Review Body on Doctors' and Dentists' Remuneration

Thirty-Ninth Report 2010

Chairman: Ron Amy, OBE

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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)*
David Grafton
Professor Alasdair Smith
David Williamson
Katrina Easterling
Sally Smedley
Professor Steve Thompson[1]

The Secretariat is provided by the Office of Manpower Economics.

[1] Professor Steve Thompson was appointed to the Review Body by the Secretary of State for Health from April 2009.

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SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. In this report we make recommendations for the annual pay increase for some 194,000 doctors and dentists comprising 43,000 consultants, 12,000 specialty doctors, associate specialists, staff grades and others, 59,000 doctors and dentists in training, 46,000 general medical practitioners (GMPs) and 26,000 general dental practitioners (GDPs). 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 not been an easy round, and in making our recommendations we have been acutely conscious of the impact of the recent global recession on employment in the wider economy, and of its severe effects on the public finances of the United Kingdom. The outlook for the economy as a whole remains uncertain. The rate of inflation reached historic lows during 2009. The Consumer Prices Index (CPI) fell from a high of 5.2 per cent in September 2008 to a five-year low of 1.1 per cent in September 2009, and then rose to 3.5 per cent in January 2010; it is expected to continue rising in the spring of 2010, but then fall back to 2 per cent by the end of the year. The Retail Prices Index (RPI) showed inflation rising to a similar high, of 5.0 per cent in September 2008, before falling substantially to give an unprecedented eight months of negative inflation from March to October 2009, with a low of -1.6 per cent in June. RPI inflation moved back into positive territory again in November 2009 (0.3 per cent) and reached 3.7 per cent in January 2010. We are therefore aware of a tension between the severe pressure on the NHS budget, which faces years of fiscal constraint, and an uncertain inflationary outlook affecting members of our remit group.

3. In reaching our decisions we have considered all the evidence and the matters we are required by our terms of reference to take into account, and we have come to an independent judgement drawing on the collective knowledge and experience of the Review Body members. We believe that the recruitment and retention situation appears relatively healthy for doctors and dentists throughout the NHS and, where there do appear to be issues of motivation, we are not convinced that these are pay related. We also recognise that considerable value must be placed on the job security enjoyed by NHS doctors and dentists, with most commentators forecasting that unemployment in the wider economy will continue rising throughout 2010. We are conscious that median gross annual full-time pay for doctors and dentists has remained around the 97th percentile for all full-time employees, so that, although our awards have at times been lower than the Average Earnings Index, the actual incomes of our remit group members appear to have kept pace with their equivalents in other sectors. In addition, doctors and dentists benefit from a pension that is more generous and more secure than private sector comparators, especially for new entrants, although the non-pension elements of the total reward package are higher in private sector comparators. Furthermore, we have taken into account the state of the public finances and the huge financial pressures facing the NHS, although we are not convinced that the Health Departments' proposals represent the limit of what is affordable.

4. We accept that pay increases for highly-paid individuals would be difficult to justify in the current circumstances. However, we are not persuaded that the government's assertion that senior groups should provide 'leadership in pay restraint' is relevant to our remit groups. This appears to be largely a political claim, and is not a matter for us. Nevertheless, in this time of stringency, we do see a need to target scarce resources where they are most needed, and we have accepted the case for a

differential uplift in order to maintain recruitment in an uncertain inflationary climate. We have concluded that only modest pay increases can be justified, and that the available resources should be targeted at the more junior grades within our remit.

5. We have divided our recommended awards into three groups:

- foundation house officers (1 and 2) and their equivalents (house officers and senior house officers) – **1.5 per cent**;
- registrars, specialty doctors and associate specialists (SAS) grades, salaried GMPs, salaried dentists – **1 per cent**; and
- consultants, independent contractor GMPs and GDPs – **0 per cent**.

However, while the awards for independent contractor GMPs and GDPs seek to provide a zero per cent income uplift, they also take account of changes in their business expenses. We consider this to be a fair and reasonable uplift in the current economic climate. We believe that the increases we have proposed will be sufficient to recruit, retain and motivate our remit groups for the coming year.

6. Our recommendations for 2010-11 are as follows:

7. **For 2010-11, we recommend an increase of 1.5 per cent to the national salary scales for foundation house officers (1 and 2), house officers and senior house officers. For the remaining grades of doctors in training, we recommend an increase of 1 per cent on the national salary scales** *(paragraph 6.18)*. In addition, **we recommend that the value of the banding multipliers[2] remain at the rates that were negotiated between the parties** *(paragraph 6.15)*. Furthermore, as an interim measure until completion of the contractual negotiations that we expect will follow the current scoping study on the juniors' contract, **we recommend that a banding multiplier be introduced for foundation house officer 1 posts that only attract basic pay, and that the multiplier should be set at 1.05 of basic salary** *(paragraph 6.16)*. Our intention is that this new banding multiplier will help to address the worsening of pay comparability of foundation house officer 1 doctors.

8. The GMP registrars' supplement was introduced at a time when recruitment into general practice was poor and 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. The evidence suggests that there are no major causes for concern with recruitment among GMP registrars. However, we are aware that the NHS is moving towards greater delivery of care through primary care, which could mean an increase in the number of GMP posts; therefore **we recommend that for 2010-11 the supplement for general medical practitioner registrars should remain at the current rate of 45 per cent.** However, we consider that should there be doctors currently receiving the higher protected level of the supplement, they should keep their existing entitlement rather than see their pay supplement reduced *(paragraph 3.42)*.

9. **For 2010-11, we recommend an increase of 1 per cent on the national salary scales for the pre-2008 and post-2008 SAS grades' contracts** *(paragraph 8.22)*.

[2] Banding multipliers are the supplements that are applied to the basic salary of doctors and dentists in hospital training. They are intended to reflect the number of hours and intensity of work in each post.

10. For salaried GMPs **we recommend that the minimum and the maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2010-11** *(paragraph 3.35)*. We continue to believe that the current pay range is appropriate and provides 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.

11. We understand that remuneration for GMP training is likely to become practice based rather than GMP trainer based. Therefore, we believe that until the reviews affecting GMP training are complete we should simply continue to increase the value of the trainers' grant in line with the other fees and allowances on which we are required to make recommendations. **We recommend that the general medical practitioners' trainers' grant be increased by 1 per cent for 2010-11** *(paragraph 3.45)*. **We recommend that the general medical practitioner educators' pay scale should rise by 1 per cent for 2010-11** in line with our recommendation for salaried GMPs *(paragraph 3.48)*.

12. **For 2010-11, we recommend increases of 1 per cent for all grades in the Salaried Primary Dental Care Services** *(paragraph 5.12)*.

13. **For 2010-11, we recommend no increase on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts** *(paragraph 7.48)*.

14. We make a number of recommendations regarding the merit awards for consultants. **We recommend that for the 2010 awards the Scottish Advisory Committee on Clinical Leadership and Excellence Awards should have the flexibility to determine the number of national Scottish Clinical Leadership and Excellence Awards to be made at each level in 2010-11, having taken account of any equality issues** *(paragraph 7.40)*. For 2010-11, **we endorse and recommend the Advisory Committee on Clinical Excellence Awards' (ACCEA) 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, in order to maintain the ratio of awards to eligible consultants.** We note that ACCEA intends to increase the number of new bronze awards by 4.5 per cent, which represents the estimated increase in the consultant population and that there is likely again to be an increase in silver awards. We also continue to recognise the need for flexibility in determining the number of different awards and therefore **we endorse and recommend the Advisory Committee on Clinical Excellence Awards' proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards to be made at each level in 2010-11** *(paragraph 7.41)*. **We recommend that for 2010-11 the value of Clinical Excellence Awards, Scottish Clinical Leadership and Excellence Awards, commitment awards, distinction awards and discretionary points should remain at current levels,** in line with our pay recommendation for consultants *(paragraph 7.42)*.

15. For independent contractor GMPs, **we recommend that the overall value of General Medical Services (GMS) contract payments be increased by a factor intended to result in no increase to general medical practitioners' net income after allowing for movement in their expenses**. Using 0 per cent for GMPs' income uplift along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 1.34 per cent. Therefore, **we recommend that an uplift of 1.34 per cent be applied to the overall value of General Medical Services contract payments for 2010-11 for general medical practitioners** *(paragraph 3.24)*. We encourage the parties to have further discussions on the question of how to distribute our recommended uplift. However, if they fail to reach agreement, **we recommend that half of our recommended overall gross uplift to contract payments be**

applied to the following five elements of the General Medical Services contract, in proportion to their current relative spend: global sum; correction factor; Quality and Outcomes Framework; enhanced services; and locum payments; and that the other half of our recommended overall gross uplift to contract payments be applied to global sum payments with no corresponding increase to correction factor payments, and that resources released through reductions in minimum practice income guarantee correction factor payments should be reinvested back into the global sum, further uplifting global sum funding and reducing the number of practices on the minimum practice income guarantee *(paragraph 3.28)*. We have excluded seniority payments from our recommendations on the uplift to the GMS contract and **we recommend that for 2010-11, seniority payments for general medical practitioners remain at their current levels** (*paragraph 3.30)*.

16. For GDPs in England and Wales **we recommend that the gross earnings base be increased by a factor intended to result in no increase to general dental practitioners' net income after allowing for movement in expenses.** Using 0 per cent for general dental practitioners' income uplift along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 1.44 per cent. Therefore, **we recommend that an uplift of 1.44 per cent be applied to the gross earnings base under the new contract for 2010-11 for general dental practitioners in England and Wales** *(paragraph 4.75)*.

17. The contracts for GDPs in Scotland and Northern Ireland are very different to those for England and Wales and therefore a different approach is needed. We believe that Scotland and Northern Ireland should make their own changes to individual items on the fee scale to allow for changes to expenses, where any additional costs are not accounted for by the various allowances that are available in those countries. Therefore, **we recommend that Scotland and Northern Ireland should adjust their fee scales in order to allow for any changes to expenses.** We note that each item-of-service within the fee scales will include two elements: an element to cover the expenses associated performing each item-of-service and an element to deliver income. We believe that Scotland and Northern Ireland should adjust their fee scales to reflect the 'expense' element of each item-of-service on an item-by-item basis where possible. However, if the necessary information is not available, an across-the-board adjustment should be made instead: this could be done using an approach similar to the one we use to calculate changes in expenses for England and Wales, but with reference to country-specific data to reflect the different systems in Scotland and Northern Ireland. **If the parties do not have evidence for the current year to enable them to make the adjustments to the fee scales in Scotland and Northern Ireland to account for expenses, then we recommend that they use the adjustment that we have identified as being appropriate for 2010-11 in England and Wales, which is an increase to each fee scale item of 1.44 per cent** *(paragraph 4.77)*.

18. For 2010-11, in line with our recommendation for net income for GDPs in England and Wales, **for the element within each item-of-service in the fee scales in Scotland and Northern Ireland that represents income, we recommend no increase. We also recommend no increase to commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland** *(paragraph 4.78)*. In addition, we propose a general approach to the treatment of the uplifts and **we recommend that November 2007 be used as a base date in Scotland and Northern Ireland and uplifts are applied unrounded to the fee scales on a yearly basis with the final result being rounded up**[3] *(paragraph 4.59)*.

[3] The base date is November 2007 in England and Wales.

19. **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 per cent for 2010-11** *(paragraph 2.27)*.

20. We estimate the cost of our recommendations[4] for doctors and dentists in the Hospital and Community Health Services to be 0.5 per cent of pay bill. This estimate does not include independent contractor GMPs and GDPs for whom we are recommending a zero increase in net income.

[4] Cost estimates are rough approximations using a number of assumptions. They are based on the projected 2010-11 pay metrics for England only, provided in the Health Departments' evidence, and scaled up for the United Kingdom according to total pay bill figures from 2007-08, the latest year for which data are available for all four countries.

Our main recommendations on pay levels are:[5]

Hospital and community doctors and dentists – main grades (full-time salaries):	*Point on scale*	*Recommended scales payable from 1 April 2010* £
Foundation house officer 1	minimum	22,523
	maximum	25,334
Foundation house officer 2	minimum	27,936
	maximum	31,589
Specialty registrar (full)	minimum	29,705
	maximum	46,708
Specialty registrar (fixed term)	minimum	29,705
	maximum	39,300
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
Specialty doctor	minimum	36,807
	maximum	68,638
Associate specialist (2008)	minimum	51,606
	maximum	84,948
Band A: Salaried dentist	minimum	37,718
	maximum	56,576
Band B: Salaried dentist	minimum	58,672
	maximum	68,625

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

Hospital and community doctors and dentists – main grades (full-time salaries):	*Point on scale*	*Recommended scales payable from 1 April 2010* £
Band C: Salaried dentist	minimum	70,197
	maximum	80,674

RON AMY, OBE *(Chairman)*
KATRINA EASTERLING
DAVID GRAFTON
SALLY SMEDLEY
PROFESSOR ALASDAIR SMITH
PROFESSOR STEVE THOMPSON
DAVID WILLIAMSON

OFFICE OF MANPOWER ECONOMICS
24 February 2010

Part I: Overview

CHAPTER 1: ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

1.1 We have divided the report into eight 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), doctors and dentists in hospital training, consultants, and specialty doctors and associate specialists (SAS). There is no chapter on ophthalmic medical practitioners in this report as their three-year deal on the sight test fee covers 2010-11. The detailed pay scales which result from our recommendations are set out in Appendix A. There are tables showing the number of doctors and dentists in the NHS in the United Kingdom in Appendix B. Links to the evidence on the parties' websites are in Appendix C, and a list of our previous reports is in Appendix D. Appendix E contains a glossary of terms and Appendix F a list of abbreviations and acronyms used in the report.

1.2 We set out the overall context for our review in this introductory chapter, 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.

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 (DHSSPSNI). However, not all data are produced on a comparable basis. These data are revised yearly 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 194,000 doctors and dentists. The breakdown by group is given in Table 1.1. Further details are given at Appendix B.

Table 1.1: Remit groups for the 2010 review, at September 2008,[1] United Kingdom

	Full-time equivalents	Headcount
Consultants[2]	40,162	42,888
Registrar group	41,043	41,950
Foundation house officers, house officers and senior house officers	17,363	17,500
Speciality doctors, associate specialists and staff grades	10,373	11,835
Other staff[3]	3,163	7,003
Total Hospital and Community Health Services staff[4]	***112,105***	***121,071***
General medical practitioners[5]	*	45,992
General dental practitioners[6]	*	26,158
Ophthalmic medical practitioners	*	410
Total[4]	*	**193,631**

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

* Data not available.

Notes:

1. Some data are not for September 2008, 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, the most recent contracts have been for the SAS grades, who had a new contract from 1 April 2008, and the SPDCS in England and Wales who agreed a new contract in January 2008 (backdated to 1 June 2007). During the past year, a scoping study has taken place with a view to negotiating a new contract for doctors and dentists in training and we hope that progress towards a new contract will continue. 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.

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 have carried out a scoping study to consider 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 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 For some of our remit groups the new contracts are still quite recent 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. While the terms of the contracts are outside our remit, we offer comment throughout the report on those elements of the contracts that we believe affect aspects of our remit. We have noted previously that the National Audit Office and Auditor General have reported that the costs of the new consultant[1] [2] and General Medical Services (GMS)[3] contracts were higher than originally estimated, and we have subsequently been under some pressure from the Health Departments and NHS Employers to redress the balance.

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 Government Health Department (SGHD) 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 set out where circumstances, initiatives and policies were distinct in Wales, Scotland or Northern Ireland. The evidence from the British Medical Association (BMA), the British Dental Association (BDA) and the Dental

[1] National Audit Office. *Pay modernisation: a new contract for NHS consultants in England.* Report by the Comptroller and Auditor General. HC 335 session 2006-07. 19 April 2007. TSO, 2007. Available from: http://www.nao.org.uk/publications/nao_reports/06-07/0607335.pdf

[2] *Implementing the NHS consultant contract in Scotland. For the Auditor General.* Audit Scotland, 9 March 2006. Available from: http://www.audit-scotland.gov.uk/docs/health/2005/nr_060309_consultant_contract.pdf

[3] 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

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

1.9 Last year we recommended a base increase of 1.5 per cent to the national salary scales for Hospital and Community Health Service (HCHS) doctors and dentists and HCHS doctors and dentists in training. For independent contractor GMPs we recommended that the overall gross uplift in GMS contract payments be increased by a factor of 2.29 per cent, which was intended to result in an average increase in GMPs' net income of 1.5 per cent after allowing for movement in their expenses. For independent contractor GDPs in England and Wales we recommended that an uplift of 0.21 per cent be applied to the gross earnings base under the new contract, which was intended to result in an increase in GDPs' net income of 1.5 per cent after allowing for movement in expenses. We also recommended that the uplift of 0.21 per cent should apply to gross fees, commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland. The government accepted our recommendations for 2009-10 in full.

The evidence

1.10 We received written evidence from the Health Departments, comprising the Department of Health, the WAG, the SGHD and the DHSSPSNI, from HM Treasury, NHS Employers,[4] the Advisory Committee on Clinical Excellence Awards (ACCEA), the Scottish Advisory Committee on Distinction Awards (SACDA), the BMA, the BDA, the DPA and ADP Dental Co. Ltd (a corporate provider of primary dental care). The main evidence can be read in full on the parties' websites (see Appendix C). 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.

1.11 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 Andy Burnham MP, the Health Departments, HM Treasury, NHS Employers, the BMA, the BDA and the DPA.

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

Visits

1.13 As always, we carried out a series of visits over the early summer. In 2009 we visited three 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. While some visits were very well attended, we were disappointed that others were poorly attended in comparison with previous years. The visits are normally made over lunch time as this is considered to be the best time for doctors and dentists to attend, but we are seeking suggestions as to how we could improve the visit programme for 2010 and future years. We recognise that these are busy people, but visits are an opportunity for management, doctors and dentists to speak to the Review Body and present and discuss their views.

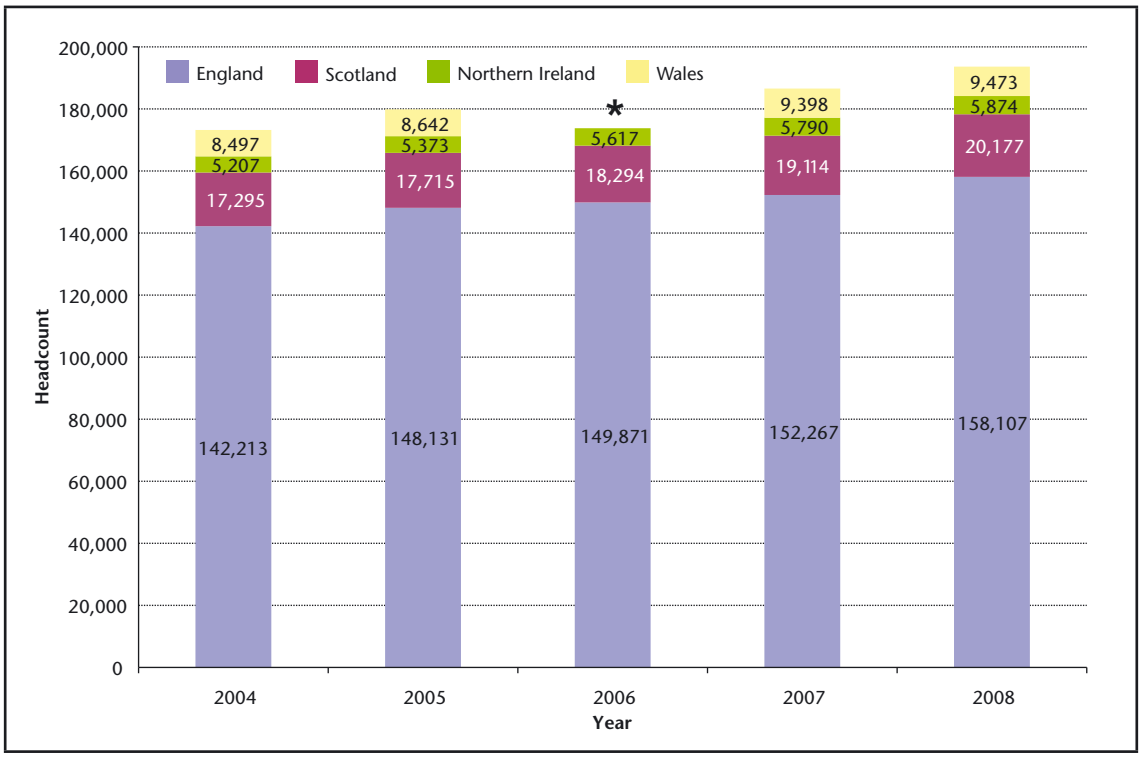
[4] The evidence from NHS Employers was based on information collected from their contacts with employers' networks and through an on-line questionnaire answered by employers of doctors and dentists in the NHS in England.

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. We ask the parties to let us have their views on the timing and other aspects of our visits so that our 2010 visit programme enables us to meet more representatives and discuss relevant issues with them.

Recruitment and retention

1.14 The need to recruit and retain doctors and dentists is a fundamental element of our terms of reference. As always, it formed a major theme in the parties' evidence. Figure 1.1 shows that the numbers of medical and dental staff in each of the devolved countries have increased year on year between 2004 and 2008. The latest data at 30 September 2008 show that the total headcount for the United Kingdom is now 194,000.

Figure 1.1: Total number of medical and dental staff, 2004 – 2008, 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, Health and Social Care Business Services Organisation in Northern Ireland.

Note:

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

1.15 The Health Departments said that there was a healthy recruitment and retention position across all NHS staff groups, and they expected that this position would strengthen further through 2010-11. They observed that the public sector was increasingly seen as an attractive and secure employment option, and that there had been a greater recognition of its pension benefits. They believed that doctors and dentists were enjoying greater levels of job security, and of certainty of future income levels, than many comparable professional groups. They reported that vacancy rates for salaried doctors were low at 1.5 per cent, compared to 4.7 per cent in 2003 and

a long-term average of 4 per cent. They noted that the NHS had seen unprecedented expansion in the medical and dental workforce since 1997, as well as record levels of doctors in training in United Kingdom medical schools and in specialty training. Northern Ireland reported that trends identified in the 2006 review of the medical profession toward a higher proportion of women in the workforce and demands for more flexible working had continued.

1.16 NHS Employers said that the recruitment and retention of doctors and dentists continued to be generally stable, which they believed suggested that the pay system was largely fit for purpose and needed only limited changes. However, they reported that about two thirds (compared to half in 2008) of the trusts responding to their questionnaire had reported recruitment and retention difficulties for doctors and dentists over the year to August 2009, and 36 separate trusts reported recruitment difficulties as 'severe'. Most common among the specialty areas involved in the severe examples were paediatrics, accident and emergency, anaesthetics and medicine. They believed that these severe difficulties were mainly related to specific labour supply shortages and said that pay was not cited at all in the severe difficulties reported. They told us that the most common approaches in use by employers to solve recruitment and retention problems were: the use of locum cover (both from external agencies and internal arrangements); job plan changes; skill mix changes; and overseas recruitment. They said that under 3 per cent of respondent employers reported the use of local labour market supplements, and they believed this meant that the market supplements were being used appropriately at local level and were not being used in areas where there were labour supply side issues. In efforts to aid recruitment and retention, they told us that employers in the NHS continued to use non-pay measures, such as: flexible hours working; flexible retirement arrangements; childcare support; career break schemes; annualised hours; term time only working; and return to practice arrangements. They believed that there was an increased awareness of the importance of pension provision and the value of public service pension schemes and expected that the impact of the NHS Pension Scheme on recruitment and retention would improve.

1.17 The BMA said that although there were still more than sufficient applicants to fill places, the downward trend in applications for medical school at a time of overall expansion in higher education suggested that medicine was becoming less popular as a career. It noted that the United Kingdom medical workforce had continued to grow in headcount terms in 2008, and that overall growth was a little under 4 per cent with the largest growth being in the SAS grades and the lowest in general practice.

1.18 The BDA said that dentists' concerns were clearly reflected in the reported trends towards private practice, with very few planning to increase their NHS work over the next three years: most intended to increase private work. It noted that despite the prevailing economic climate, it was apparent that a significant number of dentists did not currently consider expanding their NHS commitment as attractive or viable. The DPA expected that retention would continue to be an issue and that this would become more evident once the Department of Health started to operate under the new financial constraints.

1.19 Overall, however, the evidence does not lead us to believe that there are any significant problems with recruitment and retention among doctors and dentists. Medicine and dentistry continue to be popular careers, although we note that some career paths continue to be more popular than others. We include our detailed comments on the evidence on recruitment and retention in the chapters relating to the individual remit groups.

1.20 The three-month vacancy data for England from the NHS Information Centre, show higher than average vacancies in the North West (2.2 per cent), London (2.2 per cent) and the South (2.0 per cent). The long-term vacancy rate for hospital doctors and dentists in England had seen a modest rise since last year, from 0.9 per cent to 1.5 per cent (i.e. from 382 to 674), which probably reflected a slight delay in filling new posts. However, all vacancies are at a low level and give us no cause for concern. Unfortunately, neither Wales nor Scotland produce an "all medical and dental" figure. Vacancy figures for Northern Ireland are not produced on a comparable basis. We would find it helpful if the vacancy data for the four countries was produced on the same basis, so that we can make comparisons.

Workforce planning

1.21 Although workforce planning does not form part of our terms of reference it is relevant to us because of its link to recruitment and retention. The Health Departments observed that workforce planning for doctors spanned many decades. They said that it took seven years to train a doctor to the point of specialty training and around seven more years (currently three years for GMPs) to complete specialty training. Once a doctor was trained, he or she could have a subsequent career of 30 years or more. They summarised the outcomes from the most recent medical workforce modelling as follows: nationally, the balance of demand and supply for doctors as a whole suggested that the number of doctors coming through medical school and foundation programmes was at about the right level; in light of the increasing demand for primary and community care services, GMP training needed to continue to expand so that in the future around half of doctors going into specialty training should be training to become GMPs rather than consultants; the Health Departments envisaged that the annual intake for GMP training should rise to around 3,300 over time; in 2009, around 2,600 GMP training places had been filled; there was also a risk of an oversupply of other trained specialists in the long term, particularly in surgery, where training numbers were planned to reduce; and regionally, the situation differed across specialties and locations.

1.22 The SGHD told us that its policy was to move towards a health service delivered by trained doctors and to reduce the reliance on doctors in training for front-line service delivery and manage the bulge of trainees out of the system. Under the current approach to planning the medical workforce, junior doctors were recruited primarily to replace junior doctors rather than consultants or other trained doctor grades.

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

1.23 The BMA noted that vacancy rates were highest in the London strategic health authority (SHA) area, adding force to the suggestion it made last year that there may be the beginnings of a recruitment and retention issue in London. It told us in oral evidence that junior doctors said it was difficult to afford to live near to hospitals and that GMPs received no change to their income relative to where they worked, which had consequences for recruitment in the more unattractive areas of London. The BMA said that it continued to consider London weighting a cost compensation issue, and thought that the issue needed revisiting.

1.24 NHS Employers' questionnaire asked London trusts whether the level of London weighting was adequate; of those, 75 per cent thought that it was adequate, compared to 66 per cent of London based trusts in 2008. NHS Employers believed that labour market conditions had not changed significantly in London since last year and commented that vacancy rates remained historically low. They said that the number and quality of applications for vacancies remained satisfactory. They believed

that if there were specific recruitment issues in London that could be addressed by pay solutions, more employers would have said that London weighting should be increased, however, they saw the opposite trend.

1.25 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 are not persuaded by the evidence received that recruitment and retention in London are causing major problems and we therefore see no justification for readdressing our previous recommendation on London weighting.

Motivation

1.26 We are required by our terms of reference to have regard to motivation and this is of particular interest to us because of its consequent effects on recruitment and retention. Recent research carried out by GfK[5] concluded that although the terms motivation and morale tend to be used interchangeably, morale is more limited in scope than motivation as a whole. The glossary at Appendix E gives further information on our interpretation of motivation and morale.

1.27 The Health Departments commented on the need to maintain the morale and clinical engagement of staff during a challenging period for the NHS, as it worked to embed the reform programme of the *Next Stage Review* against a background of generally increasing demand. Drawing on evidence from the most recent NHS Staff Survey, they said that there was no sign of any serious morale issues, either generally or among any particular group of doctors, with job satisfaction scores generally up on 2008, and above those for other staff groups in the NHS. However, the SGHD noted that if the pay award was set too low it might damage morale, motivation and recruitment.

1.28 NHS Employers reported that the 2008 NHS Staff Survey indicated that doctors and dentists remained more likely than their colleagues in other occupations to report that they were satisfied or very satisfied with their level of pay, although they reported experiencing a poorer quality of life than the average for all NHS staff. They told us that doctors and dentists generally scored higher than average on individual questions related to job satisfaction; although, as Figure 1.4 (later in this chapter) shows, they have similar job satisfaction scores to other NHS staff when averaged over all questions. The responses for doctors and dentists showed a significantly lower level of intent to leave than the all staff average, while in relation to work-life balance, doctors' and dentists' responses indicated that job flexibility and the opportunity to balance their working and home lives were not always as accessible as for other colleagues. Results also showed that the NHS continued to be seen as a desirable place to work.

1.29 We looked at the key results for motivation and morale from the 2008 NHS Staff Survey in England and compared results for 2008 with results from the two previous years. We also compared the figures with those obtained from an Office of National Statistics Omnibus Survey,[6] confirming that the NHS Staff Survey results were valid and allowing comparisons to be made with other groups in the wider economy, and made rough comparisons with the biannual 2008 NHS Staff Survey in Scotland. There was no staff survey for Wales in 2008, and Northern Ireland does not carry out a staff survey. The main results from the 2008 surveys were:

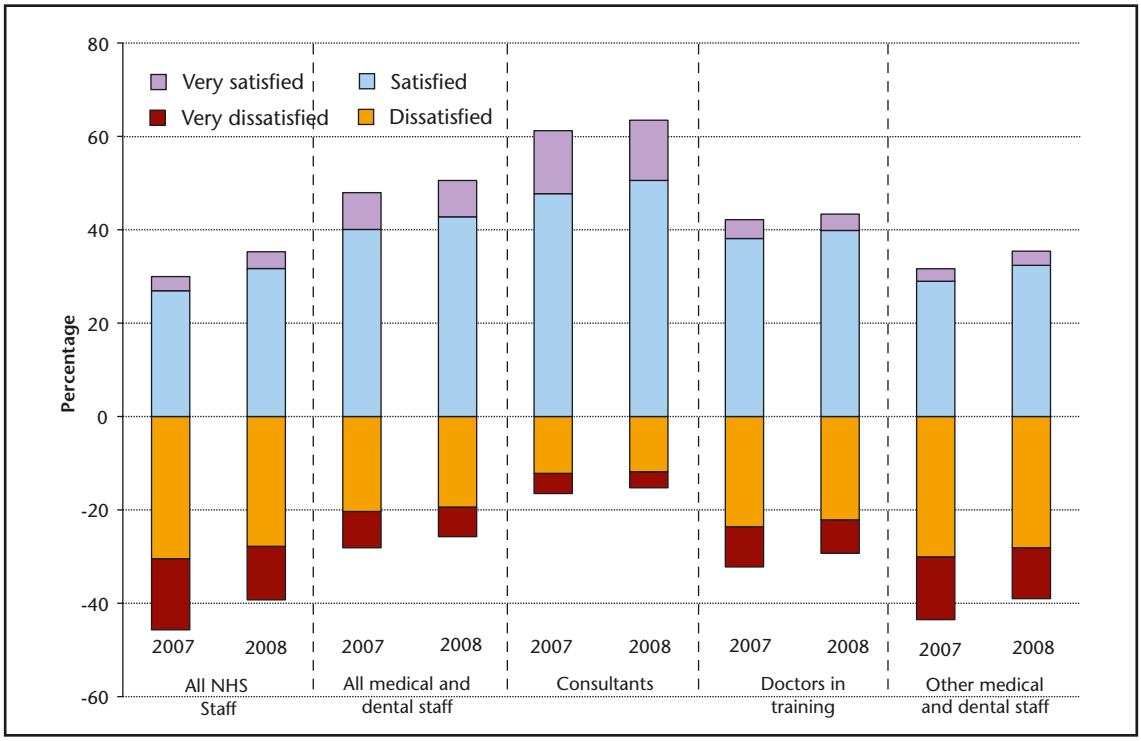
5 Mary Bard and Roger Fisher-Payne. *Motivation, morale and pay: research report*. GfK/Office of Manpower Economics, July 2009. Available from: http://www.ome.uk.com/Cross_cutting_Research.aspx

6 This is an Office for National Statistics survey covering Great Britain, which also goes by the name *Opinions*.

- all staff, including all medical and dental groups, in England were more satisfied with their pay in 2008 than in 2007;
- for all staff groups in England, except doctors in training, the average score for staff work-life balance improved slightly since 2006. For doctors in training, there was little change;
- for all medical and dental staff in England there was little change in job satisfaction since 2006, although the average score of doctors in training experienced a very slight decline;
- on average, medical and dental staff in England had felt a decrease in work pressure since 2006; this was the most notable for consultants;
- in Scotland, NHS staff felt under more work pressure than in 2006;
- in Scotland, job satisfaction had improved since 2006 for NHS staff; and
- 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.

1.30 We conclude from this that medical and dental staff in England and Scotland are generally more satisfied with their pay, job and conditions than in the past. Figure 1.2 shows staff perception of their level of pay for 2007 and 2008 from the NHS Staff Survey in England. The results suggest that NHS staff in general have comparable job satisfaction and work-life balance scores when considered on a like-for-like basis with employees in the wider economy, and that the remit group for the Review Body on Doctors' and Dentists' Remuneration (DDRB) is generally more satisfied than the NHS as a whole. Figures 1.3 and 1.4 make these comparisons using the 2008 NHS Staff Survey in England and the Omnibus Survey.

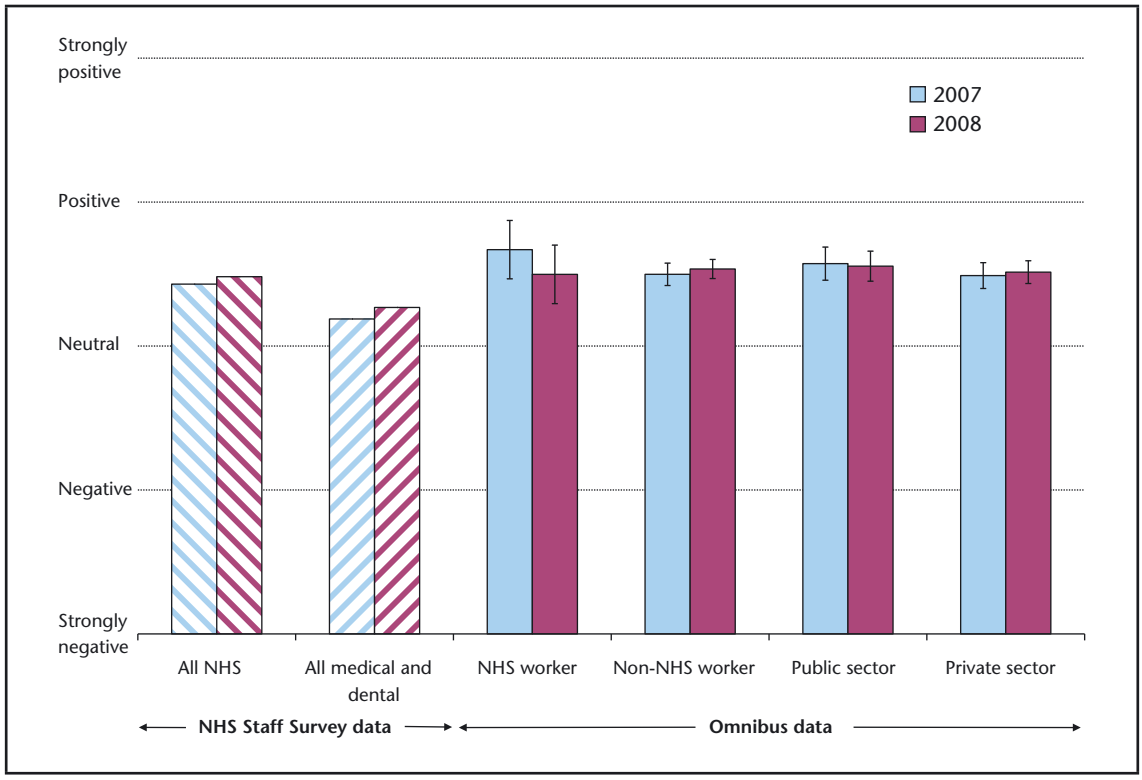
Figure 1.2: Staff perception of their level of pay – NHS Staff Survey in England, 2007 and 2008



Sources: Healthcare Commission and Office for National Statistics.

Note: Those neither satisfied nor dissatisfied are not shown.

Figure 1.3: Staff perception of work-life balance – Omnibus and NHS Staff Survey in England compared, 2007 and 2008



Sources: Healthcare Commission and Office for National Statistics.

Notes:

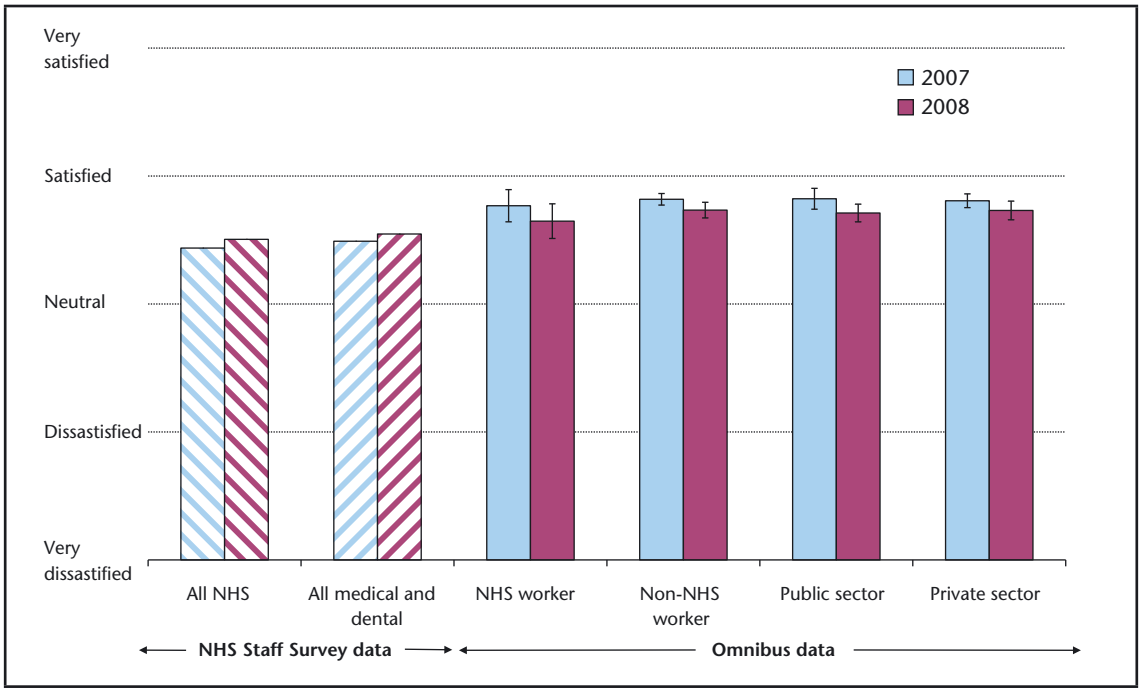
1. Scores are given for two groups from the Healthcare Commission NHS Staff Survey in England (all NHS and all medical and dental) and for four groups from the Omnibus survey (all NHS, non-NHS, public sector and private sector) in Great Britain, some of which overlap.

2. The Omnibus questions, using wording from the Healthcare Commission NHS Staff Survey in England, aimed to use the Healthcare Commission 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. The results are given in the form of an average score between 1 and 5 rather than as percentages of positive and negative responses.

4. The confidence intervals are 95 per cent; shown as error bars for Omnibus survey results.

Figure 1.4: Staff job satisfaction – Omnibus and NHS Staff Survey in England compared, 2007 and 2008



Sources: Healthcare Commission and Office for National Statistics.

Notes:

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

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3. The results are given in the form of an average score between 1 and 5 rather than as percentages of positive and negative responses.

4. The confidence intervals are 95 per cent; shown as error bars for Omnibus survey results.

Productivity and output targets

1.31 In our last report we asked the parties to give us improved information on productivity measures, specifically the University of York's research on consultants' productivity. The BMA reported that researchers at the University of York had found that since 2004-05 there had been productivity gains with output growth exceeding input growth. It said that the research had concluded that driving these gains had been: increases in the number of patients being treated; improvements in the quality of care patients receive; and a slowdown in staff recruitment and the use of agency staff. The BMA also drew our attention to the Dr Foster Analysis of Hospital Standardised Mortality Ratios for all NHS trusts in England, which showed evidence of improved performance year on year. However, NHS Employers said that there was no evidence that pay was the major issue in securing productivity gains, rather it was the effective and efficient use of staff based on good people management and staff engagement and involvement.

1.32 The Health Departments told us that linking consolidated pay for NHS workers to NHS productivity performance was problematic and raised a number of questions including whether the recent increase in productivity in 2006 and 2007 derived from doctors, *Agenda for Change,* or was shared equally between the two, and whether workers would be willing to accept pay reductions if productivity declined. They believed that in the long run, staff in the public services tended to receive earnings growth in line

with economy wide increases in productivity, and that if they did not do so, they would see their relative earnings deteriorate and there would be a shortage of workers. They said, however, that the link between economy wide productivity and public sector pay was not direct, and noted that any plans to link productivity and pay in the NHS would almost certainly consider non-consolidated bonus payments, rather than changes to base pay. Notwithstanding this, we accept that improved productivity in the form of output targets continues to be a priority for the NHS.

1.33 We are grateful to the parties for all the information on productivity and output targets which they have provided this year, and note the problems associated with linking pay to these measures. We comment further on productivity measures for consultants in Chapter 7.

General economic context and the government's inflation target

1.34 The United Kingdom economy went into recession in the middle of 2008, with gross domestic product (GDP) falling by 6 per cent from its peak in the first quarter of 2008; the GDP outturn was significantly worse than was forecast a year ago. More recent GDP figures give a slower rate of contraction, and the latest provisional data show that the economy grew by 0.1 per cent in the last quarter of 2009. HM Treasury forecast economic growth of 1.0 to 1.5 per cent in 2010,[7] which chimes broadly with independent forecasts that give an average prediction of 1.4 per cent growth.[8] The economy is not forecast to return to pre-recession levels of output until 2012.

1.35 The impact on the labour market has not been quite as bad as might be expected with this degree of economic contraction. Employment has fallen by 2.2 per cent (659,000) from a record high in the spring of 2008 at 29.6 million[9] to 28.9 million at the end of 2009. This brings overall employment back to the levels at the end of 2006. The fall in employment has affected younger people disproportionately: employment has fallen by 8.3 per cent among 18 to 24 years olds since spring 2008, compared to just 2.1 per cent for those aged 35 to 49. There are indications in the public sector generally, including the NHS, that financial pressures are leading to job cuts.

1.36 The rate of inflation reached historic lows during 2009 (see Figure 1.5). The annual rate of increase in the Consumer Prices Index (CPI) fell from a high of 5.2 per cent in September 2008,[10] pushed up by rising gas and electricity prices, to a five-year low of 1.1 per cent in September 2009, as these fuel increases fell out of the 12-month comparison. CPI inflation then rose to 3.5 per cent in January 2010 and is expected to continue rising in the spring of 2010, but then fall back to 2 per cent by the end of the year. The Retail Prices Index (RPI) showed inflation rising to a similar high of 5.0 per cent in September 2008 before falling substantially, pushed down by falling interest rates and house prices, as well as the gas and electricity prices, to give an unprecedented eight months of negative inflation from March to October 2009, with a low of -1.6 per cent in June 2009.[11] RPI inflation moved back into positive territory again in November 2009 (0.3 per cent) and reached 3.7 per cent in January 2010.

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[7] HM Treasury. *Pre-Budget Report. Securing the recovery: growth and opportunity*. Cm 7747. TSO, December 2009. Available from: http://www-hm-treasury.gov.uk/prebud_pbr09_repindex.htm

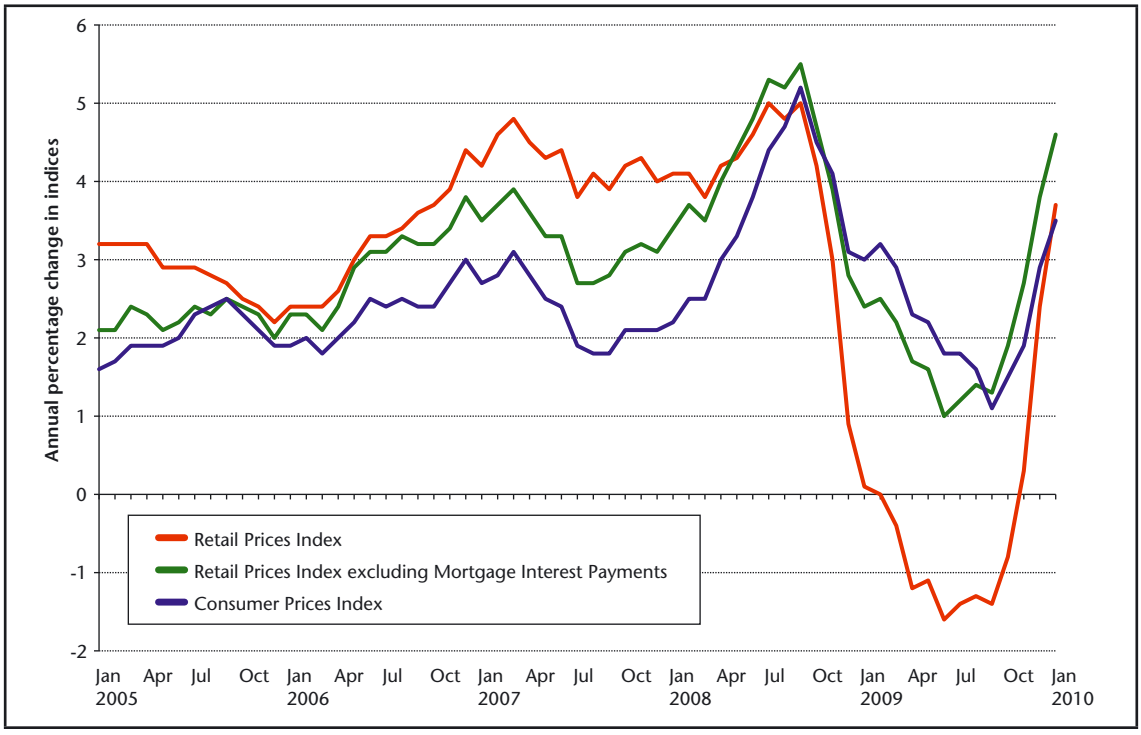
[8] HM Treasury. *Forecast for the UK economy: a comparison of independent forecasts*. February 2010. Available from: http://www.hm-treasury.gov.uk/d/201002forcomp.pdf

[9] *Labour Force Survey*. March-May 2008: 29,564,000 in employment; October-December 2009: 28,905,000 in employment.

[10] The highest since CPI records began in January 1987.

[11] The only other time in the RPI's history (since 1948) when it has been negative is in the 1959 to 1960 period. Even then, it was not negative for more than three months in a row, and the lowest figure was -0.8% (June 1959).

Figure 1.5: Annual change in consumer prices indices, January 2005 to January 2010



Source: Office for National Statistics.

1.37 Pay settlements started the year at their long-term median of 3 per cent, boosted by the high inflation in the autumn of 2008. By the middle of the year, as the proportion of pay freezes grew to near a half of all awards, the median dropped to an historic low of 1 per cent (according to Incomes Data Services (IDS)) and 0 per cent (according to IRS). Pay settlements showed a modest recovery by the autumn, reaching 1 to 2 per cent, although pay freezes still constituted around a third of all reviews. IDS forecasts that private sector pay rises could be centred on 2.5 to 3 per cent in 2010 with fewer freezes, and that there will be fewer long-term deals due to uncertainty about economic forecasts. In IRS's survey of pay prospects, private sector companies are predicting a median of 2 per cent for the September 2009 to August 2010 period. According to the Bank of England Agents' report,[12] those that were planning for their 2010 settlements expected pay growth to remain subdued. While a few of those who had frozen pay this year expected to offer small increases, there were also reports from firms that would freeze pay in 2010 after giving increases in 2009.

1.38 Rates of earnings growth in the private and public sectors have diverged significantly since the end of 2008 (see Figure 1.6). Private sector average earnings growth plummeted from 3.0 per cent in the three months to December 2008 to a low of -1.5 per cent in the three months to March 2009, pushed down by substantial cuts in bonus payments,[13] then recovered to a modest 1 per cent by the autumn. Public sector average earnings growth declined gradually during the year, from 4.0 per cent in the three months to December 2008 to 2.7 per cent in the three months to November 2009. The median forecast is for average earnings growth to be at 2.3 per cent by the end of 2010.[14]

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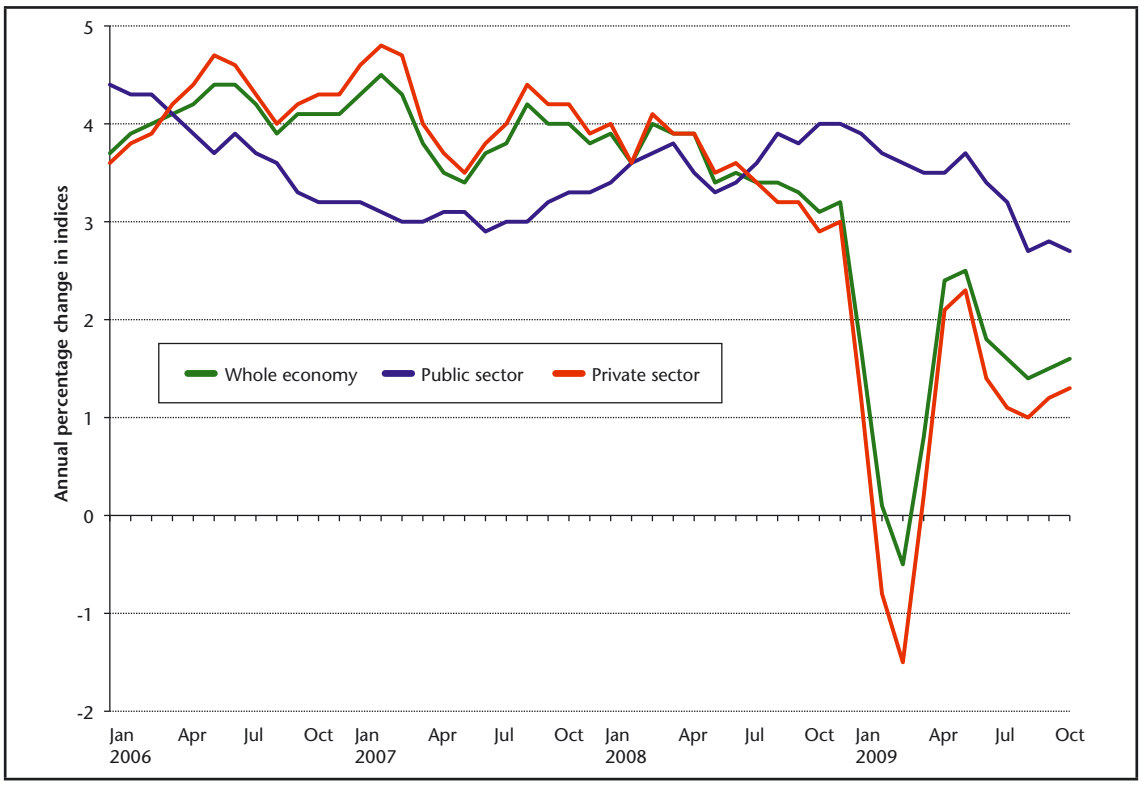
[12] Bank of England. *Agents' summary of business conditions*. December 2009. Available from: http://www.bankofengland.co.uk/publications/agentssummary/agsum09dec.pdf

[13] According to data from the Office for National Statistics measure of Average Weekly Earnings (AWE), it was still the case that around £4.6 billion was paid in bonuses across the whole economy in February 2009; 58 per cent of this was paid in financial intermediation – a sector which accounts for just four per cent of employees covered by AWE.

[14] HM Treasury. *Forecast for the UK economy: a comparison of independent forecasts*. February 2010. Available from: http://www.hm-treasury.gov.uk/d/201002forcomp.pdf

Figure 1.6: Average earnings growth (including bonuses), three-month average, January 2006 to November 2009



Source: Average Earnings Index from the Office for National Statistics.

Affordability and the Health Departments' expenditure limits

1.39 As well as being included in our terms of reference, affordability is an important consideration when setting levels of remuneration in any organisation. As always, it has formed a major theme in the evidence submitted by the Health Departments and NHS Employers, and once again there were warnings of the serious consequences for patient care and NHS strategies that would result from any uplift above that budgeted.

1.40 The Health Departments told us that there was a need for the public sector, and especially its higher-paid groups, to provide "leadership in pay restraint". They said that in view of the recurrent nature of pay uplift costs and the tighter financial position for the NHS and the wider public sector after 2010-11, any pay uplift must be fully affordable in the short and long term, and must enable the NHS to carry out its functions both now and in future. They reminded us that the funding envelope for the NHS was fixed and that pay was one of the most significant cost pressures, which accounted for around 46 per cent of NHS revenue expenditure and around 62 per cent of HCHS expenditure; every 1 per cent in uplifts for salaried doctors would cost £0.1 billion per year, which had important implications for the delivery of planned NHS service developments. A high pay settlement now would need to be maintained in future years and would lead to higher baseline costs going into the next Spending Review. They said that the funding available to the NHS was deployed to cover baseline pressures, underlying demand and service developments and, with no additional resource available to fund excess costs, a higher pay settlement would therefore have implications for the money available for other service developments and would reduce the derived demand for workforce. Doctors might therefore be unable to find posts in future years, and some vital NHS priorities could be delayed or only partially implemented. They said that obtaining better value for money from the pay bill was now even more important than ever and, as pay represented such a large

proportion of the NHS budget, managing the pay bill was key to ensuring that the NHS would be able to cope with any future slow-down in funding growth, and would enable employers and trusts to make the trade-offs that tightening finances would inevitably bring. Additionally, there would be cost pressures arising from the general increase in cost of goods and services, and the revenue cost of capital and demand led programmes such as dentistry and ophthalmology.

1.41 The government asked us, when coming to our decision for 2010-11, to consider the implications that decisions on pay in 2010-11 would have for workforces and government finances in the medium term; to recognise that there were competing priorities for spending on pay which may contribute more to public servants' ability to do their jobs and outcomes for the taxpayer; to note that since 1997, the government had invested significantly in frontline workforces both in terms of pay and workforce numbers; and to recommend a targeted approach within workforces where possible, to deliver the best value for money.

1.42 The WAG added that NHS Wales was facing significant financial challenge, which would continue for the foreseeable future. It said that the three most likely consequences of a higher pay award than was affordable would be a reduction in service capacity, a failure to meet the targets set by government and a reduction in the number of posts. The SGHD said that if pay awards were set at an excessive level, this would be at the cost of service developments and quality.

1.43 The DHSSPSNI operated within a fixed annual budget set by the Northern Ireland Executive and said there was no additional resource available to fund excess costs. Increasing the proportion of resources to be spent on pay would inevitably lead to less money being available to meet key service pressures and rising demand. The Northern Ireland Executive faced similar constraints on affordability to the other parts of the United Kingdom. It said that while total spending power was higher per capita, the application of the Barnett Formula (under HM Treasury's Statement of Funding Policy to the Devolved Administrations), meant that the rate of growth in spending was lower than in England. Over the Comprehensive Spending Review period 2008-09 to 2010-11, the DHSSPSNI's Departmental Expenditure Limit would grow by 2.3 per cent per annum in real terms, compared to over 4 per cent per annum (on resource Departmental Expenditure Limit) for the Department of Health in England. Hence, if pay continued to increase at or around the same levels as in England, there was a greater proportionate impact on other policy areas. It told us that the prime consideration was the need to secure the recruitment and retention of the workforce needed for the service, in the context of labour market conditions both locally and more widely, especially given that some health professionals were mobile within the United Kingdom, Ireland and internationally.

1.44 NHS Employers echoed much of the Health Departments' evidence on affordability. They told us that the significant cost pressures on public spending were expected to intensify from April 2011. As the largest element of NHS expenditure, pay cost pressures formed a significant risk to the employing organisation: pay typically represented 65 – 70 per cent of expenditure within provider trusts. Factors identified by employers as creating particular cost pressures during 2010-11 included: the continued achievement of waiting time targets; continued roll-out of the new SAS contract; pay progression; implementation of the European Working Time Directive; large reductions in capital allocation in 2010-11; and the *Agenda for Change* multi-year deal. They said that the NHS was facing a very severe contraction in its finances with an £8 – 10 billion real terms cut likely in the three years from 2011. Over the next spending review period, 2011-12 to 2013-14, the budget across all spending departments, including the NHS, could be reduced in real terms by an average of 2.3 per cent per year. NHS Employers concluded from all of this that only limited funds

would be available for wage increases. They stressed that a 1 per cent variation in anticipated pay awards would predominantly absorb many trusts' total operating contingencies and working capital reserves without any consideration for other in-year financial risks. Pressure on finances was widely reported to be more extreme than ever before for the NHS.

1.45 The BMA remained unconvinced about the evidence submitted by both the Health Departments and NHS Employers in relation to affordability and pay uplift. It told us that it continued to regard the RPI as its preferred indicator of inflation and said that fear of an inflationary impact should not be a reason for holding down public sector pay settlements. It observed that the third stage of the three-year *Agenda for Change* pay agreement, covering around 1.1 million staff, provided for pay rates to increase by 2.25 per cent in 2010-11, which it believed suggested that the NHS would have little difficulty in affording pay increases up to this level for NHS staff and contractors generally. It also noted that *Agenda for Change* pay bands rose as high as £95,333. It said that the relative buoyancy of pay settlements indicated that employment was bearing the brunt of the impact of the recession rather than pay.

1.46 The BDA noted that the Department of Health had announced a welcome 8.5 per cent increase in the dental budget for 2009-10. This funding had been allocated to PCTs by SHAs but the BDA believed it would not necessarily be spent on additional dental services. The Department of Health told us that this uplift related to the increase in the ring-fenced dental allocation from 2008-09, and was for PCTs to spend on dentistry in primary care, salaried or specialist services such as orthodontics.

1.47 Our view is that affordability must be considered alongside the need to recruit, retain and motivate doctors and dentists. It is clear that there are huge financial pressures facing the NHS, now and over the next few years, and we have taken this into account when making our decision about what we believe will be the appropriate uplift for 2010-11. However, affordability is not independent of other matters. It is related to the Health Departments' budgets, but these budgets have been set including assumptions about pay levels needed to address issues such as motivation and recruitment; so in considering affordability we cannot just consider the budgets themselves, we have to interrogate the assumptions that have gone into the construction of the budgets.

1.48 We address NHS finances, including the *NHS Operating Framework*, and efficiency savings later in this chapter.

Pay drift

1.49 We note, from NHS Employers, that incremental progression in the pay structures has continued to make a noticeable contribution to earnings growth for doctors and dentists employed in the NHS. As in previous years, employers in the NHS believed that these additional increases in basic pay and earnings should be factored into decisions about the recommended level of pay increase.

1.50 For completeness we reiterate our views on pay drift, which we set out in our *Thirty-Fifth Report.*[15] We 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

[15] 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/DDRB_Main_Reports.aspx

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 performance. Furthermore, both parties agree to the pay increases delivered by increments when staff are employed. We believe that it is therefore inappropriate for us to take account of such increases when considering our general uplift. We see no reason to change these views. We also recognise that pay drift is mitigated by the retirement of workers near the top of scales and their replacement by workers near the bottom of scales. In a pay structure which is in steady state, incremental drift will be zero.

NHS finances and efficiency savings

1.51 NHS Employers told us that the draft accounts for the end of year 2008-09 showed that the NHS (excluding foundation trusts) was reporting an overall year end surplus of just over £1.7 billion. The surplus sat within NHS organisations and was a small proportion of total NHS resources, at just over 2 per cent. They said that the surplus was also in line with 2008-09 forecasting, the overall NHS financial strategy and the *NHS Operating Framework* for 2009-10. It was key to achieving the financial stability and flexibility needed to deliver plans for service development, sustainability and enhancement over the next decade, which had been set out by staff and clinicians involved in the *Next Stage Review*.[16] Foundation trusts had delivered a combined net surplus of £0.5 billion (excluding exceptional items) over the 12 month period to 31 March 2009. But their independent regulator, Monitor, had told them they would need to have robust plans in place to implement efficiency savings before the financial pressures arose in 2011 and thereafter. NHS Employers told us that foundation trusts believed that they could manage within their annual earnings by keeping pay costs down. However, Monitor had warned that their predictions may prove to be optimistic given likely NHS investment cuts. They stressed that surpluses were non-recurrent. They had generally been achieved through short-term measures which would not generate such savings year-on-year. Non-recurrent savings were not therefore available for investment in recurrent areas of expenditure, such as staff pay, as to do so would generate unfunded recurrent commitments for future years. They noted that the financial management of the NHS had continued to improve. According to draft accounts six organisations were facing a cumulative deficit at the end of 2008-09 of £58 million; this compared to five organisations with an overall deficit of £125 million reported in 2007-08.

1.52 NHS Employers said that the Comprehensive Spending Review had announced that the minimum expected annual efficiency saving was being increased from 2.5 per cent to 3.0 per cent with an expectation of further value for money reforms realising annual net cash-releasing efficiency savings of at least £8.2 billion by 2010-11. They said that the NHS would need to find further efficiencies to help return the economy to balance. Their ambition was to begin to achieve these significant efficiency savings during 2010-11. The Department of Health said that it would be contributing £2.3 billion in additional savings as part of £5 billion efficiencies in spending across the public sector in 2010-11 announced by the Chancellor of the Exchequer in April 2009.

[16] 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

1.53 The Department of Health published the *NHS Operating Framework for 2010-11*[17] in December 2009, after we had completed the process for receiving written and oral evidence. We note that it places a greater emphasis on quality and makes changes to the payment system to reward quality; that there is funding growth of 5.5 per cent in 2010-11, but for 2011-12 and 2012-13, NHS frontline spending will rise in line with inflation; and that the NHS will need to make £15 – 20 billion of efficiency savings by end 2013-14. NHS Employers subsequently confirmed that the publication of the Framework did not alter their position.

1.54 We address the issue of efficiency savings in Chapters 3 and 4 in relation to GMPs and GDPs respectively. However, our general view is that while requiring cash-releasing efficiency savings may be an appropriate way to achieve cost discipline in a government department or public agency that is not subject to market forces, GMPs and GDPs operate small businesses in competitive markets and have an incentive to achieve whatever efficiency savings are possible. We therefore believe that it is unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs, as the impact of efficiency savings will become apparent, albeit with a time lag, in the data that we use in our formulae.

Overall NHS strategy – patients at the heart

1.55 Our remit requires us to have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. The BMA addressed this through their observation that productivity measurement now sought to take into account changes in quality and this had improved in recent years. In addition, 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. The Health Departments also told us that the *NHS Operating Framework* ensured that patients were at the heart of service development by clarifying key service priorities for the NHS, financial rules and an accounting framework. In the dental context we see this aspect of our remit expressed through improving access to NHS dental services and the merit awards for consultants reward exceptional achievements and contributions to patient care.

1.56 The 'patients at the heart' part of our remit was introduced in 2007, but since then we have struggled to address this issue in any depth as we have received very little evidence on the subject. While it is clear to us that a focus on patients is a central part of the overall ethos of the NHS, we do not believe that this necessarily needs to form part of our remit. As before, we ask the parties to address the issue more directly when preparing evidence for the next round. Alternatively, we suggest that consideration be given to removing this topic from our remit.

Legal obligations on the NHS including anti-discrimination legislation

1.57 We are also required to 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. The Health Departments have previously told us that they would not expect to submit evidence on this point as a matter of course, although they expect us to take this part of the remit into account when formulating recommendations. Last year we asked the parties to provide confirmation that the Clinical Excellence Awards, discretionary points and distinction awards schemes were being operated in accordance with equality legislation and we refer to this again in Chapter 7.

[17] *The operating framework for the NHS in England: 2010/11*. Department of Health, December 2009. Available from: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf

Pay comparability

1.58 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 use are: legal, tax and accounting, actuarial and pharmaceutical.[18] Further discussion of pay comparability for specific groups within our remit is included in the relevant chapters. Here, we make some brief general observations about the remuneration of doctors and dentists relative to their comparators, and in the context of the wider United Kingdom economy. We intend to carry out more detailed analyses of comparability at each anchor point once every three years; the next such analysis should therefore be included in our 2012 report.

Pay levels

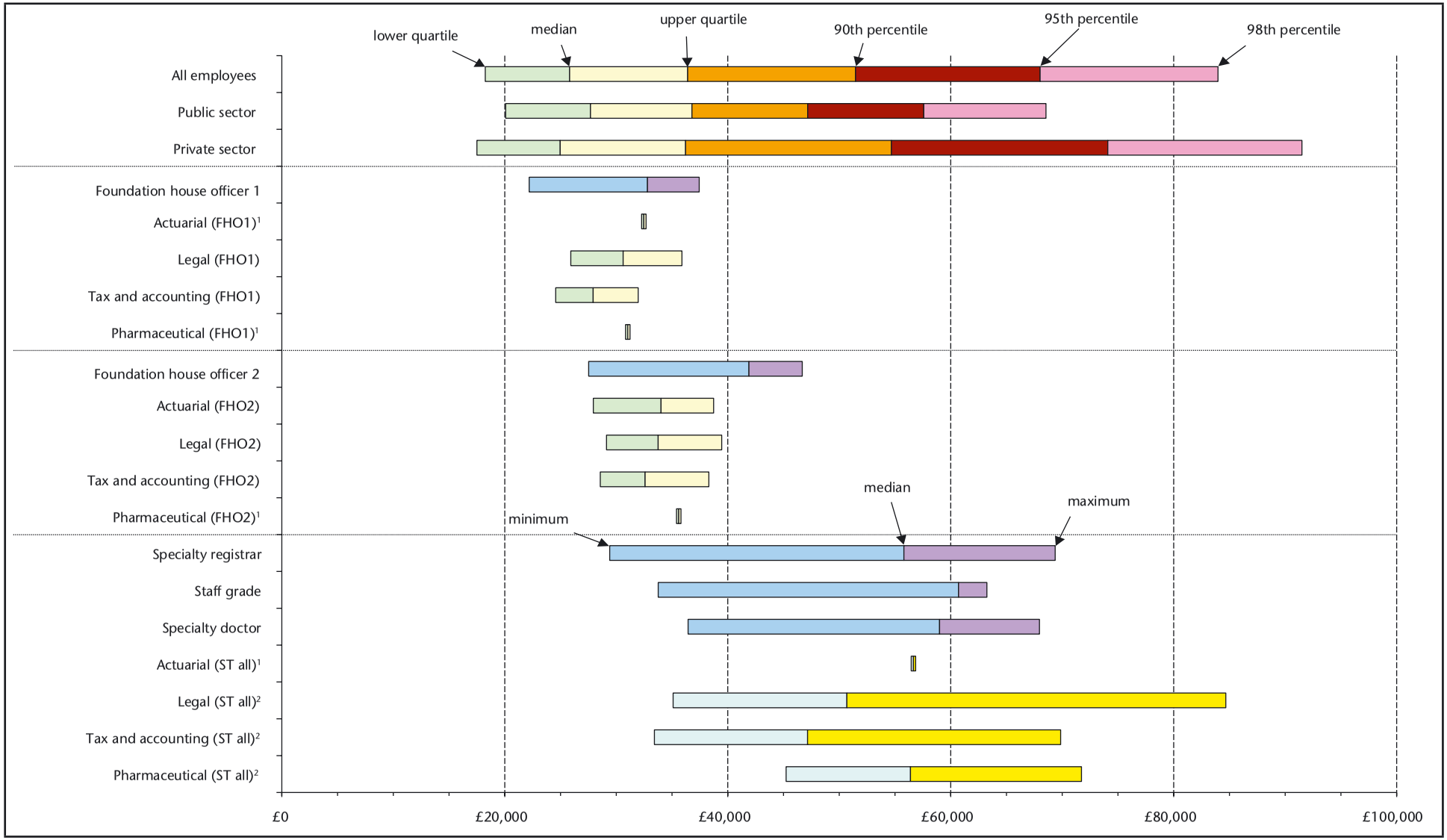
1.59 Basic salaries for junior doctors are below the lower quartile for their comparator groups at each stage, but the fact that most trainees receive banding supplements means that median incomes compare favourably with those of the comparator groups. However, it should be noted that in other professions, many graduate entrants work extended hours unpaid. The typical maximum earnings available to junior doctors have been reduced, since the maximum banding supplement for rotas compliant with the European Working Time Directive is now 50 per cent of basic salary: but median earnings for foundation house officer 1s are well above the national median, while the median for foundation house officer 2s is above the national upper quartile, and median income for specialty registrars is above the 90th percentile for the United Kingdom (see Figure 1.7).

1.60 Earnings data newly available for the specialty doctor grade shows that median earnings for this group fall between the 90th and 95th percentiles for all full-time United Kingdom employees, and slightly below the median for staff grade doctors. Maximum earnings for both of these groups are below the upper quartile of the comparator groups for which data are available (see Figure 1.7).

1.61 Total earnings for associate specialists range from around the upper quartile for the whole economy up to the 98th percentile; median income, however, is equal to, or lower than, that of the private sector comparator groups (see Figure 1.8). Basic salary for newly qualified consultants is below the median for the comparator groups; median earnings for all consultants are, however, well above the 98th percentile for all employees, and higher than median income in the comparator groups at a level of seniority considered equivalent to an experienced consultant (see Figure 1.8). General practitioners in medicine and dentistry cover a wide range of incomes. GMPs typically earn more than the 90th percentile for the United Kingdom, but while the salary scale maximum for salaried GMPs is below the national 98th percentile, mean earnings for contractor GMPs are above it (see Figure 1.8). Income for GDPs ranges from around the national median to well above the 98th percentile; but while mean earnings for performer GDPs are below the median for the comparator groups, providing-performer GDPs' earnings are on average higher than the upper quartile for the private sector comparators (see Figure 1.8).

[18] The pay comparators were identified in the report: PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups.* Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/DDRB_Research.aspx

Figure 1.7: Total earnings ranges of training grades, 2009, compared with the national pay distribution and other professional groups, full-time rates



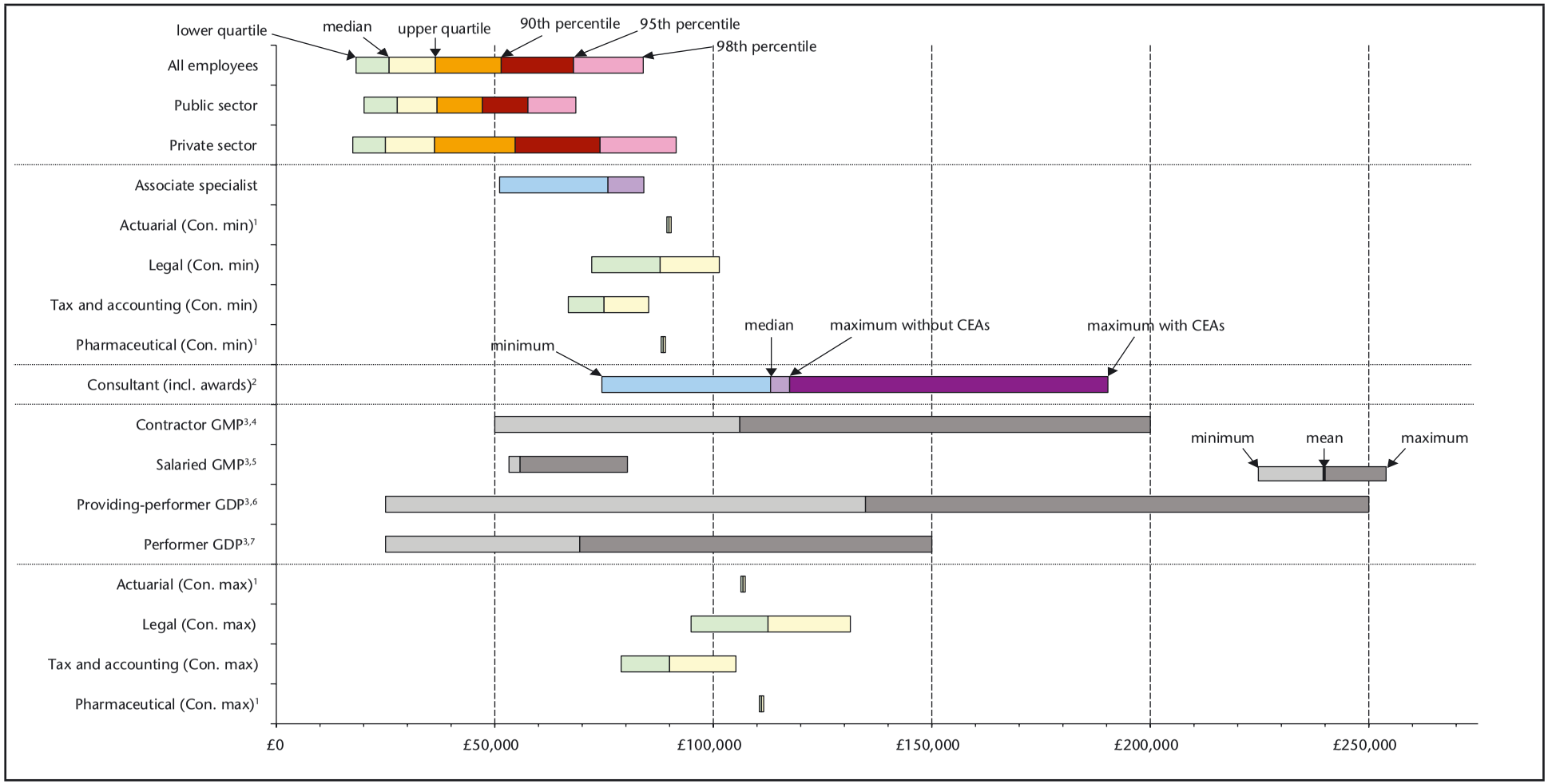
Sources: The Office for National Statistics, the NHS Information Centre, NHS Employers and Hay Group.

Notes:

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

[2] The range for specialist 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.

Figure 1.8: Total earnings ranges of consultants and equivalent grades, 2009, 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] A range is not always available for actuarial posts and pharmaceutical posts.

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

[3] Estimated mean incomes (before tax) for 2007-08 for all (both full-time and part-time) GMPs and GDPs (the latest available data) rather than medians as the latter are not available.

[4] The range given excludes the bottom 6.9 per cent (who earn less than £50,000) and the top 3 per cent (who earn £200,000 or more).

[5] The mean salary is near the bottom of the range as the range is for full-time posts and salaried GMPs are often part-time.

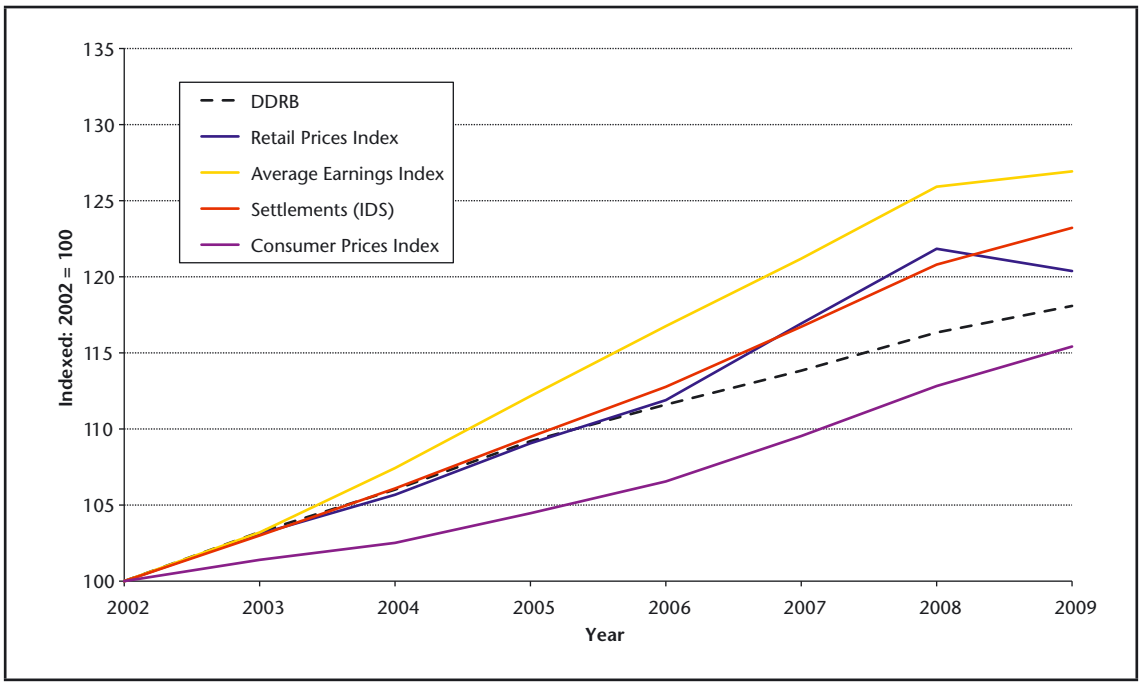
[6] The range given excludes the bottom 3.7 per cent (who earn less than £25,000) and the top 3.3 per cent (who earn £250,000 or more).

[7] The range given excludes the bottom 11.8 per cent (who earn less than £25,000) and the top 3.6 per cent (who earn £150,000 or more).

Pay movements

1.62 As in previous years, we have also looked at how our basic awards in recent times have compared with settlements and earnings in the wider economy, and with the main measures of inflation: Figure 1.9 shows the DDRB award, indexed since 2002, alongside the Average Earnings Index (AEI), the RPI, the CPI, and median pay settlements for the whole economy from IDS. Our recommendations are not, however, linked directly to any of these indices. Figure 1.9 shows that, having more or less kept pace with average earnings and settlements toward the start of the decade, our headline award over the past few years has tended to be somewhat lower than other indicators: with the exception of 2008-09, when average earnings growth slowed considerably, and RPI was negative for the twelve months to April 2009.

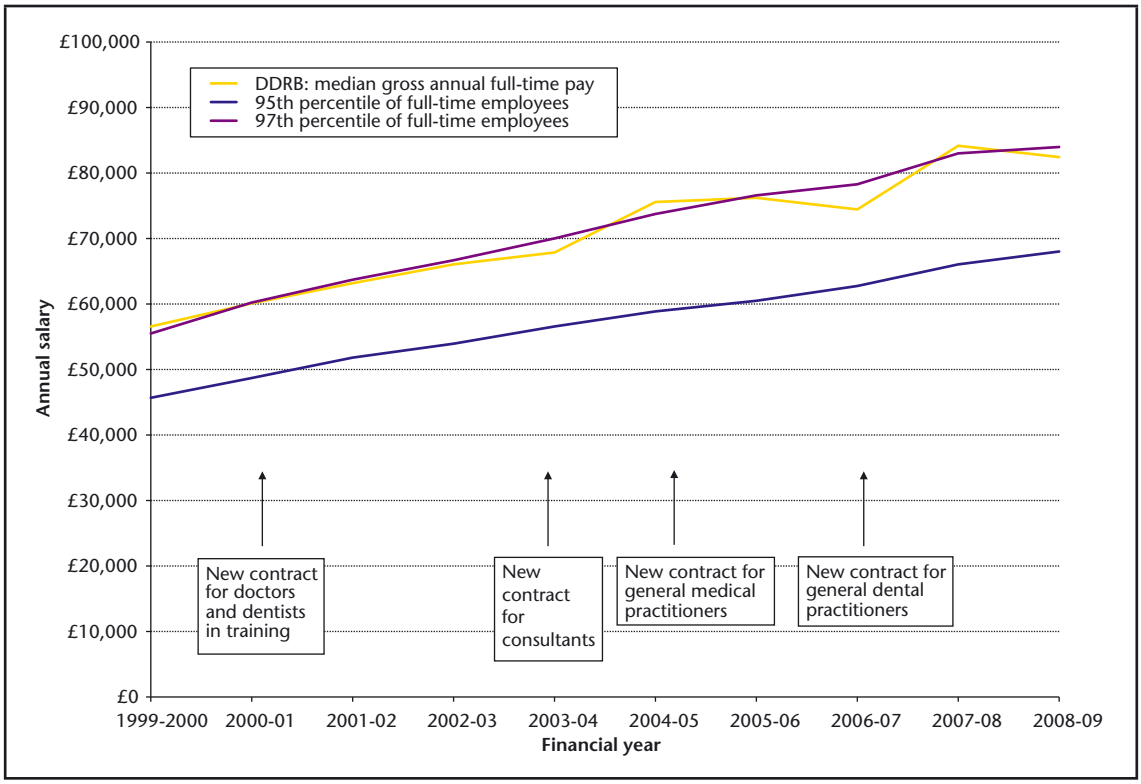
Figure 1.9: DDRB main award compared with April movement in the Retail Prices Index, Consumer Prices Index, Average Earnings Index and median (whole economy) settlements, 2002 – 2009



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

1.63 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 1.10 shows that the median gross annual full-time pay for doctors and dentists has remained around the 97th percentile for all full-time employees, so that, although our awards have at times been lower than the AEI, the actual incomes of our remit group members appear to have kept pace with their equivalents in other sectors. It should also be noted that Figure 1.10 shows movements in the earnings of *employed* doctors and dentists only: that is, it excludes independent contractor GMPs and GDPs, and is therefore not affected by the new GMS contract introduced in 2004.

Figure 1.10: Movements in earnings from the Annual Survey of Hours and Earnings, 1999-2000 to 2008-09



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

Notes:

1. The data shown are gross annual pay at the 95th and 97th percentiles of all employees on full-time rates, and the full-time gross median annual earnings for all employed doctors and dentists in the public sector.
2. The sample size used to estimate the DDRB median was reduced from 2007 onwards; figures since 2007 should therefore be treated with caution.

Total reward: pensions and fringe benefits

1.64 The NHS Pension Scheme is a defined benefit occupational scheme; final salary for most staff, but career averaged salary for GMPs and GDPs. The Health Departments noted that this sort of pension was a very valuable part of the reward package for staff. They said that the changes that had taken 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, and that staff contributions had increased in part to help pay for these improvements. In the medium to longer term, 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 that these would otherwise have reached. The agreement to lift, for future service, the cap on earnings that counted as pensionable, which was in place as a statutory requirement for benefits built up between 1989 and 2006, would mean a significant boost to the pensions of many doctors with a start date for pensionable service after 1989. Uniquely among self-employed people, GMPs and GDPs had access to a high quality defined benefit pension scheme effectively guaranteed by the Exchequer. They believed that in assessing the impact of pensions in the retention of doctors, the most pertinent comparison was with the private sector. Rather than comparing employers' contributions to the schemes, they suggested that it may be more appropriate to consider the scale of pension benefits offered.

1.65 The Health Departments said that a medical career in the NHS remained highly attractive in terms of financial reward, wider reward packages, and job satisfaction. They told us that for doctors in training the value of employers' pension contributions, and annual, study and sick leave provisions above statutory requirements, added over 20 per cent to the value of the reward package, and were worth around £11,000 to a doctor in the second year of training, and around £14,000 to a doctor five years into training. For consultants, they said that the value of these benefits over statutory provision along with employer pensions contributions was over £25,000 and represented nearly 20 per cent of the value of the reward package. This work showed 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 a doctor in training.

1.66 NHS Employers said that the whole reward package must be considered, including pensions, tangible and non-tangible rewards, with regard to its effectiveness in enabling the NHS to recruit the correct number of staff, the correct skill mix of staff and the correct application of those skills, to do all the things required of the service. The value of the NHS Pension Scheme was an increasingly important element of the NHS reward package, which they believed compared well to pensions offered to comparable occupations outside the NHS. Both employers and the NHS trade unions regarded pensions as deferred pay and recognised that the employer contribution was a significant part of earnings for NHS Pension Scheme members. NHS Employers believed that there was an increased awareness of the importance of pension provision and the value of public service pension schemes, within and outside the service. The NHS Pension Scheme continued to be a high quality final salary pension scheme, which cost around 20.5 per cent of pay. They believed that it was important that awareness of the value of this reward should be raised and should be explicit in our assessment of the correct recommendations.

1.67 The BMA observed that while pension arrangements for doctors and dentists were relatively beneficial compared with those of employees as a whole, they remained broadly in line with those of comparable groups in the public sector and the higher paid in the private sector. They noted that the availability of benefits other than pension was far less widespread in medicine and dentistry.

1.68 The BDA asked us to consider the impact of the increased pension contributions on taxable income. They said that the new tiered contribution band arrangements, which were introduced in April 2008 as a result of the NHS pension review, had resulted in increased pension contributions for dentists, with no addition to benefits. They calculated that the average net effect on pay was 0.3 per cent and said that this affected GDPs and salaried dentists equally. However, we understand that the changes to the pension scheme were negotiated with the bodies representing members of the remit group and hence that they agreed to this change. We therefore do not think that it would be appropriate to take the increased pension contributions into account when considering the pay uplift. In general, our view is that pensions are deferred pay and access to a defined benefit pension scheme is a valuable benefit for doctors and dentists, particularly as it has been widely reported that many defined benefit pension schemes in the private sector are being closed even to existing members.

1.69 Last year we commented on the growing divergence between public and private sector pensions. We said that we would continue to monitor the contribution of pensions, including benefits, to total reward both in our remit groups and in the

wider labour market. To this end, we commissioned a study[19] from Watson Wyatt (now Towers Watson), jointly with the Review Body on Senior Salaries, to look at total reward offered by comparator sectors.

1.70 The report showed that due to the non-pension benefits, the pharmaceutical, accounting and financial services roles in the private sector with an equivalent salary have a larger total reward than doctors and dentists. It found that doctors' and dentists' pension arrangements compared favourably with typical benefits for the private sector comparators. They were less valuable, however, than those of some of the other public sector groups covered in the study. The study was not able to fully investigate the value of non-pension benefits in our remit groups, but it seems clear that (at least in financial services, accounting and pharmaceuticals) private sector employees in the comparator organisations typically enjoy more generous non-pension benefits than their public sector counterparts; for example, annual bonuses, fixed payments, recognition payments and company cars.

1.71 We noted that the calculation of future rewards from the different types of pension were heavily dependent on the assumptions used; had it been available, we would have liked more detailed information about the use of long-term incentive plans. In addition, we recognised that the information about pensions related to new employees rather than those held by existing workers who would be more likely to be members of defined benefit schemes.

1.72 With time, the proportion of doctors and dentists receiving the more generous benefits available under the old NHS Pension Scheme will of course decrease as new practitioners join under the terms of the new scheme. The number of private sector employees still accruing defined benefit entitlements will also decrease, both as existing legacy scheme members retire and as more companies close their old schemes to all new accruals, not just to new entrants. Simultaneously, however, the report suggests that there is currently a trend for private sector employers to increase the rate of employer contributions under defined contribution schemes.

1.73 We conclude from this that NHS pensions are more generous than private sector comparators, and even more rewarding than private sector comparators for new entrants. However, the non-pension aspects of total reward are potentially significantly higher for most private sector comparators, so overall we are not concerned about the pensions of our remit group.

Conclusions

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

- during 2009, the economic climate has seen historic lows in inflation, followed by a rapid jump and a tentative emergence from recession;
- there are huge financial pressures facing the NHS now and over the next few years, but affordability cannot be considered in isolation as the Health Departments' budgets have been set including assumptions about the pay levels needed to address issues such as motivation and recruitment;

[19] Towers Watson. *Research into total reward offered by comparator sectors: Review Body on Doctors' and Dentists' Remuneration and Review Body on Senior Salaries.* Office of Manpower Economics, 2010. Available from: http://www.ome.uk.com/DDRB_Research.aspx

- median gross annual full-time pay for doctors and dentists has remained around the 97th percentile for all full-time employees, so that, although our awards have at times been lower than the AEI, the actual incomes of our remit group members appear to have kept pace with their equivalents in other sectors;

- doctors and dentists benefit from a pension that is more generous and more secure than private sector comparators, especially for new entrants, although the non-pension elements of the total reward package are higher in private sector comparators;

- 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 of medical and dental staff carried out in England and Scotland indicate that they are generally more satisfied with their pay, job and conditions than in the past.

CHAPTER 2: MAIN PAY RECOMMENDATIONS FOR 2010-11

The parties' proposals

2.1 As part of their evidence to us, the parties have included their recommendations on pay increases for the year 2010-11. The parties have offered detailed proposals on the uplifts for specific groups within our remit, and give a range of justifications for their views; these specific considerations are discussed in depth in the relevant chapters. In this chapter, however, we outline the parties' principal proposals for the main uplift to be awarded to each group, along with our own recommendations. As always, we have given careful consideration to all of the evidence that we have received.

2.2 The Chief Secretary to the Treasury wrote to us in October 2009 outlining the government's approach to public sector pay in 2010-11. His letter informed us that the government was proposing awards of up to 1 per cent across the board for workforces not in multi-year deals, with proposals of 0 per cent for senior groups within this; evidence from government departments to the independent review bodies, including the Review Body on Doctors' and Dentists' Remuneration (DDRB), was to reflect this approach.

2.3 Evidence from the Health Departments suggested that there was a need for the public sector, and its higher-paid groups in particular, to demonstrate "leadership in pay restraint". They stated that recruitment and retention was healthy across all NHS staff groups, and expressed the view that this position would strengthen further throughout the coming year, supported by the effects of the recession on the labour market, the excellent job security and total reward packages enjoyed by doctors and dentists. The Health Departments also pointed to the low levels of inflation at the time of their submission of evidence in October 2009, which they said were forecast to continue into 2010-11, and the need for an affordable uplift in view of the tighter financial position faced by the NHS and the wider public sector in the coming year. They felt that there were no compelling grounds for a salary uplift for hospital doctors of any grade. They therefore proposed no salary increase for consultants, and no uplift to the present values of Clinical Excellence Awards, consistent with the wider approach to senior groups within the public sector. They said, however, that the government was willing to consider an uplift of up to 1 per cent for non-consultant salaried doctors – that is, doctors in training, specialty doctors, and staff grades and associate specialists. The Health Departments also proposed an uplift of up to 1 per cent for salaried general medical practitioners (GMPs) and salaried primary dental care dentists. They suggested that there should be a 0.5 per cent increase in gross General Medical Services (GMS) contract payments, intended to yield a zero increase in net payments to self-employed GMPs (after assumed efficiency savings of 1 per cent on expenses), and no uplift in gross payments to self-employed general dental practitioners (GDPs), which they calculated would yield a 0.6 per cent increase in net payments (again, after assumed efficiency savings of 1 per cent on expenses). The Health Departments recognised the fundamental role played by doctors and dentists in delivering the objectives of the NHS, but said that the government saw no reason for the NHS to be exempt from a realistic approach to public sector pay this year, despite the challenges that it faced. They stated that the medical workforce was broadly in balance, that recruitment, retention and morale were strong, and that the maintenance of existing pay relativities and the protection of the existing values of salaries should not be among the aims pursued in setting pay awards. They did not believe, however, that a flat rate increase was necessary or justified.

2.4 The Welsh Assembly Government (WAG) expressed concerns about affordability, and noted that the recruitment and retention situation in the medical workforce was strong. It stated that it was unlikely that any pay award in 2010-11 could be afforded without significantly impacting on service provision and, while it said that the majority of trusts favoured the same percentage increase for all grades, it suggested an award of up to 1 per cent for non-consultant salaried doctors, and no uplift for consultants.

2.5 The Scottish Government Health Department (SGHD) told us that the pay settlement needed to be sufficient to maintain the motivation of staff, but that the live economic context in the public sector and beyond should also be borne in mind. It stated that recruitment and retention were good, and that doctors and dentists benefited from a very good overall remuneration package; it therefore supported a zero increase for consultants, and up to 1 per cent for all other salaried doctors. It did not support the idea of a flat rate increase.

2.6 The Northern Ireland Department of Health, Social Services and Public Safety (DHSSPSNI) said that it was committed to implementing United Kingdom national pay policy, as expressed in the Department of Health's proposal for an uplift of up to 1 per cent, with no increase for consultants; it also concurred with the Department of Health's suggestions for uplifts to contract values for GMPs. For GDPs, the DHSSPSNI said that there was scope for a small increase, in view of the fact that implementation of a new dental contract was some way off, and it was therefore unable to incorporate any assumptions relating to efficiency savings achieving a 0.6 per cent increase (as was the case in England and Wales). It therefore recommended an increase of up to 1 per cent for GDPs. It noted that, within the constraints of a fixed annual budget, increasing the proportion of resources to be spent on pay would inevitably lead to less money being available to meet key service pressures and rising demand. It did not believe that a flat rate increase was either necessary or justified in the present economic circumstances.

2.7 In their main evidence, NHS Employers proposed a flat rate increase on all pay points for employed doctors and dentists. They suggested that an increase of £450 on all points, for example, would maintain the competitiveness of graduate entry pay to medicine and dentistry while avoiding unavoidable cost pressures at more senior levels. This £450 flat increase would deliver increased costs of just under 1 per cent of the total wage bill for employed doctors and dentists. They also proposed an overall gross uplift of up to 1 per cent to be applied to GMS contracts payments for 2009-10, and an uplift of no more than 0.21 per cent to gross contract values for General Dental Services. They told us that they wanted an award that was fair to staff, but also recognised the need for organisations to achieve financial balance. Any recommendation would need to be significantly lower than last year's award, and ought to balance affordability, acceptability to the public purse, the need for continued improved delivery of services, and the maintenance of the morale and commitment of doctors and dentists. On this basis, an overall increase of more than 1 per cent would not be affordable. They reported that, among their members, some employers had indicated that they would prefer the same award for all categories of medical and dental staff, while others felt that an award should be targeted at certain categories, with doctors and dentists in training being mainly favoured for a higher award. Some employers had questioned the acceptability of significant increases for higher earners in the current economic climate.

2.8 Supplementary evidence from NHS Employers, supported by their oral evidence, represented something of a change of position. In this document, NHS Employers stated that their earlier proposal, for a flat rate increase costing up to 1 per cent of the total wage bill, would no longer be affordable on the basis of the tariff increase implied by the government's evidence. Their original suggestion had been based on

the assumption that the cost would be covered by the tariff; the government's evidence, proposing 1 per cent for hospital doctors below consultant level only, made it apparent that this assumption was unlikely to hold. This being the case, they felt that, rather than propose a smaller flat rate increase which would not fulfil the aim of maintaining competitive rates of graduate entry pay to junior doctors, unaffordable cost pressures could be avoided more effectively by having no increase for consultant doctors and GMPs, with an increase of up to 1 per cent for other grades. They said that they supported pay restraint at senior levels, and that this position reflected the views, in general, of employers and commissioners in the service. They also told us that there was no causal link between the 2.25 per cent award for other NHS staff under the third year of the *Agenda for Change* agreement, and the affordability of a prospective DDRB award: 98 per cent of respondents to their survey of employers had confirmed that affordability was one of the main concerns in setting pay recommendations this year. Employers had entered into the *Agenda for Change* deal in good faith, and saw merit with keeping to the agreement, despite the challenge it posed. There was no such multi-year deal for doctors, however, and NHS Employers said that senior doctors were of the opinion that it would not be appropriate for them to receive a large pay rise. After the oral evidence hearing, the *NHS Operating Framework*[20] was announced, with a zero uplift to the tariff. NHS Employers subsequently informed us that their position had not changed; they continued to support an increase of up to 1 per cent for salaried doctors below consultant level.

2.9 The British Medical Association (BMA) said that the basic uplift for this year should aim to protect the value of existing contracts relative to current and prospective Retail Prices Index (RPI) inflation and bear in mind the available evidence on workload. It asked for a basic earnings increase of 2 per cent, with increases in other fees and allowances that maintained or restored their relationship with basic salaries; it felt that this would be appropriate in-year, and did not include any retrospective adjustment for what it perceived as our failure to maintain the profession's position in last year's or previous reports. The BMA told us that it did not support the proposals made by NHS Employers and the Health Departments respectively for a flat rate increase or a differential uplift. It believed that flat rate increases could have unintended longer term consequences, and it did not favour an uplift that would erode pay differentials. A targeted uplift should only be used under certain specific circumstances: where special recruitment or retention issues existed, where evidence on pay comparability suggested that the benchmark for one group had moved relative to others (which might be the case for junior doctors in foundation year 1), where existing differentials did not adequately represent differing job weights, or where it was necessary to protect the earnings of a specific group from the consequences of structural changes on earnings.

2.10 The British Dental Association suggested that dentists should receive a 3.6 per cent increase in taxable income to reflect the pay awards made in the wider public sector. For salaried dentists, it requested a 3.6 per cent increase for all staff, as well as the addition of two points to the top of the band A pay spine (and the deletion of the bottom two points) to address recruitment problems. It did not believe that a flat rate uplift would be appropriate to the Salaried Primary Dental Care Services, since the recruitment and retention problem the NHS faced related to staff in the career grades, in bands A and B, and not in the lower trainee grades (for which a flat uplift might have been more appropriate).

[20] *The operating framework for the NHS in England: 2010/11*. Department of Health, December 2009. Available from: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf

2.11 The Dental Practitioners Association said that the total increase in remuneration (net of expenses) required to recruit, retain and motivate NHS dentists, taking into account their risk and workload for the financial year 2010-11, was 12.5 per cent. In oral evidence, it told us that this proposed increase was aimed at placing NHS dentists on an equal footing with dentists doing private work.

Main pay recommendations

2.12 In making our recommendations this year, we have been acutely conscious of the impact of the recent global recession on employment in the wider economy, and of its severe effects on the public finances of the United Kingdom. The outlook for the economy as a whole remains uncertain: provisional gross domestic product (GDP) data show that growth tentatively resumed in the last quarter of 2009 after a 6 per cent contraction since early 2008, and HM Treasury has forecast growth of 1.0 to 1.5 per cent in 2010.[21] Inflation, too, has been volatile. Having been negative for eight months to October 2009, with a low of -1.6 per cent in June 2009, RPI increased to 3.7 per cent in January 2010; it is expected to rise further throughout the first half of 2010 before returning to more moderate levels towards the end of the year. The Consumer Prices Index, meanwhile, rose to 3.5 per cent in January 2010, from a five-year low of 1.1 per cent in September 2009. We are therefore aware of a tension between the severe pressure on the NHS budget, which faces years of fiscal constraint, and an uncertain inflationary outlook affecting members of our remit group.

2.13 We have noted contradictory elements, too, in the government's stance this year. It has proposed uplifts of up to 1 per cent for doctors and dentists, with 0 per cent for the higher-earning groups (consultants, and independent contractor GMPs and GDPs): and yet it did not favour reviewing the third year of the *Agenda for Change* three-year pay deal awarding a 2.25 per cent increase for other NHS staff groups, some of whom are paid considerably more than many of our remit group members. As doctors' and dentists' salaries comprise only a fraction of the overall NHS pay bill, we have therefore approached the Health Departments' evidence on affordability with some reservations: but we do accept that pay increases for highly-paid individuals would be difficult to justify in the current circumstances. We are not persuaded that the government's assertion that senior groups should provide 'leadership in pay restraint' is relevant to our remit groups. This appears to be largely a political claim, and is not a matter for us. In this time of stringency, however, we do see a need to target scarce resources where they are most needed, and we have accepted the case for a differential uplift in order to maintain recruitment in an uncertain inflationary climate.

2.14 We note that the idea of a differential uplift received some measured support from a number of the parties this year. The government's evidence asked Review Bodies to recommend a targeted approach within workforces where possible, to deliver the best value for money. NHS Employers said that a number of employers had suggested that doctors and dentists in training should be favoured for a higher award. The BMA recognised that there could be grounds for differentiating between groups where evidence on pay comparability suggested that the benchmark for one group had moved differently to others, and stated that this appeared to be the case for foundation house officer 1 trainees.

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

[21] HM Treasury. *Pre-Budget Report. Securing the recovery: growth and opportunity*. Cm 7747. TSO, December 2009. Available from: http://www-hm-treasury.gov.uk/prebud_pbr09_repindex.htm

- 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 believe that the recruitment and retention situation appears relatively healthy for doctors and dentists throughout the NHS and, where there do appear to be issues of motivation, we are not convinced that these are pay related. Moreover, we recognise that considerable value must be placed on the job security enjoyed by NHS doctors and dentists, with unemployment in the wider economy forecast (according to most commentators) to continue rising throughout 2010. Although we are not convinced that the Health Departments' proposals necessarily represent the limit of what is affordable, we have also taken into account the heavy pressure currently being placed on the public finances. We therefore conclude that any uplift should remain at a modest level overall and, within that constraint, scarce resources should be targeted at the more junior grades within our remit group. In particular, our examination of pay comparability reveals that the base salary of foundation house officer 1 trainees has been considerably eroded in recent years relative to comparators; simultaneously, we note that the number of foundation house officers in unbanded posts (i.e. receiving base salary with no banding supplement) has been increasing. We include a specific recommendation to address this issue; a detailed explanation is given in Chapter 6.

2.17 We have divided our recommended awards into three groups:

- foundation house officers (1 and 2) and their equivalents (house officers and senior house officers) – **1.5 per cent**;
- registrars, specialty doctors and associate specialists (SAS) grades, salaried GMPs, salaried dentists – **1 per cent**; and
- consultants, independent contractor GMPs and GDPs – **0 per cent**.

However, while the awards for independent contractor GMPs and GDPs seek to provide a zero per cent income uplift, they also take account of changes in their business expenses. We consider this to be a fair and reasonable uplift in the current economic climate. We believe that the increases we have proposed will be sufficient to recruit, retain and motivate our remit groups for the coming year.

2.18 **For 2010-11, we recommend an increase of 1.5 per cent to the national salary scales for foundation house officers (1 and 2), house officers and senior house officers. For the remaining grades of doctors in training, we recommend an increase of 1 per cent on the national salary scales.**

2.19 **We recommend that a banding multiplier be introduced for foundation house officer 1 posts that only attract basic pay, and that the multiplier should be set at 1.05 of basic salary.**

2.20 **For 2010-11, we recommend an increase of 1 per cent on the national salary scales for the pre-2008 and post-2008 SAS grades' contracts.**

2.21 **We recommend that the minimum and the maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2010-11, and we recommend increases of 1 per cent for all grades in the Salaried Primary Dental Care Services.**

2.22 **For 2010-11, we recommend no increase on the national salary scales/pay thresholds for the pre-2003 and post-2003 consultant contracts.**

2.23 For independent contractor GMPs, **we recommend that the overall value of General Medical Services contract payments be increased by a factor intended to result in no increase to general medical practitioners' net income after allowing for movement in their expenses**. Using 0 per cent for GMPs' income uplift along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 1.34 per cent. Therefore, **we recommend that an uplift of 1.34 per cent be applied to the overall value of General Medical Services contract payments for 2010-11 for general medical practitioners**.

2.24 We encourage the parties to have further discussions on the question of how to distribute our recommended uplift. However, if they fail to reach agreement, **we recommend that half of our recommended overall gross uplift to contract payments be applied to the following five elements of the General Medical Services contract, in proportion to their current relative spend: global sum; correction factor; Quality and Outcomes Framework; enhanced services; and locum payments; and that the other half of our recommended overall gross uplift to contract payments be applied to global sum payments with no corresponding increase to correction factor payments, and that resources released through reductions in minimum practice income guarantee correction factor payments should be reinvested back into the global sum, further uplifting global sum funding and reducing the number of practices on the minimum practice income guarantee.**

2.25 For general dental practitioners in England and Wales **we recommend that the gross earnings base be increased by a factor intended to result in no increase to general dental practitioners' net income after allowing for movement in expenses.** Using 0 per cent for general dental practitioners' income uplift along with our recommended increase for expenses, our dental formula gives an overall percentage rise of 1.44 per cent. Therefore, **we recommend that an uplift of 1.44 per cent be applied to the gross earnings base under the new contract for 2010-11 for general dental practitioners in England and Wales.**

2.26 The contracts for GDPs in Scotland and Northern Ireland are very different to those for England and Wales and a different approach is needed. Therefore **we recommend that Scotland and Northern Ireland should adjust their fee scales in order to allow for any changes to expenses. If the parties do not have evidence for the current year to enable them to make the adjustments to the fee scales in Scotland and Northern Ireland to account for expenses, then we recommend that they use the adjustment that we have identified as being appropriate for 2010-11 in England and Wales, which is an increase to each fee scale item of 1.44 per cent. For the element within each item-of-service in the fee scales in Scotland and Northern Ireland that represents income, we recommend no increase. We also recommend no increase to commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland.**

2.27 **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 per cent for 2010-11.**

2.28 We estimate the cost of our recommendations[22] for doctors and dentists in the Hospital and Community Health Services to be 0.5 per cent of pay bill. This estimate does not include independent contractor GMPs and GDPs, for whom we are recommending a zero increase in net income.

[22] Cost estimates are rough approximations using a number of assumptions. They are based on the projected 2010-11 pay metrics for England only, provided in the Health Departments' evidence, and scaled up for the United Kingdom according to total pay bill figures from 2007-08, the latest year for which data are available for all four countries.

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 in the primary care sector of the NHS under one of the contracting routes: General Medical Services (GMS), Personal Medical Services (PMS) in England, Section 17C arrangements in Scotland, Alternative Providers of Medical Services (APMS), or Primary Care Trust Medical Services (PCTMS). The glossary at Appendix E explains these terms further. We are concerned only with GMS which is governed by a United Kingdom-wide contract, and we understand from the NHS Information Centre that approximately half of GMPs have GMS contracts.[23] Doctors working under PMS, Section 17C arrangements, APMS or PCTMS contract locally with primary care organisations (PCOs) or, in some cases, strategic health authorities. However, local PMS contracts and Section 17C arrangements tend to follow the main features of the GMS contract, although not obliged to.

3.2 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; some practices also belong to sole practitioners and some to companies which employ salaried doctors to staff them. The Health Departments told us that around 90 per cent of independent contractor GMPs' earnings came from contracts for the provision of public sector work, i.e. primary medical care services to NHS patients. However, unlike in other small businesses, a significant amount of the costs are provided out of public funds. In addition, whilst the doctors contribute to a defined benefit pension scheme, the balance of the costs of the scheme over members' contributions is funded by the Health Departments and therefore very secure. Such a benefit would not typically be funded by a small business.

3.3 The number of salaried GMPs employed by practices has increased substantially in recent years and continues to do so. Salaried GMPs are employed either by PCOs or by independent contractor practices. The pay range for salaried GMPs is at Appendix A.

3.4 The latest data show that at 30 September 2008 there were over 45,000 GMPs in practices with NHS contracts in the United Kingdom.

The evidence

3.5 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 C). The evidence covered a range of issues affecting GMPs, in addition to income levels, including the GMP trainers' grant and the supplement to pay received by GMP registrars, and these issues are addressed in the following paragraphs.

[23] This is a lower proportion than previously thought as there was a substantial correction made to the split for 2006 onwards.

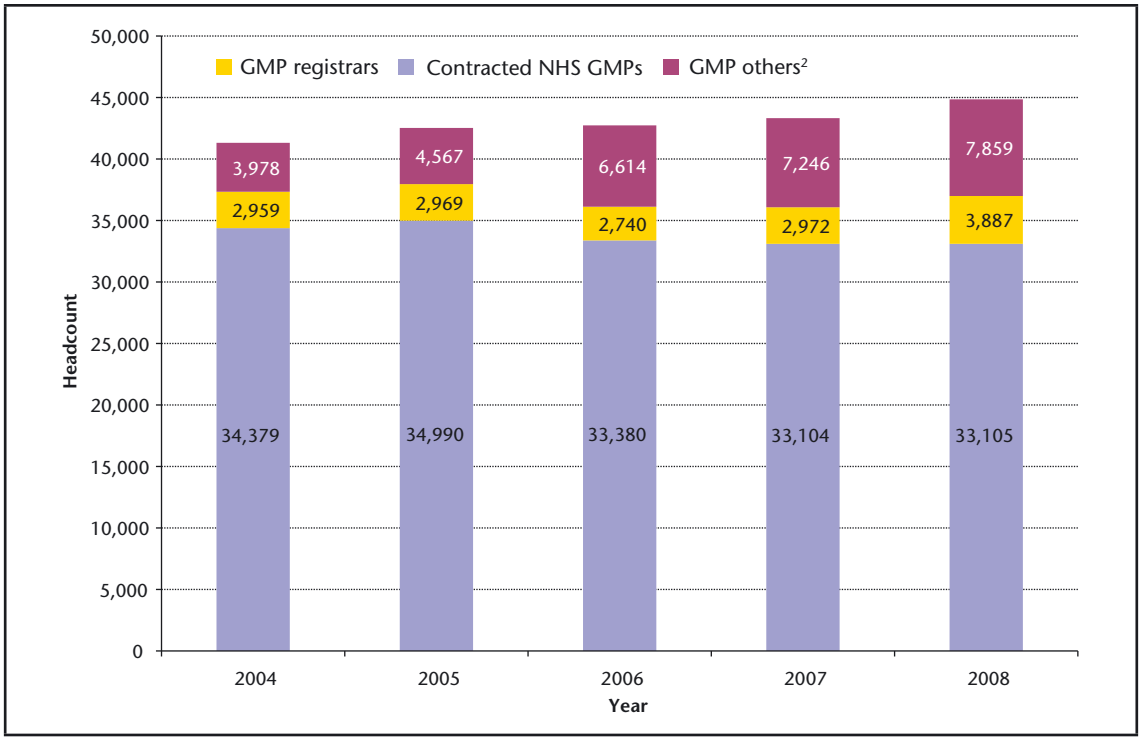
Recruitment and retention

3.6 Both the Health Departments and NHS Employers told us that there was no evidence to suggest that there were recruitment or retention problems for GMPs. NHS Employers said that the job market appeared to be buoyant and that practices were able to fill vacancies without significant problems. They noted that where problems were experienced in filling vacancies, these were generally attributed to the geographic location of practices rather than the level of pay on offer.

3.7 The Department of Health noted that long-term vacancy rates among GMPs remained unaltered at an estimated 0.3 per cent, after three successive years of decreasing vacancy rates, and the estimated three-month vacancy rate for GMPs had fallen from 2.4 per cent in 2005 to 0.3 per cent in 2009, maintaining the same level as in 2008 and representing the lowest level for a considerable time. The Welsh Assembly Government (WAG) said that while the vacancy rate appeared to have risen slightly to 0.9 per cent in 2008, there was no evidence of difficulties in filling posts; the GMP vacancy rate was below 1 per cent for the third year in a row. It reported that the three-month vacancy rate per 100,000 population was 0.5. The Scottish Government Health Department advised us that there were very few GMP contractor vacancies arising in Scotland, and the number of contractor GMPs had remained stable since 2003-04. In Northern Ireland shortfalls in the GMP group were being predicted, largely due to assumed high levels of demand for flexible working. The Department of Health, Social Services and Public Safety in Northern Ireland also told us that the earlier average retirement age for GMPs pointed to a probable increased rate of departure for these professionals over the next ten years. Finally, the Health Departments reminded us that before the introduction of the new GMS contract, GMP recruitment and retention had been a significant problem, but since then there had been dramatic improvements. The Health Departments said that although the number of GMPs and trainee GMPs continued to grow, in England the increase over the past year related entirely to salaried GMPs, with the number of GMP providers remaining constant. The Department of Health expected the trend of increasing numbers of salaried GMPs to continue. However, NHS Employers told us that several primary care trusts (PCTs) had indicated that they were starting to see a number of practices recruit partners again. They said that while older partners continued to retire, experienced salaried GMPs were now being given the opportunity to become partners as an incentive for them to stay at the practice.

3.8 The BMA commented that while the decrease in the number of contractor/performer GMPs had been arrested in 2008, the trend in the number of salaried GMPs had continued with a 10.3 per cent increase. It said that salaried GMPs now comprised almost one fifth of the United Kingdom general practice medical workforce, compared to only 8 per cent in 2004 when the new GMS contract was introduced.

Figure 3.1: Number of general medical practitioners, 2004 – 2008, Great Britain[1]



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

Notes:

1. Northern Ireland data not included as a GMP breakdown is not available.

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

3.9 As Figure 3.1 shows, the number of contracted GMPs has remained roughly constant since 2004. However the total number of GMPs has risen, mainly due to a significant increase in the number of salaried GMPs and those who work flexible arrangements. There was also a substantial increase of almost a third in GMP registrars between 2007 and 2008. We therefore do not find any cause for concern in the recruitment and retention of GMPs.

Motivation

3.10 The evidence on motivation was somewhat mixed. The Health Departments and BMA both commented on the fifth worklife survey conducted by the National Primary Care Research and Development Centre in February 2009.[24] The Health Departments noted that since the introduction of the new contract, overall satisfaction had improved significantly and 83 per cent of GMPs aged under 50 said they had either no intention or only a slight intention of leaving direct patient care over the next five years. After peaking in 2005, however, following the introduction of the new GMS contract, there had been significant declines in satisfaction with hours of work and remuneration. GMPs had also expressed the highest ever levels of stress caused by adverse publicity in the media and changes imposed by PCTs. The BMA said that these variables had all improved following the introduction of the new contract, and it was disappointing that the position had now begun to deteriorate. However, we note that although there had a been a decline in job satisfaction since the 2005 worklife survey, overall worklife satisfaction for GMPs remains at an acceptable level.

[24] Mark Hann et al. *Working conditions and job satisfaction of GPs: findings from the fifth national GP worklife survey.* National Primary Care Research and Development Centre, September 2009. Available from: http://www.npcrdc.ac.uk/pr41

Workload

3.11 The Health Departments told us that average working hours for GMPs were significantly lower than before the new contract. They said that over the past ten years, the average number of patients per medical practitioner in England had gradually fallen almost every year, and that this was mainly as a result of the increased number of GMPs. They noted that there had also been a significant increase in the number of practice staff involved with direct patient care since 1998, including practice nurses. The number of patients per practice had grown steadily each year from 1998 to 2008. At the same time, the number of practices had decreased year on year, reflecting a move towards larger practices employing more GMPs and registering more patients. This trend was also evident in the decline of single-handed GMPs in 2008. Although the number of consultations had risen, more patients were seen by nurses and other clinicians than before. They believed that changes in skill mix in general practice were compensating for increased complexity of workload. Practitioners in primary care worked closely with nurses, midwives and health visitors, and giving GMPs the flexibility to design services had made it possible to alter the skill mix to free up their time and improve patient access. The Health Departments believed that this rightly freed up GMPs to deal with the more complex cases, but also enabled them to reduce their average working week and/or increase personal income. In addition, more GMP consultations were taking place over the telephone. The Health Departments noted that the growth in GMP earnings was considerably higher over the period 2002 – 2007 than the growth in consultations, and that net earnings per consultation had increased from £12 in 2001 to £19 in 2007. The length of time GMPs spent on individual consultations had increased and was thought to reflect the fact that patients were being cared for longer in primary care settings and the incentives in the Quality and Outcomes Framework (QOF) for more systematic evidence based medicine. They said that the time spent by a GMP on home visits had fallen since 1992-93 from around 22 patients to around eight patients per week. Most GMPs had exercised their right to opt out of providing some services, such as out-of-hours care. Working hours were now on average three hours per week lower than before the introduction of the new GMS contract.

3.12 NHS Employers commented that they were not aware of any firm evidence in the public domain that proved either way that the workload of GMPs was any more or less complex. However, there was strong evidence available that clearly demonstrated that the workload of GMPs, when measured by the number of hours worked per week, had reduced significantly since the introduction of the new GMS contract.

3.13 The BMA believed that there was a case for recognising increases in the workload of GMPs. It observed that the crude consultation rate continued to rise and achievement under the QOF continued to improve from a very high base. In addition, it pointed out that there was a workload consequence from the cessation of the access directed enhanced service: if practices chose to continue to work at 2007-08 levels, they would suffer an effective funding cut, and so the majority of practices in England, Wales and Scotland were working longer hours in 2008-09 and 2009-10 than in previous years in order to earn back this 'lost income'.

Independent contractor general medical practitioners

3.14 The new GMS contract for GMPs was introduced throughout the United Kingdom on 1 April 2004. The contract is with the practice rather than with individual GMPs and allows for gross income under several different headings, including: basic services or global sum; enhanced services; PCO administered funding; and QOF payments. The glossary at Appendix E gives further information on these and other aspects of the GMS contract.

3.15 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.

3.16 In deciding the uplift for independent contractor GMPs for 2010-11, we are using a similar approach to last year, using a formula that takes into account our intended net uplift, staff costs and other costs. This formula again uses the data sources we selected and applied last year. The Health Departments and NHS Employers also think it appropriate for our formula to take account of efficiencies. We address each of these elements in the following paragraphs.

3.17 For our intended income uplift, we believe this year that independent contractor GMPs should have the same income uplift recommended for our senior remit groups working in the Hospital and Community Health Services and for general dental practitioners. This increase is 0 per cent. We set out our arguments as to why we think this appropriate for this year in more detail in Chapter 2.

3.18 As independent contractors, GMPs are ultimately responsible for setting the pay of the staff they employ; they are bound to pay neither *Agenda for Change* rates nor the *Agenda for Change* level of uplift. However, for the element of staff costs within our formula, both the Health Departments and the BMA have suggested that *Agenda for Change* rates will be paid and we therefore use 2.25 per cent, which is the increase that applies for 2010-11 under the third year of the *Agenda for Change* pay agreement. Latest data from the NHS Information Centre which uses HM Revenue and Customs (HMRC) data shows staff costs to account for 59 per cent of all costs.

3.19 For other costs, we continue to believe that the Retail Prices Index excluding Mortgage Interest Payments (RPIX) is the most suitable price index because premises costs are reimbursed and are therefore 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 2.8 per cent. Latest HMRC data shows other costs to account for 41 per cent of all costs.

3.20 Turning to the suggestion from the Health Departments and NHS Employers that our approach should take account of cash releasing efficiency savings, we continue to believe that it is unnecessary and inappropriate to include efficiency savings in our funding formula for GMPs as the impact of efficiency savings will become apparent, albeit with a time lag, in the data that we use in our formula. As we have indicated in Chapter 1, future data on practice earnings and expenses will show trends and the proportion of profit that GMPs are taking as income.

3.21 The latest data on GMPs' earnings, expenses and income continues the trend that we observed last year that the expenses to earnings ratio is moving back towards the traditional 60:40 split (see Table 3.1).

Table 3.1: General medical practitioners' earnings, expenses and income, 2003-04 to 2007-08, United Kingdom

Financial Year	Gross Earnings	Total Expenses	Net Income (before tax)			Expenses to Earnings Ratio
				Annual Increase	Increase from 2003-04	
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%	34.9%	55.1%
2006-07	£247,362	£139,694	£107,667	-2.1%	32.0%	56.5%
2007-08	£251,997	£145,925	£106,072	-1.5%	30.0%	57.9%

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

3.22 The Department of Health presented evidence to us showing that 10 per cent of costs are reimbursed directly by PCTs, and the BMA has not disputed this. Expressing each component of the formula as a percentage of non-reimbursed gross earnings gives the following:

- income is 40 per cent of total gross earnings which represents 44.4 per cent of non-reimbursed gross earnings;
- staff costs are 59 per cent of total gross earnings which represents 39.3 per cent of non-reimbursed gross earnings; and
- other costs are the remaining 16.2 per cent[25] of non-reimbursed gross earnings.

3.23 Putting all of this information into our formula for calculating the gross uplift to contract values gives the following:

$$Uplift_{2010\text{-}11} = 0.444 * x + 0.393 * AfC_{2010\text{-}11} + 0.162 * RPIX_{Q4}$$

where

x = 0 per cent income uplift

$AfC_{2010\text{-}11}$ = 2.25 per cent

$RPIX_{Q4}$ = 2.8 per cent

3.24 For independent contractor GMPs, **we recommend that the overall value of General Medical Services contract payments be increased by a factor intended to result in no increase to general medical practitioners' net income after allowing for movement in their expenses**. Using 0 per cent for GMPs' income uplift along with our estimated increase for expenses, our medical formula gives an overall percentage rise of 1.34 per cent. Therefore, **we recommend that an uplift of 1.34 per cent be applied to the overall value of General Medical Services contract payments for 2010-11 for general medical practitioners**.

[25] These figures sum to 99.9 rather than 100 due to rounding.

3.25 We then move on to the issue of how our recommended increase to contract values should be distributed. The BMA said that while it remained committed to moving practices off the minimum practice income guarantee (MPIG) in the long-term, practice stability should be the priority in the current economic climate. It believed the most appropriate solution for 2010-11 was for a flat increase to practice funding streams to ensure that, as a minimum, practices' expenses were covered. The Health Departments told us they were committed to ensuring a more equitable distribution of funding for GMP practices, and that they wanted to see any gross uplift applied in such a way as to continue to reduce reliance on the MPIG. They proposed that the whole amount of any gross uplift should be applied to increased global sum payments, with no corresponding increase to correction factor (the global sum equivalent) or to other contract payments. They also proposed that resources released through reductions in MPIG correction factor payments should be reinvested back into the global sum, further uplifting global sum funding and eroding the number of practices on MPIG. NHS Employers were in agreement with the Health Departments' proposed method of distributing the funding.

3.26 We find it frustrating that the parties have been unable to agree a method as to how our recommended uplift should be applied to the contract. For the last round, we received a joint letter[26] from the parties that said there would be differential uplifts to the global sum and global sum equivalent in order to reduce general practice reliance on correction factor payments under the MPIG, and that they had agreed the principle that there should be a comparable process to achieve the same aim in future years. This year, negotiations have been unsuccessful. The BMA believes that some practices are in danger of becoming unstable, whilst the Health Departments said that their preferred strategy was to reduce inequalities in funding by giving proportionately more uplift to practices without MPIG.

3.27 We are not in a position to say whether the current method of funding is appropriate or not, or if any practices would be unstable if funding increases were concentrated into practices without MPIG. This is properly a matter for the parties to negotiate. Nevertheless, we are required to make a recommendation for this year, so we have concluded that the most appropriate recommendation is that half of our recommended overall gross uplift to contract payments be applied to the following five elements of the GMS contract, in proportion to their current relative spend: global sum; correction factor; QOF; enhanced services; and locum payments; and that the other half of our recommended overall gross uplift to contract payments be applied to global sum payments with no corresponding increase to correction factor payments, and that resources released through reductions in MPIG correction factor payments should be reinvested back into the global sum, further uplifting global sum funding and eroding the number of practices on MPIG. For next year, we expect the parties to be able to reach an agreed position via negotiation.

3.28 We encourage the parties to have further discussions on the question of how to distribute our recommended uplift. However, if they fail to reach agreement, **we recommend that half of our recommended overall gross uplift to contract payments be applied to the following five elements of the General Medical Services contract, in proportion to their current relative spend: global sum; correction factor; Quality and Outcomes Framework; enhanced services; and locum payments; and that the other half of our recommended overall gross uplift to contract payments be applied to global sum payments with no corresponding increase to correction factor payments, and that resources released through**

[26] Review Body on Doctors' and Dentists' Remuneration. *Thirty-eighth report.* Cm 7579. TSO, 2009: Appendix F. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

reductions in minimum practice income guarantee correction factor payments should be reinvested back into the global sum, further uplifting global sum funding and reducing the number of practices on the minimum practice income guarantee.

Seniority payments

3.29 Independent contractor GMPs are also eligible for seniority payments. The Health Departments observed that seniority payments were negotiated under the new GMS contract in 2003 as a retention incentive, particularly aimed at GMPs approaching retirement. However, they believed that these payments were at odds with a practice based contract, and noted that we had raised concerns in the past about the effectiveness of seniority payments, particularly whether GMPs in receipt of seniority payments were more productive. They had no evidence to suggest improved productivity and told us that this was an area that they were considering as part of wider steps to move towards more equitable funding of general practices as part of negotiations with the BMA. The BMA pointed out that seniority payments had existed for many years prior to the new contract, although they were improved under the new contract with a view to progressively rewarding experience. It believed that the failure to uprate them since 2005-06 remained a significant anomaly.

3.30 Last year we made no recommendation on seniority payments as they formed part of the methodology agreed between the parties for the uplift of independent contractors' pay. However, we have commented in previous reports on our discomfort over the potential unfairness of seniority payments, which may not apply to all parties to the contract, and for which there is no evidence of increased productivity, such as more or better care for patients, by those in receipt of the payments. As we have said before, we support the payment of rewards to those who perform best, but to avoid any risk of discrimination we believe that the performance should be objectively demonstrated in each case. Furthermore, we note that seniority payments form part of wider negotiations between the Department of Health and the BMA and we urge the parties to make progress on this issue. For these reasons we have excluded seniority payments from our recommendations on the uplift to the GMS contract and **we recommend that for 2010-11, seniority payments for general medical practitioners remain at their current levels.**

Salaried general medical practitioners

3.31 In the financial year 2007-08 the average net income of salaried GMPs was £55,790. However, as we have noted before, many salaried GMPs work part-time, the average number of hours per week being 23.8 hours in 2006-07. As 2006-07 was the most recent workload survey,[27] we do not know if the average amount of part-time work per week has increased since then.

3.32 The Health Departments sought an uplift of up to 1 per cent to the pay range, in line with (non-consultant) hospital doctors, for salaried GMPs employed by PCTs or other NHS organisations. They said that the salary range for salaried GMPs employed by PCOs (agreed May 2003) was designed to encompass the range of possible GMP roles, with starting pay, progression and review to be determined locally. It was broadly in line with the pay range for associate specialist hospital doctors. They noted that a further 2,170 salaried GMPs had joined the workforce in the year to September 2008 and they expected the trend of increased numbers of salaried GMPs to continue.

[27] *GP Workload Survey,* 31 July 2007. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-workload-survey

They said that it was a decision for GMP partners, as owners of the business, at individual practices to decide whether they wished to recruit additional partners, or instead to recruit a salaried GMP. They also pointed out that existing GMP partners had an incentive not to replace retiring partners as it meant the profits from the practice were then split fewer ways and each remaining partner received a greater share. However, they noted that as a consequence of such decisions, the partners would themselves be taking on greater responsibility for the business management responsibility of the practice, and ultimately care of the patients registered with that practice. They believed that partners would always be judging between the competing factors of increased profits and increased workload. They also noted that the government's responsibility was to deliver fair and equitable access to appropriate resources to enable contractors to meet their obligations, not to fund a particular approach to staffing and skill mix. The WAG told us that since the changes introduced in 2004, Local Health Boards had been encouraged to make full use of salaried contracts and that this had created new employment opportunities for doctors who did not wish to enter business as independent contractors.

3.33 NHS Employers sought an increase to the pay range for salaried GMPs consistent with that for other directly employed doctors. They observed that demand for this group of staff continued to be high, that the majority of employers believed that the pay range was appropriate, and that there were no recruitment problems. They had continued to press the BMA to enter into discussions on updating the model offer letter and terms and conditions of service for salaried GMPs.

3.34 The BMA asked for a percentage uplift to the range for salaried GMPs in line with that for employed doctors generally, and pointed out that this uplift also set a benchmark for practice-employed doctors. It told us that, where arrangements for annual increases existed in contracts, it was usual for these to be linked to our recommendations for PCO-employed salaried doctors or to the award for GMP principals. Even where such arrangements did not exist it believed that it was useful for such doctors to have a reference point to use in negotiation. It told us that salaried GMPs now comprised almost one fifth of the United Kingdom general practice medical workforce, compared to only 8 per cent in 2004 when the new GMS contract was introduced. It noted that the proportions of salaried GMPs in Scotland and Wales were substantially lower (at 11 per cent and 8 per cent respectively) than in England. It said that the growth in the salaried workforce at the expense of an increase in partners entailed these doctors taking on additional duties and responsibilities compared with salaried doctors in the past. It reported that the incomes of salaried GMPs rose on average by 3.4 per cent in 2007-08. In part, it believed that this increase may have been a consequence of an expansion in full-time equivalents, but it noted that median earnings were lower than mean earnings which suggested to the BMA that the data were also distorted by a small number of comparatively high earners. Asked about its apparent reluctance to enter into discussions with NHS Employers over the model offer letter and terms and conditions of service, the BMA said that it believed that the salaried GMP contract offered an appropriate balance between the needs of the employing practice or PCO and the salaried GMP. It said that the risk of attempting to alter the contract at a time of limited resource may alter this balance adversely one way or another. It did not believe that it was in the best interests of salaried GMPs to make changes at this time.

3.35 We continue to believe that the current pay range for salaried GMPs is appropriate and that it is 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. We also contend that the salary range 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 recommend that the minimum and the maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2010-11.**

Locally determined contractual arrangements

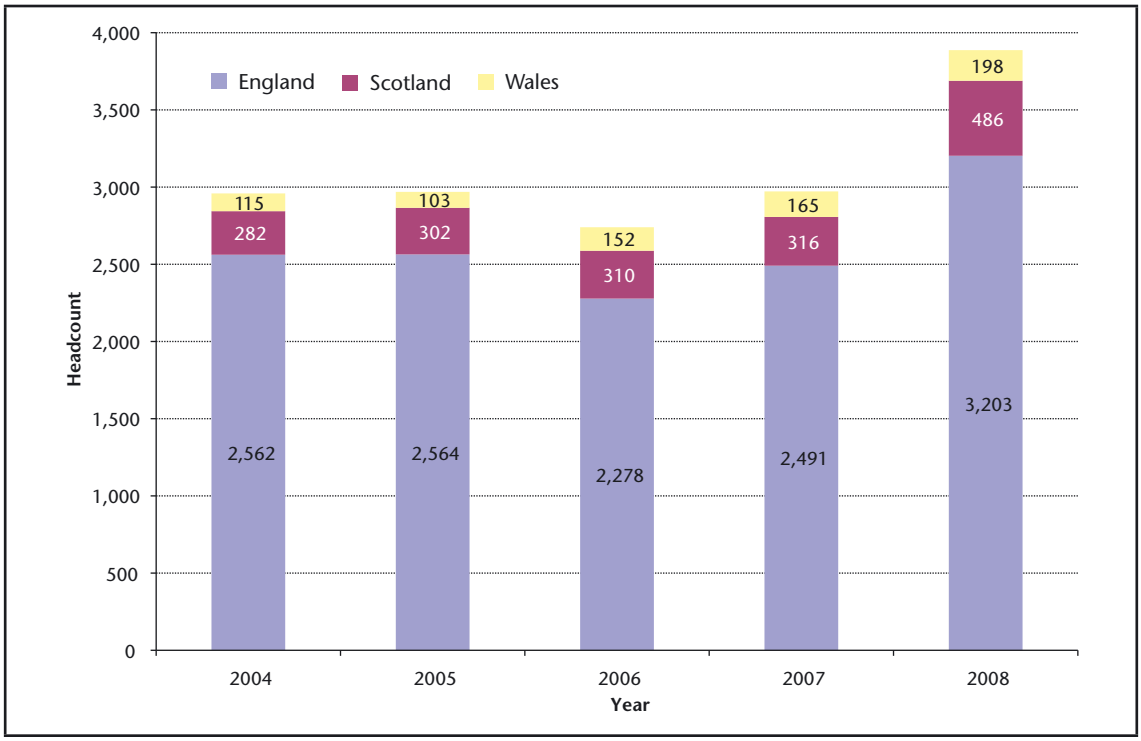
3.36 Our recommendations for independent contractor GMPs apply solely to the United Kingdom-wide GMS contract; locally determined contractual arrangements including PMS, APMS and Section 17C arrangements are all outside our remit. Nevertheless, our recommendations do inform the awards given to contractors working under locally determined contractual arrangements.

3.37 While we note that the BMA has again expressed concern that many PCOs are apparently not making similar changes to PMS contracts and Section 17C arrangements as are applied to GMS contracts, we agree with the Health Departments that any uplifts in investment for locally determined contractual arrangements are ultimately a local matter. Notwithstanding this, we are pleased that the government remains committed to maintaining, as far as possible, fair and equitable funding for the different contracting routes. NHS Employers reported that a significant number of new contracts were being let as APMS, as this allowed more flexibility than GMS to negotiate services that were tailored to local need. We note from the Health Departments that where GMPs operating under PMS contracts feel that they are being disadvantaged, they have a right of return to the GMS arrangements that operate at that time. The Health Departments said that there appeared to be no exodus of PMS contractors wishing to revert to GMS contract arrangements to obtain the level of payments set through the Review Body process. It is not clear to us, however, how easy it would be to move between contracts, should GMPs so wish.

General medical practitioner registrars

3.38 As Figure 3.2 shows, the number of GMP registrars in Great Britain increased by almost a third between 2004 and 2008, with large increases in all three countries.

Figure 3.2: Number of general medical practitioner registrars, 2004 – 2008, 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.

3.39 The GMP registrars' supplement was introduced at a time when recruitment to general practice was poor. The glossary at Appendix E provides a brief explanation. The Health Departments asked that the GMP registrar supplement be held at 45 per cent for 2010-11 as they did not want there to be any disincentive to entering general practice and wished it to be financially attractive. They said that GMP registrars received this substantial supplement despite having working patterns that were less intense than doctors training in hospitals. They told us that the number of doctors applying for general practice in 2009 had reduced by a third, but said that this reflected the overall decrease in applicants for speciality training. They suggested that the interest in GMP training may be affected by the reduction in the registrars' supplement, and a perceived shortage of partnership opportunities, but that the NHS had not experienced any significant difficulties in filling training places. The apparent difficulties in filling GMP registrar posts in Scotland in 2009 were thought to be due to having an exceptionally high number of posts to fill following the creation of a significant number of four year programmes in general practice training. The numbers of GMPs in training were higher than ever before and there were no difficulties attracting high-quality applicants for these training places. The Health Departments saw no basis therefore for the argument that there were problems with GMP recruitment. They said that the GMP registrars' supplement was not intended to reflect the work intensity of GMP registrars. It was intended to ensure that doctors who opted to train for a career in general practice were not financially disadvantaged compared with the average hospital doctor in training. They said that the 45 per cent supplement was in line with the average banding supplement paid to specialist registrars in April 2009 (46 per cent in England), although we note that in Scotland, the average banding supplement for doctors in training was still over 55 per cent.

3.40 NHS Employers said that that as recruitment to GMP training programmes continued to be strong, the argument for a recruitment payment for GMP registrars was weakened and they believed that it was appropriate to reduce the GMP registrars' supplement further to reflect the hours and intensity of registrar postings. They said that it could be reduced to 40 per cent for those entering GMP training placements after April 2010. They told us that there appeared to be a general consensus among those responsible for GMP training that the employment arrangements for GMP trainees should be aligned with those of hospital trainees and that this would facilitate the movement of trainees from trust to general practice and vice versa; parity should therefore be the long term aim. However, progress towards aligning the contractual arrangements would take time. They said that to pay GMP registrars on the same basis as a hospital trainee would see the supplement reduce from its current level of 45 per cent to between 20 per cent and 40 per cent, and in the case of those few GMP registrars undertaking little or no out-of-hours work it would be eliminated. They noted that general practice was the only medical specialty that did not have pay determined by reference to its working arrangements; they also noted that the reduction of maximum working hours meant that the average pay supplement for hospital trainees was now 45 per cent, which might make parity easier to achieve.

3.41 The BMA was disappointed that we had chosen to recommend a further reduction in the supplement for GMP registrars for 2009-10, and it remained very concerned about the impact of the continued erosion of the supplement on current and future training in general practice. It held strong views that general practice training was qualitatively different from hospital training (for example, GMP registrars worked alone with patients and were supervised only from a distance) and believed that, until there was an acceptable unified contract, a comparison between the two in order to determine the GMP registrar supplement was unjust. It disagreed that the working pattern for GMP registrars was less intense than that of hospital trainees and said that it was too simplistic to make a comparison between general practice and hospital placements on the basis of hours of work alone; because such a direct comparison between hospital training and general practice training was impossible, it believed that the supplement for general practice training should be considered in its own right. GMP registrars had seen their supplement decrease without any changes to their own training and workload, which the BMA believed to be grossly unfair. The erosion of the supplement had meant that some GMP registrars would be paid a lower supplement in their final year of training than they were paid whilst on their first six month period of training. This eliminated any incremental pay increase GMP registrars were supposed to receive to reward them for gaining additional skills and knowledge and for practising at an increasingly independent level. Any further reduction in the supplement would continue this trend and significantly impact on the morale and motivation of these trainees, as well as being counterintuitive in terms of remuneration policy. The BMA wanted the supplement restored to 50 per cent, its level before the reduction in 2009-10. It was concerned that GMP training was decreasing in popularity, and believed that the ability to recruit into the five year training programme currently under consideration would be affected if GMP registrars were to be subjected to a further erosion of pay. Disputing the Health Departments' claim that the NHS had not experienced any significant difficulties in filling training places, the BMA said that the overall number of applications to GMP training programmes in 2009 had decreased, despite an increase in the number of posts offered, and it noted that the overall number of applications from United Kingdom foundation trainees was lower than the number of GMP training posts available.

3.42 The GMP registrars' supplement was introduced at a time when recruitment into general practice was poor and 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. The evidence suggests that there are no major causes for concern

with recruitment among GMP registrars. However, we are aware that the NHS is moving towards greater delivery of care through primary care, which could mean an increase in the number of GMP posts. The Health Departments have asked that the supplement be held at 45 per cent for 2010-11 as they do not want there to be any disincentive to entering general practice and wish it to be financially attractive; in our view this is the most appropriate level for the supplement for 2010-11. Therefore, **we recommend that for 2010-11 the supplement for general medical practitioner registrars should remain at the current rate of 45 per cent.** However, we consider that should there be doctors currently receiving the higher protected level of the supplement,[28] they should keep their existing entitlement rather than see their pay supplement reduced.

General medical practitioner trainers' grant

3.43 The Health Departments sought an uplift to the GMP trainers' grant of no more than the increase proposed for non-consultant hospital doctors, i.e. up to 1 per cent. They noted that they had indicated previously their intention to hold discussions around the future of the GMP trainers' grant, which stood at £7,598 in 2009-10, but reported that these discussions had not yet taken place because of potential significant changes to the way training in general practice was funded, whereby remuneration for training would become practice based rather than GMP trainer based. Subsequently, during oral evidence, the Health Departments told us that work was ongoing on the review of GMP trainers and that they were now looking at funding. They hoped that new arrangements would be in place by April 2011, but said that negotiations needed to take place. However, in their main evidence they said that they continued to believe that the Multi Professional Education and Training (MPET) review, rather than the GMP trainers' grant, would provide a more appropriate means of addressing issues in respect of the cost of providing training in general practice. They told us that they were also working with the Royal College of General Practitioners (RCGP) to review the contents and requirements of the GMP specialty training programme. The profession wished to extend the length of the GMP specialty training programmes, particularly the amount of time spent in GMP practice placements, and this would have a significant impact on the NHS budget and may change the responsibilities of GMP trainers. They suggested that until this report was received from the RCGP, they were not in a position to take a view on how the responsibilities of GMP trainers would change.

3.44 The BMA expressed concern that while the MPET funding review continued to be delayed, the additional commitment and workload of GMP trainers remained unrewarded. It noted, in particular, that the replacement of summative assessment by workplace based assessment had increased the volume of work involved and hence the extent of supervision involved. It believed that the current training grant did not cover fully the time involved in monitoring, completing assessments, the e-portfolio, reading shared entries, marking against set competencies and preparing for tutorials. It sought some interim recognition pending the completion of the review.

3.45 We are also concerned at the apparent inertia in completion of the various reviews and consequent deferral in holding discussions around the future of the GMP trainers' grant. A review of the GMP trainers' grant has been promised by the Health Departments for several years and in expectation of this we have held off recommending anything other than an increase for the GMP trainers' grant in line with other fees and allowances. In view of the ongoing delays we do have some

[28] Review Body on Doctors' and Dentists' Remuneration. *Thirty-eighth report*. Cm 7579. TSO, 2009: paragraph 3.77. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

sympathy with the BMA's view that there should be some interim recognition for GMP trainers pending completion of the review. However, we also consider that any changes to the level of the trainers' grant should reflect changes to their responsibilities, but we have not been provided with sufficient evidence that would allow us to make such an assessment. On balance, therefore, we believe that until the reviews are complete we should simply continue to increase the value of the trainers' grant in line with the other fees and allowances on which we are required to make recommendations. Therefore **we recommend that the general medical practitioners' trainers' grant be increased by 1 per cent for 2010-11.** We ask the parties to give priority to this issue and to update us for our next review.

General medical practitioner educators

3.46 The Health Departments said that GMP educators should not receive any uplift to their pay scale in accordance with their proposal for consultant doctors, and in line with the government's wider approach to senior pay in the public sector this year. They said that they had seen no evidence to suggest that this pay scale needed to be amended.

3.47 The BMA drew our attention to the recent *United Kingdom Conference of Educational Advisers' Workforce Survey Report*.[29] It noted that the survey findings were generally positive and confirmed to some extent the BMA's view that GMPs regarded this work (in common with work as GMP trainers) as important and worthwhile and were prepared to undertake it regardless of inadequate material rewards. The report also concluded that while medical staff employed in deaneries continued to be generally happy with their employment, there was concern about reduced remuneration compared to clinical activity, heavy workload, and inadequate human resource and infrastructure support. The report said that the remuneration per session for primary care medical educators remained considerably lower than GMP clinical pay, and reports from new staff and those leaving deanery employment underlined the gap between clinical earnings and income from deanery employment. The report pointed out that it was only in the United Kingdom Conference of Educational Advisers' last two surveys that inadequate remuneration had been offered as a reason for leaving deanery employment. The BMA sought at least the same increase in salary scales for GMP educators as for salaried doctors and suggested that we monitor the relationship between these scales and the absolute level of contractor income to ensure that the present recruitment position did not deteriorate.

3.48 As GMP educators are not self-employed we believe it is appropriate to draw a parallel with other salaried GMPs. Therefore **we recommend that the general medical practitioner educators' pay scale should rise by 1 per cent for 2010-11** in line with our recommendation for salaried GMPs.

[29] *United Kingdom Conference of Educational Advisers' Workforce Survey Report*. UKCEA, July 2009.

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. As we conduct this review, GDPs in England and Wales are in the fourth year of working under the new NHS contract which was independently reviewed since our last report by a committee headed by Professor Jimmy Steele.[30] Following the introductory three-year contractual period, 2009-10 is the first year of full commissioning.[31] Dental services in Scotland, too, have changed over the decade as a result of the implementation of the then Scottish Executive's *Action Plan.*[32] Additionally there are plans in Northern Ireland for a new contract which is now expected to be piloted in 2010. Both Scotland and Northern Ireland have a remuneration system for General Dental Services (GDS) 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 in these two countries. Because of the differences between the approach to NHS dentistry in England and Wales and those in Scotland and in Northern Ireland, we present some of the evidence for the three systems separately, later in this chapter.

4.2 In 2008-09, 21,343 dentists in England had NHS activity recorded;[33] an increase of 528 (2.5 per cent) on 2007-08, the first year of the new dental contract system. There were 1,293 dentists in Wales with NHS activity recorded; an increase of 46 (3.7 per cent) on 2007-08. As at 30 September 2008, there were 2,703 dental practitioners registered to provide NHS treatment in Scotland; an increase of 157 (6.2 per cent) on 30 September 2007. As at 31 October 2008, there were 819 GDPs registered to provide NHS treatment in Northern Ireland; an increase of 24 (3.0 per cent) on 31 October 2007.

The evidence

4.3 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). We also received written evidence from ADP Dental Co. Ltd (a corporate provider of primary dental care). The main written evidence can be read in full on the parties' websites (see Appendix C). 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.

Reactions to our last report

4.4 Last year's GDP recommendations, in particular the 0.21 per cent uplift to the gross earnings base, produced strong reactions from some of the parties. We note the issues raised; in particular that the BDA and ADP Dental Co. Ltd have both requested that last year's uplift be retrospectively adjusted. However, we do not agree that this is required or appropriate. The formula that we use for making an uplift for GDPs is based on the most recent data, although these can still be some years out of date. Therefore, any

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[30] *NHS dental services in England: an independent review by Professor Jimmy Steele*. Department of Health, June 2009. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137

[31] The process of primary care organisations (PCOs) buying dental services in a full market from the most appropriate bidder. See the glossary at Appendix E for further information.

[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).

changes to the expenses or income of dentists which have occurred since the publication of data used in our formula will be incorporated when data sources are updated and therefore automatically be part of a future GDP formula uplift.

Recruitment, retention and access to dental services

4.5 Alongside other considerations, our remit requires us to take account in our recommendations of a core element of the NHS: that patients should be placed at the heart of all it does. In the context of dentistry we see this expressed through improving access to NHS dental services which we consider alongside the recruitment and retention of the dentists who provide this access.

4.6 The Department of Health's evidence stated that there were 2,738 applicants from the United Kingdom as a whole for undergraduate dental degrees through the Universities and Colleges Admissions Service for 2008-09. Applicant numbers were 2.4 times the number accepted and almost 50 per cent higher than five years earlier in 2003-04. The Department of Health also provided written evidence on access. Dental services provided in England and Wales are measured by the annual level of units of dental activity (UDAs). The level of service is reported as courses of treatment, but these are converted into UDAs based on the most complex component of the courses of treatment. The Department of Health told us that, in 2008-09, dentists delivered 81.4 million UDAs, 4.4 million more than in 2007-08, and access had risen with almost three quarters of a million additional patients seen in the last four quarters.[34] The volume of services commissioned in the year up to June 2009 was 4.3 per cent greater than for the year up to June 2008. The glossary at Appendix E contains information on UDAs and full courses of treatment.

4.7 The Scottish Government Health Department (SGHD) told us that the number of graduates from Scottish dental schools was predicted to rise over the next five years and that the total number of dental students in the Scottish dental schools was now higher than at any time in the past 20 years. The SGHD said that it was undertaking a further dental workforce review which it hoped to complete by the end of 2010.

4.8 The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) informed us last year that the Minister had approved a tender exercise for the provision of an additional 38 health service dentists in 15 locations across Northern Ireland. The DHSSPSNI told us that this would provide access to health service dentistry to an additional 57,000 patients across the province, in areas which were deemed to be particularly problematic for access. It also said that the cost of the subsequently awarded contract compared favourably with current rates of GDS expenditure.

4.9 NHS Employers again told us that primary care trusts (PCTs) were successfully tendering for new services thus improving access to NHS dentistry. However, they said PCTs were still reporting difficulties in attracting dentists to work in rural areas. NHS Employers went on to say that, instead of a blanket pay award to address the levels of pay, PCTs would rather this was left to local discussion to resolve. NHS Employers also informed us that PCTs were not persuaded that there was a strong link between the level of our award and the recruitment and retention of staff. Practices that experienced difficulties in recruiting or retaining staff were sometimes reported to be out-dated and needing investment. NHS Employers concluded that there was therefore no requirement for us to make a high award to improve recruitment or retention.

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[34] *NHS Dental Statistics for England: 2008-09.* The NHS Information Centre, 19 August 2009. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-for-england:-2008-09

4.10 The BDA reported again that some vocational dental practitioners had difficulty 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 was unchanged, with almost one in five reporting that they had not yet found a post; a figure comparable with research in the previous three years. Additionally, the BDA repeated last year's comment that vocational dental practitioners' trainers had seen an increase in their workload. It said that, in England and Wales, the fact that trainers could not guarantee keeping their vocational dental practitioners on at the practice after a successful training year had proved so frustrating that some had given up on being a trainer. The BDA again hoped to undertake joint research on this for next year. Finally, the BDA drew our attention to planned moves towards private practice reported in its yearly survey of members. It noted that all four United Kingdom countries had reported a large proportion of dentists agreeing or agreeing strongly that they planned to increase their amount of private practice work. This ranged from 53 per cent in Scotland to 79 per cent in Northern Ireland. These figures compared with smaller planned increases in NHS work that ranged from 7 per cent in Wales to 10 per cent in England and in Northern Ireland.

4.11 As we have said in our previous reports, we see both workforce numbers and the consequent patient access provided 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 continuing to increase. We also note that PCTs in England are reporting few difficulties in tendering additional services and are unconvinced that a larger uplift would assist where they are experiencing problems. However, there is some evidence that Northern Ireland is experiencing difficulties and has increased services in response. We will continue to monitor closely the recruitment and retention of dentists and the access they provide.

Motivation

4.12 Last year we asked the parties to consider a joint survey on the motivation and morale of GDPs, in line with the yearly NHS staff surveys. The Department of Health told us in written evidence this year that it hoped to work with the BDA and NHS Employers on such a joint survey for next year's evidence.

4.13 The BDA noted from its own survey[35] that the United Kingdom had only a minority of dentists reporting that their morale was high or very high. This ranged from 25 per cent in Wales to 40 per cent in Scotland. These figures compared with those reporting their morale as low or very low ranging from 21 per cent in Scotland to 31 per cent in Wales and Northern Ireland. This is the first year that the BDA has provided results by United Kingdom country. Within this the BDA provided survey results collected on the morale of dentists by NHS commitment by country. It again told us that morale was worse amongst those dentists with a high commitment to the NHS. It noted that dentists with the least commitment to the NHS were more likely to report their morale as high or very high. In addition, the BDA noted that committed NHS dentists also reported lower levels of job satisfaction.

4.14 We note the Department of Health's commitment to a joint survey on motivation and morale and look forward to hearing of further progress in this area. Additionally, we welcome the new country information from the BDA and look forward to seeing

[35] *Business trends and workload survey.* British Dental Association, 2009.

further results in future years to make comparisons; we appreciate the difficulties in collecting consistent data on these issues. We are particularly interested in tracking job satisfaction for dentists with differing levels of NHS commitment as we are concerned that dentists with high levels of NHS commitment have comparatively low levels of job satisfaction, which could impact on NHS commitment in the future.

Dental strategy and contracts in England and Wales

4.15 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 UDAs. PCOs agree contract values with providers 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 unless the provider and performer are one and the same. The link between the contract uplift and the performer's earnings is a matter for local negotiation between the provider and the performer. The glossary at Appendix E contains information on providers and performers.

Changes to the dental contract from April 2009

4.16 When the new GDS contract was introduced, it was agreed that contract values would be uplifted by our recommendations for the first three years and that income from the contract was guaranteed for those three years (subject to the achievement of UDA targets). That agreement expired in March 2009. Since then, the parties have asked us to continue to recommend yearly uplifts to existing contracts. This year we asked the parties for their views, now that full commissioning (see the glossary at Appendix E for more details) was in place, on whether it was reasonable for PCTs and Local Health Boards to agree an uplift to each contract with the providers, taking into account local circumstances, including the position on dental expenses.

4.17 The Department of Health told us that, although services were locally commissioned, the contracts for these services were still part of an overall national framework governed by national regulations. Dentists' net income from providing NHS services was linked, amongst other factors, both to local commissioning decisions and to the national framework. The Department said that it continued to believe that there was a useful and valid role for an independent pay review body to help ensure, through recommendations on annual uplift, that on average these net incomes struck the right balance in terms of affordability, recruitment, retention and other relevant factors. Over time, the Department said it might envisage that these recommendations should be more explicitly directed to PCTs rather than to itself, so that they informed local decisions on contract uplift.

4.18 NHS Employers told us that they valued the opportunity to input the views of PCTs into the current review body process. However, if the current process were to change, they concurred with the view that it would be reasonable and appropriate for PCTs to agree an uplift to each contract with the providers, taking into account local circumstances, including the position on dental expenses.

4.19 The BDA said that it believed we had a key role in providing an efficient way of determining increases in gross contract values in England and Wales. It said that passing responsibility to PCOs would result in significant duplication of effort on the part of both

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

PCOs and contractors. With PCO resources increasingly stretched, it believed having a central process made financial sense. The BDA also said that there was precedent from pre-2006 Personal Dental Services contracts to lead it to believe that PCOs, with their superior bargaining position, would, perhaps understandably, prefer to spend on short-term NHS priorities, rather than on annual rises in dental contract values. This would lead to long-term deterioration in the availability of service, inhibit continuous improvement and would have a detrimental effect on the NHS dental workforce. It felt we could provide a balanced view and promote equity for dentistry in the health service.

4.20 The DPA said in oral evidence that it did not think that PCTs were efficient enough to set the pay (and agree uplifts) to individual contracts; PCTs were essentially monopsony employers. It also said it felt that many PCTs did not have the expertise to negotiate fairly, suggesting that some contracts were awarded without an open bidding process in operation. The DPA said that our role should be determining the global sum (i.e. the dental budget for the NHS).

4.21 All parties were agreed that we should continue to make a recommendation on a national uplift to contract values at the present time. Consequently, we will continue to make recommendations on the national uplifts whilst this remains the view of the parties. However, we do not believe that it is within our remit to determine the global sum and see this as a role for the Health Departments.

Clawback

4.22 The issue of clawback was raised again this year by the BDA. It drew our attention to the fact that 41 per cent of contracts had failed to achieve their UDA target in 2008-09; a small decrease from 44 per cent in 2007-08. The BDA saw missed dental appointments as having played a part in this. We continue to hold the view that clawback is primarily related to the issue of determining a reasonable level of activity under the contract. Consequently, while we note these concerns, we see this still as a matter for local negotiation on a contract-by-contract basis rather than a matter for us. The glossary at Appendix E contains information on clawback.

Independent review of NHS dentistry led by Professor Jimmy Steele

4.23 All parties drew our attention to the publication of *NHS Dental Services in England*.[37] In evidence from the unions, and in our visits to dental practitioners, in recent years we have heard much dissatisfaction with the current dental contract (the contract is not, of course, within our remit). We note the recommendations made by this review and look forward to hearing of progress on their implementation as they impact on our remit.

Dental contract review groups in Wales

4.24 The Welsh Assembly Government (WAG) told us that the work of the dental contract review groups had continued during the year. In addition to the completed review of the community dental service[38] in Wales, a review of vocational training and the future of general professional training had reported in January 2009 and work had commenced in September 2009 to review orthodontics. The WAG also reported to us that work continued towards future action in testing new models of dental care in Wales.

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[37] *NHS dental services in England: an independent review by Professor Jimmy Steele*. Department of Health, June 2009. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137

[38] These are salaried dentists.

Capital support and practice goodwill

4.25 The BDA said in written evidence that 7 per cent of practice owners in England and 12 per cent in Wales had tried to sell their practices since 2006; 37 per cent of those in England found that the PCO refused or made it difficult for them to transfer their NHS contract to the new owner. In response to further questions about how additional funding might combat this, the BDA told us that it envisaged practice owners receiving compensation when their NHS practice was closed or sold without an NHS contract being continued from the same address. This would occur in circumstances where the PCO did not re-contract with a proposed purchaser who was otherwise qualified to take on an NHS contract. The BDA suggested that the amount of the allowance might be calculated on the basis of a percentage of the NHS contract value aggregated over, say, the previous five years.

4.26 Whilst this issue is not within our terms of reference, we believe it could impact upon future recruitment, retention and access. We therefore request the parties to provide further evidence on the number of refusals to re-contract with proposed purchasers, including the overall percentage, for next year.

Earnings and expenses in England and Wales

4.27 In August 2009, the NHS Information Centre published HM Revenue and Customs (HMRC) data on England and Wales dentists' earnings and expenses in the financial year 2007-08.[39] These data were referred to by the parties in written evidence. Not all these data are directly comparable with those produced for previous years due to changes in the contract and also in the presentation of results. Table 4.1 and Figure 4.1 compare the income and expenses of GDPs who spend 75 per cent or more of their hours on NHS dentistry in the two financial years available since the new contract. In general, taxable income levels are below those of 2006-07 and expenses are also lower (due to non-staff costs).

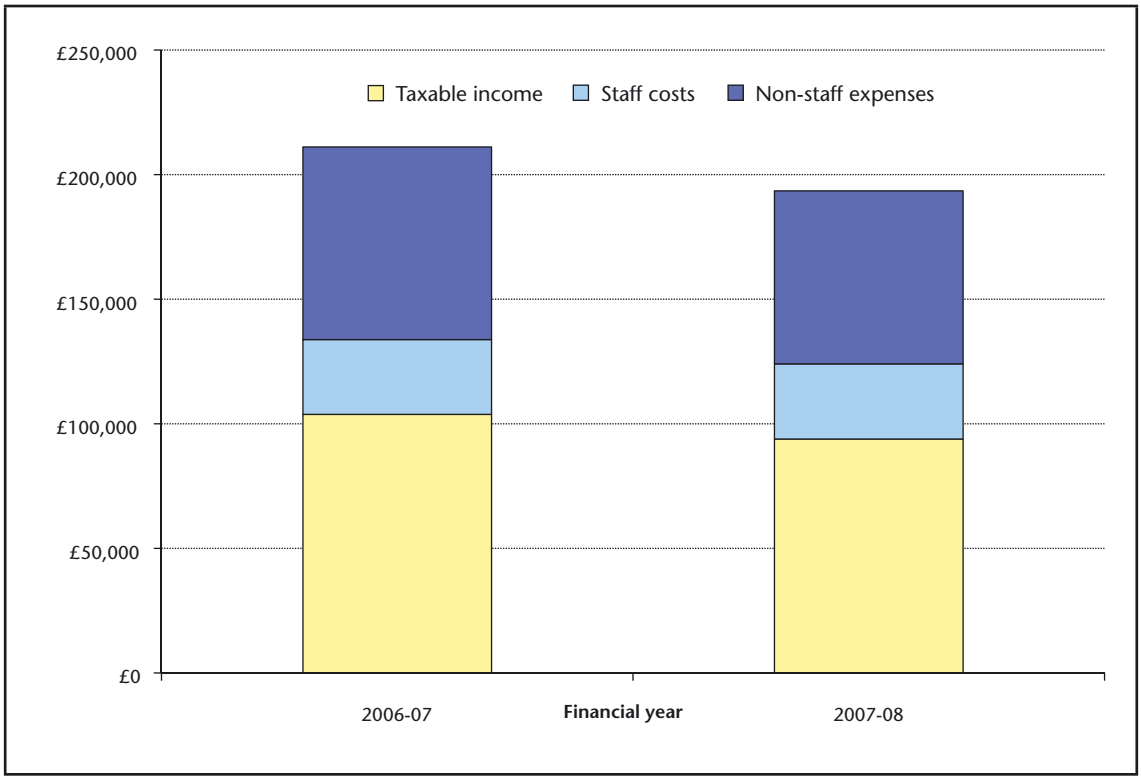
Table 4.1: A breakdown of average gross earnings (NHS and private) for all dentists with 75 per cent or more NHS commitment, England and Wales, 2006-07 and 2007-08

	Taxable income	All expenses	Staff costs	Non-staff expenses
2006-07	£103,774	£107,324	£30,032	£77,292
2007-08	£93,891	£99,589	£30,157	£69,432
Percentage change	-9.5%	-7.2%	+0.4%	-10.2%

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

[39] *Dental earnings and expenses: England and Wales, 2007/08*. NHS Information Centre, 4 August 2009. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-england-and-wales-2007-08

Figure 4.1: A breakdown of gross earnings (NHS and private) for all dentists with 75 per cent or more NHS commitment, England and Wales, 2006-07 and 2007-08[40]



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

The expenses to earnings ratio

4.28 The expenses to earnings ratio[41] for all dentists was 54.0 per cent in 2007-08 (53.4 per cent in 2006-07) and was 51.5 per cent (50.8 per cent in 2006-07) for dentists where 75 per cent or more of their working hours were spent on NHS dentistry. The percentage that staff costs represent of total expenses was 30 per cent in 2007-08 (from 28 per cent in 2006-07[42]) for all dentists with 75 per cent or more NHS commitment.

Income of providers and performers

4.29 The NHS Information Centre report also covered the incomes of dental providing-performers and performer only dentists separately. These data revealed that, in 2007-08:

- among providing-performer dentists 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 £133,000. Dentists who devoted between 25 and 75 per cent of their time to NHS work earned less; on average £126,000. Dentists who devoted 25 per cent or less of their time to NHS work earned the least with an average of £110,000; and

[40] Strictly speaking, these years are not comparable in terms of methodology, even though they are both based on tax returns. However, this should mainly affect taxable income rather than expenses. See paragraph 4.30 for further details.

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

[42] This figure was used in the formula for last year's report.

- among performer only dentists 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 £68,000. Dentists who devoted between 25 and 75 per cent of their time to NHS work earned more; on average £75,000. Dentists who devoted 25 per cent or less of their time to NHS work earned the most with an average of £77,000.

These orderings are the same as observed for 2006-07.

4.30 The NHS Information Centre commented on the lack of comparability between financial years. It said that the introduction of new dental contractual arrangements on 1 April 2006 did not allow for comparisons to be made between earnings data in the 2005-06, 2006-07 and 2007-08 *Dental Earnings and Expenses Reports for England and Wales*.[43] Transitional scheduling of payments to dentists from both the old and new contracts – primarily to those performing more orthodontic work than non-orthodontic work, but also to those performing a majority of non-orthodontic work – would have affected gross earnings (and therefore taxable income) in 2006-07; as these were one-off issues, income was not affected in 2007-08, and so the two years were not comparable. We note these issues which affect the levels of taxable income, staff expenses and other expenses. However, the division of gross earnings between taxable income, staff expenses and other expenses is relatively stable, so we continue to use these proportions in our formula.

Expenses data from other sources

4.31 In response to our request for further expenses data, the NHS Information Centre report included information from the National Association of Specialist Dental Accountants (NASDA) and Morris and Co. Specialist Dental Accountants. These sources are not directly comparable with NHS Information Centre data, but provide more detailed expenses data. See Table 4.2 for the data provided.

Table 4.2: Expenses types as a percentage of gross income, England and Wales

Data	Data provider	Practice type[1]	Year		
			2005-06	2006-07	2007-08
Non-clinical staff wages	NASDA	NHS	18.2%	17.3%	17.9%
		Private	17.2%	17.4%	17.8%
Laboratory costs	NASDA	NHS	6.4%	5.6%	6.1%
		Private	8.9%	7.8%	7.6%
Materials costs	NASDA	NHS	5.6%	5.0%	5.6%
		Private	6.7%	7.0%	7.5%
Other non-staffing costs	Morris and Co.	NHS	16.4%	16.8%	15.7%
		Private	23.0%	23.2%	23.6%

[1] NHS practices are those with at least 80 per cent NHS activity whilst private practices are those with at least 80 per cent private activity. All other practices are excluded.

[43] *Dental earnings and expenses: England and Wales, 2007/08*. NHS Information Centre, 4 August 2009. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-england-and-wales-2007-08

4.32 The Department of Health referred to the *Provisional Clinical Dental Report*[44] which gave figures for 2008-09. It again said that evidence clearly showed that, under the new contract, dentists were carrying out simpler courses of treatment since 2003-04. The Department of Health stated that the overall reduction in advanced treatments[45] was about 27 per cent and the reduction in the weighted average for other treatments was 16 per cent. It stated that dentists were carrying out about 30 per cent fewer advanced treatments and about 20 per cent fewer other treatments (compared with the figures of 33 per cent and 21 per cent given last year for the fall between 2003-04 and 2007-08) after taking into account the reduction of 5 per cent in weighted courses of treatment under the new contract. Additionally, in response to our recommendation last year that the parties work together, or commission joint independent work, on dental expenses, focusing specifically on the non-staffing element, the Department of Health told us it hoped to work jointly with the BDA and NHS Employers to examine expenses factors in more detail for next year's evidence.

4.33 NHS Employers told us that once again PCTs had reported that practices were not always passing on pay increases to their staff. This continued to be a matter of concern and created a perception that GDS contractors were using the awards to maintain and improve profits. Additionally, NHS Employers told us that PCTs reported having seen no evidence of any increase in expenses at present. However, anecdotally, contractors had highlighted their increased costs to PCTs in a number of areas this year; many of which required an initial capital investment. They noted that one area in which there may have been an increase in expenses was the costs associated with meeting the new decontamination and infection control standards. NHS Employers also said that there had been no evidence that there had been any increase in laboratory fees.

4.34 The DPA told us in written evidence that costs had gone up. It said that, on average, a private practice was now spending £250,000 on materials, laboratory bills, wages, direct costs, and overheads while NHS practices spent around £220,000; equivalent to 65 per cent and 59 per cent of practice fee income, respectively. The DPA also told us that NASDA statistics showed a considerable variation in the rate paid for UDAs, with £24.38 being the average for practices and £16.20 the lowest.

4.35 The BDA told us in written evidence that it sought a recommendation that the Health Departments work with it to undertake a comprehensive timings exercise[46] to develop a more suitable method of determining the cost of providing dental services. The BDA also reported to us feedback from a members' survey[47] illustrating how the amount of clinical dentistry where laboratory work was required had changed since 2006 in the item-of-service fees system in Scotland and Northern Ireland and, by contrast, in the UDA contract system in England and Wales.

- In Scotland and Northern Ireland 37 and 31 per cent of members, respectively, reported an increase in the amount of clinical dentistry where laboratory work was required, compared to 13 and 17 per cent of members reporting a decrease.

- In England and Wales 23 and 15 per cent of members, respectively, reported an increase in the amount of clinical dentistry where laboratory work was required, compared to 35 and 32 per cent of members reporting a decrease.

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[44] *Provisional clinical dental report, England and Wales: quarter 3, 31 December 2008 – experimental statistics.* NHS Information Centre, 2009. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/provisional-clinical-dental-report-england-and-wales:-quarter-3-31-december-2008--experimental-statistics

[45] This covers crowns, bridgework and dentures.

[46] The purpose of a timings exercise is to determine how long it takes, on average, to undertake specific items of treatment, with the intention, in the past, of determining an hourly rate for general dental practice.

[47] *Business trends and workload survey.* British Dental Association, 2009.

4.36 ADP Dental Co. Ltd told us that support staff costs had increased, particularly due to the costs of General Dental Council registration and increases in the costs of training and examinations. It also presented evidence from the *Dental Directory*,[48] a leading supplier of dental materials, showing that the supplier had raised its prices by an average of 21.3 per cent; it noted that it had no reason to doubt that this was not true across the whole industry. On the subject of laboratory costs, ADP Dental Co. Ltd included a letter demonstrating a 20 per cent rise in the cost of what it said was the most common and lowest price item.

4.37 On the issues raised, we see the use, or not, of a timings exercise as a contract issue and therefore not within our remit. On the subject of joint independent work on dental expenses, we hope that progress will now be made for next year.

Dentistry in Scotland

4.38 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 GDS 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. The list of item-of-service fees is being reviewed.

4.39 The SGHD commented on the allowances which are available to dentists in Scotland: the general dental practice allowance; the remote area allowance; the sedation allowance; the recruitment and retention allowance; and a deprived areas allowance. The glossary at Appendix E contains information on these allowances.

4.40 The BDA also updated us on the effects of decontamination requirements. Trials in Scotland, where strengthened decontamination requirements recommended the use of a local decontamination unit, showed that the capital cost was in the range of £25,000 to £45,000 per practice. Additionally, the BDA reported the example of the NHS Borders dental capital project, where the cost of equipping a unit in a six-surgery practice was found to be around £30,000. As we said last year, we see the issue of funding decontamination as a matter for the parties to negotiate. We continue to 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.

Earnings and expenses in Scotland

4.41 The SGHD told us that the lack of dental earnings information was due to Scotland's absence from the NHS Information Centre survey this year, and said that alternative means of calculating dental earnings had been discussed. Unfortunately, the SGHD had been unable to find an alternative means of measuring dental expenses in the short timescale.

4.42 Aware of the absence of comparable earnings data, the BDA obtained evidence from NHS National Services Scotland. This information came from NHS dentist claims and therefore showed earnings excluding allowances and private work; it was not comparable with the NHS Information Centre figures published for the other United Kingdom countries. These figures showed that average earnings rose from £80,800 in 2004-05 to £84,800 in 2008-09 – a rise of 5 per cent over four years, with most of

[48] *The Dental Directory: online dental product catalogue.* Available from: https://www.dental-directory.co.uk/DentalDirectory/Default.aspx

this increase occurring in the last year. The BDA noted that allowances were regarded as an important element of dental practice funding and any increase only in fees and other payments left a significant proportion of total funding unchanged.

4.43 The BDA also gave us some information on laboratory costs. It told us that information from the Scottish Dental Practice Board showed that, between 2004-05 and 2006-07, the cost as a proportion of total NHS turnover for items with laboratory work remained stable at 33.5 per cent in Scotland.

Dentistry in Northern Ireland

4.44 The DHSSPSNI has overall responsibility for the provision of health service dentistry by GDPs in Northern Ireland. In turn, each commissioner is responsible for 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 the GDS contract 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.

4.45 In response to our request last year for further details of the centrally-funded allowances available to dentists in Northern Ireland, the DHSSPSNI and the BDA have informed us of the practice allowance, the commitment allowance, vocational training payments, and re-imbursement of non-domestic rates. The glossary at Appendix E contains descriptions of these allowances. The parties also updated us on the new contract negotiations which have been in progress since Northern Ireland became part of our remit two years ago. They told us that, while the intention had been to pilot a new contract late in 2009, this may now be delayed until the following year.

4.46 The DHSSPSNI reiterated that, in recent years, there had been evidence of a drift of dentists moving from the public to the private sector. This resulted in access difficulties in certain parts of Northern Ireland. Despite significant investment in 2007 in health service dentistry totalling £7.7 million, the drift and resultant budget underspend had continued until the end of 2008-09. Consequently, the DHSSPSNI said that, in April 2009, in recognition of delays in negotiating the new Northern Ireland dental contract, and the negative reaction by the BDA to our 2009 settlement, the Minister agreed to substantially increase another allowance paid to dentists, the commitment allowance. This effectively provided an additional payment of 1.5 per cent of total GDS contract spend.

4.47 We note the differences between Northern Ireland and the situations in England and Wales and in Scotland. We also note the current funding arrangement 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 for the next round.

Earnings and expenses in Northern Ireland

4.48 In August 2009, for the first time, the NHS Information Centre published HMRC data on Northern Ireland dentists' earnings and expenses.[49] These data were referred to by the parties in written evidence. We are pleased to note this new publication from the NHS Information Centre for Northern Ireland and hope it will become a regular annual report. Table 4.3 shows the breakdown of gross earnings of GDPs who spend 75 per cent or more of their hours on NHS dentistry in Northern Ireland.

[49] *Dental earnings and expenses*: *Northern Ireland, 2007/08, experimental statistics*. NHS Information Centre, 4 August 2009. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-northern-ireland-2007-08-experimental-statistics

Table 4.3: A breakdown of gross earnings (NHS and private) for all dentists with 75 per cent or more NHS commitment, Northern Ireland, 2007-08

	Taxable income	All expenses	Staff costs	Non-staff expenses
Amount of gross earnings	£65,253	£40,160	£7,593	£32,567
Percentage of gross earnings	62%	38%	7%	31%

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

The expenses to earnings ratio

4.49 The expenses to earnings ratio for all dentists in Northern Ireland was 53.4 per cent (compared to 54.0 per cent for England and Wales) and was 38.1 per cent for dentists where 75 per cent or more of their gross income came from NHS dentistry (which can be roughly compared with 51.5 per cent for dentists in England and Wales for whom 75 per cent or more of their working hours were spent on NHS dentistry). Whilst both total expenses and taxable income are less in Northern Ireland, this smaller ratio is due to total expenses also being a smaller proportion of gross earnings. Within individual expenses categories in Northern Ireland, the amounts are roughly half of those in England and Wales for most categories and the Northern Ireland amount for staff costs is less than a third of that for England and Wales.

Income of general dental practitioners

4.50 Among all Northern Ireland dentists who carried out some NHS work across the year, average taxable income, after expenses had been deducted, was lowest for dentists where 75 per cent or more of their gross income came from NHS dentistry. This is the opposite pattern to that for England and Wales where NHS commitment is measured by the proportion of time devoted to NHS work. Table 4.4 shows the average annual income for Northern Ireland dentists with a range of NHS commitment according to income.

Table 4.4: Average annual income for dentists with a range of NHS commitment, Northern Ireland, 2007-08

Level of NHS commitment according to income	Average annual income
75 per cent or more	£65,000
Between 25 and 75 per cent	£108,000
25 per cent or less	£125,000

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

4.51 The DHSSPSNI told us that GDS expenditure had risen in recent months. This reversed a trend going back several years. It said that evidence of this increased expenditure would indicate that some dentists were returning to health service dentistry.

4.52 As for Scotland, the BDA gave us some information on laboratory costs; it told us that information from the Northern Ireland Central Services Agency showed that, between 2004-05 and 2006-07, the cost as a proportion of total NHS turnover for items with laboratory work rose from 32.1 per cent to 33.6 per cent in Northern Ireland. In addition, the BDA told us that Northern Ireland operated in a unique context. Laboratory work volumes could be expressed as a cost, given that each item carried a specific cost. In 2006-07, laboratory items made up 33.6 per cent of the gross cost of

patient care and treatment (excluding patient registration). In 2007-08 this figure was 33.5 per cent and in 2008-09 it was 32.9 per cent. The BDA concluded that laboratory volumes in Northern Ireland had been very stable.

Pay recommendations for 2010-11

4.53 The Department of Health asked for a zero uplift in gross contract values. It estimated that this would produce an increase of 0.6 per cent in net income for self-employed GDPs after applying an efficiency assumption of 1 per cent to the expenses element of the contracts. The WAG said that it supported the proposed nil uplift in gross payments to self-employed GDPs put forward by the Department of Health and the proposal to include an efficiency assumption of 1 per cent as part of the calculations. The SGHD said that, for independent GDPs, it recommended an inflationary increase on the element of item of service fee which related to costs. The DHSSPSNI said that, in view of the fact that implementation of a new dental contract was still some way off, and it was therefore unable to incorporate any assumptions relating to efficiency savings achieving a 0.6 per cent increase as was the case in England and Wales, there was scope for a small increase, of up to 1 per cent, in Northern Ireland. It therefore recommended an uplift of up to 1 per cent for GDPs.

4.54 The SGHD told us that, whilst it was recognised that our past practice of updating sessional fees by the gross contract uplift had resulted in a higher value overall than if the salaried (income or net) uplift had been applied each year, its view was that this approach needed to be rectified and it proposed that, from this year onwards, the salaried (income or net) uplift should be applied to this fee. The DHSSPSNI commented in written evidence on the application of the yearly uplift. It confirmed that it applied the percentage increase to each individual fee, and that no award was made if the fee did not rise by more than 5 pence.

4.55 NHS Employers told us that they believed that there should be a 0.21 per cent uplift to the gross contract values in GDS. This was because of the affordability concerns of PCTs who believed that if we were to recommend a large uplift in 2010-11, this could severely inhibit their ability to invest in new and additional services, and in responding to the needs of patients. NHS Employers told us that it believed it was likely that opportunities would be available to GDPs during 2010-11 to earn significant additional income from locally negotiated contracts and that practices had the ability to deliver cash releasing efficiencies.

4.56 The BDA asked us to revert this year to the formula in the 2008 report until such time as the parties were able to agree an alternative, based on longer-term figures. As part of this, the BDA asked us to make an award of 3.6 per cent on taxable income to reflect the pay awards made in the public sector. Separately, the BDA commented on the application of the uplift to the fee scale in Northern Ireland. It said that the overall effect was to dilute the pay award from 0.21 per cent to 0.126 per cent for Northern Ireland. The BDA also commented on the treatment of allowances in Northern Ireland. It told us that, in the light of the direct correlation between volume of work and number of patients registered with the value of the practice allowance, it suggested that we should continue to make a percentage award in the same way as previous years as the award to fees was automatically reflected in the practice allowance.

4.57 The DPA said that the total increase in remuneration (net of expenses) required to recruit, retain and motivate NHS dentists taking into account their risk and workload for the financial year 2010-11 was 12.5 per cent. It saw the 12.5 per cent being composed of the combined effect of all economic factors (2.0 per cent), NHS contractual factors (including workload) related to the risk of working within the NHS (5.0 per cent),

recruitment factors (0.5 per cent) and factors impacting on the risk of working within the NHS and therefore retention, (5.0 per cent). In oral evidence, it told us that this proposed increase was aimed at placing NHS dentists on an equal footing with dentists doing private work.

4.58 ADP Dental Co. Ltd said that it wanted us to continue to calculate and recommend on contract values, by looking at both income and expenses, in our report.

4.59 In response to the evidence we received on the treatment of the uplifts, we propose a general approach. **We recommend that November 2007 be used as a base date in Scotland and Northern Ireland and uplifts are applied unrounded to the fee scales on a yearly basis with the final result being rounded up**.[50]

4.60 We appreciate hearing the BDA's views on how the Northern Ireland practice allowance could be taken into account in our recommendations. We urge all the parties to provide us with their views on how to take the Scotland and Northern Ireland allowances into account.

4.61 There are now effectively two dental systems operating in parallel within the United Kingdom. Scotland and Northern Ireland have retained the item-of-service system, although this may change in Northern Ireland with the proposed new contract. The current relationship between the fee and the underlying 'cost' is unclear, although it has a historical basis and Scotland is reviewing its fees. It is therefore very hard to know how appropriate the fee/cost relationship implied by the fee is, and we have little data to assist us. Additionally, both the SGHD and the DHSSPSNI have chosen to support NHS dentists' costs by means of a practice allowance. In England and Wales, on the other hand, there is a contract whose value is designed to deliver a specified output, cover the full costs of doing so and provide a fair income to the 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

4.62 In making our judgement on the uplift to GDPs' contract values we attempt to ensure that dentists' own remuneration and their practice expenses are both provided for. We use a formula to derive the expense elements and combine expenses with dentists' take-home pay.

4.63 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. To the extent that 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-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.

[50] The base year is November 2007 in England and Wales.

4.64 The Department of Health, NHS Employers and the BDA all raised specific potential changes to the formula or related issues. The Department of Health said it would be reasonable to assume in our formula that dental contractors could achieve at least a 1 per cent efficiency saving. It also commented that on current prospects for the Retail Prices Index (RPI) in the fourth quarter, the latest figures on staff wages and a 1 per cent efficiency gain, a 0.6 per cent increase in net pay would result from keeping gross contract values at the same level as now. The Department also told us it was not able to suggest a better indicator than RPI for this year. It believed that other indices such as the Producer Price Index had their own problems.

4.65 NHS Employers said that in order to ensure that any uplift was affordable to the NHS, they recommended that practices should be required to make an efficiency saving of 1 per cent. Taking this into account, NHS Employers believed an award of 0.2 per cent to gross contract values, would deliver a 1 per cent increase in GDP net pay. In response to further questioning, they said that GDPs had the opportunity to deliver efficiency savings and to increase their income by delivering more UDAs. A small increase in contract values would go some way to addressing a small increase in practice expenses. NHS Employers believed that GDPs had the ability to increase their net pay by up to 1 per cent by delivering an increased, more efficient service to patients. NHS Employers also reiterated their desire to work with us, the Department of Health and the BDA to examine and assess the components of a formula approach. They felt this should include investigating the possibility of taking into account other factors, such as expected efficiencies.

4.66 The BDA made a number of proposals regarding the dental formula for 2010-11, asking us to return to the formula used for the 2008-09 pay award until such time as the parties were able to agree a revised and appropriate methodology for the future; award a rise in taxable income of 3.6 per cent (which they said equated to public sector average earnings growth at July 2009); provide for a rise in staff costs of 3.6 per cent; and apply RPI current at the time of the award. The BDA also asked us to work with it to define an appropriate economic indicator to assess dental inflation, and on developing a formula that was more suitable to the dental economic environment. In addition, the BDA commented on the efficiency savings proposed by some of the Health Departments and by NHS Employers. The BDA told us that it did not understand how the Health Departments had calculated that these efficiency savings were possible and how they would necessarily be achieved equally in the four countries where the systems were so different. It found no attempt within their written evidence to explain their conclusion. The BDA was also concerned that there was an assumption from the Health Departments and NHS Employers that these savings could be made in the future.

4.67 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. As we say earlier in this chapter, we hope that the parties will work together on dental expenses with a view to giving us evidence on the formula and its elements for our next report.

4.68 Our formula involves weighting together the increase in the practitioners' personal remuneration and the increase in GDPs' expenses. The weights that were used last year for this split 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. Income now accounts for 48.5 per cent of gross earnings (down from 50 per cent), with expenses accounting for the remaining 51.5 per cent (previously 50 per cent). Staff costs now account for 30 per cent of total expenses (up from 28 per cent). These changes reflect the latest

HMRC data (for the financial year 2007-08) for dentists in England and Wales with 75 per cent or more NHS commitment.

4.69 This year we have chosen to continue with the split of non-staff expenses into laboratory costs, materials and other costs for the remaining 70 per cent of total expenses. This means we have four expenses elements to consider – staff costs, laboratory costs, materials and other costs. For the second year running, we have used NASDA data to split non-staff expenses into laboratory costs, materials and other costs as this provides a more detailed breakdown than the HMRC data from the NHS Information Centre. NASDA data gave a base of 9 per cent of expenditure as laboratory costs, 10 per cent as materials and therefore the remaining 51 per cent of expenditure was classified as other costs.

4.70 In our report last year, we proposed changing the formula to reflect the reduction in laboratory costs from 13 per cent to 9 per cent of expenditure – that is a reduction of 31 per cent – shown in the NASDA data. As NASDA data have now shown a slight reverse to this trend, we propose again changing our formula to reflect the increase in laboratory costs from 9 per cent to 10 per cent of expenditure – an increase of 11 per cent. We had some reservations in making this change as we do not propose to update this element on an annual basis and see such an amendment as the exception to normal practice. However, we are persuaded that this change of trend is due to a slight increase in laboratory work as the new contract reached its second year. Therefore we are reflecting this change in our approach and will continue to observe this element until it reaches a stable proportion of expenses within the new contract.

4.71 In looking for an appropriate indicator for GDPs' income uplift, we believe this year that GDPs should have the same income uplift recommended for our senior remit groups working in the Hospital and Community Health Services and for general medical practitioners. This increase is 0 per cent. We set our arguments as to why we think this appropriate for this year in more detail in Chapter 2.

4.72 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.

- 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 3.2 per cent for 2009,[51] the most recent figure available. This is different to the approach used for general medical practitioners (GMPs) where the *Agenda for Change* increase is used, as explained in Chapter 3.

- For non-staff costs, we considered using a different price index for the laboratory costs and materials elements than for the remaining elements of non-staff costs. We have decided to use the Retail Prices Index excluding Mortgage Interest Payments (RPIX), as these elements of dental expenses do not include premises costs. The RPIX annual increase for the last quarter of 2009 was 2.8 per cent and this figure is used in our formula.

- For all other costs we again use the RPI. The annual increase for the last quarter of 2009 was 0.6 per cent. We note that this increase is low due to the exceptional run of negative inflation which ran for eight months to October

[51] This is the median year-on-year change 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/DDRB_Main_Reports.aspx

2009. However, such outliers are why we use a quarterly figure and we accept that there are years when it will fluctuate.

4.73 Turning to the suggestion from the Health Departments and NHS Employers that our approach should take account of cash releasing efficiency savings, we continue to believe that it is unnecessary and inappropriate to include efficiency savings in our funding formula for GDPs. Our thinking is the same as for GMPs; that the impact of efficiency savings will become apparent, albeit with a time lag, in the data that we use in our formula. As we have indicated in Chapter 1, future data on practice earnings and expenses will show trends and the proportion of profit that GDPs are taking as income.

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

$$Uplift_{2010\text{-}11} = 0.4850 * x + 0.1545 * HRPS_{ASHE} + 0.0979 * RPIX_{Q4} + 0.2627 * RPI_{Q4} + 0.0464 * NASDA_{LAB}$$

where

x = 0 per cent income uplift

$HRPS_{ASHE}$ = 3.2 per cent

$RPIX_{Q4}$ = 2.8 per cent

RPI_{Q4} = 0.6 per cent

$NASDA_{LAB}$ = +11.0 per cent

4.75 **We recommend that the gross earnings base be increased by a factor intended to result in no increase to general dental practitioners' net income after allowing for movement in expenses.** Our dental formula gives an overall percentage rise of 1.44 per cent. Therefore, **we recommend that an uplift of 1.44 per cent be applied to the gross earnings base under the new contract for 2010-11 for general dental practitioners in England and Wales.**

4.76 The contracts for Scotland and Northern Ireland are very different to that for England and Wales and therefore a different approach is needed. Having received evidence from the parties and considered the issue we believe a two-stage approach is appropriate in Scotland and Northern Ireland, that firstly addresses the fee scales to take account of expenses, and that the fee scales are then uplifted to deliver our intended increase in net income.

4.77 On the issue of expenses, we believe that Scotland and Northern Ireland should make their own changes to individual items on the fee scale to allow for changes to expenses, where any additional costs are not accounted for by the various allowances that are available in those countries. Therefore, **we recommend that Scotland and Northern Ireland should adjust their fee scales in order to allow for any changes to expenses.** We note that each item-of-service within the fee scales will include two elements: an element to cover the expenses associated with performing each item-of-service and an element to deliver income. We believe that Scotland and Northern Ireland should adjust their fee scales to reflect changes to the 'expense' element of each item-of-service on an item-by-item basis where possible. However, if the necessary information is not available, an across-the-board adjustment should be made instead: this could be done using an approach similar to the one we use to calculate changes in expenses for England and Wales, but with reference to country-

specific data to reflect the different systems in Scotland and Northern Ireland. **If the parties do not have evidence for the current year to enable them to make the adjustments to the fee scales in Scotland and Northern Ireland to account for expenses, then we recommend that they use the adjustment that we have identified as being appropriate for 2010-11 in England and Wales, which is an increase to each fee scale item of 1.44 per cent.** For the next round, we ask both Scotland and Northern Ireland to clarify for us how they adjusted the fee scales for 2010-11 to take account of expenses.

4.78 We also believe that the fee scales should be adjusted on a yearly basis by our recommended uplift to deliver an increase in the element of each item-of-service that delivers income. For 2010-11, however, in line with our recommendation for net income for GDPs in England and Wales, **for the element within each item-of-service in the fee scales in Scotland and Northern Ireland that represents income, we recommend no increase. We also recommend no increase to commitment payments and sessional fees for taking part in emergency dental services in Scotland and in Northern Ireland**.

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 Primary Dental Services dentists, Dental Access Centre dentists and as salaried general dental practitioners in the NHS. There are approximately 1,300 salaried dentists in England, 120 in Wales, 538 in Scotland and 98 in Northern Ireland.

The evidence

5.2 Evidence on the Salaried Primary Dental Care Services (SPDCS) was provided to us this year by the Health Departments, the British Dental Association (BDA) and NHS Employers. The main evidence can be read in full on the parties' websites (see Appendix C). This year the issues the parties updated us on included what was happening with new terms and conditions in Scotland and Northern Ireland, a new specialty of Special Care Dentistry, possible problems with recruiting and proposals to add additional points to the band A pay scale.

New terms and conditions and the devolved administrations

5.3 We noted last year that new contractual arrangements for salaried dentists had been agreed in both England and Wales. The BDA told us that it was pleased to note that full implementation of the new arrangements had been achieved in most parts of England and Wales. NHS Employers said that overall implementation continued without major concerns, and that the full impact of the new contract and its benefit realisation for patients, employers and staff was still at an early stage. The Scottish Government Health Department (SGHD) told us that its intention had been for the amalgamation of the salaried general dental services with the community dental services from 1 April 2009, but that progress had been delayed by the need to address contractual issues: negotiations were therefore ongoing. It told us that a group comprising the SGHD, NHS Employers and the BDA had been set up to align the terms and conditions of service for the two groups of dentists, but that the change would be effected whilst keeping within the bounds of existing resources. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) told us that it was considering the potential costs and benefits of a new contract, but that proposals were at an early stage and would need Ministerial approval. The BDA said it continued to press for progress on the integrated salaried service in Scotland and that the differences with the salary scales in England were notable. It also told us that the intention in Northern Ireland was to base the new contract on the new model in England and Wales, and that the delay was due to a major financial review of general Northern Ireland finances.

5.4 We recorded our hope last year that consideration of new contractual arrangements would be given priority in both Scotland and Northern Ireland, and it is therefore disappointing to hear of the latest delays in both countries. We were somewhat surprised to read in the evidence from the SGHD that it hopes to align the terms and conditions of its salaried dentists within the existing budget: it has been usual practice when modernising terms and conditions to provide additional funding, and the SGHD may wish to give consideration to whether it can realistically achieve its aim without additional cost. We have previously voiced our concern about the potential problems for recruitment in Scotland, particularly in areas that are close to the border with England. This concern is reinforced by the BDA's observation that the salary scales in England appear more attractive, although we were told by officials from the SGHD during oral evidence that they were not aware of any recruitment problems.

Nevertheless, we urge both Scotland and Northern Ireland to give this issue a measure of priority, particularly as salaried dentists are the last of our remit group to receive modernised terms and conditions.

Motivation and workload

5.5 The BDA said that increasing workload and reducing budgets were affecting motivation and morale. It was also concerned about *Transforming Community Services*,[52] the focus of which was for primary care trusts (PCTs) to separate their commissioning and providing functions, and its implications for job security. The Department of Health said it would be supporting the NHS in better defining the role of salaried dentists to ensure that full account was taken of their service contribution as part of local work to transform the quality and productivity of community health services. NHS Employers said that the new contract included job planning, which it noted had been seen in comparable medical employment contracts as being beneficial to staff and patients. We are pleased to note that the Department intends carrying out further work to fully recognise the significant contribution of this important group of dentists. We also encourage the parties to make full use of the job planning aspect of the new contractual arrangements as a tool in controlling workload.

Special Care Dentistry

5.6 We note from the Department of Health that following the decision of the General Dental Council to recognise a new specialty of Special Care Dentistry, a small number of consultant posts and specialist training posts were being created, typically based within the SPDCS but with close links to other branches of dentistry. It said that appointments to such posts were made on the relevant generic doctors' and dentists' terms and conditions, and that consultants and training grades would therefore automatically receive the same uplift to pay and allowances as other medical and dental staff in those grades.

Recruitment and retention and the BMA's pay proposals for band A dentists

5.7 The BDA said that there were serious recruitment and retention difficulties for SPDCS posts, drawing on both its own *Clinical Directors Survey 2009*[53] and the national benchmarking survey 2009.[54] The *Clinical Directors Survey* showed that 69 per cent of respondents were experiencing difficulties in recruiting dentists, citing low applicant numbers, low quality applicants and ineligible applicants. The benchmarking survey reported that 75 per cent of respondents reported difficulties in recruiting band A dentists. The BDA pointed to the better pay that was available for general practice associates and suggested that the problems were due to pay levels that did not reward salaried dentists for the work they did and were not attractive to young dentists with student debts to repay. It asked us to recommend two additional incremental points to the top of the band A pay scale, and the deletion of two points from the bottom of the pay scale.

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[52] *Transforming community services: enabling new patterns of provision*. Department of Health, 13 January 2009. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

[53] *Clinical Directors Survey*. British Dental Association, 2009.

[54] NHS Benchmarking Network. *Benchmarking primary care salaried dental services: final project report – 27 August 2009*. NHS Primary Care Commissioning and NHS Benchmarking, 2009.

5.8 On the other hand, NHS Employers said the new contract was intended to improve recruitment and retention, and that their own survey of PCTs found that only four PCTs had reported difficulties in the preceding 12 months in recruiting salaried dentists. They said that this suggested that the situation may have been improved by the new contract, although it was too early to be conclusive. Where there were recruitment difficulties, they were caused by a shortage of appropriately skilled and experienced labour rather than a pay issue failing to attract available labour. After just 18 months, they said it was too early to say that the BDA was mistaken in freely entering into the agreement to introduce the new pay and conditions package. Where there were difficulties in service provision, they said that PCTs should consider the appropriateness of jointly commissioning services across larger urban areas, or commissioning from the General Dental Services (GDS). The Department of Health also said it had no reports of any notable recruitment difficulties, that the contract was a very recently negotiated and fully agreed pay system, and that it was much too early to be considering major changes.

5.9 The parties have provided us with contrasting views on recruitment into the SPDCS. It is therefore very difficult for us to make a judgement as to what the actual position is on recruitment. Whilst we are grateful for the evidence submitted by the BDA, on balance, we are minded to agree that the new pay system is too immature to conclude that it is not fit for purpose, and are therefore not recommending any structural changes to the agreed pay system. The recent expansion in the number of dental school places certainly has the potential to alleviate any recruitment problems, but it will of course take time for the students to graduate and enter the dental market. Whilst the BDA has drawn our attention to the higher pay that is available to associate dentists in the GDS, there are clearly other advantages to working within a salaried environment. Furthermore, we assume that during the recent negotiations, the parties had the opportunity to use some flexibility as to how they allocated the funding that was set aside for the modernised terms and conditions, allocating more of the money to pay points, if that had been considered necessary. In any case, it is clearly in the interests of all parties to accurately report to us the actual position on recruitment so that the service is appropriately staffed and we can make informed recommendations. We therefore ask the parties to provide us with joint evidence on recruitment levels for our next report.

Pay recommendation for 2010-11

5.10 All of the Health Departments said that an uplift of up to 1 per cent would be appropriate. NHS Employers said that salaried dentists should receive the same award as other directly employed doctors and dentists, adding that an overall increase of more than 1 per cent would not be affordable. The BDA argued for a 3.6 per cent increase, this figure representing public sector average earnings growth at July 2009. It also drew our attention to the fact that 61.8 per cent of band A dentists, and 62.8 per cent of band B dentists, were now at their pay band maxima with no incremental increase due.

5.11 We are not convinced by the arguments linking the pay claim to the average public sector increases. Many parts of the public sector are represented by other Pay Review Bodies, all of whom work independently of each other, with separate evidence and reasons for reaching their conclusions on the pay increases that should apply to those groups. We also note that some groups in the public sector are in receipt of multi-year deals, for which it is usual for some sort of premium to be included. While we note from the BDA that many dentists are now at the top of their pay scales, we hope that the thresholds will encourage dentists to develop further their skills so that they can move on through the thresholds and improve their career and pay prospects, which was, we understand, one of the main aims of the new terms and conditions.

5.12 **For 2010-11, we recommend increases of 1 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.

Part III: Secondary Care

CHAPTER 6: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction

6.1 Since the publication of *Modernising Medical Careers*,[55] the way in which doctors are trained has undergone a radical change. Trainees enter Foundation Programmes, a (normally) two-year, general postgraduate medical training programme (as foundation house officers 1 and 2 – FHO1 and FHO2). Doctors then enter a 'run-through' grade known as specialty registrar that will complete their training. Details of all the pay scales are in Appendix A. The latest data at September 2008 show that there were 17,500 FHOs (1 and 2) and 41,950 registrars (both headcounts) working in the Hospital and Community Health Services in the United Kingdom.

The evidence

6.2 This year, we received evidence relating to doctors and dentists in hospital training from the Health Departments, NHS Employers and the British Medical Association (BMA). The main evidence can be read at the parties' websites (see Appendix C). The evidence addressed a number of issues, including the banding multipliers, the contract negotiations and flexible training.

Recruitment and retention

6.3 There were 2.2 applicants for each United Kingdom medical school place for 2008, a slight drop from the previous year's ratio of 2.3 applicants per place. However, this is within the context of a large expansion in the number of places, and we note that there continues to be a more than adequate supply of good quality applicants to study medicine, which is strong evidence that medicine continues to be seen as an attractive career. Women account for 56 per cent of accepted applicants, so again we note the need 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.

6.4 The Department of Health said there were no specific recruitment and retention problems amongst doctors in training. It said that the supply and demand for specialty training programmes appeared to be well balanced and there were sufficient training opportunities to match numbers coming from Foundation Programmes. Where there were gaps in specialties and geographies, it said that international recruitment remained available to fill less popular programmes, such as paediatrics and obstetrics and gynaecology. The Scottish Government Health Department (SGHD) said that selection and recruitment had gone well across specialty training and general medical practitioner posts, with the ratio of applicants to posts being on average 8:1. The Welsh Assembly Government (WAG), however, reported on the short-term shortage of junior doctors in some specialties, and that the sustainability of current staffing arrangements was presenting a fundamental challenge. It said that work was urgently needed to improve recruitment levels, and that it was looking at possible solutions, such as the Hospital at Night model of staffing, the extended hours working arrangements of consultants and other career grades and different rota arrangements. It maintained, however, that the recruitment problems were not directly pay related.

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

We ask the parties to provide us with an update for our next review so that we can assess whether this issue is indeed a short-term one, and for views as to whether some sort of pay solution is necessary to address recruitment. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) reported on the strong trend for local graduates being successful in gaining places on its Foundation Programme. Some vacancies remained, mainly in emergency medicine, paediatrics and obstetrics and gynaecology, but it hoped to fill these through locums and international recruitment. It said that no pay response was necessary to address vacancies: as with the WAG, we ask the DHSSPSNI to update us on this issue for our next round. NHS Employers said that they were anticipating significant changes over the next 10 to 20 years in the way NHS services were delivered, which would need a medical workforce capable of adapting to change, with implications for workforce planning and training. We ask the parties to keep us informed on developments.

6.5 On retention, we heard anecdotal reports from our visits programme that more junior doctors were leaving the United Kingdom to work abroad. However, the evidence from the BMA's cohort study[56] found that in 2008, 57 per cent of cohort doctors intended to practise medicine outside of the United Kingdom, either temporarily or permanently in the future, down from the 60 per cent recorded in the previous year. In any case, the Department of Health said that the medical workforce was very much an international workforce and that it was increasingly the case that medical training included a period gaining experience and skills overseas. It said it was working with Deans to look at ways of sponsoring more temporary placements overseas, and drew our attention to the findings of the United Kingdom Medical Careers Research Group of the University of Oxford[57] which suggested that the participation of United Kingdom trained doctors in the NHS remained high and was not falling. The evidence does not therefore suggest that retention is becoming an issue, but we ask the parties to continue to update us.

Motivation

6.6 The Department of Health said that the results of the 2008 NHS Staff Survey showed that the job satisfaction of junior doctors scored 3.52 (on a scale of 1 to 5), slightly down on the 2007 result of 3.53. Work pressure scored 2.88 (2.89 in 2007), quality of work-life balance was unchanged at 3.14, with 44 per cent reporting they were either satisfied or very satisfied with their levels of pay. NHS Employers said that worries about the longer-term morale of doctors arising from the problems associated with the 2007 Medical Training Application Service (MTAS)-led recruitment exercise[58] appeared to have diminished. They also said that foundation doctors had been included in the 2008 Postgraduate Medical Education and Training Board (PMETB) trainees' survey[59] and the results showed that they were broadly satisfied with their training. The BMA said that more intensive working patterns were having a significant negative impact on working lives and a major impact on motivation and morale. Cuts to general medical practitioner income, the decrease in partnership opportunities and less attractive consultant posts with less time for supporting professional activities were said to have added greater uncertainty for future medical careers and earnings potential and increased existing dissatisfaction with job security.

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[56] *Cohort study of 2006 medical graduates: third report*. British Medical Association, June 2009. Available from: http://www.bma.org.uk/healthcare_policy/cohort_studies/cohort3.jsp

[57] Goldacre et al. Retention in the British National Health Service of medical graduates training in Britain: cohort studies. *British Medical Journal* 3 June 2009.

[58] Review Body on Doctors' and Dentists' Remuneration. *Thirty-seventh report.* Cm 7327. TSO, 2008: paragraph 7.4. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

[59] *National training surveys 2008 – 2009: key findings.* PMETB, 2009. Available from: http://www.pmetb.org.uk/fileadmin/user/QA/Trainee_Trainer_Survey_Report/National_Training_Surveys_2008-09_20090929.pdf

6.7 Anecdotal evidence gathered from our recent visit programme appears to bear out the view of NHS Employers that the recent MTAS debacle has not had a long-term effect on junior doctors' morale. However, we note that the job satisfaction scores for trainees have again slightly dipped from the previous year's result, which is a concern for us. The BMA has listed a number of issues that it believes affect job security, including the availability of general practice partnerships. Of course, the BMA can play an important role here in looking to its membership to improve opportunities for partnerships, if it believes that to be the appropriate course of action.

Flexible working

6.8 NHS Employers told us that the number of flexible trainees continued to rise, with 2,838 trainees (around 6 per cent of the workforce) at April 2009. They said that in general, the trainees seeking flexible working arrangements were able to access them. The BMA requested our support for the ongoing Review of Flexible Training, which we are happy to give, particularly given the changing gender demographics of the medical workforce.

New Deal and the Working Time Directive

6.9 The New Deal refers to the agreed limits on working hours that formed part of the contract for junior doctors that was introduced in 2000. The Department of Health told us that 99 per cent of doctors were New Deal compliant in March 2009. It also said that its overall aim had been to ensure that, consistent with patient safety, the maximum number of services had been supported to achieve Working Time Directive compliance by 1 August 2009, when the maximum number of average hours worked per week should not exceed 48. In the end it had proved necessary for 200 service rotas in England to be included for derogation under the terms of the *Working Time (Doctors in Training) (Amendment) (No. 2) Regulations 2009*,[60] allowing a possible 52 hour working week between 2009 and 2011 (and exceptionally, until 2012). The SGHD said that 98 per cent of juniors were Working Time Directive compliant approaching August 2009 and that it was considering derogations to the Directive. It said 98.4 per cent of junior doctors were New Deal compliant at January 2009. The WAG said that 75 per cent of junior doctors were Working Time Directive compliant at August 2009, and that 38 working patterns had been submitted for derogation, around 6 per cent of all working patterns. The DHSSPSNI estimated that 80 per cent of junior doctors were Working Time Directive compliant at August 2009, with non-compliant posts in obstetrics and gynaecology, paediatrics, anaesthetics and surgery, where solutions remained difficult. It said that 16 rotas were being considered for derogation, around 6 to 7 per cent of the junior population.

6.10 The BMA said that the Working Time Directive raised two main issues: the fall in the number of hours worked and the consequent fall in the banding multiplier; and the increase in poor rota design and anti-social working arrangements. It also noted the reliance on derogations from the Directive in all countries.

New contractual arrangements

6.11 The Department of Health told us that it had asked NHS Employers to look at the effectiveness of the current contractual arrangements, and that they were due to report back on its scoping study in November 2009. However, we were told at oral evidence that NHS Employers were carrying out cost modelling work, and that a final

[60] *Working Time (Doctors in Training) (Amendment) (No. 2) Regulations 2009.* SI 2009/2766. TSO, 2009. Available from: http://www.opsi.gov.uk/si/si2009/uksi_20092766_en_1

report was not now due until April 2010. The Department of Health saw the juniors' contract as a key area for reform and said that progress would be made early in the new year, and that it would take stock with both the BMA and HM Treasury after the final report was submitted. We welcome this commitment to reform and ask the parties to update us for our next review.

Pay comparability

6.12 The Department of Health said that total earnings remained very competitive, particularly once account was taken of the availability of posts. It said that in 2009, all graduates of United Kingdom medical schools were successful in securing a place on Foundation Programmes, but by contrast, the legal profession had 31 applicants for every graduate vacancy, demonstrating a sharp rise in competition for graduate jobs. NHS Employers said that medical and dental salaries, particularly overall pay on graduation, remained competitive and attractive. The BMA, however, said that the decrease in compulsory overtime (due to the Working Time Directive) meant that total earnings had fallen and would shortly fall behind comparators. Analysis of pay comparability conducted by our secretariat suggested that total earnings for doctors in training remained competitive in comparison with the private sector groups, but that at some anchor points – in particular, for FHO1 and the first two years of specialty training – the gap between the earnings of trainee doctors and their private sector counterparts had been eroded, to the disadvantage of the former. However, we also note that in comparator professions, working unpaid for extended hours can be normal practice. Chapter 1 contains more detail on our analysis of pay comparability.

Banding multipliers

6.13 Doctors and dentists in hospital training typically receive supplements to their basic salary, intended to reflect the long hours and intensity of their work. Hospital trainees are allocated to a band on the basis of these factors, and paid the corresponding supplement for that band. The Department of Health told us that the current levels of the banding multipliers are those that were negotiated between the parties to fully recognise work intensity and out-of-hours, and it remained firmly of the view that the relativities were fair and provided an appropriate financial incentive for trusts and trainees to manage the workload of doctors in training. It said that the average banding multiplier for compliant posts was 45 per cent and was unlikely to fall significantly below this level. The SGHD noted that the average banding supplement in Scotland was 55.4 per cent. NHS Employers said that the banding supplements were intended to reflect the amount of work done and appropriately reflected the unsocial hours worked. They said that employers saw no reason to revisit the general value of banding supplements or their relationship to basic pay. They observed that the average FHO1 had total earnings of £32,300, FHO2 had total earnings of £43,300 and specialty registrars had average total earnings of £58,000.

6.14 The BMA, however, said that the average banding multiplier could soon fall to 1.42: this was a significant decrease in the pay levels for junior doctors, and would only lead to a further decrease in the satisfaction levels of juniors with their levels of remuneration. It said that even as juniors rose in seniority, their take-home pay might well remain static or fall, which it said was against the remuneration principles of rewarding skills acquisition and knowledge. The BMA said we should consider the level of the band 1 supplements and said it believed juniors were working more intensively and were more likely to be on an anti-social rota to ensure Working Time Directive compliance. It said it wanted an increase in basic pay that would ensure that those whose pay bandings moved from band 2 to band 1 were not disadvantaged.

6.15 We are required to recommend on the level of the banding multipliers. We accept that the current values of the banding multipliers, as negotiated between the parties, fully reflect both the intensity and hours of work or where posts are non-compliant with the New Deal. Therefore **we recommend that the value of the banding multipliers remain at the rates that were negotiated between the parties.**

6.16 There is one further issue that we wish to address via the banding multipliers. We noted in our analysis of pay comparability that the total earnings of FHO1 doctors has worsened, relative to their comparators. We have also examined the evidence provided by the Department of Health over the last three reviews, which shows that the number of FHO1s in unbanded posts is increasing: 11.3 per cent in 2009 compared to 8 per cent in 2008; and that the relative position of unbanded FHO1s has declined since 2007, with starting pay now only ahead of general management postings in the comparator groups listed by the Department of Health. Whilst we note that it is unlikely that FHO1s will be in unbanded posts for a full year (as typical placements are for four months each), and that their total earnings will therefore exceed basic pay, we are nevertheless concerned about the growing number of unbanded posts and the implications for earnings and how this could begin to affect recruitment. We also note that in its written evidence, NHS Employers highlighted the need for a fair level of graduate entry pay. We considered making recommendations that placed greater emphasis on basic pay with corresponding reductions in the banding multipliers, but we believe that the most appropriate route for addressing this issue is via contractual negotiations that we expect will follow the current scoping study on the juniors' contract. However, as an interim measure, **we recommend that a banding multiplier be introduced for foundation house officer 1 posts that only attract basic pay, and that the multiplier should be set at 1.05 of basic salary**. We estimate that the cost of this recommendation will be just under £1 million. The detail of our recommendations on banding multipliers is at Appendix A.

Pay recommendations for 2010-11

6.17 The Health Departments' general arguments surrounding the uplift are set out in Chapter 2. For doctors in training specifically, they proposed an uplift of up to 1 per cent. NHS Employers said they believed that in the light of known pressures on finances, an uplift of up to 1 per cent in overall cost would be affordable for directly employed doctors and dentists, dependent on a corresponding increase in the tariff for 2010-11. The BMA sought an increase in basic earnings of 2 per cent.

6.18 **For 2010-11, we recommend an increase of 1.5 per cent to the national salary scales for foundation house officers (1 and 2), house officers and senior house officers. For the remaining grades of doctors in training, we recommend an increase of 1 per cent on the national salary scales.** The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrived at our recommendations.

CHAPTER 7: CONSULTANTS

Introduction

7.1 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.

7.2 Under the new contract, consultants have to agree the number of programmed activities (PAs) they will work. Further information on PAs is contained in the glossary at Appendix E. 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 (compared to 40 hours in England); 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 salary structure with two extra incremental points.

The evidence

7.3 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 British Medical Association (BMA) and the British Dental Association (BDA). The main evidence can be read in full on the parties' websites (see Appendix C); it covered a range of issues affecting consultants, in addition to the general pay uplift, including: leadership in pay restraint; equality issues related to CEAs, discretionary points and distinction awards; and the new scheme for awards in Scotland. These issues are addressed in the following paragraphs.

Pay aspects of the new consultant contract

7.4 The Health Departments said that consultants were among the better paid public sector groups, with average earnings per full-time equivalent of £115,926 (including CEAs). They told us that 95 per cent of consultants in England, 97 per cent in Scotland and 98 per cent in Northern Ireland, were now on the 2003 consultant contract and that average earnings per head had increased significantly since the

introduction of the new contract. In the first five years of the contract, consultants' average earnings had increased by 31 per cent and they estimated that in the first seven years (to 2009-10) the increase was 39 per cent. They expected 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 noted that the average earnings of consultants in England for 2007-08 were in the 98th percentile of all employees. They said that the NHS was still working to deliver the full benefits of the new consultant contract, including annual job planning. Around a third of consultants in England and Scotland were on a pay point that entitled them to progress to the next pay threshold within the next year; this number rose to 55 per cent for Northern Ireland. Figures for Wales were not available.

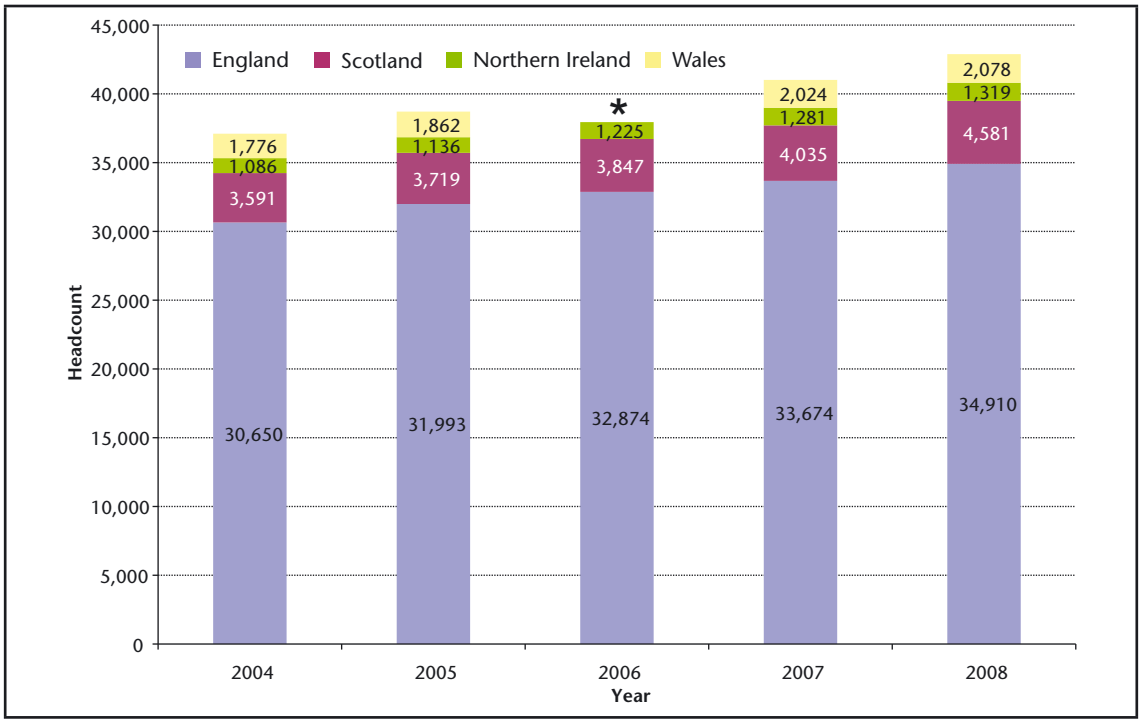
7.5 NHS Employers told us that the majority of the trusts responding to their questionnaire had reported that they were now implementing the contract more effectively by working with consultants to agree changes which had the most impact on patient care. Employers in the NHS were content that the 2003 contract continued to work well and they saw no current need for further revisions.

7.6 The BMA believed that the use of average earnings distorted the picture by reflecting the small number of very high earners, who were likely to be those with considerable additional PAs and/or national CEAs. They also expressed concern at our perceived failure to continue to protect the contract from price inflation, which they believed had the capacity to undermine the aims of the contract. However, the Health Departments made the point that the general aims in setting pay uplifts were not to maintain existing pay relativities or differentials, or to protect the real values of particular salaries over time. They were to set salaries and incomes at the right levels to recruit, retain and motivate sufficient numbers of high quality doctors, while being affordable in the short and longer terms. We address the issue of pay movements in Chapter 1.

Recruitment and retention

7.7 The Health Departments commented that there were no significant recruitment and retention problems among consultant doctors in England although vacancy rates varied between specialties. The number of consultants has increased steadily for a number of years, as shown in Figure 7.1. The latest data, at 30 September 2008, show that headcount is now over 42,000, which we note is the highest figure ever.

Figure 7.1: Number of consultants in the Hospital and Community Health Services, 2004 – 2008, 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.

7.8 The Department of Health drew our attention to the possibility in England of an oversupply of trained specialists in the future, particularly in surgery, where training numbers were planned to reduce, while the number of trained doctors in paediatrics and obstetrics, for example, might need to grow significantly, depending on local service configurations. We note also that these shifts in training will reflect the changes as the NHS moves towards a greater provision of care in the primary sector. For most specialties in Scotland, the national model was forecasting that there would be an oversupply of consultants in the future resulting in a predicted number of Certificate of Completion of Training holders being unable to find employment in Scotland over the next five years. However, the Scottish Government Health Department (SGHD) said that it was committed to move service delivery from trainees to trained doctors, but as NHS Board planning was not advanced enough to take account of this factor, it was expected that more consultants would be needed in the future than the estimated demand indicated.

7.9 We note that the three-month vacancy rate in March 2009, for consultants in England, was 1.1 per cent, slightly up on last year's figure of 0.9 per cent. The Health Departments told us that the number of vacancies that were hard to fill had increased from 276 to 349, following three successive years of decreasing vacancies. The highest vacancy rates among consultants were in London at 1.7 per cent and accounted for 33 per cent of consultant vacancies; this was followed by the North West at 1.5 per cent. They said that although London had the highest three-month vacancy rates for consultants of any strategic health authority, longer-term vacancies were the exception. There was a wide variation in vacancies across the specialties in London, which were highest in accident and emergencies, with a three-month vacancy rate of 12.6 per cent. They said that although additional training was in the pipeline, this would not meet the demand for additional consultants for a few years. This was a

supply issue, not a pay issue. All trusts in Wales reported being able to fill most posts with a good field of candidates and none reported that recruitment had been more difficult. The full-time equivalent medical and dental consultant vacancy rate for Scotland decreased from 282.0 as at 30 September 2007 to 186.5 as at 30 September 2008. The six-month vacancy rate decreased from 163.2 to 69.0 over the same period. In Northern Ireland a growth of 26 per cent in the consultant workforce was anticipated, which would be sufficient to meet demand.

7.10 The Health Departments noted that that 42 per cent (14,670) of the consultants working in the NHS in England were aged 50 or over, and 10 per cent (3,519) were aged 60 or over, observing that, for Northern Ireland, the earlier average retirement age for consultants pointed to a higher rate of departure over the next ten years.

7.11 The Health Departments observed 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. However, data from the Electronic Staff Record suggested that recruitment and retention premia were not widely used for consultants and that their use in London was in line with other parts of the country. NHS Employers said that the recruitment and retention premia were used only infrequently and for limited periods. However, employers believed that the current provisions for the local level design and use of recruitment and retention premia continued to be satisfactory, and no change was sought to these arrangements. They believed that recruitment and retention premia were useful and fit for purpose, although used only sparingly. The most common approaches used by employers to solve recruitment problems were the use of locum cover, job planning changes, skill mix changes and overseas recruitment. They said that recruitment premia could be useful to attract candidates to less popular locations, but, that they were inappropriate where the problem was a labour market shortage in a particular specialty not amenable to a simple pay solution; in the relatively new specialty of accident and emergency, for example, the labour supply was lagging the creation of posts.

7.12 For the first time we have obtained figures on the use of recruitment and retention premia. According to the Electronic Staff Record Data Warehouse, the proportion of consultants in receipt of general recruitment and retention premia in August 2009 averaged 118 whole-time equivalent (0.33 per cent) in England, ranging from 0.06 per cent in the South West to 1.72 per cent/2.07 per cent in the East Midlands (depending on how the figure was calculated). In London the figure was 0.37 per cent.

7.13 We remain slightly unclear as to why the evidence from the Health Departments and NHS Employers always points to the availability of the recruitment and retention premia for consultants, but that these premia appear to be rarely used. Indeed, the BMA said that it had no evidence to suggest that recruitment and retention premia were in use at all. Subsequently, in oral evidence, it told us that there was general pressure across all trusts to avoid using the premia, and that in Northern Ireland trusts refused to pay the premia, although they were prepared to pay substantial amounts for locums. In oral evidence NHS Employers told us that there was some local resistance to using the premia, including resistance from consultants, because individuals would be paid more for carrying out similar work, even if this was in a different specialty; but we do not know to what extent this affects use of the premia.

7.14 We conclude from this that recruitment and retention premia are a useful tool, but one that we suspect is neither being used consistently nor widely. We believe that the premia should be used as an incentive to attract consultants to work in a region where there is a shortage in a particular specialty, but not to shift a vacancy from one region

to another because there is an overall shortage of consultants in an individual specialty. It would appear that employers are managing well enough without heavy use of the premia. We ask the parties to update us on the use of recruitment premia for the next report. The glossary at Appendix E gives further information on the terms and conditions for the payment of recruitment and retention premia.

Motivation

7.15 From the evidence received, there was nothing to indicate that there were any serious problems with the motivation of consultants. The Department of Health told us that there were no significant morale problems among consultant doctors in England. The 2008 NHS Staff Survey had shown that consultants' job satisfaction levels had increased, making them one of the most highly satisfied staff groups within the NHS; workforce pressure had reduced and the quality of work-life balance was high. The numbers of consultants who reported an intention to leave their jobs had fallen and scored lower than the average for all medical and dental staff, and was well below the average for all NHS staff. We note that almost two-thirds of consultants reported satisfaction with their level of pay, compared to 61 per cent in the 2007 survey, and that these levels were significantly higher than the pay satisfaction levels reported by NHS staff as a whole. NHS Employers reported that non-pay solutions to local challenges remained as effective or more effective, than increases to pay. They echoed the Department of Health's comments that staff satisfaction had continued to improve for consultants, including satisfaction with their pay levels. They believed that the contractual provisions that underpinned annualised hours and flexible working contributed to improvements to consultant motivation and morale.

7.16 We remain concerned about the impact on consultants' motivation of the possible inequalities between the awards scheme in Northern Ireland and the rest of the United Kingdom, and we address this later in this chapter. We also continue to find it puzzling that the evidence we receive on consultants' motivation is comparatively positive when the impressions given by a relatively small sample during our visits are sometimes less so. But in the absence of additional evidence we can only draw the conclusion that there are no major motivational issues among consultants.

Workload and productivity

7.17 The BMA told us that the average number of PAs in 2008 was 11.4, including an average of 2.3 supporting professional activities (SPAs). It said that the number of SPAs was lower than last year, and that even then the number of SPAs had not adequately reflected the work involved. It believed that this suggested an increasing downward pressure on job plans which was not reflected in the duties concerned. In Scotland the average number of PAs included in job plans was 11.2 with an average of 2.4 SPAs, but it said that consultant posts in Scotland and Northern Ireland were now routinely being advertised with only one SPA in them, although there was no suggestion that the work accounted for in SPAs had fallen. Evidence continued to indicate both that consultants continued to work beyond their basic contractual commitment and that employers were failing to recognise the workload of consultants in job plans and, consequently, salaries. It said that NHS staff survey data showed that, while the incidence of paid additional hours of work was increasing, three quarters of consultants continued to work unpaid additional hours. It believed that these data suggested that the issue of consultants working unpaid additional hours was a systemic one. It noted that one of the intentions of the 2003 contract was to remove such practices, and the persistence of the trend reinforced its desire to see the contract protected in real terms. In our view, however, the arguments about additional unpaid PAs must be set against senior professional comparators who tend also to work longer hours unpaid.

7.18 On productivity, the BMA noted that medical interventions had contributed positively to the reduction in avoidable mortality; the trend in hospital acquired infections had shown consistent reductions in recent years; and there had also been statistically significant reductions in the rate of inpatient and readmission surgical site infections. NHS Employers believed that there was no indication that spending more money on consultants' earnings would increase NHS productivity or hospital outcomes. Their preferred approach was to make improvements to job planning, provide a stronger link between organisational objectives, clinical outcomes and ensuring the most effective use of consultants' time. They said that these improvements also had to be set in the context of the overall position on health service productivity which confirmed that the NHS still faced a major challenge to improve its efficiency and effectiveness.

7.19 The BMA said that its evidence on productivity and hospital outcomes most closely impacted on consultant practice. However, we believe that many other staff, especially nurses, make indispensable contributions to these productivity measures, and it would be difficult to isolate consultants' productivity. In addition, we have looked at the criteria that are applied to the various consultant reward schemes in each country: the CEA schemes in England, Wales and Northern Ireland suggest that awards can be made for a commitment to achieving service objectives, or through active participation in clinical governance contributing to continuous improvement in service organisation and delivery. In Scotland, distinction awards can be made for the contribution to clinical governance, audit and evidence based practice, or the achievement of service goals; and the new Scottish Clinical Leadership and Excellence Awards (SCLEAs) will recognise and reward individuals who contribute over and above what is contractually expected with outstanding performance. We therefore conclude that where productivity can be attributed to a consultant, the current pay system is already capable of addressing this.

Clinical Excellence Awards, Scottish Clinical Leadership and Excellence Awards, discretionary points and distinction awards

7.20 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. The glossary at Appendix E contains information on CEAs, SCLEAs, discretionary points and distinction awards. All levels of CEAs, SCLEAs, discretionary points and distinction awards are pensionable.

7.21 Every year we are asked to recommend on the number and value of awards for consultants. Our remit requires us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. In our last report we asked the parties to provide confirmation that the various awards schemes were operated in accordance with equality legislation; all the parties have confirmed this and that they will monitor any areas of concern. For example, ACCEA reported that in the 2009 round, unlike in 2008, there was significant disparity between white and non-white consultants who had received an award at silver or gold level. They believed that this may have been an unfortunate anomaly, but told us that they would keep it under review. While SACDA noted that the number of female consultants nominated had continued to increase in 2009, the DHSSPSNI recognised that there was an under representation of female consultants at higher award level, compared to lower awards and believed that the most appropriate way to address this issue was to encourage more applications for higher awards from female consultants, although the awards would only be made on merit. We are therefore satisfied that the schemes are being operated appropriately and are content to recommend on the awards. We ask the parties to continue to let us know for future rounds whether there are any issues that may raise concerns regarding equality legislation.

England and Wales

7.22 The Department of Health told us that 61 per cent of consultants were in receipt of CEAs; 13 per cent were in receipt of CEAs at level 9 or above, or a distinction award. ACCEA reported that 3,003 consultants in England and Wales held national CEAs and 1,192 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 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.

7.23 For 2010-11, the Department of Health said that 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 said that while in previous years, the values of CEAs, distinction awards and discretionary points had been increased in line with the uplift awarded to consultants, this year, in light of the significantly changed economic and financial circumstances, consultants' generous reward packages, strong recruitment and retention position and high satisfaction levels, they believed that the values of these awards did not need to be increased.

7.24 ACCEA proposed that the value of employer-based (levels 1 to 8 and 9 when awarded by employers) and higher CEAs should be increased in line with the general uplift recommended by us for consultant remuneration. It said that provision for higher awards, including distinction awards, in 2010-11 should be based on the cost of the 2009 awards (valued at 31 March 2010) with an increase of 4.5 per cent in new bronze awards, which represented the estimated increase in the consultant population and bearing in mind that there was likely again to be an increase in silver awards. This would maintain the ratio of awards to eligible consultants, but it would also need to be further uprated by any increase in the value of the awards. ACCEA said that this would enable a budget for new awards to be created while retaining the flexibility for them to determine the precise number of awards to be made at each level.

7.25 NHS Employers believed that CEAs at their current values were sufficient to reward excellence and the individual value of awards should not be increased. However, the BMA asked that the value of CEAs be increased by the same percentage as basic salaries in the current round.

Scotland

7.26 The SGHD reported that the two distinct schemes, national distinction awards and local discretionary points, continued to operate in Scotland. It said that at September 2009 around 11.9 per cent of the consultant population held distinction awards. The percentage of consultants retiring with a distinction award was estimated to be 47 per cent in 2009.

7.27 The SGHD told us that the award schemes in Scotland had been under review for some time and a new scheme, known as the SCLEA scheme, would be implemented from 1 April 2010, although the BMA expressed concern as to whether this timetable was achievable. SACDA would be replaced by a new body, the Scottish Advisory Committee on Clinical Leadership and Excellence Awards (SACCLEA). This body would continue to recommend awards at the highest levels but would also assume a new role in monitoring the allocation of the expanded discretionary points scheme. It said that no additional funding would be made available for the new scheme, but there

would be no detriment to existing award holders as a result of its introduction. Awards would continue to be up-dated each year in line with our recommendations and the current 0.35 per cent formula for the payment of Local Excellence Awards would continue to apply. It said that the new scheme sought to ensure equality of access and parity of opportunity between NHS consultants, clinical academics and senior academic GMPs. Applications for all levels of award would be by self-nomination. There would be 13 levels in the new scheme, levels 1 to 10 being administered by Local Health Boards and levels 11 to 13 by SACCLEA.

7.28 The SGHD noted in its initial evidence that the numbers of new high level awards were usually determined by SACDA in the light of the available funding and the level of awards released back into the system through retirement or resignation. However, it suggested that as the number of consultants who would be serious candidates for awards in 2010 would not be significantly different from 2009, and with the imperative of maintaining a high competitive standard, that the number of available awards should be similar to this year. In previous years, the values of CEAs, distinction awards and discretionary points had been uplifted in line with the uplift awarded to consultants. As SGHD was seeking no uplift for consultants this year, it believed that it was appropriate that the value of these awards should also remain static.

7.29 Following the oral evidence session, we received a letter from the Deputy First Minister and Cabinet Secretary for Health and Wellbeing in the Scottish Government. This referred to the difficult financial climate and SGHD's view that the pay of highly paid NHS staff should not be increased. In line with that, it said that, for the next year, there should also be no uplift in the value of distinction awards nor should there be any overall increase in the total number of awards: that the only new awards that should be available next year were those that could be funded by cash released by those who retired or left the service. The SGHD wished to see the budget held steady, in cash terms, at the 2009-10 level. At the same time, the Minister wrote to the Prime Minister and Health Ministers in the devolved countries. This made clear Scotland's intentions over the future of the awards system and sought support for the establishment of a United Kingdom-wide review of local and national merit awards for consultants with a view to bringing to an end the existing schemes and replacing them with a fairer and more cost effective mechanism for recognising clinical excellence. Nevertheless, the SGHD subsequently confirmed that the new SCLEA scheme would still go ahead in 2010-11.

7.30 SACDA noted that in previous years it had proposed a proportional uplift on the basis of the population of consultants. However, this year had seen a marked increase of 16.9 per cent in the consultant population, compared with 4.5 per cent the previous year. It said that because of the impending major changes to the scheme, and in view of the economic climate but to retain an appropriate level of competition, it was seeking the same uplift in numbers of awards as for 2009: 3 A+, 8 A and 16 B awards. The SGHD told us at oral evidence that it believed that the large increase in the number of consultants, just entering from the training route, did not warrant an immediate increase in the number of awards. It said that although it was concerned about the effect of a differential reward scheme on recruitment and retention, it would like to reduce the cost of the scheme and asked us to set the tone by not increasing the number of awards.

7.31 The BMA asked that the number of awards should be increased pro rata with the increase in consultant numbers in Scotland, with awards for academic general practitioners accounted for separately and in addition to this, retaining the historic proportions at each level. Commenting on the revised views from the SGHD on consultants' merit awards, the BMA said that it saw no reason to move away from the well accepted principle that the number of awards should increase in line with any

increase in the number of consultants and the general argument that their value should increase with that of basic pay. It added that distinction awards were a means by which to promote excellence in the NHS in Scotland; they recognised the contribution made by doctors in the field of research, education and the provision of exceptional NHS patient care. Awards not only attracted the best doctors to Scotland, but by promoting innovation and research they also brought economic benefits.

Northern Ireland

7.32 The DHSSPSNI reported that 9 per cent of all consultants were in receipt of higher awards at the end of the 2008-09 awards round.

7.33 The BMA asked us to recommend the adoption of a level of 0.35 awards per eligible consultant, in line with the English system, and that the funding for awards be increased in line with the increases in consultant numbers. It expressed concern that in the 2007-08 award round (the most recent round at the time when the evidence was submitted), only two of the five trusts in Northern Ireland met the requirement of 0.25 awards per eligible consultant for lower awards. Three of the trusts outside Belfast had fallen short of this, achieving ratios of 0.20, 0.18 and 0.08 of awards to eligible consultants. It believed that this was now creating a geographical inequality in lower awards. Although such an inequality had existed for higher awards in Northern Ireland for many years, it was concerned that the inequality in lower awards may further increase the higher award inequality outside Belfast. The BMA asked us to state that such inequalities were unacceptable in a modern CEA scheme and that this situation should be rectified. At oral evidence the BMA told us that it was very difficult to gain awards in Northern Ireland and, anecdotally, this made consultants want to go elsewhere. It said that on average it took ten years to gain an award in Northern Ireland.

7.34 The DHSSPSNI told us that application for CEAs was by self-nomination only, and that there were different rules on eligibility, and a different citation process, from the rest of the United Kingdom. The cost of the higher awards scheme in Northern Ireland was approximately £5.8 million. It said that the level of formula set (0.25 awards per eligible consultant) took into account affordability considerations. For higher awards from 2005, awards were simply recycled as higher award holders retired, resigned or died. However, it told us that as part of the review in 2008 it was agreed that the available pot of money for higher awards should not only take account of retirements, but should also take into account the increase in the eligible consultant population. In effect, the available pot for higher awards took into account three key elements: any surplus of funding from the previous year, the value of any retirements during the relevant awards round, and the value of the increase in the eligible consultant population. The DHSSPSNI determined the available funding and advised the Northern Ireland Clinical Excellence Awards Committee accordingly.

7.35 The DHSSPSNI sought no uplift in the present levels of CEAs and said that it had no plans to increase the ratio of CEA points per eligible consultant to 0.35. The current ratio of 0.25 had been introduced in 2008 following widespread consultation with the relevant stakeholders, including the BMA. It stressed that Northern Ireland operated a different CEA scheme to the rest of the United Kingdom and had different financial constraints. It confirmed during oral evidence that it had no evidence of recruitment or retention problems as a result of the scheme.

Our recommendations

7.36 There are differences between the consultant reward schemes in each country: Northern Ireland operates a scheme that is funded on the basis of 0.25 awards per

eligible consultant, compared to 0.35 in England; Wales has commitment payments instead of Local CEAs, which are paid to all consultants as they progress through the pay scale; and Scotland chose not to increase the number of awards available in that country when it was agreed that clinical academic GMPs were also eligible for distinction awards alongside consultants.[61] Furthermore, Scotland initially indicated this year that it did not want to increase the number of awards in line with the recent expansion in the consultant population, and subsequently that there should be no increase in either the value or the total number of awards.

7.37 We have previously said that we would prefer to see greater equity throughout the United Kingdom, with an alignment between the funding available for the consultant reward schemes (CEAs, discretionary points, distinction awards and the new SCLEAs), and the size of the consultant population in each country, but we accept that the different countries have implemented different schemes and see this as an example of devolution in operation. Although we accept that Northern Ireland operates a different CEA scheme to the rest of the United Kingdom, we do, however, continue to have concerns about the possible inequalities between the awards scheme in Northern Ireland and elsewhere in the United Kingdom, and the consequent potential disadvantages for eligible consultants. The BMA also notes the apparent inequalities in lower awards made outside Belfast. Nevertheless, we are not in a position to judge whether the standard of consultants in each jurisdiction differs. It could be that a greater number of consultants demonstrating the qualities rewarded by CEAs may conceivably be attracted to the larger teaching hospitals, which, it could be argued, might justify a differential allocation. At the same time, we have some concern that consultants could be discouraged from moving to Northern Ireland from other parts of the United Kingdom. In this regard, we note that the letter from Scotland's Deputy First Minister and Cabinet Secretary for Health and Wellbeing to the Prime Minister suggesting a United Kingdom-wide review of consultant merit award schemes records the concern that changes to the scheme in Scotland could undermine that country's competitiveness when it comes to recruiting consultants.

7.38 SACDA has requested that the number of new awards in each category (A+, A and B) be increased by 4.5 per cent (the increase in the consultant population between September 2007 and September 2009), rather than the actual increase in the consultant population of 16.9 per cent that occurred between September 2008 and September 2009. SACDA has traditionally recommended to us that the number of new awards in each category should be increased in line with the growth in the consultant population, but this year suggests that given the very large increase in the consultant population of 16.9 per cent (largely new entrants from the training route), it did not warrant an immediate increase in the number of awards on such a scale. While we expect the citation process for awards to determine whether or not awards are warranted, we have some sympathy with SACDA's view, as we would expect the requirement for higher awards to lag behind the growth in new consultants. However, are not in a position to judge how many additional awards are actually necessary at each level, and are therefore content for SACCLEA to determine how many awards are required at each level, in much the same way as ACCEA does. Our expectation is that, in due course, the number of higher awards will need to increase at a faster rate than the expansion in the consultant population, as the recent increase in consultants become more experienced and demonstrate the qualities necessary for such awards.

[61] We addressed the issue of awards for senior academic GMPs in Scotland in our *Thirty-Sixth* and *Thirty-Seventh reports* [paragraph 8.25 in Thirty-Sixth report; paragraphs 1.18 and 8.37 in Thirty-Seventh report] and stated our view that the failure to accept our recommendation for additional funding to be made available for distinction awards in Scotland, to cover the newly eligible senior academic GMPs, risked loss of goodwill among senior academic GMPs and undermined the distinction awards scheme, since it potentially disadvantaged consultants who might otherwise have been eligible for an award.

7.39 The SGHD has proposed freezing the number of awards, but freezing the number of awards in a growing consultant group could have potential equality implications. For example, if younger women or individuals from minority ethnic groups represent a greater proportion of potential award applicants than the existing group holding awards, freezing the number of awards may reduce their access in future, effectively treating them differently. We therefore ask that SACCLEA and the SGHD take account of any equality issues when deciding on the number of new awards.

7.40 **We recommend that for the 2010 awards the Scottish Advisory Committee on Clinical Leadership and Excellence Awards should have the flexibility to determine the number of national Scottish Clinical Leadership and Excellence Awards to be made at each level in 2010-11, having taken account of any equality issues.**

7.41 For 2010-11, **we endorse and recommend the Advisory Committee on Clinical Excellence Awards' 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, in order to maintain the ratio of awards to eligible consultants**. We note that ACCEA intends to increase the number of new bronze awards by 4.5 per cent, which represents the estimated increase in the consultant population and that there is likely again to be an increase in silver awards. We also continue to recognise the need for flexibility in determining the number of different awards and therefore **we endorse and recommend the Advisory Committee on Clinical Excellence Awards' proposal that it should continue to retain the flexibility to determine the number of Clinical Excellence Awards to be made at each level in 2010-11**.

7.42 **We recommend that for 2010-11 the value of Clinical Excellence Awards, Scottish Clinical Leadership and Excellence Awards, commitment awards, distinction awards and discretionary points should remain at current levels**, in line with our pay recommendation for consultants.

7.43 Finally, we ask the parties to advise us of any developments in relation to a possible review of these schemes, as suggested by the SGHD.

Medical managers

7.44 The BMA asked for our support on two issues relating to medical managers: that locally-negotiated remuneration schemes for medical managers should be uplifted by at least our recommendations for consultant salaries; and that guidance should be agreed between the BMA and NHS Employers on terms and conditions of service and pay for medical managers. As we have stated 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, other than to observe that many medical or clinical directors will be covered by the consultant contract and therefore eligible for the uplift recommended for consultants.

Clinical academics

7.45 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. As in previous years, both the BMA and BDA 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.

Pay comparability

7.46 Our analysis of pay comparability, using the system of comparators outlined in Chapter 1, concluded that basic earnings for consultants at the lowest point on the salary scale were relatively low compared to the private sector occupations included in the comparison, but that total earnings, including supplementary income from additional PAs, were within the range of median total earnings in the comparator groups. For an experienced consultant at the top of the salary scale, with a level four local CEA (considered to be the upper quartile for the consultant grade), total earnings are substantially higher than median incomes for the private sector comparators.

Pay recommendations for 2010-11

7.47 The different pay proposals from the parties are set out in Chapter 2 along with our main pay recommendations. The Health Departments said that in line with the government's general approach to senior public sector salaries this year, they proposed that consultants should not receive any uplift to their salaries. They said that as well as being in accordance with the general need for higher paid groups to show leadership in pay restraint, they believed that this was consistent with what was required to ensure long-term recruitment, retention, and clinical engagement. NHS Employers sought no difference in the increase awarded to those on pre and post-2003 consultant contracts and said that an overall increase of more than 1 per cent would not be affordable. In supplementary evidence they told us that unaffordable cost pressures at more senior levels would be avoided more effectively by having no increase for consultants and that they supported pay restraint at senior levels. The BMA asked for an increase of 2 per cent for consultants.

7.48 We accept that pay increases for highly-paid individuals would be difficult to justify in the current circumstances. However, we are not persuaded that the government's assertion that senior groups should provide 'leadership in pay restraint' is relevant to our remit groups. This appears to be largely a political claim, and is not a matter for us. Nevertheless, in this time of stringency, we do see a need to target scarce resources at the more junior grades within our remit, and we have accepted the case for a differential uplift. Therefore, **for 2010-11, we recommend no increase 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 8: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

Introduction

8.1 The specialty doctor and associate specialist (SAS) grades are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical medical officers, clinical assistants, hospital practitioners, and doctors working in community hospitals. Our recommendations for 2010-11 will apply to all these doctors. However, clinical assistants, hospital practitioners and doctors working within 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.

8.2 The number of members of SAS grades centrally recorded as working in the Hospital and Community Health Services (HCHS) stood at 18,838 in 2008, within which the staff grades, specialty doctor and associate specialist group increased by 658 from 11,177 in 2007 to 11,835 in 2008 (6 per cent). 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 in fact higher.

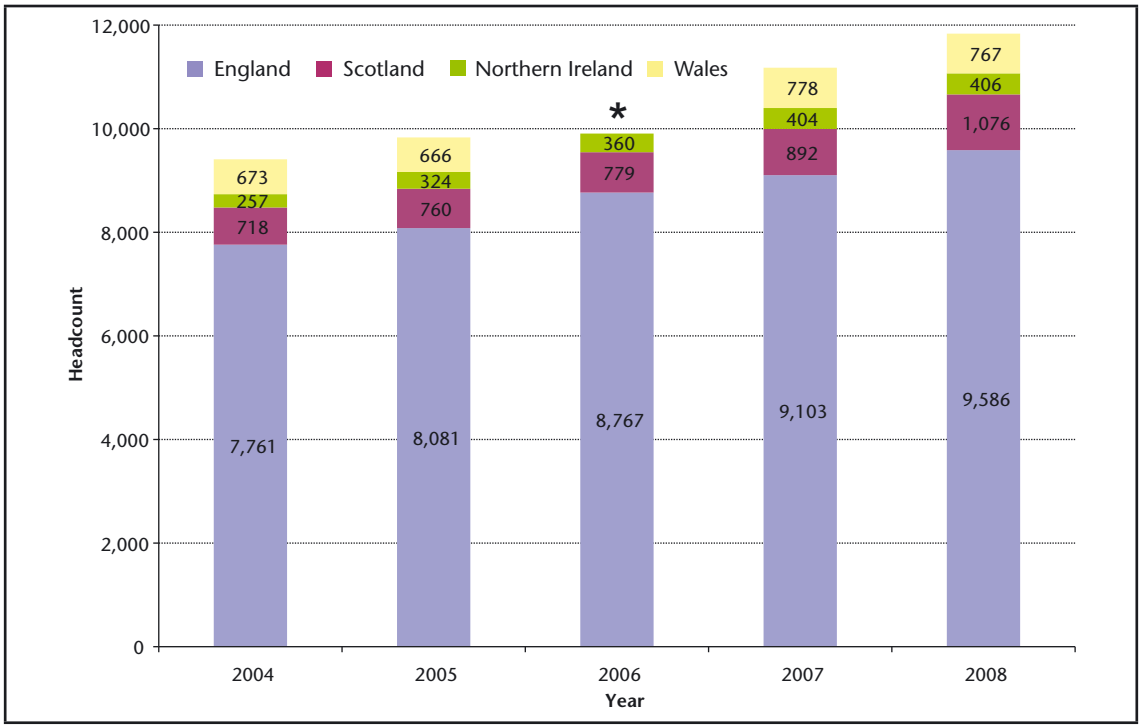
The evidence

8.3 This year, we 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 C), covered a number of issues in addition to the basic uplift, including the ongoing implementation of the new contractual arrangements and career progression.

Recruitment and retention

8.4 The Department of Health said that there continued to be evidence of healthy recruitment and retention among associate specialists, staff grades and specialty doctors. In the year to September 2008, it said that the headcount numbers of associate specialists had increased by 164 (5.4 per cent) and staff grades and specialty doctors by 319 (5.3 per cent). It also said that the three-month vacancy rate was 3 per cent in 2009. The Welsh Assembly Government (WAG) said that in the year to September 2008, associate specialists had increased in number by 24 (12 per cent) but that staff grades had decreased by 27 (6 per cent) (both full-time equivalent figures). The Scottish Government Health Department (SGHD) said that staff and associate specialist grade numbers increased by 181 (20.2 per cent) (headcount) in the year to September 2008. It said that there was currently no information available on associate specialist or staff grade vacancies, but we ask that it address this shortcoming for future rounds. The Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) told us that there were around 450 doctors eligible for the new contacts, but we would find it helpful if the DHSSPSNI was able to present its data in the same format as the other countries: a clear indication of the number of doctors in each group, vacancy rates (again, broken down by group) and how these figures are changing from year to year.

Figure 8.1: Number of staff grades, associate specialists and specialty doctors in the Hospital and Community Health Services, 2004 – 2008, 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.

Motivation

8.5 The Department of Health said that the results of the 2008 NHS Staff Survey[62] showed increasing job satisfaction for this group of doctors, with the score increasing from 3.47 to 3.52 (scale 1 to 5), just above the level reported for all NHS staff of 3.51. 35 per cent of SAS grades were either satisfied or very satisfied with their level of pay, with 26 per cent being neutral, suggesting that 39 per cent were either dissatisfied or very dissatisfied. Intention to leave jobs was slightly reduced, with survey scores falling from 2.55 to 2.46, below the NHS staff average of 2.59. Work pressure was hardly changed from last year, scoring 2.89 (compared to 2.88): well below the score of 3.09 for all NHS staff. Quality of work-life balance slightly increased in the survey from 3.30 to 3.35.

8.6 The BMA told us it had carried out a comprehensive survey of multiple aspects of the motivation and morale of SAS doctors.[63] The survey found that 61 per cent of associate specialists and 56 per cent of staff grades/specialty doctors felt the new contract made no difference to their level of motivation, with 53 per cent of associate specialists and 46 per cent of staff grades/specialty doctors reporting that the new contract made no difference in their level of contentedness with their job. Job satisfaction scored an average of 3.4 for associate specialists and 3.0 for staff grades/specialty doctors (where 1 = very dissatisfied and 5 = very satisfied). Associate specialists were least satisfied with their opportunities for career progression, their

[62] *National survey of NHS staff 2008*. Care Quality Commission, March 2009. Available from: http://www.cqc.org.uk/usingcareservices/healthcare/nhsstaffsurveys/2008nhsstaffsurvey.cfm

[63] *BMA survey of SAS doctors' workload and career progression*. Health Policy and Economic Research Unit, British Medical Association, 2009. Available from: http://www.bma.org.uk/images/sascworkload2009_tcm41-192454.pdf

opportunity to acquire new skills and competencies and their remuneration. Staff grades/specialty doctors were least satisfied with opportunities for career progression, their remuneration and their recognition for good work. Around two-thirds of SAS grades would not recommend a career as an SAS doctor to either undergraduates or a junior doctor. The BMA concluded that the new contract had failed to address many issues important to SAS doctors, and that there was a real risk of such doctors looking for opportunities either abroad or outside medicine.

Implementation of the new contracts

8.7 New contracts for specialty doctors were introduced in April 2008. The Department of Health told us that the contracts offered staff grade doctors (now specialty doctors) and associate specialists substantial pay increases in return for reform. In particular, it said that they offered the opportunity to strengthen job planning, improve incentives for working evenings and weekends, and provided the opportunity for doctors to enhance their earnings through additional reward for flexible service delivery. During oral evidence, the Department of Health said that 53 per cent of doctors were now on the new contract. It said that whilst transfer to the new contract had been slow, there had been significant progress in 2009. Feedback from NHS Employers' networks suggested that the length of time needed to complete job planning was the main reason for the delay, but that implementation of the contracts remained a priority for clinical directors. The WAG, SGHD and the DHSSPSNI also updated us on the progress made in moving across to the new contracts. NHS Employers cited the complexity of the assimilation arrangements, insufficient support to trusts for implementation, and workforce capacity issues as being reasons for the delay. However, it said that all of these other issues had now been overcome and that the time taken to complete job planning remained the main obstacle. During oral evidence, NHS Employers told us that a target date of August 2010 had just been set for the completion of movement across to the new contracts.

8.8 The BMA referred again to its survey of *SAS workload and career progression*[64] and said that in June 2009, 37 per cent of associate specialists and 25 per cent of specialty doctors/staff grades were on their new contracts. Of the associate specialist respondents on the old contract, 70 per cent reported planning to move to the new associate specialist contract, with almost half in the final stage of the transfer process. Of the staff grade respondents on the old contract, 89 per cent intended moving to the new specialty doctor contract, but just 38 per cent were in the final stages of the transfer process. In supplementary evidence, the BMA told us that progress was slowest in Northern Ireland because of funding deficits, with only one doctor on the new contract. It said that up-to-date figures were being gathered in Northern Ireland with a view to re-visiting the pay modelling. The BMA estimated that one in five associate specialists and one in ten staff grades would choose to remain on the old contracts: reasons given were that the current terms and conditions were better or that a move to the new contract would negatively affect working patterns. It also had concerns about the process for awarding optional and discretionary points which ensured that SAS doctors were on the correct point of the scale before transferring to the new contract. Correspondence between the BMA and the Employers Chair of the SAS Joint Negotiating Committee showed a difference of opinion as to whether it had been agreed (on a United Kingdom-basis) that optional and discretionary points for 2009 should be awarded along with back pay when transferring to the new contracts.

[64] *BMA survey of SAS doctors' workload and career progression*. Health Policy and Economic Research Unit, British Medical Association, 2009. Available from: http://www.bma.org.uk/images/sascworkload2009_tcm41-192454.pdf

8.9 While we welcome the progress that has been made on moving doctors across to their new contracts, we are disappointed with the limited number of migrations to date, which we note varies between countries, particularly as the slow progress appears to be having a detrimental effect on the motivation of SAS doctors. The situation in Northern Ireland is of particular concern and we ask the DHSSPSNI to address this issue as a matter of urgency. Elsewhere, job planning now appears to be the key issue that needs resolving and we note that there are many players that have a role to play: clinical directors can provide leadership in ensuring that job planning is given a high priority within trusts; the managers of the SAS grades (which we were told by the Department of Health would almost always be consultants) need to work with the doctors to agree job plans; and the SAS doctors themselves need to take personal responsibility for ensuring that their job plans are completed.

8.10 With regard to the award of optional/discretionary points prior to assimilation to the new contracts, we were not involved in the agreement as to how they should be taken account of and therefore offer no comment, but expect the parties to seek to resolve this issue as quickly as possible to enable the contract implementation to proceed without further delay.

8.11 We welcome the full support given by the Secretary of State for Health during oral evidence to achieving the new contract implementation. We ask the parties to provide us with an update for our next review.

Opportunities for career progression

8.12 The Department of Health told us that recurrent annual funding of £12 million had been provided since April 2008 for specialty doctor career support, training and continuing professional development. It had published jointly with NHS Employers *Employing and supporting specialty doctors*,[65] designed to help employers get the most out of their specialty doctor workforces through a more structured approach to their employment and professional development.

8.13 Other devolved countries have not provided any additional funding for a variety of reasons. The DHSSPSNI said that the costs of the new contracts did not include additional funding for training and continuing professional development: it said it had been unable to include any additional funding for training and development due to financial constraints.

8.14 Commenting on the funding for specialty doctor career support, the BMA said that in Scotland, £150,000 allocated in 2006-07 to assist with the provision of top-up training for doctors taking the Article 14 route had not been taken up at that time, and had since been withdrawn. In Wales, it said that it was clear that a comparable (to England) amount of funding would not be committed. The BMA again referred to its *Survey of SAS doctors' workload and career progression* and said that one third of associate specialists had a career goal to be a consultant. It said that one in ten of associate specialist respondents were on the specialist register, which would enable them to apply for a consultant post, but that 53 per cent of those on the register had applied for a consultant post unsuccessfully. It said that the average number of times that associate specialist respondents had applied unsuccessfully for a consultant post was 4.2 times with the number of unsuccessful applications ranging from one to 16. The BMA said that a quarter of staff grade and specialty doctor respondents had a

[65] Department of Health and NHS Employers. *Employing and supporting specialty doctors: a guide to good practice*. NHS Employers, April 2008. Available from: http://www.nhsemployers.org/Aboutus/Publications/Pages/EmployingSpecialtyDoctorsGoodPractice.aspx

career goal to be a consultant, with a further 44 per cent recording a career goal to be an associate specialist. The BMA also provided us with data from the Postgraduate Medical Education and Training Board (PMETB) that showed that Certificate confirming Eligibility for Specialist Registration (CESR) applicants typically took longer to obtain a consultant post than Certificate of Completion of Training applicants, and that a large proportion of CESR holders were unable to obtain consultant posts. As last year, it argued that within the specialty doctor pay scale there should be a differential increase to the pay levels for specialty doctors beyond the second thresholds to compensate them for acquiring the skills and knowledge previously compensated for through the associate specialist grade and enhanced career progression.

8.15 We are pleased to note the actions taken by the Department of Health to further develop the careers of specialty doctors, which we expect will bring about improvements in the motivation of these doctors. We reiterate our comments from last year, that we would wish the devolved authorities to give consideration to a proportionate level of funding to that in England to support career development, training and continuing professional development. The absence of such funding in our view threatens to undermine one of the main aims of the new contract, which was to support career development.

8.16 The BMA has drawn our attention to the data from PMETB about the low number of successful CESR applicants for consultant posts. It was interesting to note that the Article 14 and CESR routes have a clear, written process which include a right to feedback and an appeal process. However, at consultant post application level, there is no written procedure that guarantees feedback or appeal. When we questioned NHS Employers about the process for providing feedback to unsuccessful applicants, we were told that it was good practice, and *should* be provided, but there was no guarantee. We remain concerned about the implications for the motivation of SAS doctors whose applications are unsuccessful and suggest that a process is put in place to ensure that feedback be provided on a more formal basis.

8.17 The BMA has returned to its proposal for us to make a recommendation that would recognise the skills and knowledge of specialty doctors and compensate them for the closure of the associate specialist grade, by recommending additional pay points to the specialty doctor pay scale. Our view is that the BMA and NHS Employers freely entered into negotiations to agree pay scales for SAS doctors that would meet the requirements of the NHS and would appropriately recognise the skills and knowledge of its workforce. The closure of the associate specialist grade (along with its associated pay points) was part of the negotiated agreement upon which SAS doctors voted and ultimately accepted. We are not therefore making any recommendation to alter the structure of the pay scales that was agreed by the parties as that is a matter for the parties to consider.

Pay comparability

8.18 The BMA said that our findings on pay comparability in last year's report indicated that both median basic salary and median total earnings of associate specialists fell below that of their comparator groups, and asked for an increase in basic pay for these doctors to bring their earnings into line with comparators. It also said it was concerned with the lack of pay comparability data for staff grades and specialty doctors.

8.19 Pay comparability does not form part of our remit, but we do look at comparator groups. Part of the agreement on the new contractual arrangements for SAS grades was for a new and enhanced pay scale for associate specialists, that now gives the grade access to higher earnings than when our pay comparability research was

undertaken last year, at which point only the first year of the two-year staged increases to the pay scales had been implemented. We do not therefore believe that any recommendation for associate specialists is necessary to address pay comparability concerns.

8.20 Newly available earnings data for specialty doctors and staff grades allow us to assess pay comparability for these groups for the first time. Both basic salary and total earnings for specialty doctors fall within the range of incomes in the comparator groups; this suggests that, while the remuneration of specialty doctors is reasonably competitive against the wider market, this grade does not attract the salary lead against comparators that we observe in the training grades and at the more senior end of the consultant grade. Chapter 1 contains more detail on our analysis of pay comparability.

Pay recommendations for 2010-11

8.21 The Health Departments were in agreement that an award of up to 1 per cent would be appropriate for this group of doctors. NHS Employers said that in the light of known pressures on finances, an uplift of up to 1 per cent in overall cost would be affordable for directly employed doctors and dentists, dependent on a corresponding increase in the tariff for 2010-11. The BMA, however, said it was seeking a basic earnings increase of 2 per cent, which it said would aim to protect the value of existing contracts relative to current and prospective Retail Prices Index inflation and bear in mind the available evidence on workload.

8.22 **For 2010-11, we recommend an increase of 1 per cent on the national salary scales for the pre-2008 and post-2008 SAS grades' contracts.** The proposed scales are set out in Appendix A. Chapter 2 gives more detail as to how we arrived at our recommended increase. In the usual way, our recommendation of a 1 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 2010[1] £
Foundation house officer 1	22,190	22,523
	23,575	23,928
	24,960	25,334
Foundation house officer 2	27,523	27,936
	29,323	29,763
	31,122	31,589
Specialty registrar (full)	29,411	29,705
	31,211	31,523
	33,724	34,061
	35,244	35,596
	37,077	37,448
	38,911	39,300
	40,745	41,152
	42,578	43,003
	44,412	44,856
	46,246	46,708
Specialty registrar (fixed term)	29,411	29,705
	31,211	31,523
	33,724	34,061
	35,244	35,596
	37,077	37,448
	38,911	39,300
House officer	22,190	22,523
	23,575	23,928
	24,960	25,334
Senior house officer	27,523	27,936
	29,323	29,763
	31,122	31,589
	32,922	33,416
	34,722	35,243
	36,522	37,070[2]
	38,322	38,896[2]

[1] Our recommended basic pay uplifts, to be applied from April 2010, are applied to unrounded current scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

[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.

	Current scales £	Recommended scales payable from 1 April 2010[1] £
Registrar	30,685	30,992
	32,204	32,526
	33,724	34,061
	35,244	35,596
	37,077	37,448
Senior registrar	35,244	35,596
	37,077	37,448
	38,911	39,300
	40,745	41,152
	42,578	43,003
	44,412	44,856
	46,246	46,708[3]
Specialist registrar[4]	30,685	30,992
	32,204	32,526
	33,724	34,061
	35,244	35,596
	37,077	37,448
	38,911	39,300
	40,745	41,152
	42,578	43,003[5]
	44,412	44,856[5]
	46,246	46,708[6]
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)[7]	74,504	74,504
	76,837	76,837
	79,170	79,170
	81,502	81,502
	83,829	83,829
	89,370	89,370
	94,911	94,911
	100,446	100,446
Clinical Excellence Awards[8]	*Value*[9]	
	2,957	2,957
	5,914	5,914
	8,871	8,871
	11,828	11,828
	14,785	14,785
	17,742	17,742
	23,656	23,656
	29,570	29,570
	35,484	35,484

[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.
[8] Local level Clinical Excellence Awards (CEAs) in England. For national CEAs, see Part II of this Appendix.
[9] Local level CEAs for level 2 – 9 are multiples of the level 1 award (x2, x3, x4, x5, x6, x8, x10 and x12).

	Current scales £	Recommended scales payable from 1 April 2010[1] £
Consultant (2003 contract, Wales)	72,205	72,205
	74,504	74,504
	78,350	78,350
	82,818	82,818
	87,918	87,918
	90,827	90,827
	93,742	93,742
Commitment awards[10]	*Value*[11]	
	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632
Consultant (pre-2003 contract)[12]	61,859	61,859
	66,285	66,285
	70,712	70,712
	75,138	75,138
	80,186	80,186
Discretionary points[13]	*Value*[14]	
	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632
Specialty doctor[15]	36,443	36,807
	39,559	39,955
	43,610	44,046
	45,781	46,239
	48,909	49,398
	52,025	52,546
	55,211	55,764
	58,399	58,983
	61,586	62,201
	64,772	65,419
	67,959	68,638

[10] Awarded every three 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).
[15] The specialty doctor pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements (for further details see http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf).

	Current scales £	Recommended scales payable from 1 April 2010[1] £
Associate specialist (2008)[16]	51,095	51,606
	55,202	55,754
	59,308	59,901
	64,731	65,378
	69,432	70,126
	71,381	72,095
	73,926	74,665
	76,471	77,235
	79,015	79,805
	81,560	82,375
	84,106	84,948
Associate specialist (pre-2008)	37,321	37,694
	41,274	41,687
	45,226	45,678
	49,178	49,670
	53,132	53,663
	57,084	57,655
	62,304	62,927
	66,827	67,496
Discretionary points	*Notional scale*	
	68,705	69,392
	71,154	71,866
	73,603	74,339
	76,052	76,813
	78,501	79,286
	80,953	81,762
Staff grade practitioner (1997 contract, MH03/5)	33,762	34,100
	36,443	36,807
	39,122	39,514
	41,803	42,221
	44,483	44,928
	47,639	48,115
Discretionary points[17]	*Notional scale*	
	49,843	50,342
	52,523	53,048
	55,203	55,755
	57,884	58,462
	60,563	61,169
	63,244	63,877
Staff grade practitioner (pre-1997 contract, MH01)	33,762	34,100
	36,443	36,807
	39,122	39,514
	41,803	42,221
	44,483	44,928
	47,163	47,634
	49,843	50,342
	52,523	53,048

[16] The associate specialist (2008) pay scale has a different base year date to most other scales as this scale was changed, to take effect from 2009-10, as part of the transitional pay and incremental arrangements (for further details see http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf).

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

	Current scales £	Recommended scales payable from 1 April 2010[1] £
	(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)	4,561	4,606
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,463	4,508
	4,721	4,769
	4,981	5,031
	5,239	5,291
	5,497	5,552
	5,756	5,813
	6,014	6,074

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

B. Community health staff

Clinical medical officer	32,343	32,667
	34,094	34,435
	35,845	36,204
	37,596	37,972
	39,347	39,741
	41,098	41,509
	42,849	43,278
	44,602	45,048
Senior clinical medical officer	45,704	46,161
	48,486	48,971
	51,267	51,780
	54,049	54,589
	56,831	57,399
	59,612	60,208
	62,393	63,017
	65,175	65,827

C. Salaried primary dental care staff[18]

	Current scales £	Recommended scales payable from 1 April 2010[1] £
Band A: Salaried dentist	37,344	37,718
	41,494	41,909
	47,718	48,195
	50,830	51,338
	53,942	54,481
	56,016	56,576
Band B: Salaried dentist	58,091	58,672[19]
	60,166	60,767
	63,278	63,910
	64,834	65,482
	66,390	67,054
	67,946	68,625
Band C: Salaried dentist[20]	69,502	70,197[21,22]
	71,576	72,292
	73,651	74,387
	75,726	76,483
	77,800	78,578
	79,875	80,674
Band 1: Community dental officer	34,275	34,618
	37,048	37,418
	39,820	40,219
	42,594	43,020
	45,367	45,821
	48,140	48,621
	50,913	51,422[23]
	53,686	54,223[23]
Band 2: Senior dental officer	48,978	49,468
	52,855	53,383
	56,731	57,298
	60,608	61,214
	64,484	65,129
	65,339	65,992[24]
	66,193	66,854[24]

[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.
[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 paragraphs 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 2010[1] £
Band 3: Assistant clinical director	65,084	65,734
	66,091	66,752
	67,098	67,769
	68,105	68,786
	69,113	69,804[24]
	70,121	70,822[24]
Band 4: Clinical director	65,084	65,734
	66,091	66,752
	67,098	67,769
	68,105	68,786
	69,113	69,804
	70,121	70,822
	71,128	71,839
	72,152	72,874
	73,159	73,891[24]
	74,166	74,908[24]
Chief administrative dental officer of Western Isles, Orkney and Shetland Health Boards	57,160	57,732
	60,714	61,322
	64,269	64,912
	67,823	68,501
	72,152	72,874
	73,159	73,891[25]
	74,166	74,908[25]
Part-time dental surgeon	**Sessional fee (per hour)**	
Dental surgeon	28.12	28.40
Dental surgeon holding higher registrable qualifications	37.30	37.67
Dental surgeon employed as a consultant	46.48	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 2010. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The budget for national Clinical Excellence Awards (CEAs) should be increased in line with the increase in the number of consultants now eligible for an award, including academic general medical practitioners (GMPs), in England and Wales. In Scotland, the number of A+ awards, A awards and B awards should be determined by the Scottish Advisory Committee on Clinical Leadership and Excellence Awards.

3. The annual values of national CEAs for consultants and academic GMPs are as follows.

Bronze (Level 9):	£35,484
Silver (Level 10):	£46,644
Gold (Level 11):	£58,305
Platinum (Level 12):	£75,796

4. The annual values of distinction awards for consultants[26] are as follows.

B award:	£31,959
A award:	£55,924
A+ award:	£75,889

5. The annual values of consultant intensity payments are the following amounts:

Daytime supplement:	£1,274	
Out-of-hours supplement	(England and Scotland)	(Wales)
Band 1:	£960	£2,213
Band 2:	£1,913	£4,426
Band 3:	£2,860	£6,637

[26] From October 2003, national 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:

	From 1 April 2010
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 represented the basic salary (shown in Part I of this Appendix) and figures above 1.0 represented the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary. However, from 1 April 2010, 1.05 should represent the basic salary for foundation house officer 1 trainees in posts that receive no banding supplement.

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.

$$\text{Total salary} = \text{salary}^{1} + \text{salary}^{1} \times \begin{cases} 0.5 \\ 0.4 \\ 0.2 \end{cases}$$

[1] 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 lower 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 £81.72 to £82.52 per 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 £981.09 to £990.88 per week; from £89.19 to £90.08 per notional half day.
Specialty registrar (higher rate) appointment	from £874.56 to £883.20 per week; from £18.22 to £18.40 per standard hour.
Specialty registrar (lower rate) appointment	from £793.92 to £801.60 per week; from £16.54 to £16.70 per standard hour.
Specialist registrar appointment	from £874.56 to £883.20 per week; from £18.22 to £18.40 per standard hour.
Foundation house officer 2 appointment	from £674.88 to £684.96 per week; from £14.06 to £14.27 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.

Senior house officer appointment	from £757.92 to £769.44 per week; from £15.79 to £16.03 per standard hour.
Foundation house officer 1 appointment/ House officer appointment	from £542.88 to £551.04 per week; from £11.31 to £11.48 per standard hour.
Hospital practitioner appointment	from £100.47 to £101.47 per notional half day.
Staff grade practitioner appointment	from £827.40 to £835.70 per week; from £82.74 to £83.57 per session.
Specialty doctor appointment	from £836.40 to £844.80 per week; from £83.64 to £84.48 per programmed activity.
Associate specialist appointment (2008)	from £1,137.50 to £1,148.80 per week; from £113.75 to £114.88 per 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 £87.48 to £88.34 per notional half day.

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

London weighting

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

Doctors in public health medicine

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

	Current range of supplements £
Island Health Boards: Band E (under 50,000 population)	1,758 – 3,487
District director of public health (director of public health in Scotland/Wales):	
Band D (District of population 50,000 – 249,999)	3,487 – 6,972 (Bar)[1] 8,717[2]
Band C (District of population 250,000 – 449,999)	4,374 – 8,717 (Bar)[1] 10,474[2]
Band B (District of population 450,000 and over)	5,232 – 10,474 (Bar)[1] 13,511[2]
Regional director of public health: Band A:	13,511 – 19,612

Notes:
[1] Bar is the top of the range but high performers can go above this as long as they do not exceed the exceptional maximum.
[2] This is the exceptional maximum of the scale.

[29] See paragraph 1.64 of the *Thirty-Sixth Report*.
[30] Population size is not the sole determinant for placing posts within a particular band.

General medical practitioners

16. The supplement payable to GMP registrars is 45 per cent[31] of basic salary for 2010-11.

17. The salary range for salaried GMPs employed by primary care organisations should be £53,781 to £81,158 for 2010-11.

General dental practitioners[32]

18. There is no increase to the income or net uplift to apply to gross fees from 1 April 2010 in Scotland and Northern Ireland. Instead, fee scales should be adjusted to reflect changes in expenses.

19. The sessional fee for practitioners working a 3-hour session under Emergency Dental Service schemes is £119.55.

20. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre is £84.63.

21. The hourly rate payable in relation to the Continuing Professional Development allowance and for clinical audit/peer review is £65.21.

22. The quarterly payments under the Commitment Payments scheme are as follows:

Level 1 payment	£46 per quarter
Level 2 payment	£371 per quarter
Level 3 payment	£479 per quarter
Level 4 payment	£575 per quarter
Level 5 payment	£669 per quarter
Level 6 payment	£762 per quarter
Level 7 payment	£859 per quarter
Level 8 payment	£955 per quarter
Level 9 payment	£1,049 per quarter
Level 10 payment	£1,144 per quarter

Community health and community dental staff

23. The teaching supplement for assistant clinical directors in the community dental service should be increased from £2,413 to £2,437 per year.

24. The teaching supplement payable to clinical directors in the community dental service should be increased from £2,726 to £2,753 per year.

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[31] See Chapter 3 of this report. Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

[32] The rates specified in this section apply in Scotland and Northern Ireland only.

25. The supplement for clinical directors covering two districts should be increased from £1,762 to £1,780 per year and the supplement for those covering three or more districts should be increased from £2,813 to £2,841 per year.

26. The allowance for dental officers acting as trainers should be increased from £1,930 to £1,949 per year.

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

APPENDIX B

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

ENGLAND[33]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[34]						
Consultants	30,776	32,911	31,966	34,079	3.9	3.5
Associate specialists	2,552	2,907	2,695	3,057	5.6	5.2
Specialty doctors	n/a	n/a	361	443	n/a	n/a
Staff grades	5,275	5,840	5,122	5,698	–2.9	–2.4
Registrar group	29,788	30,354	33,838	34,584	13.6	13.9
Foundation house officers 2[35]	10,170	10,276	7,497	7,557	–26.3	–26.5
Foundation house officers 1[36]	5,189	5,225	6,016	6,041	15.9	15.6
Hospital practitioners	168	834	178	836	5.9	0.2
Clinical assistants	490	2,014	634	1,925	29.3	–4.4
Other staff	158	337	127	262	–19.4	–22.3
Total	**84,566**	**90,698**	**88,435**	**94,482**	**4.6**	**4.2**
Hospital and Community Health Services Dental Staff[34]						
Consultants	654	763	712	831	8.9	8.9
Associate specialists	98	141	107	155	9.5	9.9
Specialty doctors	n/a	n/a	0	2	n/a	n/a
Staff grades	163	215	171	231	4.6	7.4
Registrar group	388	405	434	458	11.9	13.1
Foundation house officers 2[35]	502	508	503	529	0.3	4.1
Foundation house officers 1[36]	15	15	9	9	–37.9	–40.0
Hospital practitioners	16	74	20	92	21.1	24.3
Clinical assistants	63	350	106	406	68.6	16.0
Other staff	1,068	1,469	1,088	1,508	1.8	2.7
Total	**2,967**	**3,940**	**3,151**	**4,221**	**6.2**	**7.1**
General practitioners						
General medical practitioners		**36,420**		**37,720**		**3.6**
GMP providers		27,342		27,347		0.0
GMP registrars[37]		2,491		3,203		28.6
GMP retainers[38]		565		507		–10.3
Other GMPs		6,022		6,663		10.6

[33] Data as at 30 September unless otherwise specified.
[34] 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.
[35] This includes senior house officers.
[36] This includes house officers.
[37] GMP registrars were formerly known as GMP trainees.
[38] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

ENGLAND[33]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners[39,40,41]		**20,815**		**21,343**		**2.5**
GDS only		12,438		14,605		17.4
PDS only		5,322		3,338		–37.3
GDS and PDS		1,539		1,862		21.0
Trust-led		1,516		1,538		1.5
Ophthalmic medical practitioners[42]		**394**		**341**		**–13.5**
Total		**57,629**		**59,404**		**3.1**
Total – NHS doctors and dentists		**152,267**		**158,107**		**3.8**

[39] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms at any time in the year that met the criteria for inclusion within the annual reconciliation process.
[40] Data as at 31 March of the following year.
[41] Data include salaried dentists.
[42] Data as at 31 December.

WALES[43]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[44]						
Consultants	1,862	1,961	1,947	2,030	4.6	3.5
Associate specialists	210	233	230	256	9.8	9.9
Staff grades	472	512	442	479	–6.2	–6.4
Registrar group	1,330	1,357	1,728	1,762	29.9	29.8
Foundation house officers 2[45]	1,041	1,046	616	623	–40.8	–40.4
Foundation house officers 1[46]	320	321	321	322	0.4	0.3
Hospital practitioners	8	32	6	32	–18.8	0.0
Clinical assistants	35	155	26	124	–24.3	–20.0
Other staff[47]	5	16	57	69	1,168.1	331.3
Total	**5,281**	**5,633**	**5,374**	**5,697**	**0.9**	**0.6**
Hospital and Community Health Services Dental Staff[44]						
Consultants	52	63	44	48	–14.8	–23.8
Associate specialists	6	7	7	8	16.7	14.3
Staff grades	17	26	15	24	–13.6	–7.7
Registrar group	19	19	23	24	21.3	26.3
Foundation house officers 2[45]	52	52	58	58	11.4	11.5
Foundation house officers 1[46]	0	0	0	0	n/a	n/a
Hospital practitioners	1	3	1	3	0.0	0.0
Clinical assistants	6	35	4	27	–37.7	–22.9
Other staff	86	112	46	60	–47.1	–46.4
Total	**239**	**317**	**197**	**252**	**–8.8**	**–10.3**
General practitioners						
General medical practitioners		**2,174**		**2,208**		**1.6**
GMP providers		1,936		1,940		0.2
GMP registrars[48]		165		198		20.0
GMP retainers[49]		73		70		–4.1
General dental practitioners[50,51]		**1,247**		**1,293**		**3.7**
GDS only		536		757		41.2
PDS only		571		348		–39.1
Mixed		119		148		24.4

[43] Data as at 30 September unless otherwise specified.
[44] 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.
[45] This includes senior house officers.
[46] This includes house officers.
[47] No "other staff" within hospitals were recorded in 2007; whilst only 16 (headcount) were recorded within the community.
[48] GMP registrars were formerly known as GMP trainees.
[49] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.
[50] Data include salaried dentists.
[51] Data as at 31 March of the following year.

WALES[43]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Ophthalmic medical practitioners[52]		**27**		**23**		**–14.8**
Total		**3,448**		**3,524**		**2.2**
Total – NHS doctors and dentists		**9,398**		**9,473**		**0.8**

[52] Data as at 31 December.

SCOTLAND[53,54]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[55]						
Consultants	3,720	3,938	4,166	4,483	12.0	13.8
Associate specialists	214	256	237	284	10.7	10.9
Staff grades	492	601	610	747	23.8	24.3
Registrar group	3,744	3,804	3,690	3,773	–1.4	–0.8
Foundation house officers 2[56]	1,081	1,092	868	878	–19.7	–19.6
Foundation house officers 1[57]	777	781	896	900	15.4	15.2
Hospital practitioners	27	113	26	124	–4.6	9.7
Clinical assistants	109	438	117	429	7.8	–2.1
Other staff	88	147	144	257	64.0	74.8
Total	**10,252**	**11,128**	**10,753**	**11,783**	**4.9**	**5.9**
Hospital and Community Health Services Dental Staff[55]						
Consultants	82	97	83	99	1.9	2.1
Associate specialists	9	12	14	18	51.0	50.0
Staff grades	16	23	19	27	13.2	17.4
Registrar group	33	36	30	34	–10.1	–5.6
Foundation house officers 2[56]	37	38	46	48	26.0	26.3
Foundation house officers 1[57]	0	0	3	3	n/a	n/a
Hospital practitioners	2	10	2	9	3.3	–10.0
Clinical assistants	9	45	13	58	40.6	28.9
Other staff	380	441	394	469	3.5	6.3
Total	**569**	**695**	**604**	**752**	**6.1**	**8.2**
General practitioners						
General medical practitioners		**4,721**		**4,916**		**4.1**
GMP providers		3,826		3,818		–0.2
GMP registrars[58]		316		486		53.8
GMP retainers[59]		178		168		–5.6
Other GMPs		408		451		10.5

[53] Data as at 30 September.
[54] An employee can work in more than one Board/Region/Speciality or Grade and is presented under each group but counted once in the total.
[55] 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.
[56] This includes senior house officers.
[57] This includes house officers.
[58] GMP registrars were formerly known as GMP trainees.
[59] GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of four sessions of approximately half a day per week.

SCOTLAND[53,54]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General dental practitioners[60]	**2,546**		**2,703**		**6.2**	
General dental practitioners	2,370		2,507		5.8	
Vocational dental practitioners	147		160		8.8	
Assistant dental practitioners	39		51		30.8	
Ophthalmic medical practitioners	**24**		**24**		**0.0**	
Total	**7,291**		**7,643**		**4.8**	
Total – NHS doctors and dentists	**19,114**		**20,178**		**5.6**	

[60] Data include salaried dentists.

NORTHERN IRELAND[61]	2007		2008		Percentage change 2007-2008	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff[62]						
Consultants	1,211	1,281	1,243	1,319	2.6	3.0
Associate specialists	68	83	79	92	16.0	10.8
Staff grades	269	321	266	314	–1.3	–2.2
Registrar group	1,255	1,269	1,301	1,315	3.7	3.6
Foundation house officers 1&2[63]	562	565	529	532	–5.9	–5.8
Hospital practitioners	16	71	16	68	5.3	–4.2
Other staff	163	253	158	245	–3.0	–3.2
Total	**3,544**	**3,843**	**3,592**	**3,885**	**1.3**	**1.1**
General practitioners						
General medical practitioners[64]		**1,128**		**1,148**		**1.8**
General dental practitioners[64,65]		**795**		**819**		**3.0**
Ophthalmic medical practitioners[64]		**24**		**22**		**–8.3**
Total		**1,947**		**1,989**		**2.2**
Total – NHS doctors and dentists		**5,790**		**5,874**		**1.5**

[61] Data as at 30 September unless otherwise specified.
[62] 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.
[63] This includes house officers and senior house officers.
[64] Data as at 31 October.
[65] Data include salaried dentists.

APPENDIX C

THE EVIDENCE

We received written evidence from the Health Departments, comprising the Department of Health, the Welsh Assembly Government, the Scottish Government 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 British Medical Association, the British Dental Association, the Dental Practitioners Association (now known as The Dental Professionals Association) and ADP Dental Co. Ltd. The main evidence can be read in full on the parties' websites.

Evidence from the Health Departments
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106750.pdf

Evidence from NHS Employers
http://www.nhsemployers.org/Aboutus/Publications/Documents/NHS_Employers_evidence_to_DDRB_2010-11.pdf
http://www.nhsemployers.org/Aboutus/Publications/Documents/NHS_Employers_evidence_to_the_PRB_on_GMSC_2010-11.pdf

Evidence from the Advisory Committee on Clinical Excellence Awards
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_107478.pdf

Evidence from the Scottish Advisory Committee on Distinction Awards
http://www.shsc.scot.nhs.uk/shsc/default.asp?p=78

Evidence from the British Medical Association
http://www.bma.org.uk/images/bmaddrbevidence2009_tcm41-190824.pdf

Evidence from the British Dental Association
http://www.bda.org/Images/bda_ddrb_evidence_2010-11.pdf

Evidence from the Dental Practitioners Association
http://www.uk-dentistry.org/downloads/consultations/dpa_rbddr_39.pdf

Evidence from ADP Dental Co. Ltd
http://www.ome.uk.com/Search/Default.aspx?q=adp

APPENDIX D

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. 5489, 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 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
Thirty-Eighth Report (2009)	Cm 7579, March 2009

APPENDIX E

GLOSSARY OF TERMS

ADDITIONAL SERVICES under the General Medical Services contract – these cover services outside of basic services and include: cervical screening; contraceptive services; vaccinations and immunisations; child health surveillance; some maternity services; and some minor surgery.

AGENDA FOR CHANGE – is the single pay system in operation for the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and some very senior managers.

ALTERNATIVE PROVIDERS OF MEDICAL SERVICES – one of the types of contracts primary care trusts can agree with primary care providers to deliver services tailored to local needs.

ARTICLE 14 – a route by which SAS grades can have their knowledge and experience recognised for inclusion on the Specialist Register, and thus become eligible for appointment as a consultant.

ASSOCIATE DENTIST – a self-employed dentist who enters into a contractual arrangement with a principal dentist.

BANDING MULTIPLIERS – these are used to apply supplements to the basic salary of doctors and dentists in hospital training. They are intended to reflect the number of hours and intensity of work in each post.

BASIC SERVICES under the General Medical Services contract – see: *global sum*.

BILLION – one thousand million.

CLAWBACK – the recovery of funds for units of dental activity, or other measures of dental activity which were not carried out by the contract holder in the contracting period. This period is usually a financial year.

CLINICAL EXCELLENCE AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. All levels of Clinical Excellence Awards are pensionable.

COMMITMENT ALLOWANCE (NORTHERN IRELAND) – paid on a sliding scale, subject to the amount of money earned through NHS treatments, to dentists with five years' service or more. The more NHS work a dentist carries out, the greater the reward through the commitment allowance.

COMMITMENT AWARDS – for consultants in Wales, commitment awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight commitment awards. Commitment awards replaced discretionary points in October 2003.

CORRECTION FACTOR – a payment made to practices under the General Medical Services contract to reflect the difference between the minimum practice income guarantee (MPIG) and the global sum. See also: *global sum, minimum practice income guarantee*.

COURSE OF TREATMENT – an examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient.

DENTAL PERFORMERS – those who carry out dental work; that is, individual general dental practitioners.

DENTAL PROVIDERS – those with whom primary care organisations agree contract values for a particular level of service. They can be practices, individual dentists or companies.

DENTAL PROVIDING-PERFORMERS – a dental provider who is also a dental performer.

DEPRIVED AREAS ALLOWANCE (SCOTLAND) – a payment for dentists who serve disadvantaged urban areas.

DIRECTED ENHANCED SERVICES under the General Medical Services contract – enhanced services that are under national direction with national specifications and benchmark pricing which all primary care organisations must commission to cover their relevant population. For example, support services to staff and the public for the care and treatment of patients who are violent, improved access, childhood vaccinations and immunisations, influenza immunisations, quality information preparation and advanced minor surgery.

DISCRETIONARY POINTS – now replaced by Clinical Excellence Awards in England and Northern Ireland, commitment awards in Wales, and Scottish Clinical Leadership and Excellence Awards. They remain payable to existing holders until the holder retires or gains a new award. All levels of discretionary points are pensionable.

DISTINCTION AWARDS – now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, and Scottish Clinical Leadership and Excellence Awards. They remain payable to existing holders until the holder retires or gains a new award. All levels of distinction awards are pensionable.

ENHANCED SERVICES under the General Medical Services contract – these are: essential or additional services delivered to a higher specified standard, for example extended minor surgery; and services not provided through essential or additional services.

ESSENTIAL SERVICES under the General Medical Services contract – these cover: management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable; general management of patients who are terminally ill; and management of chronic disease in the manner determined by the practice, in discussion with the patient.

EXPENSES TO EARNINGS RATIO – the percentage of earnings spent on expenses rather than income by a general medical practitioner or a general dental practitioner.

FOUNDATION HOUSE OFFICER – a trainee doctor undertaking a Foundation Programme, a (normally) two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training (either as a specialty registrar or a general medical practitioner registrar, respectively).

FULL COMMISSIONING – the process of primary care organisations buying dental services in a full market from the most appropriate bidder. Full commissioning took place following the transition period after the new contract was introduced in April 2006. The transition period had associated guarantees for dentists and ring-fencing arrangements for primary care organisation dental budgets. During this period, money from contracts that lapsed through, for example, retirement or dissolution of practices, had to be recycled by the primary care organisations to provide more dentistry.

GENERAL DENTAL PRACTICE ALLOWANCE (SCOTLAND) – a payment designed 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.

GENERAL MEDICAL PRACTITIONER EDUCATOR – a generic term for course organisers, general medical practitioner tutors and associate general medical practitioner directors. These are salaried doctors employed by the deaneries.

GENERAL MEDICAL PRACTITIONER REGISTRARS' SUPPLEMENT – a payment made to general medical practitioner registrars to ensure that such registrars are not financially disadvantaged compared to hospital doctors in training. The level of the supplement is guided by the average supplement paid to hospital registrars. It was introduced at a time when recruitment into general practice was poor and replaced a payment that had previously only covered the average out-of-hours work undertaken. In recent years, some parties have sought to reduce the level of the supplement to more accurately reflect the actual hours worked by general medical practitioner registrars.

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes. See also: *additional services; directed enhanced services; enhanced services; essential services; global sum; local enhanced services; minimum practice income guarantee; national enhanced services; Quality and Outcomes Framework; transition scheme/transitional protection; unified budget*.

GLOBAL SUM – this payment to practices under the General Medical Services contract is based on the number of patients registered with the practice. It includes provision for the delivery of essential and additional services, staff costs, and locum reimbursement including for appraisal, career development, and protected time. It does not include money for various other items including: premises, information technology, doctor based payments, the equivalent of target payments, more advanced minor surgery and others. See also: *correction factor, minimum practice income guarantee*.

GLOBAL SUM EQUIVALENT – see: *minimum practice income guarantee*.

INDEPENDENT CONTRACTOR STATUS – the method by which general medical practitioners and general dental practitioners in the United Kingdom contract with the NHS to provide services as self-employed independent contractors. See also: *salaried contractor*.

LOCAL ENHANCED SERVICES under the General Medical Services contract – enhanced services that are developed locally. The terms and conditions of these will be discussed and agreed locally between the primary care organisation and the practice.

MINIMUM PRACTICE INCOME GUARANTEE (MPIG) – also known as global sum equivalent. A guarantee of minimum practice income levels intended to ensure practice stability during the introduction of the new General Medical Services contract. It was set to ensure that practice income from the global sum was at least equal to historic total practice income from the red book payments prior to the new contract; it does not take into account new additional practice income from enhanced services or the Quality and Outcomes Framework. See also: *correction factor, global sum*.

MODERNISING MEDICAL CAREERS – a major national reform of postgraduate medical education and training for junior doctors; introduced in 2005.

MOTIVATION and MORALE – the DDRB terms of reference include "that in reaching its recommendations, the Review Body is to have regard to … the need to recruit, retain and motivate doctors and dentists". Recent research[66] carried out by GfK NOP for the Office of Manpower Economics noted that **morale** was more limited in scope than motivation as a whole, and was closely linked to engagement, feeling energised and absorbed (which were more changeable over time) and to job satisfaction (being happy with one's job and working conditions). **Motivation** was affected by extrinsic rewards, such as pay, in context with other working conditions, and was more likely to be translated into behaviour leading to higher task performance. We therefore take the view that morale is a subset of motivation.

NATIONAL ENHANCED SERVICES under the General Medical Services contract – enhanced services that have national specifications and benchmark pricing, but are not directed. These include intrapartum care, anti-coagulant monitoring, intra-uterine contraceptive device fitting, more specialised drug and alcohol misuse services, more specialised sexual health services, more specialised depression services, multiple sclerosis, enhanced care of the terminally ill, enhanced care of the homeless, enhanced services for people with learning disabilities, immediate care and first response care and minor injury services.

NOTIONAL RENT REIMBURSEMENT (SCOTLAND) – paid to dental practices who meet the NHS commitment criteria.

PERFORMER ONLY DENTISTS – dentists who perform NHS activity on a contract, but do not hold the contract with the primary care organisation.

PERSONAL MEDICAL SERVICES CONTRACTS – one of the types of contract primary care trusts can have with primary care providers. This contract is locally negotiated with practices.

PRACTICE ALLOWANCE (NORTHERN IRELAND) – a payment designed to help to address the increasing practice requirements in relation to the provision of high quality premises, health and safety, staffing support and information collection and provision.

PRIMARY CARE ORGANISATION ADMINISTERED FUNDING – paid under the General Medical Services contract to cover expenses such as premises and information technology, as well as seniority payments and payments for dispensing practices.

PRIMARY CARE PROVIDER – the new definition of a General Medical Services or Personal Medical Services practice. A primary care provider is made up of one or more individuals, at least one of whom must be a general medical practitioner, who act on their own behalf in their beneficial interest and not as representatives of commercial bodies.

PRIMARY CARE TRUST MEDICAL SERVICES – primary care trusts are able to provide services themselves by directly employing staff, under the primary care trust medical services route. The primary care trust may wish to employ full-time staff to provide a full range of services, or employ staff on a sessional or part-time basis.

PRINCIPAL DENTIST – a dental practitioner who is a practice owner or practice partner.

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[66] GfK. *Motivation, Morale and Pay.* GfK/Office of Manpower Economics, July 2009. Available from: http://www.ome.uk.com/Cross_cutting_Research.aspx

PROGRAMMED ACTIVITIES – under their new contract, consultants have to agree the number of programmed activities they will work. Each programmed activity 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 programmed activities represent a full-time post, but the contract refers only to minimum commitments and does not define a maximum. On average, 7.5 programmed activities are for direct clinical care and 2.5 are **supporting professional activities**, for example, training, continuing professional development, job planning, appraisal and research, although different patterns can be agreed through the job planning process.

QUALITY AND OUTCOMES FRAMEWORK – payments are made under the General Medical Services contract for achieving various government priorities such as managing chronic diseases, providing extra services including child health and maternity services, organising and managing the practice, and achieving targets for patient experience.

RECRUITMENT AND RETENTION ALLOWANCE (SCOTLAND) – 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.

RECRUITMENT AND RETENTION PREMIA FOR CONSULTANTS – may be paid in addition to basic salary, either as a single sum, or for a time-limited period of no more than four years. The value of the premium will not typically exceed 30 per cent of the normal starting salary for a consultant post.

REIMBURSEMENT OF NON-DOMESTIC RATES (NORTHERN IRELAND) – paid to practices on a sliding scale of up to 100 per cent of cost, depending on NHS commitment.

REMOTE AREA ALLOWANCE (SCOTLAND) – paid to each dentist who provides services in a remote area on a sliding scale related to NHS earnings.

SALARIED CONTRACTOR – a general medical practitioner or general dental practitioner who is employed by either a primary care organisation or a practice under a nationally agreed model contract.

SALARIED PRIMARY DENTAL CARE SERVICES – these were 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.

SAS GRADES – see: *specialty doctors and associate specialists*.

SCOTTISH CLINICAL LEADERSHIP AND EXCELLENCE AWARDS – a new scheme to replace distinction awards and discretionary points from 1 April 2010. The awards recognise and reward individuals for outstanding performance. All levels of Scottish Clinical Leadership and Excellence Awards are pensionable.

SECTION 17C ARRANGEMENTS – one of the types of contract arrangements that NHS boards can have with primary care providers in Scotland.

SEDATION ALLOWANCE (SCOTLAND) – paid to a dental practice which provides a minimum amount of both types of sedation and is subject to abatement related to a percentage of NHS earnings.

SENIORITY PAYMENT – paid to independent contractor general medical practitioners in the United Kingdom to reward experience, based on the number of years of reckonable service; paid to general dental practitioners in Scotland and Northern Ireland based on age and length of service.

SPECIALIST PROVIDER MEDICAL SERVICES – a Personal Medical Services agreement but with the key difference that patients do not have to be registered with the provider to receive care.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS/SAS GRADES – doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises staff grades, associate specialists, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. A new contract was implemented for this group of doctors from April 2008 which closed the associate specialist grades to new entrants and introduced a new grade called the specialty doctor grade.

SUPPORTING PROFESSIONAL ACTIVITIES – see: *programmed activities*.

TRANSITION SCHEME/TRANSITIONAL PROTECTION – the funding arrangements under the General Medical Services contract designed to ensure that no practice loses out financially under the new funding formula. Transitional protection has applied from 2004 on a practice basis. See also: *correction factor, global sum, minimum practice income guarantee*.

UNIFIED BUDGET – the discretionary health service budget allocated to primary care organisations centrally. This is separate from the global sum allocated to practices and quality payments under the General Medical Services contract, which are non-discretionary.

UNIT OF DENTAL ACTIVITY (UDA) – the technical term used in the new NHS dental contract system regulations to describe weighted courses of treatment. See also: *course of treatment*.

VOCATIONAL DENTAL PRACTITIONER – for those qualifying at a dental school in the United Kingdom, completion of one year's vocational training within dental practice is required. A vocational dental practitioner works in an approved training practice under supervision and also receives additional training of specific relevance to general or community dental practice.

WORKING TIME DIRECTIVE COMPLIANCE – since August 2009, all doctors should be working a maximum average working week of 48 hours, unless they have chosen to opt out or are working under derogations.

APPENDIX F

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
AEI	Average Earnings Index
AfC	Agenda for Change
APMS	Alternative Providers of Medical Services
ASHE	Annual Survey of Hours and Earnings
AWE	Average Weekly Earnings
BDA	British Dental Association
BMA	British Medical Association
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSSPSNI	Department of Health, Social Services and Public Safety in Northern Ireland
DPA	Dental Practitioners Association
FHO1/2	foundation house officer 1/2
GDP	general dental practitioner gross domestic product
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
HCHS	Hospital and Community Health Services
HMRC	Her Majesty's Revenue & Customs
HRPS	Healthcare and Related Personal Services
IDS	Incomes Data Services
MPET	Multi-Professional Education and Training
MPIG	minimum practice income guarantee
MTAS	Medical Training Application Service
NASDA	National Association of Specialist Dental Accountants
NHS	National Health Service
PA	programmed activity
PCO	primary care organisation
PCT	primary care trust
PCTMS	Primary Care Trust Medical Services
PMETB	Postgraduate Medical Education and Training Board
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RPI	Retail Prices Index
RPIX	Retail Prices Index excluding Mortgage Interest Payments
SACCLEA	Scottish Advisory Committee on Clinical Leadership and Excellence Awards
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	specialty doctors and associate specialists
SCLEA	Scottish Clinical Leadership and Excellence Award
SGHD	Scottish Government Health Department
SHA	strategic health authority
SPA	supporting professional activity
SPDCS	Salaried Primary Dental Care Services
UCAS	Universities and Colleges Admissions Service
UKCEA	United Kingdom Conference of Postgraduate Educational Advisers in General Practice
UDA	unit of dental activity
WAG	Welsh Assembly Government

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