Review Body on Doctors' and Dentists' Remuneration

Thirty-Eighth Report 2009

Chairman: Ron Amy, OBE

Cm 7579

£26.60

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

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

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

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

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Review Body on Doctors' and Dentists' Remuneration

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

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

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

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

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

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

the government's inflation target;

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

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

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

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

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

The members of the Review Body are:

Ron Amy, OBE *(Chairman)*	Professor John Beath
Dr Margaret Collingwood	Katrina Easterling
David Grafton	Sally Smedley[1]
Professor Alasdair Smith	David Williamson

The Secretariat is provided by the Office of Manpower Economics.

[1] Sally Smedley was appointed to the Review Body by the Secretary of State for Health from May 2008.

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SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. In this report we make recommendations for the annual pay increase for some 187,000 doctors and dentists comprising 41,000 consultants, 18,000 specialty doctors, associate specialists, staff grades and others, 57,000 doctors and dentists in training, 44,000 general medical practitioners and 25,000 general dental practitioners. We have considered extensive written and oral evidence from the Health Departments for England, Wales, Scotland and Northern Ireland, from NHS Employers, the British Medical Association, the British Dental Association, the Dental Practitioners Association and other interested parties.

2. This has been a particularly difficult round because we have been taking evidence and considering our recommendations against the background of an unexpectedly sharp downturn in the economy, with the United Kingdom moving into what some commentators think may turn out to be a prolonged recession. Unemployment is rising steeply and some employers in the private sector have announced pay freezes or short-time working. Around the time that evidence was submitted, inflation was at its peak: in September 2008 it was 5 per cent on the Retail Prices Index (RPI) measure and 5.2 per cent on the Consumer Prices Index (CPI) measure, but has since fallen sharply. The annual rate of change in the RPI was 0.1 per cent in January 2009 and for the CPI 3.0 per cent. The Treasury is forecasting that the annual rate of retail price inflation will fall to minus 2.25 per cent by the fourth quarter of 2009 while the rate of consumer price inflation will then be at 0.5 per cent. The CPI inflation rate is expected to move slightly above the 2 per cent target in 2010 and return to its target level in 2011. The government forecasts that economic recovery will begin in the second half of 2009, with growth picking up further in 2010 and 2011. Most independent commentators forecast that the recovery will not start in 2009.

3. The rapid shift in the state of the economy over the recent past and the prospects for the immediate future significantly affect the relative position of our remit groups. The economic downturn has already had quite severe consequences for employment and job security across the private sector. Employment in the public sector has therefore become more attractive, combining a high degree of job security with a state-backed, defined benefit pension. It is important to note that the written evidence that we have received was largely prepared in the summer and early autumn of 2008. It was clear, even then, that the recruitment and retention of doctors and dentists was satisfactory overall, with only minor, localised shortages in a few categories.

4. Having considered all the evidence and the matters we are required by our terms of reference to take into account, we have come to an independent judgement drawing on the collective knowledge and experience of the review body members. Doctors and dentists working for the NHS have relatively secure employment and are likely to be much less affected by the economic downturn. In the highly unusual economic circumstances this year and with the majority of doctors and dentists on new, modernised contracts, we have come to the conclusion that only modest increases are justified. **We recommend for 2009-10 a base increase of 1.5 per cent to the national salary scales for doctors and dentists** (paragraph 2.19).

5. We recognise that our recommendation may be below what the parties are expecting. However, taking into account the economic and other evidence provided by the parties as well as the various aspects of our remit, we consider this to be a fair and reasonable uplift. In the current exceptional and rapidly changing circumstances, we believe that a general increase of 1.5 per cent will be sufficient to recruit, retain and motivate our remit groups for the coming year.

6. We have considered whether any groups within our remit should be awarded a higher or lower uplift than any other group, but have concluded that there is no reason to differentiate between the salaried members of our remit groups. We have therefore made a recommendation for the same basic increase across the remit groups, although the awards for independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs) take account of changes in their business expenses and seek to provide the same base increase to net income.

7. For 2009-10, we **endorse and recommend the proposal that the budget for higher Clinical Excellence Awards should be increased in line with the increase in the number of consultants eligible for an award (estimated by ACCEA at 1.1 per cent)**. We also recognise the need for flexibility while the system continues to settle down and we therefore **endorse and recommend ACCEA's proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards to be made at each level in 2009-10** (paragraph 8.24). **We endorse and recommend SACDA's proposal to distribute a further 3 A+ awards, 8 A awards, and 16 B awards** (paragraph 8.28). **We also recommend that for 2009-10 the value of Clinical Excellence Awards, commitment awards, distinction awards and discretionary points should be increased by 1.5 per cent**, in line with our main pay recommendations (paragraph 8.41).

8. For independent contractor GMPs, we **recommend that the overall gross uplift in General Medical Services contract payments be increased by a factor intended to result in an increase in general medical practitioners' net income of 1.5 per cent after allowing for movement in their expenses**. Using this uplift for GMPs' personal remuneration along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 2.29 per cent. Therefore, we recommend that an uplift of 2.29 per cent be applied to the overall gross uplift in General Medical Services contract payments for 2009-10 for general medical practitioners (paragraph 3.59).

9. In the absence of evidence to suggest that the responsibilities, qualifications and workload of salaried GMPs have changed, we continue to believe that the salary range is appropriate and **we recommend that the minimum and maximum of the salary range for salaried general medical practitioners be increased by 1.5 per cent for 2009-10** (paragraph 3.69).

10. GMP registrars receive a substantial supplement[2] despite having a working pattern which is on the whole less intense than that of trainee hospital doctors and involves few if any additional hours. In principle, we support the alignment of contractual arrangements for GMP registrars and hospital trainees. For this year, we note that general medical practice continues to be an attractive career choice and at present we do not see any cause for concern in the recruitment of GMP registrars, although we wish to continue to monitor the situation. We are therefore content for the supplement for GMP registrars to be again adjusted downwards and **recommend that the supplement for general medical practitioner registrars entering training placements on or after 1 April 2009 be reduced from the current rate of 50 per cent to 45 per cent**. However, we consider that those doctors currently receiving the higher level of the supplement should keep their existing entitlement rather than see their pay supplement reduced (paragraph 3.77).

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

11. We understand that the GMP trainers' grant is likely to move to a tariff-based system and that a pilot study is underway considering the options for funding. Until this review is complete, we believe we should simply increase the value of the trainers' grant in line with the other fees and allowances on which we are required to recommend. We therefore **recommend that the general medical practitioner trainers' grant be increased by 1.5 per cent for 2009-10** (paragraph 3.82). We also **recommend that the general medical practitioner educators' pay scale should rise by 1.5 per cent for 2009-10** (paragraph 3.85).

12. We continue to view London weighting as a labour market issue and as we did not receive any evidence to show that recruitment and retention in London is a problem, we therefore **recommend that supplements for London weighting should remain at their existing levels** (paragraph 1.29).

13. For GDPs, we again **recommend that the parties work together, or commission joint independent work, on dental expenses, focusing specifically on the non-staffing element** (paragraph 4.49). On the uplift, we **recommend that the gross earnings base be increased by a factor intended to result in an increase in general dental practitioners' net income of 1.5 per cent after allowing for movement in expenses**. Using this uplift for general dental practitioners' personal remuneration along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 0.21 per cent. Therefore, we **recommend that an uplift of 0.21 per cent be applied to the gross earnings base under the new contract for 2009-10 for general dental practitioners in England and Wales** (paragraph 4.87). This year we have received no evidence from the parties on how to treat gross fees, commitment payments or sessional fees in Scotland and Northern Ireland to translate into a net uplift of 1.5 per cent. Therefore, to be consistent with previous years, **we are recommending that the uplift of 0.21 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland** (paragraph 4.88). We expect to receive data next year to allow us to consider Scottish dentistry and Northern Ireland dentistry separately and to make separate recommendations.

14. For doctors and dentists in hospital training, we **recommend that the value of the banding multipliers remain at the rates that were negotiated between the parties** (paragraph 7.13).

15. **For the other fees and allowances on which we are required to recommend, unless they are specifically mentioned elsewhere in the report, we recommend that these be increased by 1.5 per cent for 2009-10** (paragraph 2.20).

Our main recommendations on pay levels are:[3]

Hospital doctors and dentists – main grades (full-time salaries):	*Point on scale*[3]	*Recommended scales 1 April 2009 £*
Foundation house officer 1	minimum	22,190
	maximum	24,960
Foundation house officer 2	minimum	27,523
	maximum	31,122
Specialty registrar (full)	minimum	29,411
	maximum	46,246
Specialty registrar (fixed term)	minimum	29,411
	maximum	38,911
House officer	minimum	22,190
	maximum	24,960
Senior house officer	minimum	27,523
	maximum	38,322
Specialist registrar	minimum	30,685
	maximum	46,246
Consultant (2003 contract, England Scotland and Northern Ireland for main pay thresholds)	minimum	74,504
	maximum (normal)	100,446
	maximum (local CEA)	35,484
	CEA (Bronze)	35,484
	CEA (Silver)	46,644
	CEA (Gold)	58,305
	CEA (Platinum)	75,796
Consultant (2003 contract, Wales)	minimum	72,205
	maximum (normal)	93,742
	maximum (commitment award)	25,632
Consultant (pre-2003 contract)	minimum	61,859
	maximum (normal)	80,186
	maximum (discretionary)	25,632
	distinction award 'B'	31,959
	distinction award 'A'	55,924
	distinction award 'A plus'	75,889
Speciality doctor	minimum	36,443
	maximum	67,959

[3] Appendix A gives more detail on the salary scales.

	Point on scale	*Recommended scales 1 April 2009 £*
Associate specialist (2008)	minimum	51,095
	maximum	84,106
Staff grade practitioner	minimum	33,762
	maximum (normal)	47,639
	maximum (discretionary)	63,244
Associate specialist (pre-2008)	minimum	37,321
	maximum (normal)	66,827
	maximum (discretionary)	80,953
Clinical medical officer	minimum	32,343
	maximum	44,602
Senior clinical medical officer	minimum	45,704
	maximum	65,175
Band A: Salaried dentist	minimum	37,344
	maximum	56,016
Band B: Salaried dentist	minimum	58,091
	maximum	67,946
Band C: Salaried dentist	minimum	69,502
	maximum	79,875
Community dental officer	minimum	34,275
	maximum	53,686
Senior dental officer	minimum	48,978
	maximum	66,193
Assistant clinical director	minimum	65,084
	maximum	70,121
Clinical director	minimum	65,084
	maximum	74,166

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OFFICE OF MANPOWER ECONOMICS
25 February 2009

Part 1: Overview

CHAPTER 1: ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

1.1 For this, our *Thirty-Eighth Report*, we have again divided the report into nine chapters, comprising this introduction, a chapter with our main pay recommendations and a chapter on each of our remit groups: general medical practitioners (GMPs), general dental practitioners (GDPs), salaried primary dental care services (SPDCS), ophthalmic medical practitioners, doctors and dentists in hospital training, consultants, and specialty doctors and associate specialists (SAS). The detailed pay scales which result from our recommendations are set out in Appendix A.

1.2 In this introductory chapter we set out the overall context for our review, including the essential facts about our remit groups, how we have collected evidence, and the current economic background. The chapters for each remit group discuss some of these matters in more detail. Our terms of reference are set out at the beginning of this report. The main recommendations of our previous report are summarised in Appendix B.

1.3 Data used to produce the tables and graphs in this report come from different main sources for each of the four countries: data for England from the NHS Information Centre, for Wales from the Welsh Assembly Government (WAG), for Scotland from the Information Services Division which is part of the NHS National Services Scotland and for Northern Ireland from the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI). These data are revised by the countries on a yearly basis and revisions can be made to the historical data series going back ten years. The figures presented in our report are the most up-to-date published but consequently historical figures presented in this report may not be the same as in previous years.

1.4 Our remit groups now comprise approximately 187,000 doctors and dentists. The breakdown by group is given in Table 1.1. Further details are given at Appendix C.

Table 1.1: Remit groups for the 2009 review, at September 2007,[1] United Kingdom

	Full-time equivalents	Headcount
Consultants[2]	38,357	41,014
Registrar group	36,654	37,244
Foundation house officers, house officers and senior house officers	19,744	19,919
Speciality doctors, associate specialists and staff grades	9,862	11,177
Other staff[3]	2,895	6,943
Total Hospital and Community Health Services staff[4]	***107,513***	***116,248***
General medical practitioners[5]	*	44,443
General dental practitioners[6]	*	25,403
Ophthalmic medical practitioners	*	469
Total[4]	*	**186,563**

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

* Data not available.

Notes:

1. Some data are not for September 2007, but are for the closest time period available.

2. The grade of consultant also includes Directors of Public Health.

3. Includes hospital practitioners, clinical assistants, and public health and community medical and dental staff not elsewhere specified.

4. Total is not exactly the sum of the categories as some doctors carry out more than one role.

5. Includes independent contractor general medical practitioners, salaried general medical practitioners and general medical practitioner registrars.

6. Includes principal general dental practitioners, assistants and vocational practitioners, general dental practitioners working in Personal Dental Services, and salaried dentists working in General Dental Services.

1.5 Within our remit groups, GMPs, GDPs and consultants have all had new contract arrangements since 2003; the SPDCS in England and Wales agreed a new contract in January 2008 (backdated to 1 June 2007) and SAS grades a new contract from 1 April 2008. The way in which junior doctors are trained has also been undergoing a radical change, following the publication of *Modernising Medical Careers.*[1] Table 1.2 below gives an outline of the situation for each remit group and the changes are described more fully in the relevant chapters.

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

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

General medical practitioners	New contract from 1 April 2004.
General dental practitioners	New contract from 1 April 2006 – England and Wales (slight variations in each country). Negotiations in progress in Northern Ireland. Scotland still on an item-of-service fee scale.
Salaried primary dental care services	New contract in England and Wales – backdated to 1 June 2007; forthcoming in Scotland and Northern Ireland.
Doctors and dentists in training	New contract from December 2000. Changes to training from 2004. NHS Employers expected to be given a remit during 2009 to look at new contractual arrangements.
Consultants	New contract from October 2003 – contract differs in each of the four countries. Fewer than 10 per cent of consultants in each of England, Scotland and Northern Ireland remain on the old contract; all consultants in Wales are now on the new contract.
Speciality doctors and associate specialists	New contract from 1 April 2008 with minor differences in each of the devolved countries.

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

The devolved countries

1.7 Our remit covers the whole of the United Kingdom so in this report, unless we specify that comments are relevant only to England, Wales, Scotland or Northern Ireland, we refer to the entire United Kingdom.

1.8 The WAG, the Scottish Executive Health Department (SEHD) and the DHSSPSNI all said that their evidence, which appeared as separate chapters within the overall evidence for the Health Departments, complemented the evidence from the other Health Departments in that it drew attention to any policies that were distinctive in Wales, Scotland or Northern Ireland.

1.9 The evidence from the British Medical Association (BMA), the British Dental Association (BDA) and the Dental Practitioners Association (DPA) covered the whole of the United Kingdom, drawing out differences and specific issues where appropriate. NHS Employers' evidence, however, related only to England.

Last year's recommendations[2]

1.10 Last year we recommended a pay award of 2.2 per cent for Hospital and Community Health Services (HCHS) doctors and HCHS doctors and dentists in training. For GMPs we recommended an increase in the global sum of 2.7 per cent for each 'weighted patient', in line with the general uplift of 2.2 per cent which we recommended for doctors in the HCHS. However, because of the way in which the contract is structured, we knew that this uplift would not affect all practices equally, and we recognised that many practices would not gain anything. For GDPs we recommended that the gross earnings base be increased by a factor of 3.4 per cent, which was intended to result in an increase in GDPs' income of 2.2 per cent after allowing for an increase in expenses. The government accepted our recommendations for 2008-09 in full.

The evidence

1.11 We received written evidence from the Health Departments, comprising the Department of Health, the WAG, the SEHD and the DHSSPSNI, from HM Treasury, NHS Employers,[3] the Advisory Committee on Clinical Excellence Awards (ACCEA), the Scottish Advisory Committee on Distinction Awards (SACDA), the Northern Ireland Clinical Excellence Awards Committee (NICEAC), the BMA, the BDA and the DPA. The main evidence can be read in full on the parties' websites (see Appendix D). In an effort to keep this report concise, we have not paraphrased large portions of the evidence, although we continue to refer to issues raised by the parties in their evidence.

1.12 The parties provided supplementary written evidence in response to other parties' evidence and to our requests. In addition we heard oral evidence from the Secretary of State for Health, the Rt Hon Alan Johnson MP, the Health Departments, HM Treasury, NHS Employers, the BMA, the BDA and the DPA.

1.13 We continue to be grateful to the parties for their time and effort in preparing and presenting evidence to us, both in writing and orally, and for the speed with which they have responded to our numerous questions and requests for supplementary evidence.

Visits

1.14 As always, we carried out a series of visits over the summer. In 2008 we visited two acute trusts and four primary care organisations (PCOs) across the United Kingdom to meet representatives from management and the doctors and dentists to whom our recommendations apply. The locations for the visits are selected by our secretariat to ensure a good cross-section throughout the United Kingdom while trying not to repeat visits made in recent years. These visits do not form an official part of our evidence gathering but they are valuable in informing our views and we are grateful to those we meet for their time and the frank opinions expressed.

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[2] The main recommendations of our previous report are summarised in Appendix B.

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

Recruitment, retention and workforce planning

1.15 The Health Departments described recruitment as buoyant and told us that despite significant growth in medical and dental workforce requirements, vacancies were at or near record lows and the number of high quality applicants outstripped demand in most areas. They said that overall three-month vacancy rates in England remained very low and had fallen for hospital doctors and dentists for the fifth year running to just 0.9 per cent in 2008 (as against 4.7 per cent in 2003). According to the 2008 NHS vacancy survey, the long-term vacancy rate for hospital doctors and dentists was down to 0.9 per cent compared with 1.1 per cent in 2007. We were told that the long-term vacancy rate for medical and dental staff in Northern Ireland was 0.9 per cent in March 2008; the same as in England. DHSSPSNI also said that the current vacancy rate for medical and dental staff in Northern Ireland was 2.4 per cent in March 2008. The Health Departments said that the NHS had seen unprecedented expansion in the medical and dental workforce since 1997 and there were now record levels of doctors in training in United Kingdom medical schools and in specialty training. The Health Departments said that the increase in demand caused by population growth and demographic change alone suggested an increase in the required medical workforce of around 1 per cent every year would be needed just to 'stand still' with potentially greater increases in the number of GMPs due to their role in managing long-term conditions. They told us that the medical workforce had experienced significant growth in recent years across all workforce groups and there was a very healthy recruitment and retention position demonstrated by the falling vacancy rate. They said that workforce and associated reforms (for example, pensions) in recent years had also ensured that staff received benefits that extended to the longer term. The Health Departments observed that the medical workforce was facing good recruitment and retention and looking to the medium term, there might be a need to guard against oversupply. They said that as a result of the workforce reforms over recent years, staff were benefiting from a good overall remuneration package.

1.16 The WAG said the main difficulties in recruiting or retaining doctors were confined to the rural parts of Wales and the particular shortage of recruits in accidents and emergencies and paediatrics. The SEHD reported that in 2007-08 it had provided £600,000 funding for two projects which supported the recruitment and development of staff to remote and rural areas in NHS Highland and NHS Orkney.

1.17 NHS Employers said that recruitment and retention were generally stable, which they believed suggested that the pay system was largely fit for purpose and needed only limited changes. They said that competition with the wider labour market and the wider economic circumstances were not thought to be the primary factors in the recruitment and retention of doctors and dentists. They reported that the turnover rate for all medical staff (excluding doctors in training) leaving the NHS was 10.1 per cent (September 2005 – September 2006), but that 18 per cent of the turnover from the medical and dental workforce was aged 60 or over. NHS Employers noted that the vacancy rate had decreased every year since 2003, when it was 4.7 per cent. By specialty, NHS Employers said that the highest vacancy rates were in accidents and emergencies (2.7 per cent) and dentistry (2.3 per cent); the lowest rates were in anaesthetics and oncology (0.4 per cent each).

1.18 NHS Employers told us that half of trusts responding to their questionnaire reported recruitment and retention difficulties in relation to doctors and dentists over the year to August 2008, and just over 10 per cent of them reported doctors' and dentists' recruitment as severe. However, they observed that pay was not cited in the difficulties reported by employers, except in relation to salaried dentists.

1.19 NHS Employers said that the use of locums (from both internal and external sources) was a common measure for dealing with recruitment difficulties or for filling short-term service gaps such as maternity cover, although there had been reports during 2008 of difficulties recruiting medical locum staff, particularly for short-term assignments. They told us that a contributory factor had been confusion and misunderstanding over the recent changes to immigration rules.

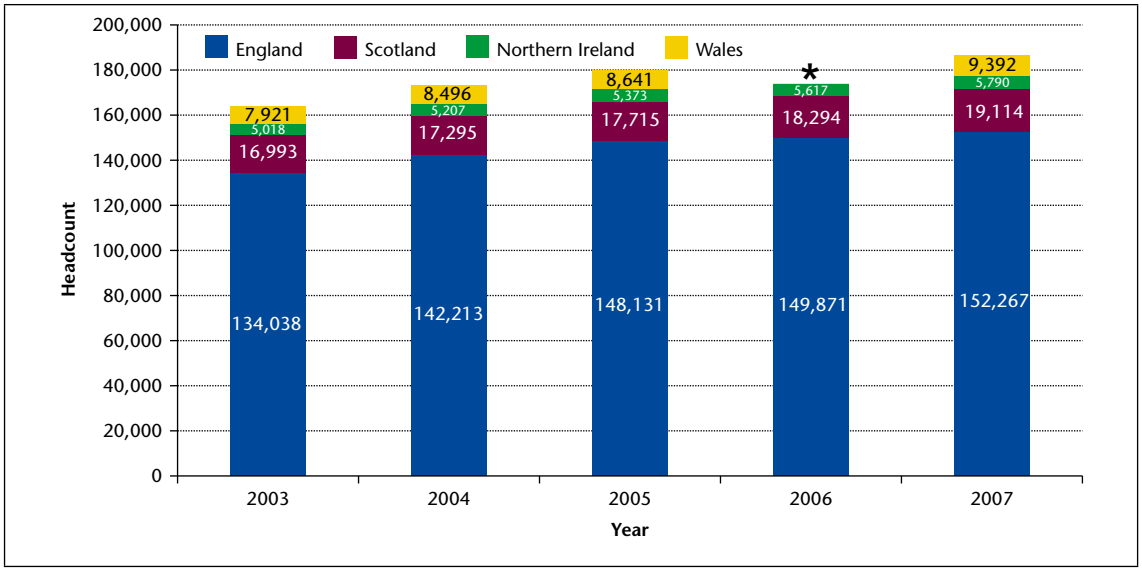
1.20 The BMA noted that the number of home applicants for places in United Kingdom medical schools fell by 1.0 per cent in 2007; provisional data for 2008 showed a further decrease of around 4.5 per cent. The BMA viewed this with concern in the light of record numbers of applicants for higher education. It said that medicine seemed to be becoming less popular as a career and there was a lack of diversity in the socio-economic background of medical school applicants.

1.21 The BDA expressed concerns that many dentists would leave the NHS this year but said that those with a substantial NHS commitment of 75 per cent or more had increased their NHS clinical commitments. Its 2008 survey of post-vocational training employment[4] showed that recruitment had not improved, with one in five reporting that they had not yet found a post, and of those who had found a post, 67 per cent had not stayed in their training practice. It also suggested the possibility of structural unemployment whereby dental graduates with commitments that tied them to a particular area might not be able to secure a vocational training place and would therefore not be able to provide NHS services. The BDA also told us that 62 per cent of the SPDCS had reported difficulty in recruiting dentists, and that in Scotland they were again recruiting dentists for the SPDCS from Poland. In addition, the DPA observed that relatively few dentists were fully dependent on the NHS.

1.22 The evidence does not give us any major cause for concern about the recruitment and retention situation, except possibly for salaried dentists (although they now have a new contract) and we note that, in general, medicine and dentistry continue to be attractive careers, though it is clear that some career paths are more popular than others. Our detailed comments on the evidence on recruitment and retention can be found later in the report, in the chapters relating to the individual remit groups. Figure 1.1 shows that the numbers of medical and dental staff in each of the devolved countries have increased year on year between 2003 and 2007. The latest data at 30 September 2007 show that the headcount is now 186,563.

[4] British Dental Association and Committee of Postgraduate Dental Deans and Directors. *Post vocational training employment survey*. BDA-COPDEND, 2008. Available from: https://www.bda.org/Images/vdp_survey_may_2008.pdf

Figure 1.1: Total number of medical and dental staff, 2003 – 2007, United Kingdom



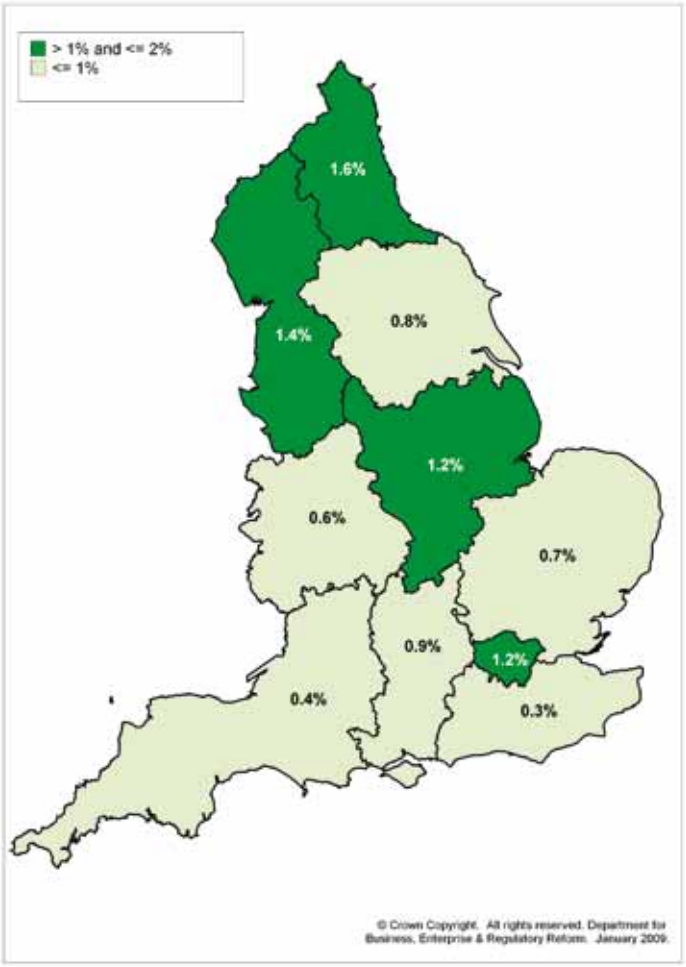
Sources: The NHS Information Centre, Welsh Assembly Government, Information Services Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

Notes:

* Data for HCHS staff in Wales not available for 2006.

1.23 Figure 1.2 shows the three-month vacancy data for England, with higher than average vacancies in London (1.2 per cent), the East Midlands (1.2 per cent), the North West (1.4 per cent) and the North East (1.6 per cent).

Figure 1.2: All Hospital and Community Health Services medical and dental staff three-month NHS vacancy rates by strategic health authority area in England, 2008



Source: The NHS Information Centre.

Notes:

1. Wales does not produce an "all medical and dental" figure.
2. Vacancy figures for Scotland and Northern Ireland are not produced on a comparable basis.

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

1.24 The Department of Health noted that whilst the three-month vacancy data for March 2008 showed that doctor vacancies in London had risen to 1.2 per cent from the March 2007 figure of 0.7 per cent, vacancies remained low and it had no evidence of recruitment problems in London. It pointed out that the March 2008 London vacancy rate was below that in the North East and the North West, the same as in the East Midlands, and well below the London rate in March 2006. It said that the data did not provide evidence that there should be a change to the current rates of London weighting.

1.25 We asked NHS Employers specifically about vacancy rates in London and were told that these were not high in comparison to the rest of the country; indeed, they said that vacancy rates were at an all-time low. NHS Employers noted that the vacancy rate in London for all doctors was 1.2 per cent, slightly above the average rate of 0.9 per cent, but other strategic health authorities showed higher than average vacancy rates, as can be seen in Figure 1.2 above. They believed that there may be some prolonged

vacancies as a result of doctors waiting to see what would happen in the reorganisation of services in London. They said that specialties could go through phases of higher vacancies, depending on the amount of funding allocated to each, suggesting that it was not pay that was driving the vacancies.

1.26 NHS Employers noted that by specialty, London vacancy rates were above average in half of the specialties and London had the highest vacancy rates in surgery, radiology, paediatrics and obstetrics and gynaecology. NHS Employers stressed that where there were specific recruitment problems in particular specialties, employers believed that the current flexibilities enabled by the local labour market supplements were sufficient. They believed that where there were labour market supply issues, which would not be helped by simply raising earnings, employers were addressing these by other means such as skill mix changes and service reconfigurations. In cases where the underlying problem was about specific labour supply issues, NHS Employers believed that it would be inappropriate to use market supplements, as far from solving recruitment and retention issues they would mask the real difficulty that needed addressing by non-pay means.

1.27 NHS Employers told us that they believed the level of London weighting was adequate. They noted that labour market conditions had not significantly changed in London, vacancy rates remained historically low, and applications for vacancies remained satisfactory. NHS Employers were not seeking an increase in London weighting. Nor did they accept that there was compelling evidence of an emerging recruitment and retention problem in London. NHS Employers said that fewer than 5 per cent of the trusts that responded to its questionnaire were using market supplements. They believed that market supplements were being used appropriately at local level and were not being used in areas where there were labour supply side issues.

1.28 The BMA told us that the vacancy data suggested that there may be the beginnings of a retention issue in London and it believed that an increase in the level of London weighting might go some way to heading this off. It was conducting research on migration from London, primarily by consultants. We have not had sight of the results of this research and look forward to seeing these in time for our next review.

1.29 We have said previously that unless evidence in future years indicated that labour market conditions in London had changed, we did not intend to revisit the decision that London weighting levels should remain at their existing levels. We were not persuaded by the evidence received that recruitment and retention in London are problematic and we therefore **recommend that supplements for London weighting should remain at their existing levels**.

Motivation and morale

1.30 Motivation is an element of our terms of reference that we take very seriously because of its consequent effects on recruitment and retention. The Health Departments told us that the NHS staff survey had shown that doctor and dentist groups as a whole were one of the most satisfied occupational groups within the NHS. NHS Employers added that relative to colleagues in other occupations in the NHS, doctors and dentists were more satisfied with the circumstances of their employment.

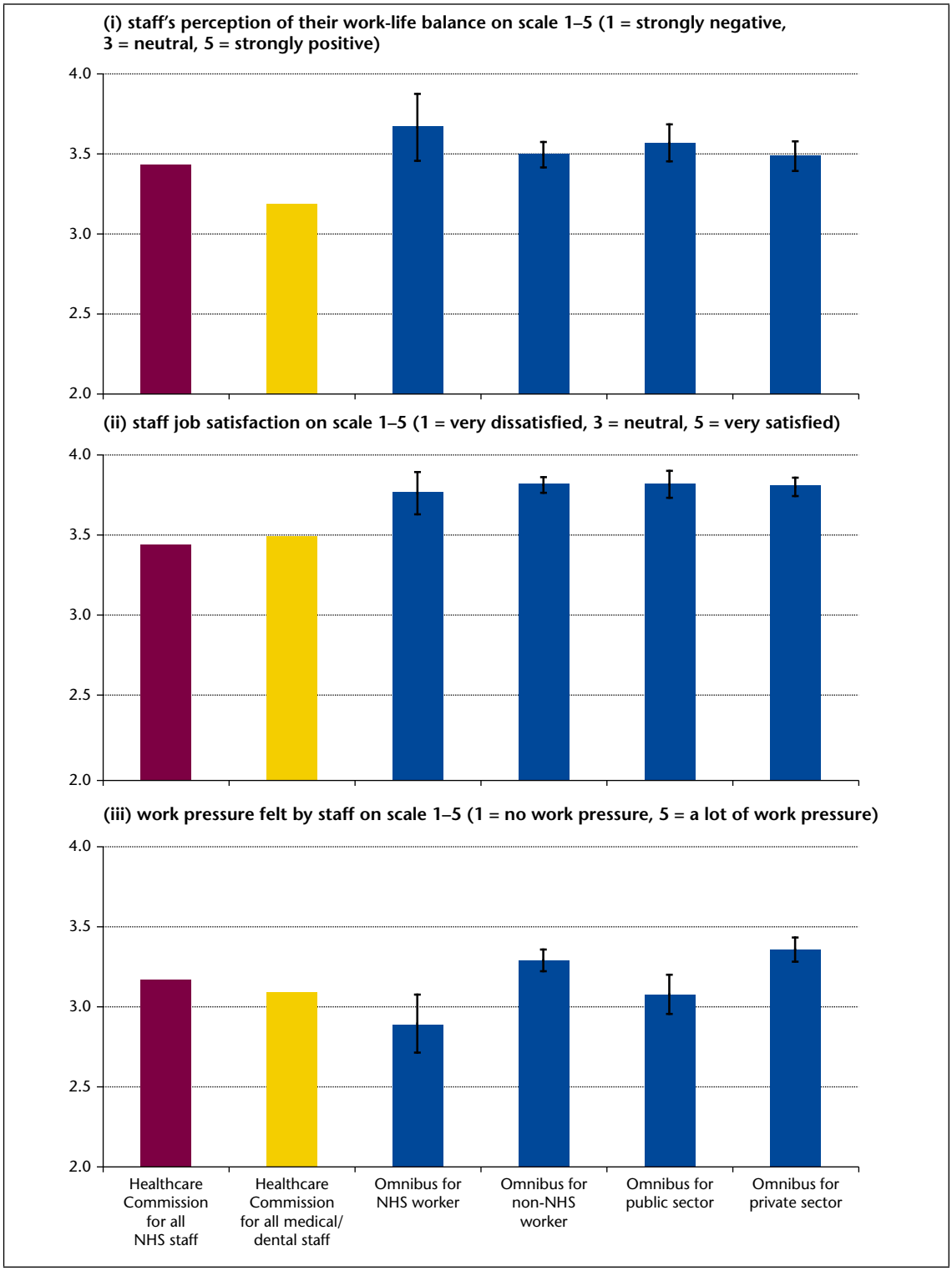
1.31 NHS Employers said that employers in the NHS remained concerned about staff morale, but they did not believe that this was directly linked to pay. They said that improved morale would not be achieved by simply giving a higher pay award. NHS Employers told us that the NHS continued to be seen as a desirable place to work and that flexible working arrangements including term time only working, flexible retirement arrangements, career breaks, return to practice and annualised hours had a positive impact on morale and motivation.

1.32 The BDA told us that dentists' work was currently target-driven and they remained on a treadmill, which had negative implications for patient care and dentists' working lives. It had also found a marked difference between the morale of those with substantial NHS practice (i.e. over 75 per cent) and those with substantial private practice (less than 25 per cent NHS). A higher proportion of committed NHS practitioners (39.3 per cent) believed that morale had declined over the past two years, compared with 17.6 per cent of those in substantially private practices.

1.33 We were concerned that the results from the 2007 NHS staff survey, quoted in the written evidence, seemed to suggest more dissatisfaction in the workforce than we might have expected, even though our remit groups were shown to be some of the most satisfied occupational groups in the NHS. We therefore decided to compare the NHS results against results obtained from the wider economy by comparing key results from the 2007 NHS staff surveys in England (carried out by the Healthcare Commission) with the Office for National Statistics Omnibus (opinions) survey. Results from the Omnibus survey indicated that NHS staff were generally at least as satisfied as other employees, and that medical and dental staff in the NHS, like NHS staff in general, did not have poor morale when compared on a like for like basis with employees in the wider economy.

1.34 Results from the Omnibus survey found that the average score for work-life balance for NHS workers was higher, but not significantly higher than that of non-NHS workers, and also higher than those in the private sector. The average scores in the NHS staff survey in England, for both job satisfaction and work-life balance, were lower than in the Omnibus survey and the differences were too great to be explained by sampling error. This may be a reflection of different reactions to the two surveys, perhaps because of differences in where, how and by whom they were carried out. Finally, within the Omnibus survey, staff in the NHS felt significantly less work pressure than non-NHS workers, and than private sector workers. In addition, public sector workers felt significantly less work pressure than those in the private sector (see Figure 1.3).

Figure 1.3: The morale of medical and dental staff compared with all NHS staff using results from the Healthcare Commission's NHS staff survey in England and the Office for National Statistics' Omnibus survey, 2007



Sources: Healthcare Commission and Office for National Statistics.

Notes

1. Scores are given for two groups from the Healthcare Commission's survey (all NHS and all medical and dental) and for four groups from the Omnibus survey (all NHS, non-NHS, public sector and private sector) some of which overlap.

2. The Omnibus questions, using wording from the Healthcare Commission's NHS Staff Survey in England, aimed to use the Healthcare Commission's methodology to enable comparisons to be made between the responses of NHS workers to these questions and those of other employees in the wider economy.

3. 95 per cent confidence intervals are provided for Omnibus survey results.

NHS Next Stage Review

1.35 We note that the *NHS Next Stage Review*[5] outlines changes to workforce planning, education and training and that the new workforce planning system is intended to ensure that high quality staff are employed in the right areas to deliver the services patients need, and combined with more flexible career structures will reduce shortages of staff in key service areas, and reduce the need to pay premium rates for shortage staff groups.

Workload, productivity and output targets

1.36 The BMA said that the public sector should not be treated less favourably than the private sector just because its productivity was difficult to measure and its outputs complex. It expressed some concern about measures of consultant productivity and reminded us of the proposed new measures of productivity that it had outlined in last year's evidence. These proposed new measures involved differentiation of activity which the BMA believed was of particular importance in assessing the contribution of hospital consultants to output and health outcomes. It observed that medical productivity did not simply relate to medical inputs, and pointed out that the total numbers of non-medical staff available to support clinicians had fallen in the past two years and that professionally qualified staff numbers grew by only 1.1 per cent last year.

1.37 The Department of Health agreed with the BMA that the simple measures of productivity showed some deterioration in recent years, and that these measures did not fully capture all inputs or all aspects of output and outcome. It said that, while work was being done to enhance productivity measurement, there was as yet no firm evidence that productivity had in fact been improving rather than deteriorating. The Department said that it also seemed right to agree that consultants should not be disadvantaged by the fact that their productivity was difficult to measure. On crude measures of patient activity per consultant, the Department believed that the trend was downward, and there was no evidence that there had not been a reduction in workload.

1.38 NHS Employers said that following the implementation of the revised pay and contractual arrangements across different staff groups, a number of potential benefits including improvement in workforce productivity had been identified.

1.39 We recognise that none of the parties is totally satisfied with productivity measures and therefore welcome the Department of Health's engagement with the University of York to look at this issue for hospital consultants, with a view to receiving improved information in time for our next report.

[5] *A high quality workforce: NHS Next Stage Review*. Department of Health, 2008. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840

General economic context and the government's inflation target

1.40 The economic context within which we have carried out our work has been complicated, and considerably changed from the position at the time of our last review. Figures from the Office for National Statistics confirm that the United Kingdom economy is now in a 'technical' recession, with negative gross domestic product growth in both the third and fourth quarters of 2008. Further quarters of negative growth are expected, with the median of independent forecasts[6] at minus 2.4 per cent for 2009 as a whole. HM Treasury expects growth over 2009 in total to fall in the range minus 1.25 per cent to minus 0.75 per cent, but forecasts it to pick up in the second half of the year.[7] However, other forecasters are more pessimistic and do not expect growth to resume before 2010.[8]

1.41 The effects of the recession are apparent in a range of economic indicators from retail sales to business confidence to household consumption. It is also apparent in the main labour market measures. Employment was at a record level in the summer of 2008, but has since fallen back. Unemployment has risen sharply on the broad International Labour Organisation measure, where it stood at 1.971 million in the three months to December 2008, and on the narrower claimant count measure, which was 1.233 million in January 2009. Other data also point to markedly weakening labour demand, with the latest figures showing a large increase in the redundancy rate coupled with the lowest level of vacancies since that series began in 2001. Press reports note that some forecasters expect unemployment as defined by the International Labour Organisation to rise to over three million by the end of 2009, while the median of independent forecasts has the claimant count at 1.9 million in the fourth quarter, some 750,000 up on the current position.

1.42 Over the last few months the rate of inflation has declined. The annual rate of increase in the Consumer Prices Index (CPI) was above target for the entirety of 2008, peaking at 5.2 per cent in September. However, expectations about the outlook for 2009 have changed substantially, with the central projection in the latest Bank of England *Inflation Report* implying a sharp fall in inflation during 2009, with the rate below target for the two year forecast period.[9] The Governor of the Bank of England notes three main downward pressures on inflation: lower global commodity prices, especially for oil and gas, the slowdown in economic activity and resulting spare capacity, and the reduction in VAT rates from 1 December 2008.[10] The annual rate of increase in the CPI has slowed sharply since September 2008, and had fallen to 3.0 per cent in January 2009. It is expected to fall further. HM Treasury forecasts the CPI rate to be 0.5 per cent in the fourth quarter of 2009, in line with the median of independent forecasts. Whilst inflation as measured by the CPI is expected to remain marginally positive during 2009, the all items Retail Prices Index (RPI) appears set for a period of negative growth as a result of additional downward pressures on the index from lower mortgage interest payments and house prices, which are not included in CPI. HM Treasury forecasts the annual rate of increase in the RPI to fall below minus 2 per cent in the third quarter of this year, somewhat lower than the median of independent forecasts (minus 1.5 per cent). While HM Treasury suggests the period of

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[6] Macroeconomics Prospects Team. *Forecasts for the UK economy: a comparison of independent forecasts*. HM Treasury, January 2009. Available from: http://www.hm-treasury.gov.uk/d/200901forecomp.pdf

[7] HM Treasury. *Pre-Budget Report. Facing global challenges: supporting people through difficult times*. Cm 7484. TSO, November 2008. Available from: http://www.hm-treasury.gov.uk/prebud_pbr08_repindex.htm

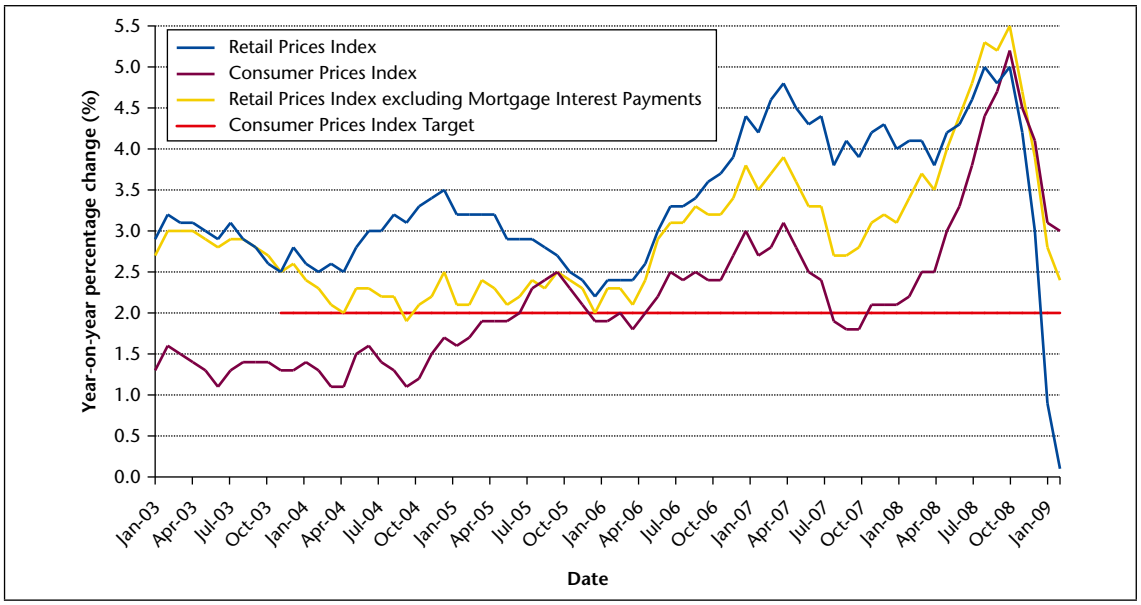
[8] See, for example: Vicky Redwood. How to spot a recovery – the evidence from past recessions. *UK Economics Focus*, 18 December 2008.

[9] *Inflation Report*. Bank of England, February 2009. Available from: http://www.bankofengland.co.uk/publications/inflationreport/ir09feb.pdf

[10] Letter from the Governor of the Bank of England to the Chancellor of the Exchequer, 15 December 2008. Available from: http://www.bankofengland.co.uk/monetarypolicy/pdf/cpiletter081215.pdf

deflation will be relatively brief, some other forecasters expect deflation throughout 2009, with the rate of retail price inflation turning positive again only in early 2010.[11] The RPI inflation rate was at 5 per cent in September 2008, but had fallen to just 0.1 per cent in January 2009, the latest data available to us.

Figure 1.4: Inflation: Consumer Prices Index, Retail Prices Index, Retail Prices Index excluding Mortgage Interest Payments, January 2003 – January 2009



Source: The Office for National Statistics.

1.43 We have also looked at data on pay settlements and average earnings. The median of pay settlements across the whole economy in 2008 generally lay between 3.5 per cent and 4 per cent, depending on the data source. Individual sectors and organisations gave awards higher or lower than the median as their particular circumstances dictated. Looking ahead, as the labour market weakens and inflation falls sharply, especially if RPI falls as forecast, settlement levels might be expected to adjust downwards, but it is difficult to assess the size of such adjustment at this stage. Many commentators suggest that the current recession will be longer and deeper than those in the 1990s and 1980s, with a period of deflation. The information available to us suggests only that awards in 2009 are likely to be lower than last year. The Bank of England's Agents reported in January 2009 that there had been a "material increase" in the proportion of their contacts planning a pay freeze, with some planning to implement pay cuts.[12]

1.44 Whole economy average earnings including bonus effects grew by around 3.9 per cent during the early months of 2008, before slowing from the summer onwards to 3.2 per cent for the three months to December 2008. All of this slowdown can be attributed to the private sector, where earnings growth, 3.9 per cent in January 2008, had fallen to 3.1 per cent in December 2008, and this in turn can largely be explained by lower bonuses in the service sector in 2008 compared to 2007. This means that pay 'drift' in the private sector – the difference between base pay increases and earnings outcomes – was negative. In contrast, average earnings growth in the public sector rose from 3.4 per cent in January 2008 to 4.0 per cent in December 2008,

[11] RPI expected to fall to negative levels throughout 2009. *IDS Pay Report*, No. 1016, January 2009: 3

[12] *Agents' summary of business conditions*. Bank of England, January 2009. Available from: http://www.bankofengland.co.uk/publications/agentssummary/agsum09jan.pdf

implying pay drift marginally above its 1.1 per cent long-term average. Independent forecasters expect no pick up in whole economy average earnings growth in 2009, with a median expectation of 2.8 per cent for the year as a whole. If so, it will be well below the level of earnings growth that might represent a threat to meeting the government's inflation target; indeed, it would be a factor contributing to the likelihood that the target will be undershot.

Affordability and the Health Departments' expenditure limits

1.45 This round has been conducted during an uncertain and rapidly changing economic climate and we believe that what may have been the case when we received the main evidence from the parties in September and October 2008, may no longer apply five months later. We have therefore endeavoured to interpret the evidence in the light of the current economic situation.

1.46 Once again, affordability was a major theme throughout the main evidence submitted by the Health Departments and NHS Employers, with warnings of the serious consequences for patient care and NHS strategies that would result from any uplift above that budgeted. Of course, any pay uplift reduces the resources available for service delivery, and during oral evidence the Health Departments confirmed that their recommended pay uplift was the one which they believed struck the appropriate balance between recruitment and retention on the one hand and service delivery priorities and other economic objectives on the other. However, affordability in this sector of the employment market cannot be considered in isolation from other issues. We have considered this evidence carefully during our deliberations and summarise it below.

1.47 The Department of Health said at the time, that it was important that decisions taken in response to the current above target inflation did not feed into domestic wages, permanently locking in temporarily high inflation and limiting the Bank of England's ability to cut interest rates and promote jobs and growth. It told us that the fundamental objectives of the government's pay policy remained unchanged, to recruit and retain high quality workforces; pay awards that were affordable and provided value for money for the tax payer; and consistency with achievement of the Bank of England's inflation target. It said that pay awards above the appropriate level would be at the cost of service improvements to benefit patients and that each 0.5 per cent increase in settlement for this group cost some £50 million, which was equivalent to two-thirds of the Department's investment in the national obesity strategy. The Department said that pay accounted for around 46 per cent of NHS revenue expenditure (and around 62 per cent of HCHS expenditure). The paybill increased as staff numbers increased but was also affected by the annual pay uplift and pay drift. It believed that there was no flexibility to bring forward expenditure, i.e. to spend more in an earlier year, with lower expenditure in future years. However, it told us that there was the flexibility to delay expenditure, i.e. to defer resources and expenditure into future years; but this was subject to approval by HM Treasury, and limited by affordability constraints on public finances in future years.

1.48 The Department of Health said that the 2007 Comprehensive Spending Review funding settlement for the NHS was significantly lower than in prior years but remained high compared to other government departments. This was in recognition of the challenging forward programme of service development for the NHS. It was not a signal that NHS staff needed higher than average pay awards or that the NHS labour markets were tight. It told us that the settlement required the NHS to deliver 3 per cent cash-releasing efficiency savings over the 2007 Comprehensive Spending Review period. It said that pay was considered as a baseline pressure and a balance needed to be made between pay remuneration and non-pay priorities, even within

the baseline. The Department estimated the HCHS paybill by combining estimates of pay settlement, pay drift and workforce growth. It said that the HCHS paybill formed a significant part of baseline pressures along with prescribing (primary care and hospital) and primary care services. Overall, these three areas consumed around £60 billion worth of resources. Additionally there would be cost pressures arising from the general increase in cost of goods and services, the revenue cost of capital and programmes such as the NHS Litigation Authority. Pay pressures were assessed on the basis of the short-run demand and supply position, evidence on staff morale, motivation and applications for training places. The Department said that the funding available to the NHS was fixed and was deployed to cover baseline pressures, underlying demand and service developments. Increases in expenditure in one area were at the cost of developments in other areas. Therefore higher levels of pay, by reducing the funds available for service developments, would also reduce the demand for workforce.

1.49 In its main evidence, the Department of Health told us that the gross cost of dental services had increased from £2.211 billion in 2006-07 to £2.371 billion in 2007-08 (7.2 per cent). This represented an increase in units of dental activity from 73.65 million in 2006-07 to 77.0 million in 2007-08 (4.5 per cent). The Department of Health evidence, based on NHS accounts data for 2007-08 showed that the net expenditure on dentistry for the year (£1.872 billion) was close to the £1.9 billion allocated to PCTs for dentistry. In oral evidence the Department of Health told us that the Comprehensive Spending Review had delivered an 11 per cent, ring-fenced, increase in the funding for NHS dentistry.

1.50 In supplementary evidence, HM Treasury drew our attention to the 2008 pre-budget report that had announced an additional £5 billion value for money target for 2010-11. Allocations for 2010-11 would therefore be adjusted accordingly in the 2009 Budget. Subsequently, it told us that delivering restrained pay awards in 2009-10 and 2010-11 would be critical to managing the pay baseline for the next spending review, and hence providing maximum flexibility for departments in managing their pay bill costs.

1.51 In its main evidence, the WAG said that pay awards would have a similar impact in Wales to that in England and added that real growth funding over the next two financial years was significantly lower than in any previous years. It said that this would significantly constrain the affordability of pay awards over the Chancellor's 2 per cent planning target. The SEHD told us that while decisions would be made locally, it was very likely that pay settlements above 2 per cent would lead to fewer staff. It said that £1 million would fund 28 qualified nurses, or ten doctors, or 426 elective procedures. We were told that in Northern Ireland each 1 per cent increase in the total paybill would equate to additional annual costs of £42 million. DHSSPSNI said that it faced significant inescapable cost pressures from existing Ministerial commitments, demographic change and organisational restructuring. It said that changes arising from pay reform were expected to cost £15 million leaving £79 million to meet the costs of pay awards, which was sufficient to meet an overall 2 per cent award in 2009-10.

1.52 NHS Employers told us, at the start of this round, that they wanted an award that was fair to staff but also recognised the need for organisations to achieve financial balance. They said that 2 per cent would be affordable, providing there was a corresponding uplift in the tariff for 2009-10, for directly employed doctors and dentists. They felt strongly that any unfunded increases in earnings would lead to cost savings elsewhere and potentially impact on patient services and care, jeopardising the local delivery of the overall NHS strategy. The headline revenue settlement announced for 2009-10 in the Comprehensive Spending Review was 6.7 per cent growth and organisations were

expected to deliver 3 per cent in cash-releasing efficiency savings, which equated to an effective increase of less than 4 per cent. NHS Employers said that it was important to consider the impact of both current and future inflation levels on the affordability of any recommendation. They told us that money within the NHS budget was not specifically allocated to spend on annual pay increases and that pay was the greatest element of expenditure across the NHS, typically between 65 and 70 per cent of expenditure within provider trusts; cost pressures against these budgets formed a significant risk to the employing organisation. They said that affordability was dependent on an appropriate increase in the tariff for 2009-10, given the confirmed spending plans over 2008-09 to 2009-10.

1.53 NHS Employers told us, in their main evidence, that likely cost pressures facing NHS organisations included: the impact of our 2008-09 recommendations, uncertainty around the introduction of International Financial Reporting Standards, continued achievement of waiting time targets, introduction of the new SAS contract, rises in referral levels, pay progression, fuel price rises and increased mileage allowances, inflation, the European Working Time Directive, VAT now being payable on agency staff and the *Agenda for Change* multi-year deal. They said that the ability of NHS trusts to fund a pay award in excess of the levels incorporated within existing financial plans varied between sectors. They believed that small variations in pay awards from planned levels would generally be manageable within day to day operational contingencies. NHS Employers said that significant increases to future pay awards would require the revisiting of operational financial plans and the potential for direct patient care, service quality or nationally set access targets to be jeopardised. They said that as an indication, a 1 per cent variation in anticipated pay awards would predominantly absorb many trusts' total operating contingencies and working capital reserves. They noted that the level of financial exposure associated with annual pay awards was not as great for primary care trusts (PCTs) as it was for other NHS organisations, because direct pay costs accounted for approximately 10 per cent of a typical PCT's expenditure baseline.

1.54 The NHS Operating Framework (the tariff) for 2009-10 was announced in December 2008. It confirmed that an assumption of a headline increase of 2.0 per cent had been built into the tariff calculation for staff within our remit. Following this announcement, NHS Employers reiterated that headline pay awards significantly higher than the assumptions built into the tariff would result in NHS organisations having to deliver efficiency savings in excess of the 3 per cent required, and could impact on patient care or lead to a reduction in workforce numbers. However, they said that the extent to which organisations would be affected would vary depending on their financial circumstances.

1.55 The BMA told us, in its main evidence, that it continued to regard RPI as the preferred indicator of inflation as it represented the most general measure, and (by including housing costs) was the most appropriate to gauge the extent of increases in living costs for doctors. It said that if, as seemed likely, the medical workforce continued to expand at around 2 per cent per annum, this would permit average pay increases of a little over 4 per cent, given existing budget shares in the absence of differential inflation. The BMA was concerned at the inclusion of efficiency savings as an offset against an affordable pay envelope. It said that at the very least such savings should be resource neutral but they were used by the Health Departments as an argument for reducing the cash resource available for revenue spending. In supplementary evidence it noted what it perceived as the ambiguity about the availability of resources to fund pay increases. It believed that cash-releasing savings were an addition to resource and entailed making a 6.7 per cent cash increase do the work of 9.7 per cent by releasing additional cash from efficiency.

1.56 The BDA expressed concern over the reported under-spend on the dental budget in Wales in 2006-07 and told us that at least one Local Health Board (LHB) had acknowledged that dental services had been under-commissioned in anticipation of possible shortfalls in patient charge revenue. The BDA stated that it was also aware that funding allocated to dentistry in England was below its target level in the current year and attributed this to the long lead-in times that PCTs appear to need to set up and start delivering projects. As a result, numerous projects commissioned in 2008 will only come on-stream effectively in 2009.

1.57 The WAG told us that, as the dental budget was ring-fenced in Wales, any underspend by LHBs had to be returned to the Assembly Government. In 2007-08 this figure was £1.981 million, only 1.59 per cent of the total net dental spend in Wales. Some of this related to difficulties in lead-in times for new-build practices. However, as LHBs and practitioners improved their management of the dental contract, this was expected to come down. Thus, at the mid-year point of the 2008-09 financial year, LHBs were predicting an underspend in the region of just £76,000.

1.58 Our view is that, as discussed above, affordability cannot be considered separately from other priorities, especially the issue of recruitment and retention. Any pay increase reduces the resources available for increased service delivery (including increased employment of staff). There have been rapid economic changes during the current round and it has not been easy for us to make decisions that will be appropriate for 2009-10 during a time of such uncertainty.

Pay drift

1.59 The Health Departments said that they believed that staff groups had done very well in pay terms over recent years and that average earnings across the directly employed staff in the remit groups had risen by an estimated 50.2 per cent, since 2000. They said for doctors, the existence of progression up incremental scales, combined with pay reforms, meant that most HCHS medical staff saw their earnings increase significantly above the level of the headline award each year.

1.60 NHS Employers stated that all hospital doctors continued to have access to incremental pay scales and that it was important that increments were factored into decisions about the recommended level of uplift.

1.61 The BMA said that any significant pay drift for SAS grade doctors could be expected to fall in future as the assimilation to the new contract worked its way out of the system, in the same way as it had done for consultants. It believed that incremental progression should not be taken into account when calculating the uplift and pointed out that progression for consultants was now at longer intervals and was no longer automatic as it depended on meeting objectives agreed during job planning. The BMA told us that the majority of consultants experienced no threshold rise in any given year and the concept of pay drift was to all intents and purposes irrelevant in general practice. It stressed that the gradual disappearance of significant pay drift in medicine meant that average earnings increases would become closer to settlements and the uplift recommended by us would become more significant.

1.62 We have set out our views on pay drift in our *Thirty-Fifth Report*[13] and see no reason to change these, even though the parties continue to calculate pay drift differently. We continue to believe that pay drift arising from increased overtime or other payments for higher volumes of work, or from the effects of recently negotiated contracts, including incremental pay scales, should not be offset against the annual award. We think that if we were to offset the earnings growth arising from increments from our recommended pay award, it would undermine the fundamental principle on which incremental pay scales are based. Incremental scales should reward increasing experience and loyalty to the employer. Furthermore, both parties agree to the pay increases delivered by increments when staff are employed. We reiterate that it is therefore inappropriate for us to take account of such increases when considering our general uplift.

NHS finances

1.63 NHS Employers reported that the NHS had delivered an overall surplus of £1.667 billion for 2007-08 and that they planned to maintain a contingency at this level; the NHS (excluding foundation trusts) was forecast to deliver an overall surplus of £1.75 billion for 2008-09 (i.e. just over 2 per cent of total NHS resources). They also told us that foundation trusts delivered a combined net surplus of £514 million for 2007-08. NHS Employers said that surpluses were non-recurrent and had generally been achieved through short-term measures which would not generate such savings year on year. They emphasised that existing non-recurrent savings were not available for investment in recurrent areas of expenditure, such as staff pay. They told us that the financial position and financial management of the NHS continued to improve and that only five organisations had faced a deficit at the end of 2007-08; the overall deficit was £125 million.

1.64 We note from NHS Employers in supplementary evidence that while last year's uplift of 2.2 per cent exceeded the 1.5 per cent assumption in the tariff, the award was manageable within the contingencies built into the financial planning assumptions. We therefore conclude that there is some flexibility within NHS finances and that the extent to which organisations would be affected would vary depending on their financial circumstances.

Overall NHS strategy – patients at the heart

1.65 A new element of our remit in 2007 was that we should have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. In our last report we asked the parties to address this issue more directly when preparing evidence for the next round so that we might better assess its implications for pay. However, again we did not receive any direct evidence relating to this, although there were many references to the Darzi *Next Stage Review,*[14] [15] which we note is focused on patients, and it was once more a recurrent theme in the evidence on affordability from the Health Departments and NHS Employers that increases above what they had budgeted would impact on patient care.

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

[14] Professor the Lord Darzi of Denham. *High quality care for all: NHS Next Stage Review final report*. Cm 7432. TSO, 2008. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[15] *A high quality workforce: NHS Next Stage Review*. Department of Health, 2008. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840

Legal obligations on the NHS including anti-discrimination legislation

1.66 A further addition to our remit in 2007 was that we should take account of the legal obligations on the NHS, including anti-discrimination legislation in relation to age, gender, race, sexual orientation, religion and belief, and disability. In our last report we asked the parties to address this in their evidence for the next round. The Health Departments told us that they would not expect to submit evidence on this point as a matter of course, although they expected us to take this part of the remit into account when formulating recommendations. The parties provided some information on the distribution of Clinical Excellence Awards (CEAs), discretionary points and distinction awards, and we refer to this again in Chapter 8.

Pay comparability

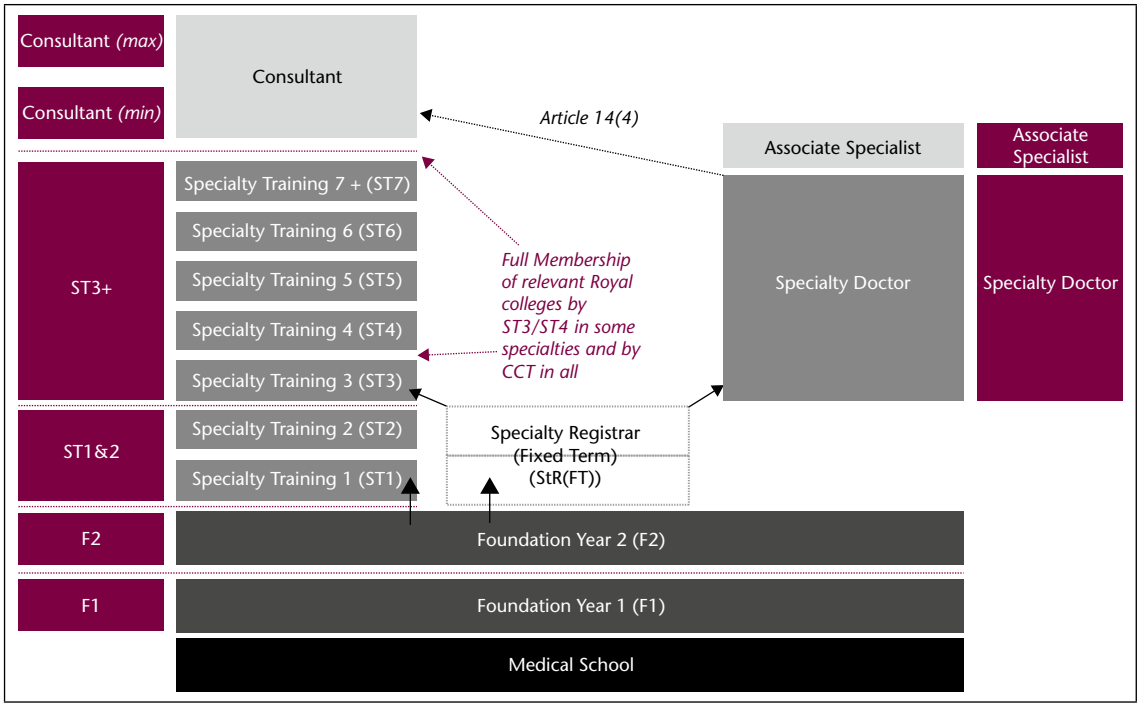
1.67 Each year our secretariat provides us with an assessment of the pay position of our remit groups relative to other groups that could be considered appropriate comparator professions, and against recent trends in general pay and price inflation measures. We look at both pay levels and movements. The specific comparator professions that we have used for a number of years are solicitors, actuaries, accountants, architects, taxation professionals and engineers. However, this year we commissioned a study from PA Consulting Group[16] to check whether the pay comparability work carried out annually for us remained appropriate.

1.68 The research found that the comparators we had used hitherto were broadly correct, although it suggested omitting taxation since it is a specialism within accountancy and law and is adequately covered by the latter two professions. It also suggested either removing engineering as a comparator or selecting specialisms within engineering, for example, civil or mechanical engineering, as it is currently too broad a comparator. For actuaries and architects the study suggested that more robust market data were needed. Having examined the existing comparators, the research identified teaching, pharmaceuticals, management consultancy and pilots as additional relevant comparators for medical career paths, on the basis of both comparison of competency and the likelihood of members of doctors' social cohorts entering those careers. As a consequence of this review, our secretariat provided us with updated comparisons with those comparator groups for which it received timely data – tax and accounting, legal, actuarial and pharmaceutical.

1.69 The research also suggested six 'anchor points', ranging from foundation year 1 to senior consultants and now incorporating SAS grades, at which doctors can be compared with other relevant careers. Figure 1.5 illustrates two career paths for our remit groups and identifies the anchor points (shown as red blocks). GMPs and dentists were not included directly in the pay comparability study.

[16] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008.
Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

Figure 1.5: Two career paths and the anchor points for pay comparability



Source: PA Consulting Group.

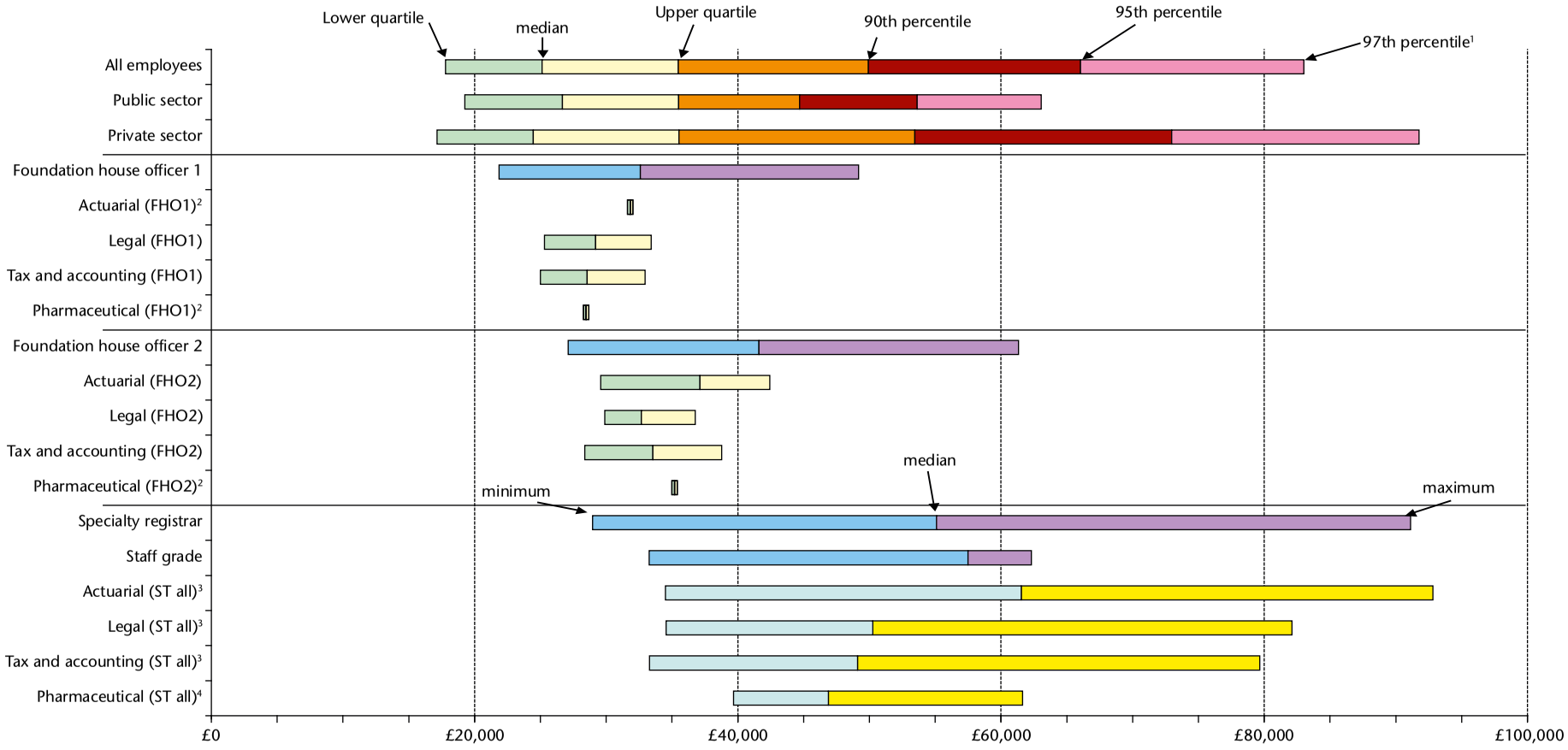
1.70 We have included details of the recommended pay comparators and some comments on pay comparability in the appropriate sections of this report, but we make some general observations here. We intend to carry out a full pay comparison by anchor point every three years. Appendix E contains further detailed analysis of pay comparability.

Pay levels

1.71 When doctors in training (foundation house officers and specialty registrars) are compared with all employees in the wider economy, only some foundation house officers in their first year are paid below the median whilst the staff grade pay range stretches from just below the upper quartile for all employees to the 95th percentile; see Figure 1.6. The majority of doctors in training have higher total earnings than those for comparator groups.

1.72 When compared with all employees in the economy, associate specialists are paid total earnings equivalent to the upper quartile or greater whilst consultants are paid above the 95th percentile of total earnings; see Figure 1.7. Mean income (before tax) for GMPs and GDPs (including part-time practitioners) is above the 90th percentile for all full-time employees. In general, consultants are paid within the range of total earnings covered by comparator professions, but median earnings are above those of most of the more experienced comparator groups and the access to CEAs provides the potential to be paid a great deal more. However, it should be noted that the median award is a level one local award and the upper quartile award is a level four local award.

Figure 1.6: Total earnings pay ranges of DDRB training grades, 2008, compared with the national pay distribution and other professional groups, full-time rates



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

Notes:

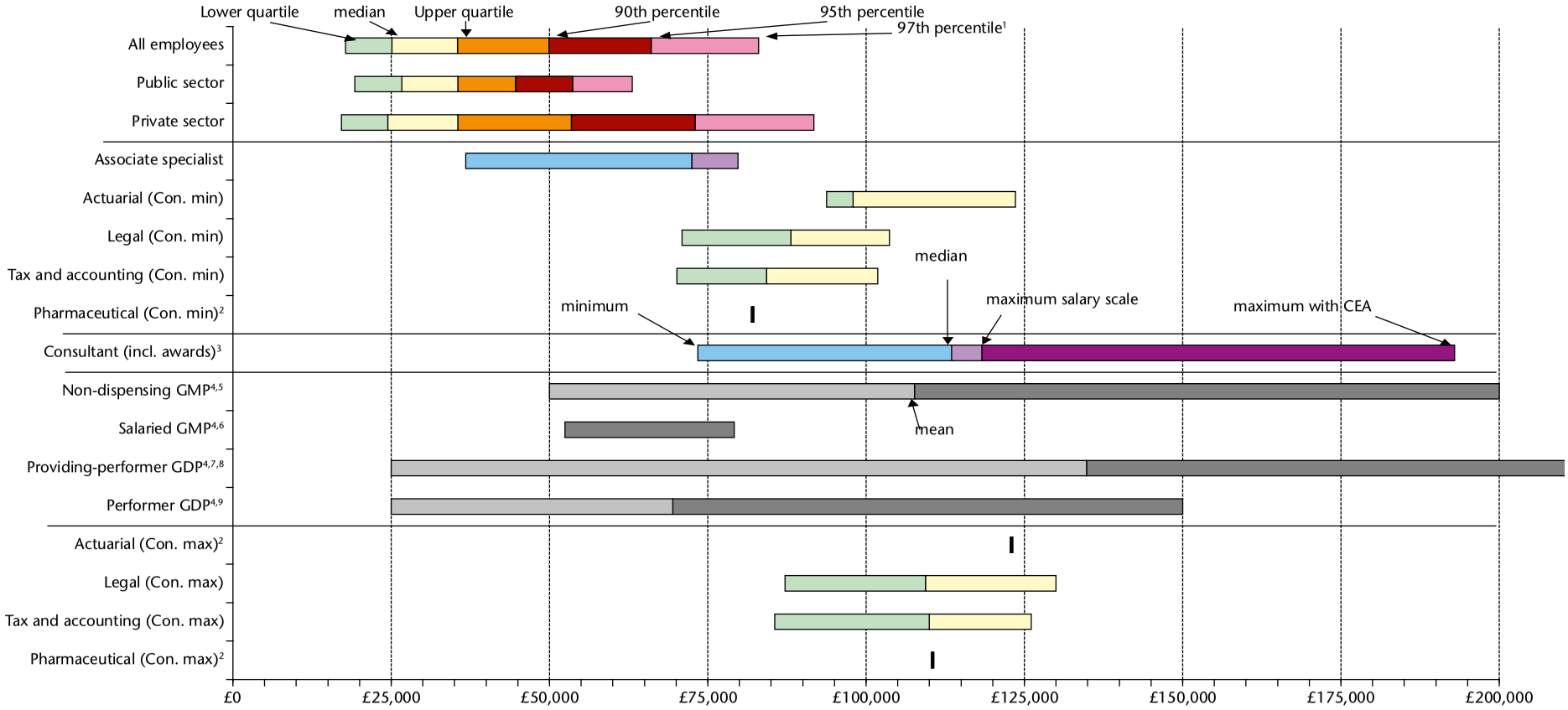
[1] The 98th percentile was used in previous years but figures are not available for 2008 for the public sector so the 97th percentile has been used this year instead.

[2] A range is not always available for actuarial posts and pharmaceutical posts.

[3] The range for specialty training (ST all) covers four distinct post types (among the comparators) and the range given is from the lower quartile of the lowest-paid post, through the mid-point between the medians of the two middle posts to the upper quartile of the highest-paid post.

[4] The range for specialty training (ST all) covers four distinct posts and the range is from the median of the lowest-paid post, through the mid-point between the medians of the two middle posts to the median of the highest-paid post.

Figure 1.7: Total earnings pay ranges of DDRB consultants and equivalent grades, 2008, compared with the national pay distribution and other professional groups, full-time rates



Sources: The Office for National Statistics, NHS Employers, the NHS Information Centre and Hay Group.

Notes:

[1] The 98th percentile was used in previous years but figures are not available for 2008 for the public sector so the 97th percentile has been used this year instead.

[2] A range is not always available for actuarial posts and never available for pharmaceutical posts.

[3] The consultant range includes Clinical Excellence Awards (CEAs); 61 per cent of consultants receive a CEA and a level 1 local award is considered the median for all consultants.

[4] Estimated mean incomes (before tax) for 2006-07 (the latest available data) for all (both full-time and part-time) GMPs and GDPs rather than medians as the latter are not available.

[5] The range given excludes the bottom 6.6 per cent (who earn less than £50,000) and the top 2.5 per cent (who earn £200,000 or more).

[6] The median salary is below the bottom of the range as the range is for full-time posts and salaried GMPs are often part-time, also the median full-time equivalent salary is above the top of the range.

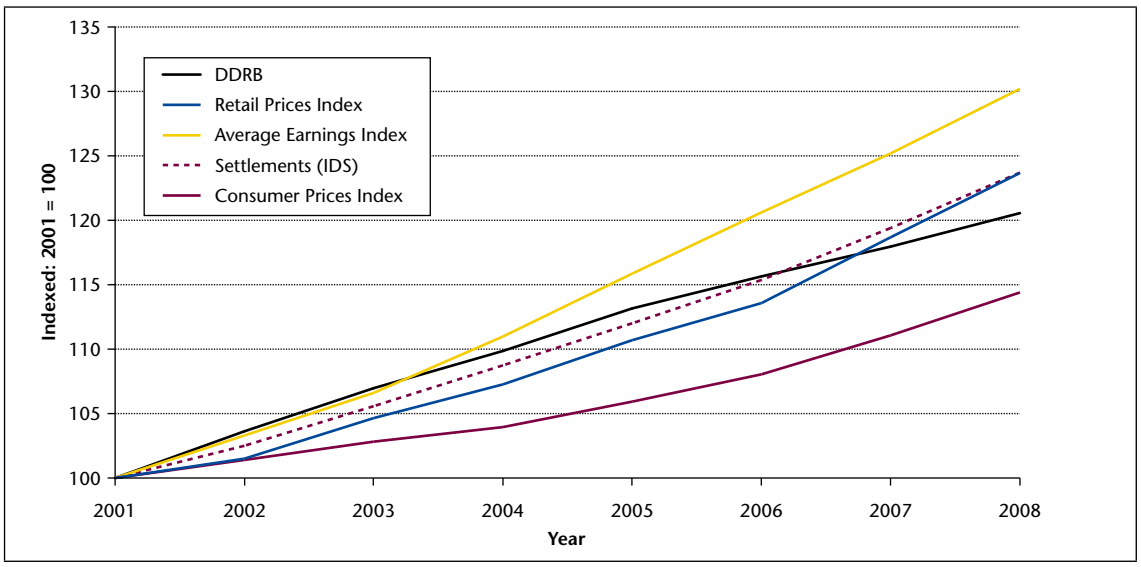
[7] The range excludes the bottom 3.1 per cent (who earn less than £25,000) and the top 5.7 per cent (who earn £300,000 or more).

[8] The top of the range is £300,000 (this excludes the top 5.7 per cent – as stated above).

[9] The range given excludes the bottom 8.9 per cent (who earn less than £25,000) and the top 4.7 per cent (who earn £150,000 or more).

1.73 As in previous years we have also looked at how our basic awards over recent years have compared to settlements and earnings in the wider economy, and the main measures of inflation (CPI and RPI). However, our recommendations are not linked, automatically or otherwise, to any particular index of pay or inflation. Figure 1.8 shows that at the start of the decade, the effect of our main awards was above comparable economic measures (the Average Earnings Index, the RPI, the CPI and settlements from Incomes Data Services (IDS)). However, by 2008 it was still yielding higher increases than CPI, but lower than the other indicators.

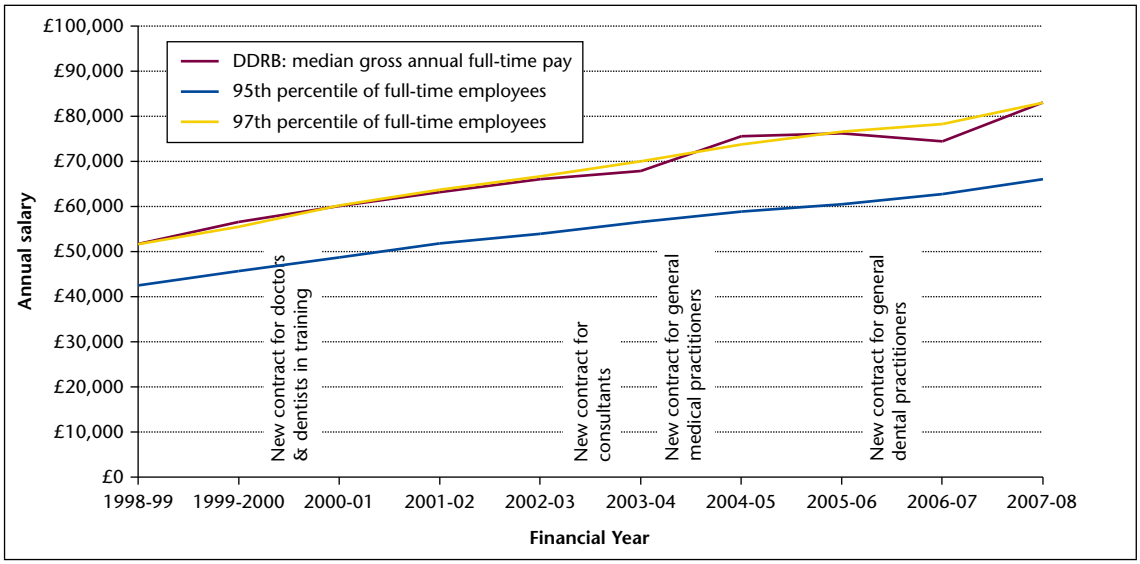
Figure 1.8: DDRB main award compared with April movement in the Retail Prices Index, Consumer Prices Index, Average Earnings Index and median (whole economy) settlements, 2001 – 2008



Sources: Office for National Statistics and Office of Manpower Economics.

1.74 We have also looked at how the earnings of our remit groups have evolved over time. Movements in their earnings are influenced by a number of factors including the basic award, overtime payments, incremental progression, performance payments and pay reform. Figure 1.9 shows that the median gross annual full-time pay for doctors and dentists has remained around the 97th percentile for all full-time employees.

Figure 1.9: Movements in earnings from the Annual Survey of Hours and Earnings, 1998-99 to 2007-08



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

Notes:

1. The data shown are gross annual pay of the 95th and 97th percentiles of all employees on full-time rates, and the full-time gross median annual earnings for all doctors and dentists in the public sector.

2. The DDRB figures for 2007 and 2008 should be used with caution as the ASHE sample was cut by 20 per cent from 2007. However, due to the technical approach taken the DDRB data were reduced by more than 20 per cent and the estimate above is now based on an even smaller sample.

Total reward: pensions and fringe benefits

1.75 The Health Departments said that there was an excellent total reward package available to our remit groups. They noted that the NHS Pension Scheme was a defined benefit occupational scheme linked to salary and that this sort of pension was a very valuable part of the reward package for staff. They believed that the changes that took place in pension arrangements from 2008 represented an improvement in the short term in the value of NHS pensions, once longevity was taken into account, which was why staff contributions had increased to help pay for these improvements. In the medium to longer term, they said, the changes to the benefit structure in the 2008 section of the scheme would reduce costs to taxpayers through holding down the cost of employers' contributions below the level these would otherwise have reached. The higher employee pension contributions represented a transfer of reward from current to deferred pay, rather than a reduction in net remuneration.

1.76 The Health Departments observed that doctors enjoyed high career pay progression and in the context of a final salary scheme tended to enjoy higher benefits in relation to the contributions made. They said that staff with high career pay progression benefited the most from a final salary pension. The employer contribution had remained at 14 per cent. Most junior hospital doctors now contributed 6.5 per cent of their pensionable pay, while consultants fell into the higher 7.5 per cent and 8.5 per cent bands. They noted that the agreement to lift the cap on pensionable earnings would mean a significant boost to the pensions of many doctors with a start date for pensionable service after 1989.

1.77 The Health Departments pointed out that GMPs and GDPs were unique among self-employed people in having access to a high quality, defined benefit pension scheme that was effectively guaranteed by the Exchequer and increased in value before payment in line with increases in earnings. They said that the normal pension age applicable to members of the NHS pension scheme was 60 for members who joined before April 2008. They believed that the general NHS reward package for hospital doctors was very competitive at postgraduate training, career grade and consultant levels. They said that a medical career in the NHS remained highly attractive in terms of financial reward, the wider reward package and job satisfaction. The Health Departments estimated base pay as a proportion of total reward to be just over 60 per cent for a consultant with 14 years seniority and just over 50 per cent for the doctors in training.

1.78 NHS Employers told us that both employers and the NHS trade unions were in agreement that pensions were deferred pay and that they recognised that the employer contribution made up a significant proportion of remuneration for members of the NHS pension scheme. NHS Employers believed that the increase in contribution rates reflected a shift in the balance between current pay and deferred pay, but should not be seen as a reduction in overall pay. They said that as the employer contribution remained the same, it should therefore be seen as neutral in pay terms. NHS Employers believed there was increased awareness of the value of the pension among NHS staff and they expected that the positive impact of the NHS pension scheme on recruitment and retention would increase. NHS Employers also recognised the importance of a final salary pension scheme as a recruitment and retention tool, particularly in relation to retaining the older workforce. They said that the NHS pension scheme continued to be a high quality final salary pension scheme costing from 2008 around 20.5 per cent of pay. They believed that the rationale for differential contributions was that higher paid staff tended to enjoy significantly higher earnings from career progression and that high earners would benefit from the removal of the earnings cap, which was £108,600 in 2006-07.

1.79 We agree that pensions are a valuable benefit for our remit groups and we set out our views on this in last year's report.[17] Our view remains that the NHS schemes are inherently more secure than those in the private sector and have the advantage of being defined benefit schemes, while the private sector is increasingly moving to defined contribution schemes where both investment risk and the risk of reduced annuities because of increasing longevity are borne by employees rather than pension schemes. Moreover, a large proportion of workers in the private sector (estimates range from 61 to 84 per cent) are currently not covered by any occupational pension provision, although the government's proposals will start to address this from 2012.

[17] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Paragraph 1.71. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

1.80 We know that there is a growing divergence between public and private sector pensions. We shall therefore continue to monitor the contribution of pensions, including benefits, to total reward both in our remit groups and in the wider labour market.

Conclusions

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

- the economic context during this round has been uncertain, and considerably changed from the position at the time of our last review. Against these rapid economic changes we have given careful consideration to what is the appropriate uplift for 2009-10;

- affordability cannot be considered separately from other priorities, especially recruitment and retention. Any pay increase reduces the resources available for increased service delivery, including increased employment of staff. However, there is clearly some flexibility in NHS finances and the extent to which organisations would be affected would vary depending on their financial circumstances;

- the majority of doctors in training have higher total earnings than those for comparator groups, but for many this is only after their out-of-hours supplements are taken into account; the base pay for foundation house officers is less competitive. The pay ranges for the remainder of our remit groups are broadly in line with those of comparator professions;

- the evidence does not give us any major cause for concern about recruitment and retention and, in general, medicine and dentistry continue to be attractive careers; and

- surveys suggest that medical and dental staff have some of the highest job satisfaction within the NHS and compare well on a like for like basis with employees in the wider economy.

CHAPTER 2: MAIN PAY RECOMMENDATIONS FOR 2009-10

The parties' proposals

2.1 Based on their interpretations of the evidence that they have provided, the parties have put forward their recommendations for pay increases in 2009-10. These recommendations differ and their proposals are described in more detail in the relevant chapters of this report. However, in this chapter, we set out the key details of the parties' proposals, together with our response. We emphasise that, as always, we have carefully considered and weighed all of the evidence that we have received.

2.2 The Health Departments said that a high award would both reduce the level of funds available for deployment in improved health care services and store up future pressures. They said that the high earnings of doctors, their job security and pension arrangements compared to the wider labour market made it unlikely that participation or morale would fall below the current relatively high levels. The Health Departments noted that many doctors and dentists had benefited from new contracts; recruitment, retention and morale remained good. They said that they supported a headline pay award of 2 per cent for directly employed groups and a simple increase in gross contract values of 1 per cent for dentists. For general medical practitioners (GMPs) they proposed a gross increase of up to 1.6 per cent. They argued that these proposals reflected the need to balance NHS aspirations for service improvements with maintaining recruitment, retention and morale, in the light of wider economic conditions. They told us that awards above these levels would unnecessarily reduce the funding available to meet NHS objectives. They said they needed a level of pay award that would not damage supply or the morale and motivation of the medical workforce in the short run but also one that would avoid storing up pressures for the mid-term. They believed that an increase above the 2 per cent assumption would generate an excess supply of staff and reduce the scope for service developments. Asked about a multi-year award, the Health Departments said they were not actively looking for such an award for doctors but would not rule it out should an agreement be possible at the right level for some categories of doctors. However, for this pay round they said they were looking for a one-year award.

2.3 The Department of Health said that it believed that the award for independent contractor general dental practitioners (GDPs) in 2009-10 should reflect the notable increase in net earnings for all groups of GDPs. While it believed it was possible to make the case from these data that there should be no increase in gross contract values this year, it recognised the need to consider implications for motivation and morale, and therefore recommended that there should instead be a simple increase in gross contract values for 2009-10 of 1 per cent. The Department of Health believed this would start to take account of the effects of the large reduction in expenses caused by the move towards more preventative and simpler courses of treatment with a lower expenses element.

2.4 The Welsh Assembly Government (WAG) said that in view of the continuing healthy position in recruitment and retention, and the morale of the medical and dental workforce, it supported a headline pay award of 2 per cent. The WAG said it would support the 1 per cent figure for the independent contractor GDPs but had no strong views on how it should be applied.

2.5 The Scottish Executive Health Department (SEHD) said a 2 per cent increase for medical staff in 2009-10 would represent a level of pay increase for medical staff that was fair and affordable. The SEHD believed it would be appropriate for dental staff to receive a net pay uplift of 2 per cent in line with the headline figure proposed for

medical staff. The SEHD also said that, while it had provided information on the additional allowances introduced in Scotland over recent years for us to take into account, it was not suggesting that these should lead to a different net pay outcome from the headline figure. The SEHD did, however, ask us to take these allowances into account in calculating the gross figure.

2.6 For Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPSNI) said it was committed to implementing United Kingdom national public sector pay policy. It said that the presumption was that the Department of Health's rationale for a pay settlement in the region of 2 per cent should apply to Northern Ireland but it reserved its position. For GDPs, the DHSSPSNI said it was seeking an increase of 2 per cent.

2.7 NHS Employers said it was necessary to consider the effectiveness of the whole reward package – including pensions, tangible and non-tangible rewards – in enabling the NHS to recruit the correct number of staff with the right skill mix to do all the things required of the service. They said that their views were based on three key areas: recruitment and retention, financial considerations linked to the tariff, and staff morale, and concluded that 2 per cent would be affordable. NHS Employers said they would welcome a multi-year award for doctors and dentists to the end of the Comprehensive Spending Review period, to give stability and predictability for employers and staff, but noted that no discussions on such a deal were taking place. NHS Employers said that the majority of employers would prefer a percentage increase rather than a flat rate increase for medical staff and did not believe that extra pay should be targeted at any particular medical or dental groups.

2.8 For GMPs, NHS Employers sought an overall gross uplift of up to 1.5 per cent to General Medical Services (GMS) contract payments for 2009-10. They also said that, based on the feedback received from their focus group, they recommended no uplift for 2009-10 to gross contract values for GDPs. This was because a general pay award would not allow PCTs to renegotiate contracts to achieve efficiency savings, access targets and improvement in the quality of services. NHS Employers said a recommendation of no increase for 2009-10 would allow PCTs to manage contracts more effectively and to invest locally in providing additional and improved services in ways that were more responsive to local requirements.

2.9 The British Medical Association (BMA) said that in recent years our recommendations had failed to keep pace with settlements in the economy as a whole and it was important that they now began to do so. It considered the basic uplift for this year should be at the upper end of the settlement range for the economy as a whole, enabling earnings increases to protect the value of existing contracts relative to current and prospective Retail Prices Index (RPI) inflation and reflect productivity increases in the economy as a whole. It sought a basic earnings increase of at least 4 per cent. In addition, it asked us to recommend increases to all other fees and allowances so as to maintain or restore their relationship with basic salaries. Asked about multi-year deals, it said it would be difficult to justify entering into long-term pay agreements at this time.

2.10 For independent contractor GMPs we received a joint letter from the Health Departments, NHS Employers and the BMA which reported the outcome of discussions between the parties on our role in relation to GMPs' pay for 2009-10. A copy of this letter is at Appendix F. The parties told us that they had agreed a methodology based on a pre-determined ratio to distribute the overall uplift agreed for 2009-10 differentially across agreed components of the GMS contract. They said that the overall purpose of the methodology was to reduce general practice reliance on correction factor payments through the application of differential uplifts to the

global sum, global sum equivalent, Quality and Outcomes Framework payments and other elements of the GMS contract. They asked us to recommend an overall gross uplift in GMS contract payments, based on what average increase in net income we thought GMPs should receive and on our assessment of the change in practice expenses. They said that we should express the gross uplift as a single percentage figure (if need be to two decimal places) and that this figure, if accepted by each government, would be used to determine a set of differential uplifts that would be applied to agreed components of the GMS contract at the start of 2009-10.

2.11 The British Dental Association (BDA) asked for a 5.3 per cent net uplift to GDP remuneration. This was based on reported average increases in dental staff pay of 5.3 per cent in 2008; the BDA considered that GDPs should receive the same increase as their staff. Its evidence highlighted that GDPs were exposed to prevailing economic conditions more than other healthcare professionals and that this should be taken into account in determining the increase in uplift.

2.12 The Dental Practitioners Association asked for an increase in fees of 5 per cent for inflation.

Main pay recommendations for 2009-10

2.13 This has been a particularly difficult round because we have been taking evidence and considering our recommendations against the background of an unexpectedly sharp downturn in the economy, with the United Kingdom moving into what some commentators think may turn out to be a prolonged recession in the second half of 2008. Unemployment is rising steeply – it reached 6.3 per cent in the fourth quarter of 2008, from 5.2 per cent a year ago – and some employers have announced pay freezes or short-time working. Around the time that evidence was submitted, inflation was at its peak: in September 2008 it was 5 per cent on the Retail Prices Index (RPI) measure and 5.2 per cent on the Consumer Prices Index (CPI) measure, but has since fallen sharply. The annual rate of change in the RPI was 0.1 per cent in January 2009 and for the CPI 3.0 per cent. The Treasury is forecasting that the annual rate of retail price inflation will fall to minus 2.25 per cent by the fourth quarter of 2009 while the rate of consumer price inflation will then be at 0.5 per cent. The CPI inflation rate is expected to move slightly above the 2 per cent target in 2010 and return to the target level in 2011. The government forecasts that economic recovery will begin in the second half of 2009, with growth picking up further in 2010 and 2011. Most independent commentators forecast that the recovery will not start in 2009.

2.14 The rapid shift in the state of the economy over the recent past and the prospects for the immediate future significantly affect the relative position of our remit groups. The economic downturn has already had quite severe consequences for employment and job security across the private sector. Employment in the public sector has therefore become more attractive, combining as it does a high degree of job security with a state-backed, defined benefit pension. It is important to note that the written evidence that we have received was largely prepared in the summer and early autumn of 2008. It was clear, even then, that the recruitment and retention of doctors and dentists was satisfactory overall, with only minor, localised shortages in a few categories.

2.15 Our terms of reference, set out at the beginning of this report, require us to take account of various factors but notably:

- the need to recruit, retain and motivate doctors and dentists;
- regional/local variations in labour markets;

- the funds available to the Health Departments;
- the government's inflation target; and
- the economic and other evidence.

2.16 We have considered all the evidence and the matters we are required by our terms of reference to take into account. Economic prospects for the general population are highly uncertain. However, doctors and dentists working for the NHS have relatively secure employment and job stability. In the highly unusual economic circumstances this year, our conclusion is that only modest increases are justified at this time.

2.17 We have examined the survey evidence on doctors' and dentists' levels of morale and found that they are generally consistent with or better than the level of morale of employees in the wider economy. Moreover, most doctors and dentists are enjoying the benefits of new contracts, including increased pay and, in many cases, reduced hours. We can see no pressures pointing to the need for a significant pay increase for our remit groups. The government's investment in the NHS in recent years, coupled with new contracts and pay modernisation, mean that all NHS staff have seen pay increases above the average for the public sector since 2000.

2.18 We have considered whether any groups within our remit should be awarded a higher uplift than any other group, but have concluded that there is no reason to differentiate between the salaried members of our remit groups. We have therefore made a recommendation for the same basic increase across the remit groups, although the awards for independent contractor GMPs and GDPs, who are running small businesses, take account of changes in their expenses.

2.19 We **recommend for 2009-10 a base increase of 1.5 per cent to the national salary scales for doctors and dentists**. The detailed recommendations for each group can be found in the relevant chapters.

2.20 **For the other fees and allowances on which we are required to recommend, unless they are specifically mentioned elsewhere in the report, we recommend that these be increased by 1.5 per cent for 2009-10.**

2.21 We **recommend that the overall gross uplift in General Medical Services contract payments be increased by a factor intended to result in an increase in general medical practitioners' net income of 1.5 per cent after allowing for movement in their expenses**. Using this uplift for GMPs' personal remuneration along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 2.29 per cent. Therefore, we recommend that an uplift of 2.29 per cent be applied to the overall gross uplift in General Medical Services contract payments for 2009-10 for general medical practitioners.

2.22 We **recommend that the gross earnings base be increased by a factor intended to result in an increase in general dental practitioners' net income of 1.5 per cent after allowing for movement in expenses**. Using this uplift for general dental practitioners' personal remuneration along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 0.21 per cent. Therefore, we **recommend that an uplift of 0.21 per cent be applied to the gross earnings base under the new contract for 2009-10 for general dental practitioners in England and Wales**. This year we have received no evidence from the parties on how to treat gross fees, commitment payments or sessional fees in Scotland and Northern Ireland to translate into a net uplift of 1.5 per cent. Therefore, to be consistent with previous years, **we are recommending that the uplift of 0.21 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland**. We expect to receive data next year to allow us to consider Scottish dentistry and Northern Ireland dentistry separately and to make separate recommendations.

2.23 We recognise that these recommendations may be below what the parties are expecting. However, taking into account the economic and other evidence provided by the parties as well as the various aspects of our remit, our independent and considered judgement is that this is a fair and reasonable uplift. In the current exceptional and rapidly changing economic circumstances and with the majority of doctors and dentists on new, modernised contracts, we believe that a general increase of 1.5 per cent will be sufficient to recruit, retain and motivate our group for the coming year.

2.24 There is a full summary of our conclusions and recommendations at the beginning of this report. Appendix A sets out the detailed pay scales arising from our recommendations.

Part II: Primary Care

CHAPTER 3: GENERAL MEDICAL PRACTITIONERS

Introduction

3.1 The core traditional role for general medical practitioners (GMPs) is the family doctor, working either in General Medical Services (GMS) or in Personal Medical Services (PMS), in the primary care sector of the NHS. We are concerned only with GMS which is governed by a United Kingdom-wide contract. Doctors working in PMS contract locally with primary care organisations (PCOs) or, in some cases, strategic health authorities. However, local contracts tend to follow the main features of the GMS contract. We understand from the National Audit Office (NAO) report[18] that approximately 62 per cent of GMPs have GMS contracts.

3.2 The pay comparability research carried out by PA Consulting Group[19] did not include GMPs. However, a comparison of GMP earnings with other doctors and dentists, and comparator groups for salaried staff, is given in Chapter 1.

3.3 Most of the doctors working in the GMS are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses; although unlike other small businesses a significant amount of the costs are provided out of public funds. For example, the Health Departments told us that around 90 per cent of independent contractor GMPs' earnings came from contracts for the provision of primary medical care services to NHS patients. Some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. The number of salaried GMPs, employed by practices, has increased substantially in recent years. A new contract was introduced throughout the United Kingdom on 1 April 2004. The contract is with the practice rather than with individual GMPs. The contract allows for gross income under several different headings:

- basic services – this is known as the global sum, a payment based on the number of patients registered with the practice;
- enhanced services – for example, dermatology or sexual health clinics;
- PCO administered funding – to cover expenses such as premises and information technology, as well as seniority payments and payments for dispensing practices; and
- Quality and Outcomes Framework (QOF) – payments to GMPs for achieving various government priorities such as managing chronic diseases, providing extra services including child health and maternity services, organising and managing the practice, and achieving targets for patient experience. Practices are currently able to earn up to 1,000 points a year, each worth £124.60 in 2008-09.

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[18] National Audit Office. *NHS pay modernisation: new contracts for general practice services in England*. Report by the Comptroller and Auditor General. HC 307 session 2007-08. 28 February 2008. TSO, 2008.
Available from: http://www.nao.org.uk/publications/0708/new_contracts_for_general_prac.aspx

[19] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008.
Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

3.4 Independent contractor GMPs can earn income from a wide range of professional activities. Many also do work for the NHS outside the contract and this is rewarded through fees and allowances, including payments to GMP educators, and the GMP trainers' grant. Payment for work in community hospitals and sessional fees for doctors in the community health service for work under collaborative arrangements are also outside the contract, and doctors set their own fees for this work.

3.5 Salaried GMPs are employed either by PCOs or by independent contractor practices. The pay range for salaried GMPs is at Appendix A.

3.6 The latest data show that at 30 September 2007 there were over 44,000 GMPs in practices with NHS contracts in the United Kingdom.

The evidence

3.7 We have received evidence relating to GMPs from the Health Departments, NHS Employers and the British Medical Association (BMA). The main evidence can be read in full on the parties' websites (see Appendix D). The evidence covered a range of issues affecting GMPs, in addition to basic pay, including the all party agreement on the recommendations for 2009-10 for GMPs, and these issues are addressed in the following paragraphs.

3.8 For this chapter of the report we have also drawn on the NAO report[20] and the Committee of Public Accounts report[21] on the *New Contracts for General Practice Services in England*.

Recruitment and retention

3.9 The Health Departments told us that there was no evidence to suggest that there were any problems with the recruitment and retention of GMPs. They believed that as the economy weakened general practice would become more attractive because there was little or no risk of redundancy. They noted that GMP numbers were continuing to grow, with an increasing proportion of salaried GMPs. The number of GMP partnerships had decreased steadily each year between 1997 and 2007, from 9,102 to 8,261 – a fall of 9 per cent. The trend towards salaried GMPs was expected to continue in the future. The Health Departments said that according to the 2008 NHS vacancy survey, the long-term vacancy rate was lowest for GMPs at an estimated 0.3 per cent. The estimated three-month vacancy rate in England had fallen from 2.4 per cent in 2005, to 1.1 per cent in 2006, to 0.8 per cent in 2007 and to 0.3 per cent in 2008. They believed that the current supply of qualified GMPs remained healthy and did not warrant increases in GMP pay. We were also told that recruitment and retention of GMPs in Wales had improved considerably since the implementation of the new practice-based contract.

3.10 NHS Employers pointed to a lack of any recruitment and retention problems amongst GMPs. They said that primary care trusts (PCTs) had reported no problems with GMP recruitment and retention which was perceived to be buoyant. NHS Employers said that there was no requirement for a significant increase in pay to ensure positions could be filled.

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[20] National Audit Office. *NHS pay modernisation: new contracts for general practice services in England*. Report by the Comptroller and Auditor General. HC 307 session 2007-08. 28 February 2008. TSO, 2008. Available from: http://www.nao.org.uk/publications/0708/new_contracts_for_general_prac.aspx

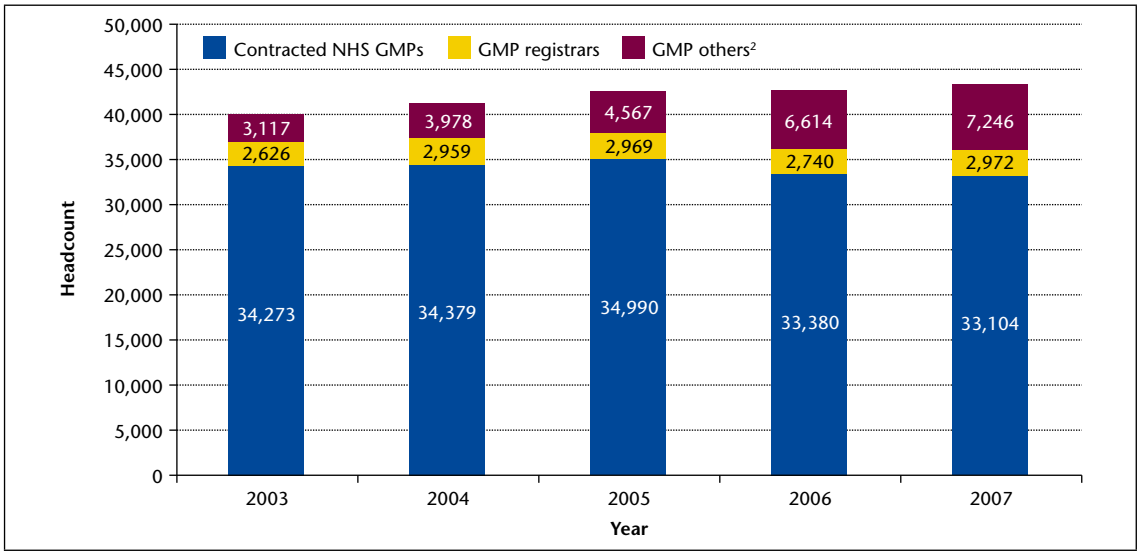
[21] House of Commons Committee of Public Accounts. *NHS pay modernisation: new contracts for general practice services in England*. Forty-first report of session 2007-08. HC 463. TSO, 2008. Available from: http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmpubacc/463/463.pdf

3.11 The BMA observed that general practice had experienced the lowest growth of all medical sectors since 1998, with an average increase of 1.7 per cent GMPs per year and only 1.1 per cent in the last year. It noted a significant difference in the increase of contractor/performer GMPs compared to salaried/other GMPs and said that salaried GMPs had increased from 872 in 1998 to 6,588 in 2007 (655.5 per cent), while GMP contractors had increased by 124 from 33,950 in 1998 to 34,074 in 2007 (0.4 per cent).

3.12 The NAO noted that while recruitment had improved in terms of applicants per available job, the number of practice partnerships on offer had reduced, with practices taking on a higher proportion of salaried GMPs. It said that while good progress had been made on increasing the number of GMPs, it was too early to say whether the new contract had helped retention.

3.13 Figure 3.1 illustrates the changing pattern of salaried and independent contractor GMPs between 2003 and 2007. It shows that while the total number of GMPs in Great Britain reached its peak of 43,332 in 2007, the number of independent contractor GMPs (which stood at 33,104 in 2007) was highest in 2005, but the number of salaried GMPs and those working flexibly has steadily increased, more than doubling in the four years between 2003 and 2006, to 7,246 in 2007. After a slight reduction in 2006, the number of GMP registrars has recovered, and reached a peak of 2,972 in 2007.

Figure 3.1: Number of general medical practitioners, 2003 – 2007, Great Britain[1]



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

Notes:

1. Northern Ireland data not included as no GMP breakdown is available.

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

Motivation and morale

3.14 The Department of Health told us that it took seriously the issue of GMP satisfaction and was supporting the NHS in addressing these concerns in a number of ways. For example: a programme to explain the benefits of new services and the importance of open competition; the publication of a refreshed vision and strategy for primary care and community health services as part of the *Next Stage Review*; and a reaffirmation of the importance of working with professional and patient groups to support continuous improvements in the quality of primary care, also as part of the *Next Stage*

Review. NHS Employers said that the 2008-09 award had been perceived to impact adversely on GMP morale and in some cases the relationship between practices and PCTs had been made more difficult because of the mismatch between the award and the expectations of GMPs. We did not receive any evidence from the BMA relating specifically to the motivation and morale of GMPs.

3.15 The NAO report stated that in response to its 2007 survey, commissioned specifically for its report, GMPs responded that while their morale had improved in 2005 it had subsequently decreased, partly as a result of negative publicity about pay increases but also the zero uplift in GMP funding for 2006-07. It noted that the removal of out-of-hours work had been an important factor in improving satisfaction for GMPs, and that employment options for GMPs had increased, as reflected in the increase in the number of part-time GMPs. However, it said that surveys carried out by various bodies in 2007 had shown a deterioration in the satisfaction of GMPs. In the NAO survey, only 31 per cent of GMPs had expressed some level of satisfaction with their work and 41 per cent expressed varying degrees of dissatisfaction with their work. The NAO found that 60 per cent of GMPs believed that the new GMS contract was an improvement on the old contract, but that personal satisfaction with their role was not so strong. The NAO commented that there could be factors apart from the contract which had affected GMP morale. The NAO's focus groups and survey had found that the initial optimism about the contract appeared to have evaporated and some groups of GMPs, for example salaried GMPs, expressed lower satisfaction.

Workload

3.16 The Health Departments told us that as a result of the new arrangements agreed with the BMA in 2008, there were currently 59 per cent of GMS practices providing additional consultations outside core opening hours. For a practice with an average patient list size, this meant providing an additional three hours per week of additional GMP consultation time (equivalent to around one hour per week for each of the GMPs in that practice).

3.17 The BMA believed that the most important determinants of workload were the number of patients and their distribution by age and gender. It said that some work went unrewarded in the absence of an increase in the payment per weighted patient under the global sum. The BMA noted the increasing complexity of GMP workload and what it considered to be the insensitivity of the global sum mechanism to changes in the demographic characteristics of the population and their impact on workload.

Independent contractor GMPs

3.18 Last year we asked the parties jointly to consider our role for the future and either to agree a mechanism whereby we could make recommendations on GMPs' net incomes, or to remove independent contractor GMPs from our remit and settle future changes to the contract by negotiation. We were therefore pleased to receive a joint letter from the parties which reported the outcome of discussions between the parties as to our role in relation to GMPs' pay for 2009-10. A copy of this letter is at Appendix F.

3.19 The letter said that the Health Departments, NHS Employers and the BMA had agreed that for 2009-10 there should be differential uplifts to the global sum and global sum equivalent in order to reduce general practice reliance on correction factor payments under the minimum practice income guarantee (MPIG). It said that they had also agreed the principle that there should be a comparable process to achieve the same aim in future years, either through differential uplifts or through possible alternative

models. For 2009-10, the parties told us that they had agreed a specific methodology based on a pre-determined ratio formula, which would be used to distribute the overall uplift agreed for 2009-10 differentially across agreed components of the GMS contract. They said that the overall purpose of the methodology was to reduce general practice reliance on correction factor payments through the application of differential uplifts to the global sum, global sum equivalent, QOF payments and other elements of the GMS contract.

3.20 With regard to our role, the parties said that they looked to us to make a recommendation on the level of overall uplift to be applied to GMS contract payments for 2009-10. They asked us to recommend an overall gross uplift in GMS contract payments, taking into account our views on the average increase in net income that GMPs should receive and our views on movements in practice expenses. They said that the gross uplift should be expressed as a single percentage figure (if need be to two decimal places) and that this single gross percentage uplift figure recommended by us (and if accepted by each government) would be used to determine a set of differential uplifts that would be applied to agreed components of the GMS contract at the start of 2009-10.

3.21 The letter said that computation of these differential uplifts would be based on a methodology that had been agreed by all the parties. We welcome this agreed methodology, but will continue to monitor the number of practices that are taken off MPIG and ask the parties to provide data on this for the next review.

3.22 In addition to the letter, we received separate evidence from the relevant parties which we were able to use in coming to our decision on the gross uplift. The relevant sections of this evidence are summarised in Table 3.1 below and in the following paragraphs.

Table 3.1: Summary of parties' uplift requests

	Health Departments	NHS Employers	BMA
Gross uplift sought	Up to 1.6%	Up to 1.5%	3.5%
Net uplift ***(resulting from gross uplift)***	0.4%	Zero	4%

Independent contractor GMPs' earnings

3.23 The Health Departments said that historically GMPs had invested approximately 60 per cent of earnings back into the practice, but by 2005-06 it had reduced to 55 per cent. They believed this meant that GMPs were retaining a significantly higher proportion of their earnings as profit. They said that this trend saw a slight reversal in 2006-07 with 56.5 per cent of income being spent on patient services. The Health Departments expected this new trend to continue into 2007-08 and 2008-09. They told us that there was evidence to suggest that GMPs had been driving down their costs (and maintaining profits at higher levels than might otherwise have been possible) in response to the 2006-07 negotiated settlement and our recommendations for 2007-08 and 2008-09 and that they would continue to be able to achieve efficiencies in delivering services to patients; for example, the increased role for practice nurses and the increased number of salaried GMPs. The Health Departments estimated that overall practice expenses would increase by around 3.1 per cent in 2009-10 and said that they expected GMPs, like the rest of the NHS, to achieve efficiency savings on operating costs (i.e. on total expenses).

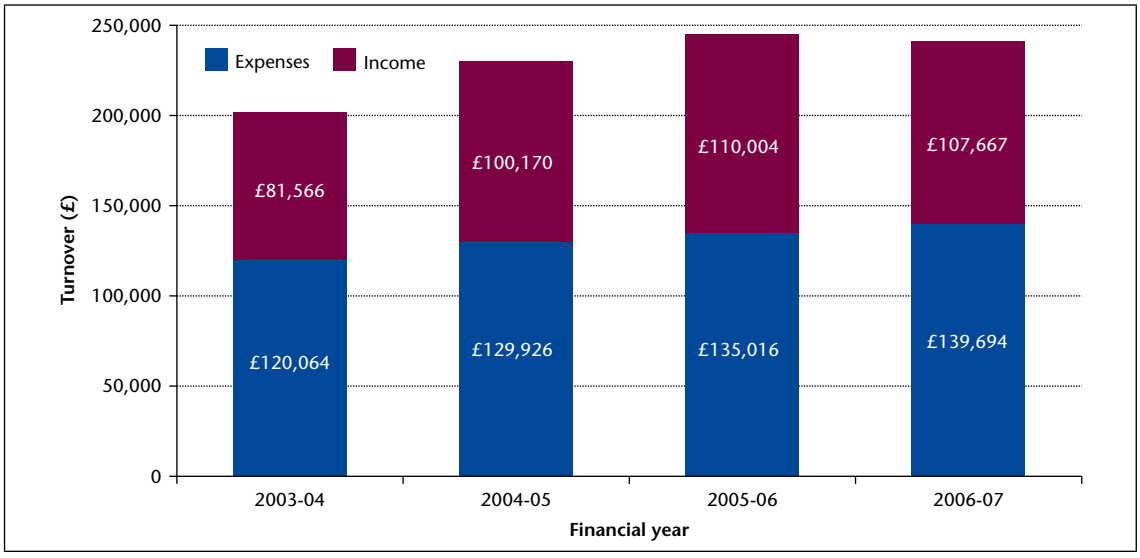
3.24 NHS Employers said that the expenses to earnings ratio for 2006-07 was 56.5:43.5 – a step closer to the traditional 60:40 ratio. NHS Employers believed that our recommendations for 2007-08 and 2008-09 had moved the expenses to earnings ratio even closer to 60:40.

3.25 The BMA anticipated, on the basis of conservative estimates of movements in expenses and increases in total gross earnings which mirrored the new GMS contract, that net incomes would have fallen further since 2006-07 (according to the latest HM Revenue and Customs (HMRC) figures) probably by at least 8 per cent over the period to 2008-09.

3.26 The NAO observed that the average pay of GMP partners had increased by 58 per cent in the first three years of the contract (2003-04 to 2005-06). However, it noted that part of the aim in introducing the new GMS contract was to make general practice a more attractive career option for doctors and that this meant increasing average pay, to bring it more closely into line with the pay received by hospital consultants. It said that this had arisen largely from a combination of increased practice income and a smaller increase in the expenses paid out by each practice. It noted that in comparison, the average pay of salaried GMPs had risen by only 3 per cent in the first two years of the contract (2003-04 to 2004-05). The NAO also noted that there was a variation in the amount of money used by GMS practices to cover practice expenses, for example some practices employed fewer staff or worked as single-handed practitioners. It said that it was not known whether this reduction in expenses was due to GMP efficiency or a reduction in spending in the practice by GMPs, but the NAO observed that average practice nurse income had reduced in real terms and salaried GMPs' income had only increased by a small percentage. It noted that the income data used for GMPs also included private work, but that this amounted to less than 5 per cent of total GMP income. The House of Commons Committee of Public Accounts, taking oral evidence in response to the NAO report, was critical of the increased pay that GMP partners had received.

3.27 Figure 3.2 and Table 3.2 show that in 2006-07 GMPs' average income saw a decrease of 2.1 per cent to £107,667, and that the expenses to earnings ratio moved back towards the traditional 60:40 split.

Figure 3.2: General medical practitioners' turnover: expenses and income 2003-04 to 2006-07, United Kingdom



Source: The NHS Information Centre using HM Revenue and Customs data.

Table 3.2: General medical practitioners' earnings, expenses and income, 2003-04 to 2006-07, United Kingdom

Financial Year	Gross Earnings	Total Expenses	Net Income (before tax)			Expenses to Earnings Ratio
	£	£	£	% Annual Increase	% Cumulative Increase	
2003-04	201,630	120,064	81,566	–	–	59.5
2004-05	230,097	129,926	100,170	22.8	22.8	56.5
2005-06	245,020	135,016	110,004	9.8	32.6	55.1
2006-07	247,362	139,694	107,667	-2.1	30.5	56.5

Source: The NHS Information Centre using HM Revenue and Customs data.

Note: The figures in the table above are averages and include the full range of general practitioner results, including dispensing doctors. However, the inclusion of dispensing doctor results does not significantly distort the average picture. The figures also include income from all sources, including private. See detailed HMRC figures and explanation.[22]

Minimum practice income guarantee

3.28 The Health Departments said that the main feature of the differential uplift was that it would reduce expenditure on correction factor payments under MPIG and allow these savings to be reinvested in global sum payments, thereby reducing the inequities that had existed in basic practice funding since the start of the new GMS contract. They told us that the effect of the formula agreed by the parties was to ensure that, whatever the overall uplift in gross funding (as a result of our recommendation), there would be some increase for all practices, but with proportionately less for practices with significant amounts of historic income protection.

3.29 NHS Employers told us that the 1.5 per cent gross uplift they sought would significantly reduce general practice reliance on correction factor payments. They said that some 17 per cent of GMS practices would no longer require income protection payments under MPIG arrangements. The proportion of GMS practices receiving correction factor payments would reduce from around the current 91 per cent to an estimated 74 per cent and there would be a saving on total correction factor payments of £125 million. They said that these savings would be reinvested into global sum payments, facilitating a fairer and more equitable distribution of resources across GMS practices. NHS Employers believed that the erosion of MPIG would start to address any issues in the distribution of funding to deprived areas. They said that the changes to the prevalence adjustment agreed for 2009-10 would ensure that by April 2010 all practices would receive the same weighting per patient with a specific disease, irrelevant of list size. They believed that the move towards full prevalence would ensure fairer funding to practices based on their population's needs.

3.30 The BMA pointed out that the agreement on a ratio approach was for the coming year only and would, depending on the uplift recommended, remove a substantial number of practices from MPIG protection.

[22] Technical Steering Committee. *GP earnings and expenses enquiry 2006/07: initial report*. NHS Information Centre, October 2008. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-2006-07--initial-report

3.31 The new methodology, although only agreed for 2009-10, is a move in the right direction. We have studied the evidence from the parties and used this to inform our recommendation. While we remain to be convinced that correction factor reliance will disappear as quickly as the parties think, we note that this is the expectation and will want to monitor progress in reducing correction factor payments. As we noted earlier, we ask the parties for a progress report on the reduction of correction factor payments and the impact of our recommendation for the uplift for independent contractor GMPs for the next round.

Gross and net uplift

3.32 The Health Departments said that this year, in recognition of the trends emerging from the 2006-07 GMP earnings and expenses data, they would not wish a recommendation that reduced the average net earnings for GMPs, but they believed that we needed only to recommend an increase in average gross income sufficient to cover expected increases in expenses in 2009-10, aiming to deliver no (or minimal) uplift of GMP profits. They said that a 1.6 per cent gross uplift (for those contract payments covered by our recommendations) would at least cover the average increase in practice expenses and, depending on the degree of cash-releasing efficiency, would potentially result in an increase of up to 1.6 per cent in net income. Without any cash-releasing efficiencies, they estimated that GMPs' net income would increase by 0.4 per cent. They said that the effect of the formula agreed by the parties was to ensure that, whatever the overall uplift in gross funding (as a result of our recommendation), there would be some increase for all practices, but with proportionately less for practices with significant amounts of historic income protection (i.e. MPIG).

3.33 NHS Employers said that independent contractor GMPs should receive an uplift to their net pay in line with that awarded to other healthcare professionals in 2009-10. They told us that PCTs would welcome some uplift to the GMS contract to help cultivate their working relationships with GMPs. NHS Employers sought an overall gross uplift of up to 1.5 per cent to GMS contract payments for 2009-10. They said that this would result in broadly a 2 per cent increase in average GMP net pay in 2009-10. However, NHS Employers have built in assumptions of cash-releasing efficiency savings of 1 per cent. Without efficiencies, they said that an uplift of 1.5 per cent to GMS contract payments would be broadly sufficient to fund the estimated growth in expenses, or a zero uplift in net income.

3.34 The BMA suggested that our recommendations for uplift included provision for an increase in net income of no less than 4 per cent. It said that this could be achieved through a 3.5 per cent gross uplift, which it believed would generate the 3.36 per cent total gross income increase necessary to deliver the 4 per cent increase in average net income. The BMA had made no contingency for cash-releasing efficiencies in its pay proposals. It said that to cover expenses without delivering a change in net income, a gross increase of 1.9 per cent would be necessary.

Staff costs

3.35 The Health Departments said that they had assumed that practice staff pay would increase by around 2.5 per cent in 2009-10. This was based on the *Agenda for Change* headline award of 2.4 per cent for 2009-10 plus a 0.13 per cent increase to reflect structural changes to Band 5, the appropriate Band for practice nurses. This gave a total increase of 2.53 per cent and was at the outer limit of how much they expected practice staff pay to increase next year. The Health Departments told us that they believed it possible that pay drift could be negative, but in the absence of firm data considered it reasonable to assume that there was neither positive nor negative drift currently in the system.

3.36 NHS Employers said that the increase in staff costs should be viewed in the light of the overall expenses to earnings ratio, which was now back to the original 60:40 ratio.

3.37 The BMA said that it had used the 4.1 per cent overall pay figure that NHS Employers had used in their PCT/acute trust income and expenditure models; however, some of the factors NHS Employers took into account were not obviously transferable to the GMS situation. The BMA looked therefore for an estimate of pure incremental drift and came up with a 2007-08 figure used in Wales; this was 0.81 per cent for *Agenda for Change* staff. It took the view that the restructuring was probably independent of this drift, so compounded this with 2.54 per cent – getting 3.37 per cent rounded to 3.4 per cent. The BMA believed that it would be advantageous to separate staff expenses from other expenses and use an alternative earnings related index for these.

3.38 We note that GMPs as independent contractors are ultimately responsible for setting the pay of the staff they employ and that this does not necessarily mean that they pay *Agenda for Change* rates, nor consequently that they are bound to apply the *Agenda for Change* levels of uplift.

Other expenses

3.39 The Health Departments estimated that overall practice expenses would increase by around 3.1 per cent in 2009-10. The estimate of a 1.6 per cent gross uplift took into account the fact that, under existing contractual arrangements, GMPs received direct reimbursement from the NHS for many of the significant drivers in expenses, including premises costs and investment in information technology systems. The Health Departments said that the gross uplift in those payments that fell within the scope of our recommendations (i.e. global sum, QOF and enhanced services) did not need to cover increases in those expenses. The Health Departments said that a 1.6 per cent gross uplift (for those contract payments covered by our recommendations) would at least cover the average increase in practice expenses and, depending on the degree of cash-releasing efficiency, would potentially result in an increase of up to 1.6 per cent in net income; this figure would be 0.4 per cent before taking account of potential additional NHS income or cash-releasing efficiency gains.

3.40 NHS Employers said that 'pass through' costs related to premises, information technology and other types of straight reimbursement by PCTs of practice spend or other spend that did not contribute directly to practice profits. They said that an uplift of 1.5 per cent to gross GMS contract payments was broadly sufficient to fund the estimated growth in expenses that practices would be expected to manage in 2009-10.

3.41 The BMA believed that remaining expenses were likely to increase by at least the projected rate of the increase in the Retail Prices Index (RPI). It was unsure why we had chosen last year to use Retail Prices Index excluding Mortgage Interest Payments (RPIX) as the expenses indicator rather than RPI as in the dental formula. The BMA had concerns about the use of RPIX as an index for total expenses. It favoured disaggregation, with separate indices applied to staff costs and to the remainder. It also considered that the formula should take some account of volume change in so far as there was a persistent tendency for expenses increases to exceed both earnings and price index movements.

3.42 As we explained last year, we used RPIX in relation to GMP practice expenses because this excludes housing costs: the cost of premises is part of PCO administered funding which is directly reimbursed.[23] On the other hand, RPI was used for the dental formula because it was considered to be the most appropriate index for dental expenses that included premises costs.[24]

3.43 Although current data were not available (the most recently published figures were for 2006-07), the parties seemed to be in agreement that the expenses to earnings ratio had moved closer to the traditional 60:40 figure.

Efficiencies

3.44 The Health Departments expected GMPs, like the rest of the NHS, to achieve efficiency savings on operating costs (i.e. on total expenses); 1 per cent was the amount they considered reasonable. Given the continuing high levels of GMP earnings and the healthy position on recruitment and retention, they considered that any increase in average GMP earnings should be linked to additional work rather than being applied through an automatic uplift in contract payments. In oral evidence they said that if we did not take account of efficiencies in our recommendations, then net income for GMPs would be likely to be in excess of what was reasonable.

3.45 NHS Employers said that GMPs had over recent years demonstrated their ability to manage their costs and maintain their profits, in particular through changing the skill mix of the practice primary care team, for example, increasing the workload undertaken by practice nurses or the employment of salaried GMPs. They said that expecting practices to achieve efficiency savings was consistent with the approach taken to other providers in the NHS. However, they said that there was little in the way of efficiency saving contained within the recently concluded agreement for 2009-10. NHS Employers believed GMPs should be expected to achieve cash-releasing efficiency savings of at least 1 per cent on the residual expense.

3.46 However, the BMA believed that the scope for efficiency savings was non-existent after three years of close to zero resource increases in the face of inflationary pressures.

3.47 With regard to cash-releasing efficiencies, we do not believe that it is appropriate for us to factor these into our recommendation on independent contractor GMPs for this year. Indeed, now that the expenses to earnings ratio has moved back towards the historical 60:40 split, it reflects efficiency savings that have already taken place. Furthermore, asking us to take efficiencies into account is effectively asking us to forecast costs, and we have said in the past that we will not do this. We believe that it is important that we are consistent in the way we treat independent contractor GMPs and general dental practitioners (GDPs). Therefore if we were to expect GMPs to make cash-releasing efficiencies we would also have to change our view in relation to GDPs. Future data on practice earnings and expenses will show trends and the proportion of profit GMPs are taking as income, and we ask the parties to update us on this issue for our next report.

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[23] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Footnote 10 to paragraph 3.32. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

[24] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Paragraph 4.66. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

Additional work

3.48 GMPs have the opportunity to increase their gross and net income from a variety of professional activities, for example: additional investment in local enhanced services, improved performance against QOF, and a new programme of vascular health checks from 2009-10. The Health Departments' estimates have not taken account of any increases in income from additional work and the BMA made no mention of it. However, NHS Employers included in their calculations (that a 1.5 per cent gross uplift would lead to a net uplift of 2 per cent) the assumption that GMPs would earn additional income outside of contract payments. Nevertheless, our view is that as additional work is not guaranteed for all practices, we believe that when deciding the uplift it would not be appropriate to take account of additional work that GMPs might take on.

Independent contractor GMPs: pay recommendations for 2009-10

3.49 While we welcomed the methodology agreed by the parties to calculate the gross uplift for GMP pay, it would have been helpful if they had agreed how to convert the gross figure to the net uplift figure. As the parties could not agree how this should be done we have decided to use our own formula to calculate the gross uplift. To assist in our consideration of this issue for the next round, we expect the parties to either accept our formula or propose an agreed alternative to calculate the gross uplift for GMP pay, even though we would expect the parties to make different assumptions in their calculations.

3.50 GMPs' net incomes fell by 2.1 per cent in 2006-07 (see Table 3.2) and the BMA told us that it believed that net incomes had continued to fall further, probably by at least 8 per cent over 2008-09. Taking the evidence into account, and given the parties' agreement of the return to the approximate 60:40 split between practice expenses and profit that existed before the new GMS contract, because expenses have gone up more than earnings, we see no reason for the net uplift for independent contractor GMPs to differ from that awarded to salaried doctors and dentists in the HCHS.

3.51 Following discussions with the parties, we have determined that the HMRC data for 2006-07, as published by the NHS Information Centre,[25] includes directly reimbursable costs (costs of premises and information technology which PCOs reimburse in full to practices) within its gross earnings total along with private income. Therefore the uplift to the GMS contract is not exactly the same as the proportion by which gross earnings increase each year. Similarly the expenses listed for GMPs include the business and premises costs for which they are reimbursed. Therefore the formula for determining the uplift needs to distinguish between expenses for which GMPs are responsible and those reimbursed by PCOs.

[25] Technical Steering Committee. *GP earnings and expenses 2006/07: initial report*. NHS Information Centre, October 2008. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-earnings-and-expenses-2006-07--initial-report

3.52 The approach we have chosen involves weighting the increase in GMPs' non-reimbursed expenses and the increase in their personal income. The weights we used last year were derived from HMRC data. However, this year, the parties agreed that the ratio of income to expenses has returned to around 60:40, after several years in which the proportion of expenses was lower. We think it likely, given the limited uplifts to the GMS contract in recent years, that the parties are correct and the ratio has indeed returned to 60:40, so we have used this split in our formula. We will monitor HMRC data so that we can consider whether to adjust our future recommendations to take account of the actual ratio of expenses to income, if it differs from this assumption.

3.53 The Health Departments and the BMA have proposed separating staff costs from other expenses and we agree that this is a sensible approach. The Health Departments and the BMA both drew attention to the fact that the latest HMRC data showed that staff costs were 58 per cent of all expenses. This is the proportion we have chosen to use for calculating the gross uplift.

3.54 We have noted above that non-staff expenses include both premises and information technology costs which are reimbursed by PCTs. The latest available data, for the financial year 2007-08, show these reimbursed costs as 10 per cent of turnover for GMPs. Therefore we have excluded this proportion from our calculations.

3.55 We have chosen to use the *Agenda for Change* increase, including the headline award and the structural changes to Band 5, the appropriate Band for practice nurses as the price increase for staff costs. This gives a price increase for the staff element of 2.53 per cent.

3.56 We continue to believe that RPIX is the most suitable price index for non-staffing costs because premises are excluded from GMPs' expenses (RPIX excludes housing costs and these can be regarded as a proxy for premises costs). The RPIX annual increase for the last quarter of 2008 was 3.8 per cent and this figure is used in our formula.

3.57 Expressing each component of the formula as a percentage of non-reimbursed turnover gives the following:

- income is 40 per cent of total turnover which represents 44.4 per cent of non-reimbursed turnover;
- staff costs are 58 per cent of total expenses, meaning they are 34.8 per cent of total turnover and therefore come to 38.7 per cent of non-reimbursed turnover; and
- other costs are the remaining 16.9 per cent of non-reimbursed turnover.

3.58 Hence the formula for uplifting the sum for non-reimbursed turnover is:

$$\text{Uplift}_{\text{year}} = 0.444 * x + 0.387 * AfC_{2009\text{-}10} + 0.169 * RPIX_{2008Q4}$$

where

x = 1.50 per cent net uplift

$AfC_{2009\text{-}10}$ = 2.53 per cent

$RPIX_{Q4}$ = 3.8 per cent

3.59 We **recommend that the overall gross uplift in General Medical Services contract payments be increased by a factor intended to result in an increase in general medical practitioners' net income of 1.5 per cent after allowing for movement in their expenses**. Using this uplift for GMPs' personal remuneration along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 2.29 per cent. Therefore, we recommend that an uplift of 2.29 per cent be applied to the overall gross uplift in General Medical Services contract payments for 2009-10 for general medical practitioners.

Seniority payments

3.60 Independent contractor GMPs are also eligible for seniority payments. Last year[26] we asked the parties for further evidence on the purpose, fairness and effectiveness of seniority payments for GMPs and for an explanation of the intention behind their inclusion in the new GMS contract. We said that we particularly wished to see evidence to demonstrate that those receiving seniority payments were more productive, i.e. that they provided more or better care for their patients. We observed that we supported the payment of rewards to those who performed best, but to avoid any risk of discrimination we believed that the performance should be objectively demonstrated in each individual case.

3.61 We received evidence on seniority payments solely from the Department of Health. It told us that seniority payments were intended to link to retention incentives, particularly for independent contractor GMPs approaching retirement; salaried GMPs were not eligible for seniority payments. However, it had no evidence on whether the existence of seniority payments (worth an average of £6,400 per eligible GMP) helped with retention or to demonstrate whether those receiving seniority payments provided more or better care. The Department said that it continued to question the fairness of the current scheme as significant seniority payments were made to individual GMPs and this was increasingly anomalous in the context of a practice-based contract for services. It pointed out that the effect of the formula agreed by the parties for 2009-10 would be to deliver a zero increase for seniority payments, regardless of any overall uplift recommended by us. The Health Departments asked us not to make any recommendation on seniority pay in this round.

3.62 In view of the fact that seniority payments form part of the methodology agreed between the parties for the uplift of independent contractors' pay, we have not made a recommendation with regard to seniority pay.

Salaried GMPs

3.63 In the financial year 2006-07 the average net income of salaried GMPs was £50,999. However, many salaried GMPs work part-time, the average number of hours per week being 23.8 hours a week in 2006-07. Therefore, the average salary for a full-time equivalent salaried GMP was £82,000[27] in 2006-07.

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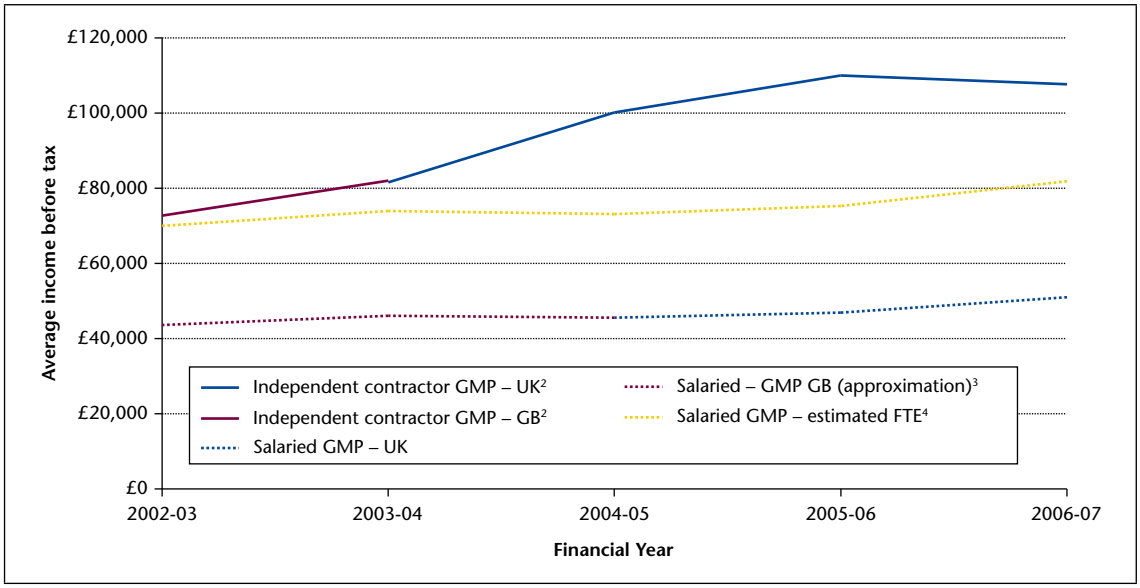
[26] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Paragraph 3.56. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

[27] This figure is based on a salaried GMP working the same number of hours per week as an independent contractor GMP (38.2 hours a week).

3.64 The NAO reported that the average pay of a salaried GMP was £46,905 (£74,000 full-time equivalent) but had only risen by 3 per cent since the new contract for independent contractor GMPs was introduced. However, as noted earlier in this chapter, it said that in the first three years of the contract the average pay of GMP partners had increased by 58 per cent (from £72,011 in 2002-03 to £113,614 in 2005-06). Figure 3.3 compares the annual earnings of independent contractor GMPs and salaried GMPs, showing the divergence in earnings since 2002-03.

Figure 3.3: Annual earnings[1] of independent contractor general medical practitioners and salaried general medical practitioners



Source: The NHS Information Centre using HM Revenue and Customs data.

Notes:

1. An independent contractor GMP worked an average of 38.2 hours a week in 2006-07 (incl. part-time) whilst a salaried GMP worked an average of 23.8 hours a week in 2006-07 (including part-time).

2. The figures for independent contractor GMPs in 2003-04 are £82,019 for Great Britain and £81,566 for the United Kingdom.

3. The figures for salaried GMPs for each year using slightly different methodology (and earlier figures are published under somewhat different terminology) and are therefore not a consistent time series (but are the figures available for each year).

4. A full-time equivalent figure for salaried GMPs has been estimated based on a comparison of working hours with independent contractor GMPs for 2006-07.

3.65 The Health Departments sought an increase to the minimum of the pay range for salaried GMPs in line with that requested for other directly employed medical staff, i.e. 2 per cent. They sought a 2 per cent pay increase in the pay scale minimum, but did not see a need to increase the pay scale maximum given the relative surplus of qualified GMPs seeking employment. They emphasised that GMPs as independent contractors were ultimately responsible for setting the pay of the staff they employed, including salaried GMPs. The Health Departments said that the salary range for salaried GMPs employed by PCOs, which was agreed in May 2003, was designed to be wide enough to cover the range of possible roles that salaried GMPs might be required to undertake, with starting pay, progression and review determined locally. The model terms and conditions of service for salaried GMPs were intended to be the minimum, with employers free to offer more favourable terms to reflect local needs and circumstances. The Health Departments said that most salaried GMPs worked part time. The level of remuneration was agreed between the salaried GMP and their employer. They told us that around 93 per cent of salaried GMPs were employed by GMP practices; the remainder were employed by PCOs, mostly PCTs. The Health

Departments said that in 2006-07, there was an increase of 8.7 per cent in salaried GMPs' average earnings, a much higher increase than in previous years. They believed this was likely to be due to salaried GMPs working longer hours as their role in the delivery of primary medical care services expanded, rather than reflecting a real pay increase of this magnitude. They said that the evidence suggested that there were no problems with recruiting or retaining salaried GMPs and noted that increasingly, practices were employing salaried GMPs.

3.66 NHS Employers also stated that the demand for salaried GMPs continued to be high and said that the majority of employers continued to report that the pay range was appropriate and that there were no recruitment problems. NHS Employers had continued to press the BMA's General Practitioners Committee to enter into discussions on updating the model offer letter and terms and conditions of service for salaried GMPs. They sought an increase to the pay range in line with that of other directly employed doctors.

3.67 The BMA said that salaried GMPs were a large and expanding part of the GMP workforce. It believed that the disproportionate growth was indicative of a desire for flexible working (and reluctance to invest in a small business), plus the increased number of GMP trainees and diminishing number of GMP partnership opportunities. It thought that it also reflected the lack of income accruing to GMP practices since 2005-06 and the ability of practices to plan. It sought a general percentage uplift to the range set for salaried GMPs and for the range to be adjusted upwards to take into account the level of skill and responsibility undertaken.

3.68 The BMA reported that it was increasingly difficult for salaried GMPs to insist on the model salaried GMP contract and/or obtain a pay increase. However, these are not matters over which we have any control, as salaried GMPs are employed on local terms and conditions. As we have said previously, we would be surprised to find that salaried GMPs were entering into contracts that did not provide for some form of annual pay review, and we expect salaried GMPs to ensure that this aspect is covered in their contractual arrangements. As the demand for salaried GMPs is increasing, we believe that they should be able to negotiate an annual pay review as part of their terms and conditions. Furthermore, although the number of salaried GMPs is increasing, and we are aware that many work part-time, we have no breakdown by gender and it is unclear in what way the nature and composition of the workforce is changing.

3.69 We note that the Health Departments wish to shorten the pay scale for salaried GMPs by increasing the minimum of the scale but not the maximum. However, we are not convinced by the argument solely on the grounds of there being a surplus of qualified GMPs seeking employment. When the pay range for salaried GMPs was first agreed by the parties,[28] the salary range was set to be sufficiently wide to bear variances in the level of responsibilities, qualifications and workload of PCO-employed GMPs, and also to take account of the need to recruit and retain salaried GMPs in the future. The fact that there is now a surplus of qualified GMPs seeking employment is not a reason in itself to restrict the range of pay available to salaried GMPs. We note that the parties also agreed that local job evaluation should be the basis for assigning to an appropriate point on the pay range, and that progression within the range should be determined locally. If the parties wish us to recommend that the range of pay available for salaried GMPs should be altered, we would wish to receive detailed

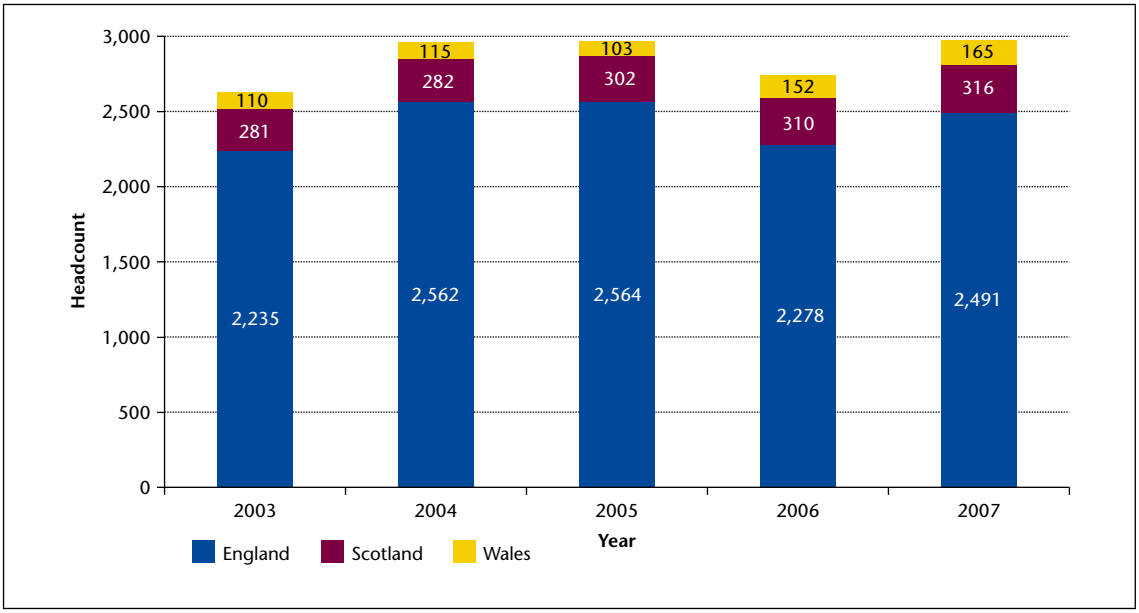
[28] Review Body on Doctors' and Dentists' Remuneration. *Supplement to the thirty-second report*. Cm 5722. TSO, 2003. Paragraphs 5.9-5.11.
Available from: http://www.ome.uk.com/downloads/Cm%205722%20supplementary%20report.pdf

evidence that the responsibilities, qualifications and workload of salaried GMPs has changed significantly. In the absence of such evidence, we continue to believe that the current range is appropriate and that it fulfils its objective in providing reasonable scope for employers and employees to negotiate an appropriate pay point within it, as there are no fixed scale points within the salary range. We therefore **recommend that the minimum and the maximum of the salary range for salaried general medical practitioners be increased by 1.5 per cent for 2009-10**.

GMP registrars

3.70 We note from Figure 3.4 that in 2007 GMP registrar numbers were at their highest in five years in both Scotland (316) and Wales (165), but that there had been a small decline in England since 2005 to 2,491 in 2007. The total number of GMP registrars in Great Britain was 2,972 in 2007.

Figure 3.4: Number of general medical practitioner registrars, 2003 – 2007, Great Britain[1]



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

Note:

1. Northern Ireland does not produce separate GMP registrar data.

3.71 Both the Health Departments and NHS Employers sought a further reduction in the supplement[29] paid to GMP registrars, from 50 per cent to 45 per cent of basic salary for those entering GMP registrar training placements after April 2009, continuing the trend towards alignment of contracts for hospital trainees and GMP registrars.

[29] When the supplement was introduced, it was paid to ensure that doctors who opted to train for a career in general practice were not financially disadvantaged compared to hospital doctors in training. It was introduced at a time when recruitment into general practice was poor.

3.72 The Health Departments said that the average banding supplement paid to hospital doctors had fallen to 48 per cent in England, and they believed that there should be a further reduction in the supplement paid to GMP registrars. They noted that there continued to be a high level of demand for GMP registrar training programme places and that they did not share the BMA's concerns about the level of recruitment of GMP registrars.

3.73 NHS Employers said that the general consensus among those responsible for GMP training was that the employment arrangements for this group of trainees should, at some point in the future, be aligned with those of hospital trainees, so as to facilitate the movement of trainees from trust to GMP practice and vice versa without a change of contractual arrangements, and using a single lead employer covering all phases of the training programme. They said that recruitment to GMP training programmes continued to be strong and that pay parity with hospital trainees should be the aim.

3.74 The BMA expressed concern about the continual erosion of the supplement paid to GMP registrars to reflect the banding multipliers received by their hospital counterparts. It believed that recruitment remained an issue and said that costs to trainees had increased dramatically in recent years. It asked us to at least maintain the relative value of total GMP registrar remuneration and maintain the supplement at 50 per cent. The BMA believed that there was not sufficient evidence to demonstrate that banding would continue to fall to 45 per cent, and it did not feel that a reduction in the supplement to 45 per cent was justified. On the proposed alignment, the BMA was concerned that it would be difficult to fairly align two very different roles (i.e. GMP registrars and hospital trainees) with very different responsibilities and levels of intensity under the current hospital contract.

3.75 The BMA also noted that new arrangements for extended hours outside of GMS practices' core hours had been introduced in many practices across the United Kingdom. Its view was that GMP specialty registrars should only undertake extended hours sessions if they replaced an equivalent 'in hours' session but it was aware that many GMP specialty registrars were being asked to work in the extended hours period as an extension to their 'in hours' work. The BMA would be monitoring this trend over the coming year, as it was concerned that it may impact on the quality of GMP training, and that it would lead to an increase in the number of anti-social hours that GMP specialty registrars were being asked to work without compensation during the working day.

3.76 In principle, we support the alignment of contractual arrangements for GMP registrars and hospital trainees: pay for all trainees should reflect the number of hours worked and intensity of work. The BMA has said that alignment may be difficult given the different roles and levels of intensity of the different roles, and the parties will need to give full consideration to such issues if alignment is to occur. The BMA has noted that GMP registrars may be undertaking work during the extended hours period in GMS practices. Given this, we would welcome evidence from the parties for our next review on how the number of hours and intensity of work of GMP registrars would translate in terms of the banding multipliers for hospital trainees – if full alignment was to occur, what do the parties estimate that the level of the GMP registrar supplement would settle at?

3.77 Historically, the GMP registrar supplement has been used as a recruitment payment to attract trainees into general practice. The supplement was received by GMP registrars, despite the fact that they have a working pattern which is on the whole, less intense and involves few if any additional hours, compared to that of hospital trainees. We believe that general medical practice continues to be an attractive career choice and at present we do not see any cause for concern in the recruitment of GMP registrars, although we would welcome further evidence for our next round on whether the parties consider there to be any recruitment issue for this group. We are therefore content to agree with the proposal put forward by the Health Departments and NHS Employers and **recommend that the supplement for general medical practitioner registrars entering training placements on or after 1 April 2009 be reduced from the current rate of 50 per cent to 45 per cent**. However, we consider that those doctors currently receiving the higher level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

GMP trainers' grant

3.78 The Health Departments said that the flat rate grant for GMP trainers (£7,485 in 2008-09) was currently paid to GMP practices. The practice partners then decided how to treat this specific income stream. They told us that if a practice had two partners, each with a GMP trainee, then two trainer grants were paid to the practice. The Health Departments noted the possibility of a new tariff-based system where funding would follow the student or trainee. They said that proposals from reviews by the Department of Health, Royal College of General Practitioners and the *Next Stage Review – Multi-Professional Education and Training Funding Review* would be developed over the coming months with key stakeholders. The Department of Health anticipated that these proposals would contain significant changes from current arrangements.

3.79 The Department of Health told us that as it was clear as to the future arrangements for GMP specialty training and the methodology by which postgraduate education and training would be funded in the future, it was prepared to commission NHS Employers to enter negotiations around the GMP trainers' grant, with a view to making it fit for purpose within the new GMP specialty training and funding architecture. The Department of Health believed that the issues the BMA was indicating were causing increased costs to GMP practices generally flowed from the implementation of the new *Modernising Medical Careers* specialty training curricula, and also changes to the balance of practice placements by medical schools reflecting changes in the undergraduate curriculum in many medical schools. It did not accept that the GMP trainers' grant was the appropriate mechanism for addressing these issues, and anticipated that the *Next Stage Review – Multi-Professional Education and Training Funding Review* would suggest a funding methodology that would cover many of the BMA's concerns in this area. It asked us to recommend increasing the GMP trainers' grant by no more than the increase the Health Departments were seeking for salaried doctors (i.e. 2 per cent). The WAG added that any increase in the GMP trainers' grant would cause budget pressures, although it accepted that if it was nationally agreed then it would have no choice but to implement it. Scotland had moved to 18 months training in general practice from August 2008, which had required a 50 per cent increase in the number of trainers. This had been achieved at the current level of the trainers' grant and the increased workload demanded of trainers. The number of practices wishing to be involved in training continued to increase. In Northern Ireland the number of GMP trainers had been increasing over the past few years, as had the workload of the trainer. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) welcomed the review of the trainer grant, but would not support any interim award pending the outcome of the review.

3.80 The BMA told us that GMP trainers had recently been required to take on the role of educational supervisor for specialty training year one and two trainees while they were undertaking the hospital component of their training and to carry out an appraisal. These trainees had limited experience of general practice and required additional supervision from a GMP trainer. The BMA said that GMP trainers had also had to implement the new training curriculum, but that many deaneries in the United Kingdom were currently not remunerating any of this work. The BMA noted that the *Tooke report*[30] had recommended that GMP training be lengthened and numbers of trainees increased. This would further increase the demand for GMP trainers. It said that it was essential that the workload and financial cost incurred by GMP trainers and their training practices were fully recognised in their remuneration and the current training grant of £7,485 was clearly now inadequate. The BMA pointed out that the independent review of remuneration for GMP trainers (to be carried out by the Health Departments) continued to be delayed. It sought a significant interim uplift to the GMP trainers' grant for 2009-10 pending completion of the review.

3.81 The BMA also suggested that the £750 per annum continuing professional development supplement be increased to cover the full range of ongoing expenses.

3.82 We understand that the GMP trainers' grant is likely to move to a tariff-based system and that a pilot study is underway considering the options for funding. The Department of Health told us in oral evidence that the aim was for shadow prices to be in place by mid-2009 and a tariff to be established in principle. It said that negotiations would need to take place before any new arrangements were put in place, but that the main aim was for the tariff to be attractive, yet affordable. With this in mind, we do not believe that it would be appropriate to make any adjustment to the supplement for additional continuing professional development for GMP trainers until the review is complete, although we still expect that it will continue to be paid annually. Furthermore, we continue to believe that until this review is complete we should simply increase the value of the trainers' grant in line with the other fees and allowances on which we are required to make recommendations. We therefore **recommend that the general medical practitioner trainers' grant be increased by 1.5 per cent for 2009-10**.

GMP educators

3.83 'GMP educator' is a generic term for course organisers, GMP tutors and Associate GMP Directors; these are salaried doctors, employed by the deaneries. The Health Departments said that there was no evidence to suggest that the GMP educators' pay scale needed to be amended and asked us to recommend an uplift in the GMP educators' pay scale of no more than the increase they were seeking for other salaried doctors (i.e. 2 per cent).

3.84 The BMA asked us to revalue the pay scale for GMP educators with effect from 2009-10, to include not only the uplift in net income received by other employed doctors but also an adjustment to bring it up to the level it would have been had it received such awards since its inception in 2003-04.

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

3.85 The BMA has returned to the issue of making an adjustment to the GMP educators' pay scale, an issue that it first raised in evidence for our *Thirty-Fifth Report*.[31] We addressed the issue at that time: we were asked to make recommendations for this group of doctors for 2006-07 onwards, and made no comment on past events. In line with this, we have recommended an increase to the pay scale for each year from 2006-07, and we do not intend making any retrospective adjustment. We do not intend to revisit this issue in future rounds. For this year, as GMP educators are not self-employed, we believe that it is appropriate to draw a parallel with other salaried GMPs, and that their pay should be increased in line with such doctors. We therefore **recommend that the general medical practitioner educators' pay scale should rise by 1.5 per cent for 2009-10** in line with our recommendation for salaried GMPs.

GMPs working in community hospitals

3.86 The BMA told us that there were some areas where problems had arisen and local arrangements were not working satisfactorily or where doctors were not being paid appropriate rates. It considered it likely that more work would take place in the community in future and asked us to reconsider the question of a national framework to assist negotiations at local level, even if we remained of the view that remuneration itself should be determined locally.

3.87 The Department of Health was not aware of any issues over the remuneration of doctors working in community hospitals and said that this had not been raised during any of the discussions it had had, including with GMPs, about new investment in community hospitals. It stressed that remuneration was a matter for local negotiation and that it had no evidence of problems or of the need for a national framework. There was no evidence in Wales of the need for a national framework for the remuneration of doctors working in community hospitals and the WAG believed that this should remain the responsibility of the employer to negotiate locally. In Northern Ireland only small numbers were involved and DHSSPSNI held no strong views on a national framework. We note however, that in Scotland work on developing a national framework on which NHS Boards could draw when negotiating local arrangements for the remuneration of GMPs working in community hospitals had been taken forward under the auspices of the Management Steering Group of the NHS Scotland Employers Reference Group. That work had yet to be completed, but the Scottish Executive Health Department believed that it should provide a valuable framework to assist local negotiations.

3.88 We have not seen sufficient evidence to persuade us of the need for a national framework, although we will view the Scottish national framework with interest, when complete. As we have said before, the remuneration of those working in community hospitals is agreed locally, and is not a matter for us. However, we would expect such doctors to be in demand given the moves by government to increasingly provide health and social services in local communities.

[31] Review Body on Doctors' and Dentists' Remuneration. *Thirty-fifth report.* Cm 6733. TSO, 2006. Paragraph 3.55. Available from: http://www.ome.uk.com/downloads/35th%20Report%202006.pdf

CHAPTER 4: GENERAL DENTAL PRACTITIONERS

Introduction

4.1 Our remit covers all independent general dental practitioners (GDPs) in primary care who are contracted to provide NHS dental services.

4.2 As we conduct this review, GDPs in England and Wales are in the third year of working under the new NHS contract. Dental services in Scotland have changed too as a result of the implementation of the Scottish Executive's *Action Plan.*[32] Additionally there are plans in Northern Ireland for a new contract which is expected to be piloted in 2009. In our last three years' reports we noted the emergence of different approaches to NHS dentistry in England and Wales to that in Scotland and, from last year, Northern Ireland. For this reason, we present the evidence for Scotland and for Northern Ireland separately, later in this chapter.

4.3 In 2007-08, 20,815 dentists in England had NHS activity recorded;[33] an increase of 655[34] (3.2 per cent) on 2006-07, the first year of the new dental contract system. There were 1,247 dentists in Wales with NHS activity recorded; an increase of 106 (9.3 per cent) on 2006-07. As at 30 September 2007, there were 2,546 dental practitioners registered to provide NHS treatment in Scotland; an increase of 112 (4.6 per cent) on 30 September 2006. As at 31 October 2007, the latest available data, there were 795 GDPs registered to provide NHS treatment in Northern Ireland; an increase of 13 (1.7 per cent) on 31 October 2006.

4.4 The pay comparability research carried out by PA Consulting Group[35] did not include GDPs. However, a comparison of GDP earnings with other doctors and dentists, and comparator groups for salaried staff, is given in Chapter 1.

The evidence

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

Dental strategy and contracts in England and Wales

4.6 First, we describe briefly the arrangements for NHS dental services in England and Wales. From 1 April 2006 GDPs have had local contracts with primary care organisations (PCOs). PCOs hold budgets for dental services for their areas which are specified in terms of an annual level of units of dental activity (UDAs). The level of service is reported in terms of courses of treatment, but these are converted into UDAs based on the most complex component of the courses of treatment.

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

[33] Activity recorded via dental payment claim forms (FP17 claim forms).

[34] This figure was disputed by the BDA in oral evidence but the consistency of the data has been confirmed subsequently by the NHS Information Centre.

[35] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

4.7 PCOs agree contract values with *providers* (companies, practices or individual dentists) for a particular level of service. Under these arrangements, they can purchase replacement services if a dentist ceases to provide NHS treatments or if a contract is terminated by the PCO.[36] Providers then pass on the work to dental *performers* (individual GDPs) unless the provider and performer are one and the same (these dentists are called *providing-performers*). The question of the link between the contract uplift and the performer's earnings is a matter of local negotiation between the provider and the performer.

4.8 When the new GDS contract was introduced in April 2006, it was agreed that contract values would be uplifted by our recommendations for the first three years. That agreement expires in March 2009. However, the parties have asked us to recommend an uplift to existing contracts to apply from April 2009.

Clawback

4.9 The issue of clawback[37] was raised by the BDA and the DPA. The BDA in its evidence drew our attention to the fact that 59 per cent of those contracts which had under-achieved on their UDA target in 2006-07 did not achieve their 2007-08 UDA target. This clearly is related to the issue of determining a reasonable level of activity under the contract but, while we note these concerns, we see this as a matter for local negotiation on a contract-by-contract basis rather than a matter for us. Indeed NHS Employers informed us of the potential reasons for under-achievement, and said that primary care trusts (PCTs) were using a 4 per cent tolerance value, were showing flexibility and were looking at matters on a case-by-case basis. As the relevant data relating to the contract are still in their infancy, it would be premature to draw any firm conclusion. Hence we will monitor this situation in future rounds.

Review of the dental contract in Wales

4.10 In November 2007, the Minister for Health and Social Services in Wales asked for a review of the dental contract. This work was taken forward by the Dental Contract Review Task and Finish Group established to explore possible solutions, the implications and cost of any changes to the contract. The final report accepted that the dental contract was broadly a workable system, and that, with amendment, would have the potential to enhance oral health. It made a number of wide-ranging recommendations, some with further work to follow, to increase the effectiveness of the contract and deliver improvements in oral health. We look forward to seeing further progress on this.

[36] The model contract sets out the conditions under which the PCO can terminate a contract. A provider on the other hand can terminate a contract by giving three months' notice.

[37] Clawback is the recovery of funds for UDAs (or other measures of dental activity) which were not carried out by the contract holder in the contracting period (usually a financial year).

4.11 The House of Commons Health Committee published its report, *Dental Services*,[38] on 2 July 2008. The government published a report providing its interim response on 7 October 2008[39] and a further response, published on 20 January 2009[40] highlighted the role of an independent review of dental services in taking the issues forward.

4.12 The DPA noted that the Health Committee recommended the reintroduction of registration of patients and the DPA stated that, if we considered that there was a case for this, we must recommend appropriate funding. The DPA also asked us to set a timescale within which those recommendations of the Health Committee which affected aspects of our remit, were enacted. We do not consider that either of the DPA's proposals fall within our current remit and therefore make no recommendations on them.

4.13 Given the range of issues relating to the 2006 contract that were highlighted in the Health Committee report, we look forward with interest to the report from the independent review of dental services which is due in the spring of 2009. We will monitor resulting developments which affect our remit.

Recruitment, retention and access to dental services

4.14 Our remit requires us to take account in our recommendations of a core element of NHS: that patients should be placed at the heart of all it does. This expresses itself in the dental context as the issue of improving access to NHS dental services. This relates to motivation, morale, recruitment and retention, factors that are central to our decisions on uplift.

4.15 The Department of Health's evidence again drew attention to the 25 per cent increase in the number of undergraduate training places, which began in October 2005, and to the fourfold increase in training places for dental therapists that were referred to in our last two reports. Additionally, the Department stated that it was clear that there are more dental vocational trainees and there was an increase in interest by dentists to provide the training; 976 applications were received from prospective vocational trainee trainers for 834 posts.

4.16 The WAG noted that there was no shortage of applicants when additional contract activity became available during the year. In 2004 the number of dental students in Wales increased from 55 to 64 and in 2010 these numbers would increase by a further 12 bringing the total up to 76. The WAG said there were no difficulties in filling the dental undergraduate programme in Cardiff as the ratio of applicants to places was in the region of ten to one. The WAG told us there was a successful bursary scheme run by the six Local Health Boards operating across the whole of North Wales.

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[38] House of Commons Health Committee. *Dental services*. HC 289-1. TSO, 2 July 2008. Available from: http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmhealth/289/289i.pdf

[39] Department of Health. *Government response to the Health Select Committee report on dental services*. Cm 7470. TSO, October 2008. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088955

[40] Department of Health. *Further government response to the Health Select Committee report on dental services*. Cm 7532. TSO, January 2009. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093318

4.17 NHS Employers reported that PCTs were successfully tendering for new services thus improving access to NHS dentistry. They said that current contract values were already attracting high interest and there was an apparent willingness across a range of providers to provide NHS services; there was no requirement for the value of these contracts to be increased in order to attract more providers.

4.18 The BDA again highlighted to us some difficulties that vocational dental practitioners were having securing post-vocational training employment. The BDA repeated its regular survey of post-vocational training employment in 2008 and the findings suggested that this recruitment issue had not improved, with one in five reporting that they had not yet found a post; a figure comparable with previous research in 2006 and 2007.

4.19 The BDA also drew our attention to the problem of student debt. However, we consider student debt to be a matter for the Health Departments to consider. There is no clear evidence at the moment that it is having a significant deterrent effect on entry to dentistry training. We do not propose to consider it further unless there is clear evidence that this issue is impacting on the recruitment of NHS dentists.

4.20 The DPA proposed that a commitment payment of £2 per UDA for the entire workload should be awarded to any dentist who performed more than 6,000 UDAs per annum. There would be an upper limit. It also proposed a national 'floor' for a UDA of £21. It argued that this was needed to ensure that clinical standards did not fall below what was generally acknowledged to be a reasonable standard. The DPA also commented that market forces could not be relied upon to set a reasonable level for the unit price of UDAs as the government was in the position of a monopsony.[41] We have considered the DPA's evidence but regard the pricing of UDAs as an individual contract matter.

4.21 As we said in our last report,[42] we see both workforce numbers and UDAs as being relevant measures for us to consider in relation to recruitment and retention, since the former is a measure of supply and the latter reflects demand. We continue to find it difficult to assess the extent to which the NHS is adequately provided with GDPs, but note that graduate numbers are increasing and PCTs are having no reported difficulty in tendering additional services. We will continue to monitor the recruitment and retention of dentists closely.

Vocational dental practitioners' trainers

4.22 We considered the issue of vocational dental practitioners' trainers last year and asked the parties to provide further information on this part of our remit.

4.23 The Department of Health said it was already looking at future arrangements for vocational trainees' training in the context of a gradual move towards a two-year training scheme giving a wider experience of NHS dentistry. However, it was not aware of any current issues regarding vocational trainees' trainer workload, or of any difficulty in recruiting trainers. In response to research proposals from the BDA, the Department of Health stated that it was happy to discuss joint work with the BDA and that the usual forum for this was the Dental Working Group which was chaired by the NHS Information Centre.

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[41] A monopsony is a single buyer of a good or service.

[42] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Paragraph 4.29. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

4.24 The WAG said that, as part of the independent Dental Contract Review in Wales, a sub-group has been established to review all aspects of vocational training in Wales including the vocational dental practitioner and trainer remuneration system and a review of workload and responsibility. A recommendation paper would be submitted to the WAG in 2009.

4.25 In its evidence, the BDA acknowledged the need for some quantifiable information on changes in trainer workload and proposed to conduct a survey over the next year in order to report to us in the next round. It also said that it would be happy to investigate the possibility of conducting this research on a joint basis with the Health Departments. Therefore we expect the parties to take this research forward, preferably jointly through the Dental Working Group or, if not, by following separate arrangements, and we look forward to seeing the results next year.

Motivation, morale and workload

4.26 The Department of Health told us that, according to a recent NHS Information Centre report,[43] dentists were working shorter hours and had more holiday. Working hours had fallen since 2000 from an average of 39.4 hours to 37.0 hours a week in 2007-08; holidays had increased from 4.4 weeks to 4.9 weeks – excluding Bank Holidays. However, the proportion of dentists' time spent on administration work had remained at 15 per cent since the year 2000.

4.27 The BDA again told us that dentists' work was currently target-driven and they remained on a treadmill; this had negative implications for patient care and dentists' working lives. It said that, according to its 2008 survey,[44] there was a marked difference between the morale of those with a substantial NHS practice (greater than 75 per cent) and those with a substantial private practice (less than 25 per cent NHS). A higher proportion of committed NHS practitioners (39.3 per cent) strongly believed that morale had declined over the past two years, compared with 17.6 per cent of those in substantially private practices.

4.28 We note that whilst obvious elements of work-life balance have improved for dentists, this does not appear to have improved their morale. We ask the parties to consider a joint survey on the motivation and morale of GDPs, in line with the yearly NHS staff surveys.

Capital support

4.29 The Department of Health stated that the £100 million additional capital allocation for NHS dentistry was issued to PCTs on a 'fair shares basis'. It commented that it was up to PCTs, with their knowledge of local service provision, to decide which schemes were the highest priorities on which to spend the money. The Department of Health informed us that, in line with its general policy on funds issued for capital investments, it had not collected accounts of how the funding was spent and that doing so, would have imposed a significant bureaucratic burden on the NHS. However, it provided some representative examples of how the money was used. Therefore, as the two-year allocation made at the start of the new contract is now completed, we do not propose to return to the issue of capital support unless there is evidence that it has become a matter for concern.

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[43] *Dental working hours: England and Wales 2006/07 and 2007/08*. NHS Information Centre, 21 August 2008. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-working-hours-england-and-wales-2006-07-and-2007-08

[44] *Business trends and workload survey*. British Dental Association, 2008.

Practice goodwill

4.30 The DPA raised the issue of practice goodwill. It believed goodwill had been threatened by some PCTs which disputed dentists' rights to sell and that to unreasonably refuse to allow the sale of goodwill was unjust to all and unnecessary. However, whilst we understand the DPA's concerns for the future, we do not propose to return to the issue of practice goodwill unless objective evidence is provided to us demonstrating that there is a problem under the current arrangements.

Seniority payments

4.31 The DPA raised the issue of the future of the seniority payment scheme in its evidence this year. In our *Thirty-Sixth Report*,[45] we reminded the parties that if they decided that an additional experience-based allowance was necessary, they should also consider its compliance with age discrimination legislation. This continues to be our view and we regard this issue as a matter for the parties to resolve themselves.

Practice expenses

4.32 In making our judgement on the uplift to GDPs' contract values we take into account both dentists' own remuneration and their practice expenses. We use a formula to derive the expense elements and combine expenses with dentists' take-home pay which we discuss later in this chapter.

The expenses to earnings ratio

4.33 In September 2008, the NHS Information Centre published HM Revenue and Customs (HMRC) data on dentists' earnings and expenses in the financial year 2006-07. These data are not directly comparable with those produced for previous years due to changes in the contract and also in the presentation of results. The expenses to earnings ratio[46] for all dentists was 53.4 per cent in 2006-07 and was 50.8 per cent for dentists where 75 per cent or more of their working hours were spent on NHS dentistry.

Income of providers and performers

4.34 The report on dentists' earnings and expenses also covered the incomes of providers and performers separately. These data revealed that:

- among providing-performer dentists[47] who carried out some NHS work across the year, average income, after expenses had been deducted, was highest for dentists who devoted 75 per cent or more of their time to NHS work. They received an average annual income of £147,000. Dentists who devoted between 25 and 75 per cent of their time to NHS work earned less; on average £128,000. Dentists who devoted 25 per cent or less of their time to NHS work earned the least with an average of £118,000; and

[45] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 4.34. Available from: http://www.ome.uk.com/downloads/Cm%207025.pdf

[46] The expenses to earnings ratio is the percentage of earnings spent on expenses rather than income.

[47] A providing-performer dentist is a dentist that holds a contract with a PCO and also performs NHS dentistry on this or another contract.

- among performer only dentists[48] who carried out some NHS work across the year, the pattern was the opposite. Average income, after expenses had been deducted, was lowest for dentists who devoted 75 per cent or more of their time to NHS work. They received an average annual income of £72,000. Dentists who devoted between 25 and 75 per cent of their time to NHS work earned more; on average £78,000. Dentists who devoted 25 per cent or less of their time to NHS work earned the most with an average of £79,000.

4.35 The NHS Information Centre commented on these figures. It said it was noticeable that in 2006-07 those providing-performer dentists who conducted mainly NHS work showed a greater average net profit compared to others and the lowest average expenses. It suggested that a possible explanation for some of the higher net profit was the change in payment timings for NHS orthodontic work under the new contractual arrangements; these changes during the transition year meant there was an additional injection of money for NHS orthodontic work, which would tend to affect gross and net income, but expenses less so.

4.36 We are pleased to note that the NHS Information Centre data published this year covered expenses and earnings information for different types of GDPs, including for different levels of NHS commitment. We would have liked a time series of these data, but appreciate that the change of contract made comparisons difficult.

4.37 Based on its own calculations, the Department of Health provided some historical comparisons for all dentists. This took into account previous data on expenses and the dental population. It calculated that total income for all dentists had increased from about £80,000 in 2004-05 to around £96,000 in 2006-07. The Department commented that, although the latest year's data were clouded by the effects of changes in the contractual system and the population of dentists surveyed, these data suggested a clear picture of increased net earnings and reduced expenses.

4.38 The Department of Health quoted figures from the National Association of Specialist Dental Accountants (NASDA), who reported that gross payments to performers fell from £84,308 in 2005-06 to £82,864 in 2006-07 and that, although their costs fell, their average net profit reduced from £70,695 to £70,306.

4.39 Both the Department of Health and NHS Employers told us that, whilst our 2008-09 uplift of 3.4 per cent included an increase in GDPs' personal remuneration of 2.2 per cent, evidence suggested that this increase was not always passed on to performers.

4.40 In contrast, the BDA told us that information from NASDA suggested that NHS income for all GDPs in 2006-07 increased in line with our recommended 3 per cent gross uplift for that year; the expected net uplift was 3.4 per cent.

4.41 In its written evidence, the DPA asked us to focus only on the lowest earners. It said these were the dentists who provide the highest volume of NHS work. The DPA's view was that, if fees were too low for this group, they were too low across the board to make NHS treatment an attractive prospect for providers.

4.42 We note the contrast between the Department of Health and the BDA's use of NASDA data and think this is likely due to the differing situation for providers and performers. We see the working of the dental contract in England and Wales as a matter for the parties, rather than for us. However, any issues arising which might affect the

[48] A performer only dentist is a dentist that performs NHS activity on a contract, but does not hold the contract with a PCO.

motivation and the retention of NHS dentists are our concern. Therefore we ask that the parties monitor the situation and we will be reviewing the NHS Information Centre figures on the changes in earnings for providing-performers and for performer only dentists as part of our review next year.

Input prices and volumes

4.43 The Department of Health said that evidence clearly showed that, under the new contract, dentists were carrying out simpler courses of treatment. Since this implied lower consumables and laboratory costs this must reduce practice expenses. It argued that the overall effect was a decrease to total expenses of about 8 per cent with a corresponding increase in net income of about 10 per cent. It noted that expenses included consumables costs and laboratory costs and that each of these was about 15 per cent of dental expenses as reported in early income and expenses surveys and in BDA surveys. The Department of Health said that, under the new contract, the volume of consumables had fallen by about 21 per cent: UDA requirement was 5 per cent less and activity within courses of treatment was down by about 17 per cent. The Department of Health also said the volume of advanced treatments had fallen by about 33 per cent; UDA requirement was 5 per cent less and activity within courses of treatment was down by about 29 per cent.

4.44 NHS Employers told us PCTs had reported that GDPs were themselves surprised by the level of the 2008-09 uplift and many had reported to PCTs that they were expecting a maximum of a 1.5 per cent uplift (if any at all).

4.45 The BDA told us that the pay increases given to dental nurses were, on average, 5.3 per cent in the 12 months to March 2008, which is on a par with the average annual increase of 5.6 per cent awarded between 2001 and 2007. It also said that staff wages made up only part of staff costs; 70 per cent of respondent practices paid the dental care professionals registration fee in full and 57 per cent of practices fully supported the costs of verifiable continuing professional development.

4.46 The BDA also commented on the costs of depreciation. Before the new contract, it saw investment in equipment and budgeting for depreciation as straightforward. Typically a practice might depreciate on a ten year straight-line basis, in line with accounting conventions, as there was nothing to imply that the contract would not continue over the medium or even long term. With the inception of the new contract in England and Wales, the BDA believed this certainty had been removed and that, in order to reflect related costs, the practice must budget for depreciation of the same assets over a much shorter period, with three years being a much more realistic proposition than ten.

4.47 Finally, the BDA believed that the UDA system as presently constituted did not reflect the true costs of providing a patient-centred quality dental service, which included costs such as set-up, maintenance, staff and capital, but also the time costs of fully involving patients in their care, communication with patients, taking a medical history, explaining care options to patients and helping them make an informed choice on what treatment they want, and the costs of cross-infection control.

4.48 The DPA drew our attention to a range of inputs and the impact of movements in their prices on dentists' costs:

- dental equipment and materials much of which are imported; therefore the declining value of sterling had an additional impact on dental inflation;

- the above inflation increases in precious metal costs; and

- the registration and training of, and additional pay for qualified staff.

4.49 We are pleased to see more detailed information on expenses from all the parties this year. However, as we have indicated in previous reports, we think it important that there should be agreement between the parties on what constitutes the relevant cost base for dental practices so that the appropriate drivers of dental expenses, and indicators of how they are changing, can be identified. We believe it is in the interests of all parties to reach a mutual understanding on this matter. We do not think it is appropriate for us to undertake or commission such work given that the relevant knowledge of the technology of providing dental services resides with the parties. As the parties already agree the published earnings and expenses figures on a yearly basis, this would be a straightforward extension of that work. Therefore, again we **recommend that the parties work together, or commission joint independent work, on dental expenses, focusing specifically on the non-staffing element** and we expect to receive agreed, joint evidence on this next year.

Dentistry in Scotland

4.50 In contrast to dentistry in England and Wales, where the responsibility for dental services is devolved to a local level, there is a Scotland-wide approach to dental services, with some elements of local flexibility. The remuneration system for General Dental Services is primarily based on item-of-service fees for adults and children, capitation and some continuing care payments. There are also centrally funded allowances available to dentists.

4.51 The Scottish Executive Health Department (SEHD) said the Action Plans were now complete and most targets had been met although work continued to develop NHS dental services in Scotland. It had spent £237 million on primary care dental services over the three years ending in 2007-08 and, as part of this, the target to increase the number of dentists by at least 200 over the March 2004 number had already been met although work continued to further expand the dental workforce. Arrangements had been in place for the management of waste following operational introduction, through a phased programme under the NHS Boards Clinical Waste Consortia Contract framework, from 1 April 2006. For 2006-07 just under £1 million was transferred to NHS Boards to meet the costs for clinical and special uplifts for dentists who fulfilled the requirements for NHS committed practices;[49] this rose to £1.038 million in 2007-08.

4.52 The SEHD commented on the allowances which are available to dentists in Scotland:

- the *general dental practice allowance* is to help address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision. Those practices that meet the definition of NHS commitment are entitled to receive an additional 6 per cent of accumulative gross practice earnings for each quarter that they meet the conditions of entitlement to payment;

[49] In order to be eligible for additional funding independent general dental practitioners must demonstrate 'NHS commitment'. This means a practice must provide NHS general dental services to all categories of patients, it will be required to have an average per dentist of at least 500 registered NHS patients of which on average at least 100 per dentist must be fee paying adults and it must have an average of £50,000 gross NHS earnings per dentist. Further details can be found here: http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/dentistry/nhsdentalservices

- the *remote area allowanc*e is paid to each qualifying dentist on a sliding scale related to NHS earnings;

- the *sedation allowance* is paid to a practice which provides a minimum amount of both types of sedation and is subject to abatement related to percentage NHS earnings;

- the notional *rent reimbursement*[50] is paid to dental practices who meet the NHS commitment criteria;

- the *recruitment and retention allowance* is available to all new dentists. Recipients must undertake to provide the full range of general dental services to all categories of NHS patients during each of the three years following receipt of the first payment. Payment of £10,000 is paid over a two year period and there is an additional £10,000 available if the dentist is in a designated area. Recipients must provide NHS general dental services at a rate of 80 per cent of total earnings for three years; and

- on 1 April 2006 a *deprived areas allowance* of £9,000 was introduced. As an interim arrangement this allowance could be claimed by those dentists who serve disadvantaged urban areas.

4.53 The BDA commented that its research amongst GDPs in Scotland found that between 2005 and 2008 there were fewer practices earning 75 per cent or more of their income from the NHS. It said the new and overly restrictive definition of a committed practice implemented in 2005 resulted in approximately 30 per cent of NHS GDS practices not qualifying for newly available money. It told us that an agreement had been reached in May 2008 with the Scottish Executive which should allow some of these practices to qualify for some of the money. However, the BDA still awaited its implementation.

4.54 The BDA survey also covered decontamination and showed that 45 per cent of GDPs had installed a local decontamination unit. Its survey additionally showed that, in the last three years, 41 per cent of practices had spent between £10,000 and £50,000, and 16 per cent had spent over £150,000, in capital expenditure.

4.55 Finally, the BDA noted that there was no longer a requirement to provide an out-of-hours service in England and Wales. It sought an increase in Scotland over the level of the rate of inflation to compensate for the anti-social hours, weekends and public holidays, including Christmas and New Year, still worked.

4.56 We see the issues of funding decontamination and out-of-hours as matters for the parties to negotiate. However, we note the differences between England and Wales and Scotland both in the nature of the contract and of the associated allowances as evidence of two distinctly different models of provision.

[50] Full rent reimbursement is a benefit that is enjoyed only by the 70 per cent of Scottish practices that are NHS committed. A further 14 per cent of practices now receive partial rent reimbursement in proportion to the amount of NHS dentistry they carry out.

Dentistry in Northern Ireland

4.57 The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) has overall responsibility for the provision of health service dentistry by GDPs in Northern Ireland. In turn, each commissioner is responsible for making the provision of services in its own area. As for Scotland, there is a country-wide approach to dental services, with some local flexibility. The remuneration system for General Dental Services is being reviewed but is currently based on payments for each service provided and some continuing care payments. A number of centrally-funded allowances are also available to dentists. Our recommendations were applied to the Northern Ireland workforce before Northern Ireland was added to our remit on 1 April 2008.

4.58 The DHSSPSNI said that, as in England, there had been a steady drift of dentists moving from the health service to the private sector which had resulted in increasing access issues in various parts of Northern Ireland. Following representations from the BDA that additional funding was required to encourage dental practitioners to remain in the NHS, the Health Minister agreed to provide an additional £2 million recurrently in the practice allowance from April 2007. During 2007 it became apparent that dentists were continuing to opt for private practice in many areas. In September 2007 the Minister agreed to a further substantial package of financial measures which meant that in total, therefore, the Department had invested £6.4 million additional funding in health service dentistry in 2007-08, of which £4.5 million was recurrent. On average, health service committed practices now received an annual practice allowance of £29,600 compared with £21,500 previously.

4.59 DHSSPSNI is currently involved in negotiations with the Dental Practice Committee of the BDA, with the aim of agreeing a new dental contract for practitioners in Northern Ireland. While progress has been slower than the parties had hoped, a pilot of a new contract is intended for 2009.

4.60 The BDA carried out research on practice costs amongst Northern Ireland GDPs in late 2007. It found that dentists believed that poor NHS fees and the historical under-funding of dentistry were the biggest current threat to practices. The BDA believed this had left dentists in Northern Ireland with little choice other than to change the balance of their practice towards more private work, best illustrated by the finding that in 2010 the average proportion of practice income from health service work was expected to be 57 per cent, down from 79 per cent in 2006. The BDA was now seeing some practices withdrawing from the NHS in their entirety or closing altogether and believed this was a consequence of the flawed eligibility criteria for a practice allowance.

4.61 The BDA survey also showed that a minimum of 16 per cent of practices did not have space at their current site to house a separate decontamination room and, as a consequence, would need to move premises at some point in the foreseeable future.

4.62 We note the differences between Northern Ireland and the situations in England and Wales and in Scotland. We also note the current funding in Northern Ireland and its aims in terms of tackling recruitment and retention. We ask the parties to continue to provide further evidence on these issues. In particular, we request further details of the centrally-funded allowances available to dentists in both Scotland and Northern Ireland along with the parties' views on how we should take these into account when making our recommendations.

Pay recommendations for 2009-10

4.63 The Department of Health said that it believed that the award for dentists in 2009-10 should reflect the notable increase in net earnings for all groups of dentists.[51] While it believed it was possible to make the case from these data that there should be no increase in gross contract values this year, it recognised the need to consider implications for motivation and morale, and therefore recommended that there should instead be a simple increase in gross contract values for 2009-10 of 1.0 per cent. The Department of Health believed this would start to take account of the effects of the large reduction in expenses caused by the move towards more preventative and simpler courses of treatment with a lower expenses element. The WAG said it would support the 1 per cent figure for the independent contractor GDPs but had no strong views on how it should be applied. The SEHD believed it would be appropriate for dental staff to receive a net pay uplift of 2 per cent in line with the headline figure proposed for medical staff. The SEHD also said that, whilst it had provided information on the additional allowances introduced in Scotland over recent years for us to take into account, it was not suggesting that these should lead to a different net pay outcome from the headline figure. The SEHD did, however, ask us to take these allowances into account in calculating the gross figure but provided no guidance for doing this. The DHSSPSNI said that Northern Ireland was seeking 2 per cent for independent contractor GDPs.

4.64 NHS Employers said that, based on the feedback received from their focus group, they recommended no uplift for 2009-10 to gross contract values. This was because a blanket pay award did not allow PCTs to successfully renegotiate contracts to ensure efficiency savings were made, access targets were met and the quality of services were improved. NHS Employers said a recommendation of no increase for 2009-10 would allow PCTs to manage contracts more effectively and locally invest in providing additional and improved services in ways that were more responsive to local requirements. When questioned in oral evidence, NHS Employers also said that they would prefer us to recommend nothing for dental contracts this year, and to leave it to PCTs to negotiate directly with providers.

4.65 The BDA asked us for a 5.3 per cent net uplift to GDP remuneration. This was based on reported average increases in dental staff pay of 5.3 per cent in 2008; the BDA considered that GDPs should receive equivalent remunerative increases to their dental team members. The BDA highlighted in its evidence that GDPs were exposed to prevailing economic conditions more than other healthcare professionals and that this should be taken into account in determining the uplift.

4.66 The DPA asked for an increase in fees of 5 per cent for inflation.

4.67 As we noted earlier, there are now effectively two dental systems operating in parallel within the United Kingdom. Scotland and Northern Ireland have retained the fee-per-item system, although this may change in Northern Ireland with the proposed new contract. The relationship between the fee and the underlying 'cost' is unclear, although it has, no doubt, a historical basis. It is therefore very hard to know how appropriate the fee/cost relationship implied by the fee is, and we have no data to assist us. However, that notwithstanding, it is the case that the SEHD has chosen to support dentists' costs by means of a practice allowance whose scale is related both to NHS income and to NHS commitment. The DHSSPSNI also uses a practice allowance to support dentists. In England and Wales, on the other hand, there is a contract

[51] The Department of Health referred to NHS Information Centre data which showed that net income increased by 12.4 per cent between 2004-05 and 2005-06 and by 6.9 per cent between 2005-06 and 2006-07.

whose value is designed to deliver a specified output, cover the full costs of doing so and provide a fair income to the contract holder. Here the link between cost and income is much clearer. Since gross income is guaranteed under the terms of the contract, the dentist's own income is simply the residual between that and expenses. It is therefore amenable to analysis and a formula-based approach to the uplift.

The formula

4.68 For the last three years we have used a specific formula to calculate the recommended uplift for dentistry. The approach is an accounting-based one that was designed to recognise that GDPs, as independent contractors, need to generate gross revenues that cover the opportunity cost of the practitioner's time, the return on capital invested (capital costs) and the costs of service delivery. However, since the coefficients and the input prices used in the formula are based on published data, they are by their nature retrospective. This means that when input prices or input coefficients change, they will not immediately impact on the uplift figure. This should provide an incentive to practices to pursue cost-efficient delivery. Practice costs are of two sorts: fixed (those that do not vary with the level of activity) and variable (those that do vary with the level of activity). Moreover, variable costs themselves have a range of elements: staff, materials, laboratory costs etc. In previous years we have simply dealt with their aggregate and sub-divided that into two elements: staff costs and other costs. The Department of Health, the SEHD, NHS Employers and the BDA all raised specific potential changes to the formula or related issues.

4.69 For the second year running, the Department of Health suggested dividing the 'other costs' category used in previous years into consumables costs, laboratory costs and other costs. As stated earlier in this chapter, the Department said that under the new contract the volume of consumables had fallen by about 21 per cent: UDA requirement was 5 per cent less and activity within courses of treatment was down by about 17 per cent. The volume of advanced treatments had fallen by about 33 per cent: UDA requirement was 5 per cent less and activity within courses of treatment was down by about 29 per cent.

4.70 The SEHD believed it was arguable that, for practices claiming rent reimbursement, the measure of inflation used in the dental formula should exclude premises costs. To do so would also require the coefficients to be changed to reflect the exclusion of premises costs from such a revised formula. However, the SEHD believed it was also arguable that this approach would be inappropriate for the 16 per cent of practices that did not receive any rent reimbursement, although those are the practices that have the lowest levels of NHS activity. The SEHD saw the issues as complex and believed it was not clear that a change of approach would necessarily have any significant impact on the outcome. The SEHD was therefore content for us to make a recommendation on what we saw as the most appropriate approach to the calculation of the gross uplift.

4.71 NHS Employers told us that the NHS was heavily critical of the use of Retail Prices Index (RPI) in the formula from which last year's recommendation was calculated. It felt that the RPI was not an appropriate measure for the changes in cost and had led to an overestimation of practice expenses. NHS Employers said they would want to work with us, the Department of Health and the BDA to examine and assess the components of a formula approach that appeared to have awarded a perhaps unintentionally generous pay award for 2008-09 and that did not take into account other factors, such as expected efficiencies.

4.72 The BDA drew our attention to the fact that there were many indicators that could be used to estimate dental expense inflation; such as the GDP deflator and the NHS-specific inflation rate. However, as there was no evidence that categorically showed either of these was a better proxy for dental expenses inflation than the RPI, it would strongly support our continuing to use the RPI.

4.73 The BDA said that it was also important to note that the 2006-07 information on dental earnings and expenses had been distorted by first year transitional payments and, due to changes in the methodology, accurate comparisons over time could not yet be made. For these reasons the BDA said it was content to continue with the use of the current formula until such time as all parties could agree on an accurate dataset of information that allowed for accurate adjustments to the formula.

4.74 While we note the differing views of the parties on our formula approach, it is important to emphasise that what we are being asked to do is to uplift contract values. Dental contracts involve a monopoly buyer (the PCT) and competitive suppliers (the providers). Because of the need to ensure that the latter continue to be willing participators, the contract price has to be related to the costs of provision, including the return to the provider. This is why we use a formula approach to uplift the value of contracts currently in force. However, it is a moot question as to whether such an approach is appropriate when all contracts are subject to the open market and we consider it important that the parties now agree on what our future role should be with regard to GDPs.

4.75 We continue to think that a transparent, formula-based approach is the appropriate one to use in framing our recommendations for the uplift in NHS dentistry in England and Wales, although we would be happy to receive from the parties further suggestions for its improvement or even replacement. The formula involves weighting together the increase in the practitioners' personal remuneration and the increase in GDPs' expenses. The weights that were used last year were derived from the NHS Information Centre's survey of dental earnings and expenses, based on HMRC data, and we continue to derive the weights for net income and staff costs in the formula using these data. This year we have changed the ratio of expenses to earnings from 55:45 to 50:50 and have changed the percentage of total expenses that is staff costs to 28 per cent; these changes reflect the latest HMRC data (for the financial year 2006-07) for dentists with 75 per cent or more NHS commitment.

4.76 This year we have chosen to split non-staff expenses into laboratory costs, materials and other costs for the first time. This means we have four expenses elements – staff costs, laboratory costs, materials and other costs. This year, due to the more detailed breakdown, we have used NASDA data to split non-staff expenses into laboratory costs, materials and other costs. We have considered the data for previous financial years and chosen 2004-05[52] as a reference year from which to take the split of these elements. This reference year gave 13 per cent of expenditure as laboratory costs, 10 per cent as materials and therefore the remaining 49 per cent of expenditure was classified as other costs.

4.77 To the extent that the movements in the underlying items of cost have been diverging, and depending on the inflation indicator we use, it is of course the case that our approach may under or over-estimate what has actually been happening to the true level of expenses. However, in the long run, we expect under and over-

[52] This was the first year for which the dental formula was used and seems a suitable reference point year (comparatively recent, but still on the old contract whilst not being the last year during which dentists were preparing for the new contract).

estimates to feed through the HMRC data on income and expenditure and therefore be taken into account in future years as part of our approach.

4.78 In looking for an appropriate indicator for the increase in GDPs' personal remuneration, we believe this year that GDPs should have the same net uplift recommended for our remit groups working in the Hospital and Community Health Services. This increase is 1.5 per cent.

4.79 For the pay and price measures for the expenses elements in the formula (staff costs, laboratory costs, materials and other costs), we continue to use the most recent pay and price data.

4.80 We again use the Annual Survey of Hours and Earnings (ASHE) Healthcare and Related Personal Services (HRPS) sector to represent staff cost inflation. This was 3.6 per cent for 2008,[53] the most recent figure available.

4.81 Turning to non-staff costs, we considered using a different price index for the laboratory costs and materials elements than for remaining elements of non-staff costs. In particular, we looked at the Producer Price Index for the manufacture of medical and surgical equipment and orthopaedic appliances. However, this index has been volatile in recent months recording the highest annual increases since the 1990s when the data series began. Therefore, we decided to use the RPI again this year for all non-staff costs; however, we would welcome any views from the parties on the Producer Price Index for future use. As explained in previous years, we use the all-items RPI for price changes within the dental formula because it includes a more general bundle of goods and services than the Consumer Prices Index. It is also a more appropriate index for dental expenses than the Retail Prices Index excluding Mortgage Interest Payments (RPIX), which we use for the medical formula detailed in Chapter 3, as dental expenses include premises costs. The RPI annual increase for the last quarter of 2008 was 2.7 per cent and this figure is used in our formula.

4.82 In our report last year, we proposed not changing the formula to reflect the suggested changes in inputs (that is, the inputs of laboratory work, materials, etc. required for dental work) as we wanted to first see these trends reflected in other data sources and over a longer time frame. For the laboratory costs, these trends have now been confirmed, over a longer time-frame, by courses of treatment analysis,[54] and also in evidence which the Dental Laboratories Association (DLA) presented to the Health Committee[55] and by data from NASDA and Morris and Co.[56] However, the courses of treatment analysis does not provide a single estimation of input change and therefore we have used NASDA data for our calculations. Using 2004-05 as a reference year for the pre-contract proportions and 2006-07 for the current proportions, this would mean a reduction in laboratory costs from 13 per cent to 9 per cent of expenditure – that is a reduction of 31 per cent. At this time, the trends for materials are less clear

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[53] This is the median year-on-year change in in gross hourly pay. For further details see Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 4.56. Available from: http://www.ome.uk.com/downloads/Cm%207025.pdf

[54] *Dental treatment band analysis: England and Wales 2007/08*. NHS Information Centre, 21 August 2008. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-treatment-band-analysis-england-and-wales-2007-08

[55] The Health Committee said that according to the DLA, there had been a significant fall in Band 3 treatments requiring laboratory work in England during the first year of the new contract. The organisation said that since 2006 dental laboratories had experienced a decline of 57 per cent in prescriptions for crowns and bridges and dentures, other than those replacing a single tooth. From: House of Commons Health Committee. *Dental services.* HC 289-1. TSO, 2 July 2008, paragraph 102. Available from: http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmhealth/289/289i.pdf

[56] Morris and Co are accountants specialising in medical, dental and optician practices.

and no figures have been received from NASDA for expenditure on materials for 2006-07 so this element has not been altered.

4.83 Taking all these factors into account, the formula for 2009-10 is set out as follows:

$$\text{Uplift}_{\text{year}} = 0.500 * x + 0.140 * HRPS_{ASHE} + 0.065 * RPI_{Q4} + 0.050 * RPI_{Q4} + 0.245 * RPI_{Q4} + 0.065 * NASDA_{LAB}$$

where

x = 1.5 per cent net uplift

$HRPS_{ASHE}$ = 3.6 per cent

RPI_{Q4} = 2.7 per cent

$NASDA_{LAB}$ = -31.0 per cent

4.84 In theory, the contracts for Scotland and Northern Ireland are very different to that for England and Wales and therefore a different approach is needed. In practice, this is difficult to do. There are comparatively few data sources available for Scotland and Northern Ireland. The DLA presented evidence to the Health Committee[57] indicating the situation in Scotland and in Northern Ireland was different to that in England and Wales. However, there was little else to confirm this or from which we could take data that would be consistent with that used for England and Wales. Therefore, although we are persuaded that the situation requires a different approach, we will continue to use the same uplift as for England and Wales as we have insufficient data to do otherwise this year.

4.85 Similarly, we have not received sufficient information on the allowances provided in Scotland and Northern Ireland, their intended effects or the method by which the parties would expect these to be taken into account, to make adjustments to our approach.

4.86 Therefore, we urge the parties to provide further information next year on the dental systems in Scotland and Northern Ireland. This should include further information about the allowances, their application and how we should take them into account.

4.87 We **recommend that the gross earnings base be increased by a factor intended to result in an increase in general dental practitioners' net income of 1.5 per cent after allowing for movement in expenses.** Using this uplift for general dental practitioners' personal remuneration along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 0.21 per cent. Therefore, we **recommend that an uplift of 0.21 per cent be applied to the gross earnings base under the new contract for 2009-10 for general dental practitioners in England and Wales.**

[57] The Health Committee said that before 2006, 8 per cent of all treatments were what are now termed Band 3 treatments. Since 2006, the figure is 4 per cent. In contrast, during the same period the percentage of complex treatments provided in both Scotland and Northern Ireland (which have not introduced the new contract) had risen by more than 15 per cent. From: House of Commons Health Committee. *Dental services.* HC 289-1. TSO, 2 July 2008, paragraph 102. Available from: http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmhealth/289/289i.pdf

4.88 This year we have received no evidence from the parties on how to treat gross fees, commitment payments or sessional fees in Scotland and Northern Ireland to translate into a net uplift of 1.5 per cent. Therefore, to be consistent with previous years, **we are recommending that the uplift of 0.21 per cent also applies to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland**. However, as we have already indicated, we expect to receive data next year to allow us to consider Scottish dentistry and Northern Ireland dentistry separately and to make separate recommendations.

CHAPTER 5: SALARIED PRIMARY DENTAL CARE SERVICES

Introduction

5.1 Salaried primary care dentists work in a range of different posts, as community dentists, salaried Personal Dental Service dentists, Dental Access Centre dentists and as salaried general dental practitioners in the NHS. The salaried primary dental care services (SPDCS) developed predominantly in response to the need for services which could complement the independent contractor general dental service. They are an important part of primary care dentistry, providing generalist and specialist care largely for vulnerable groups. They often provide specialist care outside the hospital setting, to many who might not otherwise receive NHS dental care. There are approximately 1,300 salaried dentists in England, 116 in Wales, 339 salaried dentists and 439 dentists in the Community Dental Services in Scotland, and 100 community dentists in Northern Ireland.

The evidence

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

New pay, terms and conditions and the devolved administrations

5.3 We noted last year that new contractual arrangements in England were agreed at ballot by a large majority (86 per cent) of salaried dentists. The BDA reported to us in this year's evidence that the new contract in England could be regarded as a success story. The new contract was implemented from 8 January 2008 onwards, and any increase in pay as a result of staff moving to the new contract was backdated to 1 June 2007. By August 2008, all salaried dentists had transferred to the new contract with back pay. Part of the new contract involves a determination of the complexity of the service by primary care trusts: if the service is deemed medium or high rather than standard, dentists in clinical director posts are able to progress further up the new pay scales. Results showed that 6 per cent of services were deemed standard, with 49 per cent medium and 46 per cent high. The BDA said that this clearly showed the complex and challenging nature of clinically leading the majority of SPDCS services.

5.4 In Wales, the new contract was issued to NHS trusts. As in England, back pay applied with effect from 1 June 2007, and the BDA said that all staff in Wales had received back pay.

5.5 The Department of Health, Social Services and Public Safety (DHSSPSNI) told us that it was considering whether a similar contract to that in England should be introduced for community dentists in Northern Ireland. It said it had met with the BDA to discuss the matter and that it had commenced a survey of all trusts in Northern Ireland to help establish the costs of a new contract, but stressed that things were still at a very early stage and would need approval from Ministers. For its part, the BDA said initial discussions had been positive and it hoped agreement could be reached for a possible introduction of new terms in 2009.

5.6 The Scottish Executive Health Department (SEHD) told us that it was planning to combine the current Community Dental Service and the Salaried General Dental Service to form a new Scottish Public Dental Service, beginning in April 2009. However, the BDA said that the implementation date had already slipped from April 2008, and the negative effect on morale and recruitment was becoming more obvious as April 2009 approached.

5.7 We are pleased to note the successful implementation of the new contractual arrangements for salaried dentists in England, and note the positive comments made by the BDA. The Welsh Assembly Government (WAG) is also making excellent progress in implementing the new contract. In Northern Ireland, work is in hand for new contractual arrangements, and we would strongly support that this be given urgent consideration by Ministers: as we noted last year, SPDCS dentists are among the last NHS staff to receive modernised terms and conditions and associated pay. Finally, in Scotland it is hoped that new contractual arrangements will be in place by April 2009. We hope that implementation will not slip from this date and ask the parties to update us for our next report.

Recruitment, retention and workload

5.8 The BDA said its *Survey of Clinical Directors*[58] showed that 62 per cent of the United Kingdom service reported difficulties in recruiting dentists. Over a third of clinical directors reported losing clinicians to the General Dental Services (GDS), Personal Dental Services or private practice. The majority of clinical directors reported an increase in referrals: a commonly stated reason for the increase was a lack of availability of GDS services in the area. NHS Employers also reported difficulties in recruiting salaried dentists, suggesting the cause was a combination of pay (in competition with the GDS), and most applicants not meeting the requirements of the job specification, suggesting a lack of experience in community dental work. They said that the new contract was designed to improve recruitment and retention.

5.9 Implementation of the new contract in England and Wales is at an early stage, and we will wish to receive for our next report an update on what benefits the new contractual arrangements are bringing to recruitment and retention. We have already given our strong support for priority to be given to new arrangements in both Northern Ireland and Scotland: any continued uncertainty as to future arrangements may have unwelcome recruitment and retention effects, and this may be particularly marked in the areas of Scotland near to the border with England. Job planning forms an important part of the new contract in England and Wales, and we would expect this aspect to help control the workload of salaried dentists. We also note that spending on the GDS continues to grow in both England and Wales. As the lack of GDS has been given as a reason for the increase in referrals, we would expect to see a resulting reduction in the number of referrals from that service.

Pay recommendation for 2009-10

5.10 The Department of Health said that having regard to the new contract and all the general circumstances, it would be appropriate to uplift salaries and the one remaining supplement (for Band A dentists who supervise a dental vocational practitioner or undergraduate dental students) by the same percentage as for all other NHS-employed doctors and dentists, to maintain parity. It said that 2 per cent was an appropriate uplift. The same level of uplift was supported by the WAG, the SEHD and the DHSSPSNI. NHS Employers also called for a 2 per cent increase, the same as for all

[58] *Survey of Clinical Directors*. British Dental Association, 2008.

other directly employed doctors and dentists. The BDA said that SPDCS dentists should receive the same rise in income as other dentists working in primary care to reflect the recent increase in workload and the more complex nature of patients treated. It suggested a 5.3 per cent increase to retain comparability with dentists in other branches of practice.

5.11 We think it important that the new contractual arrangements are given an opportunity to bed in so that we can take a view on whether the intended benefits of the contracts are realised and if a pay response is justified. In making our pay recommendations for this year, we have considered all of the evidence submitted by the parties, but are not persuaded of the need for a differential award for salaried dentists. For 2009-10, we therefore **recommend increases of 1.5 per cent for all grades in the salaried primary dental care services**. The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrived at our recommended increase.

CHAPTER 6: OPHTHALMIC MEDICAL PRACTITIONERS

Introduction

6.1 The Department of Health told us that between the end of 2006 and the end of 2007, the number of ophthalmic medical practitioners (OMPs) with contracts in England and Wales to carry out NHS sight tests increased from 408 to 421, while the number of optometrists had increased from 9,211 to 9,919.[59] It said that the General Ophthalmic Services continued to attract adequate numbers of good quality practitioners with appropriate training and qualifications. Surveys conducted into the working patterns of optometrists and OMPs showed that most OMPs practised part-time.

The sight test fee

6.2 Our 2007 report recommended that a unified sight test fee for OMPs and optometrists, set in negotiation between the Health Departments and representatives of both OMPs and optometrists, remained appropriate and should continue for future years.[60] The Department of Health noted its support for this position, and we have received no evidence that might lead us to adopt a contrary view. We are therefore content not to revisit our earlier recommendation.

6.3 We were subsequently told by the Department of Health that a three-year deal on the sight test fee had been agreed with the Optometric Fees Review Committee. The agreement was for 2008-09 to 2010-11 and the agreed increases for each year were 2.5 per cent, 2.3 per cent and 2.2 per cent. The negotiations also covered the payment for loss of earnings associated with undertaking continuing education and training for the 2008 calendar year and this payment increased by 2.5 per cent. As the three-year deal will also cover 2010-11, we do not expect to report on OMPs next year.

[59] These figures are the sum of England and Wales figures and so OMPs and optometrists who are on lists in both countries are counted twice in each year.

[60] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 6.2. Available from: http://www.ome.uk.com/downloads/Cm%207025.pdf

Part III: Secondary Care

CHAPTER 7: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction and reform of training

7.1 Since the publication of *Modernising Medical Careers*,[61] the way in which doctors are trained has undergone a radical change. Under the previous system, trainees (following medical school) would have entered as pre-registration house officers (HO), and once registered would enter the senior house officer (SHO) grade before becoming a registrar (either a specialist registrar (SpR) if choosing to remain within the hospital sector, or a general medical practitioner (GMP) registrar if deciding to enter general practice). With the new system, trainees now enter Foundation Programmes (foundation house officers years 1 and 2 – FHO1 and FHO2), covering the previous HO year and the first year of SHO training but with a new unified curriculum. Doctors then enter a 'run-through' grade known as a specialty registrar that will complete their training. The SHO and SpR grades are now both closed to new entrants, but both scales will be used in parallel with the new scales for some time. Details of all the pay scales are in Appendix A. The latest data at September 2007 show that there were 19,919 FHOs (years 1 and 2) and 37,244 registrars (both headcounts) working in the Hospital and Community Health Services in the United Kingdom.

The evidence

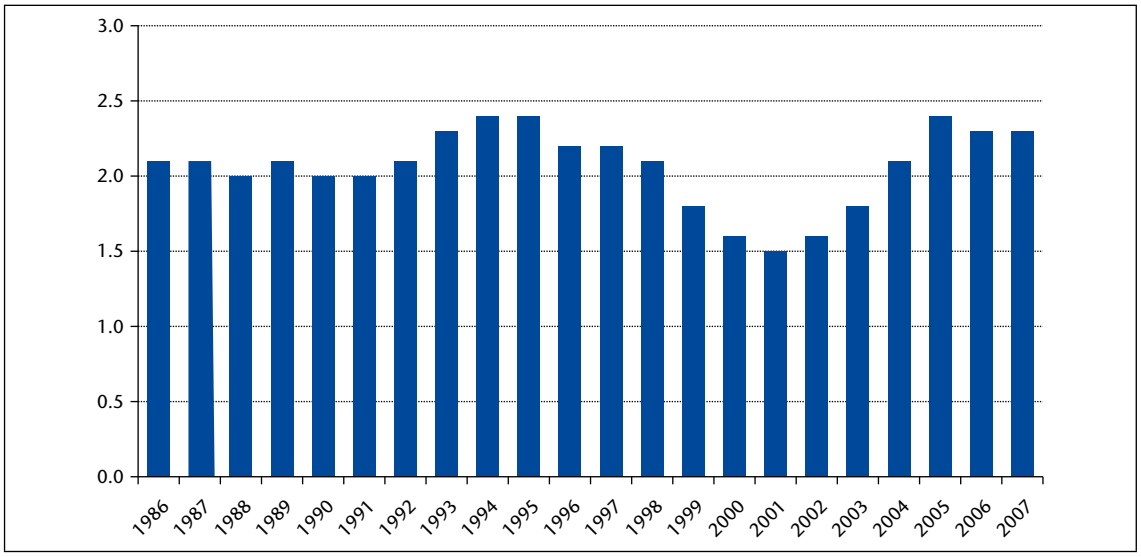
7.2 The parties have provided evidence on a number of issues concerning doctors and dentists in training. We received evidence from the Health Departments, the British Medical Association (BMA) and NHS Employers. The main evidence can be read at the parties' websites (see Appendix D). As well as the basic uplift, the parties addressed a number of other issues, including the banding multipliers and flexible training.

Recruitment and retention

7.3 The ratio of applicants to medical school places remains at 2.3: 1 this year, albeit with a very slight drop. Importantly, there continues to be a more than adequate number of good quality applicants to study medicine, which we continue to interpret as medicine being seen as an attractive career. We were pleased to note that the Department of Health has said that it will not be complacent, as the slight drop in applicants per place could suggest other professional career options are increasingly competitive. Looking at the data by gender, the trend of most entrants being female continues, with the number of female entrants to medical school accounting for 56 per cent, although this is down from 59 per cent last year. Once again, we note that it will be important for the Health Departments to consider the possible implications that this might have for future workforce planning and policies that support the retention of staff.

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

Figure 7.1: Ratio of applicants to accepted applicants to study medicine in the United Kingdom, 1986 – 2007



Source: UCAS Department of Research and Statistics.

7.4 The Department of Health told us that demand for posts at all levels of specialty training was extremely high, particularly in popular specialties and locations. The Welsh Assembly Government (WAG) said that the fill rate in the 2008 recruitment round was 86 per cent, with vacancies later filled locally. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) said that by end July 2008, 85.1 per cent of posts were filled. Follow up work was being carried out to identify how vacancies were filled. The Scottish Executive Health Department (SEHD) said there remained issues with unfilled fixed term posts and that it was looking at options for how they would be dealt with differently in future years to ensure they remained attractive options. NHS Employers told us that during recruitment to training posts in 2007, there had been very high and encouraging levels of interest in entry to training. However, they did say that some trusts were reporting difficulties in recruiting sufficient locum doctors to cover rotas. They suggested the reason might be changes to entry requirements for international medical graduates, or problems with the 2007 recruitment process itself, but did not think pay itself was an adverse factor. The BMA suggested that in recognition of the difficulties that trusts were facing in recruiting locums to fill short-term vacancies, we should recommend a relative increase in locum pay rates. Whilst we are not persuaded at present of the need for a differential increase in locum pay rates, we do not wish to lose sight of these various recruitment issues, and ask the parties to update us for our next review.

Motivation and morale

7.5 The BMA welcomed the commitment in last year's evidence from NHS Employers to bring about improvements in the morale of trainees. It said that the top three aspects that junior doctors reported they were most dissatisfied with were: the amount of flexibility in working hours; remuneration; and job security. NHS Employers told us that *Modernising Medical Careers* was providing opportunities for doctors to experience high-quality structured in-programme training that was good for morale and motivation. They said that trainees reported higher rates of satisfaction with training than in previous years. The Department of Health said that job satisfaction was one of the key indicators of staff motivation and morale, and was one of the 'vital signs' measured in the 2008-09 NHS Operating Framework; trusts would be expected to improve scores over time. It said that the

job satisfaction score for doctors and dentists in training identified them as one of the most satisfied groups within the NHS, although the score (3.53 from a range of 1 to 5) was slightly lower than the previous year.

7.6 Despite the Department's positive interpretation of these figures, we are concerned that job satisfaction scores for trainees are heading in the wrong direction, particularly given the emphasis placed on trusts to make improvements over time. We ask the parties to keep us informed on how job satisfaction develops in the future, as we find it useful in helping us to interpret the motivation strand of our remit. NHS Employers told us that they would support continued improvements in careers advice during undergraduate training and within Foundation Programmes, and we concur. Finally, we note that the BMA's survey threw up job security as one of the main issues that caused junior doctors dissatisfaction. This may be as a result of the recent problems associated with the Medical Training Application Service, even though we have not received any evidence to indicate that jobs are at risk. We ask the BMA to let us have further evidence on this point for our next review if it considers the risk to be ongoing.

Flexible training

7.7 NHS Employers told us that the proportion of people taking advantage of flexible training options was less than expected, even though the number of flexible trainees continued to increase. They said that in general, the trainees seeking flexible working arrangements were able to access them. They felt the system was working as intended and there was no need to amend the current arrangements. The BMA said that from its own research into flexible training,[62] it was concerned that those wishing to train flexibly were not able to do so and as such might leave medicine altogether. It said it was vital that opportunities for flexible training were fully supported, funded and developed by the Health Departments to ensure that the workforce could continue to train and to sustain the NHS. We note that a joint review is being conducted by the BMA, postgraduate deans and NHS Employers, and it will no doubt wish to take due account of the BMA's findings. For a number of years we have championed the benefits of flexible work opportunities to help aid recruitment and retention, particularly given the female proportion of the workforce, and we continue to do so.

New Deal and Working Time Directive

7.8 England, Wales, Scotland and Northern Ireland reported that New Deal compliance[63] was at 99 per cent, 99.6 per cent, 98.4 per cent and 92 per cent respectively. The SEHD said non-compliance was in smaller specialties or in remote and rural areas where the smallest reduction in staffing could have a great impact. DHSSPSNI said non-compliant posts were mainly in obstetrics and gynaecology, and surgery where solutions remained difficult.

7.9 The Department of Health told us about the work that was being carried out in order to meet the August 2009 Working Time Directive target, whereby trainees should not be working in excess of 48 hours per week. The SEHD said that current vacancies made designing rotas down to 48 hours difficult. DHSSPSNI said that considerable

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[62] BMA Junior Doctors' Committee. *BMA survey of junior doctors 2008: flexible training opportunities*. Health Policy and Economic Research Unit, British Medical Association, October 2008. Available from: http://www.bma.org.uk/images/Flex08_tcm41-178999.pdf

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

progress was needed to achieve compliance. The BMA said that full compliance was unlikely to be met, and suggested that it might be necessary to create an incentive for employers by increasing the Band 2 multipliers.

7.10 Whilst we are pleased to note the continuing improvements in New Deal compliance, it is becoming increasingly clear that compliance with the August 2009 Working Time Directive target will be extremely challenging. We hope that the various initiatives being carried out by the Health Departments to assist with compliance bear fruit and ask the parties to update us on progress for our next review. We comment further on banding multipliers and compliance in the next section.

Basic pay and the banding multipliers

7.11 We are required to recommend on the level of the banding multipliers that form part of the contract for trainees. NHS Employers said that they saw no reason to revisit the general value of the banding supplements or their relationship to basic pay at this time. They said that the average supplement should continue to fall, but would not drop significantly below 45 per cent. The Department of Health told us that the average banding multiplier in April 2008 for all junior doctors in compliant posts was 48 per cent. The BMA believed that the average level of total pay should not be allowed to decay by default as hours were driven down. It asked us to recommend an increase in basic pay that would ensure that junior doctors whose pay bandings moved from Band 2 into Band 1 were not disadvantaged and that the overall pay bill did not reduce further.

7.12 The current levels of the banding multipliers are those that were negotiated between the parties to fully recognise work intensity and out-of-hours commitment. It is therefore entirely appropriate that as doctors work less hours or less intensively, they should be paid less. It has always been the case that some doctors have been working the less onerous rotas, and the level of pay was considered appropriate for them at that time. Simply because more doctors are now falling into the lower banded posts is not a reason in itself for us to recommend compensating them.

7.13 We therefore **recommend that the value of the banding multipliers remain at the rates that were negotiated between the parties**. The detail of our recommendation on banding multipliers is at Appendix A. Both Band 3 and Band 2 posts will be illegal under the Working Time Directive from August 2009, although the Department of Health told us during oral evidence that it might be possible to apply for a derogation from the Directive on an individual training post basis. We wish to monitor closely the use of these bandings, and we therefore ask each country to let us have for our next review evidence on the extent to which Band 3 and Band 2 posts continue to be used after the August 2009 deadline, and whether a derogation has been applied. Owing to the timing of this evidence, we expect that the parties will need to let us have this information as supplementary evidence. We will wish to see what use is being made of these bands before deciding whether any adjustments are necessary to the banding multipliers from April 2010.

7.14 For a number of years, we have felt that the parties should give consideration to restructuring junior doctors' pay to place less emphasis on the banding multipliers. Last year, the BMA said that it wished to begin talks in earnest by August 2009, and we gave our support. This year, the Department of Health told us that as a first step, it had commissioned NHS Employers to conduct work to look at the effectiveness of the current arrangements. It said that it was important to note that a shift of total earnings into basic pay would have superannuation consequences. The SEHD said that it noted that NHS Employers was consulting with stakeholders to scope options for reforming the juniors' contract, and that it would participate in the process.

During oral evidence, the Department of Health confirmed to us that some early scoping meetings with the BMA had already been held, and that it intended to give a remit formally to NHS Employers to discuss with the BMA new contractual arrangements for junior doctors. We were told that serious discussion would begin early in 2009. We welcome this news and ask the parties to update us on progress for our next review.

Comparator groups

7.15 Both the Department of Health and NHS Employers commented that total pay remained competitive. The Department said that in the current climate, the relative security of the profession was likely to increase the attractiveness of a career in medicine or dentistry. The BMA said that the correct comparator to FHO1s was graduates one to three years into their career. It said that data from Incomes Data Services suggested the lead would be equivalent to £29,512 using average 2008 graduate earnings. It went on to say that total pay should reflect the earnings of other professionals at similar stages in their careers working at similar intensity. We note from the Department of Health that the average pay for FHO1s (at March 2008) is £30,803.

7.16 The pay comparability study carried out by PA Consulting Group[64] identified for the first time comparators for representative 'anchor points' within the junior doctors group. Consequently, the following comparators have been used for training grades:

Foundation house officer year 1

- Accounting and Tax (Hay Responsibility Level 14)
- Legal (Hay Responsibility Level 14)
- Actuarial (Hay Responsibility Level 14)
- Pharmaceutical (Hay Responsibility Level 14)

Foundation house officer year 2

- Accounting and Tax (Hay Responsibility Level 15)
- Legal (Hay Responsibility Level 15)
- Actuarial (Hay Responsibility Level 15)
- Pharmaceutical (Hay Responsibility Level 15)

[64] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups.* Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

Specialty registrar years 1 and 2

- Accounting and Tax (Hay Responsibility Level 16)
- Legal (Hay Responsibility Level 16)
- Actuarial (Hay Responsibility Level 16)
- Pharmaceutical (Hay Responsibility Level 16)

Specialty registrar years 3+

- Specialty doctor
- Accounting and Tax (Hay Responsibility Level 17 – 19)
- Legal (Hay Responsibility Level 17 – 19)
- Actuarial (Hay Responsibility Level 17 – 19)
- Pharmaceutical (Hay Responsibility Level 17 – 19)

7.17 Our own analysis of pay comparability, using the comparator points listed above, concluded that total earnings were comparable and junior doctors, particularly FHO2s and specialty registrars in their first two years, earned more than comparator groups overall. However, base pay for doctors was much lower than for comparator groups at the start of their training, but the differential was eroded as trainees progressed in their first two years. Chapter 1 and Appendix E contain a more detailed analysis of pay comparability.

Free accommodation

7.18 The BMA returned to the issue of free accommodation for FHO1s, asking us to recommend an additional pay increase for such doctors, with backdating to August 2008. It noted that some trusts were continuing to provide free accommodation for FHO1s. The WAG said FHO1 accommodation would continue to be provided until July 2009 and that a working group was considering the whole issue of availability and standards of accommodation relative to their effect on recruitment and retention. The SEHD told us that following the decision in Wales to continue offering free accommodation, it had carried out its own review. The review concluded that the circumstances in Scotland did not support the assertion that Health Boards should continue to provide free accommodation. However, it said it remained open to Health Boards to make decisions in relation to the provision of free accommodation in the best interests of the service.

7.19 We considered this issue in full during our deliberations for the last round,[65] and do not intend to revisit our decision. We note that some countries have continued to provide free accommodation, as is their right following devolution: such countries have confirmed to us that they are aware of the tax implications of continuing to provide free accommodation where there is no statutory requirement.

[65] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm 7327. TSO, 2008. Paragraphs 7.17 – 7.21. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

Pay recommendation for 2009-10

7.20 The BMA said that it was seeking a basic earnings increase of at least 4 per cent. As junior doctors in the earliest stages of their careers were relatively worse off than other juniors, it said the focus of improvements in basic pay should be for those junior doctors. In particular, it drew attention to the reduction in pay caused by the Working Time Directive and the removal of free accommodation as reasons for a differential uplift for FHO1s. Both NHS Employers and the Health Departments drew our attention to the incremental increases received by junior doctors, with NHS Employers arguing that the increases should be factored into our decisions about the uplift. NHS Employers said an award of 2 per cent was affordable, provided there was a corresponding uplift in the tariff for 2009-10. All the Health Departments called for an uplift of 2 per cent.

7.21 We have set out our arguments surrounding incremental pay in earlier reports,[66] and see no reason to revisit our decision that increments should not be taken into account in assessing an appropriate uplift to pay scales. With regard to the BMA's request for a differential award for FHO1s, we have already set out our views on the reduction in pay caused by the Working Time Directive and on the removal of free accommodation earlier in this chapter, and we are therefore not persuaded that a differential pay award is merited. Thus for 2009-10, we **recommend an increase of 1.5 per cent on the salary scales of all grades of doctors in training**. The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrived at our recommendation.

[66] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report.* Cm 7327. TSO, 2008. Paragraph 1.55. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

CHAPTER 8: CONSULTANTS

Introduction

8.1 The consultant grade is the main career grade in the hospital and public health service. New contracts were agreed in October 2003 and differ in each of the devolved countries. The contract was optional in England, Scotland and Northern Ireland, although all new appointments or moves to a new trust are under the new contract. All consultants in Wales were obliged to transfer to the new contract. We make recommendations on the pay uplift for consultants on both types of contract although a decreasing number of consultants remain on the pre-October 2003 contract. All consultants, whatever their type of contract, are now expected to have agreed job plans scheduling both their clinical and non-clinical activity.

8.2 Under the new contract, consultants have to agree the number of programmed activities (PAs) they will work. Each PA is four hours, or three hours in 'premium time', which is defined as between 7 p.m. and 7 a.m. during the week, or any time at weekends. In England, Scotland and Northern Ireland, ten PAs represent a full-time post, but the contract refers only to minimum commitments and does not define a maximum. On average, 7.5 PAs are for direct clinical care, although different patterns can be agreed through the job planning process. Total pay is composed of five elements: basic pay; additional PAs; on-call supplements; Clinical Excellence Award (CEA)/discretionary point/distinction award payments; and other fees and allowances. The current levels of payments are at Appendix A. The main differences for the new contract in Wales are: a basic 37.5 hour working week; a system of commitment awards to be paid every three years after reaching the new maximum of the pay scale, which replaces the former discretionary points scheme, although consultants in Wales are also eligible for national level CEAs; and a new salary structure with two extra incremental points.

The evidence

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

Pay aspects of the new consultant contract

8.4 The Health Departments told us that fewer than 10 per cent of consultants remained on the old contract. They said that average earnings per head for consultants had increased significantly since the introduction of the new contract and they would expect to see continued growth in average earnings per head, at a rate of about 1 per cent above the headline pay settlement, as consultants progressed through their thresholds towards the new maximum. They pointed out that average earnings for consultants in England were in the 98th percentile of earnings for all employees in the United Kingdom and noted that consultants in their first five years received year on year increases of around 3 per cent in addition to the headline settlement.

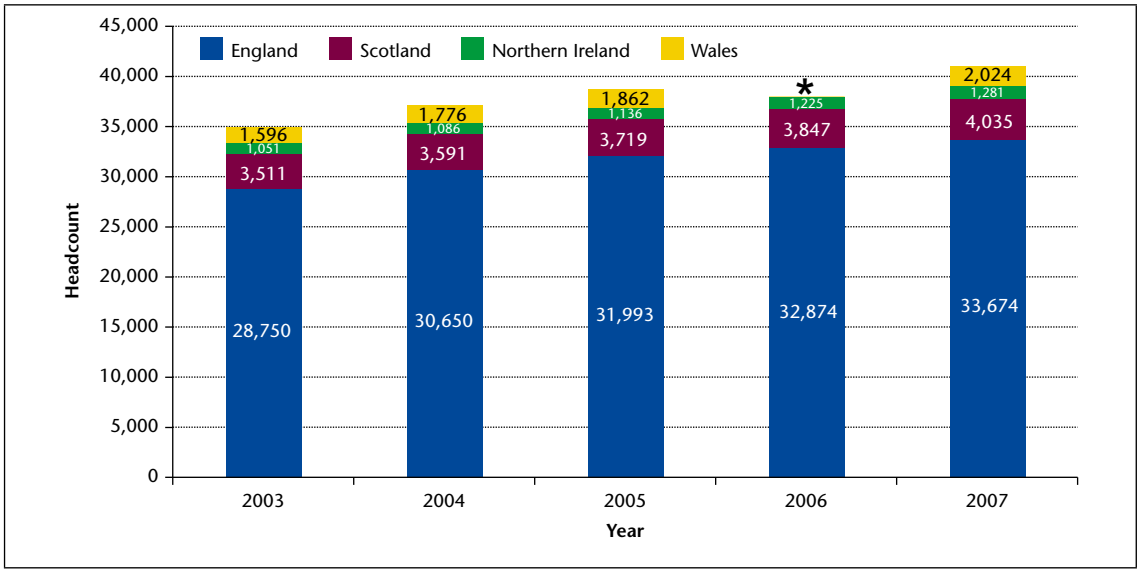
8.5 NHS Employers said that 93 per cent of consultants in England were being paid on the 2003 contract and that employers in the NHS were content that the 2003 contract continued to work well; they saw no current need for further revisions.

8.6 The BMA said that 93 per cent of consultants were now on the 2003 contract (98 per cent in Scotland). It believed that the overestimation of average earnings under the new contract and the inclusion of "distorting short-term effects" consequent on assimilation[67] had helped to create an environment conducive to real reductions in basic salaries to the detriment of the relative position of consultants. It looked forward to a climate where increases in basic pay at levels closer to those received at comparable levels elsewhere would be the norm. The BMA considered it unacceptable to maintain annual increases at what it described as "sub-inflation levels based on such illusory factors". It believed that a continuance of this position would result in further real terms decreases in pay.

Recruitment and retention

8.7 The steady increase in the number of consultants has continued, as shown in Figure 8.1. The latest data, at 30 September 2007, show that headcount is now over 41,000.

Figure 8.1: Number of consultants in the Hospital and Community Health Services, 2003 – 2007, United Kingdom



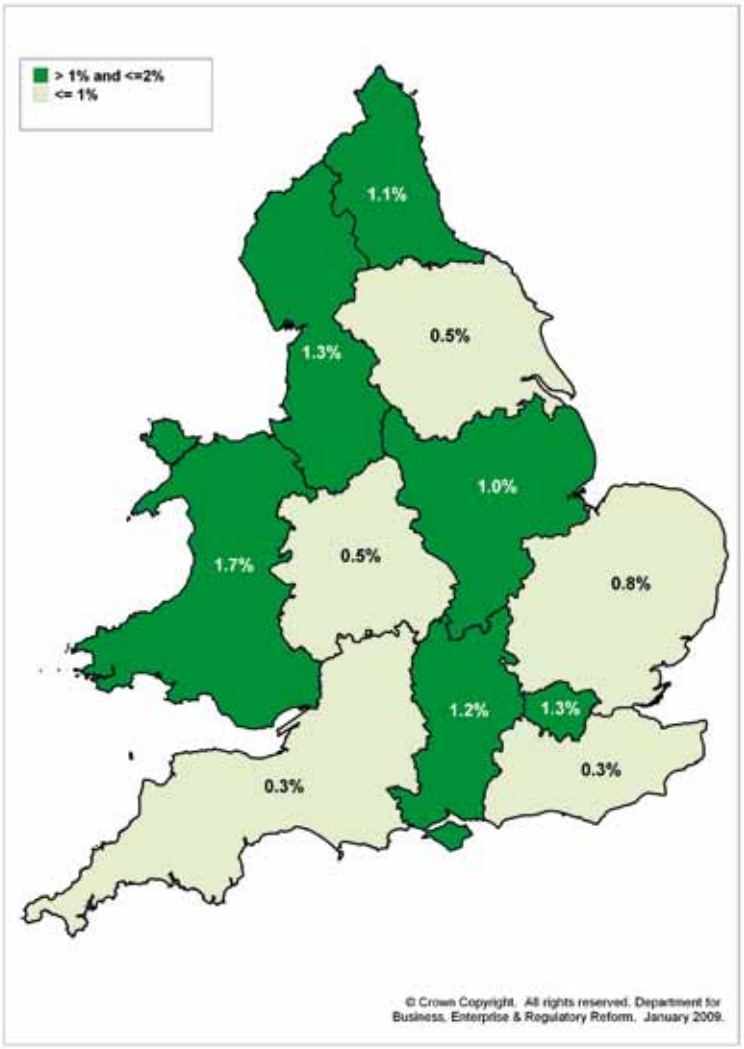
Sources: The NHS Information Centre, Welsh Assembly Government, Information Services Division Scotland, Department of Health, Social Services and Public Safety in Northern Ireland.

Note:

* Data for Wales not available for 2006.

[67] We understand that the short-term effects on assimilation referred to by the BMA are the costs of moving to the new contract, for example, the new pay scales and payment for additional hours until job plans and working patterns could be rationalised.

Figure 8.2: Consultants three-month NHS vacancy rates by strategic health authority area in England and Wales, 2008



Sources: The NHS Information Centre and Welsh Assembly Government.

Note: Figures for Scotland and Northern Ireland are not produced on a comparable basis.

8.8 We note that in March 2008 the three-month vacancy rate for medical and dental consultants was 0.9 per cent; these ranged from 1.3 per cent in the North West and London to 0.3 per cent in the South West and South East, as shown in Figure 8.2. The Department of Health observed that forecasts showed an increasing demand for consultants in England, with around 2,000 more consultants employed by 2010-11. It said that the vacancy rates varied between specialties, but that under the 2003 consultant contract there was provision for employers to pay a recruitment and retention premium of up to 30 per cent of normal starting salary under certain circumstances, although we understand that this is rarely used in England and Wales, and not at all in Scotland and Northern Ireland.

8.9 We were told by the WAG that in Wales, the medical and dental consultant three-month vacancy rate had fallen from 59.5 (3.0 per cent) in March 2007 to 37.0 (1.7 per cent) in March 2008. The majority of trusts reported being able to fill most posts with a good field of candidates; some considered recruitment to have improved in the past year and none reported that recruitment had been more difficult.

8.10 In Scotland, the Scottish Executive Health Department (SEHD) said that the latest available consultant vacancy figures confirmed that as at 30 September 2007 there were 282 whole-time equivalent medical and consultant vacancies, a small increase from the previous year's figure of 271 as at 30 September 2006. It said that the SEHD was taking measures to reduce the number of consultant vacancies.

8.11 NHS Employers reported a further decrease in vacancies and a general absence of recruitment and retention difficulties. They said that although the payment of recruitment and retention premia was still used only infrequently and for limited periods, the current provisions for the local level design and use of the premia continued to be deemed satisfactory by employers, and no change was sought to these arrangements. The NHS Information Centre's report[68] which stated that nearly a third of vacancies were in London was, in NHS Employers' opinion, true but slightly misleading. The report said that around 20 per cent of consultants worked in London, but NHS Employers believed there was likely to be more turnover in London. Consultant posts in London were often the most sought-after and selection to them was highly competitive. They said that a certain amount of churn of posts would occur in London as consultants moved between teaching hospitals while building up their career profile. Doctors/consultants in London had more choice over the hospital they worked in as they had access to all of the major teaching hospitals and those with families could move position without necessarily having to move home. NHS Employers believed that these factors could explain traditionally higher turnover rates in London. We note from the three-month vacancy tables provided by NHS Employers that posts with the highest vacancy rate across England are in accident and emergency (2.7 per cent), the dental group (2.3 per cent), psychiatry (1.6 per cent) and pathology (1.2 per cent). Obstetrics and gynaecology (3.3 per cent) and paediatrics (1.9 per cent) have above average three-month vacancy rates for the group in London.

8.12 The Health Departments reported that the most recent medical workforce modelling had shown a risk of oversupply of trained specialists, particularly in surgery. However, we do not accept that an uplift above 2 per cent will in itself lead to an oversupply. Firstly, we believe that any oversupply in future is likely to be caused by the numbers of doctors already in training. Secondly, the evidence claimed that pay rises above 2 per cent would lead to a reduction in funding for service development, which might mean a reduced need for additional doctors/consultants.

Motivation and morale

8.13 We received little evidence on the motivation and morale of consultants. However, the Health Departments reported that the NHS Staff Survey had found that doctors and dentists in consultant grades were significantly more satisfied with their level of pay than NHS staff as a whole. The survey also found that doctors and dentists in consultant grades had reported reduced levels of work pressure. In oral evidence all parties seemed to suggest that consultants were fairly content, although the anecdotal evidence presented during some of our visits was not quite so positive.

[68] *Vacancies in the NHS: England.* NHS Information Centre, 31 March 2008. Available from: http://www.ic.nhs.uk/webfiles/publications/Vacancy%20Survey%20%28NHS%20and%20%20GP%29%202008/2008%20Leaflet%20document%20final%20PDF.doc.pdf

Workload and productivity

8.14 The Health Departments reported that there had been a reduction in the number of doctors and dentists in consultant grades working extra hours in the last year (from 88 per cent to 82 per cent this year for consultants), although this figure has remained significantly higher than the NHS average (66 per cent). Average consultant weekly working hours in Wales were 41.0 hours at March 2008, a reduction of 0.5 hours over March 2007, and down from 45.6 hours in December 2003. The average number of PAs agreed in NHS Scotland as at September 2008 had risen very slightly to 11.6 from the previous level of 11.5. In Northern Ireland the average number of PAs was 10.95 (compared to 11.32 at September 2006). DHSSPSNI told us that job planning, which was key to the new contract, had been addressed over the past year, but had proved to be a difficult and challenging element of the contract in Northern Ireland.

8.15 The BMA said that the average number of PAs included in the job plans of a full-time contract was 11.3; this was a little higher than last year. It said that the average number of supporting professional activities in the job plans of full-timers remained at 2.5. The average number of hours worked per week for those on a full-time contract was 50.73 (equivalent to 12.7 PAs) with almost one in five working over 55 hours per week. The BMA commented that despite the intentions of the contract, significant time (up to six hours per week) remained unpaid, i.e. 1.4 PAs per week of unpaid work, five years on from the introduction of the contract. It considered it likely that the excess hours of work were also connected with activity which did not focus directly on clinical care but contributed to improvements in outcomes and thus productivity. While we note that the BMA's evidence suggests that many consultants are working in excess of their contracted PAs, we maintain that the job planning process is the appropriate mechanism for addressing any such grievances.

8.16 The BMA reminded us, during oral evidence, that the quality of patient care had improved, mortality rates and MRSA infections were down, and the median treatment time had reduced from 19 weeks to eight weeks in just two years. It believed that as the hospital service was consultant led, consultants should therefore enjoy a share of NHS productivity gains. We agree with the Department of Health that consultants should not be disadvantaged because productivity is difficult to measure. We also believe that the lack of proper productivity measures makes it difficult to judge the sometimes conflicting evidence from the parties. However, we understand from the Department of Health, at oral evidence, that the University of York has been commissioned to develop better measures of productivity as the current measures do not take account of quality; as we have noted in Chapter 1, we welcome this, with a view to receiving improved information in time for our next report.

Clinical Excellence Awards, discretionary points, distinction awards

8.17 Schemes to provide consultants with some form of financial reward for exceptional achievements and contributions to patient care have been in existence since the beginning of the NHS in 1948. In England and Wales, the national awards are made by ACCEA; in Scotland they are awarded by SACDA; and in Northern Ireland awards are made by NICEAC. From October 2003, local CEAs in England, and commitment awards in Wales, have replaced discretionary points; national CEAs have also replaced distinction awards in England and Wales. The new CEA scheme was introduced in Northern Ireland in 2005 replacing discretionary points and distinction awards. Discretionary points and distinction awards continue to be awarded in Scotland and remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA or commitment award. All levels of CEAs, discretionary points and distinction awards are pensionable.

8.18 The BMA was keen that the awards should at least retain their relationship with basic salary and asked us to restore the relationship that there was before the *Thirty-Sixth Report* when we declined to increase the value of awards for 2007-08.[69] In that report, our recommendations were for flat cash increases to salaries and we did not believe that there was scope to increase the value of awards for that year. The BMA has calculated that the relative decrease in the value of awards has resulted in a transfer of around £3.5 million from the salary bill to NHS surpluses, but that to rectify this would require a relative increase of a little over 1 per cent to the value of awards.

8.19 Our recommendations in the *Thirty-Sixth Report* were made in the light of financial constraints on the NHS when we limited the overall award to hospital doctors in order to maximise the limited benefits to the lower end of the salary scales. It is not our practice to make retrospective adjustments to pay uplifts and we declined to do so last year in relation to the value of CEAs. We do not intend to revisit this decision.

England and Wales

8.20 The Department of Health drew our attention to the proposals in the *Next Stage Review*[70] to increase the transparency of the CEA scheme and to link the awards more strongly to quality and leadership. In particular, we note that new awards and the renewal of existing awards will become more conditional on clinical activity and quality indicators. The Department of Health believed that for 2009-10, the numbers of new Bronze, Silver, Gold and Platinum awards should again be determined by ACCEA, having regard to the available funding and the number of awards released at each level through retirements, resignations, withdrawals and progression through the scheme. It proposed that the value of CEAs, distinction awards and discretionary points should be increased by 2 per cent, in line with the award for all salaried medical grades.

8.21 ACCEA reported that 60.6 per cent of eligible consultants held CEAs or awards under the previous schemes; 13 per cent of awards held were higher awards at level 9/B/ Bronze or above. It told us that 2,580 consultants held CEAs and 1,516 consultants continued to hold distinction awards (from the previous scheme) but that over time these would move over to the new scheme or retire. ACCEA allocated 576 awards in 2008 (see Table 8.1). It told us that some awards would be vacated during 2009-10, mainly through retirement, but we also note from ACCEA that in 2008 two awards were withdrawn because the evidence of awardable clinical contribution was insufficient to justify continuation of the awards. ACCEA observed that since the scheme had been established, the investment in new awards had been based on maintaining the number of awards in proportion to the size of the population of eligible consultants.

[69] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 2.16. Available from: http://www.ome.uk.com/downloads/Cm%207025.pdf

[70] Professor the Lord Darzi of Denham. *High quality care for all: NHS Next Stage Review final report.* Cm 7432. TSO, 2008. Chapter 5. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Table 8.1: Clinical Excellence Awards made by ACCEA in 2008

Bronze awards	344
Silver awards	159
Gold awards	42
Platinum awards	31
Total awards	**576**

Source: Advisory Committee on Clinical Excellence Awards.

8.22 We welcome the data provided by ACCEA, showing the distribution of CEAs by gender and ethnic origin. ACCEA said that there was no statistically significant evidence of gender bias in the awards, but that it had concerns about the low number of Bronze applications received from women. ACCEA also reported that 12.1 per cent of CEAs were awarded to black and ethnic minority consultants – although it was not clear from the evidence how closely this reflected their proportions in the consultant population. For next year we would welcome confirmation that the scheme is operated in accordance with equality legislation.

8.23 ACCEA sought an increase in value of employer-based CEAs (levels 1 – 8 and 9 when awarded by employers) in line with the general uplift recommended by us for consultant remuneration. It asked that the value of higher awards should be increased in line with the general uplift for consultants recommended this year. It also requested that provision for new awards should be funded at the cost of the 2008 awards (valued at 1 April 2009) increased by 1.1 per cent, which it said represented the estimated increase in the consultant population bearing in mind that there was likely to be an increase in Silver awards (because in the 2009 round there would for the first time be a significant number of applications from consultants holding level 9 employer-based awards). ACCEA believed that this would maintain the ratio of awards to eligible consultants. It said that the increase would need to be further uprated by any inflation increase in consultant remuneration, which would enable a budget for new awards to be created while retaining the flexibility for ACCEA to determine the precise number of awards to be made at each level.

8.24 For 2009-10, we **endorse and recommend the proposal that the budget for higher Clinical Excellence Awards should be increased in line with the increase in the number of consultants eligible for an award (estimated by ACCEA at 1.1 per cent).** We also recognise the need for flexibility while the system continues to settle down and we therefore **endorse and recommend ACCEA's proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards to be made at each level in 2009-10.**

Scotland

8.25 The BMA requested that the number of A+, A and B awards be increased to match consultant expansion in Scotland and that their value should be increased by the same percentage as the general pay award for consultants, adjusted for the impact of the 2007 award. It asked that discretionary points be increased by the same percentage.

8.26 SACDA told us that at 30 September 2007 there were 524 award holders in Scotland, comprising 13.2 per cent of all consultants. It reported that 109 awards had been approved in the 2008 awards round, including the 27 awards endorsed by us in our *Thirty-Seventh Report* (see Table 8.2).

Table 8.2: Distinction awards made by SACDA in 2008

B award	66
A award	32
A+ award	11
Total awards	**109**

Source: Scottish Advisory Committee on Distinction Awards.

8.27 We also welcome the report from SACDA that there was an increase in the number of female consultants nominated in the 2008 round compared to 2007, and that although the numbers were very small, there was no evidence of discrimination for nominees from ethnic minorities. For next year we would welcome confirmation that the scheme is operated in accordance with equality legislation.

8.28 For the 2009 awards SACDA proposed to distribute a further 3 A+ awards, 8 A awards, and 16 B awards. SACDA claimed that there had been an increase of approximately 4.5 per cent in the eligible population for awards, 4,124 (at 30 September 2008) up from 3,945 (at 30 September 2007), including academic GMPs. We continue to believe that the number of awards should expand with the eligible consultant population and we therefore **endorse and recommend SACDA's proposal to distribute a further 3 A+ awards, 8 A awards, and 16 B awards.**

8.29 We note from the SEHD that the long-awaited new framework for distinction awards and discretionary points has been developed, although it has still to be approved. We look forward to receiving details of the new framework in time for our next review.

Clinical academic general medical practitioners in Scotland

8.30 The SEHD told us that it had again rejected our recommendation, from our *Thirty-Sixth Report*, on additional funding for distinction awards in Scotland to cover newly eligible senior academic general medical practitioners (GMPs). It said that that it did not consider it appropriate to increase the funding as the level of dilution of the awards to the pre-existing consultant body was not considered sufficient to justify any extra resources and also in view of the current on-going review of the distinction awards scheme. The BMA has, however, raised this issue again this year asking for awards for GMPs to be accounted for separately and in addition to the general awards.

8.31 We expressed our views on distinction awards for newly eligible senior academic GMPs in Scotland in our *Thirty-Sixth* and *Thirty-Seventh Reports*.[71] [72] Our view remains that, notwithstanding the review of distinction awards in Scotland, additional funding should be made available by the SEHD to recognise the increase in the population arising from the newly eligible senior academic GMPs and to ensure that consultants who might otherwise be eligible for an award are not disadvantaged by this small increase in numbers. However, the SEHD rejected the recommendation contained in our *Thirty-Sixth Report*, which was intended to address the issue, and has continued to oppose our point of view. We do not intend to revisit this issue.

[71] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 8.25. Available from: http://www.ome.uk.com/downloads/Cm%207025.pdf

[72] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report.* Cm 7327. TSO, 2008. Paragraph 8.37. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

Northern Ireland

8.32 The BMA again expressed concerns about the operation of the CEA scheme in Northern Ireland. It said that a substantial deficit in CEAs had developed in comparison with consultants in England, with a consequent loss of earnings. It claimed that funding for CEAs in Northern Ireland (0.25 CEA steps per eligible consultant for CEA steps 1 to 8) remained inferior to the rest of the United Kingdom (0.35 steps per eligible consultant) and told us that in Northern Ireland consultants required at least a step 4 CEA to be eligible to apply for a higher level (steps 9 to 12), whereas in England any consultant was eligible to apply for higher awards. The BMA asked us to make recommendations for Northern Ireland on the numbers of step 9 CEAs to be made available for the coming year and to allow progression of deserving excellent consultants to the higher CEA steps. The BMA also asked us to examine the equity of the Northern Ireland CEA scheme compared with that in England and make recommendations to redress any imbalances. During oral evidence, the BMA expressed dissatisfaction about the award scheme in Northern Ireland and said that the new scheme had been imposed, although it had contributed to the recent review of the scheme.

8.33 DHSSPSNI told us that it had allocated an additional £100,000 to trusts in 2007-08, as an interim measure pending the outcome of the review of the scheme, to help alleviate some of the financial difficulties faced by trusts. It said that the additional funding recognised the fact that in the first two years of the new scheme all higher awards were allocated to existing B distinction award holders, which meant that no awards were freed up locally through that mechanism.

8.34 The DHSSPSNI said that the review of the scheme had started in October 2007 when a review group was established. It finalised its work in May 2008 when it made a number of recommendations to DHSSPSNI. It told us that it had agreed to introduce a formula-based approach to determine the number of lower awards, and to allocate additional resources to trusts to help meet these costs. It said that the level of formula set (0.25 awards per eligible consultant) took into account affordability considerations and changes in the handling of step 9 awards; DHSSPSNI had agreed that NICEAC should take over the handling of step 9 awards.

8.35 We were told by DHSSPSNI that although the formula set for lower awards was lower than the England formula, it should be remembered that Northern Ireland had a different awards scheme; for example there were different rules on eligibility and for the application process. It was important to ensure that the awards allocated reflected 'excellence' in the medical workforce. However, it believed that it may not always be appropriate to simply replicate elements of the English scheme in Northern Ireland. DHSSPSNI said that it intended to implement the recommendations of the review for the 2008-09 awards round, although this would mean a delay to the start of the awards round.

8.36 DHSSPSNI's report to us on the outcome of the review noted that the number of new higher awards would be considered by us. It said that it understood that we would make recommendations on higher awards and normally link any increase in awards to the increase in the consultant population. However, DHSSPSNI subsequently told us that we were not being asked to make a recommendation on the number of higher awards in Northern Ireland. It explained that it determined the number of awards taking into account the available funding, and having regard to any increase in the consultant population and retirements, resignations, and progression through the scheme of existing higher award holders, and was recommending that the value of awards be increased in line with the award proposed for all medical staff. In Northern Ireland the number of new awards was not a matter for NICEAC, but a matter for DHSSPSNI.

8.37 We were pleased to receive evidence from NICEAC for the first time, which explained some of the differences with the schemes elsewhere in the United Kingdom. It told us that in Northern Ireland application was by self nomination only, and that there were different rules on eligibility and the citation process. It reported that at the end of the 2007-08 awards round there were a total of 104 consultants in receipt of higher awards out of a consultant population of 1,190. It welcomed the decision that NICEAC would take over step 9 awards as it believed that this would take some financial pressure off trusts and help free up more local awards. It noted that higher level awards had involved a highly competitive process in recent years, but considered that for the next few years the first priority should be to increase the number of local awards.

8.38 We note from NICEAC's evidence that in 2007-08 no awards were made to female consultants, compared to two awards the previous year; in addition that the overall proportion of higher awards held by female consultants had decreased to 8.7 per cent from 11.9 per cent the previous year. NICEAC also reported that there remained a significant under representation of female consultants at the higher award level, given that 28 per cent of the consultant population in Northern Ireland was female. No data on awards to ethnic minorities were provided. These figures give us some cause for concern, particularly when compared to the rest of the United Kingdom. For next year we would welcome confirmation that the scheme is operated in accordance with equality legislation.

8.39 We commented last year[73] on our unease over the possible inequalities between the awards scheme in Northern Ireland and elsewhere in the United Kingdom, and thus the potential disadvantages for eligible consultants. We said that we would prefer to see greater equity throughout the United Kingdom and this continues to be our point of view. We accept that the review of awards in Northern Ireland has now taken place and that this has gone some way to redress the balance. However, the differences in the schemes across the United Kingdom appear to be causing regional variations in consultants' pay and we are unable to ascertain from the information available whether the scheme in Northern Ireland is disadvantageous to consultants compared to elsewhere in the United Kingdom, although we suspect that it is. We therefore emphasise the importance which we attach to the principle of equity in a labour market for consultants which is United Kingdom wide. In particular we believe that there should be an alignment between consultant numbers and the number of awards.

8.40 For England, Wales and Scotland we usually endorse the awarding bodies' proposals to distribute further awards, but neither DHSSPSNI nor NICEAC has asked us to do this, making our role with regard to CEAs in Northern Ireland unclear. For the next round we would like a report on the number of higher CEAs at each level made in 2009, as well as an indication of the number of proposed higher CEAs and how this is linked to any increase in the consultant population in Northern Ireland as we believe that the number of awards should expand in proportion to any growth in the eligible consultant population.

Our recommendations

8.41 We recognise that all the different merit awards form part of the consultant pay structure and that we have traditionally recommended the same percentage uplift for these payments as we recommend for basic pay. We therefore **recommend that for**

[73] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report.* Cm 7327. TSO, 2008. Paragraph 8.34. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

2009-10 the value of Clinical Excellence Awards, commitment awards, distinction awards and discretionary points should be increased by 1.5 per cent, in line with our main pay recommendations.

Medical managers

8.42 The BMA reported that agreement had been reached for Health Board medical directors in Scotland for an annually updated management allowance.

8.43 As we have observed in previous reports, medical managers are outside our remit, and therefore we do not consider it appropriate to offer comment on how the remuneration of such staff should be uplifted. We reiterate that locally negotiated remuneration schemes will, by their very nature, reflect local circumstances. Nevertheless, many medical or clinical directors will be covered by the consultant contract and therefore eligible for the uplift recommended for consultants.

Clinical academics

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

Public health medicine

8.45 The BMA told us that it was important that directors of public health continued to keep pace with increases to salaries elsewhere in the profession. The BDA reported that the workload of community dentists in public health continued to increase significantly with the continued move towards true commissioning and the devolution of the primary care dental budget, together with the inclusion of commissioning of secondary care and practice based commissioning.

Pay comparability

8.46 The pay comparability study carried out by PA Consulting Group[74] identified for the first time comparators for representative 'anchor points' for consultants. Consequently, the following comparators have been used for consultants:

Consultant (minimum)

- Associate specialist
- Accounting and Tax (Hay Responsibility Level 20)
- Legal (Hay Responsibility Level 20)
- Actuarial (Hay Responsibility Level 20)
- Pharmaceutical (Hay Responsibility Level 20)

[74] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups.* Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

Consultant (maximum)

- Accounting and Tax (Hay responsibility level 21)
- Legal (Hay responsibility level 21)
- Actuarial (Hay responsibility level 21)
- Pharmaceutical (Hay responsibility level 21)

8.47 Our own analysis of pay comparability, using the comparator points listed above, concluded that for newly qualified consultants (on the scale minimum), both median basic salary and median total earnings fell within the spread of the medians of comparator groups. However, for experienced consultants (on the scale maximum with the upper quartile of four CEAs), both median basic salary and median total earnings were above the spread of the medians of comparator groups. Chapter 1 and Appendix E contain a more detailed analysis of pay comparability.

Pay recommendation for 2009-10

8.48 The different pay proposals from the parties are set out in Chapter 2 along with our main pay recommendations. The Health Departments said that consultants had seen their earnings increase significantly since the introduction of the new contract and that an award of 2 per cent would be appropriate for this group. NHS Employers sought no difference in the increase awarded to those on pre and post-2003 consultant contracts and said that 2 per cent would be an affordable increase. The BMA asked for an increase of at least 4 per cent for consultants.

8.49 For 2009-10, we **recommend an increase of 1.5 per cent on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts.** The recommended pay scales and pay thresholds are set out at Appendix A. Chapter 2 gives more detail as to how we arrived at our recommendation.

CHAPTER 9: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

Introduction

9.1 In previous reports we have used the titles *staff and associate specialists/non-consultant career grades (SAS/NCCGs)* for this chapter, while we awaited the outcome of the discussions between the parties on a new generic title. To reflect the new grade of specialty doctor and the new contracts for specialty doctors and associate specialists, introduced from 1 April 2008, we will now refer to the group as *specialty doctors and associate specialists (SAS)*.

9.2 The SAS grades[75] are a diverse group including: specialty doctors (new contract), associate specialists (old and new contract), staff grades (old contract), senior clinical medical officers, clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. Our recommendations for 2009-10 will apply to all these groups. However, clinical assistants, hospital practitioners and doctors working in community hospitals can be qualified as general medical practitioners (GMPs) and our recommendations for these doctors, where appropriate, are contained in Chapter 3 of this report.

9.3 The numbers of SAS grades centrally recorded as working in the Hospital and Community Health Services (HCHS) changed from 19,175 in 2000 to 18,120[76] in 2007, within which the staff grades and associate specialists group increased from 7,439 in 2000 to 11,177 in 2007. SAS grades represent about 16 per cent of the total headcount of all HCHS doctors. However, the significant numbers of trust grade doctors employed under local terms and conditions are not included in these figures, so the true proportion of SAS grades as part of the HCHS is higher. This group therefore makes an important contribution to overall service delivery.

The evidence

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

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[75] The BMA website provides the following definitions:

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

An **associate specialist** is a doctor who will have trained and gained experience in a medical specialty but has not yet attained the status of a consultant. They will often work without direct supervision, but will be attached to a clinical team led by a consultant in their specialty. An associate specialist will have undertaken some specialist training and will almost certainly have attained the professional qualifications to be a member or fellow of the relevant medical royal college or faculty.

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

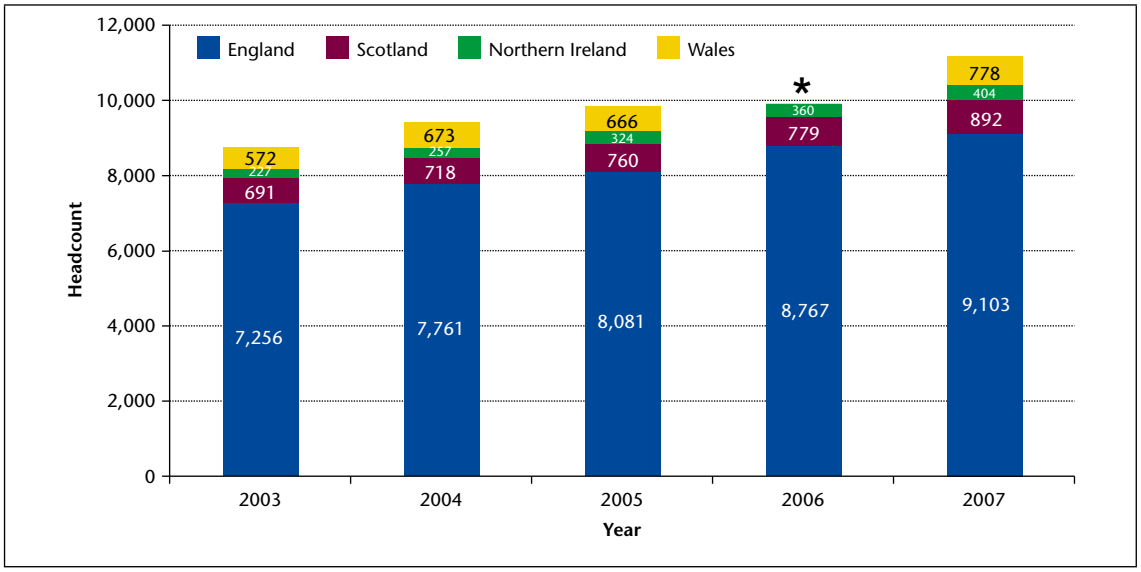
Source: BMA Glossary of doctors. Available from: http://www.bma.org.uk/patients_public/whos_who_healthcare/glossdoctors.jsp

[76] This includes all grades, not only specialty doctors (new contract), staff grades (old contract) and associate specialists (old and new contract). However, this may not include all locally employed grades.

Recruitment and retention

9.5 The Health Departments noted the continuing expansion of the specialty doctor (staff grade) group and associate specialists and this is illustrated in Figure 9.1 below. The following paragraphs give the parties' views on the reasons for this growth.

Figure 9.1: Number of staff grades and associate specialists in the Hospital and Community Health Services, 2003 – 2007, United Kingdom



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

Note:

* Data for Wales not available for 2006

9.6 The Health Departments told us that there was evidence of healthy recruitment and retention in these grades, with further increases in the numbers of associate specialists and staff grades in the year to September 2007. The three-month vacancy rate in England was 1 per cent in 2008. In Wales, there did not appear to be a significant recruitment problem for SAS grades, and at March 2008 there was a 1.7 per cent vacancy rate amongst SAS grades. The Welsh Assembly Government (WAG) believed that it was too early to say whether the position had changed as a result of the introduction of the new specialty doctor grade. The Health Departments made no specific comments on the recruitment and retention of SAS grades in Scotland and Northern Ireland, although there was an expectation in Northern Ireland that the new contract should lead to a significant improvement.

9.7 The BMA observed that in the last year the number of associate specialist doctors had increased by 8.2 per cent, compared with a 3.1 per cent increase in staff grade doctors. It believed that this suggested that a number of doctors had been regraded from staff grade posts in anticipation of the new contract and closure of the associate specialist grade. It said that two main events had created artificial recruitment to staff grade and associate specialist grades and that these would impact on future retention levels and that neither was a positive reflection on SAS grades: first, the recent restructure of postgraduate medical training through *Modernising Medical Careers*; and second, the closure of the associate specialist grade alongside a decreasing number of consultant posts.

Motivation and morale

9.8 The BMA said that as the new contract was in the early stages, it was unable to comment on the impact of the new contract on morale. However, during oral evidence the BMA stressed that morale among this group was very low. It said that the delays to the contract, transitional impositions and frustration at the failure of the new contract to deliver all that was required for the grade, manifested in the lethargy shown towards it, had all led to a very low level of morale in the SAS grades.

9.9 It is too early to tell if motivation and morale will be improved by the new contract. However, we encourage the parties to include written evidence of how the new contract has affected motivation and morale for the next round.

Education, training and opportunities for career progression

9.10 The Department of Health said that the introduction of *Modernising Medical Careers* now offered SAS grades more opportunities to undertake further training and progress their careers. It also told us that recurrent funding of £12 million in England (which we understand is available to trusts via the deaneries) had been provided for SAS grades' career support, training and continuing professional development. It noted that the BMA had argued that funding should be committed to top-up training for SAS grades, but the Health Departments said that such decisions on funding were for local determination.

9.11 The BMA said that there was a strong desire by doctors in the SAS grades for career progression and development throughout their career. *Modernising Medical Careers* had eliminated the ability for doctors to remain in the formal training structure in generalist training whilst they waited for a higher specialist training post, forcing them into the staff grade/specialty doctor grade. The BMA did not want to see the SAS grades used as an alternative to the training system, whereby doctors in the SAS grade were paid at a lower rate for obtaining the same skills and knowledge as doctors in the formal training system and providing the same level of service. It believed that the changes to postgraduate training and the increase in the number of specialist training posts alongside the decrease in growth of new consultant posts meant that the chances of an SAS doctor progressing into a consultant post would significantly decrease in the future. The BMA also told us that junior doctors did not view the SAS grades as an attractive career alternative. We welcome the fact that *Modernising Medical Careers* has provided opportunities for SAS doctors to undertake further training and progress their careers, which we would expect to deliver improvements to the motivation of this group of doctors. Whilst we accept that decisions on who progresses to consultant grade lie with employers and take place within a competitive environment, we would nevertheless welcome evidence that shows how many SAS grades actually reach consultant grade.

9.12 We also note that the £12 million funding for SAS grade career support, training and continuing professional development in England has been well received by the BMA and suggest that the devolved authorities may wish to give consideration as to whether a proportionate level of funding would be appropriate.

New contractual arrangements

9.13 The new contracts for specialty doctors and associate specialists were introduced from 1 April 2008. Specialty doctor is a new grade introduced from that date and NHS Employers said that it was expected that staff grade doctors and some clinical assistants and clinical medical officers would transfer to the new contract for specialty doctors. The associate specialist grade would close to new entrants after 31 March 2009, and there was a limited opportunity for eligible doctors to apply for regrading to associate specialist.

9.14 We were told that the transfer of existing SAS staff would take place during 2008-09. Under the new contract specialty doctors would have access to incremental scales worth between 5 and 10 per cent and associate specialists between 3 and 9 per cent. NHS Employers said that the service benefits of the new contract were: supported job planning, a common working week, a new pay structure and integrated career development through planned time for supporting activities. The contract had been negotiated and accepted by all four Health Departments, and local discussions in respect of detailed implementation in each country were continuing. NHS Employers told us that assimilation to the new rates of pay would be staged in England and that in moving to the new contract, doctors would receive an assimilation pay increase of one annual increment, of between 4 and 15 per cent of basic salary, delivered in two stages on 1 April 2008 and 1 April 2009. They said that the parties believed that the contract would be beneficial to both doctors and the service when implementation was complete. NHS Employers reported that the new contract had been offered to all eligible staff and the number of expressions of interest had been high.

9.15 The Department of Health told us that the BMA had accepted the terms for the transitional implementation of the new contract in England. The Department believed that the transitional arrangements provided a more equitable phasing of the pay benefits of the new contract and were more consistent with public sector pay restraint. It noted that the transitional arrangements related only to the pay increase of one extra increment that the contracts would award to doctors, and did not apply to other elements of the proposals. The new contracts offered staff grade doctors (now specialty doctors) and associate specialists substantial pay increases in return for reform; for example, arrangements to strengthen job planning, improved incentives for working evenings and weekends, and provided the opportunity for doctors to enhance earnings through additional reward for flexible service delivery. The Department said that the average pay increases for staff grades would be 5.2 per cent from 1 April 2008 and 5 per cent on 1 April 2009; for associate specialists these would be 1.8 per cent on each of these two dates. It noted that there was no provision for back pay prior to the introduction of the contract; and also that, as with other pay reforms, this offer was a "something for something deal". The Department believed that investment in return for reform meant that reward must be linked to the delivery of benefits.

9.16 The Department said that, informed by the Committee of Public Accounts' report on the consultant contract,[77] its offer of the new SAS contracts (in England) was conditional on a joint agreement (between the Department, the BMA and NHS Employers) that the costs of implementing the new arrangements be reported to us annually, to be taken into account when setting future pay awards. All parties had agreed to this condition. The Department said that it intended to monitor the actual costs against the projected costs in the proposals submitted by the BMA and NHS Employers (taking account of the transitioned implementation of those costs). It proposed to monitor this using the electronic staff record system. It told us that monitoring would look only at those cost elements associated with the new arrangements that arose directly as a result of the implementation. It would not include costs that were not a direct result of implementing the new contracts – so it would exclude, for example, costs associated with workforce growth and future pay awards. The Department said that the earliest that information could be expected was early 2009 and we look forward therefore to receiving these costings in time for our next round.

9.17 The WAG said that it was currently implementing the new SAS grades' contracts. The agreement for Wales was the same as for the rest of the United Kingdom except for the job plan outcomes categories, arrangements for private practice, and some terminology all of which reflected the different consultant contract in Wales. It noted that there were several hundred SAS grades who were not eligible for the new contract; these were mainly practising GMPs working in the old clinical assistant and hospital practitioner grades, but most worked only one or a small number of sessions per week.

9.18 In Scotland, the Scottish Executive Health Department told us that the new contract would follow the agreed United Kingdom terms and conditions, but with better assimilation arrangements; specifically, eligible doctors in Scotland who transferred to the new contract on 1 April 2008 would be moved on to the pay point that they would have been on had the contract been implemented from April 2007.

9.19 The Department of Health, Social Services and Public Safety in Northern Ireland noted that there were around 450 doctors in Northern Ireland eligible for the new contracts, which it believed should significantly improve the recruitment, retention and morale of this group of doctors.

9.20 The BMA believed that SAS grades were financially disadvantaged by the delay in contract negotiations. It said that the majority of doctors would not have moved onto the new contract until the end of 2008 and into 2009; in Scotland it may be as late as July 2009. A BMA survey in August 2008 had indicated that 84 per cent of respondents were planning on moving to the new contract, but a quarter of those respondents had still formally to express their interest. The BMA said that the new contract would not be beneficial to all SAS grades and that those doctors must not be disadvantaged because of this. It estimated that one fifth of SAS grades would choose to remain on the old contract and asked that the pay for the old contract should be increased in line with the new contract.

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[77] House of Commons, Committee of Public Accounts. *Pay modernisation: a new contract for NHS consultants in England.* HC 506. TSO, 22 November 2007. Available from: http://www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/506/506.pdf

9.21 We look forward to receiving information on the progress of the transfer to the new contract for our next review; in particular, we seek reassurance that there has been a proper assessment to ensure that individuals are on the correct point of the scale before transfer to the new contract.

Closure of the associate specialist grade

9.22 The BMA informed us that it had concerns about the impact of closure of the associate specialist grade on the pay and career progression of SAS grades. Its concerns included: decreased potential career earnings; negative morale and motivation; artificial recruitment and retention; and the impact on potential pension contributions and entitlement. It said that the specialty doctor grade must be made an attractive career alternative to ensure these doctors remained in the NHS. The BMA believed that specialty doctors would acquire the same knowledge and skills throughout their career as associate specialists, who would have previously been rewarded for this development by higher pay on the associate specialist pay scale. The BMA said that the pay for specialty doctors must ensure that they were equally compensated for professional development and believed this could be accomplished by a differential in the pay levels beyond the second threshold in the specialty doctor pay scale.

9.23 The BMA believed that trusts would get the same high level of service at a cheaper cost at the expense of specialty doctors – this would have an increasingly negative impact on morale and motivation of these doctors. It said that closure of the associate specialist grade created artificial retention as the options for these doctors to move posts were limited and that moving to a specialty doctor post would in most cases lead to a decrease in pay, so the only real option was to obtain a consultant post. Nevertheless, we note that these constraints were accepted as part of the new contractual arrangements.

Pay comparability

9.24 The pay comparability study carried out by PA Consulting Group[78] identified for the first time comparators for representative 'anchor points' within the SAS group. Consequently, the following comparators have been used for SAS grades:

Associate specialist

- Consultant (minimum)
- Accounting and Tax (Hay Responsibility Level 20)
- Legal (Hay Responsibility Level 20)
- Actuarial (Hay Responsibility Level 20)
- Pharmaceutical (Hay Responsibility Level 20)

[78] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups.* Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

9.25 Our own analysis of pay comparability, using the comparator points listed above, concluded that for associate specialists, both median basic salary and median total earnings fell below the medians of comparator groups. Comparative figures do not yet exist for specialty doctors. Chapter 1 and Appendix E contain a more detailed analysis of pay comparability.

Pay recommendation for 2009-10

9.26 The Health Departments said that there was evidence of healthy recruitment and retention in these grades and that the new contract offered this group of doctors substantial pay increases. It believed that a pay award of 2 per cent for this group would be appropriate. NHS Employers asked that in considering a general pay increase, the impact of the assimilation increment should be taken into account.

9.27 The BMA sought the same uplift for SAS grades choosing to remain on the old contracts and transferring to the new contracts. It also drew our attention to the losses incurred by SAS grades over the two year delay by the government in implementing the new contract. For specialty doctors, the BMA sought a differential increase in the pay points above the second threshold, which it believed would ensure that these doctors were appropriately compensated and valued.

9.28 We believe it is important that our recommendations do not conflict with the new contract before it has had the opportunity to settle down. Therefore, while we understand the BMA's concerns over the delays in implementing the contract, it is not our role to compensate individuals for any perceived loss of earnings incurred through such a delay and we make no such recommendation. Similarly, with regard to the impact that closure of the associate specialist grade may have on these doctors; closure of the associate specialist grade formed a part of the new contract which has been negotiated and agreed by the parties. We think therefore that it would be inappropriate for us to recommend a change to the negotiated pay structure before the contract has had the opportunity to settle down and we have made no recommendation to increase pay points above the second threshold for specialty doctors. We also reject NHS Employers' view that we should take account of the impact of assimilation increments when deciding the general pay increase. Any such increments formed part of the contractual negotiations, and represent payment for acceptance of modernised terms and conditions of service.

9.29 For 2009-10, we **recommend an increase of 1.5 per cent on the national salary scales for the pre-2008 and post-2008 SAS grades' contracts**. Chapter 2 gives more detail as to how we have arrived at our recommendation. In the usual way, our recommendation of a 1.5 per cent increase will also apply to the pay scales for non-GMP clinical assistants and hospital practitioners.

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: RECOMMENDED SALARY SCALES

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

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

	Current scales £	Recommended scales payable from 1 April 2009[1] £
	(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
Foundation house officer 1	21,862	22,190
	23,226	23,575
	24,591	24,960
Foundation house officer 2	27,116	27,523
	28,889	29,323
	30,663	31,122
Specialty registrar (full)	28,976	29,411
	30,749	31,211
	33,226	33,724
	34,723	35,244
	36,529	37,077
	38,336	38,911
	40,143	40,745
	41,948	42,578
	43,755	44,412
	45,562	46,246
Specialty registrar (fixed term)	28,976	29,411
	30,749	31,211
	33,226	33,724
	34,723	35,244
	36,529	37,077
	38,336	38,911
House officer	21,862	22,190
	23,226	23,575
	24,591	24,960

[1] Our recommended basic pay uplifts, to be applied from April 2009, are applied to unrounded current scales (November 2007 is the base year), with the final result being rounded up to the nearest unit.

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Senior house officer	27,116	27,523
	28,889	29,323
	30,663	31,122
	32,436	32,922
	34,209	34,722
	35,982	36,522[2]
	37,755	38,322[2]
Registrar	30,231	30,685
	31,728	32,204
	33,226	33,724
	34,723	35,244
	36,529	37,077
Senior registrar	34,723	35,244
	36,529	37,077
	38,336	38,911
	40,143	40,745
	41,948	42,578
	43,755	44,412
	45,562	46,246[3]
Specialist registrar[4]	30,231	30,685
	31,728	32,204
	33,226	33,724
	34,723	35,244
	36,529	37,077
	38,336	38,911
	40,143	40,745
	41,948	42,578[5]
	43,755	44,412[5]
	45,562	46,246[6]
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)[7]	73,403	74,504
	75,701	76,837
	78,000	79,170
	80,298	81,502
	82,590	83,829
	88,049	89,370
	93,508	94,911
	98,962	100,446

[2] To be awarded automatically except in cases of unsatisfactory performance, see *Twenty-Eighth Report*, paragraph 3.21, and *Thirty-First Report*, paragraph 6.46.
[3] To be awarded automatically except in cases of unsatisfactory performance, see *Thirty-Third Report*, paragraph 6.61.
[4] The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.
[5] To be awarded automatically except in cases of unsatisfactory performance, see *Twenty-Eighth Report*, paragraph 3.21.
[6] To be awarded automatically except in cases of unsatisfactory performance, see Thirty-*Third Report*, paragraph 6.61.
[7] Pay thresholds and transitional arrangements apply.

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Clinical Excellence Awards[8]	*Value*[9]	
	2,913	2,957
	5,826	5,914
	8,739	8,871
	11,652	11,828
	14,565	14,785
	17,478	17,742
	23,304	23,656
	29,130	29,570
	34,956	35,484
Consultant (2003 contract, Wales)	71,138	72,205
	73,403	74,504
	77,192	78,350
	81,594	82,818
	86,619	87,918
	89,485	90,827
	92,357	93,742
Commitment awards[10]	*Value*[11]	
	3,156	3,204
	6,312	6,408
	9,468	9,612
	12,624	12,816
	15,780	16,020
	18,936	19,224
	22,092	22,428
	25,248	25,632
Consultant (pre-2003 contract)[12]	60,944	61,859
	65,305	66,285
	69,667	70,712
	74,028	75,138
	79,001	80,186
Discretionary points[13]	*Value*[14]	
	3,156	3,204
	6,312	6,408
	9,468	9,612
	12,624	12,816
	15,780	16,020
	18,936	19,224
	22,092	22,428
	25,248	25,632

[8] Local level CEAs in England. For national CEAs, see Part II below.
[9] Local level CEAs for level 2 – 9 are multiples of the level 1 award (x2, x3, x4, x5, x6, x8, x10 and x12).
[10] Awarded every 3 years once the basic scale maximum is reached.
[11] Commitment awards for level 2 – 8 are multiples of the level 1 award (x2, x3, x4, x5, x6, x7 and x8).
[12] Closed to new entrants.
[13] From October 2003, local CEAs in England and Commitment awards in Wales have replaced discretionary points. Discretionary points continue to be awarded in Scotland and remain payable to existing holders in both England and Wales until the holder retires or is awarded a CEA or Commitment award.
[14] Discretionary points for level 2 – 8 are multiples of the level 1 award (x2, x3, x4, x5, x6, x7 and x8).

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Speciality doctor[15]	34,584	36,443
	37,439	39,559
	40,755	43,610
	43,145	45,781
	46,006	48,909
	49,095	52,025
	51,752	55,211
	54,641	58,399
	57,539	61,586
	60,677	64,772
	64,632	67,959
Associate specialist (2008)[16]	50,339	51,095
	52,363	55,202
	56,409	59,308
	61,103	64,731
	66,089	69,432
	69,366	71,381
	71,580	73,926
	74,087	76,471
	76,594	79,015
	79,101	81,560
	81,609	84,106
	82,863	n/a
Associate specialist (pre-2008)	36,769	37,321
	40,664	41,274
	44,558	45,226
	48,451	49,178
	52,346	53,132
	56,240	57,084
	61,383	62,304
	65,840	66,827
Discretionary points	*Notional scale*	
	67,690	68,705
	70,103	71,154
	72,515	73,603
	74,928	76,052
	77,341	78,501
	79,756	80,953
Staff grade practitioner	33,264	33,762
(1997 contract, MH03/5)	35,904	36,443
	38,544	39,122
	41,185	41,803
	43,826	44,483
	46,935	47,639

[15] The specialty doctor pay scale has a different base year to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements (for further details see http://www.nhsemployers.org/restricted/downloads/download.asp?ref=4047&hash=c82674fa3d3f7399dbac6b5d28d9963a&itemplate=e_aboutus_3col_aboutus-2028).

[16] The associate specialist (2008) pay scale has a different base year to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements (for further details see http://www.nhsemployers.org/restricted/downloads/download.asp?ref=4047&hash=c82674fa3d3f7399dbac6b5d28d9963a&itemplate=e_aboutus_3col_aboutus-2028).

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Discretionary points[17]	*Notional scale*	
	49,107	49,843
	51,746	52,523
	54,387	55,203
	57,028	57,884
	59,668	60,563
	62,310	63,244
Staff grade practitioner	33,264	33,762
(pre-1997 contract, MH01)	35,904	36,443
	38,544	39,122
	41,185	41,803
	43,826	44,483
	46,466	47,163
	49,107	49,843
	51,746	52,523
	(Annual rates on the basis of a notional half day per week)	
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,493	4,561
Hospital practitioner (limited to a maximum of	4,397	4,463
5 half day weekly sessions)	4,652	4,721
	4,907	4,981
	5,162	5,239
	5,416	5,497
	5,671	5,756
	5,925	6,014

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

[17] See *Twenty-Seventh Report*, paragraph 2.34.

B. Community health staff

	Current scales £	Recommended scales payable from 1 April 2009[1] £
	(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
Clinical medical officer	31,865	32,343
	33,591	34,094
	35,316	35,845
	37,041	37,596
	38,766	39,347
	40,491	41,098
	42,216	42,849
	43,942	44,602
Senior clinical medical officer	45,029	45,704
	47,770	48,486
	50,510	51,267
	53,250	54,049
	55,991	56,831
	58,731	59,612
	61,471	62,393
	64,212	65,175

C. Salaried primary dental care staff[18]

	Current scales £	Recommended scales payable from 1 April 2009[1] £
	(Salary scales excluding earnings from additional sources, such as out-of-hours payments for training grades)	
Band A: Salaried dentist	36,792	37,344
	40,880	41,494
	47,012	47,718
	50,078	50,830
	53,144	53,942
	55,188	56,016
Band B: Salaried dentist	57,232	58,091[19]
	59,276	60,166
	62,342	63,278
	63,875	64,834
	65,408	66,390
	66,941	67,946

[18] These scales also apply to salaried dentists working in Personal Dental Services.
[19] Salary point is the entry level to Band B but is also the extended competency point at the top of Band A.

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Band C: Salaried dentist[20]	68,474	69,502[21,22]
	70,518	71,576
	72,562	73,651
	74,606	75,726
	76,650	77,800
	78,694	79,875
Band 1: Community dental officer	33,768	34,275
	36,500	37,048
	39,232	39,820
	41,965	42,594
	44,697	45,367
	47,428	48,140
	50,160	50,913[23]
	52,893	53,686[23]
Band 2: Senior dental officer	48,254	48,978
	52,073	52,855
	55,893	56,731
	59,712	60,608
	63,531	64,484
	64,373	65,339[24]
	65,214	66,193[24]
Band 3: Assistant clinical director	64,122	65,084
	65,114	66,091
	66,107	67,098
	67,099	68,105
	68,091	69,113[24]
	69,085	70,121[24]
Band 3: Clinical director	64,122	65,084
	65,114	66,091
	66,107	67,098
	67,099	68,105
	68,091	69,113
	69,085	70,121
	70,077	71,128
	71,086	72,152
	72,078	73,159[24]
	73,070	74,166[24]

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

[21] Salary point is the entry level to Band C but is also the extended competency point at the top of Band B.

[22] The first three points on the Band C range represent those available to current assistant clinical directors under the new pay spine.

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

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

	Current scales £	Recommended scales payable from 1 April 2009[1] £
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	56,316	57,160
	59,817	60,714
	63,320	64,269
	66,821	67,823
	71,086	72,152
	72,078	73,159[25]
	73,070	74,166[25]
Part-time dental surgeon	**Sessional fee (per hour)**	
Dental surgeon	27.70	28.12
Dental surgeon holding higher registrable qualifications	36.75	37.30
Dental surgeon employed as a consultant	45.79	46.48

[25] Performance based increment, see paragraph 4.48 of the *Thirty-First Report*.

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2009. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The budget for national Clinical Excellence Awards should be increased in line with the increase in the number of consultants now eligible for an award (including academic GMPs) in England and Wales. In Scotland, the number of A+ awards should be increased by 3, the number of A awards should be increased by 8, and the number of B awards should be increased by 16.

3. The annual values of national Clinical Excellence Awards for consultants and academic GMPs should be increased as follows.

Bronze (Level 9):	from £34,956 to £35,484
Silver (Level 10):	from £45,955 to £46,644
Gold (Level 11):	from £57,443 to £58,305
Platinum (Level 12):	from £74,676 to £75,796

4. The annual values of distinction awards for consultants[26] should be increased as follows.

B award:	from £31,486 to £31,959
A award:	from £55,098 to £55,924
A+ award:	from £74,768 to £75,889

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

Daytime supplement:	from £1,256 to £1,274	
Out-of-hours supplement	(England and Scotland)	(Wales)
Band 1:	from £946 to £960	from £2,180 to £2,213
Band 2:	from £1,885 to £1,913	from £4,360 to £4,426
Band 3:	from £2,818 to £2,860	from £6,539 to £6,637

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

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

   The rates are set out in the table below.

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

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

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

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

Doctors in flexible medical training

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

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

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

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

* salary = F5 to F9 calculated above.

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

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

11. The fee for domiciliary consultations should be increased from £80.50 to £81.72 a visit. Additional fees should be increased *pro rata*.

12. Weekly[27] and sessional rates for locum appointments[28] in the hospital service should be increased as follows:

Associate specialist, senior hospital medical or dental officer appointment	from £966.57 to £981.09 a week; from £87.87 to £89.19 a notional half day.
Specialty registrar (higher rate) appointment	from £861.60 a week to £874.56; from £17.95 to £18.22 per standard hour.
Specialty registrar (lower rate) appointment	from £781.92 a week to £793.92; from £16.29 to £16.54 per standard hour.
Specialist registrar appointment	from £861.60 a week to £874.56; from £17.95 to £18.22 per standard hour.

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

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

Foundation house officer 2 appointment	from £665.28 a week to £674.88; from £13.86 to £14.06 per standard hour.
Senior house officer appointment	from £746.88 a week to £757.92; from £15.56 to £15.79 per standard hour.
Foundation house officer 1 appointment/ House officer appointment	from £534.72 a week to £542.88; from £11.14 to £11.31 per standard hour.
Hospital practitioner appointment	from £98.98 to £100.47 a notional half day.
Staff grade practitioner appointment	from £815.20 to £827.40 a week; from £81.52 to £82.74 a session.
Specialty doctor appointment	from £819.60 to £836.40 a week; from £81.96 to £83.64 a programmed activity.
Associate specialist appointment (2008)	from £1,062.24 to £1,137.50 a week; from £106.24 to £113.75 a programmed activity.
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)	from £86.17 to £87.48 a notional half day.

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

London Weighting

14. The value of London zone payment[29] is £2,162 for non-resident staff and £602 for resident staff.

Ophthalmic medical practitioners

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

[29] See paragraph 1.64 of the *Thirty-Sixth Report*.

Doctors in public health medicine

16. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows:[30]

	Current range of supplements £	Recommended range of supplements payable from 1 April 2009 £
Island Health Boards: Band E (under 50,000 population)	1,732 – 3,435	1,758 – 3,487
District director of public health (director of public health in Scotland/Wales):		
Band D (District of 50,000 – 249,999 population)	3,435 – 6,869 (Bar); 8,588	3,487 – 6,972 (Bar); 8,717
Band C (District of 250,000 – 449,999 population)	4,309 – 8,588 (Bar); 10,320	4,374 – 8,717 (Bar); 10,474
Band B (District of 450,000 and over population)	5,154 – 10,320 (Bar); 13,311	5,232 – 10,474 (Bar); 13,511
Regional director of public health: Band A:	13,311 – 19,322	13,511 – 19,612

Note: Bar is the top of the range but high performers can go above this as long as they do not exceed the exceptional maximum.

General medical practitioners

17. The supplement payable to GMP registrars is 45 per cent[31] of basic salary for 2009-10.

18. The salary range for salaried GMPs[32] employed by primary care organisations should be £53,249 to £80,354 for 2009-10.

General dental practitioners[33]

19. The contract value for providers of NHS dental services in England and Wales should be increased by 0.21 per cent from 1 April 2009. An uplift of 0.21 per cent also applies to gross fees from 1 April 2009 in Scotland and Northern Ireland.

20. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes should be increased from £119.30 to £119.55.

21. The sessional fee for part-time salaried dentists working six 3-hour sessions a week or less in a health centre should be increased from £84.45 to £84.63.

22. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review should be increased from £65.07 to £65.21.

[30] Population size is not the sole determinant for placing posts within a particular band.
[31] See Chapter 3 of this report. For those already in post on 1 April 2009, the supplement remains unchanged.
[32] See Chapter 3 of this report.
[33] The rates specified in this section apply in Scotland and Northern Ireland only.

23. The quarterly payments under the Commitment Payments scheme[34] should be changed as follows:

Level 1 payment	from £46 to £46 a quarter
Level 2 payment	from £371 to £371 a quarter
Level 3 payment	from £478 to £479 a quarter
Level 4 payment	from £573 to £575 a quarter
Level 5 payment	from £667 to £669 a quarter
Level 6 payment	from £760 to £762 a quarter
Level 7 payment	from £858 to £859 a quarter
Level 8 payment	from £953 to £955 a quarter
Level 9 payment	from £1,047 to £1,049 a quarter
Level 10 payment	from £1,142 to £1,144 a quarter

Community health and community dental staff

24. The teaching supplement for assistant clinical directors in the community dental service should be increased from £2,378 to £2,413 a year.

25. The teaching supplement payable to clinical directors in the community dental service should be increased from £2,685 to £2,726 a year.

26. The supplement for clinical directors covering two districts should be increased from £1,736 to £1,762 a year and the supplement for those covering three or more districts should be increased from £2,771 to £2,813 a year.

27. The allowance for dental officers acting as trainers should be increased from £1,901 to £1,930 a year.

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

[34] To calculate 2009-10 payments, an unlift of 0.21 per cent has been applied to unrounded 2008-09 payments (November 2007 is the base year) and the result is rounded up to the nearest pound.

APPENDIX B

THE 2008-09 SETTLEMENT

In our *Thirty-Seventh Report*[35] we put forward recommendations on the level of remuneration we considered appropriate for doctors and dentists in the NHS as at 1 April 2008. Our main recommendations were:

- an increase of 2.2 per cent to the national salary scales for doctors and dentists;
- for independent contractor general medical practitioners, an increase in the global sum for each 'weighted patient', in line with the general uplift of 2.2 per cent. However, the increase in the global sum needed also to take account of practice expenses and we therefore recommended that the global sum payments per 'weighted patient' be increased by 2.7 per cent;
- for independent contractor general dental practitioners (GDPs), we recommended that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 2.2 per cent after allowing for an increase in expenses. We therefore recommended that an uplift of 3.4 per cent be applied to the gross earnings base under the new contract for GDPs in England and Wales. We also recommended that the uplift of 3.4 per cent should apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and Northern Ireland.

The government accepted in full our main recommendations relating to 2008-09.

[35] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report*. Cm7327. TSO, 2008. Available from: http://www.ome.uk.com/downloads/DDRB%20report.pdf

APPENDIX C

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

ENGLAND[36]	2006		2007		Percentage change 2006-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[37]						
Consultants	29,995	32,113	30,776	32,911	2.6	2.5
Associate specialists	2,411	2,712	2,552	2,907	5.9	7.2
Staff grades	5,163	5,719	5,275	5,840	2.2	2.1
Registrar group	17,837	18,449	29,788	30,354	67.0	64.5
Foundation house officer 2[38]	21,869	22,066	10,170	10,276	–53.5	–53.4
Foundation house officer 1[39]	4,866	4,879	5,189	5,225	6.6	7.1
Hospital practitioner	178	862	168	834	–5.4	–3.2
Clinical assistant	578	2,215	490	2,014	–15.1	–9.1
Other staff	173	396	158	337	–8.9	–14.9
Total	**83,070**	**89,411**	**84,566**	**90,698**	**1.8**	**1.4**
Hospital and Community Health Services Dental Staff[37]						
Consultants	624	761	654	763	4.8	0.3
Associate specialists	84	118	98	141	17.3	19.5
Staff grades	162	218	163	215	0.8	–1.4
Registrar group	343	359	388	405	13.0	12.8
Foundation house officer 2[38]	483	490	502	508	4.0	3.7
Foundation house officer 1[39]	25	26	15	15	–41.2	–42.3
Hospital practitioner	15	67	16	74	6.4	10.4
Clinical assistant	77	378	63	350	–18.0	–7.4
Other staff	1,093	1,492	1,068	1,469	–2.3	–1.5
Total	**2,905**	**3,909**	**2,967**	**3,940**	**2.1**	**0.8**
General practitioners						
General medical practitioners		**36,008**		**36,420**		**1.1**
GP providers		27,691		27,342		–1.3
GP registrars[40]		2,278		2,491		9.4
GP retainers[41]		639		565		–11.6
Other GPs		5,400		6,022		11.5

[36] Data as at 30 September unless otherwise specified.

[37] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[38] This includes senior house officers.

[39] This includes house officers.

[40] GMP registrars were formerly known as GMP trainees.

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

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

ENGLAND[36]	2006		2007		Percentage change 2006-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners[42,43,44]	**20,160**		**20,815**		**3.2**	
GDS only	12,263		12,438		1.4	
PDS only	5,263		5,322		1.1	
GDS and PDS	1,129		1,539		36.3	
Trust-led	1,505		1,516		0.7	
Ophthalmic medical practitioners[45]	**383**		**394**		**2.9**	
Total	**56,551**		**57,629**		**1.9**	
Total – NHS doctors and dentists	**149,871**		**152,267**		**1.6**	

[42] Further to a recent consultation exercise, the workforce figures presented in this report are based on a new definition. The new measure counts the number of dental performers who have any NHS activity recorded against them via FP17 claim forms at any time in the year that met the criteria for inclusion within the annual reconciliation process.
[43] Data as at 31 March of the following year.
[44] Data include salaried dentists.
[45] Data as at 31 December.

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

WALES[46,47]	2005		2007		Average annual percentage change 2005-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[48]						
Consultants	1,625	1,802	1,862	1,961	7.3	4.4
Associate specialists	138	158	210	233	25.9	23.7
Staff grades	432	470	472	512	4.6	4.5
Registrar group	815	842	1,330	1,357	31.6	30.6
Foundation house officer 2[49]	1,223	1,232	795	799	–17.5	–17.6
Foundation house officer 1[50]	257	257	566	568	60.1	60.5
Hospital practitioner	12	55	8	32	–19.5	–20.9
Clinical assistant	51	253	35	155	–16.0	–19.4
Other staff	71	97	4	15	–47.0	–42.3
Total	**4,624**	**5,166**	**5,281**	**5,632**	**7.1**	**4.5**
Hospital and Community Health Services Dental Staff[48]						
Consultants	48	60	52	63	4.8	2.5
Associate specialists	11	16	6	7	–23.1	–28.1
Staff grades	15	22	17	26	7.6	9.1
Registrar group	25	25	19	19	–12.8	–12.0
Foundation house officer 2[49]	37	37	51	51	18.9	18.9
Foundation house officer 1[50]	0	0	1	1	n/a	n/a
Hospital practitioner	0	1	1	3	83.3	100.0
Clinical assistant	8	54	6	35	–14.1	–17.6
Other staff	91	118	82	107	–4.7	–4.7
Total	**235**	**333**	**235**	**312**	**–0.1**	**–3.2**
General practitioners						
General medical practitioners		**2,022**		**2,174**		**3.8**
GP providers		1,849		1,936		2.4
GP registrars[51]		103		165		30.1
GP retainers[52]		70		73		2.1

[46] Data as at 30 September unless otherwise specified.

[47] Data for Wales include 2005 rather than 2006 as Wales Hospital and Community Health Services data are not available for 2006 due to collection problems.

[48] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[49] This includes senior house officers.

[50] This includes house officers.

[51] GMP registrars were formerly known as GMP trainees.

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

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

WALES[46,47]	2005		2007		Average annual percentage change 2005-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners[53,54]	**1,087**		**1,247**		**7.4**	
GDS only	678		536		–10.5	
PDS only	409		571		19.8	
mixed	0		119		n/a	
Ophthalmic medical practitioners[55]	**33**		**27**		**–9.1**	
Total	**3,142**		**3,448**		**4.9**	
Total – NHS doctors and dentists	**8,641**		**9,392**		**4.3**	

[53] Data include salaried dentists.
[54] Data as at 31 March of the following year.
[55] Data as at 31 December.

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

SCOTLAND[56,57]	2006		2007		Percentage change 2006-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[58]						
Consultants	3,544	3,751	3,720	3,938	5.0	5.0
Associate specialists	193	231	214	256	10.7	10.8
Staff grades	418	513	492	601	17.7	17.2
Registrar group	1,550	1,611	3,842	3,804	147.9	136.1
Foundation house officer 2[59]	2,901	2,930	1,081	1,092	–62.7	–62.7
Foundation house officer 1[60]	793	793	777	781	–2.0	–1.5
Hospital practitioner	29	121	27	113	–5.7	–6.6
Clinical assistant	118	464	109	438	–7.8	–5.6
Other staff	54	122	88	147	63.4	20.5
Total	**9,600**	**10,500**	**10,350**	**11,128**	**7.8**	**6.0**
Hospital and Community Health Services Dental Staff[58]						
Consultants	81	96	82	97	1.3	1.0
Associate specialists	10	13	9	12	–11.5	–7.7
Staff grades	16	22	16	23	1.7	4.5
Registrar group	32	35	33	36	4.7	2.9
Foundation house officer 2[59]	61	63	37	38	–39.7	–39.7
Foundation house officer 1[60]	0	0	0	0	n/a	n/a
Hospital practitioner	3	14	2	10	–25.7	–28.6
Clinical assistant	11	58	9	45	–17.3	–22.4
Other staff	347	409	382	441	9.9	7.8
Total	**561**	**701**	**570**	**695**	**1.7**	**–0.9**
General practitioners						
General medical practitioners		**4,626**		**4,721**		**2.1**
GP providers		3,807		3,826		0.5
GP registrars[61]		310		316		1.9
GP retainers[62]		184		178		–3.3
Other GPs		330		408		23.6

[56] Data as at 30 September.

[57] An employee can work in more than one Board/Region/Specialty or Grade and is presented under each group but counted once in the total.

[58] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[59] This includes senior house officers.

[60] This includes house officers.

[61] GMP registrars were formerly known as GMP trainees.

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

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

SCOTLAND[56,57]	2006		2007		Percentage change 2006-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners[63]	**2,434**		**2,546**		**4.6**	
General dental practitioner	2,257		2,370		5.0	
Vocational dental practitioner	147		147		0.0	
Assistant dental practitioner	40		39		–2.5	
Ophthalmic medical practitioners	**33**		**24**		**–27.3**	
Total	**7,093**		**7,291**		**2.8**	
Total – NHS doctors and dentists	**18,294**		**19,114**		**4.5**	

[63] Data include salaried dentists.

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

NORTHERN IRELAND[64]	2006		2007		Percentage change 2006-2007	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff[65]						
Consultants	1,164	1,225	1,211	1,281	4.1	4.6
Associate specialists	57	71	68	83	19.5	16.9
Staff grades	248	289	269	321	8.4	11.1
Registrar group	665	676	1,255	1,269	88.6	87.7
Foundation house officer 1 & 2[66]	1,128	1,133	562	565	–50.2	–50.1
Hospital practitioner	16	68	16	71	–0.1	4.4
Other staff	150	246	163	253	8.4	2.8
Total	**3,429**	**3,708**	**3,544**	**3,843**	**3.4**	**3.6**
General practitioners						
General medical practitioners[67]		**1,110**		**1,128**		**1.6**
General dental practitioners[67,68]		**782**		**795**		**1.7**
Ophthalmic medical practitioners[67]		**17**		**24**		**41.2**
Total		**1,909**		**1,947**		**2.0**
Total – NHS doctors and dentists		**5,617**		**5,790**		**3.1**

[64] Data as at 30 September unless otherwise specified.
[65] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.
[66] This includes house officers and senior house officers.
[67] Data as at 31 October.
[68] Data include salaried dentists.

APPENDIX D

THE EVIDENCE

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

Evidence from the Health Departments

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089333

Evidence from NHS Employers

http://www.nhsemployers.org/pay-conditions/pay-conditions-3957.cfm

Evidence from the Advisory Committee on Clinical Excellence Awards

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

Evidence from the Scottish Advisory Committee on Distinction Awards

http://www.shsc.scot.nhs.uk/shsc/default.asp?p=78

Evidence from the Northern Ireland Clinical Excellence Awards Committee

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089333

Evidence from the British Medical Association

http://www.bma.org.uk/employmentandcontracts/pay/pay_review_bodies/ddrb2009.jsp

Evidence from the British Dental Association

http://www.bda.org/dentists/policy-research/bda-policies/ddrb/index.aspx

Evidence from the Dental Practitioners Association

http://www.uk-dentistry.org/downloads/consultations/dpa_rbddr_38.pdf

APPENDIX E

PAY COMPARABILITY

1. This appendix provides figures comparing pay levels of some of our remit groups with other professions. The pay level comparisons are made with specific professions using national data from Hay Group to match new anchor points proposed by PA Consulting Group in its 2008 report.[69]

2. Consequently, Hay Group changed some of its reference levels from those used in previous years – see Table E1.

Table E1: Anchor points used before and after the review of pay comparability

Anchor point used prior to 2008	Hay reference level	Anchor point used from 2008 (as recommended by PA Consulting)	Hay reference level
House officer	N/A (alternatives used)	Foundation house officer 1	14
Senior house officer	17	Foundation house officer 2	15
		Specialty registrar (years 1 and 2)	16
Specialist registrar (mid-point)	19	Specialty registrar (years 3 onwards)	17-19
Newly qualified consultant – scale minimum	20	Consultant on the scale minimum	20
Experienced consultant – scale maximum	21	Consultant on the scale maximum (with the upper quartile[1] CEA)	21
Very experienced consultant – scale maximum with a level 5 CEA	22		

Source: Office of Manpower Economics

[1] In 2008 this was a level four local Clinical Excellence Award

Data issues

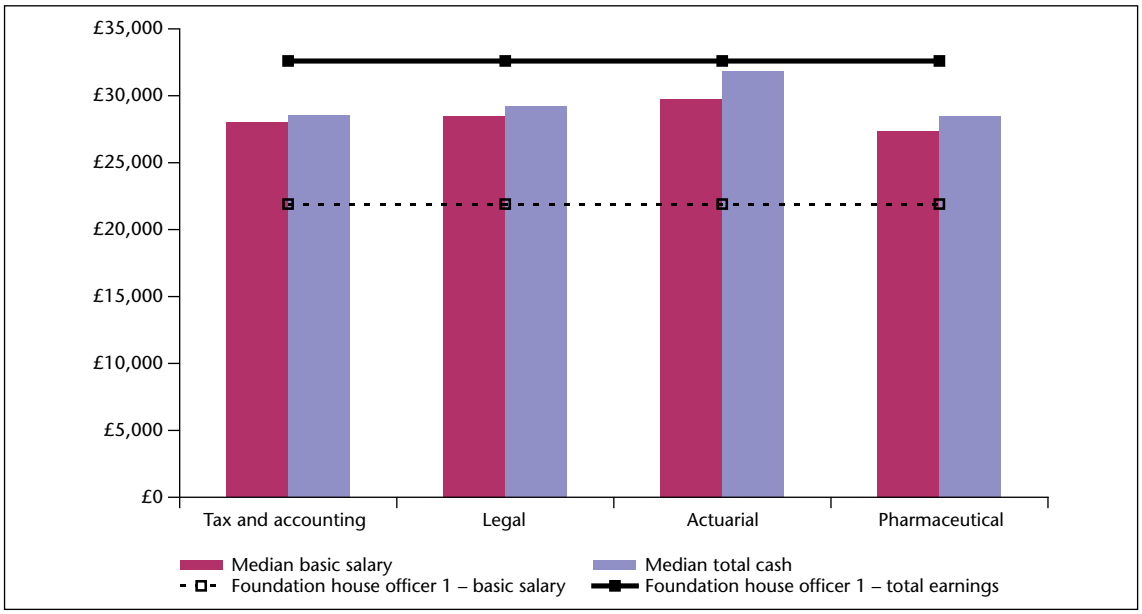
3. It should be noted that, whilst PA Consulting have proposed anchor points which cover sub-sections of the specialty registrar group, median basic salary and median total earnings are not available for these subgroups from the NHS Information Centre. Consequently Figures E3 and E4 provide the ranges covered by basic salaries and total earnings for specialty registrars (rather than a single median for each).

[69] PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/downloads/Final%20DDRB%20Report%20(29%20October%2008).pdf

Foundation house officer 1

4. This first anchor point is for the first year of training following medical school. This is the first year of a two year foundation course and builds upon the knowledge skills and competences acquired in undergraduate training. Successful completion of this year will lead to registration with the General Medical Council. This anchor point aligns with graduate entry, although medicine tends to mean a longer undergraduate course than for most other subjects. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E1.

Figure E1: Foundation house officer 1 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2008

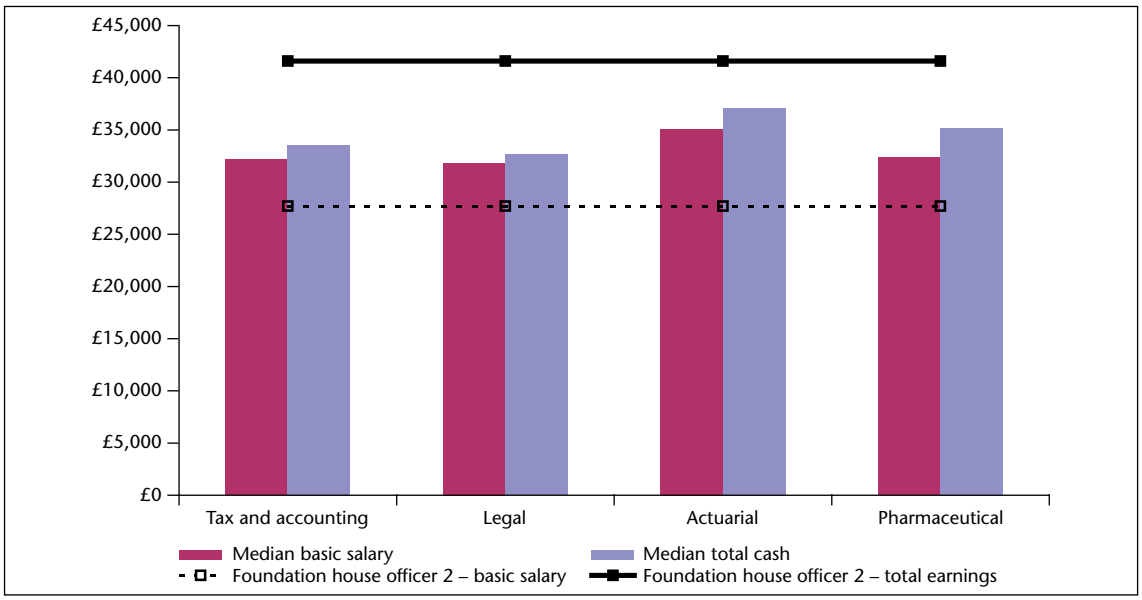


Sources: NHS Information Centre and Hay Group

Note: Median basic salary and median total earnings for foundation house officer 1 were published by the NHS Information Centre.

5. This anchor point marks the second and final year of the two year foundation course. This year focuses on training in the assessment and management of the acutely ill patient. At the end of this year, doctors and dentists in training must undergo competitive entry to obtain a place on the specialty training run-through. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E2.

Figure E2: Foundation house officer 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2008



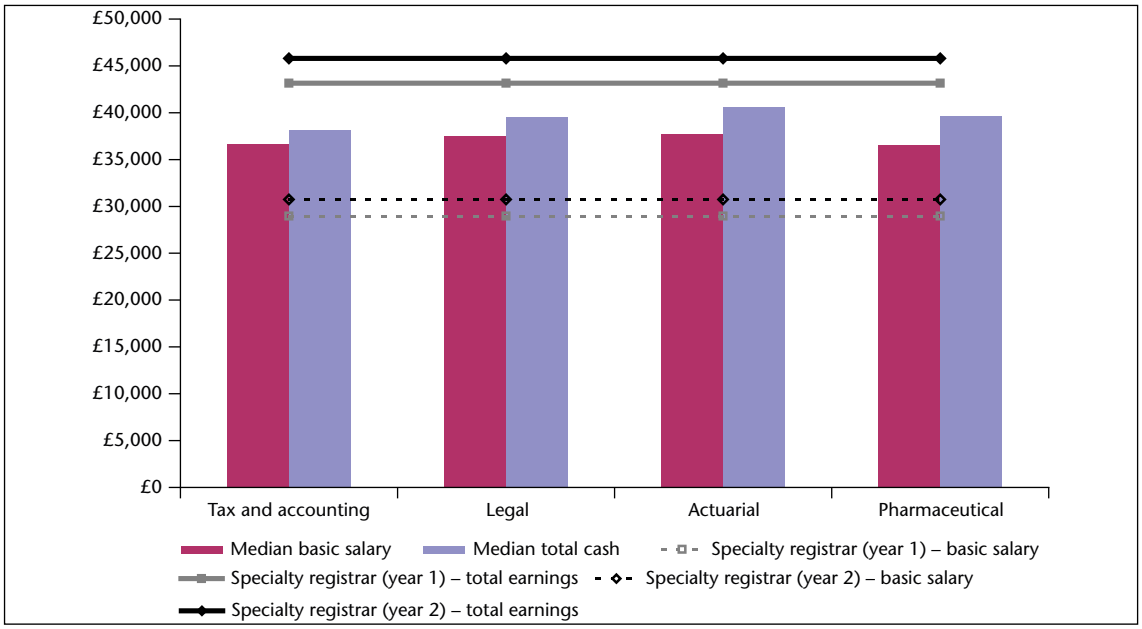
Sources: NHS Information Centre and Hay Group

Note: Median basic salary and median total earnings for foundation house officer 2 were published by the NHS Information Centre.

Specialty training years 1 and 2

6. The first two years of specialty training are often referred to as 'basic specialty training'. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E3.

Figure E3: Specialty training years 1 and 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2008



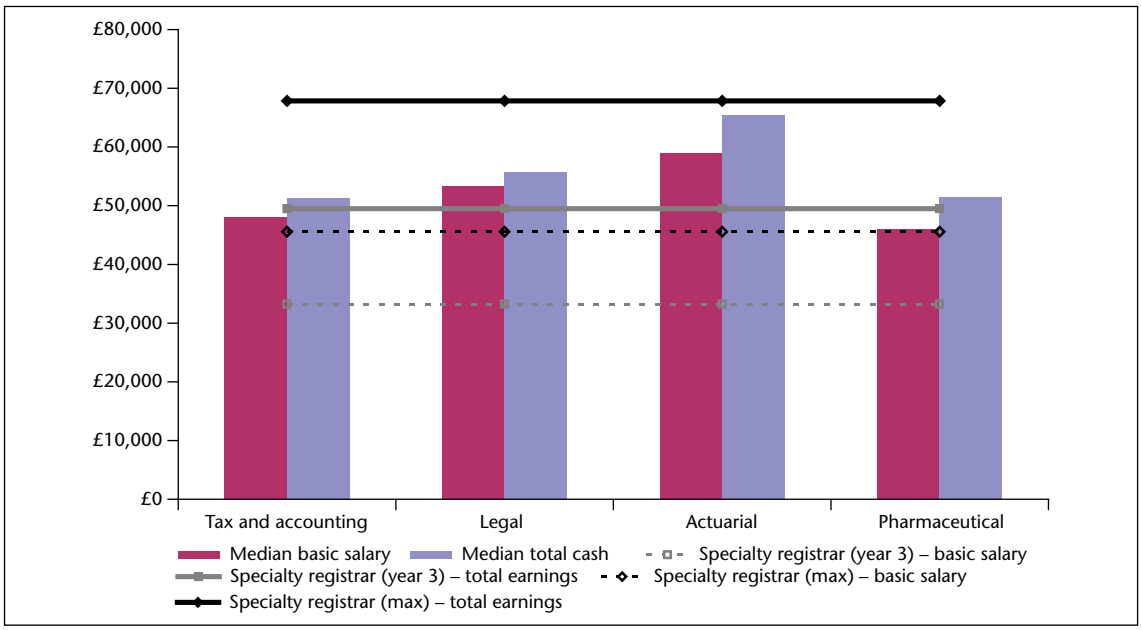
Sources: NHS Employers and Hay Group

Note: Median basic salary is taken as the first two points on the specialty registrar salary scale and median total earnings are calculated from these using the average banding multiplier for specialty registrars.

Specialty training years 3 onwards

7. The third year of specialty training marks the second competitive entry point for most doctors and dentists in training. All trainees are required to complete Royal College membership exams during this period. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E4. This will also be the anchor point for the new specialty doctor grade.

Figure E4: Specialty training year 3 onwards – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2008



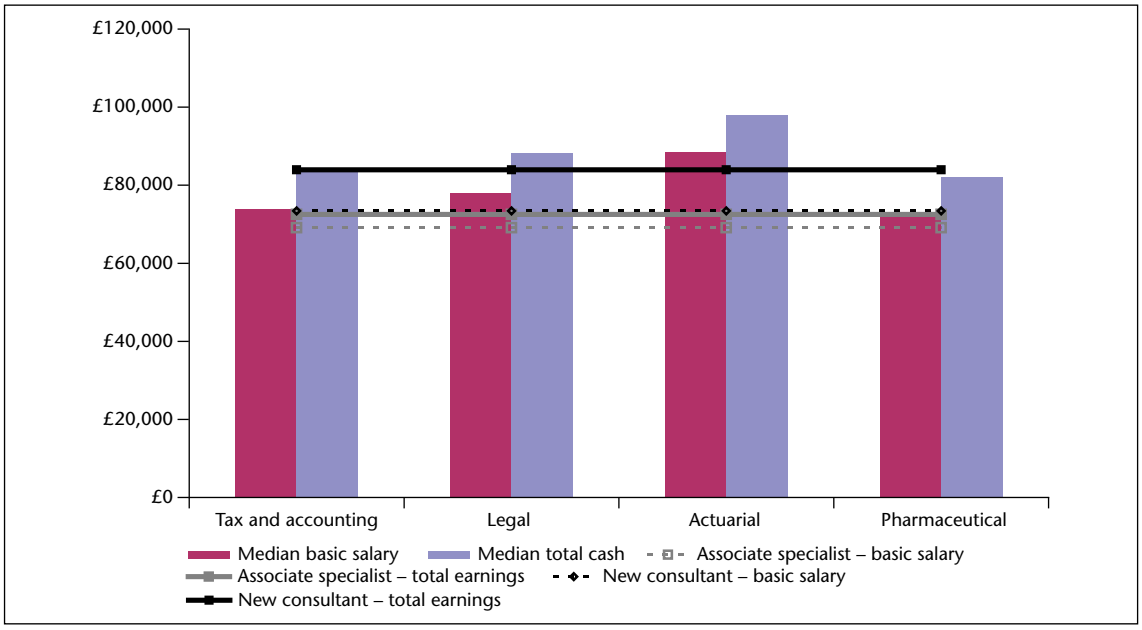
Sources: NHS Employers and Hay Group

Note: Median basic salary is taken as the third and last points on the specialty registrar salary scale and median total earnings are calculated from these using the average banding multiplier for specialty registrars.

Consultant (minimum)

8. Entry to the consultant grade requires a formal qualification (for example, Membership of the Royal College of Physicians). There is an accepted difference in the skills, responsibilities and competence required between a newly-qualified consultant and an experienced one. Associate specialists are also linked to this anchor point. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E5.

Figure E5: Newly qualified consultant (on the minimum of the scale) and associate specialist – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2008



Sources: NHS Employers, NHS Information Centre and Hay Group

Notes:

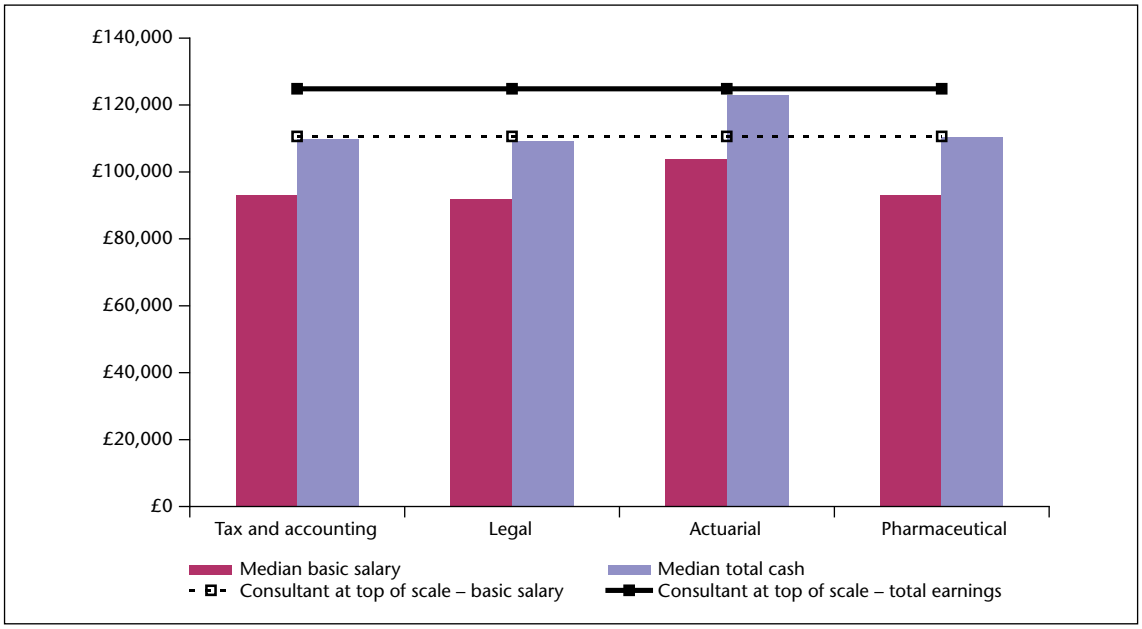
1. Basic salary for a consultant is taken as the minimum point on the salary scale and total earnings are calculated from this using the average number of programmed activities (PAs) compared to that for a full-time post (10 PAs) and also adjusting for on-call rota payments.

2. Median basic salary and median total earnings for an associate specialist were published by the NHS Information Centre.

Consultant (maximum)

9. A consultant on the maximum of the scale is assumed, for the purposes of this comparison, to have the upper quartile level of Clinical Excellence Award (a level four local award). A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E6.

Figure E6: Experienced consultant (on the maximum of the scale with level four Clinical Excellence Award) – basic salary and total earnings against median basic salary and total cash for comparator professions, 2008



Sources: NHS Employers and Hay Group

Note: Basic salary is taken as the maximum point on the salary scale, plus a level four local award and total earnings are calculated from this using the average number of programmed activities (PAs) compared to that for a full-time post (10 PAs) and also adjusting for on-call rota payments.

APPENDIX F

JOINT LETTER FROM THE PARTIES ABOUT THE GENERAL MEDICAL SERVICES CONTRACT

NHS Employers	General Practitioners Committee	Department of Health
Welsh Assembly	DH, Social Services and Public Safety – NI	Scottish Government

Ron Amy, OBE
Chair
Doctors and Dentists Review Body
Kingsgate House
66 – 74 Victoria Street
London
SW1E 6SW

14 October 2008

Dear Ron,

General Medical Practitioners Pay Recommendation 2009-10

We are writing to report the outcome of discussions between the parties as to the DDRB's role in relation to recommendations on GMPs pay for 2009-10.

Background

In its last report (the thirty-seventh), the DDRB asked the parties *"jointly to consider our role for the future and either to agree a mechanism whereby we can make recommendations on GMPs' net incomes, or to remove independent contractor GMPs from our remit and settle future changes to the contract by negotiation".*

We are pleased to report that considerable progress has been made in discussions between NHS Employers (for the four Health Departments) and the GPC and an agreement has been reached on the role of DDRB in recommending an uplift for 2009-10.

We have agreed that for 2009-10 there should be differential uplifts to the global sum and global sum equivalent in order to reduce general practice reliance on correction factor payments under the Minimum Practice Income Guarantee (MPIG). We have also agreed the principle that there should be a comparable process to achieve the same aim in future years, either through differential uplifts or through possible alternative models, and we will keep the DDRB informed.

For 2009-10, we have agreed a specific methodology, based on a pre-determined ratio formula, which will be used to distribute the overall uplift agreed for 2009/10 (on the basis of DDRB's recommendation) differentially across agreed components of the GMS contract. The overall purpose of the methodology is to reduce general practice reliance on correction factor payments through the application of differential uplifts to the global sum, global sum equivalent, QOF payments and other elements of the GMS contract. These arrangements are explained more fully below.

DDRB Role

The Health Departments, NHS Employers and GPC will look to DDRB to make a recommendation on the level of overall uplift to be applied to GMS contract payments for 2009-10.

DDRB will therefore be asked to recommend an overall gross uplift in GMS contract payments, taking into account its views on the average increase in net income that GMPs should receive and its views on movements in practice expenses. The gross uplift is to be expressed as a single percentage figure (if need be to two decimal places).

This single gross percentage uplift figure recommended by DDRB (and if accepted by each Government) will be used to determine a set of differential uplifts that will be applied to agreed components of the GMS contract at the start of 2009-10.
The computation of these differential uplifts will be based on a methodology that has been agreed by all the parties.

Whilst we jointly request DDRB to recommend an uplift, we have agreed to submit separate evidence to guide and support DDRB in making its recommendation on the level of the gross percentage uplift. These sets of evidence will reflect the differing views of the individual parties.

The Methodology

Overview

Under the formula, new money put into the contract is split, with different proportions being added to agreed components that make up part of the GMS contract, so as to apply differential uplifts to the agreed components in a way that will diminish correction factor payments under the Minimum Practice Income Guarantee (MPIG).

Detail

The gross percentage uplift figure recommended by DDRB for 2009-10 (and if accepted by each Government) will be applied to the forecast 2008-09 spend for each of the following components of the GMS contract:

- Global Sum
- Correction Factor Payments
- Quality and Outcomes Framework payments
- Enhanced Services payments
- Locum payments
- Seniority payments

The aggregated uplift in investment produced by this calculation will then be redistributed using the agreed methodology, so as to create a ratio relationship between the percentage uplifts applied to each component of the GMS contract.

We have agreed that the methodology will use the following proportions to create this ratio relationship:

Component of GMS Contract	Ratio Relationship
Global Sum	7
Correction Factor	2
Quality Outcomes Framework	5
Enhanced Services	5
Locum Payments	0
Seniority Payments	0

The ratio relationship created through using the agreed methodology will produce the differential uplifts applied to the global sum and correction factor payments received by practices operating under the GMS contract. The ratio relationship will also produce a differential uplift for QOF payments and enhanced services payments.

To assist DDRB in understanding which components of the GMS contract are covered by the agreed methodology for 2009-10, an analysis of spend on the GP contract, based on the 2007-08 audited accounts for England, is attached at Annex 1. The analysis clearly identifies which components of the GP contract are covered by and are not covered by the agreed methodology, i.e. where any inflationary investment will be applied to different income streams and where it will not. Please note that although the annex is England only, the agreed methodology would be applied by each of the four Health Departments, using their own national spend figures.

The areas not covered by the methodology include those where later negotiations will take place about any application of an inflation increase (e.g. dispensing income) and those where levels of reimbursement are governed by existing contractual arrangements e.g. premises and IM&T reimbursements.

Application of the agreed differential investment methodology to PMS and the application of any recommended DDRB inflationary increase to the PMS investment stream are local contractual matters. However, all Health Departments remain committed to ensuring an equitable approach for independent contractors operating under different contractual frameworks. The Health Departments will issue guidance to Primary Care Organisations about the application of the DDRB recommendation to local PMS contract arrangements. Please note that the equivalent to PMS in Scotland is Section 17c.

We would expect any other component not covered by the agreement or mentioned above to be treated as would normally be the case following a DDRB recommendation.

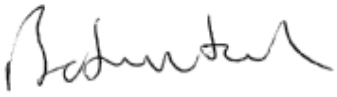
The agreed differential investment methodology will be used by each of the four Health Departments to create at an individual national level the differential uplifts applied to the components of the GMS contract identified as being covered by the methodology.

We will write to you again shortly with full details of this agreement including those changes we have agreed to the QOF, and agreed new arrangements for disease prevalence.

Whilst not covered within this agreement, we are continuing to discuss payments for dispensing doctors and possible changes to the mechanism for seniority payments.

Finally, if the DDRB Secretariat would find it helpful, we are happy for our respective experts to jointly meet with the Secretariat to discuss any outstanding questions.

Yours sincerely

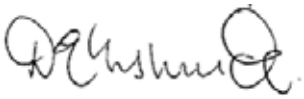


Dr Barbara Hakin
Chief Negotiator
NHS Employers

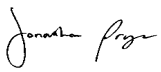
Dr Laurence Buckman
Chair
General Practitioners Committee

Richard Armstrong
Head of Primary Medical Care Contracting
Department of Health - England

Christine Jendoubi
Director of Primary and Community Care
DH, Social Services and Public Safety - NI



Derek Fishwick
Head of General Medical Services
Welsh Assembly Government



Jonathan Pryce
Head of Primary Care Division
Scottish Government

Annex 1

	ENGLAND PCTs Audited Accounts
	2007/08
COVERED BY AGREED METHODOLOGY	**£000s**
General Medical Services items only	
Global Sum	1,535,244
MPIG (Correction Factor)/GSE	327,615
Quality Outcomes Framework	602,888
Enhanced Services	401,956
Seniority	79,446
*Locum Payments	20,010
Total	**2,967,159**
OUTSIDE (NOT COVERED BY) AGREED METHODOLOGY	
General Medical Services items only	
Premises	310,671
Information Management & Technology	45,270
Out of Hours	130,020
Sub-Total	**485,961**
OUTSIDE (NOT COVERED BY) AGREED METHODOLOGY	
All Other Contract Spend	
PMS	3,204,626
APMS	148,666
PCTMS	161,124
Dispensing	813,993
PCO administration (excluding Seniority, Locum payments)	85,682
Sub-Total	**4,414,091**
Grand Total	**7,867,211**
General Medical Services items only	**2007/08**
*locum payments consist of:	**£000s**
(a) Adoptive, paternity and maternity	**9,491**
(b) Sickness	**3,728**
(c) Suspended Doctors	**4,232**
(d) Other Locum payments (SFE paragraph 20.13	**2,267**
(e) Prolonged Study Leave	**292**
TOTAL	**20,010**

APPENDIX G

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

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

Thirty-Second Report (2003)	Cm 5721, May 2003
Supplement to the Thirty-Second Report (2003)	Cm 5722, June 2003
Thirty-Third Report (2004)	Cm 6127, March 2004
Thirty-Fourth Report (2005)	Cm 6463, February 2005
Thirty-Fifth Report (2006)	Cm 6733, March 2006
Thirty-Sixth Report (2007)	Cm 7025, March 2007
Thirty-Seventh Report (2008)	Cm 7327, April 2008

APPENDIX H

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSSPSNI	Department of Health, Social Services and Public Safety in Northern Ireland
DLA	Dental Laboratories Association
DPA	Dental Practitioners Association
FHO1/2	foundation house officer year 1/year 2
GDP	general dental practitioner
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
HCHS	Hospital and Community Health Services
HMRC	Her Majesty's Revenue & Customs
HO	(pre-registration) house officer
HRPS	Healthcare and Related Personal Services
IDS	Incomes Data Services
LHB	Local Health Board
MPIG	minimum practice income guarantee
MRSA	methicillin-resistant staphylococcus aureus
NAO	National Audit Office
NASDA	National Association of Specialist Dental Accountants
NCCG	non-consultant career grade
NHS	National Health Service
NICEAC	Northern Ireland Clinical Excellence Awards Committee
OMP	ophthalmic medical practitioner
PA	programmed activity
PCO	primary care organisation
PCT	primary care trust
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RPIX	Retail Prices Index excluding Mortgage Interest Payments
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	specialty doctors and associate specialists
SEHD	Scottish Executive Health Department
SHO	senior house officer
SPDCS	salaried primary dental care services
SpR	specialist registrar
ST	specialty training
UCAS	Universities and Colleges Admissions Service
UDA	unit of dental activity
VAT	value added tax
WAG	Welsh Assembly Government

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