Review Body on Doctors' and Dentists' Remuneration

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Forty-Second Report 2014

Chair: Professor Paul Curran

Cm 8832

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

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. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

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

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

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

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

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

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

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

The members of the Review Body are:

> Professor Paul Curran[1] (*Chair*)
> Lucinda Bolton
> Mark Butler
> John Glennie, OBE
> Alan Henry,[2] OBE
> Professor Kevin Lee[3]
> Professor Steve Thompson
> Nigel Turner, OBE

The Secretariat is provided by the Office of Manpower Economics.

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[1] Professor Paul Curran was appointed to the Review Body by the Prime Minister from 1 April 2013.

[2] Alan Henry OBE was appointed to the Review Body by the Parliamentary Under Secretary of State for Health from 22 April 2013.

[3] Professor Kevin Lee was appointed to the Review Body by the Parliamentary Under Secretary of State for Health from 1 April 2013.

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Summary of main conclusions and recommendations

This year, **our central recommendation is for an increase in basic pay of 1 per cent to the national salary scales for salaried doctors and dentists for 2014-15**. We have arrived at our conclusions on pay following detailed consideration of all the written and oral evidence we have received from the parties as well as our own analysis, covering all aspects of our remit, and have come to the view that such an award is both appropriate and justified.

Terms of reference and the remits

This year, our terms of reference remain unchanged, but the specific remits and public sector pay policies for the 2014-15 pay round differ across the four countries of the United Kingdom. Chapter 1 gives details of these differences, and Chapter 10 indicates our responses to the particular requests made in those remit letters and in evidence.

We have been constrained in our decision-making this year by the government's pre-announced policy that public sector pay awards will average 1 per cent in 2014-15. This announcement sets a strong benchmark for expectations on pay outcomes: a subsequent recommendation below this level could have serious negative consequences for motivation and morale within our remit groups, whilst a recommendation above this level could appear unfair in the context of the broader public sector position. We were also mindful of ongoing negotiations between the parties on contractual arrangements for doctors and dentists which are underway separately but clearly related to pay. We are aware that any detailed recommendations on pay by us, for example involving pay differences between our remit groups, could be overturned following contract negotiations and could undermine ongoing discussions. In this context, the argument for an across-the-board uplift of 1 per cent in pay is compelling irrespective of the other features of the labour market for doctors and dentists.

We are acutely aware of the various implications of this year's recommendations for the pay position of doctors and dentists in future years. History has shown that periods of pay restraint (e.g. those experienced in the seventies) and the outcomes of previous contract negotiations (e.g. the outcome of the remit groups' negotiations in the early 2000s) can have far reaching consequences in labour market outcomes and can initiate years of subsequent pay adjustment. These adjustments arise because pay policies and contract negotiations cause parties to re-evaluate their relative positions. Having experienced a protracted period of public sector pay restraint, labour market pressures are less easy to evaluate and interpret. The current contract negotiations and subsequent changes will also introduce new structural influences on the labour market which could generate ambiguity on the relationship between pay and the recruitment, retention and motivation of doctors and dentists. It is important that there is an independent voice in defining any exit strategy for coming out of the period of pay restraint and in re-evaluating labour market conditions. **We intend to continue playing what we believe is an important role in judging the labour market of our remit groups, but feel that we can best add value if the parties are able to make clear to us their long-term pay strategy. We have spent some time reviewing these matters and outline the data we believe is necessary to undertake this task in our report. We also urge the government to give us unrestricted remits in future, so that the parties' trust and confidence in the independent Review Body process is maintained**.

Remit groups, the evidence and our conclusions

In this report, we make recommendations for the annual pay increases for 2014-15. The size of our remit groups has increased by around 1.2 per cent since last year and now consists of over 200,000 doctors and dentists comprising approximately: 46,000 full-time equivalent (FTE) consultants; 14,000 FTE specialty doctors, associate specialists, staff grades and others; 62,000 FTE doctors and dentists in training; 49,000 headcount general medical practitioners (GMPs);

29,000 headcount general dental practitioners (GDPs); and 362 headcount ophthalmic medical practitioners. We have considered written and oral evidence from: the Health Departments for England, Wales, Scotland and Northern Ireland; NHS Employers; NHS England; Health Education England; the Foundation Trust Network; the Advisory Committee on Clinical Excellence Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association (BMA); and the British Dental Association (BDA).

There have been many developments within the NHS that have influenced our consideration of the issues for this round, including: the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* by Robert Francis QC and its implications for patient safety and the redesign of NHS services; Professor Don Berwick's report *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in Englan*d; Professor Sir Bruce Keogh's report *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England*, and its implications for seven-day services; Professor David Greenaway's report *Shape of Training: Securing the Future of Excellent Patient Care*, and its proposals to adapt postgraduate training to prepare medical graduates to deliver safe and effective care in broad specialties. These reports will have implications for the NHS in all four United Kingdom countries, alongside their own policy developments, such as Northern Ireland's *Transforming Your Care* and its aim to design services around the needs of individuals, delivered as locally as possible. We have also noted the junior doctor and consultant contract negotiations: amongst other things, the latter includes an aim to explore contractual changes to facilitate seven-day services in the interests of patients. There are also developments for dentistry in each country, with new contractual arrangements planned. We believe these developments can be directly linked to our remit requirement to ensure that patients are at the heart of the NHS, and we have therefore given consideration as to how our recommendations might help facilitate the changes implied by these developments.

On affordability, we are convinced that this is a material issue for the NHS, and that it is more of an issue this year than previously. The picture on affordability varies across the four countries of the United Kingdom, with Wales stating that any pay award is unfunded, and Scotland saying that there is provision for a pay award alongside incremental pay progression. Even though NHS funding has received some protection in Spending Review settlements, costs are rising sharply and the demands on the service are increasing.

The broad recruitment and retention picture for doctors and dentists is not a cause for major concern, but there are grounds for concern within some specialties (including emergency medicine) and in some geographic areas. We have some concerns with the lack of detail on the fill rate data for trainee doctors. Newly agreed pay mechanisms that may form part of the current junior doctor and consultant contract negotiations have the potential to help address any shortages, although the consultant contract negotiations only cover England and Northern Ireland. Taking all of the recruitment and retention evidence, our conclusion is that a pay response on that basis is not required this year, although in future years we will wish to consider whether a pay response might help to address any recruitment and retention issues, either by specialty or by location.

The announcement of a pay cap of 1 per cent by government has two potentially important effects on motivation, both of which support a recommendation at the suggested cap level: first, for those otherwise predisposed to make an award greater than 1 per cent, it makes an award at the cap level more acceptable as there is recognition that others in the public sector will be limited to 1 per cent too; and for those predisposed to make an award less than 1 per cent, there is a recognition that an award made at less than the preannounced level could have a disproportionately negative impact on motivation. We are sceptical about the scope of the current evidence provided to us on motivation, that appears to focus primarily on the engagement of staff. We will therefore be asking our secretariat to explore with the parties how they might improve their motivation evidence to provide a wider view. On the basis of the current evidence, we note that the results from the 2012 NHS Staff Survey in England show that the motivation of the remit groups it covers does appear to be holding up, but we also consider

that the current contract negotiations to be vital for the future of the NHS in delivering safe and effective patient care: for those negotiations to be successful, we believe it important to ensure that the motivation of staff is maintained. We also note the comments made by the National Audit Office in its report *Progress in Making NHS Efficiency Savings* that sustaining savings made through pay restraint may have a detrimental effect on staff morale and subsequently productivity.

Pay settlements in the private sector were around 2.5 per cent in 2013, and are expected to remain at similar levels in 2014. The Institute for Fiscal Studies has commented that it is likely that by 2018, public sector pay would fall relative to private sector pay to a level similar to in the early 2000s when parts of the public sector experienced difficulties in recruiting and retaining staff. However, we also note that this comment relates to all public sector groups, rather than just our remit groups. Our analysis of pay comparability shows that in general for all of our remit groups, their relative position has declined against their comparator groups, with the comparator groups seeing, in general, larger increases in their total pay. For associate specialists and specialty doctors, both basic pay and total earnings were below the level of their comparator groups: in addition, these doctors are not subject to contract negotiations that might help to address such differences. We are, however, aware that with the recent expansion in the workforce and more staff at the lower end of pay scales, this may well be influencing the median measures for our remit groups that we consider as part of our analysis of pay comparability. Nevertheless, we believe that the decline in the relative position of our remit groups will place increasing pressure on the scale of challenge for an exit strategy from public sector restraint, although we consider the key evidence to be how recruitment, retention and motivation are holding up. At present, these indicators do not suggest to us an award above 1 per cent.

We were invited by a number of the parties to take into consideration the level of incremental pay that staff will receive. Our view on incremental pay progression has been well established over many years. We believe that pay drift arising from increased overtime or other payments for higher volumes of work, or from the effects of negotiated contracts, including incremental pay scales, should not be offset against the annual award. We think that if we were to offset the earnings growth arising from increments from our recommended pay award, it would undermine the fundamental principle on which incremental pay scales are currently based. 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 on the basis of the current contracts. In any case, the estimated growth in FTE pay bill for all Hospital and Community Health Services doctors in England in 2012-13 is just 0.6 per cent, and minus 0.4 per cent for consultants and directors of public health. We believe that if employers find the cost of increments to be unaffordable, then this issue should be addressed through contract negotiations. We note that the current contract negotiations are intending to address pay progression, for example the consultant contract negotiations are considering the contribution of individual consultants and objectively measured job-based criteria rather than length of service, which we support. It is, of course, the role of employers to ensure that the incremental pay progression arrangements are being operated fairly.

We have considered some alternative options for the uplift: whether to vary the level of the uplift in favour of some of our remit groups, or for those that are higher paid. We do not consider that the available evidence on recruitment, retention or motivation would support such action and we are therefore **recommending an increase of 1 per cent to all of our remit groups, across the board**.

We were asked by the Department of Health to consider making our pay recommendations dependent on the partners reaching agreement on contract reform. It proposed that any such recommendation should be tied to contract reform, with the parties invited to report on progress in their evidence to us next year, effectively deferring any award. It is not clear

to us what the criteria would be for deciding whether or not successful progress on contract reform had been achieved; and such a proposal might influence the willingness of the parties to engage fully in negotiations. Moreover, we do not consider it fair that remit groups (such as specialty doctors and associate specialists) that are not involved in negotiations should have any pay award deferred, when they are not able to influence the outcome of such negotiations and are not directly affected by them. We note that Health Departments in Northern Ireland, Scotland and Wales did not support this proposal. We are conscious of the need to maintain the confidence of all parties that are subject to negotiations, and conclude that it would not be appropriate for us to endorse this proposal.

We have undertaken an analysis of our formula-based approach to the uplift recommendations for independent contractor GMPs and GDPs: the data appears to show that our intended increases in income delivered via our recommendations is not being met, and the lack of detailed evidence on income and expenses and the apparent unwillingness of the parties to work together on the various coefficients within the formulae, has led to our questioning its future use. The parties stressed to us that they valued our independent assessment of expenses, and we are therefore willing to use the formulae for 2014-15. However, we are urging the parties most strongly to make significant progress on the provision of better evidence for our next review, before we consider whether or not to continue with our formula-based approach.

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 an increase of 1 per cent to GMPs' income after allowing for movement in their expenses. Using this recommendation and the formula, we calculate that this will produce an uplift of 0.28 per cent to be applied to the overall value of GMS contract payments for 2014-15 for GMPs.

For independent contractor GDPs in England, we recommend that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 1 per cent after allowing for movement in their expenses. Using this recommendation and the formula, we calculate that this will produce an uplift of 1.80 per cent to be applied to the gross earnings base under the contract for 2014-15 for GDPs in England.

For independent contractor GDPs in Wales, we recommend that the gross earnings base be increased by a factor intended to result in an increase in GDPs' income of 1 per cent after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.74 per cent to be applied to the gross earnings base under the contract for 2014-15 for GDPs in Wales.

For independent contractor GDPs in Scotland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to GDPs' income after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.71 per cent to be applied to item-of-service fees in Scotland for 2014-15.

For independent contractor GDPs in Northern Ireland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to GDPs' income after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.76 per cent to be applied to item-of-service fees in Northern Ireland for 2014-15.

We recommend that the parties work together to improve the quality of the evidence base that we use in our formula-based approach for both independent contractor GMPs and GDPs, and that progress is reported back to us for our next review. We will then consider whether or not to continue with the existing formula-based approach in the light of that progress.

We make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale. **We recommend that the minimum and maximum of the salary range for salaried GMPs be increased by 1 per cent for 2014-15**.

We make the following observation on the GMP trainers' grant. **In view of the ongoing delay in reviewing the GMP trainers' grant, we believe strongly that the GMP trainers' grant should continue to be uplifted by the same amount as basic pay, which for 2014-15 would represent an increase of 1 per cent**.

Looking forward, our report highlights our concerns about the lack of evidence in many areas, including: national and local pay strategies that form part of the thinking on total reward; exit strategies from public sector pay restraint; data on hours worked, headcount and FTE staff numbers by gender; a breakdown of earnings by age; robust statistics on vacancies, including by staff group and geographic variation; a better understanding of the factors impacting on motivation; and, as mentioned above, detailed figures on the income and expenses of general medical and dental services. Our report sets out the detailed future evidence requirements that we consider necessary to make our pay recommendations within a broader context and add value to exit strategies. Our secretariat will follow up these evidence requirements with the parties before the next round.

PROFESSOR PAUL CURRAN (*Chair*)
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MARK BUTLER
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OFFICE OF MANPOWER ECONOMICS
24 February 2014

Part I: Overview

CHAPTER 1: INTRODUCTION

The role of the Review Body

1.1 Our remit is to consider remuneration for doctors and dentists working in the NHS. In last year's report, we noted our belief that we can add more value, and operate with the trust and confidence of all the parties, when our reports are produced under the normal terms of reference, without specific restrictions being made by the government on the scope of our recommendations. Our terms of reference include the need to take account of recruitment, retention, motivation, affordability, the government's inflation target, and economic and other evidence. We accept that the government has the right to reject or modify our recommendations, although we hope that in view of the independent, evidence-based nature of our work, this would only be in exceptional circumstances.

1.2 As we noted last year, we fully appreciate the exceptional circumstances that led to the government's decision to announce a two-year public sector pay freeze over 2011-12 and 2012-13,[1] and a cap of no more than 1 per cent in 2013-14, and we believe that our remit groups understand this as well. We understand the government's concern about the affordability of changes to pay following the pay freeze and why it believes that a further period of pay restraint is necessary. We rely on receiving clear evidence on these issues, and the effect on recruitment, retention and motivation, which we consider carefully.

1.3 We remain concerned that the way in which our remit has been expressed has led to our remit groups increasingly questioning our independence, and we believe that this puts the trust and confidence that they have in us at risk. In particular, the British Medical Association (BMA) said that it wished to place on record that it was inappropriate to restrict us by a continuing cap on pay, and to limit consideration of any structural changes surrounding the pay and conditions of doctors.

1.4 A combination of a lengthy period of highly prescriptive pay policy and several major contractual changes impacting significant parts of our remit groups has limited the scope of our remit. We continue to believe that the Review Body process and the interests of the parties are best served when we are able to fulfill our terms of reference without any constraints being placed upon us. The announcement of public sector pay policy has created a level of expectation amongst our remit groups and from the other providers of our evidence, and we are concerned that this has adversely affected the quality and scope of the evidence that we received this year. We understand the government's concern about affordability and that it believes a further period of pay restraint is necessary, but we feel the Review Body process is best served when the parties are able to set out their evidence without restrictions to enable us to make a full assessment and reach our conclusions. **We urge all the governments to give us unrestricted remits in future, so that the parties' trust and confidence in the independent Review Body process is maintained.**

Last year's recommendations

1.5 Last year, which was the first year of the government policy seeking recommendations averaging 1 per cent, we recommended for 2013-14 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists; an increase of 1 per cent to

[1] We note that in 2010-11, we recommended a zero increase in the national salary scales for consultants, meaning that this remit group saw their pay frozen for three consecutive years.

the minimum and maximum of the salary range for salaried GMPs; for independent contractor GMPs, an increase in contract values intended to result in an increase of 1 per cent in their income after allowing for movement in their expenses; and for independent contractor GDPs in Scotland, an increase in item-of-service fees intended to result in an increase of 1 per cent in their income after allowing for movement in their expenses. We were not required to make recommendations on independent contractor GDPs in the other countries of the United Kingdom. The recommendations on salaried doctors and dentists were accepted. The four countries of the United Kingdom each took a different approach on the uplift for independent contractor GMPs, and we comment on the application of our recommendations for this remit group in Chapter 3.

1.6 We noted in our last report that our earlier recommendations in our Fortieth Report for independent contractor GDPs in Scotland covering 2011-12 and 2012-13 had still not been implemented. In this year's evidence, the Scottish Government told us that it had agreed with the British Dental Association (BDA) an increase of 2.51 per cent in item-of-service fees for the period 2011-12 to 2013-14 inclusive, and therefore also included consideration of the recommendation in our last report. The Scottish Government said that the agreement provided closure on the period. We also consider this matter to be closed, although we note that the BDA has drawn reference to our previous comment on the risk to the Scottish Government's partnership working with the profession and ask the parties to bear this in mind in future discussions.

Background to the current round

1.7 There have been several developments within the NHS that have influenced our consideration of the issues during this round. One such development was the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*[2] by Robert Francis QC and its implications for patient safety and the redesign of NHS services: similar considerations apply to other reports, including the report by Professor Don Berwick, *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*.[3] Professor Sir Bruce Keogh KBE's report *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*,[4] published in July 2013, also had important implications for seven-day services. Professor David Greenaway's report, *Shape of Training: Securing the Future of Excellent Patient Care*,[5] published in October 2013, set out proposals to adapt postgraduate training to prepare medical graduates to deliver safe and effective care in broad specialties. These reports will have implications for the NHS and our remit groups in all four United Kingdom countries, alongside their own policy developments, such as Northern Ireland's *Transforming Your Care*[6] and its aim to design services around the needs of individuals, delivered as locally as possible. In addition, all four United Kingdom countries are negotiating on the contract for doctors and dentists in hospital training. The consultant contract is also under negotiation in both England and Northern Ireland, with Scotland and Wales maintaining a close interest in progress. One of the main aims of the consultant contract negotiations is to explore

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2 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Robert Francis QC, chairman. HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

3 *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*. Department of Health, August 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

4 *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. Professor Sir Bruce Keogh, July 2013. Available from: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

5 *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

6 *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Health and Social Care in Northern Ireland, December 2011.
Available from: http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

contractual changes to facilitate seven-day services in the interests of patients. We have also noted the developments in each country for dentistry, with new contractual arrangements planned. We have taken account of these and all of the other NHS developments in each of the United Kingdom countries, including the structural changes taking place in England, and given consideration as to how our recommendations might help facilitate the changes implied by these developments. We have also taken account of the different remits put forward by the four countries: we describe these remits later in this chapter.

Structure of the report

1.8 Our report consists of ten chapters: this introduction; a chapter covering economic and general considerations; a chapter considering our formulae-based approach to the uplift for independent contractor GMPs and GDPs; and chapters on GMPs, GDPs, salaried dentists, doctors and dentists in hospital training, consultants, and specialty doctors and associate specialists (SAS); and finally a chapter with our main pay recommendations. The remit letters from the parties are at Appendix A. The detailed pay scales which result from our recommendations are set out at Appendix B. There are tables showing the number of doctors and dentists in the NHS in the United Kingdom in Appendix C. Links to the evidence on the parties' websites are in Appendix D. There is a list of our previous reports in Appendix E. Appendix F contains a glossary of terms and Appendix G provides a list of abbreviations and acronyms used in the report. Appendix H contains details of fill rates to specialty training for 2013. We have not included a chapter on ophthalmic medical practitioners as the recommendation in our *Thirty-Sixth Report* covered future years.[7]

1.9 We set out the overall context for our review in this introductory chapter, including the essential facts about our remit groups and how we have collected evidence. 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.

1.10 Data used to produce the tables and graphs in this report come from different primary sources for each of the four countries: data for England from the Health and Social Care Information Centre; for Wales, from the Welsh Government; for Scotland, from the Information Services Division, which is part of NHS National Services Scotland; and for Northern Ireland from the Department of Health, Social Services and Public Safety. Some but not all of the data are produced on a comparable basis. The 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.

Remit groups

1.11 At September 2012, our remit groups comprise 200,014 doctors and dentists, a 1.2 per cent increase on the previous year. The breakdown by group is given in Table 1.1. Further details are given at Appendix C, but we have particularly noted the decrease in other staff in Hospital and Community Health Services (HCHS) which is primarily driven by decreases to the number of hospital practitioners and clinical assistants. We also note the increase in the consultant population and in the number of GMPs and GDPs (although for these latter groups, we do not have full-time equivalent figures).

[7] *Thirty-Sixth Report.* Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 6.2.

Table 1.1: Review Body on Doctors' and Dentists' Remuneration (DDRB) remit groups, United Kingdom

	2010	2011	2012	Change over previous year
	Full-time equivalent	Full-time equivalent	Full-time equivalent	Full-time equivalent
Consultants [2]	43,664	45,059	46,477	3.1%
Associate specialists/staff grades/specialty doctors	10,661	10,904	11,068	1.5%
Registrar group	44,303	45,280	45,457	0.4%
Foundation house officers 1 and 2[3]	16,938	16,967	16,961	0%
Other staff[4]	2,797	2,667	2,517	-5.6%
Total Hospital and Community Health Services (HCHS)	**118,362**	**120,876**	**122,480**	**1.3%**
	Headcount	Headcount	Headcount	Headcount
General medical practitioners (GMPs) [5]	47,731	48,107	48,569	1.0%
General dental practitioners (GDPs) [6]	28,009	28,265	28,603	1.2%
Ophthalmic medical practitioners (OMPs)	392	379	362	-4.5%
Total Primary Care	**76,132**	**76,751**	**77,534**	**1.0%**
Total remit group Full-time equivalent HCHS + headcount primary care	**194,494**	**197,627**	**200,014**	**1.2%**

Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety, Health and Social Care Business Services Organisation in Northern Ireland.

Notes:

[1] Most primary care data are not as September each year, but are for the nearest time period after September: GMPs as of September 2012 in England, Wales and Scotland but as of November 2012 in Northern Ireland; GDPs as of September 2012 in Scotland, but as of March 2013 in England and Wales and as of April 2013 in Northern Ireland; and OMPs as of September 2012 in Scotland but as of December 2012 in England and Wales and as of April 2013 in Northern Ireland.

[2] The grade of consultant also includes directors of public health.

[3] Includes house officers, senior house officers and other doctors in training.

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

[5] Includes independent contractor GMPs, salaried GMPs and general practice specialty registrars.

[6] Includes principal GDPs, assistants and vocational practitioners, GDPs working in Personal Dental Services, and salaried dentists working in General Dental Services.

1.12 Table 1.2 below gives an outline of the status of the contracts for each remit group and any changes are described more fully in the relevant chapters.

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

General medical practitioners	General Medical Services contract across United Kingdom from 1 April 2004. Other contracts, on which we do not make recommendations for the uplift, include: Personal Medical Services in England; Section 17C arrangements in Scotland; Alternative Providers of Medical Services; and Primary Care Trust Medical Services.
General dental practitioners	Contract from 1 April 2006 – England and Wales (slight variations in each country). Negotiations in progress in Northern Ireland. Pilots for new contracts underway or planned in England, Wales and Northern Ireland. Scotland and Northern Ireland still on an item-of-service fee scale.
Salaried dentists	Contract in England and Wales from 1 June 2007; new contract introduced with effect from 1 April 2013 in Scotland; new contract forthcoming in Northern Ireland.
Doctors and dentists in hospital training	Contract from December 2000. Negotiations underway on new United Kingdom contract.
Consultants	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 pre-2003 contract; all consultants in Wales are on the 2003 contract. New contract negotiations underway in England and Northern Ireland; and under consideration in Scotland and Wales.
Specialty doctors and associate specialists	Contract from 1 April 2008 with minor differences in each of the devolved countries. The associate specialist grade was closed to new entrants from 31 March 2008.

The devolved countries

1.13 Our remit covers the whole of the United Kingdom. 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.

The remits

1.14 The remits for this review vary across the United Kingdom: the relevant remit letters can be seen in Appendix A. The initial guidance for this round was set by a letter from the Chief Secretary to the Treasury, dated 23 July 2013, which noted the government's need for continued pay restraint across the public sector. It reminded us of the government policy that public sector pay awards were to average 1 per cent for the two years following the pay freeze: this year's review covers the second of those two years. The letter said that pay awards would be applied to the basic salary based on the normal interpretation of basic salary in the workforce, and that the definition did not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances. It also said that substantial reforms to progression pay would

be taken forward and that we were invited to consider the impact of our remit groups' progression structure and their distribution among staff in recommending our pay awards.

1.15 We also received correspondence from each of the devolved administrations setting out their individual interpretations of the remit.

1.16 The letter from the Parliamentary Under Secretary of State for Health, Dr Dan Poulter, dated 3 September 2013, followed up on the Chief Secretary's letter, and referred to many of the points in our standing terms of reference. The letter asked us to make recommendations on appropriate uplifts for both General Medical Services (GMS) and dental contracts in the context of public sector pay policy for 2014-15, and that our recommendations were particularly welcomed on what allowance should be made for GMPs' and dentists' pay and for practice staff pay, in line with other sectors of the NHS workforce. It said that government and NHS England would make final decisions on the overall gross uplift for GMS and dental contracts in the light of our recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations. Subsequent correspondence with officials clarified that we should also consider the level of incremental pay that those staff that had not reached the top of their pay scale would receive.

1.17 The main evidence from the Department of Health also added in some additional requests: it asked us to consider and make observations on the Heads of Terms about negotiations for consultants and doctors in training, with particular emphasis on the current structure for pay progression, and whether it could help improve performance and productivity; to consider and make observations on whether any pay awards should be made to staff whose performance did not meet local standards; to make recommendations on how any pay award, if we considered one was justified, might be made dependent on the partners reaching agreement on contract reform; and to consider and make observations on whether the arrangements for working 'out of hours' supported the Department's ambition for seven-day services, in particular the need to have consultants available at evenings and weekends.

1.18 The remit letter from the Minister for Health and Social Services in Wales, Mark Drakeford, dated 25 September 2013, asked us to make recommendations on appropriate uplifts for independent medical and dental practitioners, and in doing so to consider the relevant allowances for practitioner and staff pay. It also asked us to consider: whether in the current financial environment it was appropriate to uplift the salaries for all staff; whether it would be more appropriate to provide staff with a fixed sum increase rather than a percentage uplift; and whether a pay freeze would be appropriate for higher earners.

1.19 The remit letter from the Minister for Health, Social Services and Public Safety in Northern Ireland, Edwin Poots, dated 17 October 2013, asked us to consider pay progression as part of our review, and to comment on whether there was a case for a higher award for particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties. It also asked us to make a recommendation on independent contractor GMP pay and expenses for 2014-15. For independent contractor GDPs, it asked for an assessment of earnings and expenses, similar to the work we carried out for Scotland in our Fortieth Report 2012.[8]

1.20 The remit letter from the Cabinet Secretary for Health and Wellbeing in the Scottish Government, Alex Neil, dated 24 September 2013, drew our attention to its public sector pay policy, in particular that there was provision for an increase in basic pay for all staff. It said that the increase was subject to an overall cost cap of 1 per cent, although there

[8] *Fortieth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 8301. TSO, 2012. Available from: https://www.gov.uk/government/publications/ddrb-reports-number-40-2012

was no assumption that this would equate to 1 per cent. The cost cap did not include pay progression. Beyond those parameters, the letter said it wished us to be as free as possible in considering the issues and making our recommendations for 2014-15. The letter confirmed that Scotland was seeking recommendations for both GMPs and GDPs.

The evidence

1.21 We received written evidence from: the Health Departments, comprising the English Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Northern Ireland Executive Department of Health, Social Services and Public Safety; NHS Employers; NHS England; Health Education England; the Foundation Trust Network; the Advisory Committee on Clinical Excellence Awards (ACCEA); the Scottish Advisory Committee on Distinction Awards (SACDA); the BMA; and the BDA. The parties provided supplementary written evidence in response to other parties' evidence and to our requests.

1.22 In addition, we heard oral evidence from: Jeremy Hunt, Secretary of State for Health and Dr Dan Poulter, Parliamentary Under Secretary of State; the Department of Health; the Welsh Government; Alex Neil, Cabinet Secretary for Health and Wellbeing; the Scottish Government; the Northern Ireland Executive; NHS Employers; NHS England; Health Education England; the Foundation Trust Network; the BMA; and the BDA. Oral evidence is an important part of our review process as it enables us to inform our views by following up and discussing issues that have arisen in the evidence and elsewhere.

1.23 As ever, we are grateful to the parties for their time and effort in preparing and presenting evidence to us and for the speed with which they have responded to our questions. We would, however, like to stress to the parties the importance of the deadlines that we set for the submission of evidence. The late submission of written evidence from ACCEA meant that we were unable to explore any of its issues with the other parties during oral evidence.

1.24 The main evidence can be read in full on the parties' websites (see Appendix D). In an effort to keep this report concise, we have not paraphrased the evidence, although we do refer to issues raised by the parties in their evidence.

Visits

1.25 Each year we carry out a series of visits, usually during the early summer. In 2013, we visited acute trusts, health boards and primary care organisations across the United Kingdom to meet representatives of both management and of the doctors and dentists to whom our recommendations apply. We would like to thank those organisations that we met with during 2013 for their help in ensuring the success of our visit programme. These visits do not form an official part of our evidence gathering, as the evidence is mainly anecdotal, but they are valuable in informing our views, particularly on motivation and morale, and we are grateful to those we meet for their time and the frank opinions expressed and for the opportunity to pick up issues raised by the relevant parties.

1.26 Our report begins by considering general and economic considerations, before going on to consider the issues for each remit group, and finally our recommendations on pay.

CHAPTER 2: ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

2.1 In this chapter, we consider the current economic background and the elements of our terms of reference in a general context for the review. It includes our consideration of affordability issues, which we note are of increasing significance for the NHS given the steeply rising costs for and demands on the service. We have also set out our future evidence requirements: we are particularly interested in obtaining evidence in future rounds on the earnings distribution by age for our remit groups, so that we can make an ongoing assessment of where staff are positioned within the overall labour market. A summary of our conclusions relating to economic and general considerations appears at the end of this chapter.

General economic context

2.2 We are required by our terms of reference to take careful account of the economic and other evidence and of the government's inflation target. The United Kingdom economy grew by 1.9 per cent in 2013, compared to 2012. This is ahead of the forecasts available to us at the time of our last report. The Office for Budgetary Responsibility (OBR) forecasts economic growth of 2.4 per cent in 2014.[1] Inflation was close to expected levels in 2013. The Consumer Prices Index (CPI) inflation rate was 2.0 per cent in December 2013, while the Retail Prices Index (RPI) rate was 2.7 per cent (and the Retail Prices Index excluding mortgage interest payments (RPIX) rate was 2.8 per cent). The latest OBR forecast is for CPI to be at around its current level through 2014, and for the RPI rate to rise slightly, to 3.0 per cent, pushed up by housing costs, by the end of 2014.

2.3 The employment level continued to show strong growth through 2013, increasing by 450,000 in the year to December 2013, the latest data available to us. This puts the employment level at an all-time high of 30.15 million, over 500,000 higher than the pre-recession peak. The employment rate, at 72.1 per cent, remains below its pre-recession peak of 73.0 per cent. Employment growth was notably strong for older workers, aged 50 and above, while employment fell among the under 25s. The unemployment rate fell over 2013, to 7.1 per cent, although it remains above the 6.5 per cent level which the Bank of England considers to be the medium-term equilibrium rate of unemployment, below which there would be upward pressure on wages.[2] There also remains a considerable degree of 'under-employment' in the labour market, given the large number of those currently in employment who would like to increase their working hours.

2.4 Average earnings growth was subdued throughout 2013, and below inflation. Pay settlements in the private sector were around 2.5 per cent and are expected to remain at similar levels in 2014. The median pay settlement in the public sector was 1.0 per cent in 2013.

2.5 The government's stated 'fiscal mandate' aims to balance the cyclically-adjusted current budget (CACB) five years ahead and also to have public sector net debt (PSND) falling as a share of gross domestic product in 2015-16. The programme of deficit reduction followed since 2010 has meant that our recommendations on doctors' and dentists' pay have been made in the context of an explicit government policy on public sector pay since that time. This policy has been to pursue a pay freeze in 2011-12 and 2012-13, a

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1 *Economic and Fiscal Outlook*. Office of Budget Responsibility, December 2013.

2 The Monetary Policy Committee has said that it does not intend to raise the bank rate from its current level of 0.5 per cent until the unemployment rate has fallen to 7 per cent (which it forecasts to be in mid 2015). *Inflation Report*. Bank of England, December 2013.

policy of pay awards that average 1 per cent in 2013-14 and 2014-15 and, as announced in Budget 2013, an average of up to 1 per cent in 2015-16. Based on stated government policies and its own macroeconomic projections, the OBR forecasts that the CACB will show a surplus (of 1.6 per cent of gross domestic product) for the first time for some years in the target year of 2018-19 but that PSND will still be rising in 2015-16, only falling significantly in 2017-18.

Affordability and the Health Departments' expenditure limits, NHS finances and efficiency savings

2.6 We are also required by our terms of reference to take account of the funds available to the Health Departments as set out in the government's Departmental Expenditure Limits. As ever, affordability formed a major theme of the evidence submitted to us.

2.7 The Department of Health told us that different priorities competed for the limited funding growth given to the NHS, grouped into three main categories: baseline pressures (including pay); underlying demand or increased levels of activity, due to demographic pressures or medical advances; and service developments which arose due to new policies or ministerial commitments. It said that Hospital and Community Health Services (HCHS) pay bill pressures were the largest component of baseline pressures and usually formed the first call on NHS resources. The Department said that there were £2.5 billion of increased revenue resources available in 2014-15 for the NHS to meet in-year pressures, with £1.8 billion consumed by demand pressures, leaving £0.7 billion assumed to be available for pay, equivalent to an increase in pay costs of 1.5 per cent: any increases in pay costs above that would need to be afforded by further increases in productivity and fewer staff employed. The Department said that improvements in workforce productivity were key to helping deliver the efficiency savings required by the NHS.

2.8 The Welsh Government said that in real terms, its revenue budget was 12 per cent lower for 2014-15 compared to 2010-11, and that £540 million of savings were required by 2015-16. It said that direct staff costs accounted for 62 per cent of revenue costs and that changes in pay rates therefore had a significant impact on the Health Board budget. It told us that any pay award was unfunded and would place additional pressure on the service.

2.9 The Scottish Government said that its Health Budget was £11.6 billion in 2014-15, and that NHS Boards had received 2.7 per cent additional cash funding in 2014-15 to meet pay and non-pay pressures. It estimated that 3 per cent cash-releasing efficiency savings would be required in 2014-15 to achieve financial balance. However, the Scottish Government concluded that its public sector pay policy (of an increase within a cost cap of 1 per cent, plus any incremental pay progression) was affordable.

2.10 The Northern Ireland Executive said that its Budget 2011-15 set out reductions in current and capital spend imposed by the United Kingdom Government as part of the 2010 Spending Review, and that efficiency and productivity improvements would be essential to meet key targets within current resources, given the very tight public expenditure position. It said that the budget allocation for 2014-15 represented a real terms decrease in funding of 0.7 per cent compared to 2010-11.

2.11 NHS Employers said that the service faced an unprecedented financial dilemma, with funding struggling to meet the growing demand for healthcare. They said that the NHS had to deliver 4 per cent efficiency savings each year until 2015, but that any cost improvement programmes should not adversely affect quality. They said that the financial challenge would continue beyond 2015, noting that 16 foundation trusts were in deficit in 2012-13 and that ongoing efficiencies were becoming harder to deliver as one-off savings such as cuts in management costs started to slow. The recent

announcement of an additional £500 million over the next two years to help accident and emergency departments was seen by NHS Employers as a sign that part of the NHS was struggling under financial pressure. They concluded that the reform of national pay and conditions for doctors was needed to provide financial stability for the future; and that restraining the pay bill was essential to ensure the continued delivery of high quality patient services and to minimise job losses. The Foundation Trust Network also stressed the financial challenge for trusts and said that there was also an emerging imperative for the NHS to move to different models of service delivery and to improve both the patient experience and the quality of care. It said that this twin imperative required financial savings, productivity improvements and greater innovation in the workforce, but that opportunities for "easy win" savings were now limited.

2.12 NHS England told us that its analysis of NHS funding suggested a £30 billion gap between likely available funding and expected demand levels on NHS services by 2020.

2.13 The British Medical Association (BMA) expressed concerns about the NHS budget for England and the assumption within the budget for the level of inflation to increase by 1.8 per cent, noting that recent history had shown that inflation had frequently exceeded expectations. It said that the Scottish budget growth of around 1 per cent was significantly below inflation, and the position in Wales was worse still, with a real terms cut for the next two years of 2 per cent. The BMA said that it was considering research that looked at the scope to make and measure efficiency and productivity gains in the context of ever increasing patient demand and need but within a fixed NHS budget. We welcome this proposed research and look forward to receiving the results, when these are available. In its evidence, the British Dental Association (BDA) said that the NHS was reported to have a surplus of over £2 billion for 2011-12, and that the available funding should be used to alleviate the strain of those providing care.

Report on NHS finances and productivity

2.14 In Autumn 2013, Monitor, the sector regulator for health services in England, published a report *Closing the NHS Funding Gap: How To Get Better Value Health Care For Patients*.[3] The report set out where Monitor believed changes were needed to close the projected £30 billion funding gap in 2021 identified by the Nuffield Trust and NHS England, whilst continuing to provide good quality services for patients.

2.15 Monitor believed that the sector faced its greatest financial challenge in recent times over the next eight years or so. It believed that getting better value for patients meant improving productivity which meant everyone working differently and smarter, altering or reshaping services and reinvesting the money saved in more and better services. Taking this approach could close the funding gap but it would not be easy as productivity growth in the NHS had lagged behind productivity growth in the economy as a whole. Monitor reviewed the best evidence available on improving health care productivity, identified where the biggest opportunities lay and estimated the potential gains they offered. Opportunities for significant recurrent productivity gains by 2021 fell into four main types: improving productivity within existing services (£6.5 to £12.1 billion); delivering the right care in the right setting (£2.4 to £4 billion); developing new ways of delivering care (£1.7 to £1.9 billion); and allocating spending more rationally (not costed). It also reviewed the evidence for non-recurrent savings on capital costs and on wages.

2.16 The report stated that the pay freeze (2011-12 and 2012-13) and the 1 per cent pay cap (2013-14 and 2014-15) would together save an estimated £5 billion. It said that a large proportion of the efficiency gains achieved by the NHS since 2010 could be attributed

[3] *Closing the NHS Funding Gap: How To Get Better Value Health Care For Patients*. Monitor, October 2013. Available from: http://www.monitor.gov.uk/closingthegap

to the pay freeze and pay cap, and that if the 1 per cent pay rise (for 2014-15) did not materialise, the savings would be greater. The report said that health systems across Europe had contained health spending in recent years using top-down wage freezes or reductions, rather than structural reforms to services. However, it said that the impact on the quality of patient care of freezing wages posed a significant challenge to countries pursuing such a policy. Monitor said that it did not believe this to be a sustainable strategy for improving productivity in the NHS, noting that periods of wage restraint were generally followed by periods of 'catch up' with their trend level in subsequent years. It said that extended wage restraint impaired recruitment and staff retention. The National Audit Office's report *Progress in Making NHS Efficiency Savings*[4] also noted that sustaining the savings made through pay restraint might have a detrimental effect on staff morale and productivity.

2.17 Affordability is part of the evidence base we consider alongside our deliberations about the need to recruit, retain and motivate doctors and dentists. We recognise that the huge financial pressures facing the NHS are likely to continue for several years and we have taken all of the evidence provided by the parties into account when making our decision about what we consider to be the appropriate uplift for 2014-15. We note that any surplus within the NHS is not necessarily available for recurrent costs, such as pay. Whilst the Department of Health's evidence suggests that there is funding available equivalent to an increase of 1.5 per cent in pay costs, we note that this would need to take account of all the pay drivers that form part of the pay bill. Affordability is closely linked to the Health Departments' budgets, and these budgets have been set with assumptions about pay. We note that staff are likely to be aware of the pay assumptions made by employers, given the public announcements made by the United Kingdom governments on public sector pay policies for 2014-15. None of the parties provided us with evidence on an exit strategy from the current period of public sector pay restraint that might have helped us to formulate our pay recommendations within a broader context.

2.18 We have concluded that affordability is a material issue for the NHS, and that it is more of an issue this year than previously. The picture on affordability varies across the United Kingdom, with Wales arguing that any pay award is unfunded, and Scotland stating that there was provision for a pay award alongside incremental pay progression. Even though NHS funding has received some protection in Spending Review settlements, costs are rising sharply and the demands on the service are increasing. Our recommendations on pay have taken all of the evidence on affordability into account and we provide an estimate of the costs of our recommendations in Chapter 10.

Pay and remuneration

2.19 Levels of pay and remuneration packages for doctors and dentists are, in principle, potentially very important for recruitment and retention. For this reason, we have considered how doctors' and dentists' pay has changed over time, both in real terms and compared to the whole economy distribution of pay. We also consider how doctors' and dentists' pay compares to the private sector and to comparator groups, the influence of pay scales and the role of pay as part of total reward.

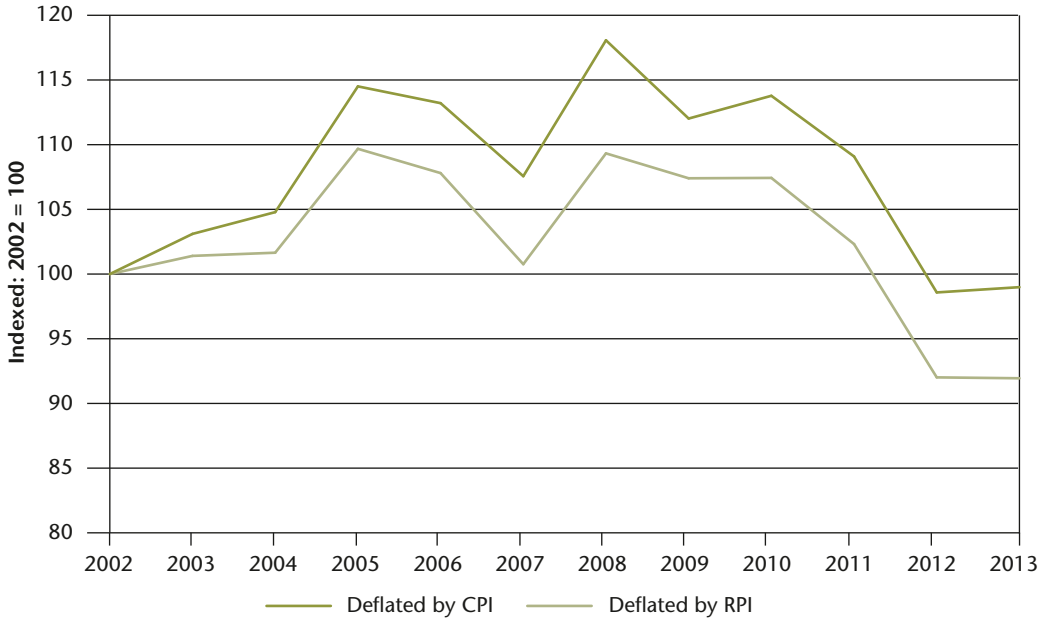
Pay levels

2.20 Figure 2.1 shows that the full-time median earnings of doctors and dentists employed in the public sector have decreased in real terms between 2002 and 2013. While the median reflects the changing composition of the workforce, with more new starters possibly applying a downward influence, it also shows the impact of recent pay restraint. As CPI is generally lower than RPI, the choice of index affects the size of the decrease in

[4] *Progress in Making NHS Efficiency Savings*. National Audit Office, 13 December 2012. Available from: http://www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

real earnings. In 2012, when deflated by CPI, earnings experienced a real terms decrease of 1.4 per cent compared to 2002, whilst deflating by RPI, the decrease is 8 per cent. The latest year's earnings figures for 2013, derived from Office for National Statistics data, have broadly kept pace with RPI, and remain around 8 per cent down in real terms compared to 2002, whilst deflating by CPI, real earnings are 1 per cent down on 2002 levels.

Figure 2.1: Real terms changes in gross earnings of public sector employed doctors and dentists, April each year, 2002 – 2013

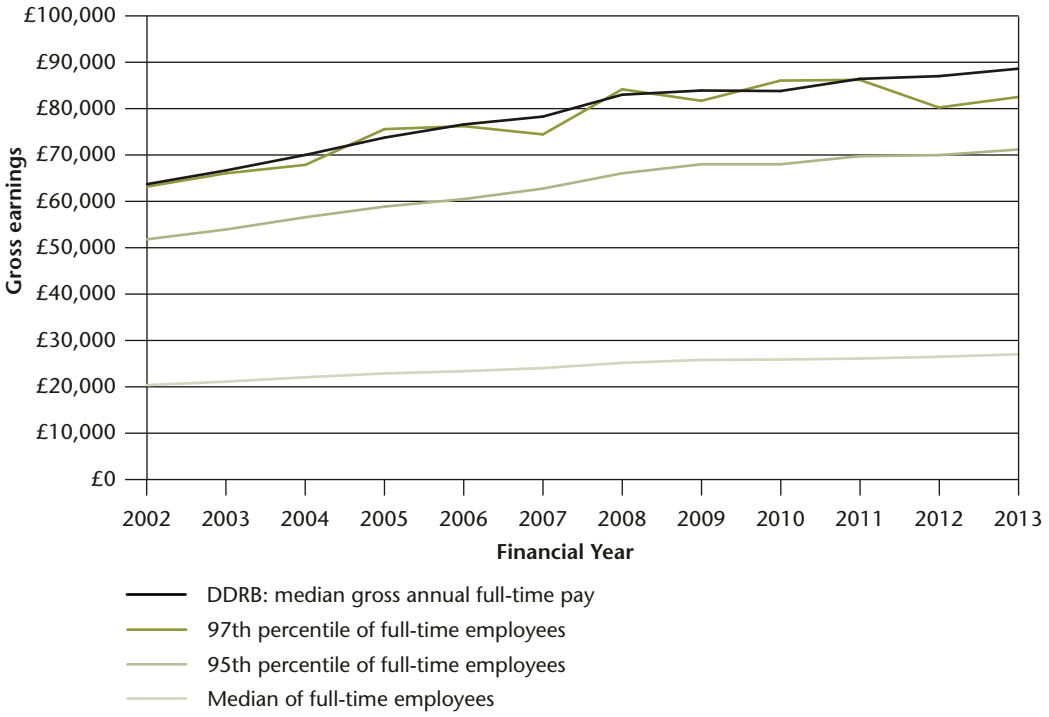


Source: Office of Manpower Economics calculations using Office for National Statistics data.

Note: The figures used are median full-time gross annual earnings of all employed doctors and dentists in the public sector (i.e. excluding independent contractor general medical practitioners and general dental practitioners) deflated by inflation as at April each year.

2.21 Even acknowledging the measurement issues, Figure 2.2 shows that the median gross annual full-time pay for employed doctors and dentists has tended to track the 97th percentile for all full-time employees. The large decrease in real terms earnings in 2012 that can be seen in Figure 2.1 can also be seen in actual earnings in Figure 2.2. Earnings have consistently been above the 95th percentile. The figure illustrates some of the issues relating to future pay settlements and the need for an exit strategy from the government's public sector pay policy. Doctors' and dentists' pay has tracked the 97th percentile through much of 2002 – 2011 but has fallen closer to the 95th percentile from 2012. As the period of pay restraint motivated by the government's fiscal mandate draws to an end, the parties will need to form a view on the appropriateness of the position of doctors' and dentists' pay in the pay distribution. Insofar as morale and motivation is concerned, this could involve judgements of fairness relating to the remit groups' historical positions in the distribution as well as issues relating to job specifications, role profiles and characteristics of the work relative to comparator groups. It will also involve issues relating to the demand for medical services and workforce planning which directly affect recruitment and retention to the profession. We intend to continue playing what we believe is an important role in judging the labour market of our remit groups, but feel that we can best add value if the parties are able to make clear to us their long-term view on the strategy for pay. We have spent some time this year reviewing these matters and outline the data we believe necessary to undertake this task in our report.

Figure 2.2: Movements in gross earnings from the Annual Survey of Hours and Earnings, United Kingdom, April each year 2002 – 2013



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

The figures used are gross annual pay of the 95th and 97th percentiles of all employees on full-time rates, and the full-time gross median annual earnings for *all* employed doctors and dentists in the public sector (i.e. excluding independent contractor general medical practitioners and general dental practitioners).

Public-private sector pay differentials

2.22 In an 'Observation'[5] published in December 2013, the Institute for Fiscal Studies (IFS) commented that revised OBR forecasts implied that by 2018-19, public sector pay was predicted to be 6.4 percentage points lower, relative to private sector pay, than it had been before the financial crisis in 2007-08. IFS stated that it was likely that public sector pay would fall to a lower level relative to private sector pay than in the early 2000s when parts of the public sector had experienced difficulties in recruiting and retaining staff. An important contributing factor to OBR's observation is the government's policy on public sector pay restraint. This will have implications for our remit groups and attention should be paid to an appropriate exit strategy.

Pay comparabilities

2.23 Although pay comparability does not form part of our terms of reference, we believe it is important to assess the pay position of our remit groups relative to other groups that could be considered appropriate comparator professions, and against recent trends in general pay and price inflation measures, to provide a broader context. Our approach looks at both pay levels and movements. The specific comparator professions that we currently use are: legal, tax and accounting, actuarial and pharmaceutical.[6] Further discussion of pay comparability for specific groups within our remit is included in the

[5] *Hard Choices Ahead for Government Cutting Public Sector Employment and Pay*. Cribb and Sibieta, December 2013. Available at http://www.ifs.org.uk/publications/7009.

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

relevant chapters. In this section, 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.

2.24 The BMA said that the value of doctors' remuneration continued to fall in real terms, due to government imposed below inflation settlements. It noted our analysis from our last report, that showed that doctors continued to fall behind the legal and actuarial comparator professions.

2.25 From our analysis for this year, the results show that: basic pay for doctors and dentists in training is lower than for their comparator groups at the same stages, but total earnings including banding supplements compare reasonably well with the comparator groups at every stage; basic pay and total earnings for associate specialists and specialty doctors are both lower than the comparator groups; new consultants' total earnings are lower than comparator groups, while experienced consultants, at the top of the salary scale and in receipt of Clinical Excellence Awards, have similar basic earnings to comparator groups but smaller total earnings; and the distribution of incomes for general medical practitioners (GMPs) and general dental practitioners (GDPs) is very large, but median earnings for independent contractor GMPs are comparable with those of the private sector comparators, while the pay range for salaried GMPs results in incomes substantially below those of the comparator groups; likewise, performer-only GDPs tend to be paid rather less than comparators, although they have the potential to earn more, while median earnings for providing-performers are in line with comparators.

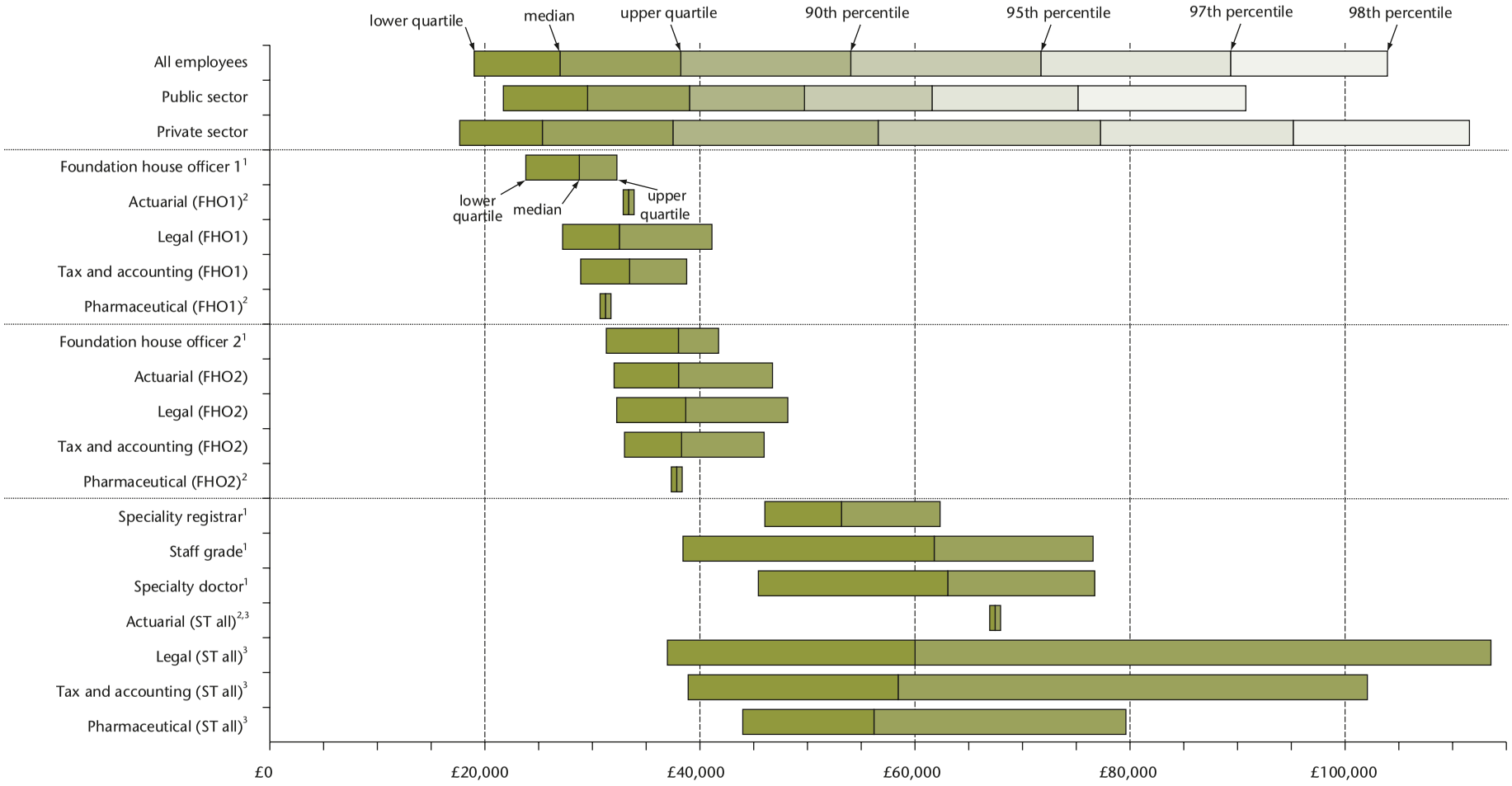
2.26 Figures 2.3 and 2.4 compare our remit groups' salaries with the national distribution for both the public and the private sector, and for the specific comparator professional groups. It is worth noting that the distribution of total earnings for doctors and dentists working in HCHS are on a per person basis and not on a full-time equivalent basis. Therefore these earnings will be biased downward by part-time staff and will therefore tend to be lower than full-time equivalent earnings and should therefore be interpreted with that in mind. They will also be influenced by workforce-mix effects (where an increase in entry to the profession may shift the distribution downwards). Figure 2.3 relates to doctors and dentists in hospital training, specialty doctors and staff grades. It shows that: median total earnings (per person) for foundation house officers (FHOs) in year one are higher than the full-time equivalent all-employees median gross pay; median total earnings of FHOs in their second year are close to being in the top 25 per cent of United Kingdom employees and, on average, earn similar levels to staff in comparator groups; and there is a large degree of overlap in the earnings distributions of training grades and the comparator groups.

2.27 Figure 2.4 relates to associate specialists, consultants, dentists and general practice: comments on the per person workforce-mix measurement issues continue to be relevant. It shows that, compared with gross pay of all employees in the wider economy: median earnings per person for associate specialists are above the 95th percentile; median earnings (including awards) for consultants are well above the 98th percentile; median income for independent contractor GMPs is just below the 98th percentile, with the lower quartile for independent contractor GMPs around the 95th percentile, while median income for salaried GMPs is slightly higher than the 90th percentile; median income for providing-performer GDPs is just below that of independent contractor GMPs; and the median income for performer-only GDPs is above that of a salaried GMP. Against their specific comparators, associate specialists tend to earn rather less on average; consultants, independent contractor GMPs and providing-performer GDPs have median incomes broadly similar to those in the comparator groups; and salaried GMPs and performer-only GDPs earn less than members of the comparator groups.

2.28 In summary, our analysis of pay comparability shows that, subject to the earlier comments on measurement issues, in general for all our remit groups, their relative position has declined against their comparator groups. The comparator groups have, in general, seen larger increases in their total pay.

2.29 To better inform our future deliberations, we would find it particularly helpful if the parties were able in future rounds to provide us with a greater understanding of our remit groups' earnings. Using the latest available annual data, for each of our remit groups within the hospital sector, we would like a breakdown by age, by gender and by country (to also include full-time equivalent (FTE) and headcount figures) in order to build up a picture of the wage distribution for our remit groups. We are particularly interested in total earnings, but would welcome any additional breakdown of the components of such earnings. We would also find it helpful to be provided with anonymised sample career profiles for different specialties and grades. Those data would enable us to track how pay is moving relative to the 95th and 97th percentile, which we consider important given the current contract negotiations, so that we can monitor where our remit groups are positioned within the overall labour market.

Figure 2.3: Total earnings ranges of DDRB training grades, staff grades and specialty doctors, 2013, compared with the national pay distribution and other professional groups, full-time rates[1]



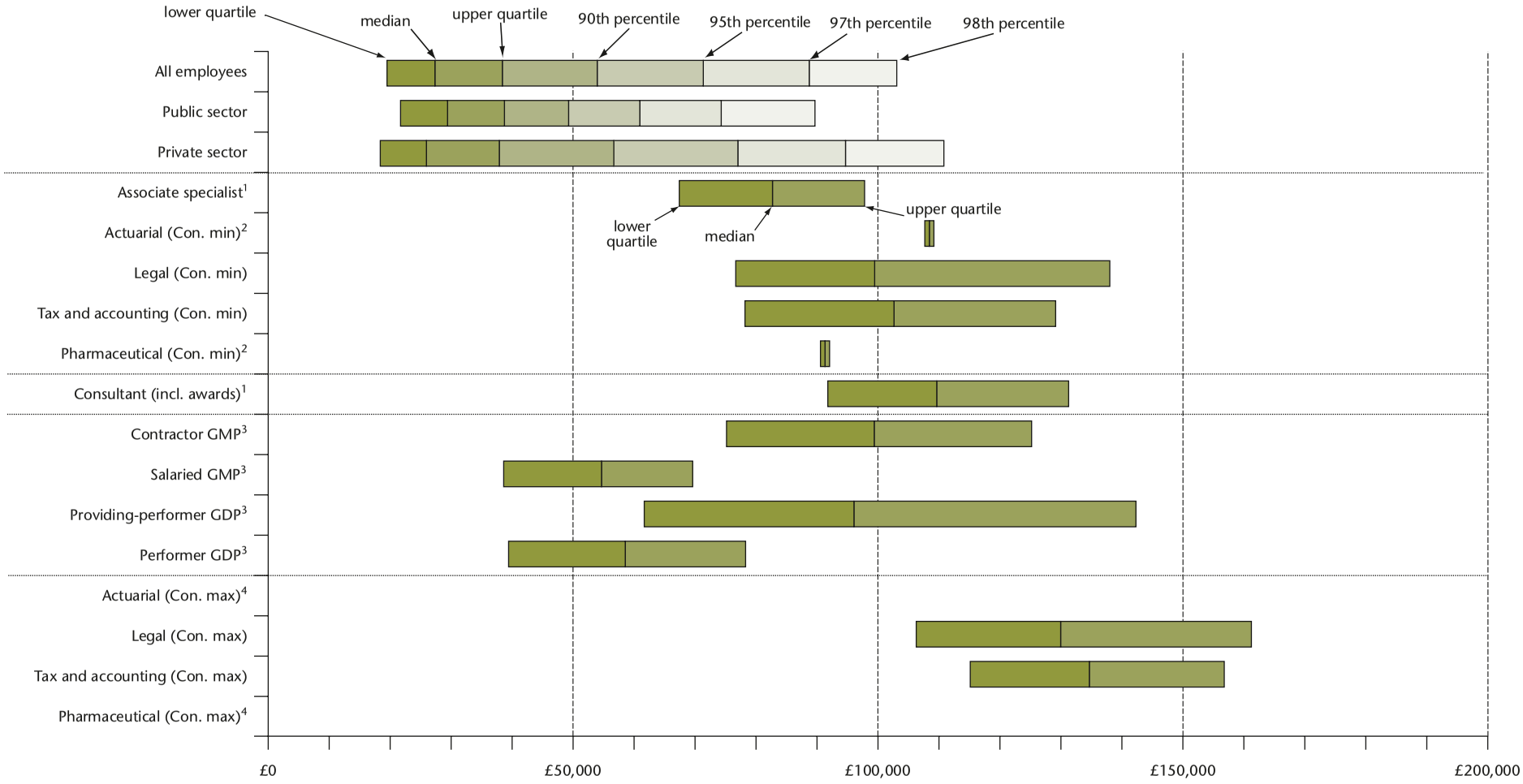
Sources: The Office for National Statistics, The Health & Social Care Information Centre, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending September 2013, by headcount.

[2] A range is not always available for these groups. A notional range of £1,000 is used to illustrate the median.

[3] The range for specialist training (ST all) covers four distinct reference levels / job weights (among the comparators) and the range given is from the lower quartile of the lowest-paid reference level, through the mid-point between the medians of the two middle level to the upper quartile of the highest paid reference level.

Figure 2.4: Total earnings ranges of consultants and equivalent grades, 2013, compared with the national pay distribution and other professional groups, full-time rates[1]



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

[1] Figures for hospital medical grades, contractor and salaried general medical practitioners and contractor general dental practitioners relate to total earnings in the year ending September 2013, by headcount.

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

[3] Estimated median incomes for 2011-12 for all (both full-time and part-time) general medical practitioners and general dental practitioners (the latest available data).

[4] Estimates are not available for these groups at this salary level.

Pay drift and incremental pay progression

2.30 Incremental pay progression is the way that the pay of staff increases as individuals move between the points within a pay scale. HM Treasury told us that automatic time-served progression was deeply rooted in the national contracts for doctors, and that in the current contract negotiations, a government requirement was to abolish automatic pay increases in the NHS. The Department of Health said that the reform of medical contracts should seek to improve the quality of patient care and outcomes by ensuring there was a better balance between pay, performance and productivity rather than time served, noting that substantial reforms to incremental pay progression would be taken forward or were already underway across the public sector. It asked us to consider and make observations on the Heads of Terms about negotiations for consultants and doctors in training, with particular emphasis on the current structure for incremental pay progression, and whether it could help improve performance and productivity. The BMA commented that it believed incremental pay progression to be an issue for contractual negotiations, but said that if incremental pay progression was targeted simply on the basis of affordability, then it would risk good faith discussion on the possible basis for pay in the future. We address the specific requests to comment on the Heads of Terms in the relevant chapters for trainees and consultants. However, in future, rather than asking us to comment on ad hoc aspects of ongoing negotiations, we ask the parties to request jointly our views (if required) at an appropriate stage in the timeline of such negotiations. We would welcome a proactive and systematic approach to consideration of contractual issues, including the pay scales.

2.31 The Welsh Government said that during 2012-13, its NHS pay bill increased by £35 million (1.2 per cent) compared to 2011-12, mainly attributed to incremental pay progression and pay awards.

2.32 The Northern Ireland Executive asked us to consider incremental pay progression as part of our review, but noted that many groups had clear contractual entitlements to progression and performance pay. It said that incremental drift accounted for approximately 3 per cent of its pay bill. It said that it would welcome our views on how the removal of incremental drift would impact on the workforce.

2.33 In contrast, the Scottish Government told us that there was provision in 2014-15 for incremental pay progression in addition to the pay award. It estimated the cost of increments to be 0.83 per cent for medical and dental staff.

2.34 NHS Employers commented that some terms and conditions could seem generous compared to other professions where career advancement often depended on performance, competence and the established need for work at a higher level, rather than purely serving time in a grade. They said that local employers wanted a clearer link between consultant pay progression and performance. Their evidence described ongoing work to make appraisal and performance management more robust. NHS Employers noted that increments gave eligible doctors increases of between 3 and 8 per cent per year. We note that the negotiated pay scales do not provide for annual increments for all doctors: for example, the final three pay scale points for consultants in England, Scotland and Northern Ireland are only obtainable at five-yearly intervals. Pay bill metrics showed that (see Table 2.1): for all HCHS doctors, pay bill per FTE growth was 0.6 per cent in 2012-13; and for consultants, pay bill per FTE growth was -0.4 per cent. However, NHS Employers said that the full impact of incremental pay progression was not evident in the basic pay per FTE metric as it was offset by negative pressures such as the changing distribution of staff across pay points (such as the growth in the workforce, with new staff near the bottom of the relevant pay scales); employers felt that increased investment in the pay bill to fund incremental pay progression was not commensurate with improved

performance or productivity. The Foundation Trust Network's evidence showed that 56 per cent of respondents to its survey (that formed the basis for its evidence) thought that the pay award should not take account of incremental pay progression.

Table 2.1: Estimated pay bill per full-time equivalent growth, England, 2009-10 to 2012-13

	2009-10	2010-11	2011-12	2012-13
All HCHS doctors (non locum)	1.8%	-0.3%	0.1%	0.6%
Consultants (including Directors of public health)	1.9%	-1.5%	-0.6%	-0.4%

Sources: Department of Health and NHS Employers.

2.35 The parties provided evidence on the current pay structures and incremental pay progression. The consultant pay scale included pay thresholds with requirements to participate in the appraisal process, job planning, meeting commitments and objectives, undertaking additional programmed activities (if offered) and adherence to rules surrounding private practice and NHS commitments. For specialty doctors and associate specialist (SAS) grades, the pay scale included pay thresholds and requirements to participate in job planning, appraisal, feedback and demonstration of higher levels of skill. In neither case therefore, could incremental pay progression be considered automatic. However, NHS Employers said that it was normal for consultants and SAS grades to receive automatic progression except in cases of unsatisfactory performance. For junior doctors, incremental progression was not dependent on performance, gateway or review, but, the BMA said, on time in service and a continuing increase in ability and responsibility. The BMA said that it would not describe increments as 'automatic' for any remit group, and that the arrangements for progression were included within the national contracts, which set out the conditions to be met. It agreed that in practice, the vast majority of salaried hospital doctors did receive an increment when due, but it considered that to be the desired outcome of an effectively implemented contract. The BDA told us that for salaried dentists in England and Wales, their pay scales included gateways and requirements to demonstrate competencies and to meet performance targets, as well as a requirement to participate in appraisal and job planning. Scotland's salaried dental service did not include performance gateways, and Northern Ireland's salaried dentists remained on an unmodernised pay system that assumed automatic pay progression unless underperformance issues were identified.

2.36 We are grateful for the work undertaken by the parties to improve the quality of the pay drift data we receive, that breaks the information down into a number of pay bill growth drivers. We have noted the comments made by NHS Employers that the increasing cost of the pay bill for consultants in 2012-13 due to the cost of paying incremental progression was entirely offset through savings from replacing workers who leave the top of the pay scale, with workers near the bottom of the scale. We also note that this is a snapshot in time, and that as these new doctors progress through the pay scales, there will be implications for the pay bill, although as shown in Table 2.1, the pay bill per FTE consultant has declined each year since 2010-11. For our next review, we would find it helpful if all of the Health Departments would provide pay drift information on the same basis as that provided by the Department of Health and NHS Employers this year, to enable us to make a meaningful comparison.

2.37 Our view on incremental pay progression has been well established over many years. We believe that pay drift arising from additional payments for higher volumes of work, or from the effects of negotiated contracts, including incremental pay scales, should not be offset against the annual award. We think that if we were to offset the earnings growth arising from increments from our recommended pay award, it would undermine the fundamental principle on which incremental pay scales are currently based. 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 on the basis of the current contracts. In any case, as shown by Table 2.1, the estimated growth in FTE pay bill for all HCHS doctors in England in 2012-13 is just 0.6 per cent, and -0.4 per cent for just consultants and directors of public health. As we have previously commented, we believe that if employers find the cost of increments to be unaffordable, then this issue should be addressed through contract negotiations: we note that the current contract negotiations are intending to address the issue of pay progression, with the consultant contract negotiations looking at the contribution of individual consultants and objectively measured job-based criteria rather than length of service, which addresses our long-held concern that the current pay scale for consultants rewards length of service more than contribution or performance,[7] and we ask the parties to update us on the outcome of the contract negotiations. It is, of course, the role of employers to ensure that the incremental pay progression arrangements are being operated fairly and that increments are withheld, when appropriate. We note that the Northern Ireland Executive sought our views on the impact of the removal of incremental pay, but as noted above, we believe that this issue should be subject to contractual negotiation.

2.38 Our view on pay drift qualifies but does not dominate our view on incremental pay progression more generally. Incremental pay progression with a strong link to performance needs to be grounded in a robust performance-based appraisal process. We note later in this chapter in the section on motivation that the *2012 NHS Staff Survey* in England recorded that although the percentage of staff saying that they had received an appraisal in the last 12 months had increased for all staff groups, the percentage having a well-structured appraisal for all groups was below 50 per cent. This suggests that there needs to be a major shift in the culture of the NHS to bring about an appraisal process that is fit for purpose.

Total reward: pensions and other benefits

2.39 We recognise that the NHS pension scheme continues to be a valuable recruitment and retention tool and note that, as with other parts of the public sector, the contribution rates increased in both April 2012 and 2013, with further increases due in 2014; and that from 2015 the final salary pension scheme will move to career average for most scheme members. GMPs and GDPs are already members of a career average scheme. Changes to the pension scheme and the tiered nature of employee contributions were two of the main themes we heard during our visit programme, and we note that the BMA took strike action over pensions in 2012.

2.40 The Department of Health said that public service pensions were among the best available, with guaranteed, index-linked benefits protected against inflation. It said that any changes to pensions, including increases in contributions, did not justify upward pay pressure, and noted that contribution increases had not led to a significant change in scheme membership, nor was there hard evidence that changes to the lifetime allowance had affected the recruitment and retention of key medical roles. The Northern Ireland Executive commented that it was unaware of a significant increase in members retiring early or leaving the scheme as a result of changes to the pension scheme or pension taxation. The Department of Health described a successful pilot scheme for total reward statements and said that a national rollout would begin when it could ensure improved employer engagement. It also said that there would potentially be further pension pressures in 2016 onwards given the changes in National Insurance and contracting out, stemming from the single tier pension policy.

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[7] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, December 2012. Page vii.

2.41 The Scottish Government told us that it was working on the terms of a new NHS pension scheme for Scotland, based firmly on the design for England and Wales, but allowing for operational differences in Scotland. Discussions were ongoing on how employee contributions would be tiered in the new scheme.

2.42 NHS Employers said that it recognised that many medical staff now had to make higher pension contributions, but said that the majority would also enjoy incremental pay progression, and noted that the age distribution of pension scheme members remained largely unchanged, suggesting members had not chosen to retire in disproportionate numbers. They said that a Treasury consultation paper on draft directions to recalculate the value of public sector pensions could raise a new and very significant cost pressure for the NHS from 2015, as would the changes to pension arrangements from 2016. NHS Employers also told us about their total reward strategy, and said that they were publishing a toolkit of resources to enable employers to deliver a more strategic approach to pay and reward, and the introduction of a benefit statement that extended beyond the basic requirement of providing pension benefit information and included details of pay and other reward benefits.

2.43 The BMA said that further increases to pension contribution rates and a reduction in the annual allowance in April 2014 had reduced doctors' take home pay and potential lifetime remuneration still further. It noted that after April 2015, NHS staff would overall fund double the proportion of their scheme's future benefits in comparison with civil servants. The BDA said that dentists who were paying contribution rates of 6 per cent prior to the pension scheme review in 2008 could be paying 13.5 per cent by 2015: an increase of 125 per cent over a seven-year period. It noted the observation by The Pensions Policy Institute that said that the impact across all members of the NHS scheme was to reduce the pension benefit from 23 per cent of a member's salary before the reforms to 14 per cent after the reforms, a reduction of more than a third.

2.44 We welcome the progress reported on the introduction of total reward statements, which as we noted last year, are particularly important in times of pay restraint and as a recruitment and retention tool, but note the concerns about the rolling out of the programme until employer engagement can be improved and, in this regard, the work being carried out by NHS Employers with the forthcoming publication of a toolkit of resources. We have, however, been struck by the absence of any strong total reward strategies from the parties, that would allow us to make our pay recommendations within a broader context. It may be the case (in England, at least) that dealing with structural changes in the NHS has inhibited employers' ability to focus on such strategies. For future rounds, we ask the parties to provide us with evidence on any national or local pay strategies that form part of the thinking on total reward, and to keep us advised of any total reward developments, and in particular, their impact on recruitment, retention and motivation.

2.45 In our previous reports, we said that we would consider the implications of any changes by the government to pension arrangements for doctors and dentists, including those following from the review of public service pensions by Lord Hutton's Independent Public Service Pensions Commission, which reported in October 2010[8] and March 2011.[9] We said that we would be interested in whether these significant changes to pension arrangements have had an effect on recruitment, retention and motivation. The evidence submitted by the parties on this issue suggests that the changes to the pension scheme

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8 *Interim Report.* Independent Public Service Pensions Commission, 7 October 2010. Available from: http://www.hm-treasury.gov.uk/d/hutton_pensionsinterim_071010.pdf

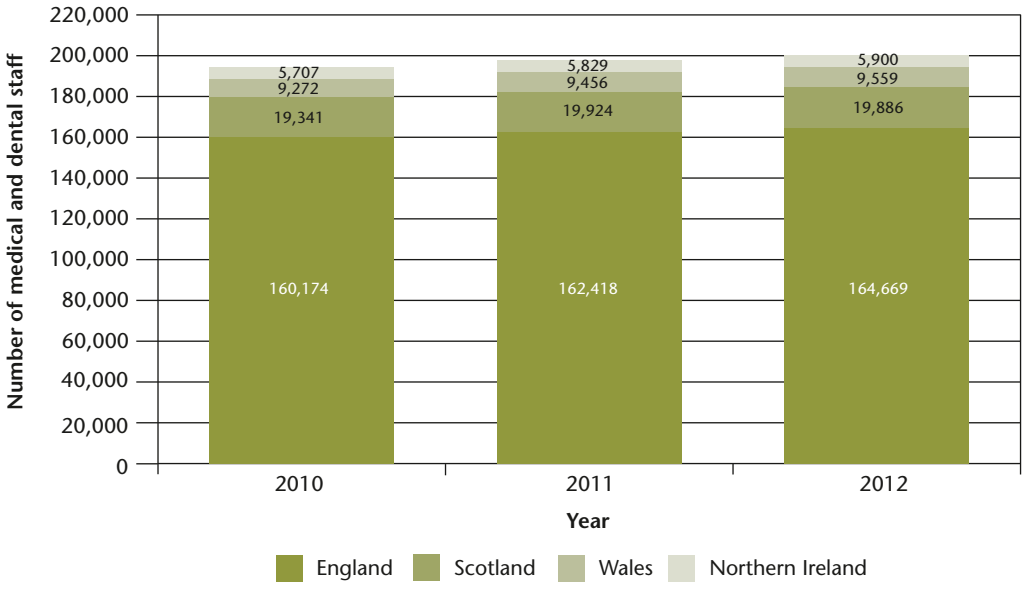
9 *Final Report.* Independent Public Service Pensions Commission, 10 March 2011. Available from: http://cdn.hm-treasury.gov.uk/hutton_final_100311.pdf

have not had a significant impact on recruitment or retention; and we have not received any substantive evidence to suggest an associated decline to motivation with the changes to the pension scheme. We will continue to monitor the situation.

Recruitment and retention

2.46 We are required to have regard to the need to recruit and retain doctors and dentists, and we see this as a fundamental element of our terms of reference. Figure 2.5 below shows that the number of medical and dental staff in each country has increased each year between 2010 and 2012,[10] except in Scotland where there was a small decrease in 2012. Our remit groups comprised approximately 200,000 staff in September 2012, a 1.2 per cent increase on the previous year.

Figure 2.5: Total number of medical and dental staff, United Kingdom, 2010 – 2012



Medical and dental staff are FTE HCHS staff and headcount of primary care staff.
Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety, Health and Social Care Business Services Organisation in Northern Ireland.

2.47 The statistics in Figure 2.5 show recent changes in the medical and dental staff workforce, however since 2002, we estimate that there has been at least a 25 per cent increase in the number of doctors and dentists. This is consistent with what NHS Employers told us when they said that the ratio of HCHS doctors to HCHS non-medical staff had increased: from 7.6 FTE doctors per 100 non-medical staff in 2002 to 9.8 in 2012. We note from Health Education England's *Workforce Plan for England*[11] that with the future supply already in the education system, it forecasts an average increase in the consultant workforce of over 1,800 posts per year, if sufficient jobs are available, with this level of growth guaranteed until at least 2020. It also notes that current planned training volumes are also forecast to enable growth to the GMP workforce at 2.7 per cent per

[10] Because of changes made in 2010 to the way in which headcount staff in Hospital and Community Health Services are counted in England – effectively removing instances of double counting – data from 2010 are not comparable with previous years. This does not affect full-time equivalent data or primary care, or other United Kingdom countries.

[11] *Workforce Plan for England*. Health Education England, December 2013.
Available from: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/12/Workforce-plan-interactive1.pdf

annum, compared to the average growth over the past ten years of 2.1 per cent. We ask the other countries to keep us informed of their assessment of how the future workforce is likely to be affected by current training volumes.

2.48 With regard to vacancies in England, the Department of Health reported that increased investment had gone some way to remedying structural skill shortages, noting that the number of specialties on the National Shortage Occupation List had reduced from 18 in November 2011 to seven in April 2013: consultant shortages remained in emergency medicine, haematology and old age psychiatry; and non-consultant, non-training shortages in anaesthetics, general medicine delivering acute services, rehabilitation medicine and psychiatry. It said that it would continue to monitor the position as part of its responsibility to ensure strategic supply for the NHS in England, and that Health Education England had been tasked to reduce the number of roles on the shortage occupation list by March 2015 and encourage more doctors into emergency medicine. We ask the Department and Health Education England to keep us informed of developments, and for the other countries to provide us with evidence to show how they are tackling shortage specialties. NHS Employers said that recruitment and retention was generally stable, and that where there were known recruitment challenges, they were not related to national pay scales and needed wider labour market supply solutions: local employers already had pay flexibilities to address any local labour market challenges. We address the use of the consultant recruitment and retention premia in Chapter 8.

2.49 The Welsh Government said that turnover figure for non-training doctors stood at 6.84 per cent in the year to March 2013, down on year from 7.25 per cent, and concluded that the workforce across NHS Wales was relatively stable. It said that the biggest recruitment problems were with emergency medicine at all grades and generally across Wales, and that there were also difficulties in a number of specialties which generally reflected United Kingdom and/or international shortages, such as radiology, some of the pathology disciplines, psychiatry, physicians specialising in the care of the elderly and paediatrics. It said that reconfiguration plans would take into account difficulties with recruiting in North and West Wales. The Welsh Government said that 97 per cent of posts were currently filled, reflecting the effective work carried out by NHS organisations. It said that generally, the problems appeared to be related to career choices within the profession, and that training programmes needed to reflect future service requirements and the mechanisms for encouraging doctors into training in specialties based on likely future requirements. We ask the parties to consider these issues alongside contractual negotiations and report back to us on developments for our next review.

2.50 The Scottish Government said that the total number of HCHS doctors at 30 June 2013 was 11,105 FTE, an increase of 96 FTE (0.9 per cent) on year. Evidence from the Scottish Government on individual remit groups is contained in the appropriate chapters of this report.

2.51 The Northern Ireland Executive said that at March 2013, the number of FTE medical and dental staff had increased by 1.4 per cent on year. It said that the overall picture on recruitment and retention was relatively stable in Northern Ireland, although some recruitment difficulties existed for particular specialties such as emergency medicine, and in specific geographical locations, largely the West of Northern Ireland. It noted that the recruitment and retention premia for consultants were available for employers to use, and said that the reconfiguration of services would lead to some specialist services being centralised, reducing the risk of recruitment difficulties. We also noted some results from

Northern Ireland's *Health and Social Care Staff Survey 2012*:[12] 47 per cent of medical and dental respondents felt there were not enough staff to allow them to do their job properly; and 26 per cent of medical and dental staff often considered leaving their organisation.

2.52 The BMA drew our attention to recruitment problems in a number of specialties, including psychiatry, emergency medicine and nuclear medicine. It said that the relationship between recruitment, retention, workload and remuneration was complex, but anecdotal evidence it had gathered reinforced its view that the NHS had reached a critical point in some specialties and some rural locations.

2.53 It is our view that the broad recruitment and retention picture for doctors and dentists is not a cause for major concern, but that there are grounds for real concern within some specialties and in some geographic areas. There does not, however, appear to be any appetite amongst the parties to consider differential pay by either specialty or region, both of which have the potential to address shortages: indeed, the Heads of Terms on the consultant negotiations specifically state that the parties agree the intent is not to produce variation in pay by region or consultant specialty. We comment on fill rates for trainee doctors in Chapter 7 and on the use of the recruitment and retention premia for consultants in Chapter 8.

2.54 In this year's evidence, emergency medicine has emerged as being a specialty with particular difficulties in recruiting and retaining sufficient doctors. The General Medical Council's recent report *The State of Medical Education and Practice in the United Kingdom* noted[13] the low acceptance rate for emergency medicine (at 35 per cent), and that overall, emergency medicine lost 12 per cent of its trainees between 2012 and 2013, and that trainees were struggling to progress. We expect the current junior doctor and consultant contract negotiations to address any pay mechanisms that might assist in recruiting to problem specialties across all grades, either by the use of the consultant recruitment and retention premia or by some other mechanism, and also to consider whether some other sort of work/life balance measures might be more appropriate. We also expect the workforce planning being undertaken by Health Education England and the recommendations contained within the report by Professor David Greenaway entitled *Shape of Training*,[14] that included suggesting introducing more broadly based training in specialties, and an increased ability to change specialties, to help address recruitment problems. During oral evidence, it was suggested that emergency medicine might be made more attractive by increasing the amount of annual and sabbatical leave available for such posts: this would have implications for the overall wage bill, but not for the pay of individual doctors. Given the contract negotiations, we do not consider it appropriate to recommend a pay response to address shortages at this stage, although we would welcome evidence from the parties on whether such a response is needed following the outcome of the negotiations, or if any other mechanism for addressing shortages might be more appropriate. Our analysis of recruitment problems for hospital trainees is contained in Chapter 7.

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[12] *Health and Social Care Staff Survey, September – October 2012*. Department of Health, Social Service and Public Safety, 2013.
Available from: http://www2.hscni.net/HSC_Staff_Survey_2012/HSC%20Staff%20Survey%20Report%202012%20%20%20PDF%20Version%20of%20Final%20Overall%20Report%20(Amended)%20and%20Shortened%20Version.PDF

[13] *The State of Medical Education and Practice in the UK*. Chapter 1. General Medical Council, 2013.
Available from: http://www.gmc-uk.org/publications/23435.asp

[14] *Shape of Training: Securing the Future of Excellent Patient Care.* Professor David Greenaway, October 2013.
Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

2.55 For our next round, we ask the parties to provide evidence on recruitment and retention that also takes into account headcount and FTE data, regional variations, the moves towards seven-day services, the increasing proportion of women in the workforce, and (in England) the target to increase the number of trainees choosing to enter general practice. We would also welcome the parties' assessment of any implications for pay of such evidence.

Vacancy data

2.56 In our last report, we asked for the Health Departments to take steps to ensure that the Health and Social Care Information Centre and its equivalents provided up-to-date vacancy information on HCHS staff and GMPs, as this is an important measure in our ongoing analysis of the workforce position. We believe it essential that our recommendations are based on robust statistics and evidence, so that they retain the confidence of government, employers, the trade unions and staff. We remain concerned about the continued absence of data on vacancies, which carry weight within the evidence available on recruitment and retention.

2.57 We noted last year that there were plans to introduce an alternative source of data on vacancies, using the re-tendered NHS Jobs website. However, we are disappointed to note that the launch of this service has been delayed, which has impacted negatively on the breadth of the evidence available to us.

2.58 Vacancies data are essential to inform long-term strategies for pay and workforce planning and these inevitably affect the quality of patient care. As we commented last year, the absence of robust statistics on vacancies also risks undermining the credibility of our recommendations. We urge the four Health Departments to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round.

2.59 We also consider it pertinent to our deliberations to consider the extent and cost of the use of locums in order to fill service gaps, broken down by specialty and grade. We therefore ask the parties to provide us with such evidence on an ongoing basis.

Workforce planning

2.60 Workforce planning does not form part of our terms of reference, but it is very important because of its link to recruitment and retention. The Department of Health told us about recent workforce supply developments: it had given a mandate to Health Education England to address the strategic objectives of government in the areas of workforce planning, health education, training and development; 13 Local Education and Training Boards (LETBs) had been created by Health Education England, with responsibilities for managing workforce planning, education commissioning and education provision across England; and the Centre for Workforce Intelligence was an independent body to provide national and strategic intelligence and consider international implications. The Department referred to some recent reviews with workforce implications: the Francis inquiry into the care provided by Mid Staffordshire NHS Foundation Trust had concluded that there was a need for evidence-based guidance and tools to inform appropriate staffing levels; and the Keogh Mortality Review report had concluded that the Department should work with the National Institute for Health and Clinical Excellence, the Care Quality Commission and NHS England to review the use of evidence-based guidance and tools to inform staffing decisions locally.

2.61 Health Education England told us that it was responsible for the provision of education, training and personal development of every member of NHS staff. It was employer-led, to provide the right workforce, with the right skills and values, in the right place at the right time, to better meet the needs and wants of patients. Its aims included a reduction

in the number of specialties in the Shortage Occupation List by March 2015. Its main workforce plan[15] was published in December 2013 and forecast an average increase in the consultant population of between 3 and 4 per cent per annum; and also set out its action to increase the number of doctors entering general practice training.

2.62 Drawing on its survey carried out to inform its evidence to us, the Foundation Trust Network said that 53 per cent of respondents were not optimistic that Health Education England and LETBs would be able to deliver on their workforce planning remits.

2.63 The devolved administrations also reported on workforce planning issues:

- The Scottish Government said that it was for Health Boards to plan workforces according to local needs and priorities, but the Scottish Government was developing its role to firmly integrate the intent of the *2020 Vision*, that committed to ensuring that Scotland had flexible approaches to workforce planning to deliver the right people, at the right time at the right place; and its Reshaping Medical Workforce Project included an aim to minimise the possibility of medical unemployment.
- The Welsh Government was looking to bring services together in fewer locations to serve a larger population with the aim of improving efficiency and effectiveness, with some services currently provided in hospitals being moved (with new facilities) to the community.
- The Northern Ireland Executive said that its medical workforce had last been reviewed in 2009 and that a further review was now due, to consider the configuration of both primary and secondary care to meet with its *Transforming Your Care* model, with more services provided locally with opportunities to access specialist hospitals when needed. It said that the review of the dental workforce (carried out last year) had been overtaken by the *Transforming Your Care* report and that its findings would no longer be published.

2.64 The BDA commented that the dental profession continued to attract an increasing number of women, while the ageing male cohort moved closer to retirement. It said that these demographic changes needed to be considered by workforce planners and by policy makers as different cohorts might seek alternative working arrangements. We support this view and ask the parties to bear this issue in mind when formulating their future plans.

2.65 We ask the parties to keep us abreast of workforce planning issues, including any staffing targets that form part of such plans, and views as to whether a pay response is required in helping to shape future workforce numbers. We note the views of the Foundation Trust Network, that it is not confident that Health Education England and LETBs will be able to deliver on their workforce planning remits, and therefore ask all parties to provide us with evidence to enable us to monitor the situation. We also ask the parties to update us on how they are taking account of demographic changes in their workforce planning, for all of our remit groups. We would find it helpful for future evidence to include headcount figures and FTE estimates, broken down by gender.

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

2.66 We are required by our terms of reference to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists. We commented earlier in this chapter that there did not appear to be any appetite from the parties to bring about regional pay for our remit groups, although we would be happy to consider such evidence in future rounds given the anxieties raised about recruitment in some rural areas and other locations. We certainly did not receive any

[15] *Investing in People for Health and Healthcare: Workforce Plan for England*. Health Education England, December 2013. Available from: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/12/Workforce-plan-investing-in-people.pdf

evidence indicating particular recruitment issues in London that could be addressed by pay. 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 should remain at the existing levels, and we have seen no evidence this year that recruitment and retention in London are causing major problems or that suggests the need to revisit our previous decision.

2.67 Last year, we noted the existence of the South West Pay, Terms and Conditions Consortium, and that it had been set up in June 2012 to produce a full business case by the end of 2012 in order to "quantify the current and future economic, financial and service challenges, and in turn consider how best to create a 'fit for purpose' set of pay, terms and conditions". We understand that the Consortium was disbanded in March 2013. In this year's evidence, the BMA said that it strongly rejected attempts to introduce local market-facing pay for doctors, and continued to believe that a national contract with independent pay recommendations represented the most efficient, effective and beneficial approach for the NHS, for patients and for the profession. It said that it believed that the disbanding of the South West Pay Consortium in March 2013 reinforced the national nature of the market for doctors and the need for national contracts. We ask the parties to provide us with evidence that could have implications for regional pay for doctors and dentists.

Motivation

2.68 Our terms of reference require us to have regard to motivation. This element of our terms of reference is of particular interest to us because of its effect on recruitment, retention and the quality of patient care. In this year, with the increasing scrutiny of and pressure on the NHS, and the plans to provide more comprehensive seven-day services, (see paragraph 1.7), we believe that we should focus more heavily on the requirement within our remit to maintain the motivation of our remit groups.

2.69 It might be helpful to the parties to set out our understanding of the concept of motivation, although we would also welcome their individual interpretation of this aspect of our remit. Motivation is used as a descriptor in four main ways:

- in the sense of being 'driven' – something fairly stable across time in an individual ("they are highly motivated");
- in the sense of something more changeable, closer to engagement ("I'm feeling motivated today");
- in terms of 'motivated behaviour' – linked to performance; and
- in terms of 'motivators' – workplace characteristics that drive levels of motivation, including pay and other factors.

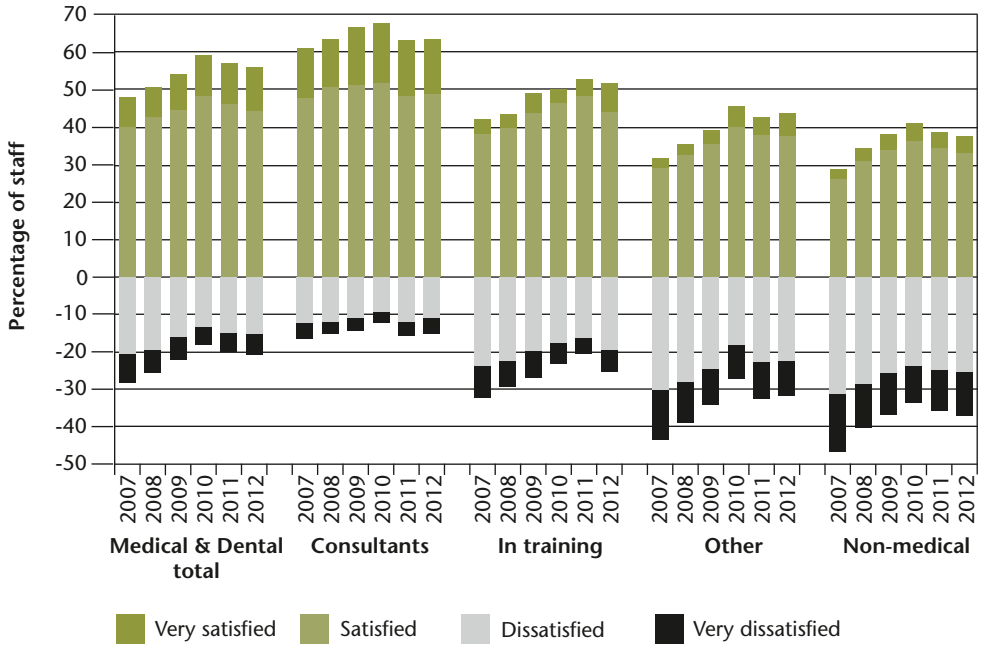
2.70 We are sceptical about the scope of the current evidence that is provided to us on motivation: at present, it appears to focus primarily on the engagement of staff. We would wish to see evidence that covered all of the aspects of motivation listed above. We believe that there is a clear case for research to be carried out to improve the knowledge base of this strand of our remit, and we stand ready to discuss with the parties any such research that they might take forward. We will be asking our secretariat to take this issue forward with the parties over the summer.

2.71 Turning to the motivation evidence that we did receive for this round, the 2012 *NHS Staff Survey*,[16] conducted in autumn 2012, was the second to be carried out during the government's two-year public sector pay freeze for our remit groups. Figure 2.6 shows that, generally, between 2011 and 2012, there was little change in staff satisfaction with their level of pay in England. The biggest change was for the training grades: for

[16] The 2012 survey for England was the tenth annual survey. Around 101,000 staff responded to the questionnaire, a response rate of 50 per cent, a decrease on the 2011 survey (54 per cent).

these, there was an increase (from 20.7 per cent to 25.3 per cent) in the percentage dissatisfied[17] with their pay. The most dissatisfied group was 'other' staff (which includes SAS doctors), 31.9 per cent were dissatisfied[18] with their pay. These results reflect the views of staff following the implementation of higher pension contribution rates from April 2012. We note that consultants are the group most satisfied with their level of pay.

Figure 2.6: HCHS staff satisfaction with their level of pay, England, 2007 – 2012



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

Source: National NHS Staff Survey.

2.72 We do not believe that the 2012 *NHS Staff Survey* provides detailed evidence on all aspects of motivation but it does provide evidence on staff engagement. We looked at the key results of several questions from the autumn 2012 *NHS Staff Survey* in England and compared results for 2012 with results for the five previous years. Table 2.2 below shows the trends for HCHS medical and dental staff, for the six years 2007 – 2012, from the *NHS Staff Survey* in England. It shows that:

- for medical and dental staff as a whole, there was little change between 2011 and 2012 in average scores for staff motivation at work;[19]
- for medical and dental staff as a whole – as well as separately for consultants, training grades and "other" medical and dental staff – there continued to be a general increasing trend in job satisfaction;
- for medical and dental staff as a whole, a continuation of the decline (since 2008) of the percentage of staff receiving job-relevant training, learning or development in the last 12 months;
- average scores for feelings of work pressure decreased (i.e. improved) slightly between 2011 and 2012 for consultants and "other" medical and dental staff, but increased (i.e. deteriorated) very slightly for training grades. Over the last five years, consultants had on average higher scores (i.e. worse) than training grades and other grades on work pressure felt by staff;

[17] Answering that they were dissatisfied or very dissatisfied with their level of pay.

[18] Answering that they were dissatisfied or very dissatisfied with their level of pay.

[19] Staff motivation at work was calculated in the following way: staff were asked the extent to which they agreed with the following three statements: "I look forward to going to work"; "I am enthusiastic about my job"; and "Time passes quickly when I am working".

- all staff groups reported increases in the number of extra worked hours between 2011 and 2012, and over the last 12 months, they also reported that they each had experienced a decline in the percentage receiving job relevant training, learning or development; and
- the percentage of staff saying that they had received an appraisal in the last 12 months increased for all staff groups, as did the percentage of staff reporting having a well-structured appraisal, although the percentage having a well-structured appraisal for all groups was below 50 per cent.

Table 2.2: Summary results from the National NHS Staff Survey, hospital medical and dental staff, England, 2007 – 2012

Measure	2007	2008	2009	2010	2011	2012	Trend[1]
Workload							
Work pressure felt by staff[2,3]	3.09	3.06	3.08	3.06	3.10	3.04	
% staff working extra hours[2]	72.8	75.0	75.3	76.8	79.4	83.5	
% staff suffering work-related stress in last 12 months[2]	26.2	22.2	25.0	24.5	23.1	32.0	
Training and appraisals							
% staff receiving job-relevant training, learning or development in last 12 months	82.9	85.5	85.2	84.6	82.5	80.5	
% staff appraised in last 12 months	76.3	74.4	78.0	79.4	81.4	87.7	
% staff having well-structured appraisals in last 12 months	29.1	29.4	31.6	34.0	35.2	37.4	
Engagement and job satisfaction							
Support from immediate managers[3]	3.50	3.53	3.55	3.56	3.61	3.57	
% staff reporting good communication between senior management and staff		29.4	27.8	31.9	34.1	30.2	
% staff able to contribute towards improvements at work		66.6	63.7	66.1	67.4	70.1	
Staff recommendation of the Trust as a place to work or receive treatment[3]			3.51	3.53	3.51	3.61	
Staff motivation at work[3]			3.97	3.94	3.94	3.95	
Staff job satisfaction[3]	3.49	3.55	3.57	3.59	3.64	3.67	

Source: National NHS Staff Survey.

Notes:

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

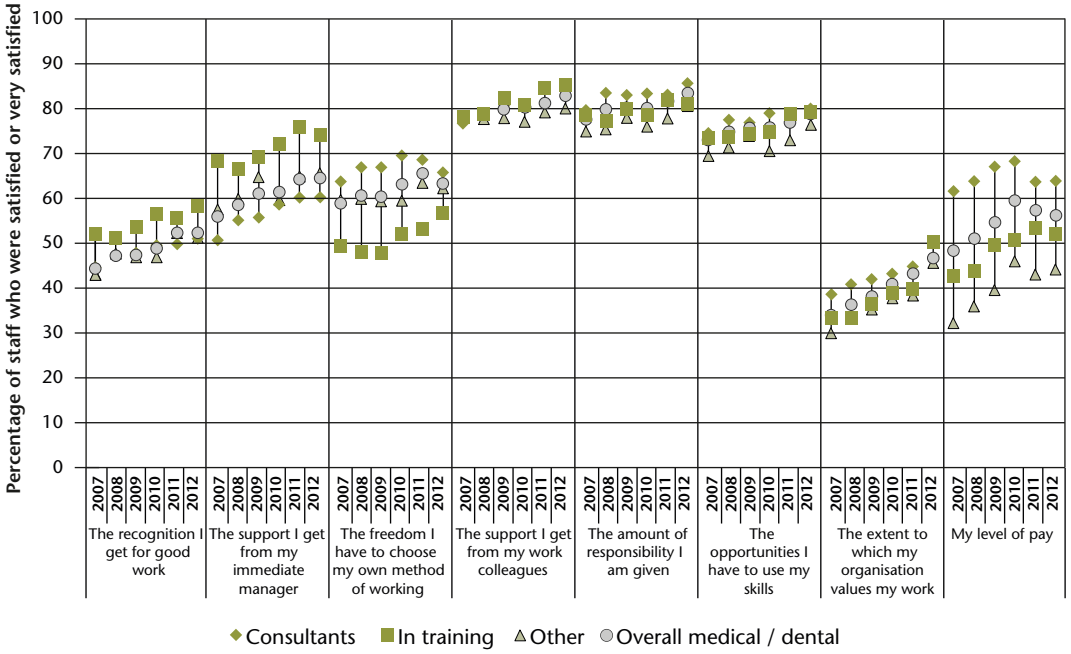
2 Lower scores are better in these cases, however, in all other cases, higher scores are better.

3 Results are on a scale from 1 to 5.

2.73 Figure 2.7 below shows the change in the percentage of staff satisfied or very satisfied with other aspects of their jobs, by grade.

- Both the percentage feeling satisfied with the recognition they get for good work, and the percentage feeling satisfied about the support they get from their immediate manager in 2012, stayed at 2011 levels. The exception to this was the training grades, which experienced a small increase in the percentage satisfied with the recognition they received for good work but a small decrease in the percentage satisfied with the support they had received from their immediate manager. Training grades remained the group most satisfied with recognition they receive from their immediate manager.
- Consultants have tended to be, on average, the grade most satisfied with freedom to choose their own method of working, responsibility they are given and their level of pay; but tended to be least satisfied with support from their immediate manager.
- Each year has seen increases in the percentage of staff satisfied with the extent to which the organisation values their work. In particular, between 2011 and 2012 there were large increases in the percentage of the training grades and "other" medical and dental staff satisfied with this aspect. These increases led to the consultant grade being overtaken by the training grades as the group most satisfied with the extent to which the organisation values their work.

Figure 2.7: HCHS medical staff satisfaction with aspects of their job, England, 2007 – 2012



Source: National NHS Staff Survey.

2.74 In 2013, all NHS staff in Wales were invited to take part in the latest staff survey[20] and it resulted in a response rate of around 27 per cent. However, as the last full survey of NHS Wales' staff was completed in 2007, there are no comparisons available for trends over time. We are not able to compare precisely the engagement scores in Wales with equivalent scores in England as different questions were asked at different periods of time. Table 2.3 shows the engagement scores for England and Wales for different staff

[20] *NHS Wales Staff Survey 2013*. NHS Wales, May 2013. Available from: http://www.wales.nhs.uk/nhswalesstaffsurveyresultspublished

groups: consultants in Wales tended to have similar levels of engagement as the Wales all staff figure, whereas in England consultants tended to be more engaged than the average across all staff.

Table 2.3: Staff survey engagement scores, England and Wales

Staff group (defined by Wales)	Wales' engagement score	Staff group (defined by England)	England's engagement score
Medical & dental (other)	60	Medical/dental (other)	58
Medical & dental (consultant)	55	Medical/dental (consultants)	64
All staff	55	All staff	56

Sources: National NHS Staff Survey, NHS Wales.

Note: Results between England and Wales are not strictly comparable as engagement scores are based on different questions.

2.75 Other results from the survey in Wales showed that in 2013, medical and dental (non-consultant) staff were one of the most satisfied staff groups (71 per cent) with their present job compared to the 64 per cent of all staff figure for NHS Wales. The survey recorded that 26 per cent of medical and dental consultants were dissatisfied with the quality of care they gave to patients/service users. All NHS Wales employees were asked to what extent they agree with the statement "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation": the endorsement of this statement by 52 per cent of employees suggested only around half of the workforce would advocate the services of the organisation they work for, however 29 per cent neither agreed nor disagreed. However, analysis by occupational group showed that advocacy of NHS Wales organisations was highest among medical and dental (non-consultants) group (63 per cent).

2.76 Scotland carried out a staff survey in 2013,[21] the latest since 2010. Around 156,600 were invited to take part and around 44,400 returned a completed questionnaire. This represented a 28 per cent response rate, which was slightly higher than the response rate for the 2010 NHS Scotland Staff Survey of 26 per cent.

2.77 Where there were significant differences, the latest attitude results in Scotland (for all staff, including non-medical staff) showed a trend of things getting worse since 2010. In the analysis of 21 attitude questions with significant differences compared to 2010, only two had increased on 2010 levels. Further, these two were relatively small improvements (+3 percentage points and +2 percentage points). The other 19 questions varied from -1 percentage point to -15 percentage points.

2.78 The survey showed that appraisal rates for our remit groups in Scotland were: 85 per cent for hospital doctors and dentists; 90 per cent for doctors in training; 71 per cent for salaried GDPs; and 89 per cent for salaried GMPs.

2.79 When asked if they agreed that there were enough staff for them to do their job properly, of all staff in Scotland, 31 per cent agreed (up 3 percentage points on 2010), whilst 47 per cent disagreed. For our remit groups, 27 per cent of medical/dental staff agreed; 29 per cent of salaried GMPs agreed; and 36 per cent of both doctors in training and salaried GDPs agreed. Less than half (42 per cent) of all staff agreed that they could

[21] *NHS Scotland Staff Survey 2013 – National Report*. Scottish Government, November 2013. Available from: http://www.scotland.gov.uk/Publications/2013/12/4235/downloads

meet all the conflicting demands on their time at work, whilst 36 per cent disagreed. For our remit groups: 32 per cent of salaried GMPs agreed; 33 per cent of medical/dental staff agreed; 44 per cent of doctors in training agreed; and 36 per cent of salaried GDPs agreed.

2.80 When comparing the responses to 40 questions across the medical staff groups we can see which staff group answered questions least[22] or most[23] positively. Amongst the medical staff groups, the salaried GDP group answered the survey least positively, with lowest scores in 16 out of 40 questions. The doctors in training staff group answered most positively, with highest scores in 19 out of 40 questions.

2.81 The Department of Health, Social Services and Public Safety in Northern Ireland carried out a survey[24] of their Health and Social Care staff in 2012. Around 17,000 staff were surveyed and around 6,800 staff participated, representing a response rate of 40 per cent. The previous survey was in 2009. Table 2.4 gives a summary of some of the questions which are broadly comparable to England. In none of these questions did Northern Ireland score higher than England. Further, there were notable negative differences in appraisal rates, recommendations as an organisation in which to work and in the feeling that staff do their job to a standard they are pleased with.

Table 2.4: Comparison of responses to staff survey questions, medical staff, Northern Ireland and England

Survey question wording	Northern Ireland (%)	England (%)
In the last 12 months, have you had an appraisal or Knowledge and Skills Framework (KSF) development review?	77	
In the last 12 months, have you had an appraisal, annual review, development review, or KSF development review?		87
I would recommend my organisation as a place to work	51	60
I am able to do my job to a standard I am personally pleased with	65	80
I feel that my role makes a difference to patients/clients/service users	92	93
Communication between senior management and staff is effective	24	34
There are enough staff in this work area/team/department for me to do my job properly	35	
There are enough staff at this organisation for me to do my job properly		35

Sources: National NHS Staff Survey, Health and Social Care Staff Survey, Northern Ireland.

2.82 The BMA referred to the National Audit Office's report *Progress in Making NHS Efficiency Savings*[25] and agreed with the report's conclusion that "sustaining the savings made through pay restraint may… have a detrimental effect on staff morale and productivity". The BMA said that it was considering research on the link between motivation, performance and different forms and levels of reward, particularly building on the

[22] Or jointly least positive.

[23] Or jointly most positive.

[24] *Health and Social Care Staff Survey 2012*. Department of Health, Social Services and Public Safety, 2013. Available from: http://www.hscni.net/HSC_Staff_Survey_2012/

[25] *Progress in Making NHS Efficiency Savings*. National Audit Office, 13 December 2012. Available from: http://www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

evidence around outcomes (clinical and patient experience) and considering the asymmetric effect of a pay rise against a pay cut. We welcome this proposed research and ask all of the parties to engage with the BMA in taking this proposal forward so that the research can inform our next round.

2.83 Comments from the BDA relating to motivation are contained in the relevant chapters for dentistry.

2.84 The evidence we receive on motivation appears to focus primarily on the engagement of staff and is largely drawn from high level staff summaries. We would, however, like to develop a better understanding and definition of the various factors impacting on morale and motivation, rather than an approach that tends to try and ascertain how respondents are 'feeling'. The parties may wish to consider alternative additional approaches to obtaining such evidence and information: perhaps by focus groups or by information gleaned from exit interviews. We will be asking our secretariat to explore with the parties how they might improve their motivation evidence to provide a wider view. We also ask that all countries undertake staff surveys on a regular, preferably annual, basis, so that we can monitor trends closely. We would also welcome a uniform approach across all countries of the United Kingdom in order to facilitate comparisons.

Overall NHS strategy – 'patients at the heart'

2.85 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 Department of Health's evidence included references to its Business Plan that supported a patient-led NHS, the NHS Constitution that said that the "NHS belongs to the people", and Robert Francis's comments when speaking about his report on Mid Staffordshire NHS Foundation Trust that "people must always come before numbers. Individual patients and their treatments are what really matters". The Department said that patients need the NHS every day, not just Monday to Friday and not just in hospitals, but increasingly in an integrated way in the community. The Welsh Government's evidence referred to its *Together for Health* plan, that sought to provide the highest possible quality and excellent experience for patients. The Scottish Government told us about its *2020 Vision*, whereby everyone would be able to live longer healthier lives at home, or in a homely setting, with a greater integration between health and social care, and its associated *2020 Workforce Vision*. It said that the biennial patient experience survey, the next of which was due to be run in November 2013, would examine patient experience of both general practice and social care services. We look forward to receiving the results of this survey for our next review. The Scottish Government said that NHS Boards could be encouraged to incorporate a greater primary care element into their annual review process, whereby Boards were held accountable for their performance across all NHS provision in their area. Clearly this is for the Scottish Government to pursue, but we are happy to endorse such an approach. The Northern Ireland Executive told us about *Transforming Your Care*, with services designed around the needs of individuals, delivered as locally as possible. It said that it was drawing out lessons that could improve care from the Francis report.

2.86 NHS Employers said that any changes to national pay and conditions needed to be seen in the context of high quality, compassionate patient services. They said that the priority was to deliver seven-day services affordably and sustainably: if patients were at the heart of the NHS, then contracts needed to be reformed. The Foundation Trust Network commented on the growing imperative for better quality patient care and seven-day services.

2.87 The BMA's evidence supported its pay claim with evidence on a range of NHS performance and outcomes measures, particularly relating to patient experience and safety, and where there was a link with doctors' interventions. It said that: increasing patient demand, when coupled with evidence on outcomes, showed doctors were continuing to add the same or greater value but for less money; between 2011-12 and 2012-13, there was an increase in total inpatient finished consultant episodes of 1.5 per cent, of outpatients of 2.7 per cent and of accident and emergency attendances of 4.1 per cent; public satisfaction with the NHS showed a static or slightly improving position; Ipsos MORI polls showed doctors as the public's most trusted profession (at 89 per cent) and 93 per cent of patients had trust and confidence in their general practitioner; and trends in waiting times (although less under the control of doctors) remained generally constant despite seasonal fluctuations. The BMA said that it made no claim that these measures should be seen as definitive, but believed that a longer-term research project was required to consider the link between pay and 'patients at the heart'.

2.88 The BDA commented that health professionals with higher levels of motivation generated better outcomes for patients, and stressed the importance of continuing care relationships between patients and dentists. It said that a properly funded service where staffing levels were safe would provide the quality of care that patients deserved.

2.89 Much of the evidence we received for this review on this aspect of our remit drew our attention to the various policy documents published by the Health Departments and to the fact that a focus on patients is a central part of the overall ethos of the NHS. Whilst the BMA found it difficult to explain how they could link patient satisfaction with pay, we are nevertheless grateful to the BMA for addressing this aspect of our remit by attempting to link its evidence on 'patients at the heart' to its pay claim: we found this approach to be very helpful in our deliberations. The other parties may wish to take a similar approach in their evidence to us for the next round. We agree with the BMA that further research on NHS performance and outcomes measures would be beneficial and invite the parties to take this proposal forward and report back to us on progress for our next review.

2.90 Recent developments within the NHS are focused on improving the link to patients, including: action taken in response to the Francis *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*,[26] with its implications for patient safety and the redesign of NHS services; the report by Professor Don Berwick, *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*;[27] Professor Sir Bruce Keogh KBE's report *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*,[28] and its implications for seven-day services; and Professor David Greenaway's report *Shape of Training: Securing the Future of Excellent Patient Care*,[29] with its proposals to adapt postgraduate training to prepare medical graduates to deliver safe and effective care in broad specialties; and the consultant contract negotiations with its aim to facilitate seven-day services in the interests of patients. These reports will also have implications for the NHS in each country of the United Kingdom. We would welcome evidence for future rounds as to how our pay recommendations might help facilitate these and other developments related to the 'patients at the heart' strand of our remit:

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[26] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Robert Francis QC, chairman. HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

[27] *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*. Department of Health, August 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[28] *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. Professor Sir Bruce Keogh, July 2013. Available from: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[29] *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

but we note that there is, amongst other things, a link to the number of doctors and dentists employed (and thus to recruitment and retention) to the quality of services that are delivered to patients, thereby linking to our requirement to ensure that patients are at the heart of the NHS.

Legal obligations on the NHS including anti-discrimination legislation

2.91 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. The Advisory Committee on Clinical Excellence Awards (ACCEA) told us that there had been a marked reduction in the proportion of new awards held by women in 2012 (16.3 per cent) compared to 2011 (24.3 per cent). It said that women were significantly less likely to apply for awards than men, and for the first time for at least five years, women applicants were also less likely to succeed than men at silver and gold levels. ACCEA's analysis of the gender distribution of awards showed that women were much more poorly recognised than men to an extent that raised concerns for ACCEA about discrimination. It also highlighted concerns about the distribution of awards by ethnicity, noting that success rates for black and minority ethnic applicants were also lower than those recorded as 'white', with the main disparity being at bronze level. ACCEA offered possible reasons for the disappointing results: the uncertainty about whether or not a 2013 Round was to be held had meant there had not been any opportunities to promote applications to the scheme from under-represented groups; and it had not been possible to recruit to committees through open competition or provide training to new and existing committee members.

2.92 The Scottish Advisory Committee on Distinction Awards (SACDA) said that it continued to operate without discrimination on the grounds of age, gender, ethnicity, belief, type of contract, specialty or area of work, or other relevant factor; it did, however, highlight concerns with the quality of the ethnicity data, but said that it was working to improve it, which we welcome. The Northern Ireland Executive said that since an awards round had not taken place since 2009-10, the distribution of awards was skewed towards males and the average age of holders continued to rise. It said that once the awards round for 2012-13 and 2013-14 was complete, an annual report would be prepared to analyse the distribution of awards and identify any issues that might raise concerns regarding equality legislation. It also told us that recruitment processes were equality proofed.

2.93 The Welsh Government said that the equality climate had moved on since the current contracts were negotiated and that this was one of the issues that contract reform should be considering. NHS Employers told us that it thought that the current consultant contract terms and conditions might be vulnerable on gender and age grounds.

2.94 In a joint letter from NHS Employers and the BMA, reporting on the agreement reached on changes to the general medical services contract in England for 2014-15, we were told that seniority payments would cease on 31 March 2020, and there would be no new entrants to the scheme from April 2014. All funding released would be added to the global sum. Previous reports have recorded our concern with seniority payment schemes given the possibility for their non-compliance with age discrimination legislation. We therefore welcome this agreement between NHS Employers and the BMA, and ask all countries to consider the seniority payment schemes for both GMPs and GDPs to assess their compliance with age legislation and to make changes where necessary, and to report back to us next year.

2.95 As we noted last year, our *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*[30] addressed the governance and operation of the award schemes, including transparency, fairness and equity. We said that we would like to see the awarding bodies continuing to monitor the diversity issues arising from the distribution of the awards and to take appropriate action to address any inequalities. We ask the parties to update us again on this for our next review and to consider the evidence submitted by ACCEA and SACDA that suggests possible discrimination issues when discussing the future of the award schemes.

2.96 Given our previous comments on the length of the consultant pay scale, whereby it takes a consultant 19 years to reach the pay band maximum, we welcome the negotiations in England and Northern Ireland. We ask all countries to report to us next year on whether there are discrimination issues linked to the length of pay scales of any of our remit groups, and if there are, how they intend to address them.

Conclusions

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

- affordability is a material issue for the NHS, and is more of an issue this year than previously. The picture of affordability varies across the four countries of the United Kingdom, with Wales stating that any pay award is unfunded, and Scotland saying that there is provision for a pay award alongside incremental pay progression. Even though NHS funding has received some protection in Spending Review settlements, costs are rising sharply and the demands on the service are increasing;
- we note that the IFS has commented that it is likely that by 2018, public sector pay will fall relative to private sector pay to a level similar to in the early 2000s when parts of the public sector experienced difficulties in recruiting and retaining staff;
- our analysis of pay comparability shows that in general and subject to the qualifications on measurement issues, for all of our remit groups, their relative position has declined against their comparator groups, and the comparator groups have, in general, seen larger increases in total pay;
- we welcome the work undertaken in England to improve the pay drift data that we receive and ask that all countries provide such information on a similar basis in future years. We note that in England, the estimated growth in FTE pay bill for all HCHS doctors in 2012-13 is just 0.6 per cent, and -0.4 per cent for consultants and directors of public health;
- the absence of any strong total reward strategies from the parties has inhibited our ability to make our pay recommendations within a broader context;
- the broad recruitment and retention picture for doctors and dentists is not a cause for major concern, but there are grounds for real concern with some specialties and some geographic areas;
- given the current contract negotiations, we do not consider it appropriate to recommend a pay response to address shortages; and
- in this year, with the increasing scrutiny of and pressure on the NHS, and the plans to provide more comprehensive seven-day services, we believe that we should focus more heavily on the requirement to maintain the motivation of our remit groups.

[30] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, 2012. Chapters 4 and 9.

Future evidence requirements

2.98 We expect the parties to provide us with updates to issues that we have identified in previous rounds, such as any developments on new contractual arrangements for junior doctors and consultants, and the new dental contract pilots. In addition, the evidence requirements that we have identified from this round for our next review are for:

- the parties to address all elements of our remit including recruitment, retention, motivation, affordability, economic evidence, 'patients at the heart' and the legal obligations on the NHS;

Affordability, NHS finances and efficiency savings

- evidence on any exit strategies from pay restraint;
- we welcome the proposed research by the BMA looking at the scope for making efficiency and productivity gains and look forward to receiving the results, when these are available;

Pay and remuneration

- the parties to provide annual evidence that gives an analysis of the remit groups' earnings by age, gender and country, and to provide as full a breakdown as possible of the components of total earnings;
- the parties to provide anonymised sample career profiles with related earnings;
- the Health Departments to provide pay drift information on the same basis as that provided by the Department of Health and NHS Employers;
- the outcome of the contract negotiations and the implications for incremental pay progression;
- the parties to keep us informed on total reward developments including changes to pension arrangements, particularly their impact on recruitment, retention and motivation, and any evidence on national or local pay strategies that form part of the thinking on total reward;
- the parties to submit evidence to explain the drop in average earnings for our remit groups compared to the 97th percentile;

Recruitment and retention

- the parties to provide evidence on recruitment and retention that also takes into account headcount and FTE data, the different staff groups, regional variations, the moves towards seven-day services, the increasing proportion of women in the workforce and (in England) the target to increase the number of trainees choosing to enter general practice, and the parties' assessment of any implications for pay of such evidence;
- the parties to provide us with evidence on how they are tackling shortage specialties;
- the parties to provide evidence on whether a pay response is required to address shortages, or if any other mechanism might be more appropriate;
- the Health Departments to prioritise the publication of vacancy statistics;
- the parties to keep us abreast of workforce planning issues, including any staffing targets that form part of such plans, whether Health Education England and LETBs are able to deliver on their workforce planning remits, and views as to whether a pay response is required in helping shape future workforce numbers. We also ask the parties to update us on how they are taking account of demographic changes in their workforce planning, for all of our remit groups. We would find it helpful for future evidence to include headcount figures and FTE estimates, broken down by gender;

- evidence on the extent and cost of the use of locums in order to fill service gaps, broken down by specialty and grade;
- the parties to keep us informed of their assessment of how the future workforce is likely to be affected by current training levels;

Regional/local pay variations

- the parties to consider providing evidence to support regional pay;

Motivation

- the parties to consider research that will lead to a better understanding and definition of the various factors impacting on motivation;
- the parties to undertake staff surveys on a regular, preferably annual, basis, so that we can monitor trends closely. We would also welcome a uniform approach across all countries of the United Kingdom in order to facilitate comparisons;
- the parties to engage with the BMA on its proposal for research looking at the link between motivation, performance and different levels of reward;
- the parties to set out their individual interpretation of 'motivation';

'Patients at the heart'

- we would welcome evidence for future rounds on how our pay recommendations can help facilitate NHS developments, and other issues related to the 'patients at the heart' strand of our remit;
- we agree with the BMA that further research on NHS performance and outcomes measures would be beneficial and invite the parties to take this proposal forward and report back to us on progress for our next review;

Legal obligations on the NHS

- all countries to consider the seniority payment schemes for both GMPs and GDPs to assess their compliance with age legislation and to make changes where necessary, and to report back to us next year;
- the parties to update us on any discrimination issues arising from the consultant award schemes; and
- the parties to report to us next year on whether there are discrimination issues linked to the length of pay scales for any of our remit groups, and if there are, how they intend to address them.

Part II: Primary Care

CHAPTER 3: FORMULAE-BASED APPROACH TO THE UPLIFT FOR INDEPENDENT CONTRACTOR GENERAL MEDICAL PRACTITIONERS AND GENERAL DENTAL PRACTITIONERS

3.1 In deciding the recommended uplift for independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs), we have for a number of years used a formula for each group that takes into account our intended net uplift, as well as estimates of actual movement in staff costs and other expenses. By way of example, Tables 3.1 and 3.2 below show the categories and weightings in the formulae that were used in the calculation of the uplifts for GMPs and Scottish GDPs (respectively) in our 41st Report 2013.

Table 3.1: GMP formula from the 41st Report 2013

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	43.5%	1% *DDRB recommendation*	0.43%
Staff costs	40.6%	3.4% *Annual Survey of Hours and Earnings (ASHE) 2012 (general medical practice activities)*	1.38%
Other costs	15.9%	3.0% *Retail Prices Index excluding mortgage interest payments (RPIX) 2012 Q4*	0.48%
			2.29%

Table 3.2: GDP (Scotland) formula from the 41st Report 2013

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	55.9%	1% *DDRB recommendation*	0.56%
Staff costs	22.8%	1.3% *ASHE 2012 (dental practice activities)*	0.30%
Laboratory costs	7.0%	3.0% *RPIX 2012 Q4*	0.21%
Materials	7.0%	3.0% *RPIX 2012 Q4*	0.21%
Other costs	7.3%	3.0% *RPIX 2012 Q4*	0.22%
			1.49%

3.2 We have decided this year to undertake a fresh appraisal of our approach to see whether or not it remains fit for purpose. We also explored the issues in detail with the parties during our oral evidence sessions. To begin with, we considered the **principle** underlying our involvement. GMPs and GDPs are independent practitioners running a small business. What determines their remuneration is not a pay scale negotiated with the Health Departments as their employer with rates based on recommendations by us, but how well they manage their businesses overall within the terms of their contract with

the NHS and any other work they take on. We explored this issue with the parties during oral evidence, but the main argument put forward was that general medical and dental practice was funded from within the public purse. We ask the parties to give this issue further consideration.

The performance of the formula-based approach

3.3 We then turn to the methodology by which we have uplifted GMP and GDP pay in recent years. As we are not dealing with points on pay scales and because our recommendations are only one factor in the determination of gross contractual payments to practices, we can only address remuneration indirectly. This is achieved through the application of a single formula approach to make a recommendation on the total contract value. In the case of GMPs, for example, we recommend an increase in the contract value based on three elements: our intended increase in GMPs' incomes, a judgement on staff costs and a judgement on other costs. In general, our practice has been to use the available backward-looking inflation data for simplicity, clarity and objectivity, but we note that the resulting 'time lag' may also be a factor in the performance of the formula in delivering our intended increase in any one year. The formula treats bygones as bygones in the sense that, each year, the recommendation takes the previous year's outcome as given. It does not explicitly attempt to compensate real wage reductions that might arise if staff and other costs turn out not to be as expected, or to recoup gains above those considered appropriate the year before. Rather any catch-up takes place only indirectly and where necessary through the year's recommendation of the intended increase in GMPs' income, made each year to ensure recruitment, retention and motivation in GMPs.

3.4 We consider the detail of how the judgments on costs are formed below. It is worth noting at the outset that the formula-based approach appears to have had only limited success in delivering our intentions on GMPs' and GDPs' net incomes over recent years. We have examined, for both GMPs and GDPs, how our intended increases in income have compared to what the actual data are showing us, based on Inland Revenue tax returns (Tables 3.3 to 3.6).

Table 3.3: Changes in UK independent contractor GMP income compared to recommended increases

Independent contractor GMP – UK				
Financial year	**Income**	**Change on previous year**	**Uplift intended from previous year**	**Intended efficiencies from previous year**
2003-04	£82,019			
2004-05	£100,170	22.1%	no recommendation	
2005-06	£110,004	9.8%	no recommendation	
2006-07	£107,667	-2.1%	no recommendation	
2007-08	£106,072	-1.5%	no recommendation	
2008-09	£105,300	-0.7%	0% (zero)	
2009-10	£105,700	0.4%	2.20%	
2010-11	£104,100	-1.5%	1.50%	
2011-12	£103,000	-1.1%	0% (zero)	1% on expenses

Source: Income from the Health & Social Care Information Centre (HSCIC) – GP Earnings and Expenses (various years).

Table 3.4: Changes in England and Wales dentists' income compared to recommended/ intended increases

England & Wales			GDP (all dentists)	
Financial year	Income	Change on previous year	Uplift intended from previous year	Intended efficiencies from previous year
2006-07	£96,135			
2007-08	£89,062	-7.4%	3.4%	
2008-09	£89,600	0.6%	2.0%	
2009-10	£84,900	-5.2%	2.2%	
2010-11	£77,900	-8.2%	1.5%	
2011-12	£74,400	-4.5%	0% (zero)*	1% on expenses

Source: Income from HSCIC Dental Earnings and Expenses: England and Wales (various years).

* no DDRB recommendation made: England and Wales negotiated directly with the BDA during the pay freeze.

Table 3.5: Changes in Scottish dentists' income compared to recommended/intended increases

Scotland			GDP (all dentists)	
Financial year	Income	Change on previous year	Uplift intended from previous year	Intended efficiencies from previous year
2006-07				
2007-08			3.4%	
2008-09	£85,000		2.0%	
2009-10	£79,300	-6.7%	2.2%	
2010-11	£73,300	-7.6%	1.5%	
2011-12	£71,700	-2.2%	0% (zero)	1% on expenses

Source: Income from HSCIC – Dental Earnings and Expenses: Scotland (various years).

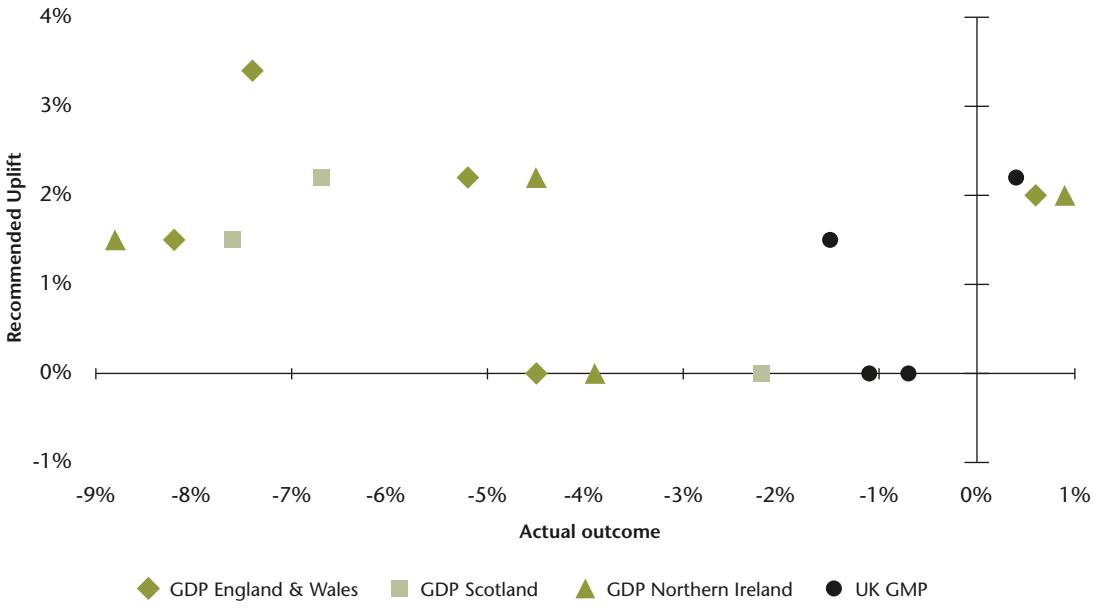
Table 3.6: Changes in Northern Ireland dentists' income compared to recommended/ intended increases

Northern Ireland			GDP (all dentists)	
Financial year	Income	Change on previous year	Uplift intended from previous year	Intended efficiencies from previous year
2006-07				
2007-08	£89,800		3.4%	
2008-09	£90,600	0.9%	2.0%	
2009-10	£86,500	-4.5%	2.2%	
2010-11	£78,900	-8.8%	1.5%	
2011-12	£75,800	-3.9%	0% (zero)*	1% on expenses

Source: Income from HSCIC – Dental Earnings and Expenses: Northern Ireland (various years).
* no DDRB recommendation made: Northern Ireland negotiated directly with the BDA during the pay freeze.

3.5 Figure 3.1 shows the tabular information in the form of a scatterplot.

Figure 3.1: Recommended/intended uplifts compared to actual outcomes for both GMPs and GDPs



Measurement issues in the formula

3.6 The data shows that the movement in average income appears not to correspond with the intended increases behind our recommendations. For several years, we have asked the parties to provide us with sample accounts of both GMPs and GDPs so that we can better understand the underlying issues, but they have not been provided with the required level of detail. There are many possible reasons that might explain the differences in average income and our intended increases, including changes in:

- staff costs (for both GMPs and GDPs) (see paragraph 3.7);
- laboratory costs (for GDPs) (see paragraph 3.12);
- materials costs (for GDPs) (see paragraph 3.12);
- other costs (for both GMPs and GDPs) (see paragraph 3.13);

- the level of efficiencies sought by the Health Departments as part of the annual negotiations on changes to contracts (for both GMPs and GDPs) (see paragraph 3.14);
- the mix between NHS and private work undertaken (for both GMPs and GDPs) (see paragraph 3.15);
- the composition of the population in the earnings figures (for GDPs) (see paragraph 3.16);
- the status of businesses (for GDPs) (see paragraph 3.17);
- the impact of multiple counting of expenses in aggregated tax returns (for GDPs) (see paragraph 3.18);
- correction factor payments and the impact of the Quality and Outcomes Framework (for GMPs) (see paragraph 3.21); and
- the number of hours worked (for both GMPs and GDPs) (see paragraph 3.22).

Staff costs

3.7 We have attempted to account for movement in staff costs using several indicators over the years. For staff working in General Medical Services (GMS) practices, we have in the past used the increase that was expected for *Agenda for Change* staff. However, we abandoned that approach when it became clear from the evidence submitted by the Department of Health that drew on the *2011 Practice Nurse Survey* that showed that just 1.3 per cent of practices provided the same pay and conditions as those received by nurses working direct for the NHS. Based on that evidence, we concluded at that time that usage of an *Agenda for Change* figure to represent the change in staff costs would be inappropriate. For staff working in dental practices, we have used for several years data from the *Annual Survey of Hours and Earnings* (ASHE) to reflect increases in staff costs. It is possible from this dataset to examine the change in median gross hourly pay for employees identified as being employed in general medical practices or general dental practices. Although these measures are backward-looking measures, they are focused on all employees (i.e. excluding self-employed contractors) and will be affected by changes in the make-up of the workforce. We considered these measures to be the most appropriate source of data then available to us to inform the uplifts for the staff element of the formulae, and we moved to the ASHE figure to represent general medical practice staff costs for our 2013-14 recommendation.

3.8 The ASHE figure for general medical practice staff for 2011-12 that we used in our formula last year was 3.4 per cent. At the time, we noted our concern that the figure appeared higher than typical pay settlements and certainly higher than the uplift we might expect from an organisation essentially working within the public sector, given the pay freeze. However, we concluded that the figure was the best available estimate of the actual increase in staff costs borne by GMPs (which was, in practice, what would have impacted on their income) and invited the parties to consider whether there was a better approach to capturing appropriate information on the increase in staff costs in general practices.

3.9 We were therefore disappointed by the Health Departments' decisions not to accept our recommendation, especially as the reason for the rejection was apparently based on our use of the ASHE figure. Where there are alternative proxy variables for the inputs in our formulae, we believe that consistency of choice of variable is important for the integrity of the Review Body process: 'cherry picking' undermines this. It might also be argued that as practitioners are independent businesses, then practice staff should not be subject to public sector pay policy, as applies to other sectors of the NHS workforce (though the counter argument is that their pay is ultimately funded by government).

3.10 We recognise that the ASHE figure we used in our formula-based approach last year for the uplift for GMPs covered all practice staff, including salaried GMPs. We have considered whether we should take a view on the increase in staff costs that represents salaried GMPs. The original agreement between the parties for salaried GMPs was that their pay was to be guided by a salary range, but that starting pay and progression should be determined locally. Our recommendations on pay for salaried GMPs have been limited to increasing the bottom and top points of the pay range. There could be an argument that our recommendation on the increase to the bottom and top points of the pay range could be used as a proxy for the increase in staff costs for salaried GMPs, but we believe that the spirit of the original agreement for local determination of any increases in pay is more compelling, and that ASHE – that shows actual movement in staff costs – is therefore a more appropriate indicator for staff costs.

3.11 We have also noted that under the GMS contract arrangements, one of the core principles surrounding the provision of staffing costs within the global sum was that practices should have greater flexibility in using skill-mix to deliver NHS services, and that providing a given level of NHS services was maintained, then funding via the global sum would not be affected. It is therefore questionable whether an approach that aims to compensate for actual movement in staff costs is appropriate, and it might therefore be better if staff costs were addressed in the annual GMS contract negotiations between the BMA and the Health Departments.

Measuring non-staff costs

3.12 For both laboratory and materials costs for general dental practices, our approach has been to use RPIX, as these elements of dental expenses do not include premises costs. In the absence of laboratory and materials cost indices, it is not clear to us whether RPIX – which uses a very wide basket of factors – is an accurate representation of the movement of these factors.

3.13 For all other costs within both general medical and general dental practices, our approach has again been to use RPIX. As with laboratory and materials costs, we do not know whether RPIX is an accurate representation of movements in such costs.

Efficiencies

3.14 Another factor that will be impacting on the delivery of our intended recommendations is the extent to which independent contractors are meeting the efficiencies that are applied to contractual arrangements, either by negotiation or by imposition. Practitioners may make an individual choice not to meet efficiency requirements and to take a reduction in income: in such cases, we would not consider it appropriate to adjust our pay recommendations, although we might do so in response to the wider picture on the impact of efficiencies to recruitment, retention and motivation. We noted in our last report that we believe efficiencies should be handled as a contractual matter, as opposed to a policy that simply abated our recommended increases, and that we therefore welcomed an approach to efficiencies sought by negotiation. We do not think it is for us to consider the level of efficiencies being sought from changes to the contracts, nor to make adjustments to the formulae to take efficiencies into account, unless the parties agree that such an approach is appropriate.

Further complexities in the formula

3.15 The data that we use for aggregating income and expenses makes no distinction between NHS and private practice income. It is therefore not clear to us the extent to which changes in the types of work undertaken by practitioners and the associated expenses are affecting the costs that we use in our formulae-based approach. It is an issue

for both types of practitioners, but probably more of an issue for dental practitioners where there are likely to be more opportunities to undertake private work. We note that in England, agreement was reached on changes to the GMS contact for 2014-15 that included a requirement for a working group to develop proposals that would lead to the publication of GMPs' NHS net earnings, to provide greater transparency. We welcome this development, and ask that the working group considers both our data requirements and whether any adjustment to our recommendations needs to be made to account for the use of NHS practices for carrying out private work. Furthermore, we ask that all countries take action to enable us to be provided with such information on a country basis, for both GMPs and GDPs, should the parties wish to continue with a formula-based approach to the uplifts.

3.16 NHS England pointed out to us that average income and expenses figures were affected by the composition of the population covered. It said that there were significant changes going on in the composition of the dentists in the earnings figures, mainly a large shift from providing-performer dentists (practice owners) to performer-only dentists (associates).

3.17 NHS England also commented that changes from year to year were affected by dental contract holders changing their business arrangements into companies, which was tax efficient. It said that some profit was retained in the company, which in turn made a self-employment payment to the dentist, with the profits retained in the company no longer covered in the self-employed earnings figures. It also said that many individual performer dentists continued to operate under limited company status, further confusing the self-employed earnings report.

3.18 Our *Forty-First Report 2013*[1] included a detailed analysis of the problem of multiple counting of expenses in the aggregated data that we use to construct the weightings in our dental formula, and which has the effect of inflating the expenses to earnings (EER) ratio. Our estimate of the true level of the EER was subject to several caveats, including the unknown effects of sampling error, dental incorporation, earnings and expenses associated with private practice, and (in some countries) reimbursement of specific expenses. We said that we were confident that the EER implied by aggregated data from dentists' tax returns was too high, but that for all countries, there appeared to be a convergence towards an EER of around 50 per cent, although we noted that this assumed no flows of money from performers (associates) to providers (principals), so the true EER was likely to be lower. Nevertheless, in the absence of better information, we concluded that an EER of 50 per cent should be used for all countries.

3.19 In evidence to us for this review, NHS England said that our methodology provided an acceptable solution in the absence of more detailed data and said that it would continue to work with the Dental Working Group to develop other approaches. The Department of Health said that it agreed with our methodology and that the evidence behind our change seemed sound, although it noted that it was a temporary fix to try and reduce the effects of multiple counting. The Northern Ireland Executive also agreed with our proposed EER of 50 per cent. The Scottish Government said that it agreed with the basic proposition that a sole trader (without help) should have the highest EER of all the business types, and that the EER of a sole trader (without help) should be used as the basis for calculating the equivalent ratio for all provider-performer dentists in Scotland. The Welsh Government did not comment on our methodology, but drew our attention to the comments made on multiple counting by the Health and Social Care Information Centre in its report on dental earnings. The British Dental Association (BDA), however, said that it had been involved in a Scottish Government working group looking at

[1] *Forty-First Report 2013*. Review Body on Doctors' and Dentists' Remuneration. Cm 8577. TSO, 2013. Paragraphs 4.52 to 4.60. Available from: https://www.gov.uk/government/collections/2012-to-2013-pay-review-body-reports

multiple counting, but the work of the group had been suspended. Until it had more evidence of the extent of multiple counting, it said that it considered it inappropriate to make adjustments.

3.20 We note that the Health Departments appear to be in agreement that an EER of 50 per cent is an appropriate adjustment in the absence of better data. The parties may also wish to conduct a sample analysis of representative practice accounts in order to estimate the extent of multiple counting: our repeated attempts to elicit such information have not been fruitful in any meaningful way. Such an analysis might also provide useful data on the other areas of expenses that feed into our formula. We note that a working group was set up in Scotland to consider the issue of multiple counting but that its work has been suspended, and would urge the parties in each country to work collaboratively on solving the various data issues for dentistry. In any case, we are firmly of the view that it should be for the parties to provide such information and to work together in order to facilitate our recommendations.

3.21 Another possible reason for the mismatch between our recommended increases in GMPs' income and the average income levels recorded by tax returns is the extent to which practice income is affected by the size of correction factor payments received, which relate to the level of global sum payments relative to the income received under the previous contract. Different countries have taken different approaches to correction factor payments, with some phasing them out, and some choosing to retain such payments. Another funding stream for practices that will vary is from the Quality and Outcomes Framework (QOF), whereby payments are made to practices for achieving various government priorities, although the data suggests that most practices are scoring very highly against the maximum possible QOF score.

3.22 The data on net income will also be affected by changes in the average number of hours worked by practitioners. NHS England reported that the average number of hours worked per week by dentists decreased from 39.4 in 2000, to 37.5 in 2011-12. We invite the parties to submit any evidence on hours worked for our future rounds, and note that the British Medical Association intends carrying out a workload survey for GMPs, which we welcome. We are, of course, interested in the number of hours worked of all GMPs, both partners and salaried doctors; and similarly of both dental practice owners and associates (and their equivalents in each country).

3.23 In England and Wales, when dentists wish to carry out additional work above their contracted Units of Dental Activity (UDAs), they are required to bid for such UDAs in an open commissioning process. It could therefore be argued that when bidding for additional UDAs, practitioners should take account of expenses when putting forward their proposals. We are therefore concerned that our formula-based approach – that attempts to address actual movement in expenses – could be seen to be undermining the commissioning process, although we note that account would need to be taken of any movement in expenses in subsequent years following a successful bid.

3.24 We are aware that in England, Wales and Northern Ireland, there are plans to move to new dental contractual arrangements. We understand that in England and Wales, the plan is to move away from a system based on UDAs, when our current approach is based on uplifting the UDA values of contracts.

The way forward

3.25 The BDA's evidence for this year commented that it had become clear that previous awards intended to implement a pay freeze had actually delivered a pay cut, and said that the profession considered that retrospective awards were necessary to counteract the effect of the cuts. It also proposed that our formula-based approach for GDPs be amended by the inclusion of an additional element for motivation, to be considered

separately from the cost of living increase. We address the latter request as part of our consideration of the main pay recommendations in Chapter 10, but we take all of these points raised by the BDA as further evidence that questions the suitability of continuing with our formula-based approach in its present form.

3.26 Having taken into account all of the above, we have serious reservations about continuing to make recommendations using the existing flawed formula-based approach. If the parties wish us to continue with making recommendations using a formula-based approach, then we believe that they should:

- work together to agree appropriate coefficients to represent staff costs, laboratory and materials costs and other costs, either by agreement on existing indicators, or through further work on how such costs should be recognised. Two years' of data will be necessary for an assessment of the annual change in expenses to be made and used as alternatives to RPI, RPIX and ASHE in the formula;
- provide a comprehensive list of all expenses and reimbursements associated with both general medical and dental practice;
- provide a comprehensive breakdown of all staffing costs, including the number of employees and hours worked, their roles, the balance between partners (providers) and salaried staff (performers), and their pay, for both general and dental practice;
- reach agreement on how efficiencies should be taken into account;
- provide information on NHS income and associated expenses, on a country specific basis, for both GMPs and GDPs, and to consider what adjustment to account for non-NHS work should be made to the weightings used in our formulae. We ask that the current plans in England to publish details of practice income take account of our data requirements;
- agree an approach as to how shifts in the composition of the workforce should be taken account of;
- agree an approach as to how any change in the status of businesses should be taken account of;
- address the ongoing data requirement to assess the extent of multiple counting of expenses in dental tax returns;
- consider how we should take account of variations in correction factor payments and scores against QOF;
- provide data on the distribution of the number of hours worked, including the mean and median;
- consider how the commissioning approach for UDAs might conflict with the formula-based approach;
- consider how any new dental arrangements would work with the formula-based approach; and
- provide the information for all four United Kingdom countries in a consistent format.

3.27 We ask the parties to report back to us next year on what progress they have made in taking forward the issues we have highlighted above. In the absence of such information, we were minded to focus on recommendations on pay, which is of course the core part of our remit. However, when we explored this possibility with the parties during oral evidence, the clear and over-riding message that we took back was that despite serious and well-understood shortcomings with the formula-based approach, the parties found our recommendations that included the various elements of expenses to be helpful. We are therefore willing to use the existing formula-based approach for 2014-15 for both GMPs and GDPs. However, we attach such importance to the provision of better data that we are recommending (in Chapter 10) that significant progress is delivered to us in time for our next review. Without such data, we have strong reservations about the use of a formula-based approach to deliver an uplift in line with our intentions.

Future evidence requirements

3.28 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to address the issues discussed in this chapter, and summarised in paragraphs 3.26 and 3.27.

CHAPTER 4: GENERAL MEDICAL PRACTITIONERS

Introduction

4.1 In this chapter, we consider issues that relate to general medical practice. We note that average income for general medical practitioners (GMPs) has again declined in 2011–12 (the latest available data), and that there has been a significant decrease in the job satisfaction score for GMPs. Although the general picture on recruitment and retention is not a cause for major concern, there are recruitment problems in some rural and some remote areas. Against this background, NHS England has a target to ensure that half of all trainees choose a career in general practice, rather than the hospital sector. We also note the agreement in England for GMPs to provide greater transparency around their NHS earnings, and ask that this transparency takes account of our data requirements, as set out in Chapter 3, and that all countries provide such information.

4.2 The core traditional role for 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). We are concerned mainly with GMS which is governed by a United Kingdom-wide contract. Doctors working under PMS, Section 17C arrangements, APMS or PCTMS contract locally with primary care organisations (PCOs).

4.3 Most of the doctors working in the GMS are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses or managers; some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. Almost 95 per cent of independent contractor GMPs' earnings come from contracts for the provision of public sector work,[1] i.e. primary medical care services to NHS patients. Whilst 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 is therefore very secure. Such a benefit would not typically be provided by a small business.

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

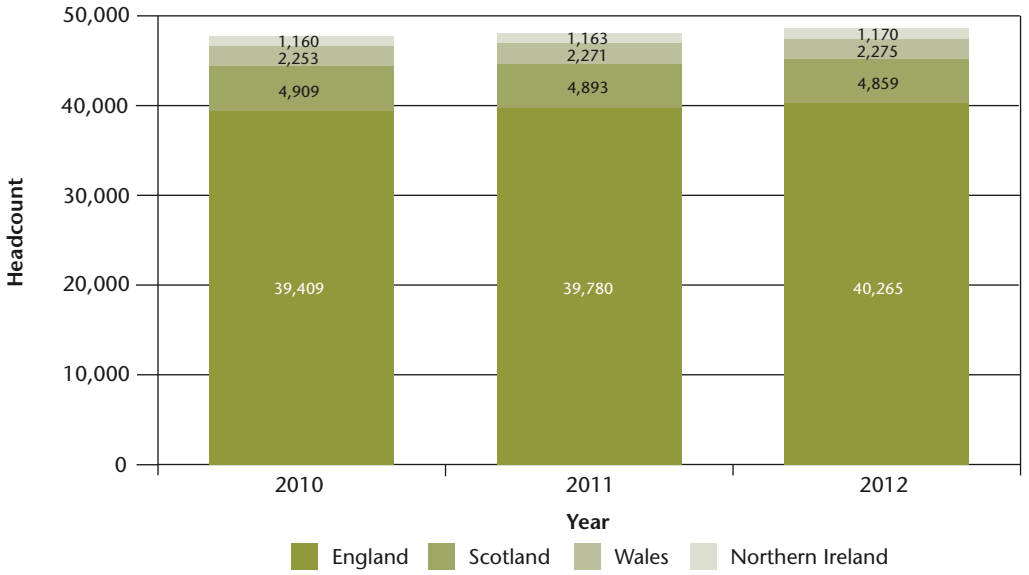
Recruitment and retention

4.5 The overall number of GMPs (headcount) in the United Kingdom increased by 1.0 per cent between September 2011 and September 2012 to 48,569 (Figure 4.1), although there was a small decrease in Scotland of 34 GMPs (0.7 per cent). The Welsh Government noted that the average age of a practitioner continued to rise, and the percentage of female GMPs increased, accounting for 44.1 per cent in 2012. NHS England also noted an increase in the average age of the workforce, with 43.1 per cent of practitioners in 2011 under the age of 45 compared with 47.5 per cent in 2002, and 22.5 per cent over the age of 55 in 2012 compared with 18 per cent in 2002. It added that the number of 'other' GMPs (typically salaried GMPs) now stood at 8,898, an increase of 3.6 per cent since 2011 and an estimated increase of 720 per cent since 2002. The Northern Ireland Executive told us that the recruitment and retention of GMPs was in a strong position and that it had not experienced any difficulties in filling training places. By contrast, the British Medical Association (BMA) said that it was aware of anecdotal evidence of increasing difficulties in recruitment in rural and remote areas across the

[1] The average NHS superannuable income for General/Personal Medical Services (GPMS) contractor GMPs in 2009-10 was 94.8 per cent of total earnings.

whole of the United Kingdom, but particularly in the devolved nations. Both the BMA and NHS England referred to the *Seventh National GP Worklife Survey*[2] that found that 54.1 per cent of GMPs aged 50 or over expected to quit direct patient care within five years, which the BMA said was driven by low levels of job satisfaction and high levels of stress (as opposed to pay).

Figure 4.1: Number of general medical practitioners, United Kingdom, 2010 – 2012



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, Health and Social Care Business Services Organisation in Northern Ireland.

4.6 Health Education England told us of its mandate that included a requirement to ensure that progress was made in each year towards ensuring that 50 per cent of all medical students became GMPs. We consider that the appropriate pay mechanism for helping, if necessary, to bring about this outcome is the general practice specialty registrar supplement, which we address later in this chapter.

4.7 Taking all of the available recruitment and retention evidence into account, we do not see any major cause for concern with the current levels of recruitment or retention that would warrant a pay response, although we would welcome more substantive evidence on any recruitment problems in rural and remote areas for future years. We ask Health Education England to keep us informed on progress towards delivering its target increase in the number of trainees choosing general practice, and its ongoing assessment of whether any targeted pay response would be beneficial. We also ask its evidence to us to take into account the increasing number of women in the GMP workforce, and the implications for the full-time equivalent number of doctors required.

Motivation and workload

4.8 Drawing again on the *Seventh National GP Workload Survey*, NHS England told us that: on a seven-point scale, overall job satisfaction had decreased to 4.5 in 2012 from 4.9 in 2010; average working hours in 2012 stood at 41.7 hours per week, a slight increase of 0.3 hours since 2010, and no change between 2010 and 2012 in the proportion of GMPs reporting undertaking out-of-hours work, with 21 per cent doing so for a median of four hours. NHS England also told us that the average number of patients per GMP in England had fallen from 1,764 in 2002 to 1,569 in 2012: a decrease of 11.1 per cent.

[2] *Seventh National GP Worklife Survey*. Institute of Population Health, University of Manchester, 2013. Available from: http://www.population-health.manchester.ac.uk/healtheconomics/research/

The Welsh Government reported similar levels of patients per GMP, at 1,575 in 2012. The Northern Ireland Executive said that the average number of patients per GMP had fallen from 1,670 in 2001 to 1,631 in 2012. The Scottish Government told us that the welfare reforms introduced by the Department of Work and Pensions had increased the workload of GMPs and that it was undertaking an analysis of these additional demands. The BMA said that it was planning a study of GMP practice workload to take place during Winter 2013/Spring 2014, to update the last research done in this area from 2006 – 2008. We welcome this research and look forward to learning of the results in evidence next year. At present, we are not provided with yearly data on the hours worked by GMPs and therefore cannot comment meaningfully on changes over time in the level of GMPs' pay.

4.9 We have noted the significant decrease in the job satisfaction score for GMPs: the drop may be partly explained by public sector pay policy – including the recent pay freezes – along with recent and ongoing changes to pension arrangements, or the other recent NHS reforms; but we will wish to monitor whether this is the beginning of a downward trend. We ask the parties to update us for our next review.

Independent contractor general medical practitioners

4.10 The 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 income under several different headings, including: basic services or global sum; enhanced services; funding administered by PCOs; and Quality and Outcomes Framework (QOF) payments. The glossary at Appendix F gives further information on aspects of the GMS contract.

4.11 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 in prisons and sessional fees for doctors in the community health service for work under collaborative arrangements are outside the contract.

4.12 This year, the parties have been negotiating directly with the Health Departments on contractual changes. In **England**, the negotiated agreement included: changes to QOF, leaving a maximum QOF score for 2014-15 of 559 points (compared to a maximum QOF score for 2013-14 of 900 points); a named GMP for all patients aged over 75; a contractual requirement for practices that have opted out of providing out-of-hours services to monitor the quality of those services; an agreement to publish GMPs' NHS net earnings; the ending of seniority payments from 2020; the introduction of new enhanced services; and a reaffirmation of the previous policy to phase out all correction factor payments over a seven-year period, with all released funding being recycled into the global sum. In **Scotland**, the negotiated agreement included: changes to QOF, leaving a maximum QOF score for 2014-15 of 659 points (compared to a maximum QOF score for 2013-14 of 923 points); a substantial transfer of funding from the QOF to core funding; the reinstatement of previous timescales for QOF; and the creation of a new Quality and Safety QOF domain. In **Wales**, the negotiated agreement included: changes to QOF, leaving a maximum score for 2014-15 of 669 points (compared to a maximum QOF score for 2013-14 of 969 points); the removal of the Minimum Practice Income Guarantee over seven years, beginning in 2015-16, but with total losses for practices to be capped at 15 per cent of the global sum; the transfer of funding from QOF to core funding; and the creation of a new local development QOF to encourage practices to work together in clusters. At the time of writing, GMS contractual negotiations in **Northern Ireland** were ongoing. We note and welcome the agreement in England to provide greater transparency around NHS earnings, and, as noted in Chapter 3, ask that the parties consider our GMS data requirements when taking this part of the agreement

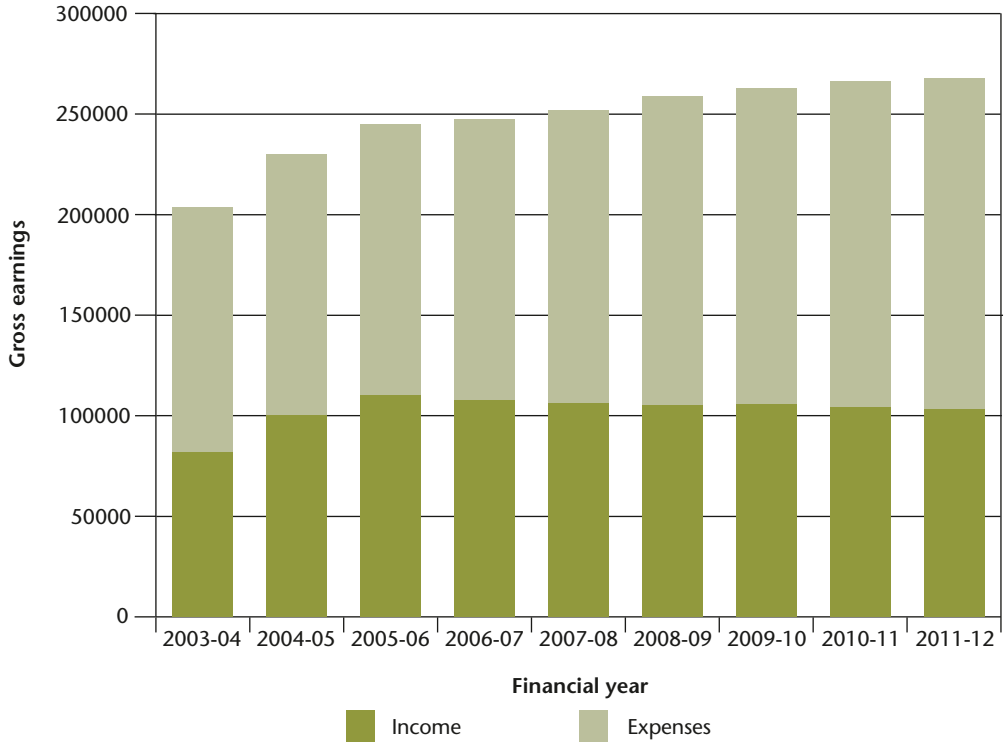
forward. We also ask each country of the United Kingdom to provide us with information on NHS earnings on the same basis as England. We also wish to record our view that we support a greater link between the performance of GMPs and their pay and hope that future negotiations on the GMS and other contracts will seek to improve such a link.

4.13 Alongside the negotiations on changes to the GMS contract, we were also invited to make recommendations: the Department of Health asked us to make recommendations on appropriate uplifts for GMS contracts in the context of public sector pay policy for 2014-15, and to make recommendations on what allowance should be made for GMPs' pay and for practice staff pay, in line with other sector of the NHS workforce; the Welsh Government also said it would welcome our recommendations on what allowance should be made for GMPs' pay and for practice staff pay, in line with other sectors of the NHS workforce; the Scottish Government sought our recommendations, but noted the increasing divergence from a United Kingdom-based framework for the GMS contract; and the Northern Ireland Executive asked us to make a recommendation on GMP pay and expenses for 2014-15.

4.14 We set out our concerns with the formula-based approach that we have adopted in recent years to uplifting GMP pay in Chapter 3. However, in view of the value placed on our recommendations that include our assessment of expenses, we are willing to make a recommendation for 2014-15 using our formula-based approach.

4.15 Notwithstanding our concerns with the reliability of the data aggregated from Inland Revenue returns, we have, in the absence of an alternative, continued to use it. In 2011-12, average income for United Kingdom GMPs based on that data was £103,000, with average expenses of £164,900. The expenses to earnings ratio (EER) increased slightly on year, from 60.9 per cent in 2010-11 to 61.6 per cent in 2011-12. Average income decreased by 1.1 per cent between 2010-11 and 2011-12 whilst average expenses increased by 1.5 per cent, as shown in Figure 4.2 and Table 4.1.

Figure 4.2: GMPs' gross earnings: income and expenses, United Kingdom, 2003-04 to 2011-12



Gross earnings relate to NHS and private work.

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Table 4.1: GMPs' gross earnings, expenses and income, United Kingdom, 2003-04 to 2011-12

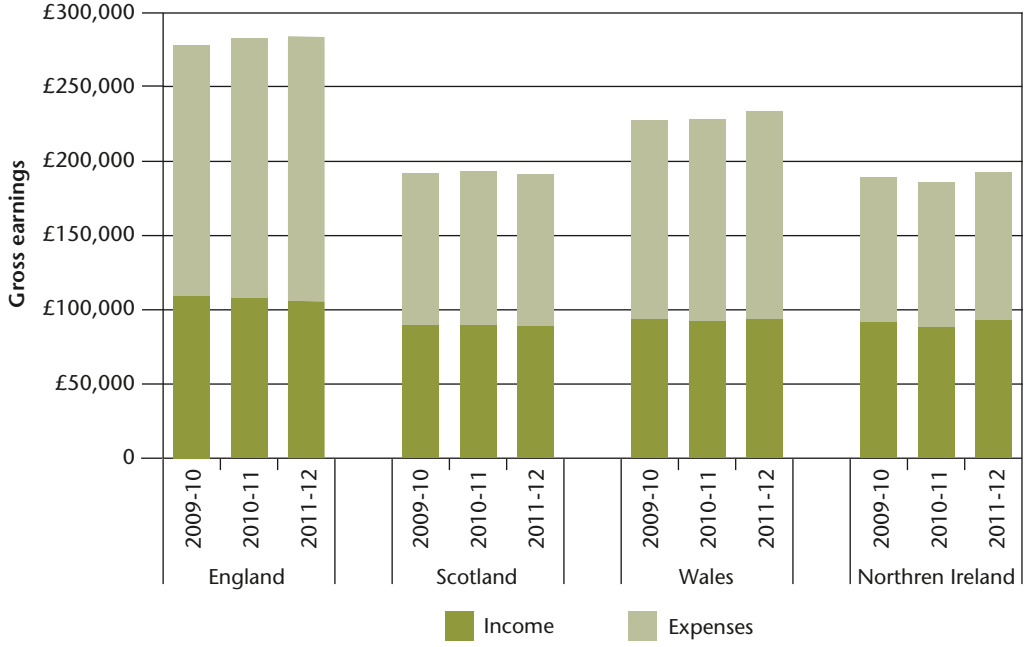
Financial year	Gross earnings	Expenses	Income			Expenses to earnings ratio (EER)
				Annual change	Change from 2003-04	
	£	£	£	%	%	%
2003-04	203,600	121,600	82,000	-	-	59.7
2004-05	230,100	129,900	100,200	22.2	22.2	56.5
2005-06	245,000	135,000	110,000	9.8	34.1	55.1
2006-07	247,400	139,700	107,700	-2.1	31.3	56.5
2007-08	252,000	145,900	106,100	-1.5	29.4	57.9
2008-09	258,600	153,300	105,300	-0.8	28.4	59.3
2009-10	262,700	156,900	105,700	0.4	28.9	59.8
2010-11	266,500	162,400	104,100	-1.5	27.0	60.9
2011-12	267,900	164,900	103,000	-1.1	25.6	61.6

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

4.16 Figure 4.3 and Table 4.2 show average income and average expenses of GMPs by United Kingdom country. They show that: in 2011-12, both average income and average

expenses were highest in England, at £106,100 and £178,200 respectively, with the EER also highest at 62.7 per cent; average taxable incomes in Scotland, Wales and Northern Ireland were all lower than in England, ranging from £88,700 in Scotland, £92,800 in Northern Ireland to £93,300 in Wales; average expenses in Wales were higher than those in Scotland or Northern Ireland; and between 2010-11 and 2011-12, average expenses increased in all United Kingdom countries except Scotland, whilst average income decreased in England and Scotland but increased in Wales and Northern Ireland.

Figure 4.3: GMPs' gross earnings: income and expenses, by United Kingdom country, 2009-10 to 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Table 4.2: GMPs' gross earnings, expenses and income by United Kingdom country, 2010-11 to 2011-12

Country	Year	Gross earnings	Expenses	Income	Expenses to earnings ratio (EER) %
England	2010-11	£283,000	£175,300	£107,700	61.9
	2011-12	£284,300	£178,200	£106,100	62.7
	% change	0.5	1.7	-1.5	
Scotland	2010-11	£193,600	£104,400	£89,300	53.9
	2011-12	£191,200	£102,500	£88,700	53.6
	% change	-1.3	-1.8	-0.6	
Wales	2010-11	£228,200	£136,000	£92,300	59.6
	2011-12	£233,700	£140,500	£93,300	60.1
	% change	2.4	3.3	1.1	
Northern Ireland	2010-11	£185,700	£97,700	£88,000	52.6
	2011-12	£192,600	£99,900	£92,800	51.8
	% change	3.7	2.2	5.4	
United Kingdom	2010-11	£266,500	£162,400	£104,100	60.9
	2011-12	£267,900	£164,900	£103,000	61.6
	% change	0.5	1.6	-1.1	

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Table 4.3: Income for General/Personal Medical Services (GPMS) contractor GMPs by Strategic Health Authority (SHA) and NHS England region, 2010-11 and 2011-12

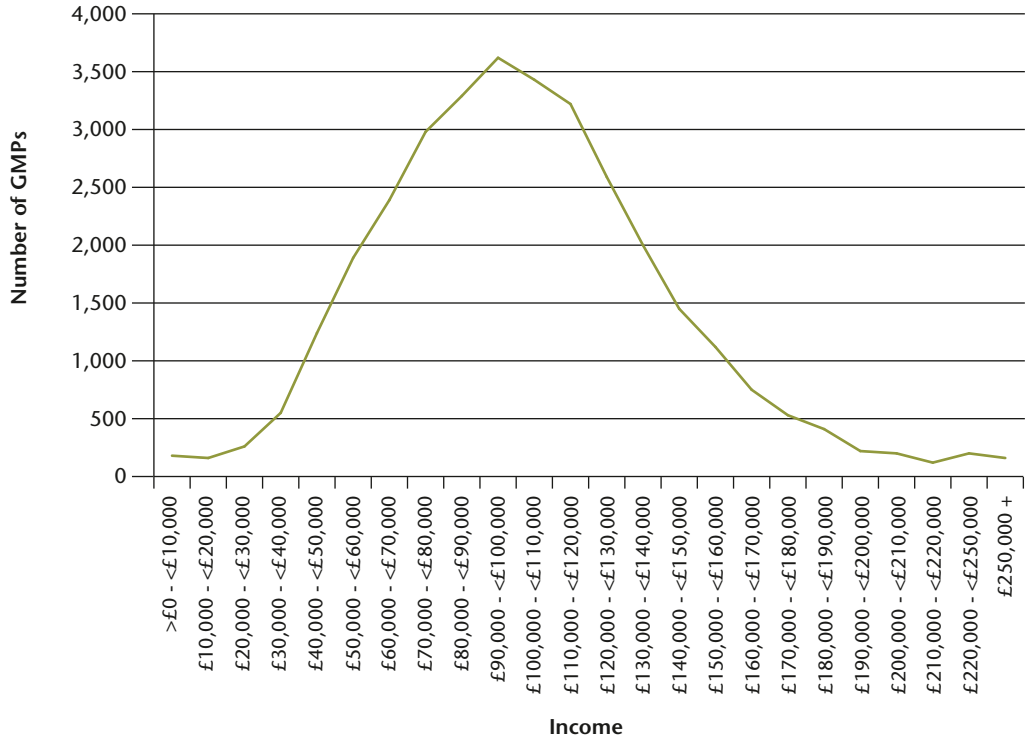
Region	Income 2010-11	Income 2011-12	Percentage change
North East SHA	£105,500	£103,800	-1.7
North West SHA	£104,700	£103,900	-0.7
Yorkshire and the Humber SHA	£104,500	£103,200	-1.3
East Midlands SHA	£114,700	£112,300	-2.1
West Midlands SHA	£113,500	£109,000	-4.0
East of England SHA	£112,200	£111,100	-0.9
London SHA	£111,200	£110,000	-1.1
South East Coast SHA	£113,300	£111,200	-1.9
South Central SHA	£103,000	£102,200	-0.8
South West SHA	£93,200	£91,600	-1.6
North of England region		£103,900	
Midlands and East of England region		£110,300	
London region		£110,000	
South of England region		£101,100	

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

4.17 There is a large amount of variability in the income of GMPs: Table 4.3 shows regional variations in the levels of average income for independent contractor GPMS GMPs; and Figure 4.4 shows the distribution of GMP income in the United Kingdom. We are unable

to tell from the evidence provided why such variations occur and we therefore invite the parties to submit evidence for our next round that attempts to explain the regional variations in income. We would also welcome a similar assessment of pay by region for the other countries of the United Kingdom.

Figure 4.4: Distribution of GMP income, United Kingdom, 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

The formula

4.18 In deciding the uplift for independent contractor GMPs for 2014-15, we are using a similar approach to last year, using a formula that takes into account our intended net uplift, as well as actual movement in staff costs and other expenses. Given our concerns with the formula-based approach, we are not proposing to refine the formula further on a country basis, although we ask the parties to consider whether or not they would wish for a country-specific recommendation for GMPs in future years.

Earnings and expenses

4.19 The formula coefficients (weights) are derived from figures on GMPs' average earnings and expenses, complied by the Health and Social Care Information Centre using data from self-assessment tax returns. The data (see Table 4.2) suggests an expenses to earnings (EER) ratio of 61.6 per cent – i.e. GMPs' profit was 38.4 per cent of their gross earnings. Some expenses (premises and IT costs) are fully reimbursed: we estimate that such reimbursements account for 10.6 per cent of expenses.

4.20 Accordingly, the formula coefficients are as follows:

- GMPs' average income is 38.4 per cent of gross earnings which represents 43.0 per cent of non-reimbursed gross earnings;
- staff costs are 36.8 per cent of total gross earnings which represents 41.2 per cent of non-reimbursed gross earnings; and

- other costs are the remaining 15.8 per cent of non-reimbursed gross earnings.

Income uplift

4.21 Government pay policy is for an average 1 per cent increase in basic pay, while the BMA requested an increase in line with inflation. Our consideration of the uplift for all our remit groups is contained in Chapter 10: it concludes that an increase of 1 per cent in basic pay is appropriate for 2014-15.

Staff costs uplift

4.22 The BMA told us that it supported our continued use of the Annual Survey of Hours and Earnings (ASHE) to represent movement in staff costs. The Department of Health's evidence for this year asked us to consider what allowance should be made for practice staff pay in line with other sectors of the NHS workforce, and the Scottish Government thought ASHE to be the best official source of information. We discuss the issue of the appropriate coefficient to represent staff costs in Chapter 3: we conclude that ASHE continues to be the most appropriate indicator. We have already noted our disappointment last year with the Health Departments' decisions not to accept our recommendation for GMPs, especially as the reason for the rejection was apparently based on our use of the ASHE general medical practice activities 2012 figure of 3.4 per cent, which might have appeared to be higher than one might have expected. The equivalent ASHE figure for 2013 is -1.4%, suggesting that taken over a longer period, it does not appear to be outside the range of what one might expect to be reasonable. We are not proposing to make a compensating adjustment to our recommendations, but note that the Health Departments are able to revisit last year's decision on the uplift in combination with this year's recommendation to account for the longer-term trajectory of ASHE, should they consider it appropriate.

Uplift for other costs

4.23 The 2013 formula used the latest quarterly figure for the Retail Prices Index excluding mortgage interest payments (RPIX) to represent other costs, because the evidence suggested that premises costs were reimbursed. RPIX was chosen as the most relevant measure as this index excludes various elements related to property payments. Whilst the BMA remained concerned that, in its belief, the use of RPIX underestimated the inflation of non-staff costs, in the absence of alternative measures of inflation, it said it was willing to support the use of RPIX for 2014-15. NHS England suggested that CPI be used as an alternative index. In the absence of evidence on a more representative index, we are not proposing to further refine our formula approach, and we believe therefore that RPIX should continue to be used to represent other costs.

The formula for 2014-15

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

Table 4.4: Uplift formula for general medical practitioners, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	43.0%	1% *DDRB recommendation*	0.43%
Staff costs	41.2%	-1.4% *ASHE 2013 (general medical practice activities)*	-0.58%
Other costs	15.8%	2.7% *RPIX for Q4 2013*	0.43%
			0.28%

4.25 Our recommendation for independent contractor GMPs is in Chapter 10.

Salaried general medical practitioners

4.26 Data from the Health and Social Care Information Centre showed that the average income for salaried GMPs was £56,800 in 2011-12, a decrease of 1.4 per cent on 2010-11. However, we recognise that many salaried GMPs work part-time: we therefore stress again that we would particularly welcome the research planned by the BMA on GMP workload, and ask that it also measure the workload and hours worked by salaried GMPs, to provide us with a more up-to-date measure of hours worked than the average of 23.8 hours per week recorded by the 2006-07 workload study. To better inform our deliberations, we would like to be provided with this data on a yearly basis, to also include data on the distribution of hours worked and full-time equivalent (FTE) numbers to assist with our examination of recruitment and retention.

4.27 NHS Employers said that the published salary range for salaried GMPs and the model contract were fit for purpose. NHS England told us that salaried GMP recruitment and retention was a problem for some areas of England, but would not necessarily be influenced or resolved through a contract uplift, and that there was no compelling labour market issue for salaried doctors that could be addressed by increasing pay. The Department of Health said that the model terms and conditions for salaried GMPs were intended to be the minimum and that employers were free to offer more favourable terms to reflect local needs and circumstances. We agree, and expect salaried GMPs in areas where recruitment is more challenging to be able to negotiate appropriate packages to reflect their demand. Our recommendation on the pay range for salaried GMPs is contained in Chapter 10.

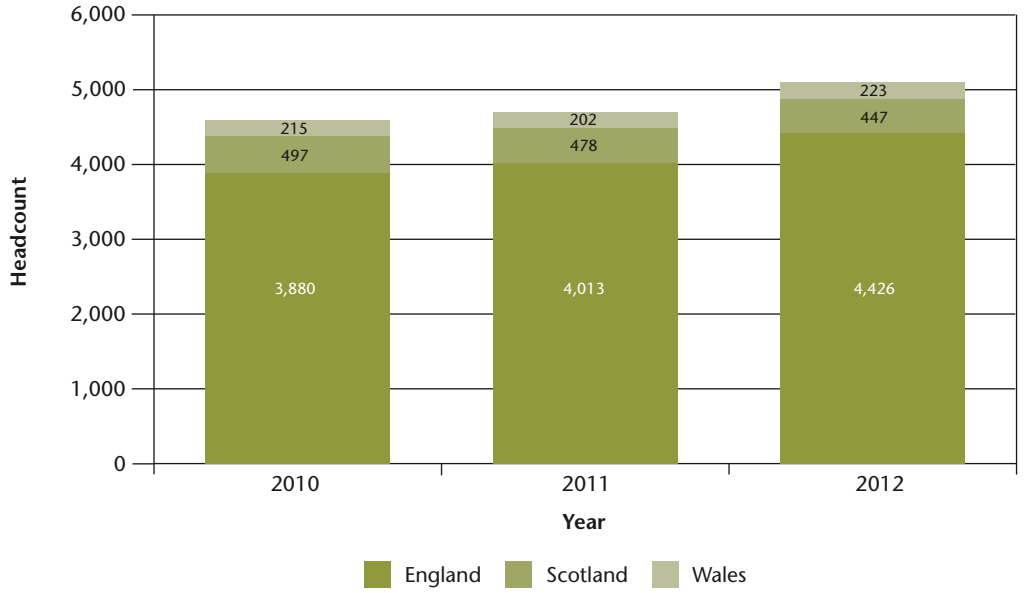
Clinical commissioning groups

4.28 Last year we asked the parties to update us on how the new system of Clinical Commissioning Groups (CCGs) in England was affecting income streams for GMPs. NHS England told us in evidence this year that it was too early to say what the impact was on income, with the overall effect on GMP income depending on both the overall level of payments to GMPs serving on CCGs and any increased expenses where those GMPs engage locums to provide backfill. We ask the parties to keep us informed on this issue.

General practice specialty registrars

4.29 The number of general practice specialty registrars has increased year on year in England, but, as can be seen in Figure 4.5, this has not been the case in Wales where the numbers have fluctuated, whilst in Scotland they have been decreasing. For future years, we ask that Northern Ireland also provide us with data on the number of general practice specialty registrars.

Figure 4.5: Number of general practice specialty registrars, 2010 – 2012, Great Britain[1]



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland.

[1]Northern Ireland does not produce separate figures for general practice specialty registrars.

4.30 In the past, we have made recommendations on the general practice specialty registrars' supplement – this 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 supplement currently stands at 45 per cent. We understand that the supplement will form part of the overall discussions on the new trainee doctors' contract. For this year, NHS Employers said that the 10.3 per cent increase in registrar numbers suggested that the level of the supplement did not need to be increased. Health Education England did not believe a pay response was required to encourage trainees into general practice, but the objective was to ensure that trainees had a positive GMP experience at an early stage of their training to encourage them towards this career path on completion of their training. Given the ongoing negotiations, we are not recommending any change to the level of the general practice specialty registrar supplement, but ask the parties to report to us on any implications for the supplement from the current negotiations.

General medical practitioner trainers' grant

4.31 Last year's report noted the ongoing delay in progress towards a tariff-based system to fund education and training, and our observation that the GMP trainers' grant should therefore be uplifted in line with our recommendation on basic pay. We have not been provided with any evidence to suggest that this issue has been settled, so we believe that the trainers' grant should be uplifted by the same amount as basic pay, which for 2014-15 would represent an increase of 1 per cent. We again urge the parties to give priority to resolving this issue and to update us for our next review.

Future evidence requirements

4.32 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to provide evidence on any recruitment problems in rural and remote areas;
- Health Education England to keep us informed on progress towards delivering its target increase in the number of trainees choosing general practice, and its ongoing assessment of whether any targeted pay response would be beneficial. We also ask its evidence to take into account the increasing number of women in the workforce, and the implications for the FTE number of doctors required, and for the other United Kingdom countries to provide a similar assessment;
- we welcome the proposed research by the BMA on GMP practice workload. At present, we are not provided with yearly data on the hours worked by GMPs and therefore cannot comment meaningfully on changes over time in the level of GMPs' pay;
- the parties to update us on the motivation of GMPs;
- the parties to consider whether they would want a country-specific recommendation for independent contractor GMPs in future years;
- the parties to provide us with annual evidence on the workload, hours worked, headcount and FTE data of salaried GMPs;
- for England to take account of our data requirements (as set out in Chapter 3) when taking forward the agreement on greater transparency around NHS earnings, and for each country to provide similar information;
- the parties to submit evidence to explain any regional variations in GMPs' income;
- the parties to keep us informed on how the new system of CCGs in England will affect income streams for GMPs;
- the parties to report to us on any implications for the general practice specialty registrar supplement from the current negotiations;
- Northern Ireland to provide data on the number of general practice specialty registrars; and
- the parties to give priority to reviewing the GMP trainers' grant and to provide us with an update on progress.

CHAPTER 5: GENERAL DENTAL PRACTITIONERS

Introduction

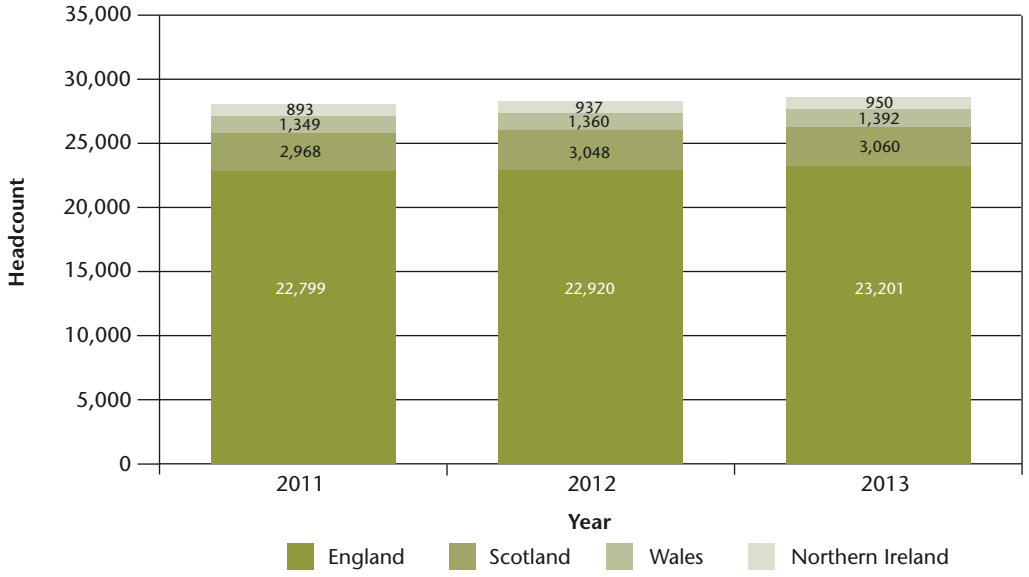
5.1 In this chapter, we consider issues surrounding general dental practice. It notes that in 2011-12 (the latest available data), there were significant decreases in the income of general dental practitioners (GDPs). Despite this, the picture on recruitment and retention appears to be generally healthy, although we note evidence suggesting problems in the recruitment of associate dentists.

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

Recruitment and retention and access to dental services in the United Kingdom

5.3 In March[1] 2013, there were 28,603 GDPs (headcount) in the United Kingdom, and an annual increase of 1.2 per cent, as shown by Figure 5.1 below. There were increases in the number of GDPs in all four countries between 2011 and 2013.

Figure 5.1: Number of general dental practitioners, United Kingdom, 2011 – 2013



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, Health and Social Care Business Services Organisation in Northern Ireland.

5.4 NHS England told us that the number of dental graduates in 2013 fell slightly to 918, but said that this still represented a 36 per cent increase since 2004 and would help to sustain the workforce numbers. It said that the Centre for Workforce Intelligence was analysing workforce needs and supply up to the year 2040, but that all scenarios suggested an excess of supply over demand or need. NHS England said that recommendations would be made to allow dental school intakes to be adjusted to reflect the new situation. It

[1] As of March 2013 in England and Wales, but as of September 2012 in Scotland and as of April 2013 in Northern Ireland.

told us that 191,000 more patients were seen in the year to June 2013. It said that commissioning plans at June 2013 were for 31,000 UDAs more than the previous year, and that dentists were enthusiastic to bid for and undertake NHS work. We note from Health Education England's *Workforce Plan for England*[2] that if no change was made to current training plans, then it forecasted a very significant oversupply of dentists widening to the year 2040, and that it therefore supported the professional advice of the Chief Dental Officer for England to reduce the number of commissions for dental undergraduate education, although it noted that the issue was subject to further discussion.

5.5 The Welsh Government noted that the number of dental students in 2014 was 80, up from 55 in 2003. Its Workforce Review found that if the rate of growth in dentist numbers continued at historical rates, then Wales was likely to have a broad balance between supply and demand. Local Health Boards were said to find little shortage of applicants for new or expanded dental contracts.

5.6 The Scottish Government told us about its dental bursary for undergraduate students studying in Scotland: it paid out £4,000 per annum on condition that the students committed to working in NHS dentistry in Scotland for up to five years following graduation. It said that in 2012-13, there were 576 students in receipt of the bursary.

5.7 The Northern Ireland Executive said that with the increase in the number of dentists, the access issues that had previously been a problem had been resolved. It said that patient registration numbers were now levelling off.

5.8 The British Dental Association (BDA) said that if pay continued to fall and there was no hope for many of ever owning a practice, then it believed that United Kingdom graduates would leave the profession permanently. It noted that in Scotland, access to NHS dental services had continued to improve. In general, it said that the NHS recruited relatively few experienced dentists each year, instead relying on graduates to boost numbers. Referring to its survey evidence, it said that around a third of practices experienced problems in their recruitment of associates. It also said that the survey suggested that 21.4 per cent of dentists aged 55 to 64 were planning to retire in the next year. Of all dentists planning to retire, 9 per cent cited declining levels of pay as the reason for their decision.

5.9 The evidence submitted on recruitment and retention paints a generally healthy picture, although we acknowledge the evidence from the BDA suggesting problems in the recruitment of associates. We note the increase in the workforce in each country and that plans are afoot in some countries to control numbers where supply is expected to exceed demand. We also note that the BDA's survey evidence suggests that pay is not the major factor influencing possible moves to retirement.

Motivation and workload

5.10 NHS England drew on the Health and Social Care Information Centre's dental working hours survey published in August 2012, that showed that dentists were working an average of 37.5 hours per week in 2011-12, compared to 39.4 hours per week in 2000, an almost 5 per cent reduction. The Welsh Government said that average total working hours per week in Wales stood at 36.4, unchanged since 2009-10. It also said it was working with the profession to reduce the administrative burden on practices. The Northern Ireland Executive said that given its budgetary pressure, it had little scope to address many issues impacting on the morale and motivation of the dental workforce. However, it had been able to reflect some of the concerns of practitioners when making some recent changes to the rules surrounding some treatments.

[2] *Workforce Plan for England*. Health Education England, December 2013. Available from: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/12/Workforce-plan-interactive1.pdf

5.11 The BDA argued that pay was a strong motivating factor for GDPs, with its survey showing that over 89 per cent of respondents thought that pay was either very or moderately important; and fewer than 13 per cent finding their pay for NHS work to be fair. The BDA said that satisfaction with pay was linked to high morale. It said that in Northern Ireland, principal dentists worked an average of 43 hours per week.

5.12 We do, of course, welcome the evidence submitted by the BDA on motivation. Nevertheless, we have noted that the number of respondents to its survey evidence have dropped over the last few years: from 42 per cent in 2011, to 27 per cent in 2012, to just 13 per cent in 2013 (although the survey evidence for salaried dentists has held up at 42 per cent for 2013). Decreasing response rates increases the risk of unintended bias and it becomes increasingly important to monitor the representativeness of the respondents to the GDP population. Whilst there may be an increased risk of bias in results, on the other hand, a reduction in respondents to a survey can say something in itself about the engagement and motivation of dentists.

Contractual changes

5.13 NHS England told us about a new pilot scheme for the delivery of NHS dental services that was based on capitation and quality, and focused on patient need and avoided unnecessary treatments. The aim of the new contractual arrangements was to improve the quality of patient care and increase NHS access, with an additional focus on the oral health of children. It hoped that the new contract would address the concerns of the profession and drive further improvements in oral health in England.

5.14 The Welsh Government also described new pilot programmes for the delivery of NHS dental services. It said that the fundamental purpose was to engender a shift in focus within the NHS from treatment to oral health-focused clinical practice and prevention. It involved a move away from the existing payments via UDAs towards a system focused on tailored patient care based on risk assessment. Any changes would be tested and developed before making national changes to contracts.

5.15 The Northern Ireland Executive said that it remained committed to the development of a new stand-alone contract for Northern Ireland which met the needs of practitioners and commissioners and would protect and improve the oral health of patients. It said that negotiations were ongoing on a model that proposed a global sum formula applied to a weighted capitation and quality payment model. It said that it was intended that the new contracts would be a "high trust" model with regular payments to practitioners that would provide greater stability and would alleviate some of the concerns highlighted by the BDA.

5.16 We welcome the progress reported on new contractual arrangements, and ask that when finalising any new arrangements, appropriate account is taken of the impact on motivation. We also ask that the parties consider how our future recommendations might fit alongside new contractual arrangements: Chapter 3 outlined our concerns with our existing formula-based approach – if the parties wish us to continue with an approach that takes account of dental expenses, then they need to consider how such an approach would fit with any new contractual arrangements.

Earnings and expenses

England and Wales

5.17 In 2011-12, GDPs on average had income of £74,400 and expenses of £86,600, giving an expenses to earnings (EER) ratio of 53.8 per cent (Table 5.1).

Providing-performer dentists[3] had average income of £112,800 and expenses of £245,600 (EER 68.5 per cent); for performer-only dentists[4] the figures were £61,800 and £34,500 respectively (EER 35.8 per cent).

Table 5.1: Average income and expenses for GDPs, England and Wales, 2009-10 to 2011-12

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
Providing-performer	2009-10	6,250	370,900	77,600	165,300	128,000	65.5
	2010-11	5,750	364,300	79,000	168,100	117,200	67.8
	2011-12	5,250	358,400	80,700	164,900	112,800	68.5
	Latest % change	*-8.7%*	*-1.6%*	*2.2%*	*-1.9%*	*-3.7%*	
Performer-only	2009-10	14,050	101,700	6,700	29,400	65,600	35.5
	2010-11	15,050	98,400	5,900	29,600	62,900	36
	2011-12	16,050	96,200	5,600	28,900	61,800	35.8
	Latest % change	*6.6%*	*-2.2%*	*-5.1%*	*-2.4%*	*-1.8%*	
All dentists	2009-10	20,300	184,900	28,600	71,400	84,900	54.1
	2010-11	20,800	172,000	26,100	68,000	77,900	54.7
	2011-12	21,300	161,000	24,100	62,500	74,400	53.8
	Latest % change	*2.4%*	*-6.4%*	*-7.7%*	*-8.1%*	*-4.6%*	

* Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by the Health & Social Care Information Centre (HSCIC) from unrounded figures.

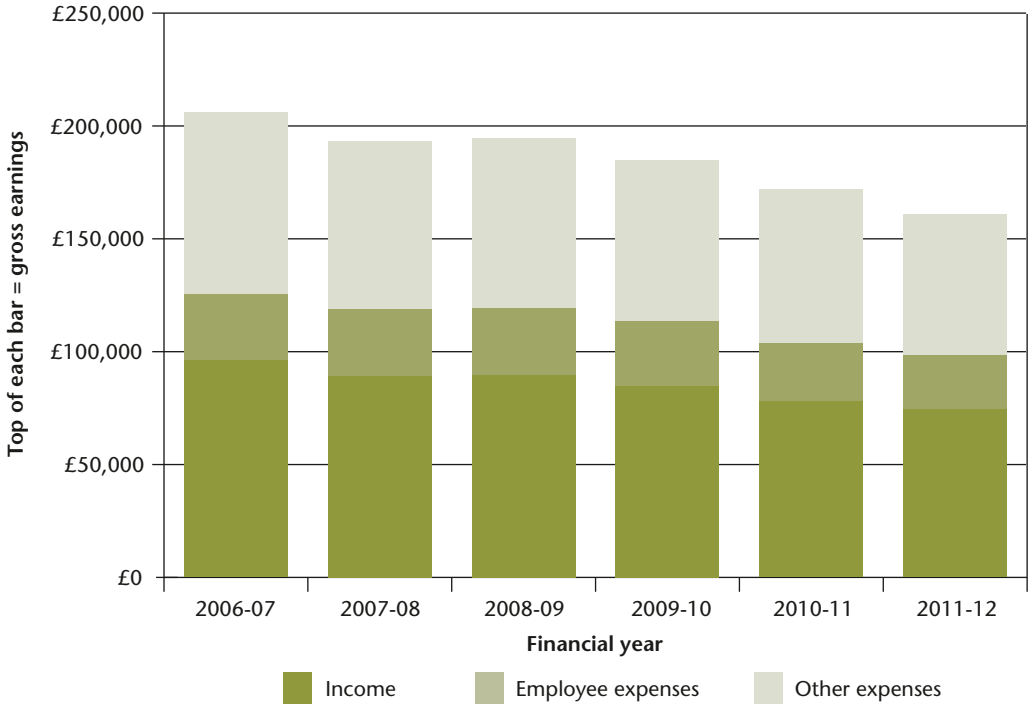
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

5.18 Figures 5.2, 5.3 and 5.4 show recent trends in income and expenses. Average incomes (from self-employment) are at their lowest levels over the five available years of the series.

[3] A providing-performer dentist performs NHS dentistry and holds a contract with a Primary Care Trust (PCT) or a Local Health Board (LHB) and also performs NHS dentistry on this or another contract.

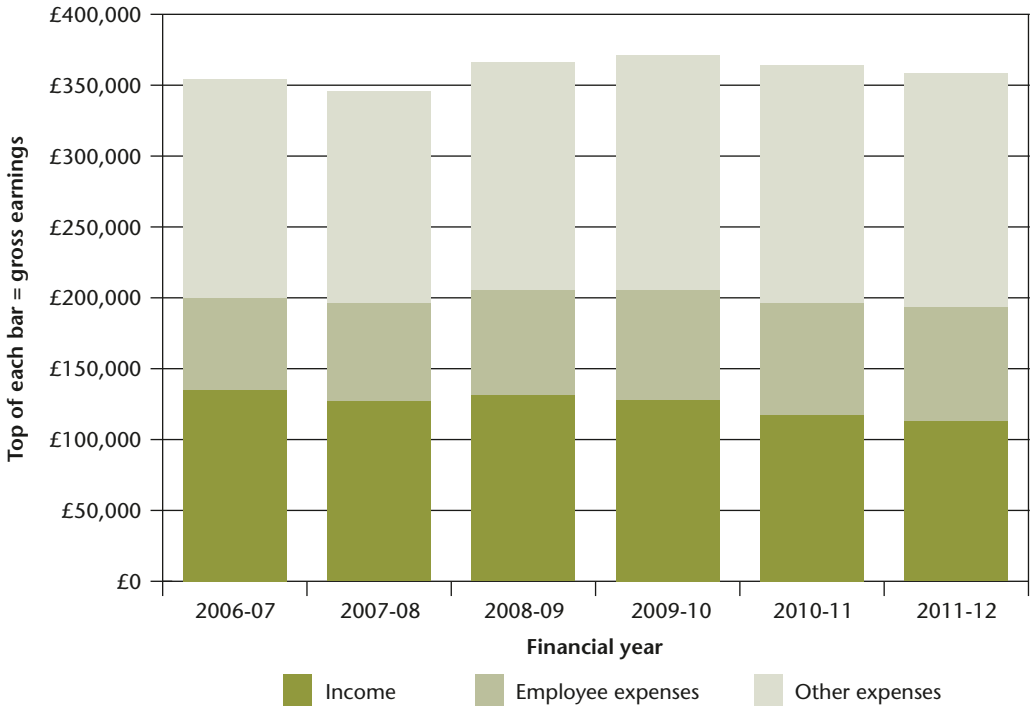
[4] A performer-only dentist performs NHS dentistry but does not hold a contract with a PCT or a LHB.

Figure 5.2: Gross earnings (NHS and private) for all self-employed dentists, England and Wales, 2006-07 to 2011-12



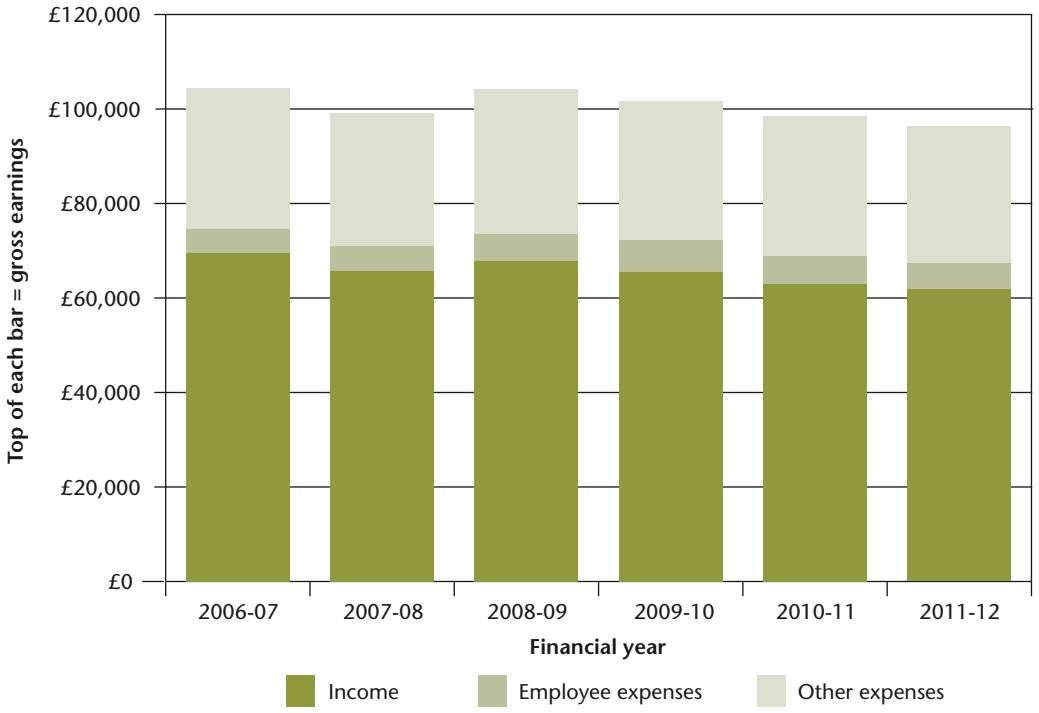
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure 5.3: Gross earnings (NHS and private) for self-employed providing-performer dentists, England and Wales, 2006-07 to 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure 5.4: Gross earnings (NHS and private) for all self-employed performer-only dentists, England and Wales, 2006-07 to 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

5.19 The issue of "double" or "multiple counting", which arose in the review in the Fortieth Report of dental earnings and expenses in Scotland, also applies in England – and may indeed be a greater issue, as all payments for NHS dentistry are made to contract holders, rather than to individual dentists. Multiple counting artificially inflates estimates of average gross earnings, expenses and the EER, but taxable income is not affected. The Health and Social Care Information Centre (HSCIC) notes in its latest statistical report (paragraph 1.19):[5]

> *"The extent of this multiple counting is difficult to quantify, but may have increased since the introduction of the dental contractual arrangements on 1 April 2006. Under this system, payments for NHS dentistry are made to the providing-performer dentist (or in some cases to a corporate body) who holds the contract under which the dentistry is performed; if the providing-performer has sub-contracted this work, then some of the payment will be passed on to a performer-only dentist. A single sum of money can be declared as gross earnings by both the providing-performer and performer-only dentist, and also as an expense by the providing-performer. Where a dentist is a sole-trader (i.e. the only dentist working in a practice), multiple counting will not occur, and where dentists operate in an Expenses Sharing Group, multiple counting is likely to be kept to a minimum."*

5.20 In our Fortieth Report, an estimate was made of the extent of double counting in Scotland. Using the same methodology, the adjusted EER for all dentists in England and Wales is 47.4 per cent – compared with an unadjusted EER of 53.8 per cent.

5.21 Our Forty-First Report 2013 set out an alternative method, which instead assumed an average EER for providing-performers that was close to the figure for sole traders (for

[5] *Dental Earnings and Expenses: England and Wales, 2011-12*. Health and Social Care Information Centre, August 2013. Available from: http://www.hscic.gov.uk/catalogue/PUB11473/dent-earn-expe-eng-wale-2011-12-rep.pdf

whom, as noted above, multiple counting does not occur). This alternative method gives an adjusted EER for all dentists in England and Wales of 47.7 per cent.

Longitudinal results

5.22 Changes in income and expenses for all GDPs were influenced by a change in the composition of the workforce: there were more performer-only dentists, and fewer providing-performers, in the population. Other factors which make it difficult to reliably make comparisons between years include:

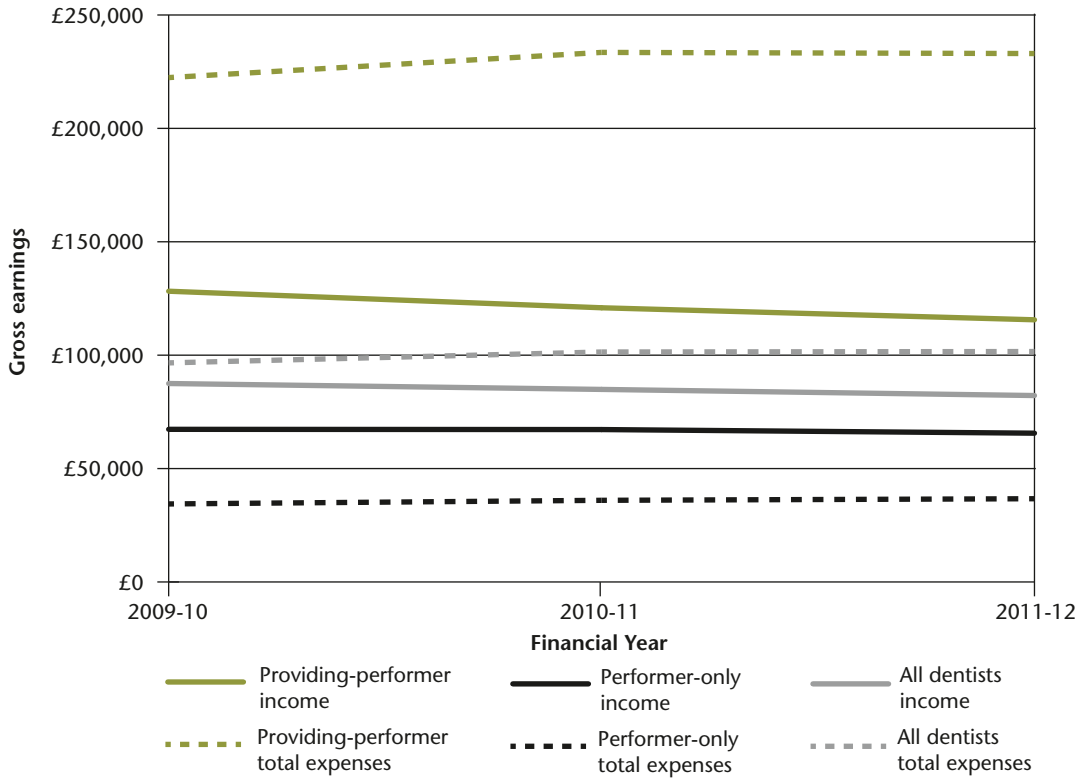
- changes in contract type – there were fewer dentists performing solely on Personal Dental Services contracts;
- changes in income type – 1,550 dentists were excluded from the 2011-12 sample because they had employment income but no self-employment income (the same number as were excluded from the 2010-11 sample); and
- changes in type and volume of activity per dentist – for example changes in the levels of dental, orthodontic, NHS and private activity undertaken.

5.23 For the second time, the HSCIC has presented changes in income and total expenses for the cohort of dentists that had not changed dental type or contract type over the period 2009-10 to 2011-12. This controls for some of the population and sample changes, but not for external factors such as changes to VAT and the Bank rate (although we note that the Bank of England rate has remained unchanged since March 2009), or the uplift to contract values recommended by us.

5.24 Figures 5.5 and 5.6 show the changes in income and expenses for the longitudinal cohort over this period, with the former showing the data in current prices and the latter as an index. For all dentists, income decreased by 2.9 per cent in 2010-11 and by a further 3.3 per cent in 2011-12. For providing-performer dentists, income decreased by 5.7 per cent in 2010-11 and then by a further 4.4 per cent in 2011-12. Income decreased for performer-only dentists by 0.3 per cent in 2010-11 and by a further 2.2 per cent in 2011-12. Average expenses in 2011-12 increased by around 5 per cent for all types of dentist but rose much more modestly in 2011-12 (falling for provider-performer dentists by 0.2%).

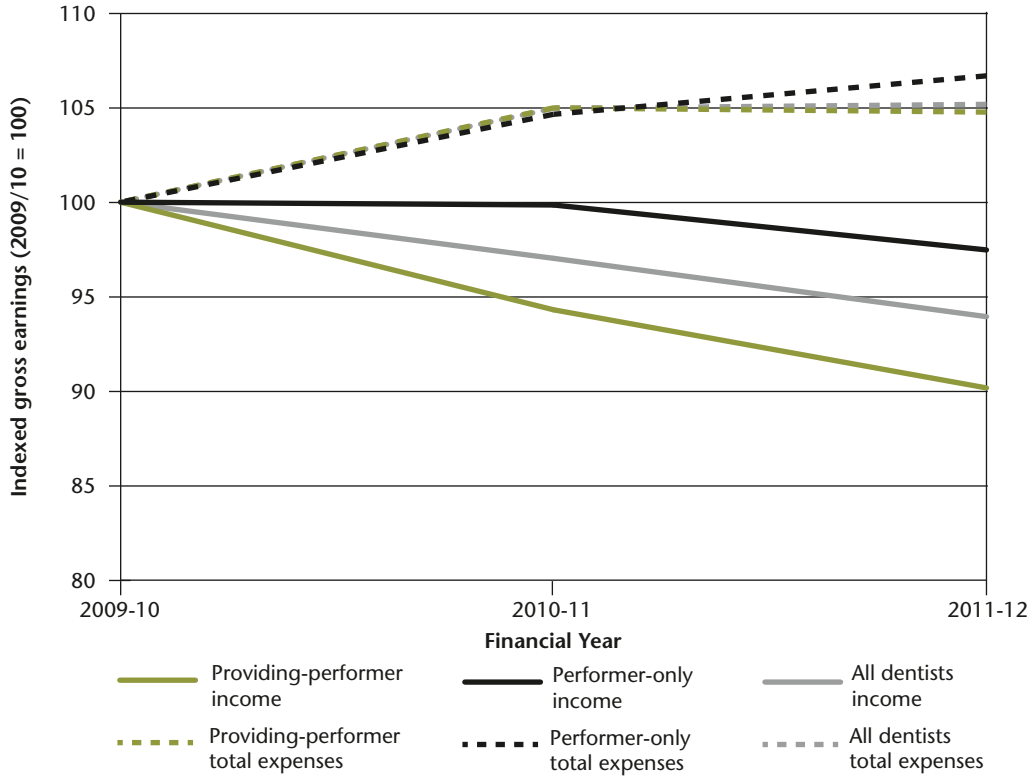
5.25 Comparing the change between 2010-11 and 2011-12, the magnitude of the decrease in income for the longitudinal cohort is lower than for the entire sample, suggesting that some of the change in income is due to movement within the dental population and changes within the sample.

Figure 5.5: Longitudinal gross earnings (NHS and private) by dental type, England and Wales, 2009-10 to 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure 5.6: Indexed longitudinal gross earnings (NHS and private) by dental type, England and Wales, 2009-10 to 2011-12



Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Scotland

5.26 In 2011-12, GDPs in Scotland on average had income of £71,700 and expenses of £90,700, giving an EER of 55.8 per cent (Table 5.2). Principal dentists had average income of £102,900 and expenses of £230,000 (EER 69.1 per cent); for associate dentists the figures were £57,600 and £27,500 respectively (EER 32.3 per cent). Despite increases to average incomes of principal dentists (+1.8%), average income for all dentists actually decreased (-2.2%). This has been driven by decreases in the average income of the more numerous associate dentists (-4.3%).

Table 5.2: Average income and expenses for GDPs, Scotland, 2009-10 to 2011-12

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
	2009-10	650	337,000	85,800	137,400	113,800	66.2
Principal	2010-11	700	334,700	89,300	144,300	101,100	69.8
	2011-12	700	332,900	86,200	143,800	102,900	69.1
	Latest % change	*0.0%*	*-0.5%*	*-3.5%*	*-0.3%*	*1.8%*	
	2009-10	1,450	91,900	1,100	27,700	63,100	31.3
Associate	2010-11	1,450	87,900	1,200	26,600	60,100	31.6
	2011-12	1,550	85,000	600	26,900	57,600	32.3
	Latest % change	*6.9%*	*-3.3%*	*-50.0%*	*1.1%*	*-4.3%*	
	2009-10	2,100	170,200	28,200	62,700	79,300	53.4
All dentists	2010-11	2,150	167,300	29,500	64,500	73,300	56.2
	2011-12	2,250	162,400	27,300	63,400	71,700	55.8
	Latest % change	*4.7%*	*-2.9%*	*-7.5%*	*-1.7%*	*-2.2%*	

* Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by HSCIC from unrounded figures.

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

5.27 Using the same methodology to estimate multiple counting as was used in our Fortieth Report, the adjusted EER for all dentists in Scotland is 49.7 per cent – compared with an unadjusted EER of 55.8 per cent. The alternative method (see paragraph 5.21) gives an adjusted EER of 48.3 per cent.

Northern Ireland

5.28 In 2011-12, GDPs in Northern Ireland on average had income of £75,800 and expenses of £96,200, giving an EER of 55.9 per cent (Table 5.3). Principal dentists had average income of £112,500 and expenses of £206,100 (EER 64.7 per cent); for associate dentists the figures were £55,700 and £35,800 respectively (EER 39.1 per cent). Average income has decreased for both principal and associate dentists, and overall, since 2009-10.

Table 5.3: Average income and expenses for GDPs, Northern Ireland, 2009-10 to 2011-12

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
	2009-10	350	344,600	73,200	148,500	122,900	64.3
Principal	2010-11	300	331,000	79,200	137,600	114,200	65.5
	2011-12	350	318,600	77,000	129,100	112,500	64.7
	Latest % change	*16.7%*	*-3.8%*	*-2.8%*	*-6.2%*	*-1.5%*	
	2009-10	500	97,900	1,100	34,100	62,700	36
Associate	2010-11	550	96,200	500	36,400	59,400	38.3
	2011-12	600	91,600	800	35,000	55,700	39.1
	Latest % change	*9.1%*	*-4.9%*	*60.0%*	*-3.8%*	*-6.2%*	
	2009-10	850	195,300	29,500	79,300	86,500	55.7
All dentists	2010-11	900	180,100	28,600	72,600	78,900	56.2
	2011-12	900	172,000	27,800	68,400	75,800	55.9
	Latest % change	*0.0%*	*-4.5%*	*-2.8%*	*-5.8%*	*-3.9%*	

* Percentage changes are calculated from the rounded figures in the table. All other percentages are calculated by HSCIC from unrounded figures.

Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

5.29 Using the same methodology to estimate multiple counting as was used in our Fortieth Report, the adjusted EER for all dentists in Northern Ireland is 49.6 per cent – compared with an unadjusted EER of 55.9 per cent. The alternative method (see paragraph 5.21) gives an adjusted EER of 52.5 per cent.

The formula approach to recommending the uplift for 2014-15

5.30 In recent years, we have used a formula-based approach 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. Chapter 3 sets out our concerns related to the formula-based approach. However, in view of the value placed on our recommendations that include our assessment of expenses, we are willing to make recommendations using our formula-based approach for 2014-15.

Earnings and expenses in Northern Ireland

5.31 The Northern Ireland Executive asked us to carry out an assessment of dental earnings and expenses for GDPs in Northern Ireland, similar to the work that we undertook in our Fortieth Report 2012 for GDPs in Scotland. Our calculation using the formula appears later in this chapter, and the recommendation for GDPs in Northern Ireland is in Chapter 10. We have also been able to update our analysis of multiple counting in aggregated Inland Revenue returns. We note that in its evidence, the Northern Ireland Executive agreed with the proposed EER of 50 per cent that we put forward in our Forty-First Report 2013. As noted earlier, our analysis this year uses two alternative methods for calculating the EER in Northern Ireland: it suggests an EER of either 49.6 per cent or 52.5 per cent.

The formulae for 2014-15

Formula weights

5.32 The weights that we use in our formulae are derived from figures on GDPs' average earnings and expenses, compiled by the HSCIC using data from self-assessment tax returns, with an adjustment made to reflect the estimated effect of the multiple counting of expenses. In our last report, we proposed that an EER of 50 per cent should be used: we propose to continue using this figure, as there are not large deviations between it and the revised EERs in each country of the United Kingdom (England and Wales' revised EER is 47.4 per cent, Scotland's revised EER is 49.7 per cent, and Northern Ireland's revised EER is 49.6 per cent). Whilst there is a small difference between England and Wales' revised EER and the assumed 50 per cent, the assumed EER is still broadly in line with the aggregation of non-clinical staffing costs, laboratory costs, materials costs and other non-staffing costs figures, as a percentage of gross income which are published by HSCIC[6] (in 2011-12 these accounted for 49.2 per cent of the gross income of NHS practices).

5.33 The Scottish Government highlighted the allowances and reimbursements paid to GDPs. We continue to believe that these should be offset in our formula, and in 2011-12 they accounted for 10.33 per cent of all expenditure on GDS in Scotland. Expressing dentists' income as a percentage of non-reimbursed gross earnings gives 50 per cent ÷ 0.8967 = 55.8. We sought evidence from all countries on the level of reimbursements received by dentists. In Wales and Northern Ireland, reimbursements accounted for 6.2 per cent and 4.1 per cent respectively and are offset in the formulae. In England there is no reliable estimate for reimbursements and so accordingly we do not account for these in the formula for England. Taking into account reimbursements leads to an adjustment of the formula weights.

Income uplift

5.34 Our recommendation this year is for the same uplift across our remit groups. Our recommendation for the intended uplift to income for independent contractor GDPs is 1 per cent: our rationale for this is set out in Chapter 10.

Staff costs

5.35 For staff costs, we again use data from the Annual Survey of Hours and Earnings (ASHE), for the dental practice activities industrial classification. The change in median gross hourly pay between April 2012 and April 2013 was 2.5 per cent.

Laboratory, materials and other costs

5.36 For laboratory and materials costs, we again 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 2013 was 2.7 per cent.

5.37 For all other costs, we also use RPIX in Scotland because dentists receive reimbursements for rent, and this element has already been accounted for by expressing the formula coefficients as a percentage of non-reimbursed gross earnings. However in England, Wales and Northern Ireland the costs for rent are not reimbursed and therefore we use RPI to account for changes in other costs.

5.38 Putting these coefficients into the formulae, and adjusting the weights to account for reimbursements and using an EER of 50 per cent produces the following for each country (Tables 5.4, 5.5, 5.6 and 5.7):

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[6] *Dental Earnings and Expenses: England and Wales, 2011-12*. Health and Social Care Information Centre, August 2013. Table 26. Available from: http://www.hscic.gov.uk/catalogue/PUB11473

Table 5.4: Uplift formula for general dental practitioners, England, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	50.0%	1% *DDRB recommendation*	0.50%
Staff costs	16.2%	2.5% *ASHE 2013 (general dental practice activities)*	0.41%
Laboratory costs	6.1%	2.7% *RPIX for Q4 2013*	0.16%
Materials	6.6%	2.7% *RPIX for Q4 2013*	0.18%
Other costs	21.1%	2.6% *RPI for Q4 2013*	0.55%
			1.80%

Table 5.5: Uplift formula for general dental practitioners, Wales, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	53.3%	1% *DDRB recommendation*	0.53%
Staff costs	18.3%	2.5% *ASHE 2013 (general dental practice activities)*	0.46%
Laboratory costs	6.5%	2.7% *RPIX for Q4 2013*	0.18%
Materials	7.0%	2.7% *RPIX for Q4 2013*	0.19%
Other costs	14.9%	2.6% *RPI for Q4 2013*	0.39%
			1.74%

Table 5.6: Uplift formula for general dental practitioners, Scotland, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	55.8%	1% *DDRB recommendation*	0.56%
Staff costs	21.2%	2.5% *ASHE 2013 (general dental practice activities)*	0.53%
Laboratory costs	6.8%	2.7% *RPIX for Q4 2013*	0.18%
Materials	7.4%	2.7% *RPIX for Q4 2013*	0.20%
Other costs	8.8%	2.7% *RPIX for Q4 2013*	0.24%
			1.71%

Table 5.7: Uplift formula for general dental practitioners, Northern Ireland, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	52.1%	1% *DDRB recommendation*	0.52%
Staff costs	19.1%	2.5% *ASHE 2013 (general dental practice activities)*	0.48%
Laboratory costs	6.4%	2.7% *RPIX for Q4 2013*	0.17%
Materials	6.9%	2.7% *RPIX for Q4 2013*	0.19%
Other costs	15.5%	2.6% *RPI for Q4 2013*	0.40%
			1.76%

Efficiencies

5.39 The BDA said that it was disappointed by the continued insistence on the application of 4 per cent efficiencies, and said it would welcome a reiteration of our statement that GDPs run their businesses as efficiently as possible. NHS England said that it was meeting with the BDA to discuss possible quality and efficiency improvements. We welcome this approach: as we noted in our last report, as GDPs are running small businesses, they should have every incentive to achieve whatever efficiency savings are possible; but if the Health Departments continue to think it appropriate to impose an efficiency requirement, then such a requirement should be a contractual matter rather than abating our recommended increases.

Future evidence requirements

5.40 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to consider how our recommendations on pay might fit alongside new contractual arrangements.

CHAPTER 6: SALARIED DENTISTS

Introduction

6.1 This chapter considers issues surrounding the various salaried dental services in the United Kingdom. It notes that recruitment and retention does not appear to be a major issue, and that pay does not appear to be the main driver behind any motivation issues, but with the exception of the evidence submitted by the British Dental Association (BDA), we are concerned about the significant lack of detailed information for this remit group. We also welcome the progress made on contract reform in both Scotland and Northern Ireland.

6.2 Salaried 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. The parties indicated that there were approximately 1,000 salaried dentists in England, 168 in Wales, 535 in Scotland and approximately 70 in Northern Ireland.

Recruitment and retention

6.3 NHS England reported that there were no difficulties with recruitment. By contrast, the BDA pointed out that 77 per cent of salaried dentists were female, and the largest group of salaried dentists was in the age range 45 – 54, which could lead to problems when they were to retire in the next 5 – 10 years. It suggested that pay and reward would therefore need to be improved to attract new dentists into the service. The BDA drew on its Freedom of Information request that had revealed 35.7 unfilled advertised posts. The parties were unable to quantify with any degree of certainty the actual number of salaried dentists – we note that the number of salaried dentists in England was estimated last year as 1,353; and this year as 1,000: but in any case, 35.7 vacancies does not suggest to us a particular problem with recruitment or retention. We do, however, stress the importance we attach to receiving up-to-date vacancies data: such data are essential to inform long-term strategies for pay and workforce planning and the absence of robust statistics on vacancies data also risks undermining the credibility of our recommendations. We urge the Health Departments to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round.

Motivation and workload

6.4 From its survey of salaried dentists, the BDA reported that poor management, lack of staff and pressures on services were causes of low morale, with pay being the third most cited reason affecting dentists. It said that over 40 per cent of respondents rated their morale as low or very low. Thirty-six per cent of salaried dentists reported that they found their work very stressful or extremely stressful. The BDA asked us to recommend that we ask NHS Employers, and their equivalents in the devolved countries, to undertake an analysis of what organisational improvements were required to address the motivation of those in the salaried services. We do not consider such a request to fall within our remit, although we were struck by the lack of detail provided by NHS Employers on this remit group, even down to such basic details as the number of salaried dentists. We would, of course, welcome any evidence from the parties on the link between pay and motivation. We note that the evidence put forward by the BDA does not suggest that pay is the main driver affecting motivation: of the reasons cited as 'very important' affecting motivation, pay scored the lowest.

New contractual arrangements in Scotland and Northern Ireland

6.5 The Scottish Government reported on the successful outcome of negotiations on a new contract for its salaried dentists, with new pay rates backdated to April 2013. It said that the new pay arrangements aligned pay rates with those applied in England and Wales, and the BDA welcomed the new pay, terms and conditions. The new pay scales are shown in Appendix A.

6.6 The Northern Ireland Executive confirmed Ministerial approval to enter into negotiations with the BDA to implement new contractual arrangements for community dentists in Northern Ireland. We welcome this progress, as salaried dentists in Northern Ireland are the final remit group for whom modernised pay, terms and conditions remains outstanding. We ask the parties to update us on progress for our next review.

Pay recommendation

6.7 Our recommendation on pay for salaried dentists in contained in Chapter 10.

Future evidence requirements

6.8 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to provide us with up-to-date vacancies data;
- the parties to provide us with evidence on the link between pay and motivation; and
- the parties to update us on progress towards new contractual arrangements for salaried dentists in Northern Ireland.

Part III: Secondary care

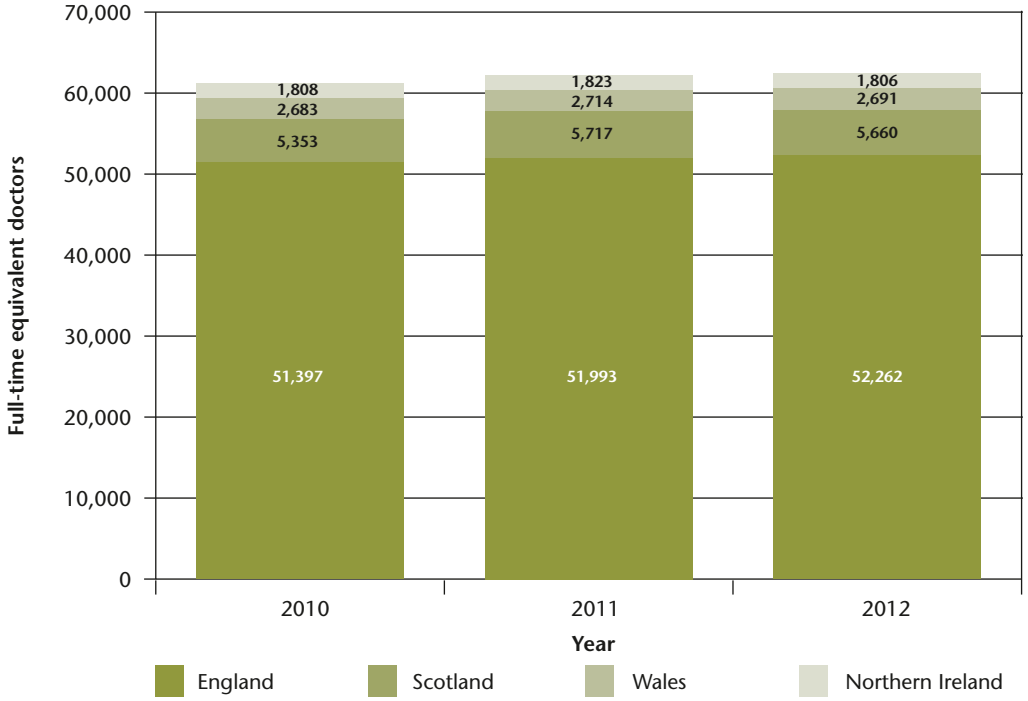
CHAPTER 7: DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction

7.1 In this chapter, we consider issues related to doctors and dentists in hospital training. We consider fill rate data, noting that for some specialties such as emergency medicine and psychiatry, a problem may be emerging that we wish to monitor closely. We also note the ongoing contractual negotiations.

7.2 Doctors in the United Kingdom begin their hospital training in Foundation Programmes, normally a two-year, general postgraduate medical training programme, where they are known as foundation house officers (FHOs). Following this doctors are faced with a choice of remaining in the hospital sector as a specialty registrar, or choosing to enter general practice via the general practice specialty registrar route. In September 2012, there were 62,418 doctors and dentists in hospital training (Figure 7.1), an increase of 0.3 per cent in the United Kingdom as a whole since September 2011, though it was only England which experienced an increase in its numbers (+0.5 per cent).

Figure 7.1: Number of doctors in training in the Hospital and Community Health Services, United Kingdom, 2010 – 2012



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety

New contract discussions

7.3 NHS Employers outlined the jointly agreed (with the British Medical Association (BMA)) Heads of Terms that set out the framework for the United Kingdom-wide negotiations on a reformed contract for junior doctors. The main aims of the contract were to:

- promote safe care for patients and safety for doctors in training and be fair for doctors in training, employers and other NHS staff;

- be affordable for employers;
- facilitate high quality NHS patient care through sustainable service provision;
- deliver safe working patterns;
- address dissonance between the New Deal and the Working Time Directive; and
- seek to make it easier for employers to offer longer contracts.

7.4 The Department of Health asked us to consider and make observations on the Heads of Terms, with particular emphasis on the current pay structure for pay progression and whether it could be used to help improve performance, patient care, and productivity. During oral evidence, the BMA stressed the importance of our maintaining our independence from the Health Departments and highlighted the associated risks to delivering a successful outcome to negotiations. We also note that the negotiations on the junior doctors' contract are United Kingdom-wide, yet the request for our comments on the Heads of Terms is from England only. We are therefore minded to reserve any comment on the Heads of Terms, pending the outcome of the negotiations, although we feel it worth reminding the parties of the comment from our last report that we would support a contract that strengthened the link between pay and better quality patient care and outcomes, particularly for the service delivery aspect of the junior doctors' contract. We also remind the parties later in this chapter of our long-held view for the restructuring of junior doctors' pay to place less emphasis on the banding supplements, to help ensure that starting salaries do not fall behind comparable graduate entry professions. We note from NHS Employers that the aim is to complete the negotiations by October 2014. We ask the parties to update us on the outcome of the negotiations for our next review.

The Shape of Training

7.5 We also noted the recent report[1] by Professor David Greenaway following the *Shape of Training* review of postgraduate medical education and training. The report concluded that patients and the public needed more doctors who were capable of providing general care in broad specialties across a range of different settings, and that postgraduate training needed to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties. It said that medicine had to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers. The report recommended that doctors should enter broad based specialty training, with specialties or areas of practice grouped together, with the groupings characterised by patient care themes.

7.6 The report noted that restructuring training to produce a more broadly trained specialist might ease some of the current workforce pressures. It said that by training more doctors capable of managing acute and emergency cases, there would be a larger pool of medical staff to cover acute care. This would reduce the stress and intensity of the workload currently experienced by those providing acute care, and would also break the vicious cycle of unattractive areas of medicine failing to recruit staff and so becoming more understaffed, more stressful and more unattractive. The report concluded that to meet current issues with emergency and acute medicine, some specialties might introduce broader training through piloting and early adoption of broad based postgraduate training. We ask the parties to update us on how they are taking forward the proposals contained in the report.

Recruitment and retention

7.7 NHS Employers reported that in 2012, there were 2.3 home applicants for each medical school place in the United Kingdom, a little down from 2.4 in the previous year. This

[1] *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

demonstrates strong evidence that at the undergraduate level, medicine continues to be seen as an attractive career, and we have noted that the average Universities and Colleges Admissions Service (UCAS) tariff points score held by home domiciled accepted applicants has increased markedly in 2012 to 417 points, up from 406 the previous year: this score is significantly higher than the average tariff score of all applicants accepted through UCAS in 2012 of 259 points. Women accounted for 54 per cent of accepted medical applicants in the United Kingdom although we note from a report[2] by the General Medical Council that the increase in the proportion of women in the workforce appears to have leveled off. The report notes that female doctors were far more likely to work part-time, and to choose specialisms conducive to part-time working. Given the potential impact on retention, we ask the parties to continue to bear this in mind when considering their workforce planning.

7.8 The Scottish Government told us about its Strategy for Attracting and Retaining Trainees, a coordinated response to the challenges of the recruitment of medical trainees. It had a number of recruitment goals by 2016: to increase overall applications to Scottish training programmes by Scottish foundation completers; to increase first choice preferencing of Scottish training programmes; to increase fill rates of hard to fill programmes in emergency medicine, general practice and psychiatry; and to reduce gaps due to failure to fill; all by 5 per cent. We would welcome evidence for our next review on progress to meeting these targets, alongside evidence from all countries on any adopted strategies for tackling recruitment issues for trainees.

7.9 Health Education England provided us with fill rates at the various levels for different specialties (the levels range from year 1 to year 6) for trainees in the United Kingdom, after the initial two rounds of recruitment. Clearly, many of the vacancies will be filled at a subsequent stage of recruitment, but the data does suggest that within different levels some specialties are less attractive to applicants than others: for example, emergency medicine, core psychiatry training and obstetrics and gynaecology specialties, which is in line with what we heard during oral evidence. Table 7.1 shows those specialties with more than ten posts and fill rates that are below 50 per cent after two rounds of recruitment: the full list of specialty training fill rates can be found in Appendix H. We are grateful for this information, and wish to continue to monitor the position on recruitment. We therefore ask all countries to update us each year on the fill rates across all specialties, and to update us with the 2013 position after the final round of recruitment. We understand that the vacancies could be filled by trainees, or by locums or other service posts. When the parties update us on the final 2013 position, we ask that they clarify how many of the vacancies were eventually filled by training posts, as this will clearly have implications for the long-term supply of trained doctors.

[2] *The State of Medical Education and Practice in the UK: 2013*. General Medical Council, October 2013. Available from: http://www.gmc-uk.org/publications/23435.asp

Table 7.1: United Kingdom 2013 fill rates for hospital trainees after the initial two rounds of recruitment

	Level	Fill rate (%)	Number of posts (vacancies)
Metabolic Medicine	3	0	25 (25)
Core Psychiatry Training	3	14.8	27 (23)
Neurosurgery	2	18.2	11 (9)
Emergency Medicine	4	30.9	473 (327)
Emergency Medicine	1	36.8	19 (12)
Core Psychiatry Training	2	38.2	34 (21)
Immunology	3	38.5	13 (8)
Rehabilitation Medicine	3	41.7	36 (21)
Obstetrics and Gynaecology	2	43.8	16 (9)
Obstetrics and Gynaecology	3	43.8	32 (18)
Ophthalmology	3	45.8	24 (13)

Source: NHS England.

7.10 Some of the parties highlighted recruitment into emergency medicine as a particular issue. The Foundation Trust Network said that there were a range of structural factors underlying the shortages, including education and training pathways, career attractiveness compared to other available occupations, and the lifestyle issues associated with accident and emergency (A&E), including unsocial hours and reduced private work. During oral evidence, the Scottish Government stressed problems in retaining junior doctors within emergency medicine, with the fill rate in 2013 for specialty training year 4 posts being just 31 per cent. Its written evidence said that financial incentives for shortages would be discussed as part of the contract negotiations, and asked us to consider recommendations to address the issue, though it also said that the recommendations might not necessarily be for additional pay, but perhaps more in relation to addressing the work/life balance. The BMA said that there was no short-term solution to the shortages in A&E, as at training level the competition ratio for A&E medicine was well below one (i.e. more training places than applicants), and only 1.4 for intensive care, meaning there would not be an expansion in trained doctor numbers in the near future. Health Education England suggested the reason for the shortage in emergency medicine was the perception about work/life balance and therefore some pay response could be helpful as part of a wider coordinated approach by employers in the use of recruitment and retention premia. However, during oral evidence, Health Education England suggested enhanced annual leave and opportunities for sabbatical leave might ameliorate lifestyle issues and that payment premia alone might not have much effect.

7.11 We are not able from the evidence provided on fill rates to assess whether any shortages are pay-related, or if there are other, perhaps lifestyle reasons for why particular specialties are understaffed. We are, however, very concerned with the fill rates for some specialties, including emergency medicine. Given the ongoing negotiations on the junior doctors' contract, we do not consider it appropriate at this stage to recommend any pay response to shortages in any particular specialties, but ask the parties to consider as part of the contract negotiations whether a pay mechanism might be helpful. Of course, the parties will also wish to consider whether other, strictly non-pay, responses might be of benefit, such as increased annual leave or opportunities for sabbatical leave. We ask the parties to update us for our next review, and, as noted above, to provide us with regular updates on fill rates to the various specialties, including emergency medicine. We will also wish to receive evidence on how the recommendations of the *Shape of Training* review

are being taken forward, and an assessment of whether the review's recommendations will help to alleviate recruitment difficulties, such as in emergency medicine.

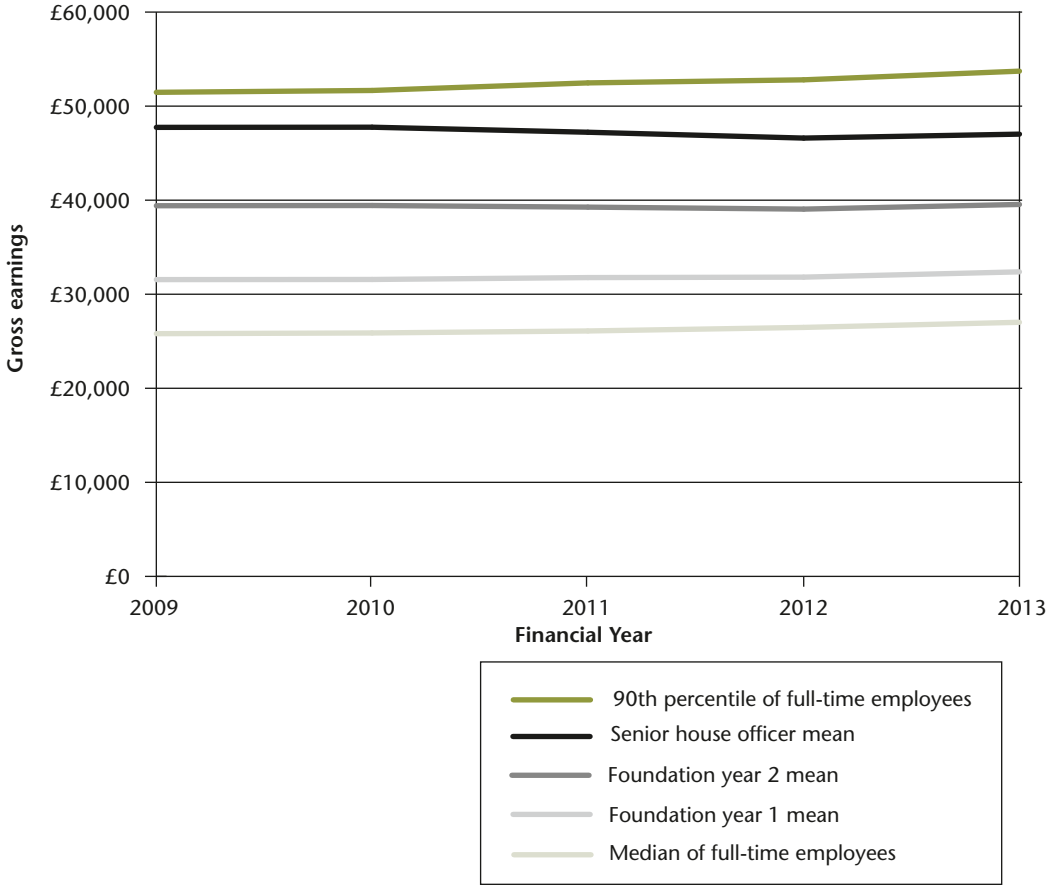
Banding supplements

7.12 The Department of Health told us that it believed there should be no adjustment to the levels of banding supplements for either hospital trainees or for general practice specialty registrars, pending the conclusion of negotiations on new contractual arrangements. It said it would be content with proposals for increased basic pay and the removal of banding supplements. It said that any pressure on employer contributions resulting from moving earnings out of non-pensionable banding supplements into basic pay should be funded from outside the pay bill for junior doctors, although it is clear that this funding shortfall will need to be met from some part of the NHS budget and will therefore have some implications for affordability. Nevertheless, we welcome these developments for junior doctors: we have long supported a move to restructuring junior doctors' pay to place less emphasis on the banding supplements and to help ensure that starting salaries do not fall behind comparable graduate entry professions. Given the ongoing negotiations, we are content not to consider any adjustments to the current levels of the banding supplements. We look forward to learning of the outcome of the negotiations.

Comparator groups

7.13 The BMA said that the FHO1 salary of £22,636 was significantly below the national median starting salary of £26,500 recorded by the Association of Graduate Recruiters. In addition they found that *High Fliers Research*, which collected data from *The Times* Top 100 graduate employers, gave a median starting salary of £29,000. Our own research on pay comparability, using the system of comparators outlined in Chapter 2, shows that for FHO1s, the mean basic salary has been broadly flat since 2010, and in 2013 is below mean basic salary of that of the comparator groups. Mean total earnings are also generally down relative to comparator groups. For FHO2s, total earnings are broadly similar to their comparators, although their mean basic salary is still below that of the other professions. In previous years, the comparator groups had earnings significantly lower than that of FHO2s, but after recent increases in the earnings of comparator groups, they are now broadly similar. Doctors in their first two years of specialty training receive basic salaries considerably lower than those of their comparators, but mean total earnings including banding supplements for second year registrars remain broadly competitive with total cash paid to the comparator groups. Specialty registrar salaries have remained quite flat over the last four years, whilst most of their comparator groups have seen increases over the last couple of years. For specialty registrars in the third year onwards, mean total earnings are broadly comparable to mean total earnings in the tax and accounting and pharmaceutical groups, but are significantly behind total cash earnings in the legal and actuarial sectors. As can be seen in Figure 7.2, the level change in earnings of a FHO1 over the last few years has been relatively similar to employees in the wider economy whilst FHO2 earnings have been flat. However, for senior house officers there has been a slight decrease over the last few years and the gap between the 90th percentile and senior house officers has grown.

Figure 7.2: Gross earnings comparison between foundation house officers and senior house officers in England and the wider economy, 12 month period to April



Sources: The Health & Social Care Information Centre and Annual Survey of Hours and Earnings (Office for National Statistics).

Pay recommendation

7.14 Our recommendation on pay for junior doctors can be found in Chapter 10.

Future evidence requirements

7.15 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to update us on the outcome of the negotiations on the junior doctors' contract;
- the parties to update us on how they are taking forward the proposals in the *Shape of Training* report;
- the Scottish Government to provide evidence on progress towards meeting its recruitment goals, alongside evidence from all countries on any adopted strategies for tackling recruitment issues for junior doctors;
- the parties to update us each year on the fill rates (including the number of posts) across all specialties for junior doctors, and to update us on the final position for the 2013 round, with a breakdown on how many vacancies were filled with training posts or with locums or other service posts;
- the parties to provide evidence on whether a pay response is required to address shortage specialties, or to indicate how such shortages are being addressed; and
- the parties to provide evidence on the implications for the banding supplements of the outcome of the contract negotiations.

CHAPTER 8: CONSULTANTS

Introduction

8.1 This chapter considers the consultant group, which is the main career grade in the hospital and public health service. The England staff survey results on engagement of this group does not, at present, give any cause for major concern, although the engagement score for consultants in Wales is disappointing. The picture on recruitment and retention is generally holding up, although there are issues with some specialties and some geographic areas. We note the contract negotiations that are underway in both England and Northern Ireland, and the watching position adopted by Scotland and Wales.

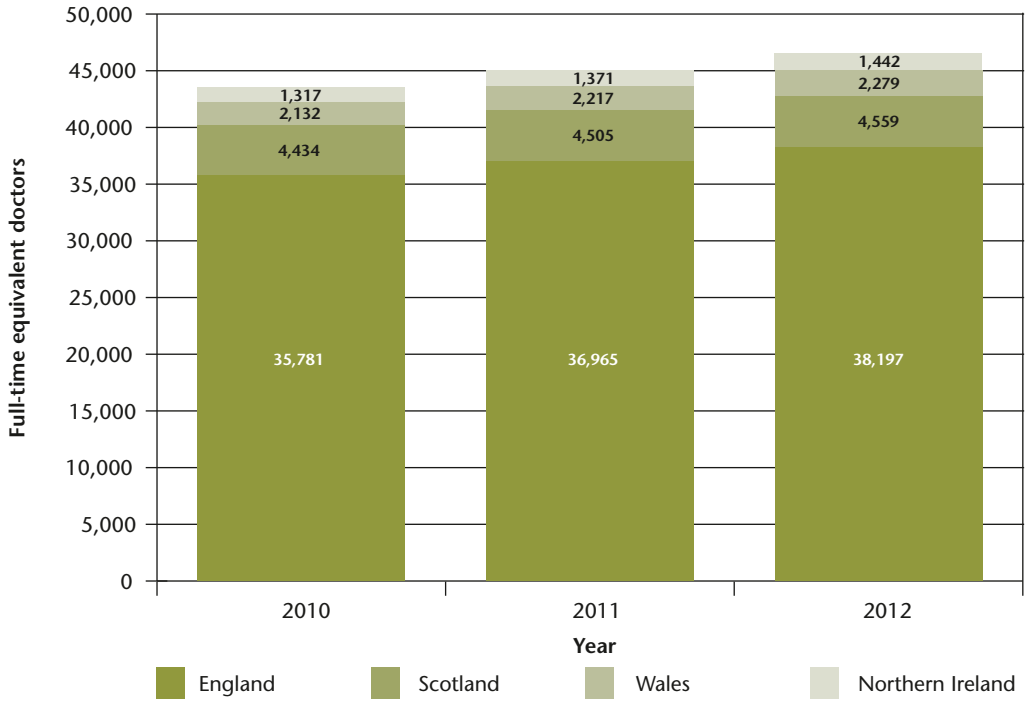
8.2 The most recent consultant contracts were agreed in October 2003 and differ somewhat in each of the devolved countries. The contract was optional in England, Scotland and Northern Ireland, although all new appointments or moves to a new employer are under the new contract. All consultants in Wales were obliged to transfer to the new contract. We make recommendations on the pay uplift for consultants on all types of contract although a decreasing number of consultants (fewer than 10 per cent) remain on the pre-October 2003 contract. All consultants, whatever their type of contract, are now expected to have agreed job plans scheduling both their clinical and non-clinical activity.

8.3 Under the 2003 contract, consultants have to agree the number of programmed activities (PAs) and supporting professional activities (SPAs) they will work. Further information on PAs is contained in the glossary at Appendix F. Total pay is composed of five elements: basic pay on an eight-point scale; 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 B. The main differences for the 2003 contract in Wales are: a basic 37.5 hour working week (compared to 40 hours in the rest of the United Kingdom); a salary structure with seven incremental points; and a system of Commitment Awards to be paid every three years after reaching the maximum of the pay scale, which replaced the former Discretionary Points scheme, although consultants in Wales are also eligible for national level CEAs.

Recruitment and retention

8.4 In September 2012, there were 46,477 full-time equivalent (FTE) consultants, an increase of 3.1 per cent on the previous year, with the number of consultants increasing in each United Kingdom country each year between 2010 and 2012 (Figure 8.1).

Figure 8.1: Number of consultants in the Hospital and Community Health Services, United Kingdom, 2010 – 2012



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety.

8.5 We received evidence from the parties on some recruitment problems for consultants in some specialties. The Northern Ireland Executive said that the FTE vacancy rate at March 2013 was 4.6 per cent, and noted problems with several specialties, including radiology, emergency medicine, psychiatry and care of the elderly. The Welsh Government noted recruitment difficulties for consultants in emergency medicine, haematology, old age psychiatry, radiology and care of the elderly. The British Medical Association (BMA) told us of a trend increase in total vacancy rates for consultants in Scotland, with particular shortages in emergency and acute medicine, and the Scottish Advisory Committee on Distinction Awards (SACDA) referred to press reports that employers in Scotland were facing difficulties in recruiting consultants to key roles. Anecdotally, we also heard during our visit programme that the starting point for discussions about job plans in Scotland was an assumption of a 9/1 split between PAs and SPAs, and it was suggested that this was also affecting recruitment and retention. However, the Scottish Government said that its overall consultant vacancy rate at June 2013 was 4.7 per cent and that there was no substantive evidence to suggest that Scotland was not able to recruit and retain high calibre consultants. We comment on SACDA's evidence later in this chapter in the section on Distinction Awards. With regard to the split between PAs and SPAs in job plans, we consider this to be a matter for local determination, although the parties will wish to consider the impact on recruitment and retention when agreeing job plans.

8.6 Health Education England referred to a potential oversupply of hospital consultants of 2,000 by 2020, unless there were changes in the way that care was delivered, for example the presence of consultants in hospitals for 24 hours a day, every day. It added that the forecast oversupply was a small percentage against the overall numbers for the group, and was possibly still within the accepted margins of error for such forecasts.

8.7 The broad recruitment and retention picture for consultants does not give us cause for major concern, but there are grounds for real concern with some specialties and

some geographic areas. We would welcome more detailed evidence on recruitment and retention: where recruitment problems exist, there is the facility to use recruitment and retention premia, although we are aware that they are not used widely. Health Education England said that for some specialties, such as psychiatry, recruitment and retention premia had been used to good effect in some parts of the country, when employers worked together on a regional basis in taking forward recruitment initiatives, and in the focused application of the premia. It said that this kind of co-ordinated action should be encouraged and supported as the most effective long-term means of addressing such recruitment problems. We support such action, and hope that the consultant contract negotiations will include consideration of a more flexible approach to the use of recruitment and retention premia, so that they can be used more widely to address recruitment problems. For future rounds, we ask the parties to provide us with evidence on the current use of the consultant recruitment and retention premia: what levels of payment are made, for what specialties, and in what regions of the countries. We also stress the importance we attach to receiving up-to-date vacancies data: such data are essential to inform long-term strategies for pay and workforce planning and the absence of robust statistics on vacancies data also risks undermining the credibility of our recommendations. We urge the Health Departments to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round.

Motivation and workload

8.8 We set out in Chapter 2 our future requirement for a more systematic approach to the evidence on motivation. In the current absence of detailed evidence on motivation, we have looked at the results to several questions in the *2012 NHS staff survey*[1] for England, conducted in autumn 2012. These showed no change on year in the percentage of consultants satisfied or very satisfied with their level of pay (at 63 per cent), a general increasing trend in job satisfaction, but an increase of almost 2 per cent (to 89 per cent) of consultants working extra hours. The Welsh Government referred to its NHS Wales Staff Survey 2013, that measured staff engagement by a combination of three variables: employee motivation; the ability to contribute towards improvements at work; and staff advocacy. The engagement index for consultants was just 55 per cent, the same score as for the NHS in Wales as a whole. This seems disappointing, given that we might expect consultants to be amongst the highest scoring of the staff groups within the NHS: we would welcome the parties' views on the reasons for this result. Results from the 2013 Scottish Staff Survey are summarised in Chapter 2, but do not break results down to the level of consultant. The Northern Ireland Executive's evidence that drew on its 2012 staff survey did not highlight any results that were specific to the consultant group. The BMA said that it was planning a survey of consultant workload for later this year: we will, of course, be interested in the results of this research.

8.9 From the survey results available to us, we do not have any major cause for concern regarding the engagement of the consultant group. We do, however, wish to keep a close eye on this issue, to monitor the impact of the changes to the NHS Pension Scheme, the various NHS reforms across the United Kingdom and the contract negotiations.

New consultant contract negotiations

8.10 In our last report, we commented that changes to the consultant contract were in prospect, following the publication of our own *Review of Compensation Levels, Incentives*

[1] *2012 NHS Staff Survey*. National NHS Staff Survey Coordination Centre, 2013. Available from: http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/

and the Clinical Excellence and Distinction Award Schemes for NHS Consultants[2] and the government's acceptance of a "compelling case" for changes to the consultant contract. We noted the announcement by the Secretary of State for Health that doctors' pay arrangements needed to be affordable and sustainable in the longer term, and that he would be seeking to agree changes to doctors' contracts to better support seven-day working in the NHS alongside better availability of community services and primary care.[3] Our report recommended a variety of changes in local and national awards, changes to pay scales with progression based on performance, and a new principal consultant grade and we continue to believe such a package to be appropriate. Our view remains unchanged from that report, when it said:

> *It is our view that the current system pays increments for a consultant continuing to carry out their basic job, rather than reflecting the evidence of job growth that a progression system should reward. We believe that the current structure rewards length of service more than contribution or performance, and provides less of an incentive for job growth or development than we would expect, with, in practice, only a weak link to appraised performance. Near-automatic progression is not typically a feature of any of the professional roles we use for comparators at this level.*[4]

8.11 Our report also included a recommendation that, in order to obtain value for money from the consultants' award schemes, there should be a stronger link to performance with improved links to measures of activity, quality of patient care, patient feedback, cost and a clear definition of excellence for each discipline. The report recommended that the Royal Colleges and equivalent bodies defined excellence for their disciplines. We continue to support such a recommendation.

8.12 As we commented last year, we believe that pay scales cannot be looked at in isolation. There need to be opportunities for consultants to achieve promotion and we also have concerns about the consistent application of performance appraisal, and incremental scales not linked to performance.

8.13 The parties updated us on the position of consultant contract negotiations. NHS Employers said that one of the key enablers to delivering the necessary changes to the NHS was to reform the consultant contract. NHS Employers said that negotiations covering England and Northern Ireland would begin in October 2013 and would focus on: facilitating seven-day services within current contractual provisions; timings and rates of pay for plain and premium time working; the CEA scheme; what pay progression structure would best reward the acquisition of new skills, the development of new techniques, taking on leadership roles, teaching and mentorship, innovation and research; and how thresholds for pay progression could fairly and objectively be judged by taking into account objective measures of job-based criteria. The Department of Health invited us to consider and make observations on the Heads of Terms about negotiations for consultants, with particular emphasis on the current structure for pay progression, and whether it could help improve performance (so staff are paid for what they do for patients) and productivity; and to consider and make observations on whether the current arrangements for working out of hours supports the Department's ambition for seven-day services, in particular the need to have consultants available at evenings and weekends. The Department suggested that we might wish to make observations on how the out-of-hours rates of pay and the hours that would attract

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[2] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, 2012.

[3] Written Ministerial Statement: review of awards for NHS consultants and publication of NHS Employers report on junior doctors' contracts. Department of Health. *Hansard,* 17 December 2012, column 74WS-76WS. Available from: http://www.parliament.uk/documents/commons-vote-office/December_2012/17-12-12/8.HEALTH-Review-awards-NHS-consultants.pdf

[4] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants.* Review Body on Doctors' and Denitsts' Remuneration. Cm 8518. TSO, 2012. Paragraph 4.40.

premium rates compared with other staff/industries with similar levels of pay. During oral evidence, we were told that the Department of Health was considering commissioning research on out-of-hours premia paid to comparator groups: this research[5] (by Incomes Data Services) was subsequently carried out and provided to us in supplementary evidence. We understand that the findings of the research will be used to inform the negotiations.

8.14 We have considered very carefully the request for us to make observations on the Heads of Terms. We have noted the BMA's significant shift in position in giving a commitment to high-quality, seven-day working. However, we also note that the BMA clearly believes some issues, such as pay progression, to be for contractual negotiation. During oral evidence, the BMA stressed the importance of our maintaining our independence from the Health Departments and highlighted the associated risks to delivering a successful outcome to the negotiations. Furthermore, we are not convinced on the appropriateness of our commenting on a single aspect of the negotiations, such as the rates of pay for out-of-hours work, when the entire consultant contract was negotiated within an overall funding envelope, covering all aspects of the agreement. We note that the findings of the research into unsocial hours payments will inform the negotiations. We are therefore minded to reserve any comment on the Heads of Terms pending the outcome of the negotiations. Clearly, our previous views in published reports on related issues are available for the parties to draw on, and indeed we refer to and reinforce some of those views throughout this chapter; but we ask the parties to bear in mind that our comments were part of a larger discussion (as set out in our report on the *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*).

8.15 We gave considerable thought as to whether our recommendations this year might help to facilitate the contractual change sought by the negotiations. Our views are set out in Chapter 10.

8.16 The position in Scotland and Wales was very different. The Scottish Government told us that the BMA in Scotland had declined to take part in United Kingdom talks on contract reform: Scotland said that it maintained a close interest in progress and was continuing its dialogue with the BMA. The Welsh Government said that the BMA had also made it clear that, like in Scotland, it was not prepared to join United Kingdom-wide negotiations, but that it remained willing to discuss the contract in Wales. The Welsh Government said that it wished to address the provision of seven-day services and the creation of a stratified consultant pay structure, removing the outdated commitment awards in Wales. It said that Ministers were considering the overall position and would shortly decide on how contract negotiations for Wales should be taken forward. The Welsh Government said that it would welcome a re-enforcement of our previous report messages about incentives to excellence; and to the 'time served' element of commitment awards being inconsistent with this aim. As Wales is not part of the negotiations, we are happy to do so: our review of the CEA scheme concluded that national awards should recognise those consultants with the greatest sustained levels of performance and commitment to the NHS and whose achievements are of national or international significance[6]; and that in the absence of firm evidence on the recruitment and retention benefits of the commitment awards scheme, we are unable to support a pay system that rewards length of service, rather than the achievement of excellence.[7]

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[5] *Unsocial Hours Payments: A Research Report for the Department of Health*. Incomes Data Services, January 2014.

[6] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, 2012. Recommendation 5, first bullet. Available from: https://www.gov.uk/government/collections/ddrb-annual-reports

[7] *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants*. Review Body on Doctors' and Dentists' Remuneration. Cm 8518. TSO, 2012. Paragraph 5.14. Available from: https://www.gov.uk/government/collections/ddrb-annual-reports

8.17 We ask the parties to update us on developments surrounding contractual reform for our next review.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

8.18 Schemes to provide consultants with some form of financial reward for exceptional achievements and contribution to patient care have been in existence since the beginning of the NHS in 1948. The glossary at Appendix F contains information on CEAs, Distinction Awards and Discretionary Points.

8.19 Since the publication of our *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants* in December 2012, we have been waiting for the parties to decide how to take forward our proposals on the future of the awards schemes. The Department of Health told us that whilst our report made recommendations about future awards being non-pensionable, Ministers were prepared, given the move to a career-average pension scheme, to consider the continued, affordable pensionability of awards, subject to agreement on a package of changes as recommended in our report. The Department said that discussions about the future shape of CEAs at both national and local level were taking place in the context of contract negotiations.

8.20 The Department of Health said that nearly 300 new 2012 awards were announced in March 2013; and that a 2013 awards round had been launched in July 2013, with the results due to be announced in March 2014. It also reported on the outcome of the consultation on the anomalous features of the current schemes: no one would receive pay protection after September 2014 if their award had been previously or was subsequently withdrawn; the possibility of applying for reinstatement of a Distinction Award upon return to work after retirement was being phased out; and no one would hold a reinstated award after March 2015.

8.21 The Northern Ireland Executive said that the award rounds for both 2012-13 and 2013-14 would proceed as one exercise, although the number of award recipients would not increase. It said that Ministers were keen that work on the development of a new scheme to acknowledge clinical excellence, in line with the recommendations in our report, would commence shortly. As with England, the work was being taken forward as part of consultant contract negotiations. It said that it was expected that a set of principles which would be applied across the United Kingdom to awards schemes would be agreed, but that the actual detail of the new award scheme in Northern Ireland would be developed, consulted upon and implemented locally.

8.22 The Welsh Government's evidence noted that reform of the awards schemes was tied up with contractual negotiations and that a decision on how and when changes to the Welsh consultant contract would be taken forward was expected in the autumn, taking into account the draft Heads of Terms agreed by England and Northern Ireland.

8.23 The Scottish Government said that it continued to impose a freeze on Distinction Awards, but that Discretionary Points continued to be awarded; a decision on whether the freeze would continue for 2014-15 would be made towards the end of the financial year. It said that consideration was being given to talks being taken forward in parallel with the consultant contract negotiations. The Scottish Government said that it was, in principle, supportive of such a move, and had consistently stated that it would look to take this forward initially on a United Kingdom-wide basis whilst reserving the right to explore a specifically Scottish solution.

8.24 We note the positions adopted in each country on how possible changes to the schemes are to be taken forward, and ask the parties to update us for our next review. Our report on the future of the schemes was written at the request of the four Health Departments

and we are keen to see progress. We would stress that our report noted our belief that variable award schemes continue to be required to reward, recognise and provide incentives for those consultants who perform significantly beyond expectations: this remains our view.

8.25 The parties also provided evidence on equality and discrimination issues related to the award schemes: we address that evidence in Chapter 2.

Advisory Committee on Clinical Excellence Awards

8.26 The Advisory Committee on Clinical Excellence Awards (ACCEA) reported that for 2012, the number of national award holders had reduced significantly, with an increase showing only at gold (4) and silver (6). Reductions at A+ (-14), A (-48) and B (-99) were likely to reflect retirements, but bronze also showed a reduction (-16). ACCEA said that national award holders comprised 7.98 per cent of the consultant body, significantly below the level of 10 per cent suggested by our review of the scheme. ACCEA reported a modest increase in the number of local awards, but a reduction against expectations given the increase in consultant numbers. However, it said that Level 9 employer-based awards now comprised 4.08 per cent of the consultant population, suggesting the balance between reward for local and national contributions had shifted. ACCEA said that the 2013 Round had yet to be completed, and the results were not due to be announced until March 2014, with the awards backdated to April 2013.

Scottish Advisory Committee on Distinction Awards

8.27 SACDA reported that as at September 2012, there were 440 award holders in Scotland: 33 A+; 104 A; and 303 B. They represented 8.9 per cent of all consultants. It said that the number of award holders had dropped substantially from the previous year, when there were 494 award holders (10.6 per cent of consultants); and that since awards were last granted in 2010, the number of distinction award holders had reduced by 30.8 per cent. This reduction in award holders was making it increasingly difficult for SACDA to perform the procedures for five yearly reviews as it relied heavily on higher award holders to carry out peer assessments, and there were now significant numbers of specialties with no senior award holders. We ask the Scottish Government to address these concerns as part of its consideration of the reforming of the award scheme in Scotland.

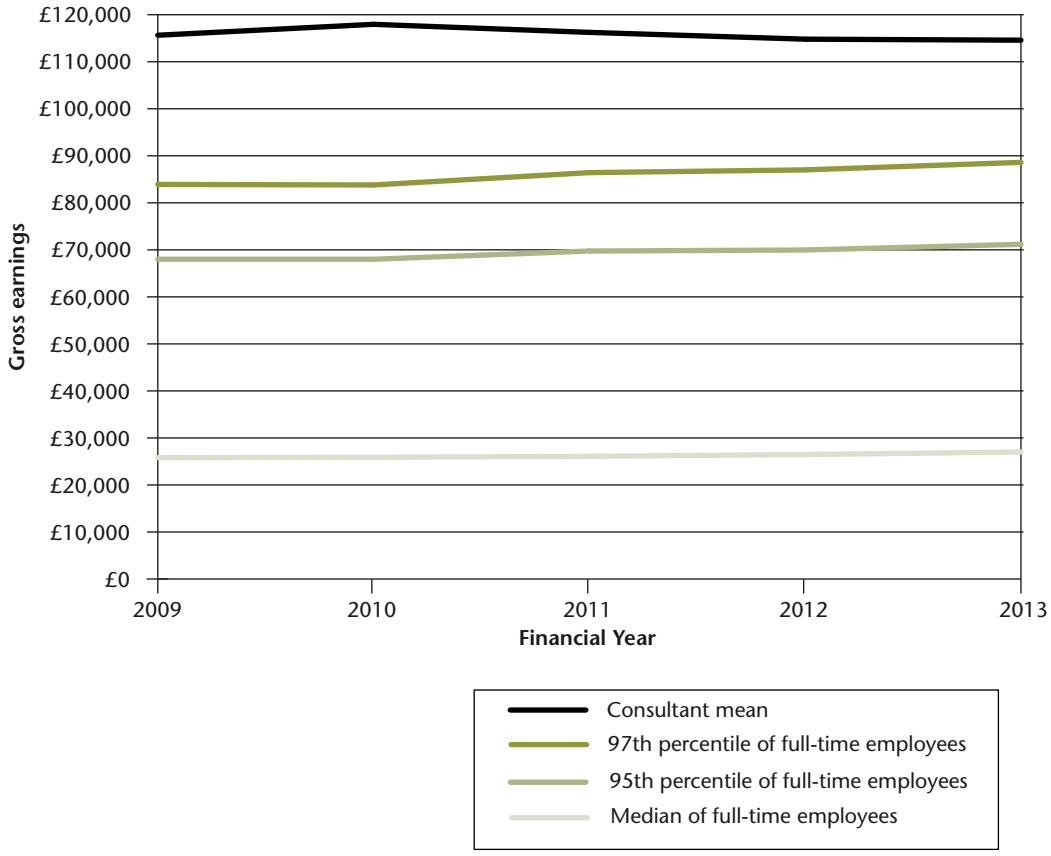
8.28 SACDA also said that anecdotal evidence was suggesting that consultants were now much less willing to undertake internal additional quality and service improvement work on top of their normal role, and external duties for medical Royal Colleges: we heard similar anecdotal evidence during our visit programme in Scotland. However, the Scottish Government said that there was no substantive evidence that the freeze on distinction awards was proving to be detrimental to the recruitment and retention of high calibre consultants, noting that since the implementation of the freeze, it now had 7 per cent more consultants working in the NHS. We were told during oral evidence that Scottish Ministers would wish to receive substantive evidence before considering any action. We would also welcome such evidence for our next round.

Pay comparability

8.29 The BMA told us that the mean earnings of consultants, adjusted for inflation, had fallen by around 13 per cent between 2008 and 2013; and that their real earnings were now below the level they were in the first year of the new contract a decade ago.

8.30 Figure 8.2 shows a narrowing of the gap between the mean total earnings[8] of consultants and the 97th percentile of all full-time employee annual gross pay between 2009 and 2013.

Figure 8.2: Gross earnings comparison between consultants in England and the wider economy, 12 month period to April

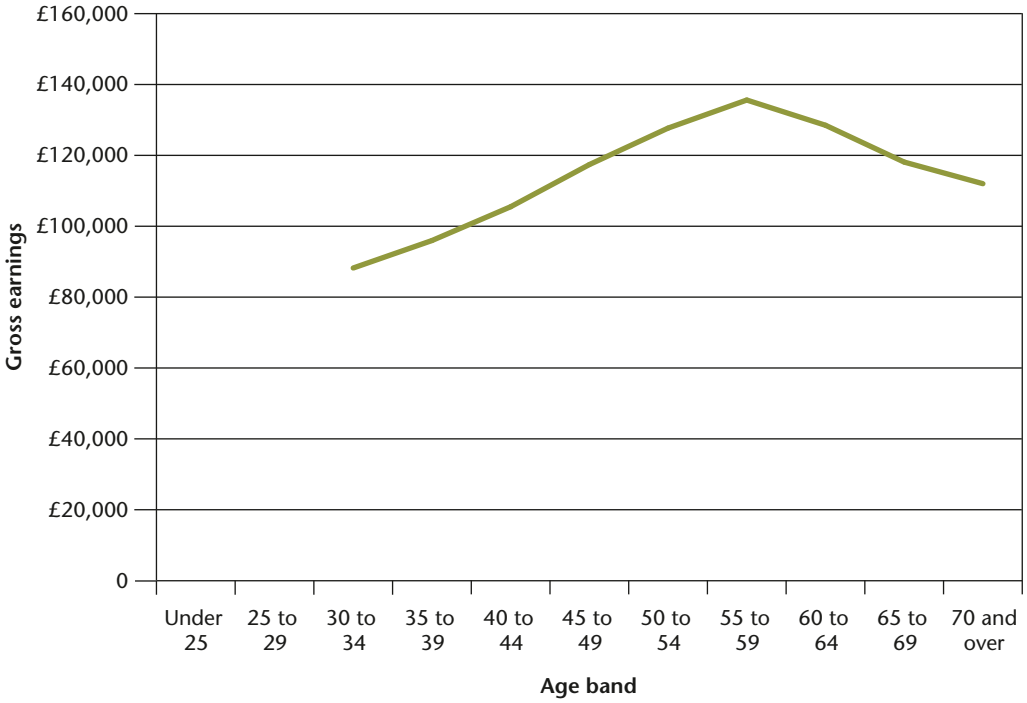


Sources: The Health & Social Care Information Centre and Annual Survey of Hours and Earnings (Office for National Statistics).

8.31 Whilst figure 8.2 gives the mean total earnings of consultants, there is a large amount of variation in the earnings of consultants. Over time consultants would move up the pay scales and acquire experience and potentially earn higher value CEAs. Figure 8.3 gives the mean total earnings of consultants broken down by age band and shows that over time there is a consistent increasing trend up to the age of 60 when total earnings start to decline.

[8] Total earnings calculated as mean annual basic pay per FTE plus mean annual non-basic pay per person.

Figure 8.3: Gross earnings of consultants, averaged at each age band, in the Hospital and Community Health Services, England, 12 month period ending October 2013



Source: The Health & Social Care Information Centre.

8.32 Our analysis of pay comparability, using the system of comparators outlined in Chapter 2, concluded that mean basic salary and total earnings for newly qualified consultants were both lower than those generally seen in the comparator groups. For a consultant with 19 years' experience, basic salary was broadly comparable with the legal and tax and accounting comparator groups, although total earnings were lower, and their relative position had worsened over the last several years. We address pay comparability more fully in Chapter 2.

Pay recommendation for 2014-15

8.33 The Department of Health said that if we considered any award was needed for consultants, then it recommended that it should be tied to securing agreement on changes to the contract, with the parties invited to report on progress in evidence for the next round.

8.34 Our recommendation for consultants can be found in Chapter 10.

Future evidence requirements

8.35 The evidence requirements that we have identified from this round for our next review are for:

- the parties to provide us with up-to-date vacancies data to include fill rates by both specialty and location;
- the parties to provide us with evidence on the use of the consultant recruitment and retention premia: what level of payments are made, for what specialties and in what regions of the countries;
- the parties to consider reasons for the engagement index score for consultants in Wales;
- the results of the BMA's research on consultant workload;
- the parties to provide ongoing evidence on the motivation of consultants, including their assessment of the impact of changes to pensions, contract negotiations and the various NHS reforms;
- the parties to update us on the developments surrounding contractual reform;
- the parties to update us on the future of the consultant award schemes; and
- the parties to provide evidence as to whether or not the freezing of the distinction award scheme in Scotland is affecting the recruitment and retention of high calibre consultants.

CHAPTER 9: SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

Introduction

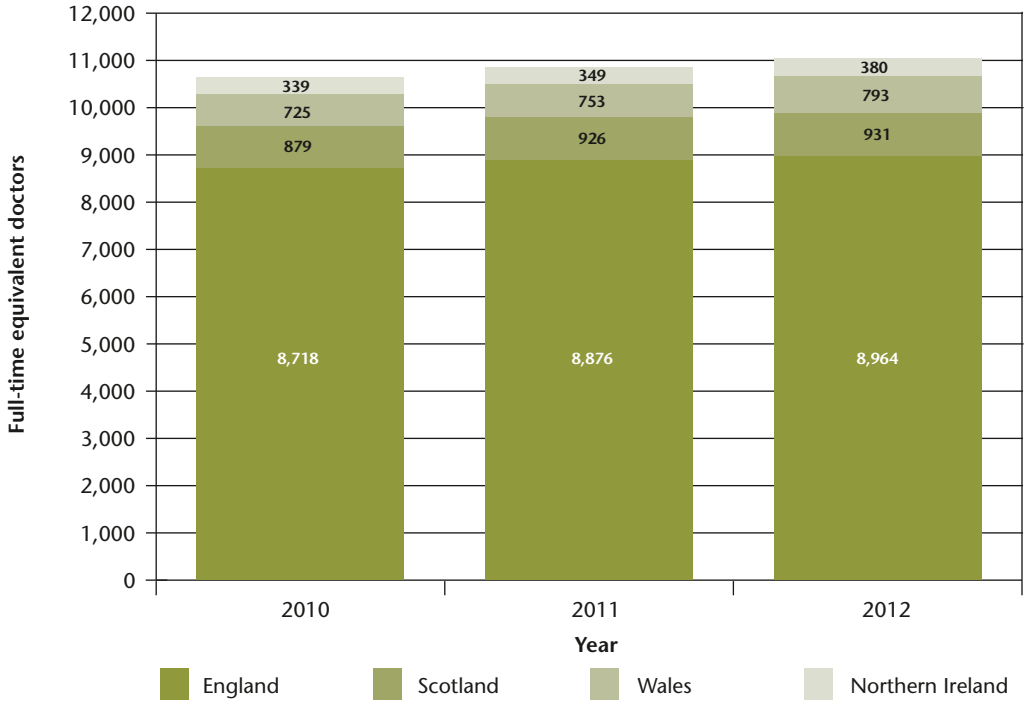
9.1 This chapter considers issues concerned with the specialty doctor and associate specialist (SAS) grades. As noted in Chapter 2, SAS grades are the hospital grade with the lowest score for satisfaction with their level of pay, although the score did increase on year. There were also improvements in the scores for both job satisfaction and the extent to which the organisation values their work. We wish to keep a close eye on any recruitment issues for this important group of doctors.

9.2 The SAS grades are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals.

Recruitment and retention

9.3 In September 2012, there were 11,068 associate specialists, staff grades and specialty doctors, an increase of 1.5 per cent on September 2011 levels for the United Kingdom as a whole, and numbers increased in all countries (Figure 9.1).

Figure 9.1: Number of staff grades, associate specialists and specialty doctors in the Hospital and Community Health Services, United Kingdom, 2010 – 2012



Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety.

9.4 The Northern Ireland Executive said that the vacancy rate at March 2013 for staff grades/specialty doctors was 11.8 per cent, and it noted recruitment difficulties in several specialties for SAS doctors, including anaesthetics, emergency medicine, paediatrics, obstetrics and gynaecology, psychiatry and learning disability. The Welsh Government told us about recruitment problems in anaesthetics, emergency medicine and psychiatry, all of which were highlighted by three or more Welsh Health Boards/Trusts. It said that detailed work would be undertaken to analyse the information of recruitment problems:

we ask the Welsh Government to let us know the results of this analysis for our next review and to consider whether or not a pay response is required. We note the paucity of vacancy data and stress the importance we attach to receiving up-to-date vacancies data, by specialty and location: such data are essential to inform long-term strategies for pay and workforce planning and the absence of robust statistics on vacancies data also risks undermining the credibility of our recommendations. We urge the Health Departments to prioritise the publication of vacancy statistics, so that we and the parties to our review process can draw on them in our next round

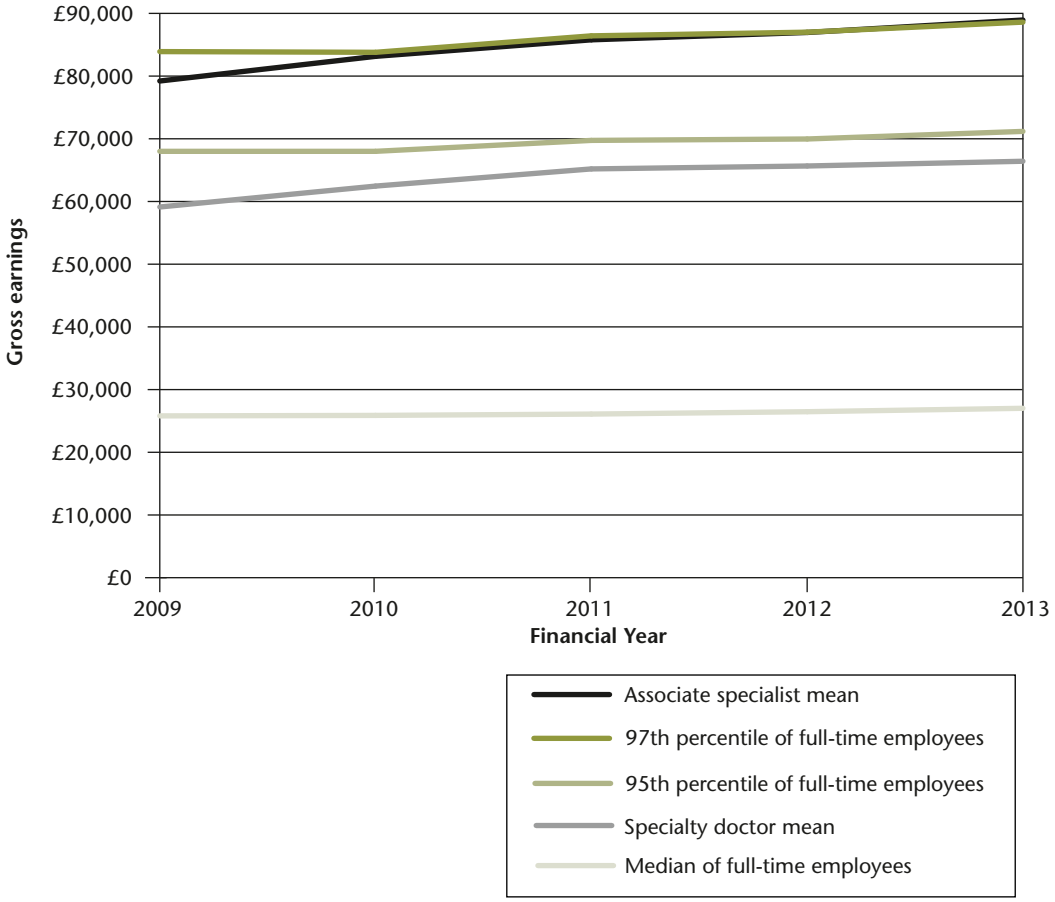
Career development issues

9.5 Our previous reports have commented on the importance of funding for SAS doctors to support career development; we believe that this can positively impact on the motivation of this group of doctors. We are already aware of the £12 million recurrent funding in England (up-rated for inflation) for specialty doctor career support, training and continuing professional development. The Scottish Government told us last year about the establishment of the SAS Doctors Professional Development Fund, consisting of £1.4 million over three years from 2012-13, for Scottish SAS doctors' continuing professional development needs. We welcome the work being undertaken to develop case studies that will be used to encourage others to engage with the new scheme, and ask the British Medical Association (BMA) to also encourage Scottish SAS doctors to take advantage of the available funding. The Northern Ireland Executive told us that although funding was an issue, it would explore career development opportunities through dialogue with the BMA. We ask all of the parties to update us for our next review.

Pay comparability

9.6 Our pay comparability research, using the system of comparators outlined in Chapter 2, shows that mean total earnings of specialty doctors are broadly comparable to mean total cash earnings in the tax and accounting and pharmaceutical groups but are significantly behind total cash earnings in the legal and actuarial sectors. Associate specialists are broadly comparable when measured against their mean basic earnings, but have significantly lower mean total earnings than employees in the comparator groups. As can be seen in Figure 9.2, specialty doctors and associate specialists have seen similar levels of growth in earnings compared to the 95th and 97th percentile of all full-time employees in the wider economy.

Figure 9.2: Total earnings comparison between associate specialists and specialty doctors in England and the wider economy, 12 month period to April



Sources: The Health & Social Care Information Centre and Annual Survey of Hours and Earnings (Office for National Statistics).

Appraisals

9.7 In last year's report, we voiced our concerns about the low incidence of appraisals. In this year's evidence, we received some mixed messages on the number of appraisals: NHS Employers told us that appraisal rates (for medical and dental staff (other) stood at 80 per cent in 2012 (from 73 per cent in 2011); yet the Department of Health drew our attention to evidence suggesting that a third of staff grades and associate specialists were not having regular appraisals. The Scottish Government said that good progress had been made in introducing advanced appraisal required for revalidation, and said that its initial analysis showed that in excess of 93 per cent of consultants and SAS doctors had received an appraisal in the last year. We welcome this progress in Scotland, particularly given our earlier comments in Chapter 2 on the importance of appraisal as a cornerstone of incremental pay, and ask for an update on the incidence of appraisal, including the incidence of a well-structured appraisal, for our next review.

Pay recommendation and contract reform

9.8 NHS Employers said that it believed the 2008 contract remained satisfactory, but that if other contractual changes (for consultants and juniors) were agreed, then consequential changes might be required to the SAS contract. The Department of Health said that if any award was needed for SAS doctors, then it should be tied to making changes consistent with the other discussions, for which evidence could be provided next year. We consider this point as part of our discussion of the uplift in Chapter 10.

9.9 Our recommendation this year for SAS doctors can be found in Chapter 10.

Future evidence requirements

9.10 The specific evidence requirements that we have identified in this chapter for our next review are for:

- the parties to provide us with up-to-date vacancies data, by specialty and location;
- the parties to update us on career development issues;
- the parties to update us on the incidence of appraisal, including the incidence of a well-structured appraisal;
- the Northern Ireland Executive to keep us informed on any recruitment problems for SAS grades; and
- the Welsh Government to provide us with the outcome of its analysis of recruitment problems and to let us know if a pay response is required.

CHAPTER 10: MAIN PAY RECOMMENDATIONS FOR 2014-15

The parties' proposals

10.1 In this chapter, we outline the parties' principal proposals for the main uplift to be awarded to each group for 2014-15, along with our recommendations, which we have made following careful consideration of all the written and oral evidence we have received. The remit letters from the parties are at Appendix A. Chapter 1 covers the remits in more detail and issues specific to certain groups are addressed in the relevant chapters.

10.2 The Chief Secretary to the Treasury wrote to us saying that the government believed that the case for continued pay restraint across the public sector remained strong. The letter said that government policy was for public sector pay awards to average 1 per cent. It asked us to consider what award was justified by the evidence and whether there was a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties. It said that the pay award should be applied to basic salary on the normal interpretation of basic salary in the workforce, and the definition did not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances. Finally, the letter asked us to consider the impact of the progression structure and its distribution amongst staff when recommending our annual pay award. We address the specific points raised by this letter in paragraphs 2.37, 2.38 and 10.24.

10.3 The remit letter from the Department of Health said that time served was no longer an appropriate rationale for pay progression for staff in the public sector: it noted that discussions were underway about changes to the national contractual arrangements for consultants and doctors and dentists in training, but said that as any changes would take time to be agreed, implemented and take effect, it asked us to consider the existing progression structure for employed doctors and dentists and its distribution among staff when considering the annual pay award. The letter said that for the NHS, affordability and the level of incremental pay that staff would receive, alongside recruitment and retention pressures, would be a critical element when we determined whether any award was justified. In its evidence, the Department said that recruitment and retention remained strong and measures of staff engagement in the staff survey remained good: its view was that basic pay increases should only be implemented if there was strong evidence that recruitment, retention, morale or motivation issues required it. It said that employers faced a stark choice for staff on national pay contracts: either pay staff more, accepting that this might do little to improve the quality of care and was likely to restrict the number of staff employers could afford to employ; or to reform contracts to enable employers to use their pay bill as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity. It said that the 1 per cent available for pay would be best deployed in supporting the modernisation of national pay frameworks, and invited us to make recommendations on how any pay award, if we considered one was justified, might be made dependent on the partners reaching agreement on contract reform. It proposed that any such recommendation should be tied to contract reform, with the parties invited to report on progress in their evidence to us next year, effectively deferring any award. The Department also asked us to consider and make observations on whether any pay awards should be made to staff whose performance did not meet local standards, defined as those agreed with an employer and judged at an annual performance review. We address the specific points raised in this letter in paragraphs 2.37, 2.38, 10.26 and 10.27.

10.4 The Welsh Government's remit letter asked us to consider: whether in the current financial environment it was appropriate to uplift the salaries of all staff; whether if an

award was given it would be more appropriate to provide staff with a fixed sum increase rather than a percentage uplift; and whether a pay freeze would be appropriate for higher earners. We sought clarity on what the Welsh Government meant by "higher earners": in response, we were told that it was a matter of judgement and not specifically defined. The evidence asked us to consider allowing employers the ability to address recruitment and retention issues locally rather than recommending an across the board pay lift for all staff; but in supplementary evidence, it said that present contractual arrangements might not allow the best use of local flexibilities and might be better addressed as part of contractual reform. It said that any pay award was unfunded and would place additional pressures on the service. We address the points raised in this letter in paragraph 10.22.

10.5 The Northern Ireland Executive told us that the funding arrangements for 2014-15 were not agreed, but that it would adhere to government's public sector pay policy. It also asked us to consider pay progression as part of our review, and to comment on whether there was a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties. We address the points raised in this letter in paragraphs 2.37, 2.38 and 10.24.

10.6 The public sector pay policy for 2014-15 for the Scottish Government stated that there was provision for an increase in basic pay for all staff: the increase was subject to an overall cost cap of 1 per cent, although there was no assumption that it would equate to a 1 per cent uplift. It also said that the cost cap did not include pay progression.

10.7 NHS Employers asked that our recommendations should be used to support necessary contract reforms, to link pay progression better to individual and organisational performance and remove the barriers to seven-day working, rather than to increase the national pay scales. They said that there were no national pay-related recruitment and retention difficulties that could be addressed by increased national pay scales, and that there was no compelling evidence to change national pay scales more for some staff groups, specialties or geographical areas than for others. They also asked us to consider the level of progression pay. We address this latter point in paragraphs 2.37 and 2.38.

10.8 The Foundation Trust Network said that it needed to recognise that the current economic environment of stalled wages, increasing costs and a greater tax burden for many was bringing real challenges to staff. Despite this, it referred to the survey of its members that formed the basis of its evidence, noting that 56 per cent of respondents believed that doctors and dentists should not receive a pay award averaging 1 per cent. In addition, 53.6 per cent of respondents supported the introduction of non-consolidated pay awards should an award be considered appropriate. It said that there was widespread support for significant changes to pay, terms and conditions and that transformative issues needed to be tackled in the pay system. It said that the pay award alone could not solve recruitment and retention problems where they existed for medical staff, and that if a pay award was made, it should be applied equally across all staff groups. The Foundation Trust Network said that it believed that expectations were set by the government's remit that a 1 per cent average increase was affordable, and as a result, there was an acceptance amongst many trusts that a 1 per cent increase would be applied. It said that if an award was made, it must not amount to an additional efficiency pressure on providers, and that trusts were increasingly becoming financially unsustainable. It asked us to focus on the pressing need for a shift to a more comprehensive seven-day service and the role the pay system for doctors must play in enabling, rather than hindering, that shift: in that regard, it welcomed the consultant contract negotiations. Over 80 per cent of its respondents said that if a 1 per cent funding resource allocation was made available for other than a pay award, they would use the funding to help bring about a transition to seven-day services. We address this latter point in paragraph 10.28.

10.9 NHS England reminded us of affordability issues and public sector pay policy, and asked us to consider very carefully what, if any, uplift was appropriate for 2014-15.

10.10 Health Education England said that it recognised that in the current climate of pay restraint, any increases or other changes to NHS pay and terms and conditions of service that we recommended should explicitly support and be linked to wider system reform. We address this point in paragraph 10.26.

10.11 The British Medical Association (BMA) said that whilst it understood the economic context, it was extremely concerned that the erosion in the real value of contracts for doctors due to relatively high levels of inflation but with low or zero pay awards, adverse changes to pensions over the last few years, in addition to widening differentials with comparator professions, reward had now reached a critical point. It noted that the performance of the NHS, and in particular patient outcomes and satisfaction with the NHS, had not declined and in many cases had improved since last year despite cuts in funding. The BMA said that doctors should not face a further cut in real income, and in recognition of their part in maintaining a quality health service, said it was seeking an increase in line with inflation. It said that any increase should be applied equally to the net incomes of all doctors. The BMA requested that our pay recommendation be made outside the contractual negotiation process, especially as it did not cover all remit groups.

10.12 The British Dental Association (BDA) said that it wanted us to consider a separate element to take account of the motivating force of pay that should be applied to our formula-based approach to the uplift for independent contractor general dental practitioners (GDPs), which was to be separate to the cost of living increase. We do not consider this necessary: our recommendation on pay already takes into account our overall assessment of what is necessary to address all aspects of our remit, including motivation. For salaried dentists, the BDA said that over 40 per cent of respondents to its survey reported that they felt that their pay was not fair. It argued that feeling undervalued would affect motivation in the long term and said it was vital that salaried dentists achieved a pay increase above 1 per cent.

Main pay recommendations

10.13 In making our recommendations for this pay round, we have been mindful of our standing terms of reference[1] and have taken account of the governments' public sector pay policies. We have noted the letters received from the Chief Secretary to the Treasury on public sector pay for 2014-15, and the remit letters from each of the Health Departments.

10.14 We have been constrained in our decision-making this year by the government's pre-announced policy that public sector pay awards will average 1 per cent in 2014-15. This announcement sets a strong benchmark for expectations on pay outcomes: a subsequent recommendation below this level could have serious negative consequences for motivation and morale while a recommendation above this level could appear unfair in the context of the broader public sector position. We were also mindful of ongoing negotiations between the parties on contractual arrangements for doctors and dentists which are separate but clearly related to pay. We are aware that any detailed recommendations on pay by us, for example involving pay differences between the remit groups, could be overturned following contract negotiations and could undermine ongoing discussions. In this context, the argument for an across-the-board uplift of 1 per cent in pay is compelling irrespective of the other features of the labour market for doctors and dentists.

[1] Our terms of reference can be found at the beginning of this report.

10.15 We are acutely aware of the various implications of this year's recommendation for the pay position of doctors and dentists in future years. History has shown that periods of pay restraint (e.g. those experienced in the seventies) and the outcomes of previous contract negotiations (e.g. the outcome of the remit groups' negotiations in the early 2000s) can have far reaching consequences in labour market outcomes and can initiate years of subsequent pay adjustment. These adjustments arise because pay policies and contract negotiations cause parties to re-evaluate their relative positions. Having experienced a protracted period of public sector pay restraint, labour market pressures are less easy to evaluate and interpret. The current contract negotiations and subsequent changes will also introduce new structural influences on the labour market which could generate ambiguity on the relationship between pay and the recruitment, retention and motivation of doctors and dentists. It is important that there is an independent voice in defining any exit strategy for coming out of the period of pay restraint and in re-evaluating labour market conditions. We intend to continue playing what we believe is an important role in judging the labour market of our remit groups, but feel that we can best add value if the parties are able to make clear to us their long-term pay strategy. We have spent some time reviewing these matters and outline the data we believe is necessary to undertaken this task in our report.

10.16 There have been many developments within the NHS that have influenced our consideration of the issues for this round, including: the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*[2] by Robert Francis QC and its implications for patient safety and the redesign of NHS services; Professor Don Berwick's report *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*;[3] Professor Sir Bruce Keogh's report *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England*,[4] and its implications for seven-day services; and Professor David Greenaway's report *Shape of Training: Securing the Future of Excellent Patient Care*,[5] and its proposals to adapt postgraduate training to prepare medical graduates to deliver safe and effective care in broad specialties. These reports will have implications for the NHS in all four United Kingdom countries. As mentioned earlier, we have also noted the junior doctor and consultant contract negotiations: the latter includes an aim to explore contractual changes to facilitate seven-day services in the interests of patients. There are also developments for dentistry in each country, with new contractual arrangements planned. We have given consideration as to how our recommendations might help facilitate the changes implied by these developments.

10.17 Our consideration of the issues surrounding incremental pay progression is contained within Chapter 2.

10.18 As in previous years, we have considered the usual range of economic and labour market evidence, as well as that provided by the parties. The broad picture on recruitment and retention for doctors and dentists is not a cause for major concern, but we believe there are grounds for real concern with some specialties and some geographic areas. There does not, however, appear to be any appetite amongst the parties to consider differential pay by either specialty or region, both of which have the potential to address shortages. The level of detail provided in this year's evidence does not allow us to conclude whether

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[2] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Robert Francis QC, chairman. HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

[3] *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*. Department of Health, August 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[4] *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. Professor Sir Bruce Keogh, July 2013. Available from: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[5] *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

any shortages are pay related, or whether some other, perhaps lifestyle choice, might be the reason for vacancies. We have also noted the current negotiations for both junior doctors and consultants: these negotiations have the potential to help address any shortages by newly agreed pay mechanisms, including, we hope, a more flexible use of the consultant recruitment and retention premia so that they can be used more widely to address recruitment problems, where appropriate. Taking all of the recruitment and retention evidence, our conclusion is that a pay response on that basis is not required this year, although in future years we will wish to consider whether or not a pay response might help to address vacancies, either by specialty or by location.

10.19 Pay settlements in the private sector were around 2.5 per cent in 2013, and are expected to remain at similar levels in 2014. The Institute for Fiscal Studies has commented that it is likely that public sector pay would fall lower relative to private sector pay than its level in the early 2000s when parts of the public sector experienced difficulties in recruiting and retaining staff, although we note that this comment relates to all public sector groups, rather than just our remit groups. Our analysis of pay comparability shows that in general for our remit groups, their relative position has declined against their comparator groups: the comparator groups have, in general, seen larger increases in their total pay. We note that given the recent pay freeze and changes to pension arrangements, some doctors and dentists will have seen actual declines in their take-home pay. We acknowledge that our analysis looks at median earnings, and that the expansion in the workforce will apply a downward pressure on the median. Nevertheless, doctors' and dentists' pay has tracked the 97th percentile through much of 2002 – 2011 but has fallen closer to the 95th percentile from 2012. As the period of pay restraint motivated by the government's fiscal mandate draws to an end, the parties will need to form a view on the appropriateness of the position of our remit groups in the pay distribution. Insofar as morale and motivation is concerned, this could involve judgements on fairness relating to the remit groups' historical positions in the distribution as well as issues relating to job specifications, role profiles and characteristics of the work relative to comparator groups. It will also involve issues relating to the demand for medical services and workforce planning which directly affect recruitment and retention to the professions.

10.20 Despite these developments, from the evidence available to us, it appears that the engagement of staff is holding up, judging by the results of the latest NHS Staff Survey in England, although we note that the survey does not cover all of our remit groups, only the hospital groups: the lack of regular, annual staff surveys in the other countries inhibits out ability to monitor trends across the United Kingdom. However, we also consider the current negotiations for both junior doctors and consultants, and for dentists in some of the countries, to be vital for the future of the NHS: for those negotiations to be successful, we believe it important to ensure that the motivation and engagement of staff is maintained. The announcement of a pay cap of 1 per cent by government has two potentially important effects on motivation, both of which support a recommendation at the suggested cap level: first, for those otherwise predisposed to make an award greater than 1 per cent, it makes an award at the cap level more acceptable as there is recognition that others in the public sector will only obtain 1 per cent too; and for those predisposed to make an award less than 1 per cent, there is a recognition that an award made at less than the preannounced level could have a disproportionate impact on motivation. We set out in Chapter 2 our desire for evidence that, for future rounds, will allow us to develop a better understanding and definition of the various factors impacting on motivation.

10.21 We recognise that the huge financial pressures facing the NHS will continue for several years and we have taken all of the evidence provided by the parties on affordability into account when making our decision about what we consider to be the appropriate uplift for 2014-15. Affordability is closely linked to the Health Departments' budgets, and these budgets have been set with assumptions about pay. The Welsh Government has argued

that any award would be unfunded and would place additional pressure on the service, yet it still wishes to maintain national pay rates to remain competitive with the other countries. The Scottish Government told it had made provision for an award of 1 per cent and considered it to be affordable. In oral evidence, the Secretary of State said that he would like to be able to give doctors and dentists an award in line with inflation, but that the stark choice for the NHS was more pay or more staff: if a 1 per cent award was to be given, it needed to be done in a sustainable way. The Northern Ireland Executive told us that the funding arrangements for 2014-15 were not agreed, but that it would adhere to government's public sector pay policy. We are convinced that affordability is a material issue for the NHS, and that it is more of an issue this year than previously. Although NHS funding has received some protection in Spending Review settlements, costs are rising sharply and the demands on the service are increasing.

10.22 The Welsh Government asked us to consider a fixed sum increase, rather than a percentage uplift; and whether a pay freeze might be appropriate for high earners. On the first suggestion, such a proposal would result in a change in the pay relativities between our remit groups: we have not received any evidence to suggest that such a proposal is warranted, nor is such a proposal supported by any of the other parties. We therefore reject the first proposal. On the latter suggestion, we have not received any recruitment, retention or motivation evidence to suggest that the pay of high earners, however defined, should be frozen. In the absence of such evidence, a decision to freeze the pay of high earners would appear to be a political matter.

10.23 We have noted the absence of any strong total reward strategies from the parties, or indeed an exit strategy from the current period of public sector pay restraint, that might help us to frame our pay recommendation within a broader context. Despite the lack of evidence from the parties on an exit strategy from pay restraint, we have also weighed up the importance of mitigating against the pressure on future pay claims that might result, should our remit groups feel they are not being treated fairly, although we consider that the key evidence relates to how recruitment, retention and motivation are holding up: at present, these indicators do not suggest to us an award above 1 per cent. Our report identifies our evidence requirements for future rounds, to assist us in our deliberations on pay. We are particularly keen to get a handle on how the total earnings of our remit groups changes during the course of a career.

10.24 Weighing all of these factors, and given the current contract negotiations, our judgement is that there should be an increase of 1 per cent in basic pay. We note that none of the parties put forward specific proposals for differential awards for the various remit groups, and in the absence of any evidence (such as particular recruitment problems for a remit group) to suggest otherwise, we believe that the 1 per cent increase should apply to all of our remit groups, across the board.

Recommendation 1: We recommend for 2014-15 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists.

10.25 We have given consideration to recommending a non-consolidated uplift, which would mean that costs would only apply for the current financial year and would not attract employers' pension contributions. Apart from the Foundation Trust Network, none of the parties have asked for this. We are not convinced that to make such a recommendation this year would be appropriate.

10.26 We then turn to the proposal by the Department of Health to make our recommended increase dependent on the partners reaching agreement on contract reform. It proposed that any such recommendation should be tied to contract reform, with the parties invited to report on progress in their evidence to us next year, effectively deferring any award.

It is not clear to us what the criteria would be for deciding whether or not successful progress on contract reform had been achieved; and such a proposal might influence the willingness of the parties to engage fully in negotiations. Moreover, we do not consider it fair that remit groups (such as specialty doctors and associate specialists) that are not involved in negotiations should have any pay award deferred, when they are not able to influence the outcome of such negotiations and are not directly affected by them. We note that Health Departments in Northern Ireland, Scotland and Wales did not support this proposal. We are conscious of the need to maintain the confidence of all parties that are subject to negotiations, and conclude that it would not be appropriate for us to endorse this proposal.

10.27 The Department also asked us to consider and make observations on whether any pay awards should be made to staff whose performance did not meet local standards, defined as those agreed with an employer and judged at an annual performance review. Whilst we support a greater link between pay and performance for all of our remit groups (although for trainee doctors and dentists, for just the service delivery part of their contract), we consider that this proposal is properly a matter for negotiation.

10.28 We were struck in this year's evidence by the importance of the contract negotiations and the moves towards providing a more comprehensive level of services to patients across seven days, which we consider to be vital given the requirement within our remit to place patients at the heart of the NHS. We noted the significant shift by the BMA in agreeing that the case had been made for a move to a more comprehensive seven-day service, and that the consultant contract negotiations would explore contractual change to facilitate seven-day services in the interests of patients. NHS Employers told us during oral evidence that the negotiations were to take place within the existing funding envelope for consultants. We therefore considered whether to recommend that the funding from our recommended 1 per cent uplift might be used to help bring about contract reform, for those countries that thought it appropriate. While we thought that this suggestion might have some merit, we had concerns about the sort of level of funding that might be required to help with the negotiations: such a recommendation might necessitate the need for funding to be diverted from some of our remit groups to the groups subject to negotiation, and we were concerned about the impact this would have on the motivation of the affected groups. We are also conscious to the fact that the level of funding that is made available for contracts is in reality a political decision. On balance, therefore, we decided not to make such a recommendation. We do, however, wish to place on record our desire for a successful outcome to the negotiations.

10.29 We make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale.

Recommendation 2: We recommend that the minimum and maximum of the salary range for salaried general medical practitioners be increased by 1 per cent for 2014-15.

10.30 Our recommendation for independent contractor GMPs is intended to provide an income uplift of 1 per cent after allowing for movement in their expenses. We use a formula to calculate the gross uplift and the rationale for our recommendation is given in Chapter 4.

10.31 Using 1 per cent for GMPs' income uplift along with our estimate of movement in expenses, our medical formula gives an overall percentage rise of 0.28 per cent (Table 10.1).

Table 10.1: Uplift formula for general medical practitioners, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	43.0%	1% *DDRB recommendation*	0.43%
Staff costs	41.2%	-1.4% *Annual Survey of Hours and Earnings (ASHE) 2013 (general medical practice activities)*	-0.58%
Other costs	15.8%	2.7% *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2013*	0.43%
			0.28%

Recommendation 3: For independent contractor general medical practitioners, we recommend that the overall value of General Medical Services contract payments be increased by a factor intended to result in an increase of 1 per cent to general medical practitioners' income after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 0.28 per cent to be applied to the overall value of General Medical Services contract payments for 2014-15 for general medical practitioners.

10.32 Our recommendations for independent contractor GDPs are intended to provide an income uplift of 1 per cent after allowing for movement in expenses. We use a formula to calculate the gross uplifts and the rationale for our recommendations is given in Chapter 5.

10.33 Using 1 per cent for GDPs' income uplift along with our estimate of movement in expenses, our dental formulae gives an overall percentage rise of 1.80 per cent for dentists in England, 1.74 per cent for dentists in Wales, 1.71 per cent for dentists in Scotland and 1.76 per cent for dentists in Northern Ireland (Tables 10.2, 10.3, 10.4 and 10.5).

Table 10.2: Uplift formula for general dental practitioners, England, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	50.0%	1% *DDRB recommendation*	0.50%
Staff costs	16.2%	2.5% *ASHE 2013 (general dental practice activities)*	0.41%
Laboratory costs	6.1%	2.7% *RPIX for Q4 2013*	0.16%
Materials	6.6%	2.7% *RPIX for Q4 2013*	0.18%
Other costs	21.1%	2.6% *RPI for Q4 2013*	0.55%
			1.80%

Recommendation 4: For independent contractor general dental practitioners in England, we recommend that the gross earnings base be increased by a factor intended to result in an increase in general dental practitioners' income of 1 per cent after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.80 per cent to be applied to the gross earnings base under the contract for 2014-15 for general dental practitioners in England.

Table 10.3: Uplift formula for general dental practitioners, Wales, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	53.3%	1% *DDRB recommendation*	0.53%
Staff costs	18.3%	2.5% *ASHE 2013 (general dental practice activities)*	0.46%
Laboratory costs	6.5%	2.7% *RPIX for Q4 2013*	0.18%
Materials	7.0%	2.7% *RPIX for Q4 2013*	0.19%
Other costs	14.9%	2.6% *RPI for Q4 2013*	0.39%
			1.74%

Recommendation 5: For independent contractor general dental practitioners in Wales, we recommend that the gross earnings base be increased by a factor intended to result in an increase in general dental practitioners' income of 1 per cent after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.74 per cent to be applied to the gross earnings base under the contract for 2014-15 for general dental practitioners in Wales.

Table 10.4: Uplift formula for general dental practitioners, Scotland, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	55.8%	1% *DDRB recommendation*	0.56%
Staff costs	21.2%	2.5% *ASHE 2013 (general dental practice activities)*	0.53%
Laboratory costs	6.8%	2.7% *RPIX for Q4 2013*	0.18%
Materials	7.4%	2.7% *RPIX for Q4 2013*	0.20%
Other costs	8.8%	2.7% *RPIX for Q4 2013*	0.24%
			1.71%

Recommendation 6: For independent contractor general dental practitioners in Scotland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to general dental practitioners' income after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.71 per cent to be applied to item-of-service fees in Scotland for 2014-15.

Table 10.5: Uplift formula for general dental practitioners, Northern Ireland, 2014-15

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Income	52.1%	1% *DDRB recommendation*	0.52%
Staff costs	19.1%	2.5% *ASHE 2013 (general dental practice activities)*	0.48%
Laboratory costs	6.4%	2.7% *RPIX for Q4 2013*	0.17%
Materials	6.9%	2.7% *RPIX for Q4 2013*	0.19%
Other costs	15.5%	2.6% *RPI for Q4 2013*	0.40%
			1.76%

Recommendation 7: For independent contractor general dental practitioners in Northern Ireland, we recommend that the overall value of item-of-service fees be increased by a factor intended to result in an increase of 1 per cent to general dental practitioners' income after allowing for movement in their expenses. Using this recommendation and our formula, we calculate that this will produce an uplift of 1.76 per cent to be applied to item-of-service fees in Northern Ireland for 2014-15.

Recommendation 8: We recommend that the parties work together to improve the quality of the evidence-base that we use in our formula-based approach for both independent contractor GMPs and GDPs, and that progress is reported back to us for our next review. We will then consider whether or not to continue with the existing formula-based approach in the light of that progress.

10.34 We also make the following observation on the GMP trainers' grant, which has been under review for several years.

Observation 1: In view of the ongoing delay in reviewing the general medical practitioner trainers' grant, we believe strongly that the general medical practitioner trainers' grant should continue to be uplifted by the same amount as basic pay, which for 2014-15 would represent an increase of 1 per cent.

The cost of our recommendations

10.35 We estimate that the cost of our recommendations will be approximately £176 million per annum on pay bill. Appendix B sets out the detailed pay scales arising from our recommendations.

10.36 There is a full summary of our conclusions and recommendations at the beginning of this report.

APPENDIX A – REMIT LETTERS FROM THE PARTIES

UNCLASSIFIED

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

Professor Paul Curran
Review Body of Doctor and Dentists' Renumeration
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

23 July 2013

Dear Paul,

PUBLIC SECTOR PAY 2014-15

I would like to thank you for your work on the 2013-14 pay round. The Government greatly values the contribution of the DDRB in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced its policy that public sector pay awards will average 1 per cent for the two years following the pay freeze. The Government also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups. The Government published these reports at the 2012 Autumn Statement and has accepted the key recommendations, including that there should be no new centrally determined local pay rates or zones but that there should be greater use of existing flexibilities.

3. The Government believes that the case for continued pay restraint across the public sector remains strong. Detailed evidence will be set out in the pay round, but at the highest level, reasons for this include:

a. Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

b Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

4. The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher

award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties.

5. Pay awards should be applied to the basic salary based on the normal interpretation of basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

6. A number of Review Bodies will be considering additional elements of reward such as non-pay terms and conditions and specific allowances. These recommendations form an important part of managing the total reward package of public sector workers, and the Government welcomes the contribution of the Review Bodies in these areas.

7. Finally, in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group's progression structure and its distribution among staff in recommending annual pay awards.

I look forward to continued dialogue with you in the future.

DANNY ALEXANDER

Department of Health

From Dr Dan Poulter MP
Parliamentary Under Secretary of State for Health

POC5 805694

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

03 SEP 2013

Dear Paul,

DOCTORS AND DENTISTS PAY REVIEW BODY
Review Body on Doctors' & Dentists' Remuneration – Remit 2014/15

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander, on 23 July 2013 confirming the Government's approach to the 2014/15 pay round.

Once again, I would like to thank you and your colleagues for the vital and independent expert work undertaken by the Doctors' and Dentists' Review Body (DDRB) in considering remuneration for doctors and dentists working for the NHS.

As always, while DDRB's remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay review round and to communicate this to you directly.

We continue to keep in close touch with our counterparts in the other countries and my officials will do all they can to support you in handling any consequences that may arise as a result of different approaches taken by each country.

This year, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy. Separate detailed evidence will be provided by:

- NHS Employers – on recruitment, retention, motivation and morale for employed doctors and dentists;
- NHS England – on independent primary care contractors; and
- Health Education England – on education, training and workforce capacity.

The Department will work closely with all these organisations and the DDRB secretariat to ensure that, overall, the evidence meets the needs of the DDRB.

You will be aware that in the 2013 Spending Round, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector.

The Government is clear that time served is no longer an appropriate rationale for pay progression for staff in the public sector. In his remit letter the CST states:

".....in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group's progression structure and its distribution among staff in recommending annual pay awards".

You will be aware that discussions with the representatives of medical and dental staff are underway about changes to the national contractual arrangements for consultants and doctors and dentists in training. However, since any changes will take time to be agreed, implemented and take effect, I would ask that the Review Body consider the existing progression structure for employed doctors and dentists and its distribution among staff when considering and recommending the annual pay award.

NHS England has begun negotiations with the BMA General Practitioners Committee on potential improvements to the 2014/15 General Medical Services (GMS) contract, and will be seeking comparable improvements from the contractual framework for general

dental services. These negotiations will not cover the question of what gross uplift there should be in the value of GMS or dental contracts. DDRB is, therefore, invited to make recommendations on appropriate uplifts for these two contractor groups, in the context of public sector pay policy for 2014/15. We would also particularly welcome DDRB's recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay, in line with other sectors of the NHS workforce. The Government and NHS England will make final decisions on the overall gross uplift for GMS and dental contracts in the light of DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

As CST set out, the case for continued pay restraint across the public sector remains strong. The Government is clear that it is for each Pay Review Body to consider the evidence and affordability for each workforce. The Chief Secretary's letter also observes that:

"... there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year".

" Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services".

"The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties".

For the NHS, affordability and the level of incremental pay staff will receive, alongside recruitment and retention pressures, will be a critical element as the Review Body determines whether any award is justified.

I should be grateful if you would make recommendations for the basic pay of doctors and dentists working in the NHS. In doing so, you should consider evidence in respect of:

- the level of incremental pay staff that have not reached the top of their pay band will receive;
- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the DH, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS; and
- 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.

I look forward to receiving your report on 2014/15 pay for your remit group in due course.

Best wishes,

DR DAN POULTER

Cabinet Secretary for Health and Wellbeing
Alex Neil MSP

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E: scottish.ministers@scotland.gsi.gov.uk

The Scottish Government

LEGACY 2014

Professor Paul Curran
Chair
Doctors' and Dentists' Pay Review Body
Office of Manpower Economics
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

24 September 2013

Dear Paul

This letter follows the announcement of the Scottish Government's Public Sector Pay Policy for 2014-15 by the Cabinet Secretary for Finance, Employment and Sustainable Growth on 11 September 2013. A copy of that policy is included for ease of reference. It applies directly to the list of organisations at Annex A and is intended to inform considerations around pay for other public sector groups including NHSScotland staff.

The main feature of Scotland's Public Sector Pay Policy for 2014-15 which is of particular relevance to the DDRB Pay Review Body process is the provision for an increase in basic pay for all staff. This increase is subject to an overall cost cap of 1%, although there is no assumption that this will equate to a 1% uplift. The cost cap does not include pay progression.

Beyond the parameters set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2014-15.

The Scottish Government's policies differ in a number of key respects from those contained in the letter of 23 July to the OME from the Chief Secretary to the Treasury, Danny Alexander, and the further letter of 3 September from Dr Dan Poulter, Parliamentary Under Secretary of State for Health, which set out the remit which the Department of Health wishes the Pay Review Body to work within for 2014-15. I recognise that this may present challenges for the Review Body in putting forward recommendations which will cover the whole of the UK. The Scottish Government's preference would be to maintain one unified pay system. You will appreciate, however, that all consideration on this issue must be informed by the policy framework which we have set for public sector pay in Scotland. It is also important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

BB007SEPT2013
St Andrew's House, Regent Road, Edinburgh EH1 3DG

The Scottish Government has recently made an award for independent dentists covering the period 2011-12 to 2013-14 inclusive. We would like to invite the Review Body to make a recommendation on an uplift for item-of-service payments for independent dentists providing general dental services for 2014-15. In view of the continued challenges around earnings and expenses information with respect to this group, we would view this recommendation as a frame of reference for any future award that would be made.

In respect of General Practitioners, the same principles of affordability apply. Our considerations for an uplift for GPs in 2014-15 will once again be made in the context of what we believe is the right approach for Scotland. This is a context which is also increasingly moving away from a UK based framework for the GMS contract (as was reported in Pulse magazine recently) and where separate contract negotiations will take place between the devolved countries and their respective sub-committees of GPC. It would be helpful if the Review Body could bear this in mind when making recommendations for General Practitioners.

Finally, let me take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to greatly value the independent voice which the Review Body offers on doctors' and dentists' pay.

Copies of this letter have been sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS employers.

ALEX NEIL

BB007SEPT2013
St Andrew's House, Regent Road, Edinburgh EH1 3DG

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref : SF/MD/3293/13

Professor Paul Curran
Chair, Review Body on Doctors'
and Dentists' Remuneration
Office of Manpower Economics
6th Floor
Victoria House
London
WC1B 4AD

25 September 2013

Dear Professor Curran

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: REMIT 2014/15

I would like to relay my gratitude to you and your colleagues on the Review Body on Doctors' and Dentists' Remuneration for your work on the 2013-14 pay round. The Welsh Government values the work of the Review Body on Doctors' and Dentists' Remuneration in delivering robust evidence and recommendations regarding remuneration for Medical staff.

In accordance with your recommendations, a 1% pay increase was applied to all employed Medical staff pay points for doctors and dentists employed within NHS Wales with effect from 1st April 2013. In addition, a 1.5% uplift was awarded to General Medical Practitioners and General Dental Practitioners.

The intention is for the Welsh Government to submit evidence for the 2014/15 pay round by 27th September 2013. The evidence will focus upon the current pressures faced by NHS Wales in a environment of increasing demand for health services, combined with a budget that in real terms will be 12% lower in 2014/ 15 than it was in 2010/11.

DDRB is also asked to make recommendations on appropriate uplifts to the contracts of independent General Medical and Dental Practitioners. In doing so we would invite DDRB to include as part of your considerations the relevant allowances for both practitioner and practice staff pay. Welsh Government will make the final decision on the overall uplift of contracts, taking account of DDRB recommendations and efficiencies resulting from contract negotiations with the professions.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

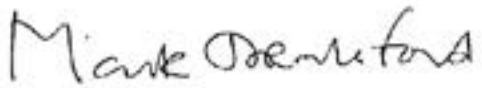
English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford@wales.gsi.gov.uk

In making your recommendations, I would ask you to consider:

- Whether in the current financial environment it is appropriate to uplift salaries for all staff;
- Whether if an award is given it would be more appropriate to provide staff with fixed sum increase rather than a percentage uplift, and;
- Whether a pay freeze would be appropriate for higher earners

Copies of this letter have been sent to the Secretary of State for Health in England, the Cabinet Secretary for Health and Wellbeing in Scotland, and the Minister for Health, Social Services and Public Safety in Northern Ireland.

Yours sincerely



Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Professor Paul Curran
Chair, Review Body on Doctors' and Dentists'
Remuneration
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6th Floor, Victoria House
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WC1B 4AD

Our Ref: SUB/873/2013

Date: 17 October 2013

Dear Professor Curran

Doctors' and Dentists' Review Body 2014/15

Firstly, I would like to congratulate you on your appointment as Chair of the Review Body on Doctors' and Dentists' Remuneration. I value the work of the Pay Review Body in considering remuneration for this group of Health Care staff.

In his letter to you of 3rd September 2013 Dr Dan Poulter MP, Parliamentary Under Secretary of State for Health, outlined his position in relation to providing evidence to the DDRB for the 2014/15 pay round and indicated it was up to each of the UK Administrations to make their own decision on their approach to this year's pay review round and to communicate this to you.

In Northern Ireland the Executive of the NI Assembly has not agreed the funding arrangements for 2014/15 but I can confirm that it will adhere to public sector pay policy as outlined by the Government.

HSC Salaried Doctors and Dentists

In terms of affordability Northern Ireland, in line with the other UK countries is facing significant and increasing financial pressures. This is in the context of an environment of increasing demand for health services in conjunction with a budget allocation for 2014-15 that represents a real terms decrease in funding of 0.7% compared to 2010-11. Consequently I welcome, in the 2013 Spending Review, the Government's announcement that substantial reforms to progression pay will be taken forward, and I would ask DDRB to consider pay progression as part of its review, and to comment on whether there is a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties. I welcome the forthcoming discussion on proposals for a revised Clinical Excellence Awards Scheme.

General Medical Practitioners

My Department provides full details on General Medical Practitioners in the information we submit to DDRB, as enclosed with this letter, and I would ask DDRB to consider this information and to make a recommendation in regard to GP pay and expenses for 2014/15.

General Dental Practitioners

As advised in my pay remit letter for 2013/14, I would welcome a similar assessment for Northern Ireland to that which DDRB completed in relation to earnings and expenses for dentists in Scotland in your Fortieth Report in 2012, for proposed implementation in 2014/15 when the current restrictions on public sector pay end. My Department has provided further details in the information we are submitting to DDRB.

I would also like to express my appreciation for the valuable contribution that the DDRB makes in reaching appropriate pay rates for health and social care staff.

I enclose herewith Northern Ireland written evidence for the 2014/15 pay round process.

I am copying this letter to Dan Poulter (Parliamentary Under Secretary of State for Health), Alex Neil (Scottish Government), Mark Drakeford (Welsh Government) and Simon Hamilton MLA, Minister for Finance and Personnel in the NI Assembly.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

APPENDIX B: DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: SALARY SCALES[1]

The salary scales that we recommend should apply from 1 April 2014 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	England and Northern Ireland[2]		Scotland and Wales	
	2013 £	2014 £	2013 £	2014 £
Foundation house officer 1	22,636	22,862	22,748	22,976
	24,049	24,289	24,168	24,409
	25,461	25,716	25,587	25,843
Foundation house officer 2	28,076	28,357	28,215	28,497
	29,912	30,211	30,060	30,361
	31,748	32,066	31,905	32,224

	United Kingdom	
	2013 £	2014 £
Specialty registrar (full)[3]	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647

[1] Our recommended basic pay uplifts, to be applied from 1 April 2014, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

[2] In England and Northern Ireland, the governments abated our 2010-11 recommendation for a 1.5 per cent uplift to 1 per cent for foundation house officers 1 and 2, house officers and senior house officers. In Scotland and Wales, the 1.5 per cent uplift was applied in full.

[3] The last three points on the scale are to be awarded automatically except in cases of unsatisfactory performance.

	United Kingdom	
	2013 £	2014 £
Specialty registrar (fixed term)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090

	England and Northern Ireland[2]		Scotland and Wales	
	2013 £	2014 £	2013 £	2014 £
House officer	22,636	22,862	22,748	22,976
	24,049	24,289	24,168	24,409
	25,461	25,716	25,587	25,843
Senior house officer[4]	28,076	28,357	28,215	28,497
	29,912	30,211	30,060	30,361
	31,748	32,066	31,905	32,224
	33,584	33,920	33,750	34,088
	35,420	35,774	35,595	35,951
	37,256	37,628	37,440	37,815
	39,092	39,483	39,285	39,678

	United Kingdom	
	2013 £	2014 £
Specialist registrar[5,6]	31,301	31,614
	32,852	33,180
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647

[4] The last two points on the scale are to be awarded automatically except in cases of unsatisfactory performance.

[5] The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.

[6] The last three points on the scale are to be awarded automatically except in cases of unsatisfactory performance.

	England, Scotland and Northern Ireland	
	2013	**2014**
	£	**£**
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)	75,249	76,001
	77,605	78,381
	79,961	80,761
	82,318	83,141
	84,667	85,514
	90,263	91,166
	95,860	96,819
	101,451	102,465

	England and Northern Ireland[7]	
	2013	**2014**
	£	**£**
Clinical Excellence Awards[8]	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

	Scotland[9]	
	2013	**2014**
	£	**£**
Discretionary Points[10]	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

[7] Local level Clinical Excellence Awards (CEAs) for levels 2 – 9 are multiples of the level 1 award (x2, x3, x4, x5, x6, x8, x10 and x12).

[8] Local level CEAs in England and Northern Ireland. For national CEAs, see Part II of this Appendix.

[9] Discretionary Points for levels 2 – 8 are multiples of the level 1 value (x2, x3, x4, x5, x6, x7 and x8).

[10] From October 2003 in England, and from 2005 in Northern Ireland, local CEAs have replaced Discretionary Points. From October 2003 in Wales, Commitment Awards have replaced Discretionary Points. Discretionary Points are the current scheme in Scotland. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA or Commitment Award.

	Wales	
	2013 £	**2014 £**
Consultant (2003 contract, Wales)	72,927	73,656
	75,249	76,001
	79,134	79,925
	83,646	84,482
	88,798	89,686
	91,735	92,653
	94,679	95,626

	Wales[11]	
	2013 £	**2014 £**
Commitment Awards[12]	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

	United Kingdom	
	2013 £	**2014 £**
Consultant (pre-2003 contract)[13]	62,477	63,102
	66,948	67,617
	71,419	72,133
	75,890	76,649
	80,988	81,798

[11] Commitment Awards for levels 2 – 8 are multiples of the level 1 award (x2, x3, x4, x5, x6, x7 and x8).

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

[13] Closed to new entrants.

	United Kingdom	
	2013 £	2014 £
Specialty doctor[14]	37,176	37,547
	40,354	40,758
	44,487	44,931
	46,701	47,168
	49,892	50,391
	53,071	53,602
	56,321	56,884
	59,572	60,168
	62,823	63,452
	66,074	66,734
	69,325	70,018
Associate specialist (2008)[15]	52,122	52,643
	56,312	56,875
	60,500	61,105
	66,032	66,693
	70,827	71,535
	72,816	73,544
	75,412	76,166
	78,008	78,788
	80,603	81,409
	83,199	84,031
	85,797	86,655

[14] 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 *Transitional pay and incremental arrangements* http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf

[15] 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 *Transitional pay and incremental arrangements* http://www.nhsemployers.org/SiteCollectionDocuments/Transitional%20pay%20increases%2018.06.09.pdf

	United Kingdom	
	2013	**2014**
	£	**£**
Associate specialist (pre-2008)	38,071	38,451
	42,103	42,524
	46,135	46,596
	50,167	50,668
	54,199	54,741
	58,231	58,813
	63,556	64,191
	68,171	68,852
Discretionary Points	*Notional scale*	
	70,086	70,787
	72,584	73,310
	75,083	75,833
	77,581	78,357
	80,079	80,880
	82,580	83,406
Staff grade practitioner	34,441	34,786
(1997 contract, MH03/5)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,596	49,082
Discretionary Points	*Notional scale*	
	50,845	51,353
	53,578	54,114
	56,313	56,876
	59,047	59,637
	61,780	62,398
	64,516	65,161
Staff grade practitioner	34,441	34,786
(pre-1997 contract, MH01)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,111	48,592
	50,845	51,353
	53,578	54,114

	United Kingdom *(Annual rates on the basis of a notional half day per week)*	
	2013 £	**2014 £**
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,652	4,699
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553	4,598
	4,816	4,864
	5,081	5,132
	5,344	5,398
	5,608	5,664
	5,871	5,930
	6,135	6,196

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

B. Community health staff

	United Kingdom	
	2013 £	**2014 £**
Clinical medical officer	32,994	33,323
	34,780	35,128
	36,566	36,932
	38,352	38,736
	40,138	40,540
	41,925	42,344
	43,711	44,148
	45,498	45,953
Senior clinical medical officer	46,623	47,089
	49,461	49,956
	52,298	52,821
	55,135	55,686
	57,973	58,553
	60,810	61,418
	63,647	64,283
	66,485	67,150

C. Salaried primary dental care staff[16]

	England and Wales	
	2013 £	2014 £
Band A: Salaried dentist	38,095	38,476
	42,328	42,751
	48,677	49,164
	51,851	52,370
	55,026	55,576
	57,142	57,714
Band B: Salaried dentist[17]	59,259	59,851
	61,375	61,989
	64,550	65,195
	66,137	66,798
	67,724	68,401
	69,311	70,004
Band C: Salaried dentist[18, 19, 20]	70,899	71,608
	73,015	73,745
	75,131	75,883
	77,248	78,020
	79,364	80,158
	81,480	82,295

	Scotland	
	2013 £	2014 £
Dental Foundation Year 1	30,628	30,934
Dental Foundation Year 2	33,321	33,655

[16] These scales also apply to salaried dentists working in Personal Dental Services.

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

[18] 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.

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

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

	Scotland[21]	
	2013	**2014**
	£	**£**
Band A: Dental Officer	38,095	38,476
	42,328	42,752
	48,677	49,164
	51,851	52,370
	55,026	55,577
	57,142	57,714
Band B: Senior Dental Officer	59,259	59,852
	61,375	61,989
	64,549	65,195
	66,137	66,799
	67,725	68,403
	69,311	70,005
Band C: Assistant Clinical Director	70,899	71,608
	73,015	73,746
	75,131	75,883
Band C: Specialist Dental Officer	70,899	71,608
	73,015	73,746
	75,131	75,883
	77,248	78,021
Band C: Clinical Director/Chief	70,899	71,608
Administrative Dental Officers (Western	73,015	73,746
Isles, Orkney and Shetland Health Boards)	75,131	75,883
	77,248	78,021
	79,364	80,158
	81,481	82,296

[21] Scotland has a different base year date to most other scales as this scale was introduced in April 2013.

	Northern Ireland[22]	
	2013	2014
	£	£
Dental Foundation Year 1	30,628	30,934
Dental Foundation Year 2	33,321	33,655
Band 1: Community dental officer	34,964	35,313
	37,792	38,170
	40,621	41,027
	43,450	43,885
	46,279	46,742
	49,107	49,599
	51,936	52,455
	54,766	55,313
Band 2: Senior dental officer	49,962	50,462
	53,917	54,456
	57,871	58,450
	61,826	62,444
	65,780	66,438
	66,652	67,319
	67,523	68,198
Band 3: Assistant clinical director	66,392	67,056
	67,419	68,093
	68,447	69,131
	69,474	70,169
	70,502	71,207
	71,530	72,246
Band 3: Clinical director	66,392	67,056
	67,419	68,093
	68,447	69,131
	69,474	70,169
	70,502	71,207
	71,530	72,246
	72,558	73,283
	73,602	74,338
	74,630	75,376
	75,657	76,414

Part-time dental surgeon	**Sessional fee (per hour)**	
	2013	**2014**
	£	**£**
Dental surgeon	28.68	28.97
Dental surgeon holding higher registrable qualifications	38.05	38.43
Dental surgeon employed as a consultant	46.94	47.41

[22] The last two points in Band 1, Band 2, Band 3: assistant clinical director and Band 3: clinical director are performance-based increments.

PART II: FEES AND ALLOWANCES

Operative date

1. The new levels of remuneration set out below should operate from 1 April 2014. The previous levels quoted are those currently in force.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards for consultants and academic general medical practitioners (GMPs) should remain at current levels.

	2013 £	2014 £
Bronze (Level 9):	35,484	35,484
Silver (Level 10):	46,644	46,644
Gold (Level 11):	58,305	58,305
Platinum (Level 12):	75,796	75,796

3. The annual values of Distinction Awards for consultants[23] should remain at current levels.

	2013 £	2014 £
B award:	31,959	31,959
A award:	55,924	55,924
A+ award:	75,889	75,889

4. The annual values of consultant intensity payments should be unchanged:

	United Kingdom	
	2013 £	2014 £
Daytime supplement:	1,274	1,274

	England, Scotland and Northern Ireland		Wales	
	2013 £	2014 £	2013 £	2014 £
Band 1:	960	960	2,213	2,213
Band 2:	1,913	1,913	4,426	4,426
Band 3:	2,860	2,860	6,637	6,637

[23] From October 2003 in England and Wales, and from 2005 in Northern Ireland, national CEAs have replaced Distinction Awards. Distinction Awards are the current scheme in Scotland. They remain payable to existing holders in England, Wales and Northern Ireland until the holder retires or is awarded a CEA.

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

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%

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

	Multiplier
Band 2A (more than 48 hours and up to 52 hours)	1.80
Band 2B (more than 48 hours and up to 52 hours)	1.50
Band 1A (48 hours or fewer)	1.50
Band 1B (48 hours or fewer)	1.40
Band 1C (48 hours or fewer)	1.20

7. Under the contract agreed by the parties, 1.0 represented the basic salary (shown in Part I of this Appendix) and figures above 1.0 represented the total salary to be paid, including a supplement, expressed as a multiplier of the basic salary. However, from 1 April 2010, 1.05 represented the basic salary for foundation house officer 1 trainees and 1.00 represented the basic salary for all other training grades.

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

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

9. A supplement is added to the basic salary to reflect the intensity of the duties.

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

* salary = F5 to F9 calculated above.

The supplements will be applied as set out below.

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

10. The fee for domiciliary consultations should be increased from £83.37 to £84.20 per visit. Additional fees should be increased *pro rata.*

11. Weekly[24] and sessional rates for locum appointments[25] in the hospital service should be increased as follows:[26]

	Per week		Per notional half day	
	2013 £	2014 £	2013 £	2014 £
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	1,010.79	90.98	91.89
Hospital practitioner appointment			102.49	103.51
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			89.22	90.11

	Per week		Per standard hour	
	2013 £	2014 £	2013 £	2014 £
Specialty registrar (higher rate) appointment	892.32	901.25	18.59	18.77
Specialty registrar (lower rate) appointment	809.76	817.86	16.87	17.04
Specialist registrar appointment	892.32	901.25	18.59	18.77
Foundation house officer 2 appointment:				
England and Northern Ireland	688.80	695.69	14.35	14.49
Scotland and Wales	692.16	699.09	14.42	14.56
Senior house officer appointment:				
England and Northern Ireland	773.28	781.02	16.11	16.27
Scotland and Wales	777.12	784.90	16.19	16.35
Foundation house officer 1 appointment / House officer appointment:				
England and Northern Ireland	553.44	558.98	11.53	11.65
Scotland and Wales	556.32	561.89	11.59	11.71

	Per week		Per session	
	2013 £	2014 £	2013 £	2014 £
Staff grade practitioner appointment	844.10	852.55	84.41	85.25

	Per week		Per programmed activity	
	2013 £	2014 £	2013 £	2014 £
Specialty doctor appointment	853.20	861.74	85.32	86.17
Associate specialist appointment (2008)	1,160.30	1,171.91	116.03	117.19

[24] The hourly rates given for junior doctors are the basic rate (the midpoint of the current salary scale) divided by 365, multiplied by 7 and divided by 40, rounded up to the nearest penny. The weekly rates are the hourly rates multiplied by 1.2 and multiplied by 40. Hourly and weekly rates have not been adjusted for banding.

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

[26] Figures relate to the United Kingdom except where specified.

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

London weighting

13. The value of the London zone payment[27] is £2,162 for non-resident staff and £602 for resident staff.

Doctors in public health medicine

14. The supplements payable to district directors of public health (directors of public health in Scotland and Wales) and for regional directors of public health should be increased as follows:[28]

	2013			2014		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Island Health Boards: Band E (under 50,000 population)	1,835	3,638		1,853	3,674	
District director of public health (director of public health in Scotland/Wales):						
Band D (District of 50,000 – 249,999 population)	3,522	7,042	8,804	3,557	7,113	8,892
Band C (District of 250,000 – 449,999 population)	4,418	8,804	10,579	4,462	8,892	10,685
Band B (District of 450,000 and over population)	5,284	10,579	13,646	5,337	10,685	13,782
Regional director of public health: Band A	13,646	19,808		13,782	20,006	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

15. The supplement payable to general practice specialty registrars is 45 per cent[29] of basic salary.

16. The salary range for salaried GMPs employed by primary care organisations should be increased from £54,319 – £81,969, to £54,862 – £82,789.

[27] *Thirty-Sixth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

[28] Population size is not the sole determinant for placing posts within a particular band.

[29] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

General dental practitioners (Scotland and Northern Ireland)

17. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre should be increased from £85.48 to £86.33.

Community health and community dental staff (Northern Ireland)

18. The teaching supplement for assistant clinical directors in the community dental service should continue to be £2,437 per year.

19. The teaching supplement payable to clinical directors in the community dental service should continue to be £2,753 per year.

20. The supplement for clinical directors covering two districts should continue to be £1,780 per year and the supplement for those covering three or more districts should continue to be £2,841 per year.

21. The allowance for dental officers acting as trainers should continue to be £1,949 per year.

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM[1]

ENGLAND[2]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[3]						
Consultants	36,301	38,341	37,510	39,613	3.3	3.3
Associate specialists	3,170	3,572	2,995	3,364	-5.5	-5.8
Specialty doctors	4,698	5,478	5,138	5,948	9.4	8.6
Staff grades	674	808	474	587	-29.6	-27.4
Registrar group	37,641	38,386	37,964	38,866	0.9	1.3
Foundation house officers 2[4]	7,055	7,102	6,978	7,022	-1.1	-1.1
Foundation house officers 1[5]	6,185	6,225	6,171	6,215	-0.2	-0.2
Other doctors in training	48	124	45	130	-5.6	4.8
Hospital practitioners/Clinical assistants	402	1,782	350	1,547	-13.0	-13.2
Other staff	136	313	130	300	-4.1	-4.2
Total	**96,310**	**101,705**	**97,756**	**103,190**	**1.5**	**1.5**
Hospital and Community Health Services Dental Staff[2]						
Consultants	664	758	686	787	3.4	3.8
Associate specialists	116	170	128	176	10.4	3.5
Specialty doctors	191	372	211	410	10.5	10.2
Staff grades	27	51	17	36	-37.9	-29.4
Registrar group	492	511	525	545	6.5	6.7
Foundation house officers 2[4]	523	542	522	537	-0.2	-0.9
Foundation house officers 1[5]	49	49	58	60	17.6	22.4
Other doctors in training	0	0	0	0	:	:
Hospital practitioners/Clinical assistants	46	276	38	238	-18.1	-13.8
Other staff	976	1,386	959	1,373	-1.8	-0.9
Total	**3,085**	**4,030**	**3,143**	**4,070**	**1.9**	**1.0**

: Not applicable

[1] An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.

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

[3] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[4] This includes senior house officers.

[5] This includes house officers.

ENGLAND[2]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**35,319**	**39,780**	**35,871**	**40,265**	**1.6**	**1.2**
GMP providers	24,415	27,218	24,095	26,886	-1.3	-1.2
General practice specialty registrars[6]	3,784	4,013	4,138	4,426	9.3	10.3
GMP retainers[7]	143	365	155	321	8.1	-12.1
Other GMPs	6,976	8,585	7,483	8,898	7.3	3.6
General dental practitioners[8, 9, 10]		**22,920**		**23,201**		**1.2**
General Dental Services only		17,834		18,447		3.4
Personal Dental Services only		2,151		1,924		-10.6
Mixed		1,826		1,812		-0.8
Trust-led		1,109		1,018		-8.2
Ophthalmic medical practitioners[11]		**324**		**304**		**-6.2**
Total general practitioners		**63,024**		**63,770**		**1.2**
Total – NHS doctors and dentists		**168,735**		**171,012**		**1.3**

6 General practice specialty registrars were formerly known as GMP registrars.

7 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.

8 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.

9 Data as at 31 March of the following year.

10 Data include salaried dentists.

11 Data as at 31 December.

WALES[12]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[13]						
Consultants	2,167	2,311	2,225	2,381	2.6	3.0
Associate specialists	352	404	346	395	-1.8	-2.2
Specialty doctors	357	448	407	510	14.0	13.8
Staff grades	13	41	7	32	-50.7	-22.0
Specialist registrars	1,855	2,030	1,820	1,979	-1.9	-2.5
Foundation house officers 2[14]	438	526	443	521	1.2	-1.0
Foundation house officers 1[15]	340	345	340	344	-0.1	-0.3
Hospital practitioners	4	21	3	18	-15.8	-14.3
Clinical assistants	14	157	12	127	-13.4	-19.1
Other staff	4	28	4	14	-4.8	-50.0
Total	**5,546**	**6,311**	**5,606**	**6,321**	**1.1**	**0.2**
Hospital and Community Health Services Dental Staff[13]						
Consultants	50	57	54	62	8.8	8.8
Associate specialists	9	12	11	13	25.9	8.3
Specialty doctors	17	41	21	55	25.0	34.1
Staff grades	5	7	1	2	-71.1	-71.4
Specialist registrars	23	25	22	25	-4.4	0.0
Foundation house officers 2[14]	58	60	67	68	15.5	13.3
Foundation house officers 1[15]	0	0	0	0	:	:
Hospital practitioners	<1	1	<1	1	0.0	0.0
Clinical assistants	2	18	2	13	5.0	-27.8
Other staff[16]	105	140	94	130	-10.5	-7.1
Total	**267**	**361**	**272**	**369**	**1.8**	**2.2**

: Not applicable

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

[13] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[14] This includes senior house officers.

[15] This includes house officers.

[16] This group consists mainly of dental officers.

WALES[12]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**2,271**		**2,275**		**0.2**	
GMP providers	2,022		2,015		-0.3	
General practice specialty registrars[17]	202		223		10.4	
GMP retainers[18]	47		37		-21.3	
General dental practitioners[19, 20]	**1,360**		**1,392**		**2.4**	
General Dental Services only	968		988		2.1	
Personal Dental Services only	204		197		-3.4	
Mixed	117		123		5.1	
Ophthalmic medical practitioners[21]	**12**		**14**		**16.7**	
Total general practitioners	**3,643**		**3,681**		**1.0**	
Total – NHS doctors and dentists	**10,315**		**10,371**		**0.5**	

[17] General practice specialty registrars were formerly known as GMP registrars.

[18] 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.

[19] Data as of year ending 31 March of the following year.

[20] Includes some dentists working in the Emergency Dental service and some community dental service staff working on a PDS contract.

[21] Data as at 31 December.

SCOTLAND[22]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[23]						
Consultants	4,374	4,669	4,427	4,717	1.2	1.0
Associate specialists	330	380	323	379	-2.2	-0.3
Specialty doctors	460	654	493	685	7.1	4.7
Staff grades	89	117	67	88	-24.8	-24.8
Registrar group	3,931	4,077	3,832	3,983	-2.5	-2.3
Foundation House Officers 2[24]	738	748	753	764	2.1	2.1
Foundation House Officers 1[25]	955	956	989	992	3.5	3.8
Hospital practitioners	20	103	16	96	-22.7	-6.8
Clinical assistants	49	198	35	158	-29.0	-20.2
Other staff	291	640	297	675	2.1	5.5
Total	**11,237**	**12,446**	**11,231**	**12,434**	**-0.1**	**-0.1**
Hospital and Community Health Services Dental Staff[23]						
Consultants	131	149	132	149	0.4	0.0
Associate specialists	17	22	17	21	1.4	-4.5
Specialty doctors	26	47	28	53	7.9	12.8
Staff grades	4	7	4	5	-16.4	-28.6
Registrar group	46	50	38	44	-16.4	-12.0
Foundation house officers 2[24]	47	51	48	55	2.2	7.8
Foundation house officers 1[25]	1	1	0	0	-100.0	-100.0
Hospital practitioners	<1	1	<1	1	0.0	0.0
Clinical assistants	<1	1	<1	1	3.8	0.0
Other staff	451	583	446	576	-1.2	-1.2
Total	**724**	**892**	**713**	**886**	**-1.5**	**-0.7**

[22] Data as at 30 September.

[23] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[24] This includes senior house officers.

[25] This includes house officers.

SCOTLAND[22]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**4,893**		**4,859**		**-0.7**	
GMP providers	3,750		3,745		-0.1	
General practice specialty registrars[26]	478		447		-6.5	
GMP retainers[27]	145		138		-4.8	
Other GMPs	526		539		2.5	
General dental services[28]	**3,048**		**3,060**		**0.4**	
Principal dental practitioners	2,437		2,456		0.8	
Vocational dental practitioners	200		179		-10.5	
Assistant dental practitioners	57		59		3.5	
Ophthalmic medical practitioners	**22**		**23**		**4.5**	
Total general practitioners	**7,963**		**7,942**		**-0.3**	
Total – NHS doctors and dentists	**21,299**		**21,259**		**-0.2**	

[26] General practice specialty registrars were formerly known as GMP registrars.

[27] 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.

[28] Data include salaried dentists.

NORTHERN IRELAND[29]	2011		2012		Percentage change 2011 – 2012	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff[30]						
Consultants	1,371	1,453	1,442	1,529	5.2	5.2
Associate specialists	117	135	139	163	19.3	20.7
Specialty doctors	147	178	205	257	38.9	44.4
Staff grades	85	103	37	46	-56.7	-55.3
Specialist registrars	1,291	1,316	1,256	1,281	-2.7	-2.7
Foundation house officers 1 and 2[31]	532	536	549	553	3.3	3.2
Hospital practitioners	84	150	39	93	-53.1	-38.0
Other staff	82	125	91	134	11.6	7.2
Total	**3,708**	**3,996**	**3,759**	**4,056**	**1.4**	**1.5**
General medical practitioners[32]		**1,163**		**1,170**		**0.6**
General dental practitioners[33]		**937**		**950**		**1.4**
Ophthalmic medical practitioners[33]		**21**		**21**		**0.0**
Total general practitioners		**2,121**		**2,141**		**0.9**
Total – NHS doctors and dentists		**6,117**		**6,197**		**1.3**

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

[30] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[31] This includes house officers and senior house officers.

[32] Data as of November.

[33] Data as at April of the following year.

APPENDIX D: THE EVIDENCE

We received written information and evidence from: the Health Departments, comprising the Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Northern Ireland Executive Department of Health, Social Services and Public Safety; NHS England; NHS Employers; Health Education England; the Foundation Trust Network; the Advisory Committee on Clinical Excellence Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association; and the British Dental Association. The main evidence can be read in full on the parties' websites or by contacting the appropriate body.

Evidence from the Department of Health
https://www.gov.uk/government/publications/nhs-pay-2014-department-of-health-evidence-to-pay-review-bodies

Evidence from the Welsh Government
Contact: Kay.Hannigan@wales.gsi.gov.uk

Evidence from the Scottish Government Health and Social Care Directorates
http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/Pay-Conditions/EvidSGtoDDRB2014-15

Evidence from the Northern Ireland Executive Department of Health, Social Services and Public Safety
http://www.dhsspsni.gov.uk/northern_ireland_information_to_ddrb_for_2014_15.pdf

Evidence from NHS Employers:
http://www.nhsemployers.org/PayAndContracts/AnnualPayReview/Pages/201415Doctorsanddentists.aspx

Evidence from NHS England:
http://www.england.nhs.uk/wp-content/uploads/2013/09/ddrb-evid.pdf

Evidence from Health Education England
http://hee.nhs.uk/

Evidence from the Foundation Trust Network
http://www.foundationtrustnetwork.org/

Evidence from the Advisory Committee on Clinical Excellence Awards
[https://www.gov.uk/government/publications/accea-evidence-to-the-ddrb-2013

Evidence from the Scottish Advisory Committee on Distinction Awards
(http://www.shsc.scot.nhs.uk/shsc/default.asp?p=84)

Evidence from the British Medical Association
http://bma.org.uk/

Information/evidence from the British Dental Association
http://www.bda.org/

APPENDIX E: 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
Thirty-Ninth Report (2010)	Cm 7837, March 2010
Fortieth Report (2012)	Cm 8301, March 2012
Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants (2011)	Cm 8518, December 2012
Forty-First Report (2013)	Cm 8577, March 2013

APPENDIX F: GLOSSARY OF TERMS

AGENDA FOR CHANGE – the harmonised 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. See *Very Senior Managers*.

ASSOCIATE DENTISTS (SCOTLAND AND NORTHERN IRELAND) – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. Associate dentists also have an arrangement with an NHS board and provide General Dental Services. The equivalent in England and Wales is performer-only dentists. See also *performer-only dentists*.

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

BASIC PAY – the annual rate of salary without any allowances or additional payments.

CENTRALLY FUNDED ALLOWANCES (SCOTLAND AND NORTHERN IRELAND) – centrally funded contractual payments including: rent reimbursement; reimbursement of non-domestic rates; seniority payments; recruitment and retention allowance; long-term sickness; maternity and paternity pay; continuing professional development; remote areas; vocational training; sedation; clinical audit; and non-contractual payments in kind and benefits.
See also *reimbursement of practice rental costs, seniority payment*.

CLINICAL COMMISSIONING GROUPS – the groups of general medical practitioners and other healthcare professionals that have taken over commissioning from primary care trusts in England under NHS reforms.

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

COMMITMENT AWARDS – for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003.
See also *Discretionary Points*.

COMMITMENT PAYMENTS (SCOTLAND) – paid quarterly to dentists who carry out NHS General Dental Services and who meet the criteria for payment.

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial and pharmaceutical.[1]

DENTAL BODIES CORPORATE – limited companies operating dental practices.
See also *incorporated business*.

DENTAL PERFORMERS – those who carry out dental work; that is, individual general dental practitioners. See also *performer-only dentists, associate dentists, principal dentists, providing-performer dentists*.

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.
See also *performer-only dentists, associate dentists, principal dentists, providing-performer dentists*.

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

DISCRETIONARY POINTS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by local Clinical Excellence Awards in England and Northern Ireland, and Commitment Awards in Wales, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Discretionary Points are pensionable.
See also Clinical Excellence Awards, Commitment Awards, Distinction Awards.

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable.
See also *Clinical Excellence Awards, Discretionary Points*.

DOUBLE COUNTING OF DENTISTS' GROSS EARNINGS AND EXPENSES – see *Multiple counting of dentists' gross earnings and expenses*

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.

EXPENSE SHARING ARRANGEMENT – Dentists who share expenses with other dentists, but retain their own profits.

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

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.

GENERAL DENTAL PRACTICE ALLOWANCE (SCOTLAND) – an allowance, which varies according to the level of NHS commitment, introduced to retain dentists in NHS General Dental Services.

GENERAL DENTAL SERVICES CONTRACT – can be practice based, where the contract is held by an individual dentist, partnership (including limited liability partnership), company, or one individual dentist with a number of dentist performers working under the contract.

GENERAL MEDICAL PRACTITIONER TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training to a general practice specialty registrar.

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes.
See also *global sum; minimum practice income guarantee; Quality and Outcomes Framework*.

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, and more advanced minor surgery. See also *minimum practice income guarantee*.

HEALTH SERVICE SHARE – the equivalent of NHS share, in Northern Ireland. See *NHS share*.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

INCORPORATED BUSINESS – both providing-performer/principal and performer-only/associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For providing-performer/principal dentists, the business tends to be a dental practice. For performer-only/associate dentists, the business is the service they provide as a sub-contractor.

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*.

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 *global sum*.

MULTIPLE COUNTING OF EXPENSES – flows of money between dentists (for example, between a principal and an associate working in the former's practice) mean that gross earnings and expenses can be double counted across the tax returns of the dental population. This will cause estimates of gross earnings and expenses for the dental population as a whole to be artificially inflated. A single sum of money can (legitimately for tax accounting purposes) be declared as gross earnings by both the principal and the associate, and also as an expense by the principal. This is explained fully in Chapter 2 of the *Fortieth Report*[2]. See also *expenses to earnings ratio*.

NHS COMMITMENT – see *NHS share*.

NHS SHARE – in England, Wales and Scotland, the percentage of time devoted to NHS dentistry, as opposed to private dentistry. This is calculated from dentists' own responses to the *Dental Working Patterns Survey*, and was previously known as NHS Commitment.

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – dentists who perform NHS activity on a contract, but do not hold the contract with the primary care organisation. The equivalent in Scotland and Northern Ireland is associate dentists. See also *associate dentists*.

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists*.

PROGRAMMED ACTIVITIES – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and 7 am during the week, or any time at weekends. A number of **SUPPORTING PROFESSIONAL ACTIVITIES** are also agreed within the job planning process to carry out training, continuing professional development, job planning, appraisal and research.

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[2] *Fortieth Repor*t. Review Body on Doctors' and Dentists' Remuneration. Cm8301. TSO, 2012. Chapter 2.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists*.

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

REVALIDATION – came into force across the United Kingdom on 3 December 2012. Licensed doctors are now legally required to demonstrate that they are keeping up to date and are fit to practise. Revalidation will usually be required every five years and will involve regular appraisals with the employer. The process will be overseen by the General Medical Council. The majority of licensed doctors in the United Kingdom will undergo revalidation for the first time by March 2016. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council.

SALARIED CONTRACTORS – general medical practitioners or general dental practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract. See also *independent contractor status*.

SALARIED DENTISTS – provide generalist and specialist care largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care.

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

SENIORITY PAYMENT – paid to reward dentists over the age of 55, who stay within the NHS and continue to undertake NHS dentistry.

SOLE TRADER (WITH HELP) – self-employed dentist who performs dental services, but also employs and/or sub-contracts other dentists to perform dental services within their sole trader business arrangement. See also *sole trader (without help)*.

SOLE TRADER (WITHOUT HELP) – self-employed dentist without other dentists working for them. See also *sole trader (with help)*.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS / SAS GRADES – doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors, associate specialists, staff grades, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. The associate specialist grade is now closed.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities*.

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

VERY SENIOR MANAGERS (VSMs) – these include chief executives, executive directors (with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and requirements of the post) and other senior managers with board level responsibility who report directly to the chief executive.

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.

APPENDIX G: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ACCS	Acute Care Common Stem
A&E	Accident and Emergency
APMS	Alternative Providers of Personal Medical Services
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CACB	cyclically-adjusted current budget
CCG	Clinical Commissioning Group
CEA	Clinical Excellence Award
CMT	Core Medical Training
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
EER	expenses to earnings ratio
ENT	Ear, Nose and Throat
FHO	foundation house officer
FTE	full-time equivalent
FTN	Foundation Trust Network
GDP	general dental practitioner
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
GP	general practitioner
GPMS	General/Personal Medical Services
GUM	Genito-Urinary Medicine
HCHS	Hospital and Community Health Services
HSCIC	Health and Social Care Information Centre
ICM	Intensive Care Medicine
IFS	Institute for Fiscal Studies
IT	information technology
KSF	Knowledge and Skills Framework
LETB	Local Education Training Board

LHB	Local Health Board
NHS	National Health Service
OBR	Office for Budgetary Responsibility
OMFS	Oral and Maxillofacial Surgery
OMP	opthalmic medical practitioner
PA	programmed activity
PCO	primary care organisation
PCT	Primary Care Trust
PCTMS	Primary Care Trust Medical Services
PMS	Personal Medical Services
PSND	Public Sector Net Debt
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RPIX	Retail Prices Index excluding mortgage interest payments
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	specialty doctors and associate specialists
SHA	Strategic Health Authority
SPA	supporting professional activity
TSO	The Stationery Office
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UK	United Kingdom
VAT	Value Added Tax
VSM	Very Senior Managers

APPENDIX H: FILL RATES FOR HOSPITAL TRAINEES AFTER THE INITIAL TWO ROUNDS OF RECRUITMENT, UNITED KINGDOM, 2013

	Level	Fill rate (%)	Number of posts (vacancies)
ACCS Emergency Medicine	1	100	250 (0)
ACCS Emergency Medicine	3	33.3	9 (6)
Acute Medicine	3	53	166 (78)
Allergy	3	42.9	7 (4)
Anaesthetics	1	99.5	628 (3)
Anaesthetics	2	75	12 (3)
Anaesthetics	3	84.4	604 (94)
Audiological Medicine	3	100	1 (0)
Broad Based Training	1	82.7	52 (9)
Cardiology	3	84.4	173 (27)
Cardiothoracic Surgery	1	100	8 (0)
Cardiothoracic Surgery	3	96.7	30 (1)
Chemical Pathology	1	100	3 (0)
Chemical Pathology	3	100	1 (0)
Child & Adolescent Psychiatry	4	67.1	85 (28)
Clinical Genetics	3	88.9	18 (2)
Clinical Neurophysiology	3	71.4	7 (2)
Clinical Oncology	3	76.2	101 (24)
Clinical Pharmacology & Therapeutics	3	72.7	11 (3)
Clinical Radiology	1	100	219 (0)
CMT/ACCS Acute	1	98.9	1575 (17)
CMT/ACCS Acute	2	83.7	43 (7)
Community Sexual & Reproductive Health	1	100	9 (0)
Core Psychiatry Training	1	88.9	557 (62)
Core Psychiatry Training	2	38.2	34 (21)
Core Psychiatry Training	3	14.8	27 (23)
Core Surgical Training	1	93.7	734 (46)
Core Surgical Training	2	81.2	16 (3)
Dental Foundation	1	100	970 (0)
Dermatology	3	98.6	69 (1)
Diagnostic Neuropathology	3	50	4 (2)
Dual Anaesthesia / ICM	3	80	10 (2)
Emergency Medicine	1	36.8	19 (12)
Emergency Medicine	3	100	8 (0)
Emergency Medicine	4	30.9	473 (327)
Endocrinology and Diabetes Mellitus	3	58.8	131 (54)
Forensic Psychiatry	4	80	45 (9)

	Level	Fill rate (%)	Number of posts (vacancies)
Forensic Psychiatry and Medical Psychotherapy	4	100	1 (0)
Gastroenterology	3	78.6	173 (37)
General (Internal) Medicine	3	75	12 (3)
General Adult Psychiatry	4	67.1	234 (77)
General Adult Psychiatry/Old Age Psychiatry	4	82.9	35 (6)
General Adult Psychiatry/Psychotherapy	4	75	4 (1)
General Practice	1	98.1	3260 (62)
General Practice (Academic)	1	84.6	26 (4)
General Surgery and Vascular Surgery	3	96.5	285 (10)
Geriatric Medicine	3	70.3	219 (65)
GUM	3	69.4	49 (15)
Haematology	3	88.9	99 (11)
Histopathology	1	69	126 (39)
Immunology	3	38.5	13 (8)
Infectious Diseases	3	64.5	76 (27)
Intensive Care Medicine	3	90	90 (9)
Intensive Care Medicine	4	50	2 (1)
Medical Microbiology	1	96.4	28 (1)
Medical Oncology	3	50	74 (37)
Medical Ophthalmology	3	33.3	3 (2)
Medical Psychotherapy	4	70	10 (3)
Medical Virology	1	100	2 (0)
Metabolic Medicine	3	0	25 (25)
Neurology	3	71.4	77 (22)
Neurosurgery	1	90.2	41 (4)
Neurosurgery	2	18.2	11 (9)
Neurosurgery	3	100	6 (0)
Nuclear Medicine	3	22.2	9 (7)
Nuclear Medicine	6	16.7	6 (5)
Obstetrics and Gynaecology	1	98	253 (5)
Obstetrics and Gynaecology	2	43.8	16 (9)
Obstetrics and Gynaecology	3	43.8	32 (18)
Obstetrics and Gynaecology	6	0	2 (2)
Occupational Medicine	3	50	10 (5)
Old Age Psychiatry	4	55.1	69 (31)
Old Age Psychiatry/General Adult Psychiatry	4	83.3	6 (1)
OMFS	3	65.8	38 (13)
Ophthalmology	1	100	92 (0)
Ophthalmology	3	45.8	24 (13)

	Level	Fill rate (%)	Number of posts (vacancies)
Orthodontics	1	100	46 (0)
Otolaryngology (ENT)	3	98.3	59 (1)
Paediatric Accident and Emergency Medicine	1	50	2 (1)
Paediatric and perinatal pathology	3	100	1 (0)
Paediatric Cardiology	4	81.2	16 (3)
Paediatric Surgery	3	94.7	19 (1)
Paediatrics	1	98.6	425 (6)
Paediatrics	2	100	29 (0)
Paediatrics	3	75	12 (3)
Paediatrics	4	98.2	56 (1)
Palliative Medicine	3	91.1	56 (5)
Plastic Surgery	3	94.6	111 (6)
Pre-Hospital Emergency Medicine	1	50	2 (1)
Psychiatry of Learning Disability	4	54.1	37 (17)
Public Health	1	96.2	78 (3)
Rehabilitation Medicine	3	41.7	36 (21)
Renal Medicine	3	73.2	82 (22)
Respiratory Medicine	3	78.6	182 (39)
Rheumatology	3	56.7	104 (45)
Sport and Exercise Medicine	3	61.5	13 (5)
Trauma and Orthopaedic Surgery	1	100	14 (0)
Trauma and Orthopaedic Surgery	3	100	242 (0)
Urology	3	93.9	66 (4)

Source: NHS England.

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