Figure 6.2, are as follows:

- Twice as many male SAS doctors (50 per cent) as female SAS doctors (26 per cent) said they worked additional paid hours. Slightly more male than female SAS doctors said they were likely to work unpaid hours;

[3] Charters were published for England and Scotland in 2014, Northern Ireland in 2015 and Wales in 2016. The Welsh Charter also explicitly covers dentists.

- A larger proportion of male SAS doctors (74 per cent) than female SAS doctors (61 per cent) said they looked forward to going to work;
- Similarly, more male SAS doctors said they were able to meet the conflicting demands on their time at work (48 per cent) than female SAS doctors (43 per cent).

Figure 6.2: HCHS SAS (other) doctors' satisfaction with aspects of the job and work pressures, by gender, England, 2017



Source: NHS Staff Survey data.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

6.21 The BMA said that its survey of SAS doctors identified substantial issues with morale and motivation for this group, with almost half of respondents describing their morale as being low or very low. Amongst the results, it highlighted 46 per cent of respondents saying their morale had worsened over the previous year, and 27 per cent saying that they had been victims of bullying, harassment or victimisation in the workplace. The BMA also said that: just 22 per cent of respondents said that the SAS Charter had been introduced where they worked; two-thirds of respondents said that they had not used the SAS Development Fund in the last 12 months; 41 per cent of respondents said they did not have appropriate opportunities to apply for management posts; more than 50 per cent said they had insufficient time for professional development; and less than half of SAS doctors said they would recommend their career path.

6.22 In its survey of employers, NHS Employers found that the issue that most affected the morale and motivation of SAS doctors was professional development, and in particular career progression, access to study leave and lack of funding for development. Other issues included long incremental pay scales, a perception of not being sufficiently valued, ineffective job planning, lack of access to clinical awards and a lack of engagement in service change.

6.23 Actions that employers had taken to improve the morale of SAS doctors included establishing SAS doctors' forums, appointing SAS tutors, providing support to gain the CESR and for wider professional development, improved job planning and implementing the SAS Charter.

6.24 NHS Employers said that evidence from the NHS Staff Survey indicated areas of dissatisfaction, and that it was working with the BMA's SAS committee to address those concerns, and to help spread and embed good practice. NHS Employers also said that it would engage with the HCSA on issues concerning this group.

Scotland, Wales and Northern Ireland

6.25 The most recent staff survey results for Wales and Northern Ireland were published before our 45th Report 2017, so we have no new data to report on. The latest published Scottish staff surveys, published earlier in 2018, are not available in sufficient detail to identify SAS level results.

Contract reform

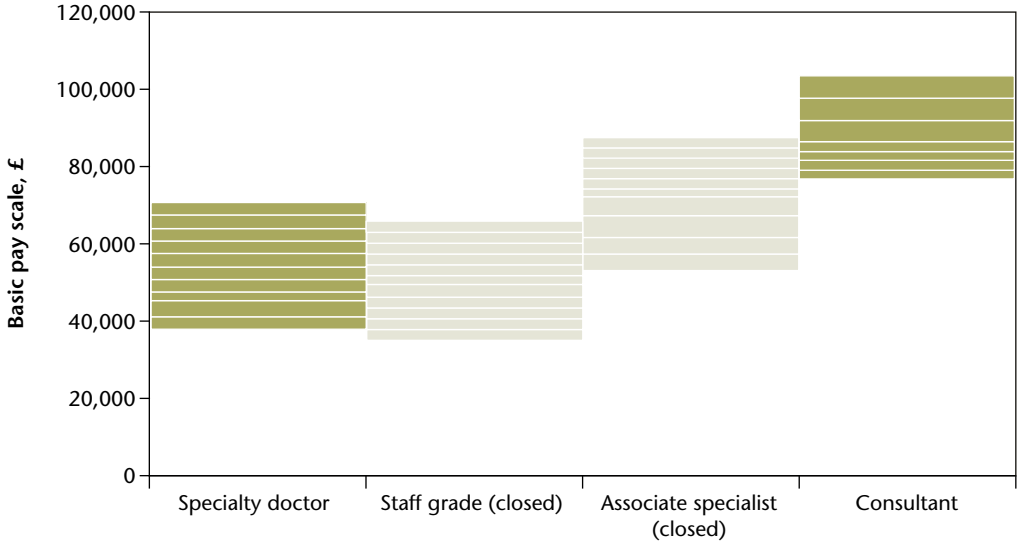
England

6.26 The DHSC said that the SAS doctors' contract is maintained through the Joint Negotiating Committee (SAS), the forum for the BMA to raise issues with NHS Employers. It also said that neither the BMA nor NHS Employers had raised any concerns or proposals to change this contract. The BMA said it did not expect negotiations on the SAS doctors' contract until the completion of the consultants' contract negotiations in England and Northern Ireland. The DHSC said it was likely that it would want to review the contract once reforms had been made to the contracts for consultants. According to DHSC the issues that such a review might cover included the links between pay and job weight and performance, and payments for work during unsocial hours periods.

6.27 NHS Providers said that SAS doctors provided a valuable service, but that they felt neglected, and were unable to improve the value of their package in ways that were available to consultants, such as through access to Clinical Excellence Awards. It reported that, in some areas, contracts that were equivalent to associate specialist contracts had been resurrected, but that this was happening in a piecemeal way, with no co-ordinated national approach. The BMA said that co-ordinated action should be taken at national level to re-open the associate specialist grade, as a policy of leaving trusts to devise local solutions had led to inconsistency of application. NHS Employers said that they were not looking to re-open the associate specialist grade, but conceded that there was a risk that trusts would develop local solutions to this issue.

6.28 Figure 6.3 shows the basic pay scales for specialty doctors and consultants in England, compared to the closed staff and associate specialist grades. This shows that the current specialty doctor pay scale is much more in line with the previous staff grade scale than with the associate specialist scale, and that the possible maximum pay point for doctors joining the specialty doctor grade today is £17,000 lower than the maximum pay point of the associate specialist grade, severely limiting the potential earnings of the SAS career path. Previously, staff grade doctors had the potential to follow a pathway that led to promotion to associate specialist, and to generate earnings in that higher grade similar to a consultant with 5 years' experience. However, today a similar pathway is not available to an experienced specialty doctor, who will not earn as much in basic pay as a newly appointed consultant.

Figure 6.3: Specialty doctor, staff grade, associate specialist and consultant basic pay scales, England, 2017



Source: OME analysis of NHS pay scales.

Scotland

6.29 The Scottish Government said that SAS doctors were an important part of the NHS workforce and continued to play a pivotal role in the provision of services. In order to ensure that this group were given equal consideration, it had been agreed that the employers should begin discussions with the BMA, with the aim of making career grade posts more attractive.

Our comments

6.30 Although the number of SAS doctors fell slightly this year, those providing evidence to us said that this group still formed an important part of the hospital workforce. We are pleased to see that both the BMA and NHS Employers, by undertaking surveys of SAS doctors and their employers, have responded to our requests and helped improve the evidence base on this group.

6.31 In our 45th Report 2017 we welcomed the introduction of the SAS Doctors' Charters and Development Funds. However, we are disappointed to hear that only a small proportion of SAS doctors are aware of the existence of a Charter where they work or have accessed the Development Fund. It is clear that more work needs to be done to embed and raise awareness of both the Charter and Development Funds.

6.32 The responses to the 2017 Staff Survey for England for SAS doctors were not encouraging. Satisfaction with pay had declined, engagement had fallen, respondents' satisfaction with support from their immediate manager had fallen, and SAS doctors were the group least satisfied with the opportunity to use their skills and with the extent to which the organisation valued their work. These findings are consistent with the messages we heard from SAS doctors on our visits in both 2016 and 2017.

6.33 It is also clear, both from the evidence we received from the parties this year and from what we heard on our visits, that SAS doctors are a valuable group of medical staff who have the potential to play an even more important role in helping fill rota gaps. We are pleased that the draft workforce strategy for England recognises this group and the important role they can play in addressing some medical shortages. At the time of completing our report the final version of the strategy had yet to be published, but we hope that it will address the question of who has overall responsibility for furthering the development of this group.

6.34 On our visits in 2017, and in evidence from the BMA and from NHS Providers, we heard support for the re-introduction of the associate specialist grade. It is clear that individual employers are responding locally to the problems of recruiting, retaining and motivating SAS doctors by developing arrangements which have some of the characteristics of the associate specialist grade. Neither the terms of our remit this year nor the evidence we received in the course of our work on this current report have put us in a position where we feel able to recommend on such a change. Nevertheless, a review of the salary structure for SAS doctors should be a part of the wider review of their role, their career structure and the developmental support available to them which appears to us to be urgently needed.

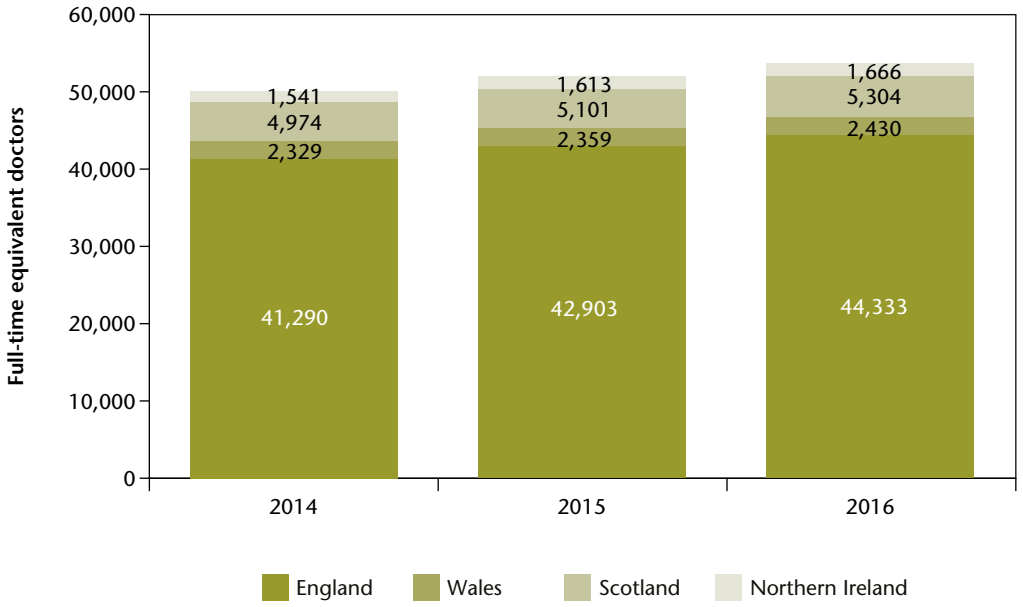
CHAPTER 7: CONSULTANTS

Introduction

7.1 This chapter covers consultants, the main career grade in hospitals.

7.2 In September 2016, on a full-time equivalent (FTE) basis, there were 53,732 consultants, an increase of 3.4 per cent from a year earlier (Figure 7.1), similar to the increase between 2014 and 2015 of 3.7 per cent. All countries in the UK experienced an increase: 4.0 per cent in Scotland, 3.3 per cent in both England and Northern Ireland[1], and 3.0 per cent in Wales.

Figure 7.1: Number of consultants in the Hospital and Community Health Services (HCHS), United Kingdom, 2014 to 2016



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

7.3 NHS Digital data showed that, in England, in September 2016, just over one-third (35 per cent) of consultants were female. This proportion is likely to increase, as over 50 per cent of doctors in training are female.

7.4 NHS Digital data also showed that, in England, in September 2016, for those who provided information on their ethnicity, 63 per cent identified themselves as white, and 27 per cent as Asian, or Asian British.

Recruitment and retention

England

7.5 Health Education England (HEE) has provided the DDRB with shortfall data for the consultant group. Providers were asked to supply information on the number of consultants in post by specialty, expressed in FTE, not including agency doctors temporarily filling substantive posts.

[1] Data for Northern Ireland as at March 2017.

7.6 Table 7.1 shows that the average shortfall across England in 2016 was 9 per cent. The North and the Midlands and East each had shortfalls of 10 per cent, compared with 9 per cent in London and the South East and 7 per cent in the South. The overall shortfall grew slightly between 2015 and 2016. This happened in a context of increased supply, meaning that while supply grew in the year, demand grew more than supply.

Table 7.1: Consultant shortfall by HEE region and specialty, England

	Relative size of consultant workforce (2016 FTE)	2015	2016	North	Midlands & East	London, Kent, Surrey, Sussex	South
A&E (Emergency Medicine)	1,569	13%	15%	12%	18%	20%	8%
'Acute Take' specialties	5,076	10%	13%	14%	14%	13%	11%
Pathology & Laboratory based specialties	1,386	10%	11%	13%	9%	10%	10%
'Other medical' (ie non-acute take)	7,189	8%	11%	14%	12%	9%	7%
Clinical Radiology	2,846	12%	10%	12%	13%	6%	6%
Psychiatry specialties	4,325	13%	10%	11%	9%	10%	9%
Ophthalmology (inc. medical)	1,198	10%	8%	12%	7%	6%	7%
Surgery specialties	7,983	8%	7%	7%	7%	8%	5%
Anaesthetics & ICM	6,781	5%	6%	5%	8%	8%	3%
Obstetrics & Gynacology	2,126	4%	6%	6%	5%	10%	5%
Paediatrics	3,029	4%	5%	7%	4%	4%	3%
All medical specialties	**43,507**	**8%**	**9%**	**10%**	**10%**	**9%**	**7%**

Source: HEE data collections from providers at March 2015 and 2016.

7.7 The highest shortfall shown across England as a whole was for emergency medicine (15 per cent), followed by 'acute take' specialties (13 per cent). At regional level, the highest shortfall was for emergency medicine, in London and the South East at 20 per cent, and the smallest shortfall was for paediatrics, in the South, at 3 per cent.

7.8 NHS Improvement has published vacancy information for the first time, as part of its quarterly performance of the NHS provider sector report. These data suggested that, in 2017-18, the full-time equivalent vacancy rate for medical staff was about 8-9 per cent, with a total of around 10,000 medical vacancies. Approximately 95 per cent of those vacancies were being filled by a combination of bank (35 per cent) and agency (locum) staff (60 per cent).

7.9 The BMA said that vacancies were directly linked to increased workloads, and had a negative effect on doctors' wellbeing, morale and motivation. It felt that there was a lack of adequate data on consultant vacancies in England.

7.10 The Hospital Consultants and Specialists Association (HCSA) included in its evidence the results from a survey of its members. These included two-thirds of respondents reporting vacancies remaining unfilled for over 12 months; three-quarters always or often working beyond contracted hours; and over 80 per cent having considered leaving the profession early. The HCSA described the vacancy rate as high, and said that this put additional pressure on those staff who were in post, risking a further increase in outflow. The HCSA also said that carrying vacancies meant that trusts were less likely to agree to changes to working patterns that would improve work/life balance for consultants.

Wales

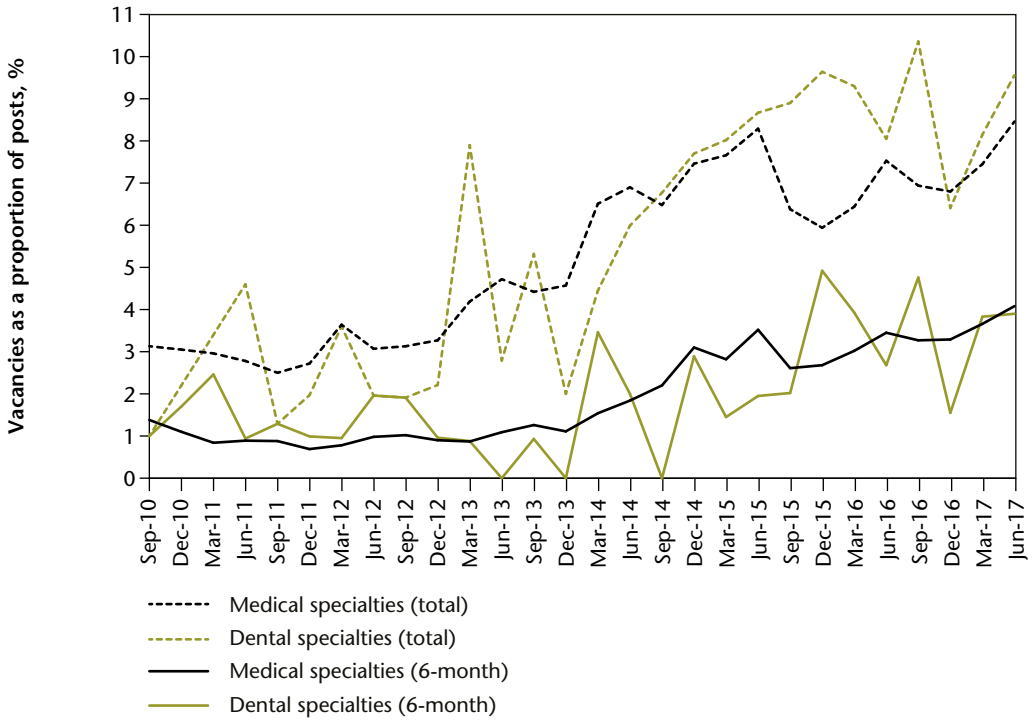
7.11 The Welsh Government provided information on turnover rates and the number of advertised vacancies for 2016-17 for medical and dental staff (excluding trainees). Between March 2016 and March 2017, the leaving rate was 7.3 per cent, and the joining rate 9.5 per cent. In March 2017 there were advertised vacancies for 305 FTE medical and dental staff (excluding locums and junior doctors).

Scotland

7.12 The Scottish Government told us that there were 430 FTE vacant posts for medical and dental consultants at the end of September 2017, a vacancy rate of 7.7 per cent. Of those vacancies, just over 250, or 4.5 per cent of the posts concerned, had been vacant for six months or more. This was an increase from 390 vacancies at the end of September 2016, a vacancy rate of 7 per cent, of which just over 180 (3¼ per cent) were in posts which had been vacant for six months or more.

7.13 Figure 7.2 shows that in Scotland, the trend in the six-month vacancy rate for both medical and dental specialties has been increasing, especially since the start of 2014. However, while the total vacancy rate is more volatile, it has noticeably increased since 2013.

Figure 7.2: Vacancy rates in Scotland, total and long-term, 2010 to 2017



Source: Information Services Division Scotland.

7.14 Of the specialties included in Table 7.2, the six-month vacancy rate for emergency medicine has fallen by 1.5 percentage points in the last year to June 2017, but still remains one of the highest rates: 0.9 percentage points higher than the average for all medical specialties.

7.15 The BMA considered that these data under-represented the true extent of recruitment and retention problems. This was because the definition of a vacancy did not include posts which the post-holder had left, but where the advertisement for their replacement has not been authorised, and nor did it include vacant posts where an employer had tried and failed to recruit and was not currently re-advertising. The BMA also felt that the figures took no account of the use of locums to maintain services.

Table 7.2: Vacancy rates in Scotland by specialty, June 2017

		Six-month vacancies		Total vacancies	
	Staff in post (FTE)	Vacancy rate (%)	Annual percentage point change	Vacancy rate (%)	Annual percentage point change
All specialties	**5,140**	**4.1**	**0.6**	**8.5**	**0.9**
All medical specialties	**5,047**	**4.1**	**0.6**	**8.5**	**0.9**
Emergency medicine	216	5.0	-1.5	9.3	-0.4
Anaesthetics	741	3.0	1.0	5.7	0.9
Intensive care medicine	15	6.2	6.2	10.8	-31.7
Clinical laboratory specialties	628	6.3	1.1	11.7	1.8
Medical specialties	1,245	4.8	0.8	8.6	0.4
Public health medicine	88	1.7	-2.3	8.6	3.0
Occupational medicine	11	18.6	12.1	18.6	-0.9
Psychiatric specialties	539	4.1	-0.3	10.9	1.7
Surgical specialties	967	3.4	0.9	6.9	-0.1
Obstetrics & gynaecology	243	1.2	0.4	5.4	2.0
Paediatrics specialties	305	3.3	0.2	7.6	1.7
General practice	12	0.0	0.0	0.0	-8.1
Not known medical specialty	34	0.0	0.0	0.0	0.0
All dental specialties	**93**	**3.9**	**1.2**	**9.6**	**1.5**

Source: Information Services Division Scotland

Northern Ireland

7.16 The Department of Health (Northern Ireland) said that there were 115 consultant vacancies at the end of June 2017, an increase from 101 at the end of March 2017. Between April 2016 and March 2017 there were 56 (3.2 per cent) consultant joiners and 69 (4.0 per cent) consultants left the Health and Social Care system.

Motivation

England

7.17 According to the 2017 NHS Staff Survey[2], a greater proportion of consultants expressed satisfaction with their pay than other medical staff groups. Although the proportion expressing satisfaction had decreased by 0.6 percentage points since 2016, to 63.2 per cent, this was still about 20 percentage points above that for other medical staff groups.

[2] The results for the remit group as a whole are discussed in Chapter 4.

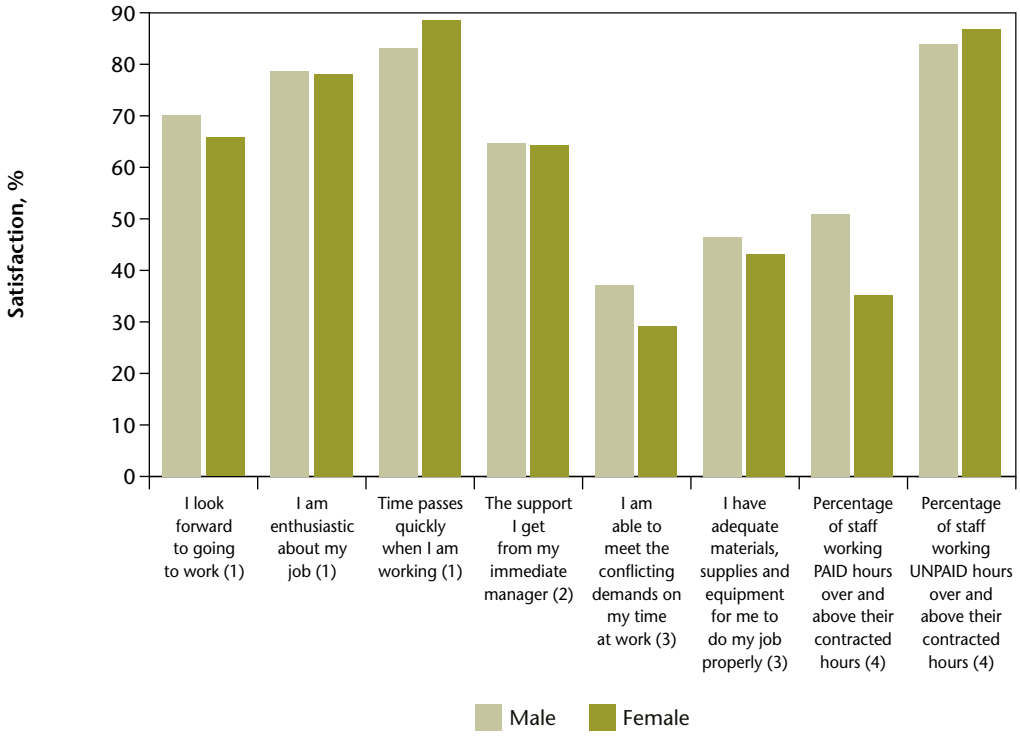
7.18 There were mixed results for consultants in terms of job satisfaction. There were small increases since 2016, in satisfaction with recognition for good work (0.1 percentage points), support from work colleagues (0.4) and amount of responsibility (0.6), but declines in the proportion expressing satisfaction with support from their manager (-1.6), opportunities to use their skills (-0.6) and the organisation valuing their work (-0.5).

7.19 A greater proportion of consultants than in 2016 said that they were able to meet conflicting demands on their time (an increase of 3.7 percentage points) and a smaller proportion said that they were working unpaid hours, by 2.0 percentage points.

7.20 We have done additional analysis which allows us to look at differences for 2016 and 2017 in satisfaction by gender within medical groups. For consultants, in Figure 7.3:

- The largest difference is between the proportion of males and females saying that they worked additional paid hours. 51.0 per cent of male consultants said they worked additional paid hours, compared to 35.2 per cent of female consultants (largely unchanged from 2016), although slightly more female consultants than in 2016 said they were working unpaid hours;
- 37.2 per cent of male consultants felt that they were able to meet all of the demands on their time at work. This was nearly 8 percentage points higher than the figure for females, at 29.3 per cent;
- A higher proportion of female consultants than their male counterparts said that time passed more quickly at work, 88.6 per cent and 83.2 per cent respectively.

Figure 7.3: HCHS consultant satisfaction with aspects of the job and work pressures, by gender, England, 2017



Source: NHS Staff Survey data.
Notes:
(1) Staff responding "often" or "always"
(2) Staff responding "satisfied" or "very satisfied"
(3) Staff responding "agree" or "strongly agree"
(4) Staff indicating one or more additional hours

Scotland, Wales and Northern Ireland

7.21 The most recent staff survey results for Wales and Northern Ireland were published before our 45th Report 2017, so we have no new data to report on. The latest published Scottish staff surveys, published earlier in 2018, are not available in sufficient detail to identify consultant level results.

Contract reform

England

7.22 The DHSC said that NHS Employers had been discussing reform of the consultant contract in England with the medical trades unions, in one form or another, since 2013, although negotiations on changing the contract for doctors and dentists in training had taken priority for some of that time. NHS Employers said that there was a compelling case for reform to help meet quality and efficiency/productivity challenges, the changing needs of patients and new models of care. The BMA said that the parties were broadly aligned on changes to the structure of the consultant contract, including replacing an eight-point scale, which takes 19 years to move from bottom to top, with a two-point scale with movement to the top likely to be within five years. The BMA also said that the parties were considering the potential for pensions flexibilities, including allowing consultants to opt-out of the NHS pension scheme and choose to be paid a proportion of the employers' pension contribution.

7.23 In March 2018 the BMA and NHS Employers issued a joint statement saying that they had reached a collective agreement on changes to the local Clinical Excellence Awards (CEA) scheme in England[3], which had been endorsed by the DHSC. We return to this issue at Paragraph 7.27. The BMA said that it expected to resume contract negotiations in the near future, following the agreement on CEAs.

Wales

7.24 The Welsh Government said that the Welsh Audit Office had reported that the current consultant contract fell short of securing the intended benefits. The Government said it would like to reform the contract, but that the BMA would need to be persuaded to enter into discussions on the issue.

Scotland

7.25 The Scottish Government said that it will continue to monitor developments in the rest of the UK to ensure that NHS Scotland remains an attractive place to work. It said that any future changes to the consultant contract in Scotland would be negotiated with the BMA.

Northern Ireland

7.26 The Department of Health said it had had an observer present at the discussions taking place in England on consultant contract reform. It said that it would not be in a position to take any action on contract reform in Northern Ireland without a Minister in place, or without talks with the local BMA.

[3] http://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Consultants---LCEA/Joint-statement-LCEA-agreement.pdf?la=en&hash=101CF825F1D129DF0A9875895A45F5DE524FD73A

Clinical Excellence Awards, Distinction Awards and Discretionary Points

England

7.27 In March 2018 the BMA and NHS Employers issued a joint statement saying that they had reached a collective agreement, which had also been endorsed by the DHSC, on changes to the local CEA scheme in England. Key points from the agreement included:

- From 1 April 2018 all employers in England will be obliged to run regular local CEA rounds;
- All new awards will be non-pensionable and time-limited to better reflect current performance;
- All local CEAs made prior to 1 April 2018 will be retained but subject to a nationally agreed review process from 2021 onwards. These awards will remain pensionable and consolidated;
- Consultants will continue to have access to national CEAs;
- It is the intention of the parties that from no later than April 2021 a jointly agreed new local CEA scheme will be introduced. Whatever scheme is introduced, awards will continue to be run, the level of investment in the scheme will be maintained, and existing awards will be maintained subject to a nationally agreed review process.

7.28 NHS Employers said that the existing arrangements had resulted in the award of 0.2 new CEA points per eligible consultant per year, while the new arrangements committed all employers to awarding local CEAs and at a minimum rate of 0.3 new CEA points per eligible consultant per year.

7.29 NHS Employers asked that we recommend that the value of local CEAs be maintained at the current level. It said that this would ease cost pressures on employers introducing the new arrangements, and could provide additional flexibility for some employers to increase the new CEA points in excess of the contractual minimum. It went on to say that DDRB should target its recommendations in ways that increased the proportion of earnings that rewarded current, not historical, excellent performance.

7.30 The BMA said that local CEAs should be increased in line with any pay recommendation that DDRB made. It also said that any change to the minimum rate of 0.3 new CEA points per eligible consultant per year, rather than increasing the value of existing awards, would undermine the agreement and might foster a climate of suspicion which could compromise the success of the wider consultant contract discussions.

7.31 The HCSA said that it agreed that local CEAs needed to be reformed. However, it did not support the outcome agreed by NHS Employers and the BMA. It said that local CEAs should be discussed as part of an overall package, rather than being negotiated on a piecemeal basis.

Scotland

7.32 The Scottish Government rejected our 2017 recommendation that the Distinction Award scheme in Scotland should be reopened to new applicants, and that the value of the Distinction Awards and Discretionary Points should be uplifted by 1 per cent. It felt this approach was not consistent with the Scottish Government's public sector pay policy. In its evidence for this round the Scottish Government said that there was no evidence that freezing Distinction Awards had had a negative impact on the recruitment and retention of consultants, nor on the quality of their work. However, it also said that there was a need to reform the schemes and that the first step towards this - an internal review of the schemes in Scotland - had taken place, but that there was no broad consensus on how to move forward. It added that any changes to the schemes would form part of incentivising the workforce through the National Health and Social Care Workforce Plan[4].

[4] http://www.gov.scot/Publications/2017/06/1354

Our comments

7.33 The number of consultants has expanded steadily over recent years, by 30 per cent in England and 21 per cent in Scotland since September 2010. However, different data sources indicate that between 8-10 per cent of programmed activities in consultant posts are not being filled by a permanent member of medical staff. That said, the effect on service provision is mitigated to some extent, as many of these vacancies are being covered by locums or bank staff. Nevertheless, using locums or bank staff incurs additional costs, and impacts on the potential output and quality of the service. In England, although shortfalls are generally more widespread in the North, the largest shortfalls of 18-20 per cent are in emergency medicine in London and the South East and Midlands and East.

7.34 The 2017 Staff Survey results for consultants in England were mixed. Although consultants were more likely to be satisfied with their pay than other groups of doctors, and fewer said that they were working unpaid hours than in 2016, fewer were satisfied with their ability to be able to use their skills and feeling valued by their employer.

7.35 In recent years we have made recommendations for consultant awards that have mirrored those for basic pay. Last year, our recommendations on consultant awards were rejected in Scotland and Northern Ireland, and in evidence this year the Cabinet Secretary for Health and Sport in Scotland made a robust defence of that decision.

7.36 In England, employers are negotiating on a new consultant contract with the BMA and the HCSA. We were pleased to be told that NHS Employers and the BMA had finally been able to make progress in England towards implementing our 2012 recommendations on CEAs, though there is still further to go. NHS Employers have asked that the value of CEAs be frozen, and that we should target our recommendations in ways that increase the proportion of earnings that reward current, not historical, excellent performance. For England, we return to this issue in Chapter 10.

7.37 We remain clear that recognising performance through pay is an established and important part of the consultants' pay system and therefore in the rest of the UK, where consultant awards are not being reformed, we believe that the value of these awards should continue to increase in line with our main pay recommendation for consultants.

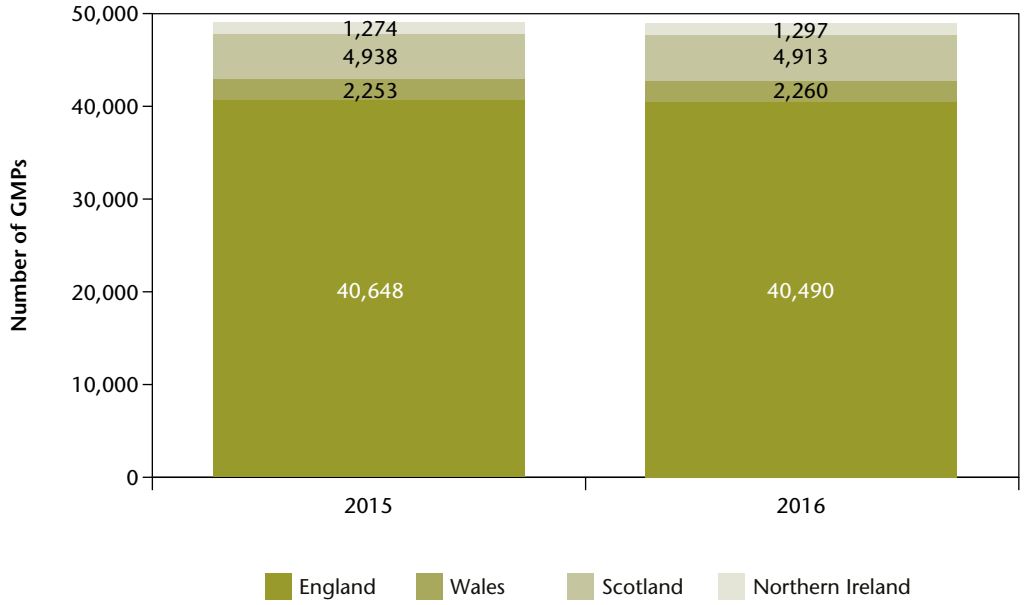
CHAPTER 8: GENERAL MEDICAL PRACTITIONERS

Introduction

8.1 In this chapter we consider issues relating to General Medical Practitioners (GMPs). The traditional role for GMPs is as the family doctor, working in the primary care sector of the NHS. There are several contracting arrangements in place, under which primary care services are provided, and GMPs can work as independent contractors, salaried GMPs or as locums.

8.2 In September[1] 2016, there were 48,960 (headcount) GMPs in the UK, which was a decrease of 0.3 per cent compared to 2015 (Figure 8.1). There was a decrease of 158 GMPs in England and 25 in Scotland, whilst in Wales and Northern Ireland the numbers increased by 7 and 23 respectively.

Figure 8.1: Number of General Medical Practitioners (GMPs), United Kingdom, 2015 and 2016



Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, Health and Social Care Services Organisation, Northern Ireland.

Note: Figures exclude locums.

Access to GMP services

England

8.3 In April 2016 NHS England published the *General Practice Forward View* which set out a package of support to improve patient care. Measures include increasing funding by £2.4 billion a year, by 2020-21 (a real-terms increase of 14 per cent), increasing the number of GMPs by 5,000 by 2020, increasing the number of other practice staff by 5,000 by 2020-21, development of a practice resilience programme to support struggling practices, and direct funding for improving access to GMP services both in and out of hours. NHS England told us it had piloted new approaches to extending and improving access which it said had stimulated transformational change, with practices joining together to deliver a broader range of services through multi-disciplinary teams and increased use of digital technology.

[1] As of September 2016, for England, Scotland and Wales but October 2016 for Northern Ireland.

Wales

8.4 The Welsh Government said that it was working with the General Practitioners Committee (GPC) Wales, and NHS Wales to improve access to GMP services and to manage demand for services.

Scotland

8.5 In April the Scottish Government published the third part of its *National Health and Social Care Workforce Plan* which focused on primary care. The plan highlighted the need to reform primary care by developing multi-disciplinary capacity. The plan also said that 800 additional GMPs would be added to the workforce over the next ten years to meet increasing patient demand.

8.6 The Scottish Health and Social Care Experience survey is carried out every two years. The 2017-18 survey was published in May 2018[2] and the results are based on the responses of over 130,000 individuals registered with a GMP in Scotland. Eighty-three per cent of respondents reported a positive experience of their GMP care, a reduction from 85 per cent in 2015-16. Eighty-seven per cent of respondents said they found it easy to contact their GMP practice in the way they wanted to, and 76 per cent were happy with the opening hours of their GMP practice (down from 78 per cent in 2015-16). The survey also found that 87 per cent of respondents were able to see or speak to a doctor or nurse within two working days, compared with 84 per cent in 2015-16.

Northern Ireland

8.7 In May 2018 the Department of Health (Northern Ireland)[3] announced a planned package of investments for enhancing primary care for the year 2018-19, worth £15 million. It said that this included £5 million for the roll-out of multi-disciplinary teams at GMP practices, which would include practice-based physiotherapists, mental health specialists and social workers. The Department of Health said that invitations to apply to become one of the initial roll-out sites were issued to Trusts and GMP Federations at the end of May 2018 with a closing date for applications of 29 June 2018. Two GMP Federation areas will be selected from those that applied to become the initial roll out sites in 2018-19. In addition, in June 2018, the Department also said that a further £1.8 million was being allocated to address demographic pressures on GMP practices, such as population growth and an increase in the number of people with long-term conditions who need care.

Recruitment and retention

England

8.8 As we said in Chapter 5, the general practice training programme in England had a fill rate of 95 per cent in 2017, an improvement on 2016 (90 per cent) and 2015 (86 per cent). However, a third of all unfilled training places in 2017 were on the general practice training programme. Under the new junior doctors' contract, whilst training in a GMP setting, full-time trainees will receive a flexible pay premium (FPP) of £8,282, replacing the GMP supplement under the old contract. The total paybill cost of the general practice FPP is estimated by DHSC to be over £30 million, and likely to rise to about £40 million once all trainees are on the new contract.

8.9 NHS England and Health Education England have set ambitious targets to create an extra 5,000 additional doctors working in general practice by 2020 and a further 5,000 other practice staff by 2020-21. The number of GMP training places has been increased

[2] http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2017-18
[3] https://www.health-ni.gov.uk/news/health-and-social-care-transformation-funding-announced

to 3,250 per year. We were told there have been improvements to the induction and refresher scheme to help GMPs return to general practice in England, with a target of attracting back an additional 500 doctors between 2016-17 and 2020-21. NHS England also announced that it would be rapidly expanding its international recruitment programme, looking to recruit 2,000 doctors working abroad to come to work as a GMP in England.

8.10 In Chapter 4 (Table 4.2) we showed the numbers claiming their NHS pension on a voluntary early retirement basis in England. In 2011-12 just over 500 GMPs claimed their pension on this basis, one-third of all GMP retirements. By 2016-17 this number had increased to over 700 and accounted for over sixty per cent of all GMP retirements.

Wales

8.11 The Welsh Government told us that it had published a primary care workforce plan in July 2015[4]. The plan included actions to stabilise core sections of the workforce, including GMPs, by: supporting people who wanted to return to practice or work part-time; exploring how training and working in general practice could be encouraged in areas of greatest need; reimbursing medical school fees when a newly qualified doctor committed to a career in general practice; making it easier for GMPs registered in England to work in Wales for short periods of time without the need to make a full application to join a Health Board's performers list; and communicating the opportunities afforded by general practice in Wales. The Welsh Government told us that it was building on its Train, Work, Live campaign which focused on GMPs and set out the benefits of coming to Wales.

Scotland

8.12 In its evidence the Scottish Government said that according to its latest workforce survey, 22 per cent of GMP practices had vacant GMP sessions at 31 August 2015, in comparison with 9 per cent of practices in 2013. The headcount of GMP vacancies reported by practices was 150, equating to full-time equivalent vacancies of 114. The vacancy rate (as a percentage of total sessions) was 4.8 per cent, and had increased in all board regions since 2013, with the exception of NHS Borders. Of the vacancies that were unfilled at 31 August 2015, half had been vacant for over six months.

8.13 The Scottish Government also told us about 'Golden Hellos', lump sum payments of between £5,000 and £12,500, to qualified doctors who were starting out as GMPs in their first eligible post. Posts were considered to be eligible if they were attracting payments for remoteness, rurality or deprivation.

8.14 In August 2016, 100 new GMP training posts were announced in Scotland, 37 of which came with a one-off £20,000 bursary for trainees who choose to take up posts in hard-to-fill locations, such as remote and rural areas. The Scottish Government said that it and NHS Education Scotland aimed to highlight the benefits of living and working as a GMP in Scotland, and a series of adverts and a social media campaign were being run to raise awareness of the opportunities that medical training in Scotland provided.

8.15 In Scotland, Seniority Payments are made to GMP practices, to reward experience. Payments are made to the practice, rather than the GMP, and can be worth up to £13,900 per year for a GMP who has worked for 47 years.

Northern Ireland

8.16 The Department of Health (Northern Ireland) told us, that following a 2014 review of training in general practice, the number of GMP training places increased from 65 to 85 in 2016-17, and in 2018-19 there would be an intake of 111 GMP trainees.

[4] https://gov.wales/newsroom/health-and-social-services/2015/workforce/?lang=en

8.17 The Department said that the GMP Induction and Refresher Scheme provided an opportunity for GMPs who had previously been on the General Medical Council's (GMC) GMP Register and on a UK Performers' List to safely return to general practice following a career break, or time spent working abroad. We were told that at September 2017, 15 doctors had completed the scheme with a further seven on the scheme at that time.

8.18 The Department also told us about the GMP Retainer Scheme, which provided stable work in a practice and included some out-of-hours sessions, with a mandatory funded development programme to assist with appraisal and revalidation. The intention was to make available 20 places per year, each lasting a maximum of two years. At the time of submitting evidence there were 24 doctors on the scheme, with five waiting to commence it.

UK

8.19 We were told by NHS England and the Governments in Scotland and Wales that, although they were all looking to expand their GMP workforce through overseas recruitment, they were doing so independently of each other.

2017-18 contract

8.20 In 2016 we decided to make recommendations on our intended increase in pay net of expenses. This approach required the parties to discuss expenses in order to agree a gross increase. For 2017-18 NHS England and the GMP Committee of the BMA agreed an increase of £239 million, to deliver a pay uplift of one per cent and a general expenses uplift of 1.4 per cent. In Wales a similar one per cent pay uplift and general expenses uplift were introduced for 2017-18.

8.21 In Scotland the Scottish Government said that it had implemented our recommendation to uplift GMP pay, net of expenses, by 1 per cent. It also included a 1 per cent uplift to practice staff expenses, and a 3.5 per cent uplift to wider practice expenses in line with RPIX.

8.22 In Northern Ireland there was a 1 per cent uplift to GMP pay and staff expenses and a 1.4 per cent uplift for other expenses.

2018-19 contract

8.23 On 22 March 2018 NHS Employers and the GPC of the BMA wrote to advise us that a package of changes to the contract for 2018-19 in England had been agreed. This included an overall funding uplift of 3.4 per cent (£256 million), which included a 1 per cent pay uplift, and a 3 per cent uplift in expenses (in line with CPI inflation at the time of the letter). It also said that a further uplift might be made following the Government's response to this report.

8.24 On 13 November 2017, the Scottish Government and the BMA issued a joint statement about a proposed new Scottish General Medical Services contract, to take effect from April 2018. They said the contract would be introduced in two phases. The key points of Phase 1 of the contract were:

- GMPs would be expert medical generalists within a wider primary care multi-disciplinary team. Some tasks currently carried out by GMPs would be carried out by members of this wider team, allowing GMPs to focus on the job they train to do;
- A new funding formula that better reflected practice workload would be introduced, and this would be accompanied by £23 million, available to fund practices that benefited from this change while protecting all other practices;

- A new minimum earnings expectation of £80,430 (for 40 hours a week) from April 2019. This was expected to benefit a fifth of GMP partners;
- The establishment of a GMP Premises Sustainability Fund, worth £30 million over the next three years. All GMP contractors who owned premises would be eligible for an interest-free loan for an amount worth up to 20 per cent of the Existing-Use Value of the premises;
- The contract supported a shift towards a model which did not presume GMPs owned their own premises. Where GMP contractors needed to enter a lease with a private landlord, NHS Boards would gradually take on responsibility for negotiating those leases (unless contractors wished to continue to provide their own accommodation);
- Contractor GMPs would not be exposed to increased risk from being an employer. The intention was that the wider primary care teams would be employed by NHS Boards, and deployed in practices.

8.25 The introduction of the new contract in April 2018 was approved by a ballot of GMPs in December 2017. A second phase of the contract, to begin in 2020, introducing an income range and direct reimbursement of expenses, would be subject to a second ballot.

8.26 The Scottish Government said that for this round it expected DDRB to recommend an uplift for GMP pay as usual.

8.27 In Wales, in March 2018, a pay uplift of 1 per cent and 1.4 per cent for expenses was announced. Again, this was pending any recommendation from DDRB.

Motivation

8.28 The Ninth National GP Work Life Survey conducted by the University of Manchester, published in May 2018, covered GMPs in England. The survey was conducted between October and December 2017, and was based on responses from 2,200 GPs in England. Key findings include:

- Overall job satisfaction increased slightly between 2015 and 2017, albeit from levels that were the lowest since 2001;
- Satisfaction with remuneration, hours of work and amount of responsibility given are lower than in the surveys undertaken before the introduction of the new GP contract in 2004;
- 39 per cent of respondents said there was a considerable or high likelihood that they would leave direct patient care in the next five years. The percentage indicating that they would leave has been much higher in the surveys conducted since 2010;
- The mean number of sessions worked in 2017 was 6.7, compared with 7.2 in 2015, although the average number of hours worked per week increased from 41.4 in 2015 to 41.8 in 2017.

8.29 The survey report concludes that, 'although the declines in satisfaction seen between previous years have not continued, the low levels of satisfaction and high levels of pressure have remained. This may have implications for recruitment, retention and patient care.'

8.30 The BMA said that GMPs had consistently been reporting low morale. It said that a 2015 survey of GMPs across the UK[5] reported that 68 per cent of GMPs experienced a significant but manageable level of work-related stress, but a further 16 per cent reported experiencing an unmanageable amount of work-related stress. The BMA said that, as a result, less than half would recommend general practice as a career path. The BMA also highlighted a 2017 survey of sessional GMPs[6], where a majority of respondents said that the volume, intensity and complexity of their workload had increased in the previous 12 months.

GMP trainers' grant and GMP appraisers

8.31 After being increased in line with our recommendation for the GMPs pay increase in 2017 the GMP trainer grant is currently £7,908. The BMA said that the real-terms value of the grant had declined over time, and that as GMP educators and trainers spent a significant amount of time on these duties, this has had a significant impact on their total earnings. Seventy per cent of GMPs responding to a BMA survey[7] thought that the workload of a GMP trainer had increased over the past year. The survey also reported that workload was the most cited reason for ceasing to be a trainer, followed by the 'amount of work associated with training compared to the size of the trainer grant.' The BMA concluded that this was indicative of possible recruitment issues if the grant continued to diminish in real terms, and relative to the workload of a GMP trainer.

8.32 In our 45th Report 2017, we said we were content for the £500 rate for GMP appraisers to stand, although we would keep the rate under review and would welcome evidence in future rounds. The BMA said that the appraiser fee formed a significant part of overall GMP earnings and therefore needed to be adjusted annually, as had been the case for the GMP trainers' grant, or the combination of increased costs and stagnant fees would produce further downward pressure on the already compressed GMP real earnings. In a recent BMA survey of appraisers,[8] over 60 per cent said that their workload per appraisal had increased in the past year, and no respondents said that the workload had decreased. Of those who had previously been appraisers and given up, 87 per cent gave increased bureaucratic workload as a major reason for ceasing to work as appraisers.

Independent contractor GMPs

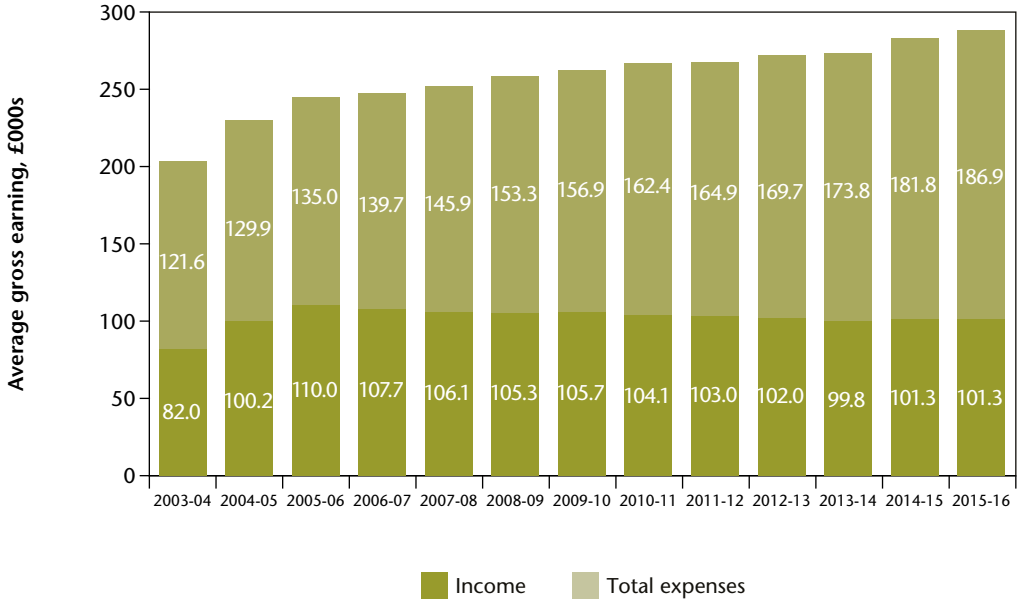
Income

8.33 In 2015-16, on a headcount basis, average gross earnings of independent contractor GMPs was £288,200. Contractor GMPs had average expenses of £186,900, giving an average income of £101,300, almost unchanged from 2014-15. Average income peaked in 2005-06 at just over £110,000, before falling to a low of £99,800 in 2013-14 (Figure 8.2).

8.34 There was variation in income by country, with the average income highest in England (£104,900), followed by Wales (£93,400), Northern Ireland (£92,000) and Scotland (£89,500). Scotland was the only country to see a reduction in income in 2015-16, of 2.5 per cent. Within England, average income was 38 per cent higher in the East (£116,600) than in the South West (£84,200).

[5] British Medical Association (2015) *National survey of GPs – the future of general practice.*
[6] British Medical Association (2017) *Survey of sessional general practice.*
[7] British Medical Association (2017) *BMA survey of GP appraisers and trainers.*
[8] British Medical Association (2017) *BMA survey of GP appraisers and trainers.*

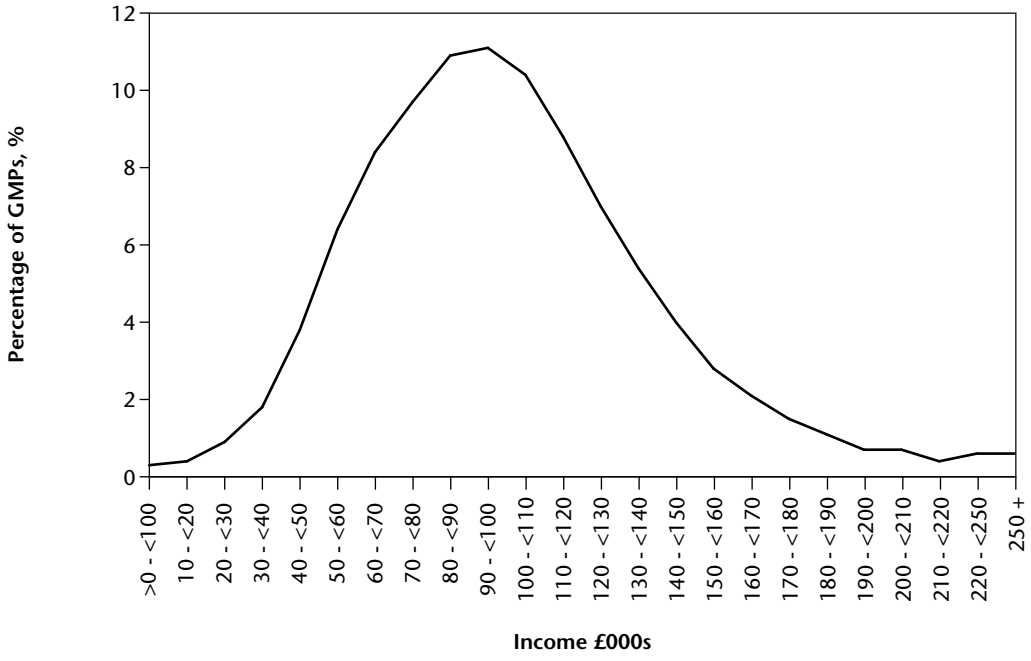
Figure 8.2: GMP contractors' average gross earnings, income and expenses, United Kingdom, 2003-04 to 2015-16



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.35 The distribution of contractor GMP income is largely unchanged from 2014-15, about 1 in 5 GMPs' income was less than £70,000, whilst a similar proportion had an income over £130,000 (Figure 8.3). Since these income figures are done on a headcount, rather than an hours-worked basis, it is likely that the lowest paid GMPs are working part time.

Figure 8.3: Distribution of GMP contractors' income before tax, United Kingdom, 2015-16



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.

8.36 The average income for male GMPs was about 32 per cent higher than that of female GMPs, with average incomes of £113,400 and £86,200 respectively. However, these figures do not take into account, hours worked, experience, and the type of work done. Our analysis using NHS Digital data (Table 8.1) suggests that male GMPs work more contracted hours, on average, than female GMPs, which may explain much of the difference in income. Contractor GMPs have about one-third more contracted hours than salaried GMPs.

Table 8.1: Ratio of full-time equivalent to headcount of GMPs, England, 2016

	Male	Female	All
All GMPs	**0.93**	**0.76**	**0.83**
Independent contractor	0.96	0.79	0.88
Salaried/Other GMPs	0.75	0.63	0.66

Source: OME analysis of NHS Digital data

Note: Specialty registrars and retainers are not shown separately, but are included in the all GMPs total.

Salaried GMPs

8.37 NHS Employers told us that a model contract for salaried GMPs was agreed in 2004 and was designed mainly for use where GMPs were directly employed by PCTs, which have since ceased to exist. Salaried GMPs were now employed by a range of different NHS organisations providing a range of services. As a result, there was now some confusion about what terms and conditions should apply to a GMP employed by an NHS Trust, and whether the work they undertook met the definition of primary care. Employers were also unsure about the status of the salaried GMP pay range, and the extent of their discretion in applying the recommended pay range. However, NHS Employers said that the General Medical Services contract requires a contract to be offered in practices that were at least as good as the model contract.

8.38 While the salaried GMP contract within GMP practices has always been an option, there have been some examples recently where contractor or partner GMPs have opted for employed status. There has also been an increasing number of cases where NHS Trusts have taken on the provision of GMP services. Additionally, working arrangements developed under new models of care and new collaborative structures are testing the current salaried GMP contract. However, there is no formal mechanism where the current model salaried GMP contract is discussed.

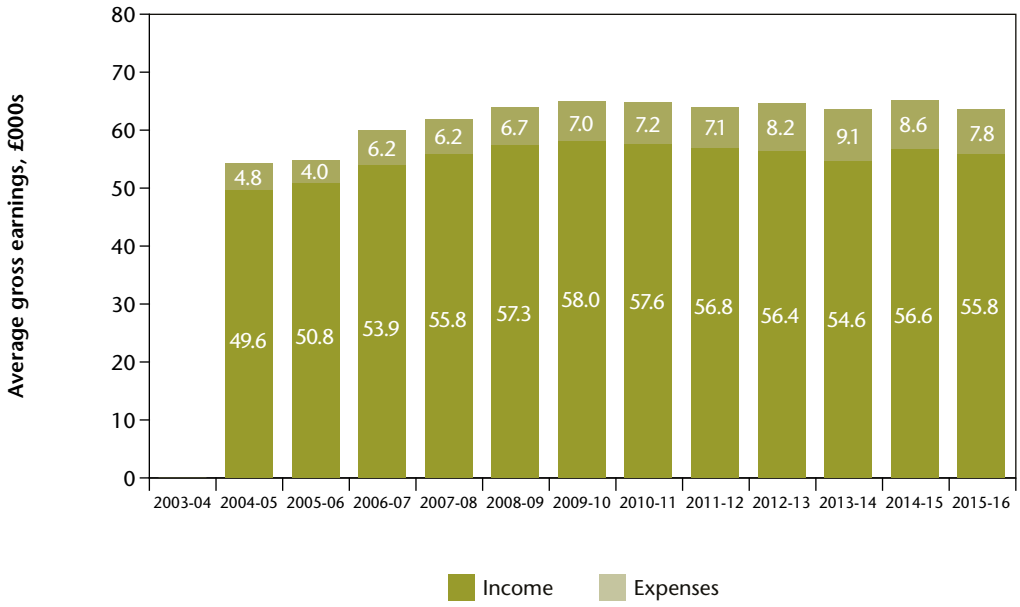
Income

8.39 In 2015-16, on a headcount basis, average gross earnings of salaried GMPs was £63,600. Salaried GMPs had average expenses of £7,800, giving an average income of £55,800, a decrease of 1.4 per cent from 2014-15 (Figure 8.4).

8.40 About a quarter of salaried GMPs had an income below £40,000, whilst a quarter had income above £70,000 and only about 5 percent had income above £100,000.

8.41 The average income was highest in Scotland (£57,800), followed by England (£55,900), Wales (£51,700) and Northern Ireland (£47,300). Scotland was the only country to see an increase in salaried GMP income over 2014-15, of 1.2 per cent (£700).

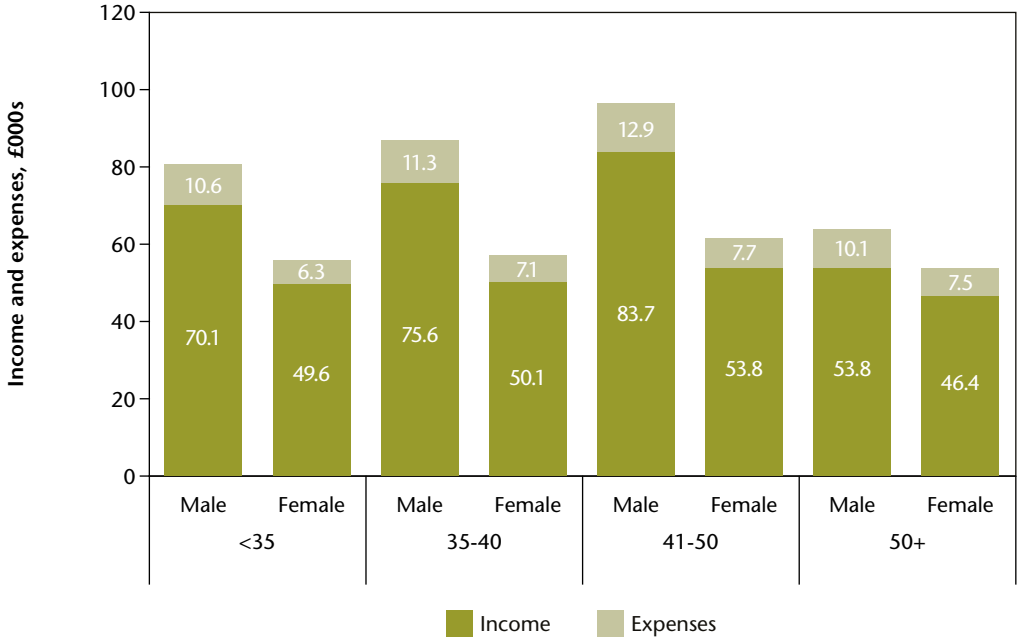
Figure 8.4: Salaried GMPs' average gross earnings, income and expenses, United Kingdom, 2003-04 to 2015-16



Source: NHS Digital using Her Majesty's Revenue and Customs data, GMP Earnings and Expenses.
Note: Gross earnings relate to NHS and private work and are on a headcount basis.

8.42 Figure 8.5 shows that for all age groups, male salaried GMPs earned more on average than female salaried GMPs. It also shows that earnings for female salaried GMPs are similar across each age group, compared to male salaried GMPs who have a clear increase in earnings as they age, before a large reduction in earnings after age 50. This may in part be due to differences in working hours.

Figure 8.5: Salaried GMP average income and expenses, by gender and age group, United Kingdom, 2015-16



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

Expenses and formula

8.43 In 2016 we took a decision to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses in order to ascertain a gross increase. For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formula for both GMPs and GDPs had we used the formula-based approach. In its written evidence the BMA had originally asked us to make a recommendation on expenses for this round in England, but has since reached agreement with NHS Employers on a figure.

Our comments

8.44 We have heard from across the UK about the importance placed on primary care and this has been reinforced by an increase in funding for primary care and the aim to increase the number of GMPs providing services. If the targets to expand the GMP workforce are to be met, this will require a combination of increasing the throughput from training, overseas recruitment, and improving the retention of existing GMPs. In England there is a financial incentive to train as a GMP as part of the new junior doctors' contract, and in Scotland payments are made to GMPs to incentivise them to work in remote and rural areas. However, we have seen an increase in the number of GMPs choosing to take early retirement, which we have heard may be linked to changes to NHS pensions and the way in which pension benefits are taxed. Overseas recruitment, which is being undertaken by the services in England, Wales and Scotland, is unlikely to be helped by the uncertainty surrounding the UK's exit from the EU and the recent difficulty that some potential employers had with obtaining certificates of sponsorship which allow them to employ GPs from overseas. Despite having a target to increase GMP numbers by 5,000 by 2020, data show that, rather than increasing, the full-time equivalent number of doctors working in general practice in England has fallen by almost 1,300, or 3.8 per cent, between September 2015 and March 2018.

8.45 If these challenging workforce expansion plans are to be achieved, it is important that the rewards from working as a GMP in the NHS provide an incentive either to join, or to remain in the service, or both. Although it is hard to be certain of the true changes in earnings - because the figures are based on headcount rather than hours worked - the average nominal earnings of GMP contractors in the UK have been drifting downwards since 2005-06, and in 2015-16 were 8 per cent lower than a decade earlier.

8.46 The results of the Ninth National GP Work Life Survey, which were published in May 2018, did not present a positive view from GMPs in England. An increased proportion of GMPs said there was a considerable or high likelihood that they would leave direct patient care in the next five years. Overall job satisfaction reported in the two most recent surveys were the worst since 2001 and those conducting the survey said the results may have implications for recruitment, retention and patient care.

8.47 The Scottish Government and the BMA issued a joint statement about a new Scottish General Medical Services contract, that took effect from April 2018. The statement said that GMPs would be expert medical generalists with a wider primary care multi-disciplinary team, and some tasks currently carried out by GMPs would be carried out by members of this wider team, allowing GMPs to focus on the job that they had trained to do. We welcome this policy direction to utilise more effectively the skill mix of the workforce, and will be interested to see how these initiatives develop.

CHAPTER 9: DENTISTS

Introduction

9.1 Our remit covers all independent contractor General Dental Practitioners (GDPs) and salaried dentists.

General Dental Practitioners (GDPs)

9.2 In England and Wales, GDPs working for the NHS comprise 'providing-performer' dentists and 'performer-only' dentists. 'Providing-performer' dentists hold a contract with the NHS and also perform dentistry. A 'performer-only' dentist works, as an employee or is self-employed, under a contract held by a practice that may be either providing-performer owned or owned by a limited company. The equivalents in Scotland and Northern Ireland are 'principal dentist' and 'associate dentist'.

9.3 As with General Medical Practitioners (GMPs), the remit of the DDRB includes making recommendations on the pay of GDPs. Performer-only dentists will be paid by the practice owner or company concerned. Providing-performer dentists will be paid from the income of the relevant practice (in which they will have an equity interest). In either case their income will be funded from the income from contracts negotiated with the NHS, or from the revenues from private work, or a mixture of both.

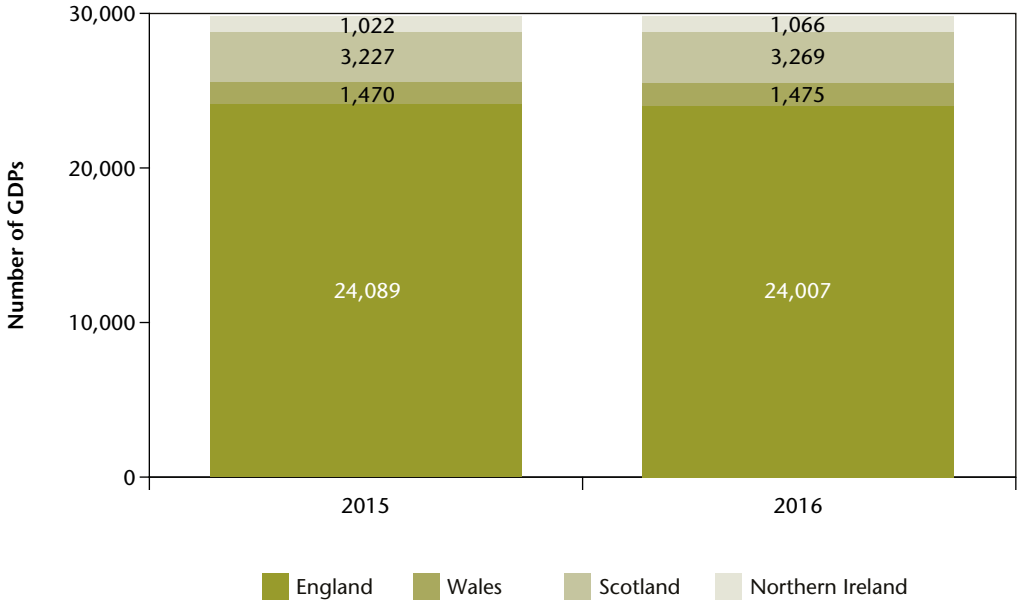
9.4 GDPs differ from GMPs in that, typically, a relatively larger proportion of a dentist's income is based on dental work undertaken outside the NHS, so that the practice income, and hence their own income, is subject to an element of wider market pressure.

9.5 A career in dentistry starts with at least five years undergraduate study and then a further two years in dental foundation training. In the longer-term, earnings differ depending on the route taken, the balance of NHS and private work undertaken and the location of the practice, but providing-performer dentists in England and Wales earned on average in the region of £115,700 in 2015-16, while performer-only dentists earned £60,200.

Workforce

9.6 In September 2016 there were 29,817 dentists providing NHS services in the UK, little changed from a year earlier. The was an increase of 42 GDPs in Scotland, five in Wales and 44 in Northern Ireland, but a fall of 82 in England.

Figure 9.1: Number of General Dental Practitioners, United Kingdom, 2015 and 2016



Source: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, Health and Social Care Services Organisation, Northern Ireland.

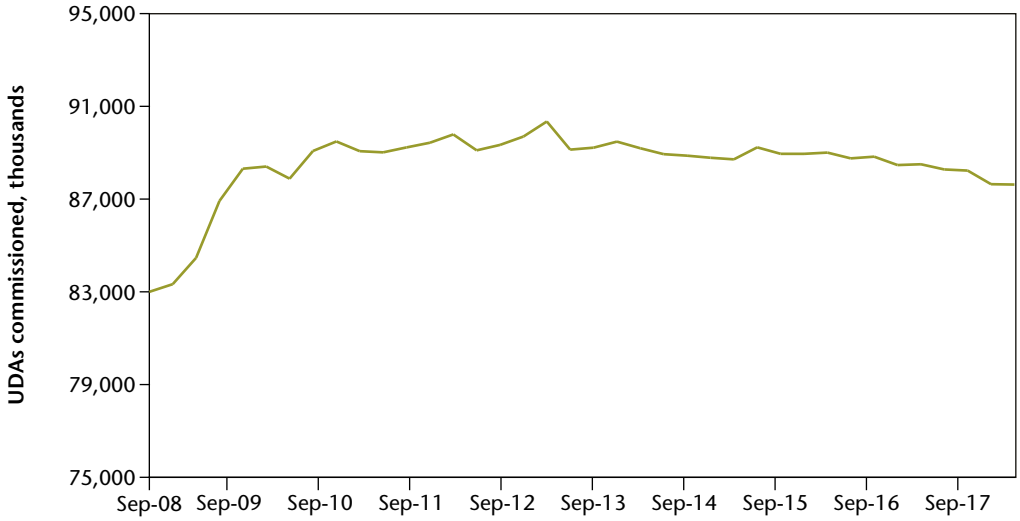
Access to dental services

England

9.7 NHS England said that the GP Patient Survey Dental Statistics for March 2017 showed that 95 per cent of people who tried to get an appointment with an NHS dentist in the past two years were successful, rising to 96 per cent in the six months to March 2017. 22.2 million adult patients (51.4 per cent of the population) were seen by an NHS dentist in the 24-month period ending June 2017. In the 12-month period ending June 2017, 6.8 million children (58.2 per cent of the childhood population) accessed NHS dental services. 85.7 million units of dental activity (UDAs) were carried out in 2016-17, a fall of 0.6 million from 2015-16. In England, the percentage of dentists' time spent on NHS work fell to 70.7 per cent in 2015-16 from 71.4 per cent in 2013-14.

9.8 Despite an increase in the number of patients being seen, the number of UDAs commissioned in England has been slowly declining since 2012. This could be for a number of reasons, including improving oral health across the population, and new contracting methods reducing the reliance on UDAs.

Figure 9.2: Units of Dental Activity (UDAs) commissioned, England, September 2008 to March 2018



Source: NHS England Dental Commissioning Statistics.

9.9 The draft workforce strategy published by Health Education England[1] said that the increase in the number and proportion of older people in the population meant that dental care for this group would assume greater significance and complexity. It also said that there was a need for dental therapists, hygienists and clinical dental technicians to undertake many elements of the routine care prescribed by a dentist.

Wales

9.10 The Welsh Government said that 1.71 million patients were recorded as having been treated in the two years to December 2017, 9,000 more than in the two years to December 2016, and 113,000 more than in the two years to March 2008. 5.02 million UDAs were carried out in 2016-17, an increase of 1.6 per cent from 2015-16. Almost 94 per cent of patients surveyed said they were satisfied with the dentistry they received, up 2 per cent on the previous year.

Scotland

9.11 The Scottish Government told us that the percentage of the population registered with an NHS dentist continued to increase. In September 2017, 92.5 per cent of the population were registered, compared with 89.9 per cent in September 2016, and 73.3 per cent in September 2011. The number of adults and children, who attended their dentist in the two years to September 2017, at 3.53 million, was 0.6 per cent fewer than in the two years to September 2016, but 11.2 per cent more than in the two years to September 2011.

9.12 In January 2018 the Scottish Government launched an *Oral Health Improvement Plan*[2], which it described as setting the direction of travel for oral health improvement, with a strong focus on preventing oral disease. The Government said that GDPs would continue to be the mainstay for the provision of NHS dental care. The BDA said that the proposals set out in the plan would require investment in the service over a sustained period of time and it also believed that the proposals may impact on the financial viability of dental practices.

[1] https://hee.nhs.uk/our-work/workforce-strategy
[2] http://www.gov.scot/Publications/2018/01/9275

Northern Ireland

9.13 The Department of Health (Northern Ireland) said that there were 1,110 GDPs, working in 387 practice sites. Compared with the evidence provided for our previous report, this is an increase of 58 GDPs and seven practice sites. The Department also said that access issues had now been resolved, with 64.5 per cent of the population registered with a dentist.

Motivation

9.14 The latest results from the Dental Working Hours Motivation Analysis survey, published by NHS Digital, are for 2015-16, which we referenced in our 45th Report 2017, and cover the whole of the UK. The main points from the responses to the 2015-16 survey were:

- Dentists in England and Wales were generally more positive than those in Scotland and Northern Ireland;
- Performer-only dentists felt better about their job as a dentist and their opportunities to progress their career compared to providing-performer dentists;
- The more hours worked and the higher the proportion of work done on NHS/ Health Service work, the lower the levels of motivation;
- Dentists in Scotland and Northern Ireland were less positive about their pay than colleagues in England and Wales.

9.15 The BDA conducted a survey in 2017 of its members broken down between associates and practice owners. Results from the survey include:

- More than 50 per cent of both associates and practice owners that responded said they would not recommend a career as a dentist;
- Thirty-four percent of associates rated their morale as high or very high, compared with 31 per cent who said their morale was low or very low. Thirty-seven per cent of practice owners rated their morale as high or very high and 34 per cent said their morale was low or very low;
- Thirty-two per cent of associates and 38 per cent of practice owners said they agreed that they were fairly remunerated. This compared with 45 per cent of associates and 40 per cent of practice owners who said they disagreed that they were fairly remunerated;
- The results for each of these questions were less positive in 2017 than they had been in 2016;
- For those spending more than 75 per cent of their time on NHS activity the responses were less positive than for those spending less than 75 per cent of their time on NHS activity.

Recruitment and retention

England

9.16 NHS England said that dentists were still generally ready, and indeed enthusiastic, to bid for and undertake NHS contracts. In contrast, the BDA said that there were examples of contracts being returned, as the service provider was unable to make a profit on the contract. The BDA pointed out that the problem of returned contracts was not restricted to smaller independent practices, but also applied to major corporate practices.

Wales

9.17 The Welsh Government said that there were problems recruiting and retaining dentists in rural areas, especially in the areas covered by the Betsi Cadwaladr University Health Board, the Hywel Dda University Health Board, and the Powys Teaching Health Board.

It said it was working with those Health Boards to agree how to provide more support to dentists in rural areas. One possible approach would be for dentists based in more densely populated areas to spend part of their time working in nearby areas that were more rural in nature.

Scotland

9.18 The Scottish Government said that Brexit was a big challenge, with 1 in 10 dentists coming from the EU. The issue was most acute in Dumfries and Galloway where 47 per cent of dentists were from the EU. The Scottish Government said that it was confident that those who had already arrived, settled, put down roots and invested in practices would remain, but were more concerned about continuing to be able to attract new overseas dentists to Scotland.

9.19 The Scottish Government told us that there was a range of incentive payments to attract dentists to remote and rural areas. Dentists joining a dental list in Orkney, Shetland and the Western Isles within 3 months of completing their vocational training period may qualify to claim a 'golden-hello' allowance of £25,000 over two years. Those joining a dental list in Dumfries, Invergordon, Lochgilphead, Nairn, and Wick may qualify for a payment of £10,000. A remote areas allowance was also available to dentists who provided general dental services on an island or a mainland location which had fewer than 0.5 persons per hectare.

9.20 The Scottish Government also told us about the Scottish Dental Access Initiative (SDAI) grant. It said that the SDAI was a scheme to help independent contractors establish new NHS dental practices or expand/purchase existing practices in areas of 'unmet need', where access to dental services was relatively low. The areas where the grant was available were similar to those where the golden hello was in place. Data from the Scottish Government showed that between 2007 and 2017 the total number of dentists and the number of patients registered had increased in Highlands, Orkney, Shetland and the Western Isles.

Northern Ireland

9.21 The Department of Health (Northern Ireland) said that it was content with the number of dentists, and that Northern Ireland was well served. It went on to say that places at dental schools were over-subscribed, but the economic slowdown had meant that the private market for dental treatment had shrunk, potentially reducing overall dental incomes.

BDA

9.22 The BDA said that it believed that increased pressures in the NHS and a reduction in dental incomes meant there was a looming crisis in general practice recruitment and retention. It said that recruitment of associates was increasingly problematic, especially in some regions outside London and the South East of England. In the 2017 BDA survey of practice owners, 63 per cent of respondents said that they had had difficulties recruiting associates, an increase from 45 per cent in 2016.

9.23 The BDA said that of those responding to their 2017 survey, over a quarter of associates were looking to increase the time they spent on private work while just two per cent said they were intending to increase the time they spent on NHS work. The proportion of younger dentists saying they were looking to increase the time they spent on private work was even larger.

9.24 The BDA also highlighted the issue of retirements. Twenty per cent of associates responding to their survey in 2017 said they were considering retirement, up from 13 per cent the previous year.

Earnings and expenses for providing-performer and principal GDPs

9.25 NHS Digital, using HMRC data, publishes statistics on the earnings and expenses of primary care dentists who carried out NHS/Health Service work in each part of the UK. The overall picture on earnings is unclear as it is not known how many hours work the statistics were based on, and some dentists choose to take incorporated status, affecting how their income appears in the statistics.

England and Wales

9.26 Table 9.1 shows that in 2015-16, providing-performer dentists in England and Wales had average taxable income of £115,700, a fall of 1.4 per cent from 2014-15, and average expenses (employee plus other) of £262,100 (Expenses to earnings ratio (EER) of 69.4 per cent). The table also shows that employee expenses for providing-performer dentists decreased by 2.2 per cent to £83,600, while non-employee expenses decreased by 2.4 per cent.

Table 9.1: Providing-performer GDPs' average gross earnings, income and expenses, England and Wales, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000)	(£000)	(£000)	(£000)	(%)
2008-09	6,783	366.5	74.7	160.8	131.0	64.3
2009-10	6,250	370.9	77.6	165.3	128.0	65.5
2010-11	5,750	364.3	79.0	168.1	117.2	67.8
2011-12	5,250	358.4	80.7	164.9	112.8	68.5
2012-13	4,750	368.0	80.5	173.3	114.1	69.0
2013-14	4,350	375.0	81.7	178.1	115.2	69.3
2014-15	3,950	385.6	85.5	182.8	117.4	69.6
2015-16	3,450	377.8	83.6	178.5	115.7	69.4
Latest change (%)	*-12.7%*	*-2.0%*	*-2.2%*	*-2.4%*	*-1.4%*	*-0.2pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.

Scotland

9.27 Table 9.2 shows that in 2015-16 principal dentists in Scotland had average taxable income of £110,800, an increase of 7.7 per cent from 2014-15, and average expenses (employee plus other) of £267,000 (EER 70.7 per cent). The table also shows that income for principal dentists in Scotland rose for the third consecutive year, and in 2015-16 was at the highest level since 2009-10.

Table 9.2: Principal GDPs' average gross earnings, income and expenses, Scotland, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000s)	(£000s)	(£000s)	(£000s)	(%)
2008-09	699	343.9	86.7	138.5	118.7	65.5
2009-10	650	337.0	85.8	137.4	113.8	66.2
2010-11	700	334.7	89.3	144.3	101.1	69.8
2011-12	700	332.9	86.2	143.8	102.9	69.1
2012-13	650	319.6	84.0	138.3	97.4	69.5
2013-14	650	330.3	85.0	146.9	98.4	70.2
2014-15	600	347.2	89.9	154.4	102.9	70.4
2015-16	500	377.8	97.8	169.2	110.8	70.7
Latest change (%)	*-16.7%**	*8.8%*	*8.8%*	*9.6%*	*7.7%*	*0.3pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.
* based on rounded data

Northern Ireland

9.28 Table 9.3 shows that in 2015-16, principal dentists had average taxable income of £117,600 and average expenses (employee plus other) of £218,400 (EER 65.0 per cent). The table also shows that income for principal dentists in Northern Ireland was 5.3 per cent higher than in 2014-15 and at the highest level since 2009-10.

Table 9.3: Principal GDPs' average gross earnings, income and expenses, Northern Ireland, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000)	(£000)	(£000)	(£000)	(%)
2008-09	319	333.7	66.6	137.5	129.6	61.2
2009-10	350	344.6	73.2	148.5	122.9	64.3
2010-11	300	331.0	79.2	137.6	114.2	65.5
2011-12	350	318.6	77.0	129.1	112.5	64.7
2012-13	300	316.0	79.1	126.1	110.9	64.9
2013-14	300	335.6	76.9	146.2	112.5	66.5
2014-15	250	328.7	76.1	140.9	111.7	66.0
2015-16	250	336.0	78.6	139.8	117.6	65.0
Latest change (%)	*0.0%*	*2.2%*	*3.3%*	*-0.8%*	*5.3%*	*-1.0pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.

Earnings and expenses for performer-only GDPs

England and Wales

9.29 Table 9.4 shows that in 2015-16, performer-only dentists in England and Wales had average taxable income of £60,200, an increase of 0.5 per cent from 2014-15, and average expenses (employee plus other) of £43,400 (EER of 41.9 per cent). The table also shows that non-employee expenses for performer-only dentists increased by 7.6 per cent.

Table 9.4: Performer-only GDPs' average gross earnings, income and expenses, England and Wales, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000)	(£000)	(£000)	(£000)	(%)
2008-09	12,853	104.0	5.6	30.7	67.8	34.9
2009-10	14,050	101.7	6.7	29.4	65.6	35.5
2010-11	15,050	98.4	5.9	29.6	62.9	36.0
2011-12	16,050	96.2	5.6	28.9	61.8	35.8
2012-13	16,800	96.2	6.0	29.4	60.8	36.8
2013-14	17,150	99.0	6.7	31.8	60.6	38.8
2014-15	17,400	99.8	6.9	33.0	59.9	39.9
2015-16	17,750	103.5	7.9	35.5	60.2	41.9
Latest change (%)	*2.0%*	*3.7%*	*14.5%*	*7.6%*	*0.5%*	*2.0pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.

Scotland

9.30 Table 9.5 shows that, in 2015-16, performer-only dentists in Scotland had average taxable income of £55,200, an increase of 0.4 per cent from 2014-15, and average expenses (employee plus other) of £30,700 (EER of 35.7 per cent). The table also shows that non-employee expenses for performer-only dentists increased by 3.1 per cent.

Table 9.5: Performer-only GDPs' average gross earnings, income and expenses, Scotland, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000)	(£000)	(£000)	(£000)	(%)
2008-09	1,318	100.5	2.1	31.3	67.1	33.2
2009-10	1,450	91.9	1.1	27.7	63.1	31.3
2010-11	1,450	87.9	1.2	26.6	60.1	31.6
2011-12	1,550	85.0	0.6	26.9	57.6	32.3
2012-13	1,650	84.9	0.8	26.9	57.2	32.6
2013-14	1,650	84.9	0.6	28.1	56.2	33.8
2014-15	1,750	84.7	0.3	29.4	55.0	35.1
2015-16	1,700	86.0	0.4	30.3	55.2	35.7
Latest change (%)	*-2.9%*	*1.5%*	*33.3%*	*3.1%*	*0.4%*	*0.6pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.

Northern Ireland

9.31 Table 9.6 shows that in 2015-16, performer-only dentists in Northern Ireland had average taxable income of £54,200, an increase of 0.4 per cent from 2014-15, and average expenses (employee plus other) of £44,700 (EER of 45.2 per cent). The table also shows that non-employee expenses for performer-only dentists increased by 24.2 per cent.

Table 9.6: Performer-only GDPs' average gross earnings, income and expenses, Northern Ireland, 2008-09 to 2015-16

Year	Estimated population	Gross earnings	Employee expenses	Non-employee expenses	Income	Earnings to expenses ratio (EER)
		(£000)	(£000)	(£000)	(£000)	(%)
2008-09	522	105.3	2.5	36.1	66.7	36.7
2009-10	500	97.9	1.1	34.1	62.7	36.0
2010-11	550	96.2	0.5	36.4	59.4	38.3
2011-12	600	91.6	0.8	35.0	55.7	39.1
2012-13	650	86.7	0.2	33.5	53.0	38.9
2013-14	700	89.7	0.7	34.8	54.2	39.6
2014-15	700	90.2	0.5	35.6	54.0	40.1
2015-16	750	98.9	0.5	44.2	54.2	45.2
Latest change (%)	*7.1%*	*9.6%*	*0.0%*	*24.2%*	*0.4%*	*5.1pp*

Source: NHS Digital using Her Majesty's Revenue and Customs data.
pp: percentage point change.

Earnings and motivation analysis

9.32 In our previous reports we have expressed a desire to explore whether there was evidence of a link between earnings and motivation. This year, for the first time, answers to the motivation questions of the Dental Working Patterns survey were linked to HMRC earnings data. This research has helped give an insight into the correlations between earnings and motivation[3].

9.33 Experimental statistics published by NHS Digital[4] suggest that for providing-performer/principal dentists there was a small but statistically significant positive correlation between income and motivation in England & Wales and Northern Ireland, but not in Scotland. In all countries, the higher the percentage of NHS work, the lower the motivation; this is consistent with findings from the previous motivation survey.

9.34 The results suggest that for performer-only/associate dentists there is not a statistically significant link between income and motivation. Again, the higher the proportion of NHS work, the lower was the motivation in all countries. In England & Wales and Northern Ireland, annual leave is positively correlated with motivation.

Contract reform

England

9.35 NHS England said it had been responsible for commissioning dental services in England for four years and was in discussions with the BDA with a view to aligning key contract changes to the *Five Year Forward View.*

[3] A combination of 6 questions relating to motivation (including I feel my pay is fair), where higher numbers are related to higher motivation.
[4] https://digital.nhs.uk/data-and-information/publications/statistical/dental-working-hours/dental-working-hours-2012-13-and-2013-14-motivation-and-earnings-analysis-experimental-statistics

9.36 The DHSC said that the Government was committed to reforming the current dental contractual framework, moving away from the current all activity remuneration system to a part capitation, part activity model. It said that since April 2016 selected practices had been testing the proposed new remuneration system which was currently being evaluated.

9.37 The BDA said that it was fully engaged in the contract reform process and that a contract putting prevention first was required urgently. However, it disagreed with the inclusion of UDAs as a payment measure in a contract that it said should be focusing on prevention, outcomes and improving health. It was also concerned that the new arrangements might lead to a rise in expenses, as patients took more time to see and treat, and that this would lead to a fall in dentists' incomes.

Wales

9.38 The Welsh Government published *Taking oral health improvement and dental services forward in Wales,* in March 2017, which identified contract reform as a priority. It said that it looked to learn from previous dental pilots which had taken place between 2011 and 2016, and ongoing prototype practices being used to design the new programme. It expected 10 per cent of dental practices to be participating in contract reform in 2018.

Scotland

9.39 A key proposal of the *Oral Health Improvement Plan* was to reposition primary dental services to focus on prevention and anticipatory care. The Government told us that the current system of service payments to GDPs is largely predicated on restorative services, for historical reasons, but that the focus in the future will be to introduce a more prevention-based approach to oral health care.

Northern Ireland

9.40 In Northern Ireland the Department of Health said that it remained committed to the development of a new contract for Northern Ireland. Negotiations were ongoing on a model that would allow the commissioner of dental services to manage the available budget and provide a sustainable and predictable remuneration system for General Dental Services (GDS) dentists. The BDA said that negotiations towards a new GDS contract in Northern Ireland had stalled as the outcome of an evaluation of GDS pilots was awaited. It said that the results of the evaluation would inform negotiations on a new contract.

Expenses and formula

9.41 In 2016 we decided to make recommendations on our intended increase in pay net of expenses. Taking this approach required the parties to discuss expenses to agree a gross increase. The BDA have said that its preferred position remained that DDRB should recommend on an expenses uplift.

9.42 For this pay round we are again making a recommendation on pay net of expenses. However, we are including (at Appendix E) the latest data that would have populated the formula for both GMPs and GDPs, had we continued to use the formula-based approach.

9.43 For our 45th Report 2017, the Scottish Government commissioned an exercise to provide information on expenses incurred by 30 dental practices. Although we felt that there was value in the data we did not see a way to generalise from it to produce a new formula. However, as we said at that time, the information was a step in the right direction, and could be used to support a greater understanding of expenses by the parties in the future.

9.44 Following our 45th Report 2017, GDPs in England received a 1.14 per cent uplift in contract values and GDPs in Wales a 1.44 per cent uplift. The BDA said that the difference in uplifts was due to the Welsh Government implementing an increase that used the expenses formula, while in England the increase in staff pay was capped at one percent and inflation linked to CPI. In Scotland there was a 1 per cent pay uplift and a 2.25 per cent increase in item of service fees, from 1 April 2017. The Northern Ireland Department of Health said that in March 2018 it implemented a 1.5 per cent increase to gross fees and a 1 per cent increase to income for GDPs.

Payment recovery

9.45 The BDA highlighted the issue of what it described as 'clawback'. It said that in England, if providers fail to deliver at least 96 per cent of their contracted activity, and Wales if providers fail to deliver at least 95 per cent of their contracted activity, commissioners were able to recover the payments made for this missed activity. The BDA said that the amount being recovered was increasing and in 2016-17 was worth £81.5 million in England and £6.6 million in Wales. It said that clawback could have a considerable impact on practice finances and arose in the wake of difficulties experienced by practices recruiting associates.

9.46 The BDA said that clawback was being used by finance managers of Health Boards as a potential income source, rather than the money being invested back into dentistry. The Welsh Government acknowledged that Health Boards had been taking a robust line on clawback, as finances were tight, but that it expected the savings to be reinvested in dentistry. The Government went on to say that discussions about performance against targets should take place throughout the year, as in its view the existing contract was flexible enough to allow targets to be changed mid-year.

Salaried dentists

9.47 GDPs who are employed directly by the NHS will be on a salary directly paid by an NHS organisation. Salaried dentists 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

9.48 The DHSC told us that it believed that salaried dentists working in the Community Dental Service (CDS) in England filled an important role in dental health service provision. DHSC were not aware of any specific difficulties in filling vacancies faced by providers. NHS Employers said that employers had not raised any particular difficulties around the recruitment, retention and morale of salaried primary dental care dentists, other than to raise some isolated, local issues, largely to do with geography in relation to recruitment.

9.49 In its evidence the BDA reported that the number of patients treated by the CDS fell from just over 400,000 in 2015, to 370,000 in 2016 but increased to almost 420,000 in 2017. It said that over 80 per cent of CDS dentists that it surveyed perceived their workload to be high or very high in 2017, and over half said they were required to work in excess of their contracted hours a great deal or by a moderate amount.

9.50 The BDA said that motivation and morale amongst CDS dentists was falling. In its 2017 survey of its CDS members, almost half reported low or very low morale, with less than a quarter reporting high or very high morale. The BDA said that these figures were worse than equivalent figures for 2016. In the same survey, the BDA said that just over half the respondents had disagreed or strongly disagreed that they were fairly paid, nine percentage points more than in 2016.

9.51 The BDA said that 72 per cent of CDS dentists in England had now reached the top of their salary scale, with no further opportunity for progression. It said that this was evidence of loyalty to the service. It also said that it had asked that respondents to the NHS Staff Survey be allowed to self-identify as CDS dentists but that this request had not been accepted, meaning it was unable to provide as much detailed evidence on issues such as morale and working hours, as it would have liked.

Wales

9.52 The Welsh Government told us that the CDS provides NHS dentistry to vulnerable people, for those who have experienced difficulty obtaining treatment from the general dental service, or for whom there is evidence that they would otherwise not seek treatment. The Welsh Government also delivered oral health promotion and intervention programmes including their *Designed to Smile* child oral health improvement scheme. At March 2017 there were 106 full-time equivalent (FTE) dentists working in the CDS in Wales, an increase of 6 from the previous year.

9.53 The BDA described the domiciliary service in Wales as patchy and underfunded. It was concerned about maintaining oral hygiene in older people, which it believed should be part of a check-list when looking at the early stages of dementia.

Scotland

9.54 The Scottish Government said that it continued to meet regularly with the BDA (Scotland) through the Scottish Joint Negotiating Forum to discuss pay and terms and conditions of service issues relating to salaried dentists. It said that the forum offered the opportunity to discuss and share any national issues which were causing concern, and that at the time the evidence was submitted, there were no significant national issues.

9.55 The BDA said that it was concerned about how the Public Dental Service (PDS) in Scotland would meet the growing demands of an ageing population at a time when the number of PDS dentists and clinics was reducing. It was also concerned about the retirement of senior dentists, which it attributed to stress, restructuring of services and the need for retraining to take on new roles.

Northern Ireland

9.56 The Department of Health (Northern Ireland) said that the introduction of new contractual terms and conditions had been delayed because of the need for ministerial agreement. The BDA said the continued delay in agreement and implementation of the contract was unacceptable, and had created significant frustration amongst community dentists in Northern Ireland and the wider dental community, creating a climate where the current workforce did not feel valued.

Our comments

9.57 We note again, as we have in previous years, the difference between the picture painted by the data we have received, and the anecdotal evidence we have heard both from the BDA and from dentists we have met on our visits. According to the data we saw, dentist numbers are steady, while figures showing access to and satisfaction with dental services are generally positive. Despite this, the BDA tell us that increased pressures in the NHS and a reduction in dental incomes mean there is a looming crisis in general practice. This is a view we have also heard expressed on visits.

9.58 Although the headline income statistics show a reduction in dental incomes it is difficult to draw firm conclusions from them. The figures are based on a headcount rather than FTE basis, so may reflect changes in working patterns rather than income. Moreover, we understand that some dentists choose to take incorporated status, which has an impact on whether income is classed as personal or company income. However, the BDA said that incorporation was relevant for no more than 3 per cent of dentists, as choosing to incorporate meant losing access to the NHS pension scheme. A further complication is that dentists, particularly in certain areas of the country, can supplement their income through private practice. Nevertheless, we note that, in 2015-16, dental incomes from NHS work increased in nominal terms, except for providing-performer GDPs in England and Wales, which recorded a decrease.

9.59 One indication of the relative profitability of dental contracts should be the ease with which they can be let, and the performance of the contractors who take them up. We were told by NHS England that dentists were ready and enthusiastic to bid for NHS contracts. The BDA, however, said that a number of contracts were being returned, as contractors were unable to make an adequate profit on them. It is difficult to reconcile these views without knowing more about the number of contracts being returned, what proportion this represents of total contract lettings, and what the trends have been over recent years. We heard during oral evidence from NHS England that some partnerships were being bought on the open market for high prices, suggesting that owning a dental practice was still thought to be profitable. But we were told by the BDA that the values of practices may be held up artificially by bids from relatively junior dentists who are not sufficiently experienced in the business of running a dental practice, and hence who may be tempted to make a more optimistic assessment of practice profitability than is actually justified.

9.60 In our 45th Report 2017, we included the results from the 2015-16 Dental Working Hours Motivation Analysis survey. Unfortunately, the next results from this survey are not available until later this year. The BDA did however include the results from a 2017 survey of its members. Although a long time-series of data was not available, the results for 2017 were less positive than those from 2016.

9.61 The Scottish Government told us it had taken action to improve dental services in remote and rural areas, through the introduction of 'golden hellos' and the Scottish Dental Access Initiative (SDAI) grant, which encouraged dentists to join dental lists in particular areas, and helped independent contractors to establish new or expand existing practices in areas of unmet need. We also heard that there were some problems in rural Wales recruiting and retaining dentists. The Welsh Government said that it was discussing with health boards how to address this issue, through the use of incentives and different skill mixes. We look forward to hearing in evidence next year about any action taken and the impact it has had.

9.62 We would like to thank everyone involved in producing the new earnings and motivation analysis, which we discussed in paragraphs 9.32 to 9.34. They have helped shed light on the link between earnings and motivation, showing a statistically significant correlation for three out of four countries for providing-performers, but not for any of the countries for performer-only dentists. We also note the apparent demotivational effect that doing more NHS work at the expense of private work has on dentists, and look forward to understanding more about this, together with the possible reasons for it, when the results from the next survey are available.

9.63 We have heard that reform of dental contracts is an issue across the UK as a whole. We were told that new models of service provision had been piloted, some as far back as 2011. We expect to be kept informed of developments in this area and hope that at least in some parts of the UK the parties are able to reach agreement on the introduction of new arrangements.

9.64 In 2016 we took a decision to make recommendations net of expenses. We did this because of our concerns that the recommendations made against gross earnings – the "formula-based" approach – were not translating on the ground into the pay uplifts that we had intended. We think the net-of-expenses approach is a better way to express our recommendations for this part of the workforce, and we will use the same approach this year. We have however included at Appendix E the data that would have populated the formula had we chosen to make a recommendation using that approach.

9.65 We were interested to hear the comments about the system of 'clawback', where commissioners 'clawback' part of the value of the contract where the providers fail to deliver a portion of the contracted activity. We can understand the desire to ensure that public monies paid in support of dental services are used for their intended purpose, and that surpluses should be returned to the public purse. However, we can also see the difficulties from the perspective of someone managing a dental practice and trying to plan how to use the anticipated income. If it is the case that clawback is becoming a regular annual feature of the financial landscape in this area, then we feel that work might usefully be done to understand the principal causes, and ensure contracts are designed in a way that minimises business planning uncertainties. Where clawback cannot be avoided, we would encourage the design of systems which ensure that the possibility of over-bidding is identified sufficiently early to allow time for appropriate remedial action to be taken.

9.66 We note the BDA evidence that almost three-quarters of salaried dentists in England are at the top of their pay scale, with no further opportunity for progression, and no opportunity for an increase in pay other than directly through our pay recommendation. We also note that if we are to be able to make a better-informed assessment of the position of this group, it would be helpful if data were available from the NHS Staff Survey.

9.67 We also note the impact that the late implementation of pay awards in Northern Ireland has on our remit group. We understand that the lack of an Executive or Minister will have an impact on how quickly our recommendations can be considered and implemented. While we sympathise with those facing the difficulty of operating the system within the current constraints, we nonetheless observe that the delay will inevitably have a negative impact on how valued people feel.

CHAPTER 10: PAY RECOMMENDATIONS AND OBSERVATIONS

Introduction

10.1 In this chapter we discuss our main pay recommendation and other recommendations that target particular parts of our remit group.

Pay proposals

10.2 In September 2017 the Chief Secretary to the Treasury (CST) wrote to us saying that the last Spending Review had budgeted for a 1 per cent average increase in basic pay and that there was still a need for pay discipline, to ensure the affordability of public services and the sustainability of public sector employment. However, the CST also said that the Government recognised that in some parts of the public sector more flexibility may be required, particularly in areas of skill shortage and in return for improvements to productivity.

10.3 The Department of Health and Social Care (DHSC) invited us to make recommendations in relation to the employed medical workforce about targeting funding to support productivity and recruitment and retention. It said that it would like us to consider how resources might be targeted, including through the existing mechanisms of the flexible pay premia in the contracts for doctors and dentists in training.

10.4 The Welsh Government asked us to recommend on what a fair pay award would be for medical and dental staff in Wales and what level of pay could be afforded without further funding from the UK Treasury. The Welsh Government went on to say that the NHS in Wales needed to continue to be able to attract staff from across the UK, and beyond and that the development of significant differences in pay and terms and conditions across the UK could have a significant undesirable impact on recruitment and retention in Wales.

10.5 The Scottish Government set out its revised public sector pay policy of:

- A guaranteed minimum increase of 3 per cent for those earning £36,500 or less;
- A limit of up to 2 per cent for those earning above £36,500 and below £80,000; and
- A maximum pay increase of £1,600 for those earning £80,000 or more.

10.6 The Scottish Government said that, beyond the elements of the pay policy, it wished us to be as free as possible in considering the issues and making recommendations for Scotland in 2018-19. It also asked that for General Medical Practitioners we make a recommendation for pay and contractual uplift, and for General Dental Practitioners that we recommend on pay only while the Government discussed the issue of expenses with the BDA.

10.7 On 9 June 2018 the First Minister announced that Agenda for Change staff in the NHS earning up to £80,000 would receive at least a 3 per cent uplift in 2018-19 and those earning £80,000 and over would receive a flat rate increase of £1,600.

10.8 The Department of Health (Northern Ireland) wrote to us asking that we make recommendations for Northern Ireland for 2018-19.

10.9 The BMA asked that we make a recommendation to uplift the pay of all doctors across the UK in line with the Retail Price Index (RPI), plus £800 or 2 per cent, whichever is greater. It said that it believed that a low or zero real-terms pay increase, at a time when pay rises in the wider economy were running well above inflation, would further impede the ability of the NHS to recruit and retain staff to deliver safe patient care.

10.10 The BDA proposed that we make a recommendation of 2 per cent above inflation, as measured by the RPI, and similar to that for other NHS professionals. It said that such an award should at the very least curb any further erosion of pay in real terms.

10.11 The Hospital Consultants and Specialists Association proposed an award in line with the RPI, which it said at the time of submitting its evidence, was 3.9 per cent. It said that this would represent a first step in the process of acknowledging the impact of the damaging pay erosion that medical staff had endured.

10.12 NHS Employers said that it welcomed the announcement by the CST confirming the relaxation of pay restraint. However, any additional investment in pay over 1 per cent must be fully funded through additional funds from the Treasury. It said that any award greater than 1 per cent should target investment in pay which supported employers' pay reform priorities and the longer-term ambitions of reform of the consultant contract. Specifically, it proposed a 1 per cent consolidated award for the entry level, years 1-4 and the top of the consultant pay structure, and that DDRB focus funding on mid-range consultant career pay points and local Clinical Excellence Awards.

10.13 NHS Providers did not make an explicit pay proposal but said that in the absence of additional funding from the Government, an end to pay restraint for doctors would be unaffordable for provider trusts.

10.14 Health Education England said that it recommended the introduction of a pay premium for histopathology training programmes.

The case for an award

10.15 We understand that pressure on health services remains severe, given the current financial settlement. We have been comfortable over recent years with pay settlements for our remit group that have been in line with the Government's pay policy, but we noted last year that the case for continued pay restraint was diminishing. We have not seen sufficient evidence to persuade us of the case for any settlement that would undo the effects of this period of pay restraint, but we have heard evidence that employers are facing increasing difficulties recruiting and retaining the medical and dental workforce they need, and that the morale of doctors and dentists, and their satisfaction with their pay, have declined.

10.16 On recruitment, medicine and dentistry are disciplines where there is no shortage of high quality candidates seeking a career, but training a doctor or dentist involves a large investment of both time and money. We have seen this year a continuing decline in the numbers of university applications for pre-clinical medicine, pre-clinical dentistry and other courses in medicine and dentistry. We have been presented with no evidence however that this has reached a point at which quality problems are starting to emerge.

10.17 Given the long lead-time and cost of training a doctor or dentist, one approach to increasing staff numbers is to look to recruit trained doctors and dentists from overseas. We have heard that overseas recruitment may be affected by uncertainty around Brexit, by the ability of candidates to obtain visas to enter the UK, and by the time taken to procure such visas. Moreover, the relative fall in the value of the pound since the middle of 2016, particularly against the Euro, will have reduced for overseas applicants the financial value of medical posts paid in sterling.

10.18 There are also indications of challenges relating to retention. An increasing proportion of junior doctors are stepping out of training after Foundation Year 2. We note that some are undertaking locum work for financial reasons, and filling vacancies in training rotas, but this phenomenon may be a reflection of the choices doctors and dentists are now making in their early working life about work-life balance. We referred to this in our 45th Report 2017, and employers in the NHS may have to accommodate such demands. However, the data we have seen suggests that the vast majority are returning within a year or two and are not being permanently lost to the NHS.

10.19 We have seen an increase in the number of doctors choosing to retire at an earlier age. One cause may be the impact of lowering the thresholds of the pensions annual and lifetime allowances, which could be encouraging experienced staff to leave the NHS pension scheme, reduce their workload or leave the workforce early.

10.20 On motivation, Staff Survey data for 2017 in England were generally less positive than in 2016. The results showed a decrease in engagement scores, a fall in satisfaction with pay, and a fall in job satisfaction in general. Meanwhile, workforce pressures remained high and showed little sign of easing.

10.21 We recognise that our remit group is a complex and varied one, and that there are different pressures and concerns in the different sections comprising it. We considered the extent to which it was appropriate to target some or all of our recommendations on specific areas, as we were urged to do by some of the evidence providers. We had to balance this against the possible demotivating and divisive effect on those who would have lost out with an approach based solely on targeting.

10.22 We are convinced by the evidence we have seen that we have reached a point at which, if we are properly to balance the different factors listed in our terms of reference, a pay recommendation with a general uplift significantly greater than the 1 per cent which the UK Government says it has funded now becomes necessary. Indeed, and without ruling out specific action on targeting in certain areas as we discuss below, we do not believe the workforce represented by our remit group is in a position where any particular sub-group should be expected to see their pay decline significantly further in real-terms.

10.23 As to the size of uplift required, both price inflation (as measured by CPI) and average earnings growth are an important part of this year's context. At the time of reporting both are at or around 2½ per cent, although CPI over the period of the settlement is generally expected to be close to 2 per cent.

10.24 Taking account of all these circumstances, we conclude that the appropriate level for a general increase, should be 2 per cent, which broadly maintains pay in real-terms. In making our recommendations we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs and GDPs net of expenses.

We recommend:

- **A minimum 2 per cent increase to the national salary scales for salaried doctors and dentists across the UK;**
- **For independent contractor GMPs and GDPs across the UK a minimum increase in pay, net of expenses, of 2 per cent;**
- **The maximum and minimum of the salary range for salaried GMPs be increased by 2 per cent;**
- **An increase in the GMPs trainers' grant and rate for GMP appraisers of 2 per cent;**
- **That the flexible pay premia included in the junior doctors' contract in England increase by 2 per cent.**

Targeting

10.25 As invited to do so by some of our evidence providers, we considered the case for targeting in some specific areas.

10.26 In considering targeting options, we have focused on areas where the needs seem greatest. That has led us to focus our recommendations on GMPs and specialty doctors and associate specialists (SAS) this year, but we have also set out our comments and observations in relation to other groups within our remit.

General Medical Practitioners

10.27 Our first priority area was GMPs. In line with the vision set out in the GP Five Year Forward View, in England, and the National Health and Social Care Workforce Plan, in Scotland, health providers are looking to increase the emphasis on primary care and to do so, increase the number of GMPs. This will require a combination of increasing the number of training places, overseas recruitment and encouraging others to remain in or return to the workforce. Expanding the number of trainees will take a considerable number of years to have an impact, but overseas recruitment could have an impact more quickly. The ambition to achieve NHS England's target of an additional 5,000 GMPs by 2020, compared with 2014, and the commitment from the Cabinet Secretary for Health and Sport in Scotland to expand the GMP workforce by at least 800 over the next ten years may be affected by uncertainty around Brexit and by the recent limited ability of candidates to obtain visas to enter the UK. We welcome these initiatives as they have the potential to help utilise more effectively the skills of the workforce.

10.28 We observed that for GMPs in particular there were several specific issues potentially impacting on retention:

- The extent to which demand will be further increased by health policy changes placing greater emphasis on primary care, and the role of the GMP, to improve the integration of healthcare with social care and to reduce the burden on secondary care;
- The increasing regulatory and administrative burden of running practices;
- The increasing demands posed by a rising and an ageing population with more complex needs;
- A decreasing willingness on the part of younger GMPs to work the number of sessions their predecessors worked;
- The increasing tendency for GMPs to prefer salaried employment to practice ownership, and the problems this creates for practice owners having to share the burdens and financial risks of partnership between an ever-declining number of partners;
- The data show an increase in the number of GMPs taking voluntary early retirement which may be linked to lowering the thresholds of the pensions annual and lifetime allowances;
- Whilst it is not straightforward to match earnings with hours worked data, we noted that average gross earnings for GMPs, both contracted and salaried, were lower in nominal terms in 2015-16 than in 2006-07.

10.29 These concerns were underlined by results from the University of Manchester National GP Work Life Survey, published in May 2018. The survey reported an increase in the number of GMPs in England saying they were likely to leave direct patient care in the next five years, to almost 40 per cent, and 90 per cent reporting considerable or high pressure from increasing workloads. Pressures reported by the Survey included a lack of time to do the job justice, paperwork and increased demand from patients. Those conducting the survey found that low satisfaction and high pressure reported by GMPs in 2015 had been repeated again in 2017, and said that this may have implications for recruitment, retention and patient care.

10.30 These factors all appear to have combined to make it less attractive for doctors to pursue the traditional GMP career path, leading ultimately to practice ownership. This is a matter of increasing concern to us, particularly given the renewed emphasis being placed on the role of the GMP in addressing demand for health services, and hence delivering the productivity improvements sought from this. Using pay to improve the recruitment and retention of this group can be justified by the productivity gains achieved and those that could be delivered.

10.31 Pay premia have already been introduced in England to encourage trainees to take up GMP training places and in Scotland to encourage GMPs to locate in remote, rural or deprived areas. Although the numbers undertaking GMP training has increased, it will be some time before this results in a significant throughput of new GMPs.

10.32 We recognise that many of the problems facing this part of our remit group are not necessarily resolved through pay alone. However, we believe that if sufficient number of GMPs are either to be recruited from overseas or be encouraged to remain in the service longer than they otherwise would have done, a pay response is required now, and that such a response needs to go well beyond our recommended base increase for the pay remit group as a whole.

- **We recommend for independent contractor GMPs an additional increase in pay, net of expenses, of 2 per cent above our minimum pay recommendation**[1]**;**
- **We make a similar additional 2 per cent recommendation to the maximum and minimum of the salary range for salaried GMPs and to the GMP trainers' grant and the rate for GMP appraisers.**

Specialty doctors and associate specialists (SAS)

10.33 SAS doctors are the specialty doctors and associate specialists in the hospital system, of which there are about 11,000 working across the UK, or around 1 in 10 of the hospital doctor workforce. Data supplied by NHS Digital showed that, in England, the SAS doctors contained the highest proportion of BAME staff, with only about 4 in 10 staff identifying as white, and that for consultants, specialty registrars and training grades, the proportions were closer to 6 in 10 staff. The evidence also showed that SAS grades contained a higher proportion of women, at 45 per cent, when compared to consultants, where the figure was 35 per cent. Health Education England (HEE) data suggested that three-quarters of SAS doctors in England had obtained their primary medical qualification abroad, about 60 per cent from a non-EU country, with a further 12 per cent from EU countries.

10.34 We have drawn attention over several years to the pivotal role that SAS doctors play in the provision of hospital services. We were pleased to see this acknowledged by HEE who said that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas'. HEE also told us that many rotas were staffed by non-consultant, non-training grade (i.e., SAS) doctors, and that how this group were looked after and offered a rewarding career was critically important.

[1] In making our recommendation we follow the practice we adopted in 2016 of expressing our pay recommendations for GMPs net of expenses.

10.35 SAS doctors told us on visits that many of them performed consultant-level work, brought consultant-level expertise to their particular area of activity, worked on consultant rotas and provided cover for absent consultants. SAS doctors are a significant element of the wider medical team and in many respects represent the "hidden workforce" of the NHS. These factors reflect our belief that this group of doctors, through their front-line roles, make an important contribution to productivity. We would further observe that the role of an SAS doctor, if properly structured and managed in career terms, could potentially offer flexibilities, and hence be attractive to those whose commitments might otherwise deter them from following the path to consultant.

10.36 Despite the contribution which this group can bring, the results from the NHS Employers and BMA surveys highlighted problems with recruitment and retention to SAS posts, and pay, morale, workload, career progression and development were cited as factors. Results from the 2017 Staff Survey in England showed that, compared with other medical groups, a greater proportion of SAS doctors said they were dissatisfied with pay, and fewer said they felt valued for their work. We were told that SAS doctors were unable to access parts of the consultant package, such as CEAs and training. SAS doctors also said that they were 'disheartened' due to a lack of progression opportunities and wanted recognition and adequate remuneration in their existing grade, rather than being asked to retrain as consultants, which they felt would add substantially to already heavy workloads and was often incompatible with family commitments.

10.37 On our visits we have heard from SAS doctors that there is a demand for the associate specialist grade to be re-opened. We observe that the closure of the grade will have the inevitable effect over time of leaving an increasing proportion of staff trapped at the top of their salary scale, with the attendant demotivation which follows. A further complication is that some doctors we regard as falling into this loosely-defined group will be paid as trust doctors on locally determined arrangements, rather than on national pay scales.

10.38 SAS doctors do not appear to be recognised as a coherent group for the purposes of career management. We have observed that, in England in particular, priority has been given over the past few years to negotiating and introducing a new contract for doctors and dentists in training, and now a new consultant contract. Regrettably this has left little time to consider the SAS contract, which was last reformed in 2008.

10.39 Some steps have been taken to try to address these issues, such as through the introduction of the SAS Charters and the establishment of SAS doctors' development funds. Nonetheless we were not encouraged to discover, from the results of the BMA survey of SAS doctors, that a majority of the doctors concerned were unaware of the existence of a Charter where they worked and had not accessed the development funds which it was designed to provide.

10.40 The lack of any substantial progress in this area tends to reinforce the impression that the needs of this group are not being treated with what we feel should be the appropriate level of priority. We do not regard the current situation as satisfactory. We have said that we would like to see this group reflected more in the quality and quantity of evidence that we receive. With that in mind we are pleased to see that NHS Employers and the BMA have conducted surveys that focused on SAS doctors, and that the evidence emerging from this work was fed into their submissions to us this year. However, a review covering the roles, career structure, salary structure and developmental support available to SAS doctors appears to us to be urgently needed. In the meantime, and in the interests of addressing the motivation of this group and HEE's view that 'a genuine focus on recruiting, investing, supporting, rewarding and recognising SAS doctors can significantly help deliver medical rotas', we believe that a pay solution is required, and therefore,

- **We recommend for SAS doctors an additional increase in pay, of 1.5 per cent, above our minimum pay recommendation.**

Doctors and dentists in training

10.41 We considered whether the position of doctors and dentists in training needed any special attention beyond the general minimum base increase of 2 per cent.

10.42 In 2016 a new contract for doctors and dentists in training was introduced in England, with new trainees moving on to it from October of that year. NHS Employers said that all eligible trainees in England were now working on the new contract. The BMA said that the contract was being introduced without its agreement. Those working in Scotland, Wales and Northern Ireland are still on the previous contract.

10.43 Competition for places on pre-clinical medicine, pre-clinical dentistry and other undergraduate courses in medicine and dentistry, remained strong: there were roughly nine applications per acceptance for medical and dental subjects in 2017. The number of applications for these courses have declined in recent years but we have seen no evidence to suggest this is leading to a reduction in quality.

10.44 On remuneration of this group generally, between 2011 and 2016, for Foundation Years 1 and 2, the average total earnings for both doctors and dentists in training in England have remained significantly higher than median earnings of full-time employees but have nonetheless fallen back towards the median. However, we also observe that between September 2016 and September 2017, Foundation Year 1 and 2 monthly average total earnings for doctors in training in England has increased, following the introduction of the new contract, increasing by 5.4 per cent for F1, 2.4 per cent for F2, 4.3 per cent for core training, and 2.8 per cent for Registrars.

10.45 On this basis we do not believe that any further uplifts are required for doctors and dentists in training, beyond the minimum base increase which we have recommended above across the whole of our remit group.

10.46 We noted that the 2016 doctor and dentist in training contract in England includes flexible pay premia for different groups, and that pay premia were currently available for those undertaking general practice training, emergency medicine and psychiatry. Health Education England (HEE) told us it had a key role in making recommendations on the targeting of flexible pay for hard to recruit specialties, and that it was now recommending the application of a premium for histopathology.

10.47 We heard some anecdotal evidence to suggest that the geographical distribution of both doctors and dentists may be influenced by where they finished their training, with cities and towns with medical and dental schools tending to be better served than areas remote from such schools.

10.48 As a matter of general principle, it seems right to us that any geographically-targeted RRPs should be designed so that they provide an incentive to doctors and dentists at the points in their careers where they will have the greatest impact. HEE said that the Targeted Enhanced Recruitment Scheme (TERS), for GMPs, which targets this group early in their career, has been effective in encouraging trainees to take up posts in hard-to-fill areas. There are also a range of incentives in Scotland targeted at hard to fill areas, including "Golden Hellos" for doctors and dentists in remote and rural areas, and relocation packages for GMPs. We noted however that the Welsh Government said in its evidence that it was opposed to targeting pay to specific staff groups, and the evidence from the Department of Health in Northern Ireland did not cover the issue. In general, however, Targeted Enhancement Recruitment Schemes seem to us to be a potentially helpful way to address specialism and geographical shortages.

10.49 On implementation of either specialty or geographic premia, we observe that the DDRB was not asked to make a recommendation on specific proposals before it was decided to introduce the existing premia in England for general practice, psychiatry and emergency medicine. We would support strongly the introduction of specialty premia in appropriate circumstances, particularly that proposed for histopathology. We would also strongly support the parties in their efforts to move forward the application of appropriately targeted geographic premia.

10.50 On the interaction between geographic and specialty shortages, it seems to us unlikely that any map will show a neat correspondence or relationship between the two. There may, for example, be pockets of specialty shortages in areas which, in geographical terms, could never be considered as hard-to-recruit parts of the country. And the reverse may also be true. The map of incentives is likely therefore to develop into a relatively complicated matrix, consisting of areas and points which may be hard to fill because of geography, or because of specialty, or both.

10.51 The work required to create the necessary maps of shortage specialties and areas, and deciding precisely how to target them, is and ought to be, a matter for employers in the NHS, with input from the medical trades unions. We saw little evidence that the required modelling work for England had yet been done, or at any rate in the detail which would be needed. The DDRB is keen to accommodate these systemic elements of pay into its decision making and urges the parties to undertake the required modelling work and produce associated evidence.

10.52 We would find it helpful in the evidence next year to receive reports on the impact of those premia already in place. The nature and the size of any such specialty or geographical premia should however be kept under regular review to ensure that they do not outlive their usefulness in relation to the specialties or geographies that they cover, and that the value of the premia is appropriately set so as to continue to generate the desired incentive effect. There may well be scope to expand existing premia further, but decisions on extension should be subject to the same careful review as decisions on continuation of the current schemes.

Consultants

10.53 In England the consultant workforce has doubled in size between 2000 and 2017. Some of this increase is the result of a conscious decision to change from a consultant-led service to a consultant-delivered service, and to grow consultant numbers in order to deliver that change. We also observe that, insofar as it is possible to measure it, NHS output has grown, but at a slower rate than growth in consultant numbers.

10.54 Despite the long-term increase in consultant numbers, the evidence demonstrates that there continue to be persistent vacancies at consultant level. In seeking the causes of this, one issue that has been raised with us is the taxation of pensions. We have heard some evidence that lowering the thresholds of the pensions annual and lifetime allowances are leading to some more experienced members of the workforce choosing to retire earlier than they would otherwise have done.

10.55 We observe that, while anecdotal evidence is readily available, the numerical evidence in support of this assertion is not currently strong, and that some of those nominally retiring could, for example, be continuing to serve in the NHS in other ways. A further element is that certain consultants in certain specialties and in certain locations may be able to benefit from private practice and this may be impacting on their decisions. More work needs to be done to understand the general picture. But to the extent that such further work confirms an emerging problem, we would suggest that the DHSC, the employers and the BMA get together to discuss how the NHS pensions schemes currently apply and what scope there may to be make changes to minimise adverse effects on those members of the remit group who are affected.

10.56 Overall however, we see no case at this stage for an uplift in the basic salary scales for consultants beyond our recommended minimum base increase of 2 per cent. Additional increases may become appropriate in the future if negotiations over a new contract for consultants deliver substantial productivity increases.

10.57 In 2012 we produced a report which proposed reform of Clinical Excellence Awards (CEAs). We are pleased to see that NHS Employers and the BMA have now been able to make progress towards implementing our 2012 recommendations in England, though there is still further to go. We recognise the merits of the changes that have been agreed to local CEAs by NHS Employers and the BMA as part of the wider on-going consultant contract negotiations, including changes that make new awards non-pensionable, and the increased investment ratio. We recognise that these arrangements, which have only recently been negotiated, need to be given time to bed down in order to deliver the productivity outcomes which they are designed to support, before further changes are made to implement our 2012 recommendations more fully.

10.58 In recent years we have recommended increasing the value of consultant awards in line with our main pay recommendation for consultants. We are clear that recognising performance through pay remains an established and important part of the pay system for consultants. We see no case for extending CEAs other than the increase which would flow as a result of the minimum base increase of 2 per cent which we are recommending for all salary scales, and which would apply equally to CEAs.

- **We recommend that the value of Clinical Excellence Awards, Distinction Awards and Discretionary Points increase in line with our recommendation for the basic consultant pay scales.**

Dentists

10.59 According to the data we saw, dentist numbers are steady, while figures showing access to and satisfaction with dental services are generally positive. The BDA told us that increased pressures in the NHS and a reduction in dental incomes mean there is a looming crisis in general dental practice. Despite this, we were told in oral evidence from NHS England that some partnerships were being bought on the open market for good prices, suggesting that owning a dental practice was still thought to be a sufficiently profitable business venture for dentists still to want to consider becoming contractors. However, the BDA challenged whether the prices paid represented the true earnings potential and that dental contracts were being handed back.

10.60 Although the headline income statistics show a reduction in dental incomes it is difficult to draw firm conclusions. The figures are based on headcount rather than full-time equivalents so may reflect changes in working patterns rather than income. Moreover, we understand that a small proportion of dentists choose to take incorporated status, which has an impact on whether income is classed as self-employment or dividend income. A further complication is that dentists, particularly in certain areas of the country, can supplement their income through private practice.

10.61 We have heard that reform of dental contracts is an issue across the UK as a whole. The proposed introduction of new contractual arrangements may improve the working conditions of dentists in the future, and we cannot rule out that this will have an impact on morale. We were told that new models of service provision had been piloted, some as far back as 2011, but we were given little evidence to help determine whether they were providing a suitable role model for the way(s) ahead. We expect to be kept informed of developments in this area and hope that at least in some parts of the UK the parties are able to reach agreement on the introduction of new arrangements.

10.62 On this occasion, as in previous years, we were struck by the relative absence of evidence or data to underpin any argument for recommendations going beyond the basic minimum increase we are recommending for the remit group in general. We will continue to monitor the situation, but we would ask the parties to consider what further firm data might be available. In the meantime, in the absence of evidence to justify particular targeting for dentists, we have concluded that pay net of expenses should be increased by the same basic increase as for the rest of the remit group, namely 2 per cent[2].

Pay policy and affordability

10.63 DDRB makes evidence-based pay recommendations and all four countries in the UK have asked for recommendations, which we have made on the basis of the evidence we have received. Each of the Governments asked us for independent advice, and it is for each of them to decide how they respond. They will each face their own local challenges.

10.64 We regard the market for doctors and dentists as, for the most part, a UK-wide one. We have not seen any evidence to suggest that our remit group faces fundamentally different issues in different national markets, so our pay recommendations have not distinguished between the constituent countries within the UK.

10.65 We have noted in this respect the Welsh Government's view that considerations of fairness dictate that pay should align across the UK for the individuals fulfilling equivalent roles across the UK NHS, and to avoid unhelpful internal competition for staff within the NHS workforce.

10.66 We have also noted that the pay policy in Scotland, devised for the public sector as a whole, relates to our remit group differentially. We have not sought to adjust our recommendations to take account of this. We have however noted that this different treatment may result in different outcomes for individual groups.

10.67 The Department of Health in Northern Ireland said that the 2016-17 pay policy as set by the previous Finance Minister continued to apply in 2017-18. In practical terms this may limit the extent to which any awards greater than 1 per cent may be implemented. We recognise the political circumstances in Northern Ireland currently present challenges to moving ahead in the development of policy in this area.

10.68 Clearly, proposals for pay increases imply spending money which is not then available for other health service priorities. Our remit groups do not comprise the largest element of NHS staff costs, but they are nevertheless significant. However, those who give us evidence regularly remind us that people are the most important asset for the NHS. The overall effectiveness of the service depends on recruiting, retaining and motivating adequate numbers of qualified staff, who can focus on caring for patients and on improving productivity. In that context, after nine years of pay awards no greater than 1 per cent, we are clear that increases of the order that we recommend this year are appropriate under the terms of our remit.

[2] In making our recommendation we follow the practice we adopted in 2016 of expressing our pay recommendations for GDPs net of expenses.

Gender pay gap

10.69 NHS Digital figures (Table 10.1) show a gender pay gap[3] across the NHS in England as a whole of 23 per cent, and of 15 per cent amongst medical staff as a group. The gender pay gap is much smaller when looking at individual staff groups, between 0 and 3 per cent for most medical staff groups. However, for the (closed) staff grade the gap is 12 per cent, suggesting that male staff are either on higher points on the pay scales, or more likely to get discretionary points than female staff. Although this group of staff is relatively small in overall terms, it raises questions about parity within a grade that has a high proportion of women.

Table 10.1: NHS HCHS gender pay gap, England, 2017

	Mean annual basic pay per FTE(1)		
	Male	**Female**	**Gap**
All staff	37,470	28,702	**23%**
Medical Staff	67,788	57,569	**15%**
Consultant (including Directors of Public Health)	91,254	89,435	**2%**
Associate Specialist	81,978	82,040	**0%**
Specialty Doctor	61,459	59,791	**3%**
Staff Grade	56,434	49,828	**12%**
Specialty Registrar	41,490	40,309	**3%**
Core Training	32,983	32,706	**1%**
Foundation Doctor Year 2	29,657	29,656	**0%**
Foundation Doctor Year 1	26,488	26,482	**0%**
Hospital Practitioner/Clinical Assistant	109,262	106,069	**3%**
Other and Local HCHS Doctor Grades	96,340	70,899	**26%**
AfC Staff	28,156	26,941	**4%**

Source: NHS Digital, provisional NHS staff earnings estimates

(1) Mean annual basic pay per FTE is the mean amount of basic pay paid per 1 Full-Time Equivalent post in a 12-month period.

10.70 We note that Professor Dame Jane Dacre, President of the Royal College of Physicians, has been chosen to lead a review of the gender pay gap in the NHS in England. We look forward to that review informing the evidence we receive in future years.

[3] Using mean basic pay per full-time equivalent.

CHAPTER 11: LOOKING FORWARD

11.1 In this final chapter we look ahead to some of the challenges facing our remit groups which we expect to see covered in evidence over the next few years.

Our 47th Report 2019

11.2 If the review body process is to work effectively it is important that all the parties strive to work to an agreed timetable. Much of the Government evidence for our 46th Report 2018 was delayed. This meant that there was a subsequent delay to the sharing of evidence by DDRB until all parties had submitted their evidence. Both the BMA and the BDA were concerned that the process was delayed to such an extent this year that they gave evidence to DDRB after the date on which any award would have been due. For our 47th Report 2019 we are seeking an early indication of when we can expect to receive evidence so that we can give a better indication of when we should be able to submit our report.

Economic outlook

11.3 Economic growth eased slightly, to 1.8 per cent in 2017 and the OBR forecast growth of 1.5 per cent in 2018 followed by two years of growth of 1.3 per cent. After growing through 2016 and 2017 price inflation is expected to continue to fall back through 2018, and CPI is forecast to stabilise at around 2 per cent. At the time of reporting average earnings were growing by around 2½ per cent, suggesting we may be about to enter a period of real-terms earnings growth.

11.4 There is always uncertainty attached to forecasting the outturn of the economy. But at this time, with major changes such as Brexit on the horizon, there is greater uncertainty than usual. In addition to affecting the wider economy this is an issue that has the potential to impact directly on our remit group as the UK looks to recruit doctors and dentists from overseas.

Affordability and productivity

11.5 It is clear that the financial challenges that have faced the NHS will continue over the coming years, and that these will be an important factor for us in our deliberations.

11.6 Through the Lord Carter of Coles Report, NHS Improvement highlighted the potential for the NHS to make efficiencies which could be worth £5 billion in terms of improved patient care in England. We look forward to hearing about progress made towards securing those improvements, and the role played by the doctors and dentists in our remit group in that process.

11.7 Labour productivity in the NHS has grown broadly in line with that of the wider economy. However, identifying the impact of those in our remit group on the overall output of the system is difficult, as the delivery of healthcare is a collaborative effort between those in our remit group and other NHS staff. We would welcome more detailed evidence showing the contribution of the various components of our remit group, and consultants in particular, towards improvements in productivity.

Workforce planning

11.8 Across the UK health departments are developing strategies to help them meet the demands of the future, especially the move towards improved integration of health and social care. We do not underestimate the difficulty of this task, especially given the uncertainty surrounding Brexit, the change in gender balance and the characteristics and behaviours of Generation 'Y'. We look forward to seeing in our evidence next year how these strategies are being developed and implemented and impacting on the provision of patient care.

Doctors and dentists in training

11.9 We have been told that all eligible trainees in England are now on the new contract (some, who have not changed post since 2016, remain on the old contract) and we look forward to hearing about the outcome of a review of the contract to be undertaken in line with an agreement reached at the Advisory, Conciliation and Arbitration Service (ACAS). We will also be interested to hear of any reform to the contract arrangements for doctors and dentists in training in other parts of the UK.

11.10 We look forward to receiving evidence about the effectiveness of the flexible pay premia in the junior doctors' contract in England. We would also welcome evidence or proposals that look at extending the range of pay premia to cover other specialties and the introduction of pay premia related to geography.

Specialty doctors and associate specialists

11.11 We were pleased to see that NHS Employers and the BMA included evidence for this report based on surveys about SAS doctors. We remain of the view that this is an important part of the NHS workforce that continues to play a key role in the provision of services but that they are often overlooked. We believe a review covering the roles, career structure, salary structure and developmental support available to SAS doctors is urgently needed.

11.12 We were also told about the introduction of Charters and development funds for SAS doctors, and we expect to receive updates on the impact they are having on the motivation and career development opportunities for this group.

Consultants

11.13 We were told this year of an agreement between the BMA and NHS Employers to change the local CEA scheme in England as part of wider discussions on the consultant contract. We expect to be kept informed of progress made in those negotiations and would be interested to hear about any reform to the contract arrangements for consultants in other parts of the UK.

General Medical Practitioners

11.14 The move to better integrate health and social care is placing new and greater demands on GMPs and the NHS is looking to increase the number of GMPs in the system. We were told that campaigns to recruit GMPs from overseas were in place across the UK. We expect to hear how successful those campaigns have been, and whether employers were able to recruit the numbers required. We also expect to hear about attempts to improve the retention of GMPs and improved understanding of the impact of the way that pension benefits are taxed.

11.15 In Scotland the Government and the BMA agreed a new General Medical Services contract from April 2018. We look forward to hearing from the parties about their experiences of introducing the new arrangements, whether the expected benefits are being realised, and if there are elements of the new contract that could be applied in other parts of the UK.

Dentists

11.16 We have heard again from the BDA that NHS dentistry has reached crisis point due to pay and workload issues. However, these reports continue to contrast with the assessments we receive from the health departments, which report improving access for patients and quality of care and an ability to be able to let competitive contracts for NHS dentistry. We are interested in hearing in more detail about the frequency with which dental contracts are returned to those commissioning dental services, and some assessment of how the value of dental practices has changed.

Pay

11.17 Issues that we will look to see covered in the future include:

- Data published since the introduction of the new contract for junior doctors showed an average increase in the earnings of doctors at the Foundation stage. We will look with interest to see if that becomes a trend or if the data starts to show greater variability;
- A full assessment of the impact of the pay premia already introduced as part of the junior doctors' contract and any further premia that are introduced;
- It may not be available until the evidence for our 2021 report, but we will be interested to see if the recommendations we made on the pay of GMPs actually feed through to the income figures for GMPs and if the introduction of the new General Medical Services contract in Scotland has an impact on GMP earnings;
- Attempts to develop a sound methodology that would allow the introduction of pay premia based on specific geographies;
- An assessment of the size of the gender pay gaps in our remit group, an explanation of why any gaps exist and any action planned.

Future data requirements

11.18 We very much welcome the progress being made on the provision of better pay and workforce data. 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. Several organisations and working groups provide us with such information, for which we are grateful.

11.19 Data gaps have emerged during this round, and Table 11.1 summarises these by UK country. We are interested in these data broken down by staff group, region, gender and age where possible. We are also particularly interested in time series of these data as this enables us to track changes over time.

Table 11.1 Data gaps by UK country

	England	Wales	Scotland	Northern Ireland
Paybill data (Chapter 3)	Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Sample career pathways.	Total health expenditure. Total medical paybill. Elements of paybill growth. Sample career pathways.
Locum use and rates (Chapter 3)	Information about the number of hours worked, type of work, pay rates, demographics and why people choose to do locum work.			
Productivity (Chapter 3)		Information about productivity in the NHS.	Information about productivity in the NHS.	Information about productivity in the NHS.
Workforce information (Chapter 4)	Average total earnings by FTE. Nationality of workforce by staff group.	Average earnings of medical staff by FTE, staff group. Nationality of workforce. Turnover by staff group.	Average earnings of medical staff by FTE, staff group. Nationality of workforce.	Average earnings of medical staff by FTE, staff group. Nationality of workforce.
Early retirement and pensions (Chapter 4)	Information and time series about the number of staff taking early retirement and whether they re-join the workforce. Withdrawals from the NHS pension scheme. Data on the impact of pension tax changes.			
Staff survey results by hospital medical and dental group (Chapters 4, 5, 6, 7)	Breakdown by age/sex and staff group.	Breakdown by staff group.	Breakdown by staff group.	Breakdown by staff group.
International recruitment and retention (Chapter 4)	Potential impact of Brexit and measures to mitigate the impact. Numbers, destinations and motivation of leavers, particularly of those who go overseas.			
Career choices for junior doctors (Chapter 5)	Average UCAS scores for those starting on medical and dental degrees. Career paths of junior doctors, understanding of why they make those choices.			

	England	Wales	Scotland	Northern Ireland
Vacancy rates (Chapters 4, 5, 6, 7, 8, 9)	Dentists in training; SAS Doctors; GMPs and GDPs.	Vacancy or shortfall rates across all remit groups. Junior doctor fill rates by region and specialism.	Junior doctor fill rates by region and specialism.	Vacancy or shortfall rates across all remit groups. Junior doctor fill rates by region and specialism.
SAS doctors (Chapter 6)	SAS Doctors recruitment and retention patterns. Use of the SAS Development Fund.			
Consultants (Chapter 7)	Consultant recruitment and retention patterns, including sources of recruitment.			
GMP and GDP motivation data (Chapters 8 and 9)	GMP and GDP motivation. Systematic data on salaried GMPs and GDPs.			
GMP and GDP earnings by FTE (Chapters 8 and 9)	Earnings by FTE (as well as headcount). Demographic information and working hours of GMPs. Number of consultations carried out. Timeseries of the value of dental clawback. NHS and private earnings split.			
Gender pay gap (Chapter 10)	Gender pay analysis. Relevant comparator group pay			

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APPENDIX A: REMIT LETTERS FROM THE PARTIES

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Professor Sir Paul Curran
Chair of DDRB
c/o Office of Manpower Economics
Fleetbank House
2-6 Salisbury House
EC4Y 8JX

21 September 2017

Dear Paul,

PUBLIC SECTOR PAY 2018 -19

1. Thank you for your work on the 2017/18 pay round. The Pay review Bodies continue to play an invaluable role in making independent, evidence-based recommendations on public sector pay awards. I am extremely grateful to you and your colleagues for your considered work. This letter sets out the Treasury's overarching approach for the 2018/19 pay round.

2. Our public-sector workers are among the most extraordinarily talented and hardworking people in our society. They, like everyone else, deserve to have fulfilling jobs that are fairly rewarded. The Government takes a balanced approach to public spending, dealing with our debts to keep our economy strong, while also making sure we invest in our public services.

3. The Government will continue to ensure that the overall package for public sector workers is fair to them and ensures that we can deliver world class public services while also being affordable within the public finances and fair to taxpayers as a whole.

4. The last Spending Review budgeted for a 1% average increase in basic pay and progression pay awards for specific work forces, and there will still be a need for pay discipline over the coming years, to ensure the affordability of the public services and the sustainability of public sector employment. However, the Government recognises that in some parts of the public sector, particularly in areas of skill shortage, more flexibility may be required to deliver world class public services including in return for improvements to public sector productivity.

5. As the Office for Budget Responsibility's Fiscal risks report published on 13 July reminds us, at nearly 90 per cent of GDP, our public debt is still too high. So, while continuing

to invest in and improve our public services, we must also maintain our ambition to reduce debt at a pace which is sensitive to the needs of the economy.

6. With a more flexible policy it is of even greater importance that recommendations on annual pay awards are based on independent advice and underpinned by robust evidence, submitted by departments, that takes into account the context of wider economic circumstances, private sector comparators, and overall remuneration of public sector workers (including progression pay and pension entitlements). the role of the Pay Review Bodies is therefore more important than ever.

7. The Government values hugely the role of the Pay Review Bodies and appreciates the length of time it takes to complete a thorough process. As you know, the forthcoming 2018/19 annual pay round also marks the shift to a Single Fiscal Event in the autumn which will delay your receipt of departmental evidence. The process will therefore run to a later timeline this year: a letter will follow this in due course from relevant Secretaries of State and written evidence will likely be received in December rather than September as is usual for most PRB workforces.

8. I realise that the change in timing will impact on when the Government can expect to receive your report and, as a consequence, on when individuals will receive their pay award. I recognise that this is far from ideal as our hard-working public servants are entitled to receive their awards promptly. However, on balance given the importance of the process and the change in timing that has already occurred, I feel it is important we work to a later timeline rather than considering the process. I hope that by making the timing clear at the beginning of the process workforces can be made aware, with plans put in place to work to a later timeline, and for you and your PRB members to manage your own time. The Office for Manpower Economics will be able to support you in this but, do get in touch if you have concerns in this regards.

9. I appreciate that you may have further questions about this change in approach and I would be pleased to discuss this further when we meet soon. I look forward to working with you over the coming years.

Best wishes,

RT HON ELIZABETH TRUSS MP

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

39 Victoria Street
London
SW1H 0EU

Mb-sofs@dh.gsi.gov.uk

Professor Sir Paul Curran
Chair Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

7 December 2017

Dear Professor Curran,

I am writing firstly to express my thanks for your valuable work on the 2017-18 pay round and secondly, to formally commence the 2018-19 pay round.

The Chief Secretary to the Treasury wrote to you in September setting out the Government's overall approach to pay. That letter confirmed that the Government has adopted a more flexible approach to public sector pay, to address any areas of skills shortages and in return for improvements to public sector productivity. The last Spending Review budgeted for one per cent average basic pay awards, in addition to progression pay for specific workforces, and there will still be a need for pay discipline over the coming years to ensure the affordability of the public service and the sustainability of public sector employment; review bodies should continue to consider affordability when making their recommendations.

You are invited to make recommendations in relation to the employed medical workforce about targeting funding to support productivity and recruitment and retention. We would like you to consider how resources might be targeted, including: through the existing mechanisms of the flexible pay premier in the contract for doctors and dentists in training, taking account of views from Health Education England on hard-to-fill training programmes; and as a response to discussions between NHS Employers and the BMA on reform of the consultant contract, where the expectation is that the parties – the BMA and NHS Employers – will update you on the progress of negotiations. The parties

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Department of Health

will also update you on the progress of negotiations with the GPC and other discussions with independent contractors in relation to expenses.

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.

JEREMY HUNT

Vaughan Getting AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health & Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/4168/17

Professor Paul Curran
Chair, Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
6th Floor
Victoria House
London
WC1B 4AD
By Email: Neil.Higginbottom@beis.gov.uk

21 December 2017

Dear Professor Curran

Doctors and Dentists Remuneration Review Body remit for Wales 2018-19

Thank you for the DDRB work on the 2017-18 pay round. I am writing to formally commence the 2018-19 pay round for medical and dental staff in Wales.

In this pay round, I would like you to consider evidence and make recommendations on two questions:

- What would be a fair pay award for medical and dental staff in Wales?; and
- Taking into account your recommendations on a fair pay award, and the very challenging financial circumstances of the Welsh Government, what level of pay award could be afforded by the NHS in Wales in the absence of further funding from the UK Treasury?

Your advice and recommendations on these two questions will enable me to determine a fair pay award for medical and dental staff in Wales, and to seek a sufficient transfer of funding from the UK Government to Wales to enable us to fund that award and protect patient services.

In order to support your work, I intend to provide evidence to the Pay Review Bodies in the New Year and for my officials to attend the planned oral evidence sessions.

I would like to receive your advice and recommendations before the end of March 2018 to ensure that payment of any award to hard pressed NHS staff is not unduly delayed.

I have seen the remit letters issues by the Secretary of State for health in England which conflate issues about fair pay for the NHS workforce with discussions about contractual reforms. I am not convinced that linking these issues is either helpful nor is it clear how the sequencing of this will work without compromising the process and timetable of the pay review bodies. I have asked

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officials to discuss these letters with the Department of Health so that we can understand how any contractual reform discussions will align with the Pay Review process in England.

The NHS across the four UK nations benefits from a degree of mobility within the workforce, which supports flexibility in recruitment, ease of movement for career development and training and to ensure equity for professional staff working across the UK. This means it is essential that employers and staff side representatives from Wales are aware of contractual negotiations and are able to determine how to effectively represent the view and interests of Wales. We will also be seeking early discussions with the Department of Health on this matter.

I look forward to receiving your advice and recommendations in March.

Vaughan Getting AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health & Social Service

Cabinet Secretary for Health and Sport
Shona Robison MSP

T: 0300 244 4000
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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 Salisbury Square
LONDON EC4Y 8JX

7 February 2018

Dear Prof Curran,

Further to my letter of 8 January, I am now pleased to present you with our remit and evidence for employed doctors and dentists for the 2018 pay round, which we would like you to consider.

As previously advised, the Cabinet Secretary for Finance and the Constitution announced the Scottish Government's Public Sector Pay Policy for 2018-19 on 14 December 2017 as part of his draft budget announcements. Stage 1 of the draft budget took place in Parliament on 31 January and there was a change to the Scottish Public Sector Pay Policy which will impact on the information we included in our previous letter to you. The revised pay policy summarised below provides the basis for the remit we would now like you to consider. It is a single year policy and sets out the parameters for pay increases for staff.

With regard to Pay Review Body interests, the main features of this policy are:

- lifting the pay cap by providing a guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent on the increase in baseline payroll for those earning above £36,500 and below £80,000;
- limiting the maximum pay increase for those earning £80,000 or more to £1,600;
- continuation of the policy commitment to No Compulsory Redundancy.

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 2018-19.

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 a new formula for allocating funds to GP practices based on the 2016 review of the Scottish Allocation formula, and an updated and improved methodological approach. The BMA is currently polling the profession on this and other proposed changes to the GMS contract with a view to these changes coming into effect in April 2018. Details of the contract offer can be found at: http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract.

For General Dental Practitioners we are seeking a recommendation on the pay element only. As DDRB are aware the Scottish Government has in previous years commissioned information on expenses. In view of DDRB's request last year that we take forward the expenses element ourselves, we intend to undertake another exercise for the 2018/19 pay round which will form the basis for discussion with the BDA's Scottish Dental Practice Committee.

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

SHONA ROBISON

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Upper Newtownards Road
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Tel: 02890520559
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Email: richard.pengelly@health-ni.gov.uk

Our ref: RP1784

Date: 18 December 2017

Professor Sir Paul Curran
Chair of the Review body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email: Neil.Higginbottom@beis.gov.uk

Dear Sir Paul,

2018/19 Pay Recommendations

I am writing to submit my Department's evidence to the Pay Review Body, to assist you in the task of providing recommendations for Northern Ireland in relation to the 2018/19 pay round.

I wish to advise that the Department of Finance has agreed that the 2016/17 Public Sector Pay Policy that was set by the previous Finance Minister, will continue to apply in 2017/18. This, in keeping with the overarching HM Treasury policy on UK public sector pay this year, will limit pay increases to 1 per cent. This determination, announced on 13 December, together with the recent allocation of £26million, now allows the Department of Health to implement the 1% pay award for health and social care workers.

I would also like to take this opportunity to thank all members of the Pay Review Body for the important work that you continue to carry out in making independent, evidence-based recommendations on pay awards for the medical and dental workforce.

I am copying this letter to the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland, the Minister for Health, Social Services in Wales, and Staff Side representatives.

Yours sincerely

RICHARD PENGELLY

Working for a Healthier People

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN ENGLAND

SALARY SCALES[1]

The salary scales that we recommend apply from 1 April 2018 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics website.

A. Basic pay scales and awards

	2017	2018
	£	£
Doctors in training (2016 contract)		
Foundation doctor – year 1	26,614	27,146
Foundation doctor – year 2	30,805	31,422
Core/Run-through training – year 1 & 2	36,461	37,191
Core/Run-through/Higher training – year 3 +	46,208	47,132
Specialty doctor (2008 contract)	37,923	39,250
	41,165	42,606
	45,381	46,969
	47,640	49,307
	50,895	52,676
	54,138	56,033
	57,453	59,464
	60,770	62,897
	64,086	66,329
	67,402	69,761
	70,718	73,193
Associate specialist (2008 contract)	53,169	55,030
	57,444	59,454
	61,716	63,876
	67,359	69,717
	72,251	74,780
	74,280	76,880
	76,928	79,620
	79,576	82,361
	82,224	85,101
	84,871	87,842
	87,521	90,585

[1] Our recommended basic pay uplifts, to be applied from 1 April 2018, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2017	2018
	£	£
Staff grade practitioner	35,133	36,363
(1997 contract, MH03/5)	37,923	39,250
	40,711	42,136
	43,500	45,023
	46,289	47,910
	49,573	51,308
Discretionary points	*Notional scale*	
	51,867	53,682
	54,655	56,568
	57,444	59,455
	60,234	62,342
	63,022	65,228
	65,812	68,116
Consultant (2003 contract)	76,761	78,296
	79,165	80,748
	81,568	83,200
	83,972	85,652
	86,369	88,097
	92,078	93,919
	97,787	99,743
	103,490	105,560
Clinical Excellence Awards (local)		
Level 1	3,016	3,077
Level 2	6,032	6,154
Level 3	9,048	9,231
Level 4	12,064	12,308
Level 5	15,080	15,385
Level 6	18,096	18,462
Level 7	24,128	24,616
Level 8	30,160	30,770
Level 9	36,192	36,924
Salaried General Medical Practitioner range		
Minimum	56,525	58,786
Maximum	85,298	88,709
Dental foundation training	31,355	31,982
Dentists in training (2016 contract)		
Foundation dentist – year 1	26,614	27,146
Foundation dentist – year 2	30,805	31,422
Dental core training – year 1 & 2	36,461	37,191
Dental core & specialty training – year 3 +	46,208	47,132

	2017	2018
	£	£
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	38,861	39,638
	43,178	44,042
	49,655	50,648
	52,894	53,951
	56,132	57,255
	58,291	59,457
Band B: Salaried dentist[2]	60,450	61,659
	62,609	63,861
	65,847	67,164
	67,466	68,815
	69,085	70,467
	70,704	72,119
Band C: Salaried dentist[3, 4]	72,324	73,770
	74,483	75,972
	76,641	78,174
	78,800	80,376
	80,959	82,578
	83,118	84,780

B. Pay premia

	2017	2018
	£	£
Flexible pay premia – doctors and dentists in training (2016 contract)		
General practice	8,282	8,448
Psychiatry core training	3,367	3,434
Psychiatry higher training (3 year)	3,367	3,434
Psychiatry higher training (4 year)	2,525	2,576
Academia	4,040	4,121
Emergency medicine/Oral & maxillofacial surgery		
3 years	6,734	6,868
4 years	5,050	5,151
5 years	4,040	4,121
6 years	3,367	3,434
7 years	2,886	2,944
8 years	2,525	2,576

London weighting

The value of the London zone payment[5] is unchanged at £2,162 for non-resident staff and £602 for resident staff.

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[2] The first salary point of Band B is also the extended competency point at the top of Band A.
[3] The first salary point of Band C is also the extended competency point at the top of Band B.
[4] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.
[5] *Thirty-Sixth Report.* Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

SALARY SCALES[6]

The salary scales that we recommend apply from 1 April 2018 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics website.

Basic pay scales and awards

	2017	2018
	£	£
Foundation house officer 1 (2015 contract)	23,091	23,553
	24,532	25,023
	25,974	26,493
Foundation house officer 2 (2015 contract)	28,641	29,213
	30,514	31,124
	32,387	33,034
Specialty registrar (full)	30,606	31,217
	32,478	33,127
	35,094	35,795
	36,676	37,408
	38,582	39,354
	40,491	41,300
	42,399	43,247
	44,307	45,193
	46,215	47,139
	48,124	49,086
Specialty doctor	37,923	39,250
	41,166	42,606
	45,381	46,969
	47,640	49,307
	50,895	52,676
	54,139	56,033
	57,453	59,464
	60,770	62,897
	64,087	66,329
	67,402	69,761
	70,719	73,193

[6] Our recommended basic pay uplifts, to be applied from 1 April 2018, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2017	2018
	£	£
Associate specialist (2008)	53,170	55,030
	57,444	59,454
	61,717	63,876
	67,360	69,717
	72,251	74,780
	74,280	76,880
	76,928	79,620
	79,576	82,361
	82,224	85,101
	84,872	87,842
	87,522	90,585
Staff grade practitioner	35,134	36,363
(1997 contract, MH03/5)	37,923	39,250
	40,712	42,136
	43,500	45,023
	46,290	47,910
	49,573	51,308
Discretionary points	*Notional scale*	
	51,867	53,682
	54,656	56,568
	57,445	59,455
	60,234	62,342
	63,022	65,228
	65,813	68,116
Consultant (2003 contract)	74,393	75,881
	76,762	78,296
	80,725	82,339
	85,327	87,034
	90,583	92,394
	93,580	95,451
	96,583	98,514
Commitment awards[7]	3,270	3,334
	6,538	6,668
	9,807	10,002
	13,075	13,336
	16,343	16,670
	19,612	20,004
	22,880	23,338
	26,148	26,672

[7] Awarded every three years once the basic scale maximum is reached.

	2017 £	2018 £
Salaried General Medical Practitioner range		
Minimum	56,525	58,787
Maximum	85,298	88,710
Dental foundation training	31,044	31,665
Dental core training	28,783	29,358
	30,665	31,278
	32,548	33,197
	34,430	35,117
	36,311	37,037
	38,194	38,957
	40,076	40,876
Salaried primary care dental staff (2008 contract)		
Band A: Salaried dentist	38,861	39,638
	43,179	44,042
	49,656	50,648
	52,894	53,951
	56,132	57,255
	58,292	59,457
Band B: Salaried dentist[8]	60,450	61,659
	62,609	63,861
	65,847	67,164
	67,466	68,815
	69,086	70,467
	70,705	72,119
Band C: Salaried dentist[9, 10]	72,325	73,770
	74,483	75,972
	76,642	78,174
	78,801	80,376
	80,960	82,578
	83,118	84,780

[8] The first salary point of Band B is also the extended competency point at the top of Band A.
[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.

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

SALARY SCALES[11]

The salary scales that we recommend apply from 1 April 2018 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics website.

Basic pay scales and awards

	2017	2018
	£	£
Foundation house officer 1	23,672	24,145
	25,149	25,652
	26,626	27,159
Foundation house officer 2	29,361	29,948
	31,281	31,906
	33,201	33,865
Specialty registrar (full)	31,220	31,845
	33,131	33,793
	35,799	36,515
	37,412	38,160
	39,358	40,145
	41,305	42,131
	43,251	44,116
	45,197	46,101
	47,144	48,087
	49,091	50,073
Specialty doctor	38,685	40,039
	41,993	43,462
	46,293	47,913
	48,597	50,298
	51,918	53,735
	55,226	57,159
	58,608	60,659
	61,991	64,161
	65,374	67,662
	68,756	71,163
	72,140	74,664

[11] Our recommended basic pay uplifts, to be applied from 1 April 2018, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2017	2018
	£	£
Associate specialist (2008 contract)	54,238	56,136
	58,598	60,649
	62,957	65,160
	68,713	71,118
	73,703	76,283
	75,773	78,425
	78,474	81,220
	81,175	84,016
	83,876	86,812
	86,577	89,608
	89,281	92,405
Staff grade practitioner	35,840	37,094
(1997 contract)	38,685	40,039
	41,529	42,983
	44,375	45,928
	47,220	48,873
	50,570	52,339
Discretionary points	*Notional scale*	
	52,909	54,761
	55,754	57,705
	58,599	60,650
	61,444	63,595
	64,289	66,539
	67,135	69,485
Consultant (2004 contract)	78,304	79,870
	80,756	82,371
	83,208	84,872
	85,660	87,373
	88,105	89,867
	93,928	95,807
	99,752	101,747
	105,570	107,681
Discretionary points for consultants	3,204	3,268
	6,408	6,536
	9,612	9,804
	12,816	13,072
	16,020	16,340
	19,224	19,608
	22,428	22,876
	25,632	26,144

	2017 £	2018 £
Salaried General Medical Practitioner range		
Minimum	56,525	58,786
Maximum	85,298	88,709
Dental core training[12]	34,674	35,368
Dental senior house officer/Senior house officer	29,361	29,948
	31,281	31,906
	33,201	33,865
	35,121	35,823
	37,041	37,781
	38,960	39,740
	40,880	41,698
Salaried primary care dental staff (2008 contract)		
Band A: Dental officer	39,642	40,435
	44,047	44,928
	50,654	51,667
	53,957	55,036
	57,261	58,406
	59,463	60,652
Band B: Senior dental officer	61,666	62,899
	63,868	65,145
	67,170	68,514
	68,823	70,199
	70,475	71,885
	72,126	73,568
Band C: Assistant clinical director	73,778	75,254
	75,980	77,500
	78,182	79,746
Band C: Specialist dental officer	73,778	75,254
	75,980	77,500
	78,182	79,746
	80,385	81,993
Band C: Clinical director/Chief administrative	73,778	75,254
dental officers	75,980	77,500
	78,182	79,746
	80,385	81,993
	82,587	84,239
	84,790	86,486

[12] On completion of core training employees will move to the nearest point on or above their existing salary on the dental senior house officer scale.

APPENDIX B4: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

SALARY SCALES[13]

The salary scales that we recommend apply from 1 April 2018 for full-time hospital and community doctors and dentists and are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

Further recommended pay scales, allowances and fees, including those for previous contracts, can be found on the Office of Manpower Economics website.

Basic pay scales and awards

	2017	2018
	£	£
Foundation house officer 1	23,091	23,553
	24,532	25,023
	25,973	26,493
Foundation house officer 2	28,641	29,213
	30,513	31,124
	32,386	33,034
Specialty registrar (full)	30,605	31,217
	32,478	33,127
	35,093	35,795
	36,675	37,408
	38,582	39,354
	40,491	41,300
	42,400	43,247
	44,307	45,193
	46,215	47,139
	48,123	49,086
Specialty doctor	37,923	39,250
	41,166	42,606
	45,381	46,969
	47,640	49,307
	50,895	52,676
	54,138	56,033
	57,453	59,464
	60,770	62,897
	64,086	66,329
	67,402	69,761
	70,718	73,193

[13] Our recommended basic pay uplifts, to be applied from 1 April 2018, are applied to unrounded current salaries (November 2007 is the base year date for most staff groups), with the final result being rounded up to the nearest pound.

	2017	2018
	£	£
Associate specialist (2008 contract)	53,169	55,030
	57,444	59,454
	61,716	63,876
	67,359	69,717
	72,250	74,780
	74,279	76,880
	76,928	79,620
	79,576	82,361
	82,223	85,101
	84,871	87,842
	87,522	90,585
Staff grade practitioner	35,133	36,363
(1997 contract)	37,922	39,250
	40,711	42,136
	43,500	45,023
	46,289	47,910
	49,573	51,308
Discretionary points	*Notional scale*	
	51,867	53,682
	54,655	56,568
	57,445	59,455
	60,233	62,342
	63,022	65,228
	65,813	68,116
Consultant (2004 contract)	76,761	78,296
	79,165	80,748
	81,569	83,200
	83,972	85,652
	86,369	88,097
	92,078	93,919
	97,787	99,743
	103,491	105,560
Clinical Excellence Awards (local)		
Step 1	2,957	3,016
Step 2	5,914	6,032
Step 3	8,871	9,048
Step 4	11,828	12,064
Step 5	14,785	15,080
Step 6	17,742	18,096
Step 7	23,656	24,128
Step 8	29,570	30,160

	2017 £	2018 £
Salaried General Medical Practitioner range		
Minimum	55,966	58,786
Maximum	84,453	88,709
Salaried primary care dental staff		
Band 1: Salaried dentist	35,667	36,380
	38,552	39,323
	41,436	42,266
	44,324	45,210
	47,209	48,153
	50,094	51,096
	52,980	54,039
	55,866	56,984
Band 2: Senior salaried dentist	50,968	51,986
	55,002	56,101
	59,035	60,215
	63,068	64,330
	67,102	68,444
	67,992	69,352
	68,881	70,258
Band 3: Assistant clinical director salaried dentist	67,727	69,081
	68,775	70,150
	69,822	71,219
	70,871	72,288
	71,919	73,357
	72,967	74,427
Band 4: Clinical director salaried dentist	67,727	69,081
	68,775	70,151
	69,822	71,219
	70,871	72,288
	71,919	73,357
	72,967	74,427
	74,016	75,497
	75,082	76,583
	76,130	77,652
	77,178	78,721

APPENDIX B5: OTHER FEES AND ALLOWANCES

Operative date

1. The levels of remuneration set out below are recommended to apply from 1 April 2018.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards (CEAs) for consultants and academic General Medical Practitioners should be increased as follows:

	England and Wales[14]		Northern Ireland[15]	
	2017	2018	2017	2018
	£	£	£	£
Level 9 (Bronze)	36,192	36,924	35,484	36,192
Level 10 (Silver)	47,582	48,533	46,644	47,577
Level 11 (Gold)	59,477	60,666	58,305	59,471
Level 12 (Platinum)	77,320	78,866	75,796	77,312

3. The annual values of Distinction Awards for consultants[16] should be increased as follows:

	England and Wales		Scotland and Northern Ireland	
	2017	2018	2017	2018
	£	£	£	£
B award	32,601	33,253	31,959	32,598
A award	57,048	58,189	55,924	57,042
A+ award	77,415	78,963	75,889	77,407

General Medical Practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[17, 18] of basic salary.

5. The value of the GP trainer grant should be increased from £7,908 to £8,225.

6. The value of the GP appraiser fee should be increased from £500 to £520.

[14] Awarded by the Advisory Committee on Clinical Excellence Awards (ACCEA).
[15] Awarded by the Northern Ireland Clinical Excellence Awards Committee (NICEAC).
[16] From October 2003 in England and Wales, and from 2005 in Northern Ireland, national CEAs have replaced Distinction Awards. Distinction Awards are the current scheme in Scotland. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA.
[17] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.
[18] Doctors employed on the 2016 Junior Doctors contract in England will not receive this supplement but may be eligible for the General Practice Flexible Pay Premia instead.

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NHS IN THE UNITED KINGDOM [1]

ENGLAND [2]	2015		2016		Percentage change 2015 - 2016	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff [3]						
Consultants	42,903	45,349	44,333	46,955	3.3%	3.5%
Associate specialists	2,416	2,727	2,212	2,483	-8.4%	-8.9%
Specialty doctors	6,064	7,156	6,238	7,337	2.9%	2.5%
Staff grades	402	478	382	455	-5.0%	-4.8%
Registrar group	29,458	30,569	29,857	30,999	1.4%	1.4%
Foundation house officers 2 [4]	6,576	6,626	6,538	6,593	-0.6%	-0.5%
Foundation house officers 1 [5]	6,364	6,391	6,189	6,217	-2.7%	-2.7%
Other doctors in training	8,910	9,047	8,991	9,129	0.9%	0.9%
Hospital practitioners/ Clinical assistants	489	1,762	511	1,748	4.4%	-0.8%
Other staff	917	1,407	881	1,328	-3.9%	-5.6%
Total	**104,498**	**111,127**	**106,131**	**112,875**	**1.6%**	**1.6%**
General Medical Practitioners [6]	**34,025**	**40,648**	**33,804**	**40,490**	**-0.7%**	**-0.4%**
GMP providers	21,937	24,826	21,163	23,937	-3.5%	-3.6%
General practice specialty registrars [7]	4,729	4,996	5,273	5,503	11.5%	10.1%
GMP retainers [8]	67	155	72	171	8.0%	10.3%
Other GMPs	7,292	10,775	7,295	10,988	0.0%	2.0%
General Dental Practitioners [9, 10, 11]		**24,089**		**24,007**		**-0.3%**
General Dental Services only		19,976		20,046		0.4%
Personal Dental Services only		1,709		1,625		-4.9%
Mixed		1,543		1,542		-0.1%
Trust-led		861		794		-7.8%
Ophthalmic medical practitioners [12]		**245**		**217**		**-11.4%**
Total general practitioners		**64,982**		**64,714**		**-0.4%**
Total - NHS doctors and dentists		**176,109**		**177,589**		**0.8%**

[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 at 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.
[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. Data excludes locums.
[7] Were formerly 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]	2015		2016		Percentage change 2015 - 2016	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff [14]						
Consultants	2,359	2,499	2,430	2,564	3.0%	2.6%
Associate specialists	282	320	267	304	-5.3%	-5.0%
Specialty doctors	508	607	517	605	1.7%	-0.3%
Staff grades	4	7	5	7	18.2%	0.0%
Specialist registrars	1,996	2,088	2,072	2,180	3.8%	4.4%
Foundation house officers 2 [15]	533	546	498	511	-6.6%	-6.4%
Foundation house officers 1 [16]	393	416	397	417	1.1%	0.2%
Hospital practitioners	2	8	2	6	-15.0%	-25.0%
Clinical assistants	9	51	8	35	-4.7%	-31.4%
Other staff [17]	34	85	36	88	7.9%	3.5%
Total	**6,120**	**6,627**	**6,233**	**6,717**	**1.8%**	**1.4%**
General Medical Practitioners		**2,253**		**2,260**		**0.3%**
GMP providers		1,997		2,009		0.6%
General practice specialty registrars		231		232		0.4%
GMP retainers		25		19		-24.0%
General Dental Practitioners [18]		**1,470**		**1,475**		**0.3%**
General Dental Services only		1,185		1,207		1.9%
Personal Dental Services only		79		77		-2.5%
Mixed		110		101		-8.2%
Ophthalmic medical practitioners [19]		**7**		**6**		**-14.3%**
Total general practitioners		**3,730**		**3,741**		**0.3%**
Total - NHS doctors and dentists		**9,850**		**9,974**		**1.3%**

[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 mainly of dental officers.
[18] Data as of 31 March of the following year.
[19] Data as of 31 December of that year.

SCOTLAND [20]	2015		2016		Percentage change 2015 - 2016	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff						
Consultants	5,101	5,456	5,304	5,698	4.0%	4.4%
Specialty doctors	1,056	1,490	954	1,297	-9.7%	-13.0%
Registrar group	4,099	4,268	4,076	4,266	-0.6%	0.0%
Foundation house officers 2 [21]	877	915	877	911	-0.1%	-0.4%
Foundation house officers 1 [22]	1,211	1,267	1,153	1,208	-4.8%	-4.7%
Other staff	467	961	755	1,317	61.6%	37.0%
Total	**12,812**	**14,357**	**13,118**	**14,697**	**2.4%**	**2.4%**
General Medical Practitioners		**4,938**		**4,913**		**-0.5%**
GMP providers		3,657		3,568		-2.4%
General practice specialty registrars [23]		492		500		1.6%
GMP retainers [24]		113		87		-23.0%
Other GMPs		692		773		11.7%
General Dental Practitioners (non-hospital) [25]		**3,227**		**3,269**		**1.3%**
General Dental Service		2,910		2,972		2.1%
Public Dental Service		438		425		-3.0%
Ophthalmic medical practitioners		**30**		**23**		**-23.3%**
Total general practitioners		**8,195**		**8,205**		**0.1%**
Total - NHS doctors and dentists		**22,448**		**22,786**		**1.5%**

[20] Data as at 30 September of that year.
[21] Includes senior house officers.
[22] Includes house officers.
[23] Were formerly known as GMP registrars.
[24] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[25] Includes salaried, community and public dental service dentists.

NORTHERN IRELAND [26]	2015		2016		Percentage change 2015 - 2016	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff [27, 28]						
Consultant	1,613	1,711	1,666	1,770	3.3%	3.4%
Associate specialist/Specialty doctor/Staff grade	430	519	441	531	2.5%	2.3%
Specialty/Specialist registrar	1,289	1,323	1,309	1,343	1.5%	1.5%
Foundation/Senior house officer	530	533	542	544	2.3%	2.1%
Other [29]	140	292	140	293	0.2%	0.3%
Total	**4,002**	**4,378**	**4,098**	**4,481**	**2.4%**	**2.4%**
General Medical Practitioners [30]		**1,274**		**1,297**		**1.8%**
General Dental Practitioners [31, 32]		**1,022**		**1,066**		**4.3%**
Ophthalmic medical practitioners [33]		**11**		**11**		**0.0%**
Total general practitioners		**2,307**		**2,374**		**2.9%**
Total - NHS doctors and dentists		**6,685**		**6,855**		**2.5%**

[26] As at 30 September unless otherwise specified.
[27] Some hospital practitioners and clinical assistants also appear as General Medical Practitioners, General Dental Practitioners or ophthalmic practitioners.
[28] Data as at March of the following year.
[29] Due to changes in the collection of staff groups data, the 'other' category is not consistent across year groups and should not be compared with previous years.
[30] Data as October of that year.
[31] Data as April the following year.
[32] It is possible for someone to be a dentist in one location and an assistant at another location. The final total will not represent individual people.
[33] Data 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 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 took over commissioning from primary care trusts in England.

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, with the exception of the local Clinical Excellence Awards in England awarded from March 2018 onwards. 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 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, higher education, pharmaceutical and veterinary.

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 remain 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 remain 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, centred 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 of 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 staff 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 (Geography) 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 RETAINER – a general medical practitioner, who provides service sessions in general practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

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 for 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) – 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 associate dentist. 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 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 social 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.

APPENDIX E: THE DATA HISTORICALLY USED IN OUR FORMULA-BASED DECISIONS FOR INDEPENDENT CONTRACTOR GMPs AND GDPs

E.1 This appendix supports Chapters 8 and 9 and gives the latest data that would have populated the formula for both GMPs and GDPs, had we used the formula-based approach (Table E.1).

E.2 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.1 the data that would have populated the formula. 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.1: Data historically used in our formula-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) *DDRB recommendation*	4.0%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2017 (general medical practice activities)*	0.8%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2017*	4.1%
Income (GDPs) *DDRB recommendation*	2.0%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2017 (dental practice activities)*	3.2%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2017*	4.1%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2017*	4.1%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2017*	4.0%
Other costs (GDPs) Scotland *RPIX for Q4 2017*	4.1%

Sources: Annual Survey of Hours and Earnings (Table 16.5a), Consumer Price Inflation Time Series (CDKQ, CZBH).

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACAS	Advisory, Conciliation and Arbitration Service
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
BAME	Black, Asian and Minority Ethnic
BDA	British Dental Association
BMA	British Medical Association
CCG	Clinical Commissioning Group
CDS	Community Dental Service
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
CPIH	Consumer Prices Index including owner occupiers' housing costs
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
DHSC	Department of Health and Social Care (England)
DLHE	Destination of Leavers of Higher Education
DWP	Department for Work and Pensions
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
HCSA	Hospital Consultants and Specialists Association
HEE	Health Education England
HESA	Higher Education Statistics Agency
HMRC	Her Majesty's Revenue and Customs
HSCNI	Health and Social Care Northern Ireland
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 for 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
SDAI	Scottish Dental Access Initiative
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 G – PREVIOUS DDRB RECOMMENDATIONS AND THE GOVERNMENT'S 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
2008	2.2% to 3.4%	4.3	2.1	Accepted
2009	1.5%	3.0****	4.1	Accepted

[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
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	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%	2.2 Q4	1.2 Q4	Accepted with the exception of uplifts to CEAs, discretionary points and distinction awards in Scotland and Northern Ireland.
2018	2%	4.0 Q4#	3.0 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%)

Due to the late running of the round, DDRB was also able to take account of the Q1 2018 RPI (3.7%) and CPI (2.7%) figures.

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