Review Body on Doctors' and Dentists' Remuneration

Fortieth Report 2012

Chairman: Ron Amy, OBE

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

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

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, Wellbeing and Cities Strategy 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, Wellbeing and Cities Strategy 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:[1]

Ron Amy, OBE *(Chairman)*
Lucinda Bolton[2]
Katrina Easterling
John Glennie, OBE[3]
Professor Steve Thompson
Professor Ian Walker[4]
David Williamson

The Secretariat is provided by the Office of Manpower Economics.

1 Sally Smedley resigned from the Review Body in October 2011.
2 Lucinda Bolton was appointed to the Review Body by the Minister of State for Health from July 2011.
3 John Glennie was appointed to the Review Body by the Parliamentary Under Secretary of State for Health from April 2010.
4 Professor Ian Walker was appointed to the Review Body by the Parliamentary Under Secretary of State for Health from April 2010.

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Chapter 1: DDRB monitoring round 2012

1. In the June 2010 Budget, the government announced a two year public sector pay freeze from 2011-12 for public sector workforces earning in excess of £21,000 per annum on a full-time equivalent basis ("the pay freeze"). Due to the pay freeze, we are not required to make recommendations on the remuneration of doctors and dentists, including independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs), in the United Kingdom for 2012-13, as all doctors and dentists have full-time equivalent earnings of more than £21,000 per annum.

2. In the context of this revised remit, we have continued to monitor recruitment, retention, motivation and other relevant matters. To this end, we invited the parties to submit any information they considered appropriate for us to carry out this role and we make our observations in Chapter 1 of this report.

3. The Scottish Government has sought our recommendations in relation to dental practice expenses of independent contractors in the General Dental Services in Scotland. We make these recommendations in Chapter 2 of this report.

4. We received written and oral evidence and information from: the Health Departments, comprising the Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Department of Health, Social Services and Public Safety in Northern Ireland; NHS Employers; the Advisory Committee on Clinical Excellence Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association (BMA); the British Dental Association (BDA) and its Scottish Dental Practice Committee.

5. Our remit groups comprised just over 200,000 staff in September 2010, a 1.2 per cent increase on the previous year. This was made up of approximately: 46,000 consultants; 13,000 specialty doctors, associate specialists and staff grades (SAS grades); 62,000 doctors and dentists in hospital training; 2,000 salaried dentists; 4,000 other Hospital and Community Health Services (HCHS) staff; 48,000 GMPs; 28,000 GDPs; and 400 ophthalmic medical practitioners. The total number of medical and dental staff in the United Kingdom has increased each year between 2006 and 2010. The number of female doctors in England has risen by 74 per cent since 1999, to just over 43,000 in 2009, while male numbers grew by 32 per cent over the same period. Females now account for around 43 per cent of all doctors in England.

6. There were 2.4 applicants for each United Kingdom medical school place in 2010, up from 2.2 the previous year. We note that there continues to be a more than adequate supply of good quality applicants to study medicine, which we interpret as strong evidence that medicine is still seen as an attractive career. Women account for 55 per cent of accepted applicants, so we welcome the assurances given by the Department of Health that any related workforce planning issues are being addressed.

7. Taken together, the increase in medical and dental staff and the current available vacancy rates for the different countries of the United Kingdom do not give us any real cause for concern on recruitment and retention grounds. We were, however, told about United Kingdom-wide difficulties in recruiting into certain specialties over the last year, including: accident and emergency, anaesthetics, obstetrics and gynaecology, paediatrics and psychiatry; and some difficulty in recruiting into general practice in Scotland. The loss of the vacancy surveys for England, with no immediate alternative source of data, has a detrimental impact on the evidence base to enable us to assess changes in recruitment and retention, both important elements of our remit. We ask the Health

Departments to take steps to ensure that the NHS Information Centre and its equivalents provide 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 also ask the Health Departments to take steps to ensure that the NHS Information Centre and its equivalents provide data on full-time equivalents in addition to headcount data for all our remit groups.

8. As last year, the major surveys of NHS HCHS staff and from the BMA did not give us any real cause for concern regarding motivation. However, we are conscious that while these surveys took place after the announcement of the pay freeze, they predated the first year of the pay freeze taking effect, the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom. We will be monitoring closely the impact of these changes on the motivation of our remit groups. The BDA's information has again presented motivation as an issue of concern. However, we note that most of the issues linked to motivation cited by the BDA are not capable of being addressed through pay, and therefore ask the Health Departments to consider the issues raised by the BDA when developing future policy.

9. Economic growth was modest in 2011, at just 0.9 per cent in the year, and well below the forecast made when we last reported. The economy is forecast to grow by just 0.7 per cent in 2012. Employment levels rose in the first half of 2011, but fell in the second half, to remain broadly unchanged on the year. Unemployment, meanwhile, rose by 179,000 in the year to December 2011. The employment level is expected to remain broadly stable in 2012. Inflation remained relatively high throughout 2011, at over 5 per cent on the Retail Prices Index (RPI), then fell back in January 2012 to 3.9 per cent on the RPI, and 4.0 per cent on the RPI excluding mortgage interest payments (RPIX), and 3.6 per cent on the Consumer Prices Index (CPI). Inflation is forecast to continue to fall during 2012 and reach the Monetary Policy Committee's 2 per cent CPI target by the end of the year. Pay settlements across the economy centred on 2.5 per cent throughout 2011 (excluding the public sector), and are expected to remain at similar levels in 2012. Average earnings growth is around 2 per cent in the private sector and 1.5 per cent in the public sector.

10. We recognise from the evidence that affordability continues to dominate the thinking of many employers. The Health Departments emphasised: the need for tight control of public spending, including pay, in England; the considerable budget pressures in Scotland; and the very tight public expenditure position in Northern Ireland.

11. We note that, yet again, efficiency savings have been applied to our formulae for the contract uplifts for GMPs and GDPs. We reiterate our general view that while requiring cash-releasing efficiency savings may be an appropriate way to achieve cost discipline in a government department or agency that is not subject to market forces, GMPs and GDPs operate small businesses in competitive markets and have an incentive to achieve whatever efficiency savings are possible. We therefore believe that it is both unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs as the impact of efficiency savings will become apparent, albeit with a time lag, in the data used in the formulae. If the Health Departments continue to think it appropriate to impose a requirement on independent contractor GMPs and GDPs to make efficiency savings, then we believe that any such requirement should be a contractual matter, rather than abating our recommended increases.

12. The relative position of total earnings for the majority of our remit groups has declined slightly since 2010, when measured against comparator professions.[5] Although there are some slight differences between the various grades, the median total earnings of all categories in our remit group (except foundation house officers) are within the top decile when compared with all full-time employees in the wider economy. The median gross annual full-time pay for employed doctors and dentists has remained around the 97th percentile for all full-time employees. We will continue to monitor pay comparability as we move through and beyond the pay freeze, particularly as it impacts on recruitment and retention.

13. In our next report, we expect to return to making recommendations on pay and other allowances for the doctors and dentists within our remit group.

14. We welcome the progress made in both Scotland and Northern Ireland on new contractual arrangements for salaried dentists as we consider such arrangements to be long overdue.

15. While we understand that the Health Departments are operating within financial constraints, we wish to stress to all countries the importance of ensuring that the investment in the new SAS contracts is not wasted and that the benefits of the new contracts are fully realised: ongoing career development was seen by the parties as an important aspect of the new contract and therefore should not be ignored.

Chapter 2: General dental practitioners' expenses in Scotland

16. The Scottish Government sought our recommendations in relation to dental practice expenses of independent contractors in the General Dental Services in Scotland. The letter from the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy noted that:

    "The system for Primary Care Dentistry in Scotland is different from England and has not been considered by DDRB for some time. We would find it helpful if DDRB could carry out a detailed consideration and assessment of all the changes that have been made to practitioners' earnings and expenses in Scotland and make recommendations as appropriate for 2011-12 and 2012-13."

17. The remuneration system for General Dental Services in Scotland is primarily based on item-of-service fees for adults and children, capitation and some continuing care payments. There are also centrally funded allowances available to dentists.[6]

18. We note the broad support of the parties in continuing with a formula-based approach, and consider that the formula for Scotland should utilise, where appropriate, data specific to Scotland. Our formula involves weighting together the increase in the practitioners' personal remuneration and the increase in GDPs' expenses. The weights that have been used in the formula for England and Wales in recent years have been based on HM Revenue and Customs data for these countries; now that data for Scotland are available, we derive the weights for net income and staff costs in the formula using these data.

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[5] The specific comparator professions that we use are: legal, tax and accounting, actuarial and pharmaceutical. The pay comparators were identified in the report: PA Consulting Group. *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008. Available from: http://www.ome.uk.com/DDRB_research.aspx

[6] A similar arrangement exists in Northern Ireland. In England and Wales, primary care organisations (PCOs) hold budgets for dental services for their areas which are specified in terms of units of dental activity. PCOs agree contract values with providers for a particular level of service.

19. Our examination of GDPs' expenses in Scotland has brought to light the issue of the double counting of gross earnings and expenses. Double counting can occur when dentistry is performed by an associate working in a principal's practice: where payments are made to the principal, some of that payment will be passed on to the associate. On these individuals' tax returns, the same sum of money can be declared as gross earnings by both the principal and associate, and also as an expense by the principal. When the data are aggregated, estimates of gross earnings and expenses are inflated by this double counting, though taxable income is not affected. The issue of double counting of dentists' gross earnings and expenses means that estimates of the expenses to earnings ratio are artificially inflated, which has the potential to distort the outcomes of our formulae for uplifting dentists' item-of-service fees. We have considered how best to account for this.

20. Our estimate of double counting is £39.3 million. This would reduce the expenses to earnings ratio from 53.4 per cent to 47.6 per cent.

21. We are confident that the expenses to earnings ratio implied by the aggregated HM Revenue and Customs data is too high, but acknowledge that the revised estimate may not accurately reflect double counting. It is not possible from the evidence available to estimate the true figure with a high degree of precision. We have concluded that, in the absence of definitive data, it is appropriate to use an expenses to earnings ratio of 50 per cent for our 2011-12 and 2012-13 recommendations.

22. The Scottish Government has drawn to our attention that a number of allowances and reimbursements are paid to dentists in Scotland. We think it would be inappropriate for the uplift to item-of-service fees to be influenced by changes in the discretionary allowances, and have identified a number of allowances which in our view the formula should discount. Taking all factors into account, the formulae for 2011-12 and 2012-13 are set out in Table 1 and Table 2 respectively.

Table 1: Dental formula for Scotland, 2011-12

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.6%	0% *Scottish Government public sector pay policy*	0%
Staff costs	19.7%	–0.8% *Annual Survey of Hours and Earnings (dental practice activities) 2010*	–0.16%
Laboratory costs	5.6%	4.7% *RPIX 2010 Q4*	0.26%
Materials	5.6%	4.7% *RPIX 2010 Q4*	0.26%
Other costs	13.5%	4.7% *RPIX 2010 Q4*	0.64%
		Total	**1.00%**

Table 2: Dental formula for Scotland, 2012-13

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.6%	0% *Scottish Government public sector pay policy*	0%
Staff costs	19.7%	0.4% *Annual Survey of Hours and Earnings (dental practice activities) 2011*	0.08%
Laboratory costs	5.6%	5.3% *RPIX 2011 Q4*	0.29%
Materials	5.6%	5.3% *RPIX 2011 Q4*	0.29%
Other costs	13.5%	5.3% *RPIX 2011 Q4*	0.72%
		Total	**1.38%**

23. We have been asked to make a recommendation that item-of-service fees in Scotland are increased by a factor intended to result in no increase to GDPs' net income after allowing for movement in expenses. Our dental formula gives an overall percentage rise of 1.00 per cent in 2011-12 and 1.38 per cent in 2012-13. Therefore, we recommend that an uplift of 1.00 per cent be applied to item-of-service fees in Scotland for 2011-12, and a further compound increase of 1.38 per cent be applied for 2012-13. The parties should agree the effective dates of these increases.

We recommend that an uplift of 1.00 per cent be applied to item-of-service fees in Scotland for 2011-12, and a further compound increase of 1.38 per cent be applied for 2012-13. The parties should agree the effective dates of these increases.

24. The specific remit on dental expenses in Scotland has given us the opportunity to revisit the methodology for our formula, and we have found that adjustments for double counting of earnings and expenses, as well as reimbursements and allowances, have a substantial impact on the coefficients used in our formula. In the absence of definitive data, we have used our judgement to construct a formula that is appropriate. We welcome the parties' views on our approach.

25. The particular issue of double counting is not confined to dentists in Scotland: the NHS Information Centre has identified that it causes distortions to the statistics in England and Wales,[7] and in Northern Ireland.[8] In England and Wales in particular, this practice could be widespread since the introduction of new contractual arrangements in 2006, because all payments for NHS dentists are made to the providing-performer dentist (or the corporate body) which holds the contract under which the dentistry is performed. We ask the parties to quantify the extent to which dentists' gross earnings and expenses are double counted in each United Kingdom country, and provide us with this information for our next review.

[7] *Dental earnings and expenses, England and Wales, 2009/10*. NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-england-and-wales-2009-10

[8] *Dental earnings and expenses, Northern Ireland, 2009/10*. NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-northern-ireland-2009-10

26. For the 2012-13 round, we ask the parties to provide better estimates of the expenses to earnings ratio, and associated formula coefficients, that could be used in our formulae for dentists in each country.

Ron Amy, OBE *(Chairman)*
Lucinda Bolton
Katrina Easterling
John Glennie, OBE
Professor Steve Thompson
Professor Ian Walker
David Williamson

Office of Manpower Economics
27 February 2012

CHAPTER 1: DDRB MONITORING ROUND 2012

Economic and general considerations

Introduction

1.1 The Chief Secretary to the Treasury wrote to the Review Body chairs on 20 June 2011 setting out the government's approach to public sector pay for the 2012-13 round and said that the case for pay restraint remained strong. The letter confirmed the approach announced in the June 2010 Budget for a two-year public sector pay freeze from 2011-12 for public sector workforces earning in excess of £21,000 per annum on a full-time equivalent basis ("the pay freeze"). The Health Ministers for England, Wales and Scotland subsequently wrote to us stating that due to the pay freeze, we were not required to make recommendations on the remuneration of doctors and dentists, including independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs), in the United Kingdom for 2012-13. The Minister for Health, Social Services and Public Safety in Northern Ireland had previously written to us in October 2010 with reference to both the 2011-12 and 2012-13 rounds. These letters can all be found at Appendix A. All doctors and dentists have full-time equivalent earnings of more than £21,000 per annum and are therefore subject to the pay freeze.

1.2 In the context of this revised remit, we have continued to monitor recruitment, retention, motivation and other relevant matters. To this end, we invited the parties to submit any information they considered appropriate for us to carry out this role and we make our observations in Chapter 1 of this report.

1.3 In her letter of October 2011, the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy for the Scottish Government sought our recommendations in relation to dental practice expenses of independent contractors in the General Dental Services in Scotland. We make these recommendations in Chapter 2 of this report.

1.4 We have divided this report into two chapters: Chapter 1, on the monitoring round for each of our remit groups; and Chapter 2 on GDPs' expenses in Scotland. The various remit letters are shown in Appendix A. For completeness, we have included in Appendix B the detailed pay scales which have resulted from our previous recommendations. Appendix C contains tables showing the number of doctors and dentists in the NHS. Links to the information and evidence on the parties' websites are in Appendix D. Appendix E covers pay comparability by anchor point. Appendix F contains a list of our previous reports and Appendix G our letter to the United Kingdom Health Ministers on the 2011 monitoring round, which was written in place of a report last year. Finally, there is a glossary of terms used in this report in Appendix H and a list of abbreviations and acronyms in Appendix I.

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

Remit groups

1.6 Our remit groups comprised approximately 202,800 staff in September 2010, a 1.2 per cent increase on the previous year. The breakdown by remit group is in Table 1.1 below.

Table 1.1: DDRB remit groups at September 2010[1] and change since September 2009, United Kingdom

	Staff as at September 2010		Change since September 2009 (%)	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Consultants[2]	43,664	46,134	3.3	2.3
Specialty doctors/associate specialists/ staff grades	10,661	12,659	0.0	2.5
Registrar group	44,303	45,121	1.9	2.4
Foundation house officer 1 and 2	16,938	17,130	–4.3	–2.7
Other staff[3]	2,797	6,257	–6.6	–3.0
Total Hospital and Community Health Services[4]	**118,362**	**126,664**	**1.1**	**1.0**
General medical practitioners[5]	*	47,782	*	0.7
General dental practitioners[6]	*	27,973	*	3.6
Ophthalmic medical practitioners	*	398	*	–3.6
Total[4]	*	**202,817**	*	**1.2**

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

Notes:

* Data not available.

1. Some data are not for September 2010, but are for the closest time period available.
2. The grade of consultant also includes Directors of Public Health.
3. Includes hospital practitioners, clinical assistants, and public health and community medical and dental staff not elsewhere specified.
4. Total is not exactly the sum of the categories as some doctors carry out more than one role.
5. Includes independent contractor general medical practitioners, salaried general medical practitioners and general medical practitioner registrars.
6. Includes principal general dental practitioners, assistants and vocational practitioners, general dental practitioners working in Personal Dental Services, and salaried dentists working in General Dental Services.

Devolved countries

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

The information and evidence

1.8 We received written information in support of our monitoring round from: the Health Departments, comprising the Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates (SGHSCD) and the DHSSPSNI; NHS Employers; the Advisory Committee on Clinical Excellence Awards (ACCEA); the Scottish Advisory Committee on Distinction Awards (SACDA); the British Medical Association (BMA); and the British Dental Association (BDA). We received written evidence on GDPs' expenses in Scotland from the SGHSCD and the BDA's Scottish Dental Practice Committee. The parties provided supplementary written evidence in response to other parties' evidence and to our requests. In addition we heard oral evidence from the Chief Dental Officer for Scotland, the SGHSCD and the BDA's Scottish

Dental Practice Committee. We are grateful to the parties for their time and effort in preparing and presenting information to us and for the speed with which they have responded to our questions.

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

Visits

1.10 Each year we carry out a series of visits, usually over the early summer, although in 2011 the visit programme was carried out during the autumn. We visited acute trusts, health boards and primary care organisations in the four countries across the United Kingdom to meet representatives of both management and of the doctors and dentists to whom our recommendations apply, and were pleased that our visits attracted a large number of attendees. 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.

1.11 Common themes across the visits included: the perceived difficulty in attracting quality applicants to posts in general medical and dental practices, and in attracting doctors and dentists to become partners, because of the costs and increased responsibility; remuneration for GMPs involved in commissioning work; the constraints that the Working Time Directive has placed on junior doctors' time for training; pressures on consultants to reduce the number of Supporting Professional Activities in their job plans; and concerns over the current review of pensions and changes to pensions' taxation.

Role of the Review Body

1.12 The BMA wished to place on record that it continued to disagree with the governments' instructions to us in relation to the pay freeze and that it believed it was inappropriate for the Review Body process to be restricted in this manner. It said that the governments had, by their actions, also prevented consideration of any structural issues surrounding the pay of doctors and dentists, as well as the practice expenses of GMPs, for which it noted we had devised an explicit formula. The BMA remained concerned about the relative position of doctors' income and the general erosion of contract values due to high levels of inflation and low or zero awards.

1.13 The BDA also noted its disappointment at the governments' decisions neither to require us to report on contract values for two years nor to address the issue of expenses for dentists in Northern Ireland.

1.14 NHS Employers, the BMA and the BDA all emphasised the significance of the independent Review Body process to them. NHS Employers said that it continued to value our expert and independent view on remuneration issues during the pay freeze. The BMA considered the Review Body process to be the most appropriate mechanism for determining the pay of our remit groups. It also said that it expected us to consider and comment on its evidence about the real impact of the recent low pay awards and pay freeze on doctors this year and that it would provide more extensive evidence next year. The BDA saw the Review Body process as an important source of stability for the profession and hoped that the governments would seek recommendations from us next year.

1.15 Our terms of reference require us to have regard to a range of factors, including the need to recruit, retain and motivate doctors and dentists. Although pay comparability is not explicit in our remit, we consider it important and have addressed this issue later in this chapter and in Appendix E. We will continue to monitor pay comparability as we move through and beyond the pay freeze, particularly as it impacts on recruitment and retention, and ask the parties to update us for our next review.

Last year's monitoring round

1.16 Last year, we did not prepare a formal report as we were given a revised remit that did not require us to make any formal recommendations. Instead, we wrote a letter to the four United Kingdom Health Ministers, in which we reported on recruitment, retention, motivation and other relevant matters as outlined in our terms of reference.[1] The letter can be found at Appendix G to this report. The Annex to that letter, containing a supporting paper which looked at economic and general considerations as well as each of our remit groups is available, with the letter, on the Office of Manpower Economics website.[2]

Recruitment and retention

1.17 Figure 1.1 shows that the total number of medical and dental staff in the United Kingdom has increased each year between 2006 and 2010.[3] We note from NHS Employers that the number of female doctors in England has risen by 74 per cent since 1999, to just over 43,000 in 2009, and that male numbers grew by 32 per cent over the same period. We understand that females now account for around 43 per cent of all doctors in England. While we note that headcount numbers have increased, as recorded in Table 1.1, we do not have full-time equivalent data for GMPs,[4] GDPs and ophthalmic medical practitioners (OMPs). We ask the Health Departments to take steps to ensure that the NHS Information Centre and its equivalents provide data on full-time equivalents in addition to headcount data for all our remit groups: this is important given the increase in part-time working, which is likely to be a particular issue with the increase in the number of female doctors.

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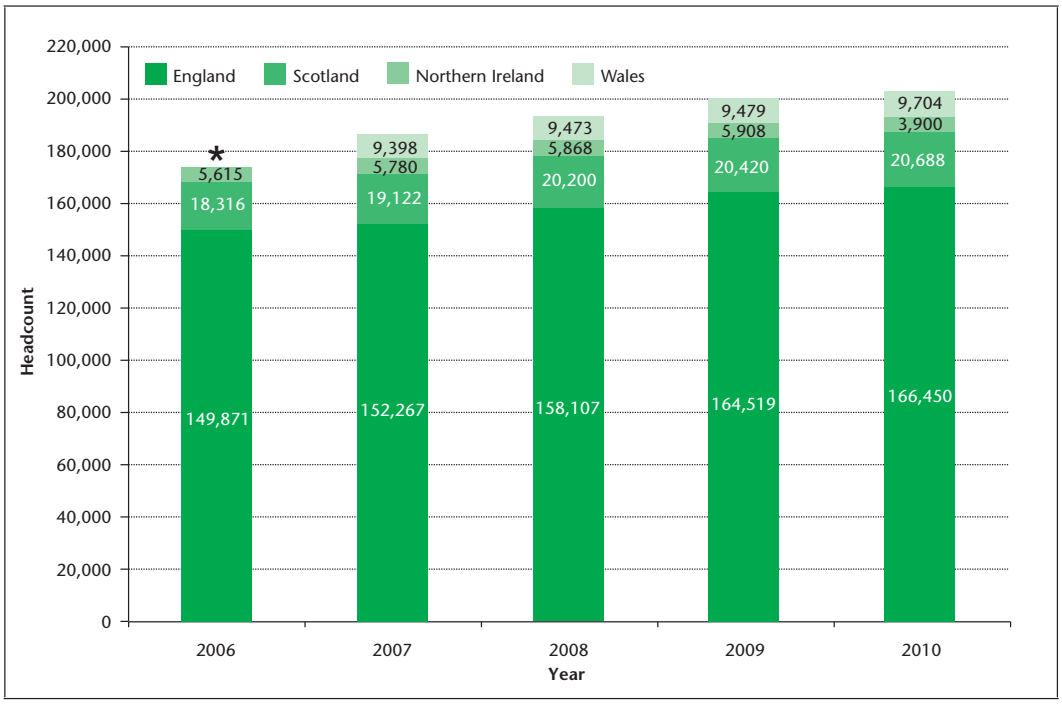
1 Our terms of reference can be found on page iii at the beginning of this report.

2 Review Body on Doctors' and Dentists' Remuneration. *DDRB monitoring round – 2011*. Letter to Secretary of State for Health, Department of Health; Minister for Health and Social Services, Welsh Assembly Government; Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Scottish Government; and Minister for Health, Social Services and Public Safety, Northern Ireland Executive. 7 February 2011. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

3 Because of changes made in 2010 to the way in which headcount staff in Hospital and Community Health Services (HCHS) are counted in England – effectively removing instances of double counting – comparisons between 2009 and 2010 data should be made with caution. This does not affect full-time equivalent data or primary care, or other United Kingdom countries. The overall effect of removing double counting is estimated to reduce the published total HCHS medical and dental headcount by around 1.5 per cent in 2009, though the impact is likely to be different for individual grades and has not been published in this form.

4 Full-time equivalent data for GMPs are produced for England and Wales each year, and are based on the weekly number of sessions worked by GMPs; a GMP working nine sessions per week is deemed to be working full-time. Data were collected in Scotland in 2009, based on a one-off survey of practices, but in this country a GMP working eight sessions per week was deemed to be working full-time. Data are not collected on this basis in Northern Ireland. The number of hours in a session can vary between practices, and some GMPs additionally work outside their formal clinical sessions: defining full-time equivalents in terms of the number of sessions can therefore produce underestimates. There is no clearly defined concept of what constitutes the full-time commitment of GMPs.

Figure 1.1: Total number of medical and dental staff, 2006 – 2010, United Kingdom



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

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

1.18 Taken together, the increase in medical and dental staff and the current available vacancy rates for the different countries of the United Kingdom do not give us any real cause for concern on recruitment and retention grounds, although the Health Departments reported United Kingdom-wide difficulties in recruiting into certain specialties over the last year, including: accident and emergency, anaesthetics, obstetrics and gynaecology, paediatrics and psychiatry; and some difficulty in recruiting into general practice in Scotland. The BDA raised its concern that in Wales, Scotland and Northern Ireland, there were difficulties in recruiting dentists for NHS work. In addition, the BMA told us that while doctors had traditionally enjoyed strong job security in the NHS, it had begun to receive reports of employers consulting on staff redundancies, some of which involved doctors.

1.19 However, it is difficult to make comparisons as the NHS Information Centre has suspended the collection and publication of Hospital and Community Health Services (HCHS) and GMP vacancy figures in England for 2011. This worries us as the loss of the vacancy surveys, with no immediate alternative source of data, has a detrimental impact on the evidence base to enable us to assess changes in recruitment and retention, both important elements of our remit. We are also not convinced that alternative data from the new NHS Jobs website will be available for the autumn 2012 evidence; the first set of useable data, therefore, may only be available for the autumn 2013 review, meaning a gap of three years in vacancy data. These concerns have also been stated in our response to the *Fundamental Review of Data Returns*.[5] We ask the Health Departments to take steps to ensure that the NHS Information Centre and its equivalents provide up-to-date vacancy information on HCHS staff and GMPs, as this is an important measure in our ongoing analysis of the workforce position.

[5] *Fundamental review of data returns: a consultation on the recommendations of the review.* Department of Health, 30 August 2011. Available from: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_129725

Motivation

1.20 As last year, the major surveys of NHS HCHS staff and from the BMA did not give us any real cause for concern regarding motivation. We note that the *NHS staff survey* for 2010[6] found that of all grades of staff, consultants were the most satisfied with their level of pay. However, the BDA survey provided evidence of a continuing decline in morale among GDPs, particularly those with a high NHS commitment. We are conscious that while these surveys took place after the announcement of the pay freeze, they predated the first year of the pay freeze taking effect, the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom. We will be monitoring closely the impact of these changes on the motivation of our remit groups and ask the parties to update us on this issue for our next review.

Workforce planning

1.21 The SGHSCD provided further information about the move towards a health service predominantly delivered by trained doctors, where the reliance on doctors in training for front-line service delivery was reduced. It told us that a trained doctor service would consist of a "mixed economy" of consultants, specialty doctors, other existing specialty doctors and associate specialists (SAS) grades and doctors in training, with a role for other healthcare professionals to make the most of their potential. It expected to deliver this change over the period 2012 – 2017, when significant numbers of postgraduate medical trainees would achieve their Certificates of Completion of Training (CCT). We look forward to hearing more about this for our next review.

General economic context

1.22 Economic growth was modest in 2011, at just 0.9 per cent in the year, and well below the forecast made when we last reported. The economy is forecast to grow by just 0.7 per cent in 2012.[7] Employment levels rose in the first half of 2011, but fell in the second half, to remain broadly unchanged on the year. Unemployment, meanwhile, rose by 179,000 in the year to December 2011. The employment level is expected to remain broadly stable in 2012. Inflation remained relatively high throughout 2011, at over 5 per cent on the Retail Prices Index (RPI), then fell back in January 2012 to 3.9 per cent on the RPI, and 4.0 per cent on the RPI excluding mortgage interest payments (RPIX), and 3.6 per cent on the Consumer Prices Index (CPI). Inflation is forecast to continue to fall during 2012 and reach the Monetary Policy Committee's 2 per cent CPI target by the end of the year. Pay settlements across the economy centred on 2.5 per cent throughout 2011 (excluding the public sector), and are expected to remain at similar levels in 2012. Average earnings growth is around 2 per cent in the private sector and 1.5 per cent in the public sector.

Affordability

1.23 As we are not required to make any recommendations for the uplift of doctors' and dentists' pay this year, we can only note the information on affordability. We recognise that affordability continues to dominate the thinking of many employers. As last year, NHS Employers told us that any increase in pay costs would be unaffordable unless matched by commensurate increases in the tariff. They told us that in a NHS

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6 *2010 NHS staff survey.* Care Quality Commission, March 2011. Available from: http://webarchive.nationalarchives.gov.uk/20110718105843/http:/www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2010.cfm

7 Office for Budget Responsibility. *Economic and Fiscal Outlook*. Cm 8218. TSO, November 2011. Available from: http://cdn.budgetresponsibility.independent.gov.uk/Autumn2011EFO_web_version138469072346.pdf

Confederation members' survey carried out in spring 2011, 42 per cent of members said the financial position facing the organisation was the worst they had ever experienced and 47 per cent said it was very serious, but not the worst experienced.

1.24 In their evidence to us, the Department of Health reported that the government's top priority was the reduction of an unsustainable structural deficit, and that this strategy necessarily involved tight control of public spending, including pay, which represented around 50 per cent of Departmental resource budgets in England. It said that although the NHS in England had received a better spending review settlement than many other parts of the public sector, including a guarantee of real terms increases in NHS funding in each year of this parliament, NHS resources would be under considerable pressure. It estimated that the NHS would need to deliver annual quality and productivity (QIPP) savings of up to £20 billion by 2014-15 to cope with demographic increases in demand, fund the increased cost of non-pay inputs such as drugs, and meet the cost of introducing new medical technologies and procedures. It believed that NHS pay must also be seen within the wider context of the current economic situation and could not be immune from the serious economic challenges faced. Similarly, the SGHSCD told us that NHSScotland would still face considerable budget pressures and the DHSSPSNI reported the very tight public expenditure position in Northern Ireland.

1.25 The Department of Health pointed out that the funding available to the NHS was fixed and extremely tight compared with the recent past. It said that increases in pay would reduce the funds available for service developments and activity growth and reduce the derived demand for staff. NHS Employers noted that incremental progression in the pay structures each year continued to make a noticeable contribution to earnings growth and told us that employers believed that earnings should be frozen.

Efficiency savings

1.26 We note from the Department of Health that work has already begun on releasing up to £20 billion of efficiency savings needed by the end of the Spending Review period (2014-15) and that these savings will be reinvested in front-line services. However, NHS Employers told us that these cost pressures made employers increasingly concerned that the present national pay and conditions arrangements were not affordable. They believed that restraining pay bill costs was essential to minimise potential job losses and protect services. They also said that the majority of provider organisations were facing cost reduction targets in excess of the 4 per cent efficiency saving assumed in the 2011-12 tariff, with some NHS foundation trusts setting targets of as much as 9 per cent.

1.27 The BDA told us that the application to dental contract values of continued efficiency savings in the NHS was a source of ongoing disappointment and anger to the profession. It said that as this followed only partial implementations of previous DDRB recommendations on contract value increases, many dentists had been facing continuous pay cuts. Similarly, the BMA also expressed concern that the failure to uplift the contract to meet rising expenses would result in a personal pay cut for GMPs.

1.28 We note that, yet again, efficiency savings have been applied to our formulae for the contract uplifts for GMPs and GDPs. We reiterate our general view that while requiring cash-releasing efficiency savings may be an appropriate way to achieve cost discipline in a government department or agency that is not subject to market forces, GMPs and GDPs operate small businesses in competitive markets and have an incentive to achieve whatever efficiency savings are possible. We therefore believe that it is both unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs as the impact of efficiency savings will become apparent, albeit with a time lag, in the data used in the formulae. If the Health Departments continue to think it appropriate

to impose a requirement on independent contractor GMPs and GDPs to make efficiency savings, then we believe that any such requirement should be a contractual matter, rather than abating our recommended increases.

Pay comparability

1.29 The BMA told us that it remained concerned about the relative position of doctors' income and what it saw as the general erosion of contract values due to high levels of inflation and low/zero awards. It calculated that since 2005-06, the real basic pay contract erosion for GMPs was 26.6 per cent and for consultants 15.9 per cent; since 2009-10, it believed that investment in the SAS contracts had eroded by 11.5 per cent; and that the erosion of contract investment for junior doctors since 2000-01 was 10.9 per cent. With this in mind, it asked us to consider the impact of the accumulation of all the changes to pension schemes in assessing the relative position of doctors' pay not only this year during the pay freeze, but particularly next year when the pay freeze is due to end and it believed that the relative position of doctors' pay would need to be urgently addressed. It also asked us to update our work on pay comparators in light of the pay freeze for doctors.

1.30 Each year our secretariat provides us with an assessment of the pay position of our remit groups relative to other groups that could be considered comparator professions, and against recent trends in general pay and price inflation measures. We look at both pay levels and movements. The specific comparator professions that we have been using are: legal, tax and accounting, actuarial and pharmaceutical.[8] In this chapter we make some general observations about the remuneration of doctors and dentists relative to their comparators, and in the context of the wider United Kingdom economy. Every three years we publish our more detailed analyses of pay comparability at each anchor point and these can be found at Appendix E.

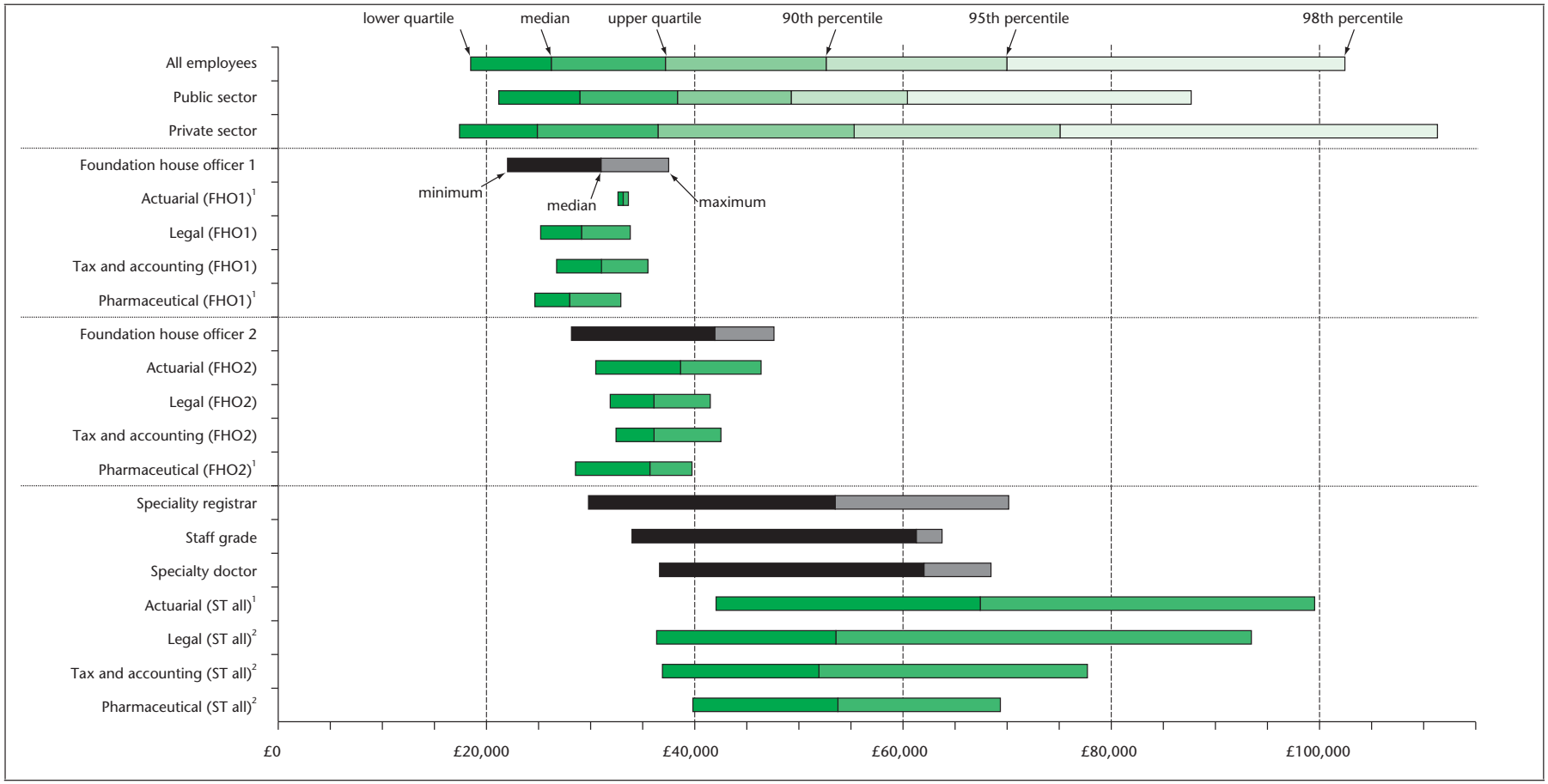
Pay levels

1.31 Figure 1.2 compares the total earnings ranges of doctors in training, specialty doctors and staff grades with their comparator professions. This shows that although basic pay for foundation house officers in year one is below the national median, actual median earnings for all training grades is above both the national public and private sector medians, while the maximum earnings of specialty registrars, staff grade doctors and specialty doctors are close to the 95th percentile for all full-time employees (£70,000). Minimum basic pay for each training grade and staff grade is below the lower quartile for most comparator groups, but median pay is generally in line with or higher than the comparator medians at all levels. The total earnings ranges of associate specialists, consultants, GMPs and GDPs are compared with comparator professions in Figure 1.3.

1.32 Although there are some slight differences between the various grades, the median total earnings of all categories in our remit group (except foundation house officers) are within the top decile (£52,643) when compared with all full-time employees in the wider economy.

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

Figure 1.2: Total earnings ranges of training grades, 2011, compared with the national pay distribution and other professional groups, full-time rates

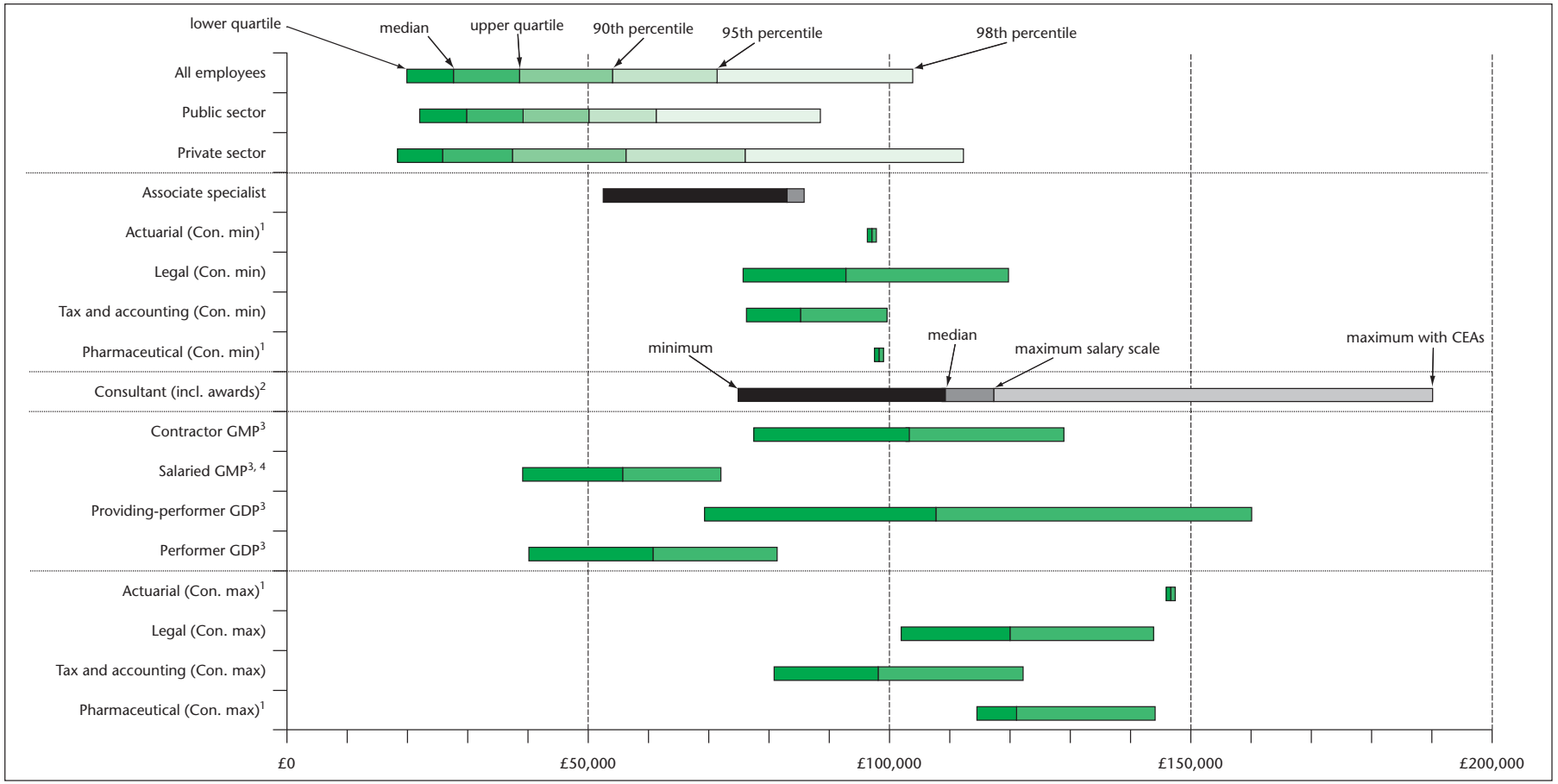


Sources: The Office for National Statistics, NHS Information Centre, NHS Employers and Hay Group.

[1] A range is not always available for actuarial posts. A notional inter-quartile range of £1,000 is used in order to illustrate the median.

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

Figure 1.3: Total earnings ranges of consultants and equivalent grades, 2011, compared with the national pay distribution and other professional groups, full-time rates



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

[1] A range is not always available for actuarial and pharmaceutical posts. A notional inter-quartile range of £1,500 is used in order to illustrate the median.

[2] The consultant range includes Clinical Excellence Awards (CEAs) (over 60 per cent of consultants received a CEA and a level 1 local award is considered the median for all consultants); the figures for 'maximum pay scale' and 'maximum with CEAs' also include the average of 1.4 additional Programmed Activities.

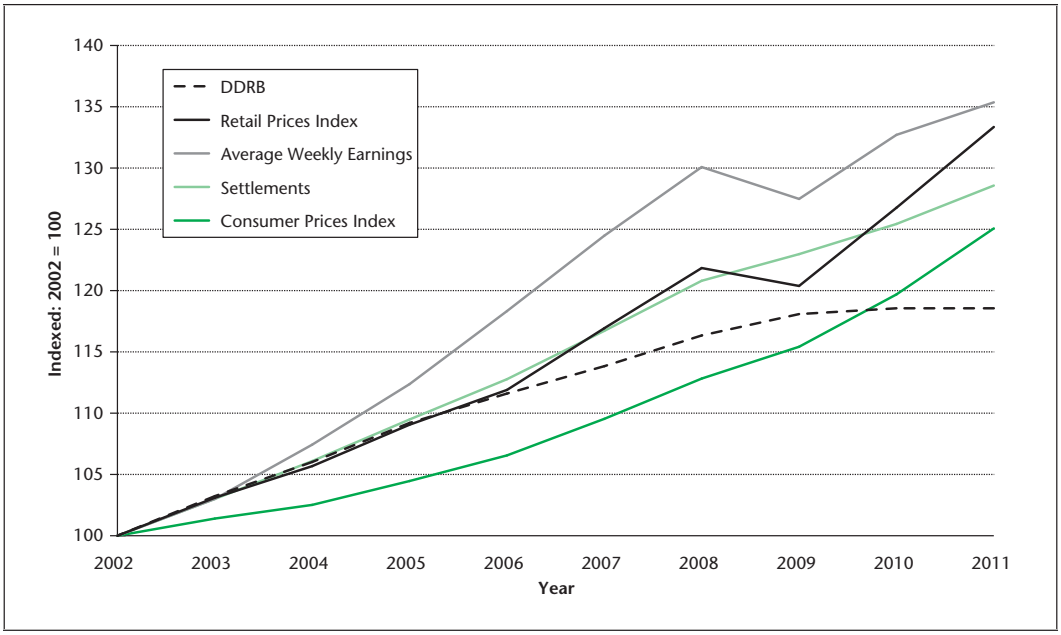
[3] Estimated median incomes (before tax) for 2009-10 for all (both full-time and part-time) GMPs and GDPs (the latest available data).

[4] Upper and lower quartiles estimated by the Office of Manpower Economics using distributional data.

Pay movements

1.33 As in previous years, we have also looked at how our basic awards in recent times have compared with settlements and earnings in the wider economy, and with the main measures of inflation. Figure 1.4 shows our main award compared with April movements in the RPI, CPI, Average Weekly Earnings and median pay settlements for the whole economy. However, our recommendations are not linked directly to any of these indices. Figure 1.4 shows that our main awards at the start of the last decade were well within the range of earnings and price indices for the relevant periods, but tended to be lower towards the end of the decade, so that by 2008 our award was no longer keeping pace with other indicators apart from the CPI. In 2009, the RPI was negative, and growth in Average Weekly Earnings also reversed, but our award remained below the Incomes Data Services whole-economy median for pay settlements. In 2010, the cumulative effect of our awards since 2002 was overtaken by the CPI, and is now lower than all these indicators. Strong price inflation in 2011 and a return to consistent growth in earnings and settlements, while our remit group was subject to a pay freeze, has widened the gap.

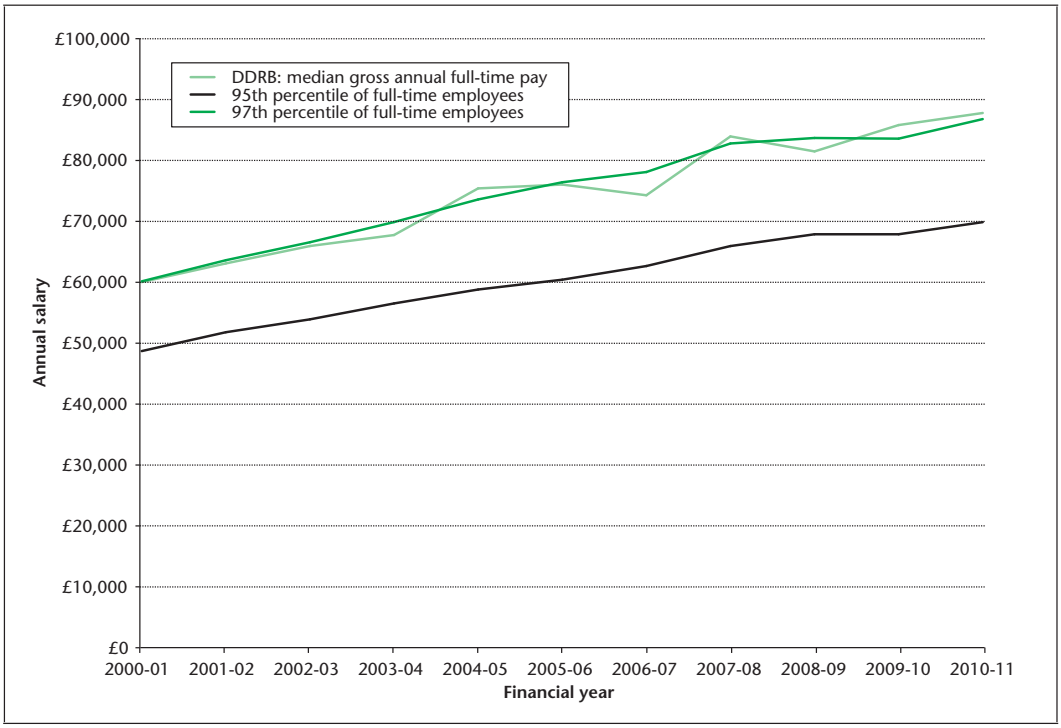
Figure 1.4: DDRB main award compared with April movements in the Retail Prices Index, Consumer Prices Index, Average Weekly Earnings and median (whole economy) settlements, 2002 – 2011



Sources: Office for National Statistics, Incomes Data Services and Office of Manpower Economics.

1.34 However, we have also looked at how the earnings of our remit groups have evolved over time. Movements in their earnings are influenced by a number of factors including the basic award, overtime payments, incremental progression, performance payments and pay reform. As shown in Figure 1.5, the median gross annual full-time pay for employed doctors and dentists has remained around the 97th percentile for all full-time employees.

Figure 1.5: Movements in earnings from the Annual Survey of Hours and Earnings, 2000-01 to 2010-11



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 contractor GMPs and GDPs).

Pensions

1.35 The Department of Health and NHS Employers stressed that any changes in pensions, including the proposed increase in contributions from 2012-13, did not justify upward pressure on pay. They believed that the general NHS total reward package for hospital doctors was very competitive, including the pension element, and it was a valuable retention and recruitment tool. The Department of Health told us that for doctors in training the value of employers' current pension contributions, in addition to annual, study and sick leave provisions above statutory requirements, added over 20 per cent to the value of the reward package. They were worth around £13,000 to a doctor in the second year of training, and around £17,000 to a doctor five years into training. For consultants, the value of these benefits over statutory provision along with employer pensions contributions was over £26,000 and represented nearly 20 per cent of the value of the reward package.

1.36 On the other hand, the BMA pointed out that since the renegotiation of the NHS Pension Scheme in 2008, doctors had already been faced with higher pension contributions. It said that the value of doctors' pensions had therefore been recently reduced and that there were likely to be further attacks on doctors' pensions over the coming years.

1.37 Although opposed to the increases to employee contribution rates being introduced from April 2012, the SGHSCD said that it had reluctantly decided to implement the increases as the United Kingdom government would reduce the Scottish Budget by an equal amount if the increases were not introduced.

1.38 We said last year, 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[9] and March 2011.[10] However, as the proposed changes to the NHS Pension Scheme are still under discussion, we do not think that it is appropriate for us to make any comment at this stage. We ask the parties to update us on these issues for our next review.

Looking forward

1.39 The Chancellor of the Exchequer wrote to us in December 2011.[11] He said that while the public sector pay freeze would end after 2012-13, in order to support fiscal consolidation, for each of the following two years the government would seek public sector pay awards that averaged 1 per cent. The letter stated that doctors and dentists were currently excluded from the work on how pay could be made more market facing in local areas, work which is at present being addressed by the NHS Pay Review Body and several other Review Bodies.

1.40 In our next report, we expect to return to making recommendations on pay and other allowances for the doctors and dentists within our remit group. We ask the parties to update us on these issues for our next review, and to address all elements of our remit, including: recruitment, retention, motivation, affordability, economic evidence, 'patients at the heart' and the legal obligations of the NHS. Our secretariat will be discussing, in detail with the parties, our evidence requirements for the next round.

General medical practitioners

Recruitment and retention

1.41 The number of GMPs in the United Kingdom increased by 0.7 per cent between September 2009 and September 2010 (Figure 1.6). The increase in the overall GMP population between 2006 and 2010 has mainly been due to recent increases in the number of GMP specialty trainees, and GMP "others" (which includes salaried GMPs, and GMPs who work flexible arrangements): by contrast, the number of independent contractors in Great Britain[12] decreased by 0.4 per cent between September 2009 and September 2010.

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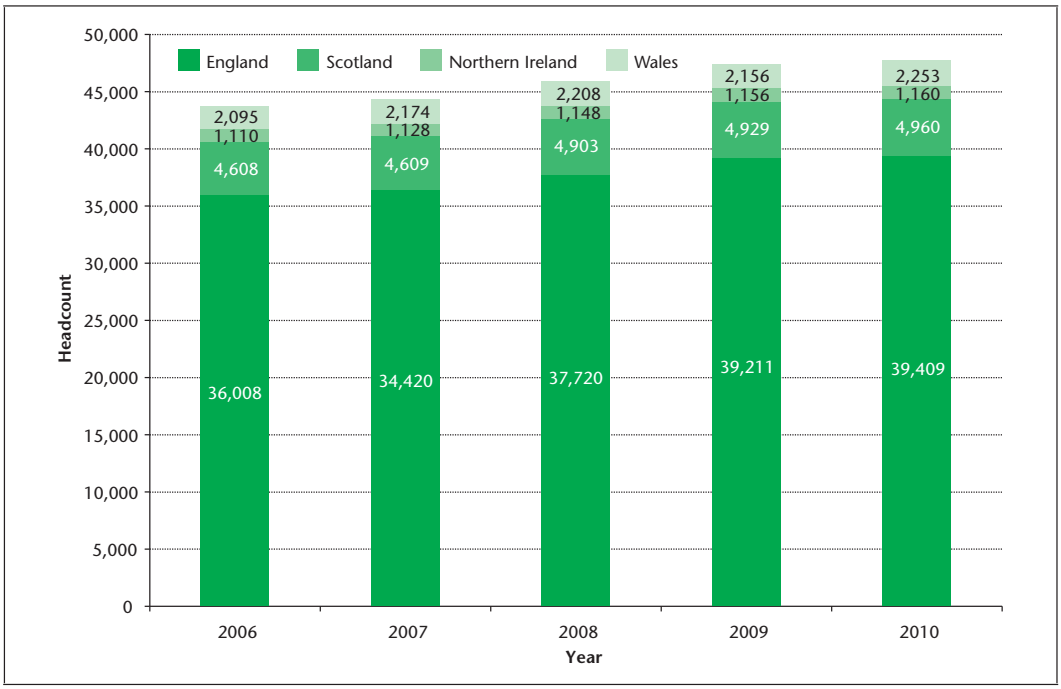
9 Independent Public Service Pensions Commission. *Interim report.* 7 October 2010. Available from: http://www.hm-treasury.gov.uk/d/hutton_pensionsinterim_071010.pdf

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

11 Chancellor of the Exchequer. Letter to the DDRB chairman. 7 December 2011. Available from: http://www.hm-treasury.gov.uk/d/chx_letter_doctors_dentist_pay_review_body_071211.pdf

12 A breakdown of GMPs is not available in Northern Ireland.

Figure 1.6: Number of general medical practitioners, 2006 – 2010, United Kingdom



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

Motivation

1.42 The BMA said that its *survey of national GP opinion* in 2011 found that overall satisfaction amongst GMP contractors had not changed since 2010. The survey showed that around half of GMPs considered their earnings to be fair. However, for salaried GMPs, the level of satisfaction with their remuneration/earnings and their satisfaction with the amount of flexibility in their working hours/arrangements had decreased in the last year; satisfaction with their remuneration/earnings was slightly below that for independent contractor GMPs.

1.43 The survey found that GMPs' satisfaction with different elements of their job had changed since 2010. Satisfaction had decreased in relation to opportunities to pursue special interests, hours of work and workload, earnings, and the amount of flexibility in their working hours. However, levels of satisfaction among independent contractor GMPs had increased in relation to their colleagues and fellow workers, ability to drive improvements in patient care and their relationship with NHS management.

1.44 We note the results of the BMA's survey with interest as we are conscious that while this survey took place after the announcement of the pay freeze, it predated the first year of the pay freeze taking effect, the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom. We will be monitoring closely the impact of these changes on the motivation of our remit groups and ask the parties to update us on this issue for our next review.

General medical practitioners' earnings and expenses

1.45 We are not required to make any recommendations on the pay of independent contractor GMPs during the pay freeze. We were told by the Health Departments that they would make decisions on the contract uplifts (if any) that would be applied over 2011-12 and 2012-13 to achieve a pay freeze, following discussions with the BMA. In reaching decisions, the Health Departments said they would take into account the formula used for expenses, together with assumptions on the efficiency gains that they thought it was reasonable for practices to achieve.

1.46 The Health Departments, NHS Employers and the BMA reported on the outcome of the General Medical Services (GMS) contract negotiations agreement for 2012-13.[13] The overall value of GMS contract payments would be increased by 0.5 per cent, making a contribution towards the cost of increased expenses, including pay increases for employed staff on a full-time equivalent salary of less than £21,000. The uplift would be delivered through an increase in the value of a Quality and Outcomes Framework (QOF) point from £127.29 to £130.51. In line with the pay freeze, there would be no uplift to GMPs' net pay in 2012-13.

1.47 The Department of Health told us that it had estimated that GMPs in the United Kingdom would need to deliver efficiencies of around 4 per cent and that this was in line with efficiencies sought from other parts of the NHS. It said that these efficiencies would be achieved through no uplift in pay and a lower than inflation uplift in expenses, plus releasing resources from lower value areas within contracted services to reinvest in new higher value clinical activity. We have already given our views on the requirement to make efficiency savings at paragraph 1.28.

1.48 Our analysis of GMP income and expenses is based on averages, which masks a significant variation in practice income. Figures from the NHS Information Centre showed that in the United Kingdom in 2009-10, average taxable income for GMPs was £105,700, with average expenses of £156,900. The expenses to earnings ratio was 59.8 per cent, close to the 60 per cent assumed by us in the uplift formula in our *Thirty-Ninth Report*.[14] In 2009-10, average taxable income increased by 0.4 per cent, reversing the trend of decreases in the previous three years; average expenses increased at the faster rate of 2.4 per cent.

1.49 We note from Table 1.2 that GMPs' average taxable income and expenses vary quite considerably by United Kingdom country, being highest in England at £109,400 and £168,700 respectively; the expenses to earnings ratio was also highest at 60.6 per cent. Average taxable income in Scotland, Wales and Northern Ireland were at similar levels, between £89,500 and £93,500. Average expenses in Wales were higher than in Scotland or Northern Ireland; consequently, the expenses to earnings ratio in Wales was higher (59 per cent, compared with 53.4 per cent in Scotland and 51.7 per cent in Northern Ireland). Within England, average income was highest in the East Midlands, West Midlands, East of England, London and South East Coast (all between £112,000 and £116,000). Average income was lowest in the South West (£94,800).

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13 Department of Health. *2012/13 GMS contract negotiations.* Letter dated 2 November 2011. Available from: http://www.dh.gov.uk/health/2011/11/gms-contract-negotiations/

14 Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report.* Cm 7837. TSO, 2010. Paragraphs 3.21-3.23. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

Table 1.2: General medical practitioners' average earnings, expenses and income by United Kingdom country, 2008-09 to 2009-10

Country	Year	Gross Earnings	Total Expenses	Income Before Tax	Expenses to Earnings Ratio
England	2008-09	£274,100	£164,500	£109,600	60.0
	2009-10	£278,100	£168,700	£109,400	60.6
	% change	1.5	2.5	–0.1	0.6pp
Scotland	2008-09	£188,500	£102,100	£86,500	54.1
	2009-10	£192,200	£102,700	£89,500	53.4
	% change	1.9	0.6	3.5	–0.7pp
Wales	2008-09	£221,000	£130,300	£90,700	59.0
	2009-10	£227,700	£134,300	£93,500	59.0
	% change	3.1	3.1	3.1	0.0pp
Northern Ireland	2008-09	£183,700	£94,000	£89,700	51.2
	2009-10	£189,200	£97,800	£91,400	51.7
	% change	3.0	4.1	1.9	0.5pp

pp: percentage point change.
Source: NHS Information Centre using HM Revenue and Customs data.

1.50 The BMA again expressed concern that the failure to uplift the contract to meet rising expenses would result in a personal pay cut for independent contractor GMPs. Using our formula, the BMA had calculated that gross incomes would need to increase by between 0.6 per cent and 1.0 per cent to compensate for increased expenses.

1.51 We note from the Department of Health that as a result of the increase in global sum payments per patient from £64.59 to £64.67 in 2012-13, the number of practices on the minimum practice income guarantee (MPIG) would reduce from 61.4 per cent to 61.0 per cent; the figure for Northern Ireland was 56 per cent. The Department of Health believed that, taken together with the below-inflation increase for expenses, these changes would deliver an estimated efficiency gain of around 3.5 per cent.

Salaried general medical practitioners

1.52 We note from NHS Information Centre data that the average taxable income for salaried GMPs was £58,000 in 2009-10, an increase of 1.2 per cent since 2008-09. Many salaried GMPs work part-time, the average number of hours per week being 23.8 hours in 2006-07. As 2006-07 was the most recent workload survey, we do not know if the average amount of part-time work per week has increased since then.

Clinical Commissioning Groups

1.53 The BMA said that it expected us to consider the changing nature of the medical profession's responsibility for the commissioning and planning of the NHS as a system, and to reflect these new and extended skills and responsibilities in the total remuneration for doctors. Asked whether it had had any discussions with either the Department of Health or NHS Employers about remuneration to recognise commissioning work undertaken by GMPs, the BMA said that no discussions had taken place. It said that it had a strong objection, in principle, to the concept of financial incentives other than those already in place in the GMS contract, particularly if those incentives were linked to any initiative to save money while reducing patient choice or care options. The BMA could not feel confident that the incentives or financial reward associated with commissioning would not adversely affect the doctor-patient relationship until it saw the

full details of these proposals, which would emerge in secondary legislation. It believed that if such payments were eventually introduced, funding should not be from existing GMP remuneration.

1.54 In response to our questions, the Department of Health told us that the proposed contractual requirement for practices to be members of a Clinical Commissioning Group (CCG) did not mean that all GMPs would have to be actively involved in every aspect of commissioning, or the day-to-day running of their CCG. It told us that there would be further discussion with the BMA as to how the requirement to be a member of a CCG would be reflected in GMP contracts. The Department of Health also told us that where an individual GMP took on a defined role in a CCG, over and above their role as a GMP in their practice, the CCG, through its governing body, would need to determine pay arrangements, although it would be required to remain within its overall running costs envelope.

1.55 We are very interested in how the proposed new system of CCGs in England will operate in practice; in particular, what it will mean to be a 'member' of the groups and the effect on income streams for GMPs. We ask the parties to update us on this issue for the next review, including the outcome of the further discussions between the Department of Health and the BMA referred to above.

General medical practitioner trainers' grant

1.56 Last year, we asked the parties to let us know whether or not the initiative arising from the review of the Multi-Professional Education and Training Budget (MPET Review) and the associated review of primary care training funding had resolved the long-running issue of the way that training in general practice is funded.

1.57 We note that the BMA did not raise this issue with us this year. The Department of Health did, however, provide some information. It told us that the GMP trainers' grant was no longer treated at local level as an individual GMP's remuneration. Instead, it was generally treated as a practice income stream, for which the allocation was decided collectively by the practice. Furthermore, the payments reflected that GMP trainers were operating as educational supervisors to GMP specialty trainees, when they were on their HCHS placements, and not just when they were in general practice placements. It continued to believe that the GMP trainers' grant should fall within the scope of the review resulting from *Liberating the NHS: developing the healthcare workforce.*[15] A work stream had been set up to look at the funding arrangements for education and training across all aspects of primary care and it would provide us with details of the impact on the GMP trainers' grant, once the future funding model was confirmed. We ask the parties to update us on this issue for our next review.

[15] *Liberating the NHS: developing the healthcare workforce. A consultation on proposals.* Department of Health, December 2010. Available from: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_122590

Looking forward

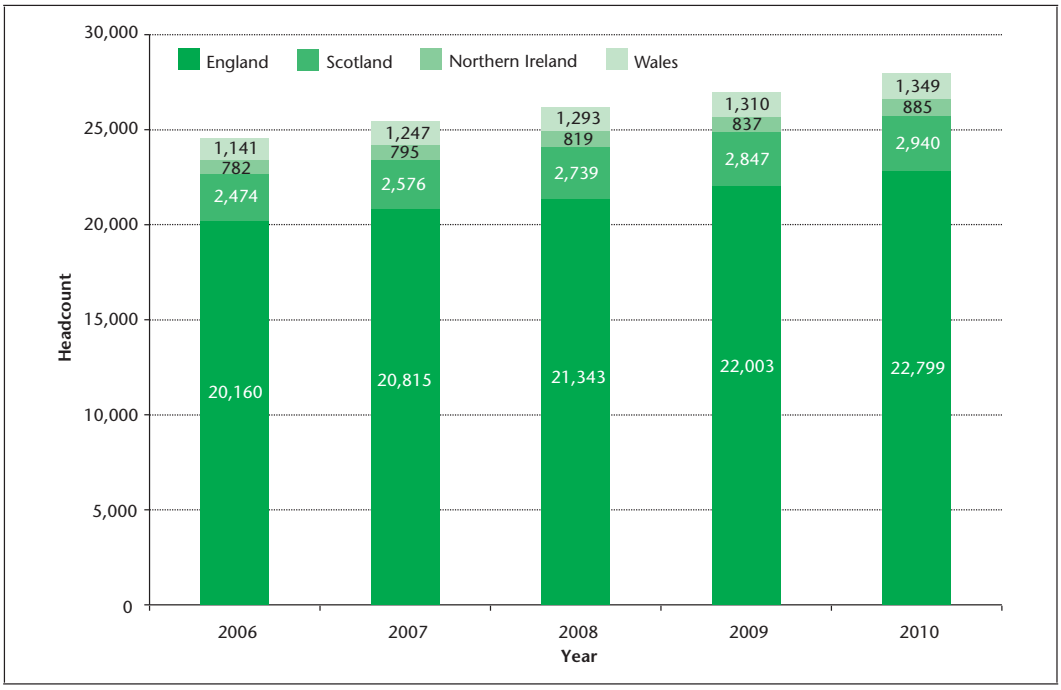
1.58 In our next report, we expect to return to making recommendations on the GMS contract, GMP seniority payments, the salary range for salaried GMPs, the GMP registrar supplement, the GMP trainers' grant and the GMP educators' pay scale. We ask the parties to update us on these issues for our next review.

General dental practitioners

Recruitment, retention and access to dental services

1.59 In September 2010, there were 27,973 GDPs in the United Kingdom, an increase of 3.6 per cent on September 2009 (Figure 1.7). There have been increases in the number of GDPs in all United Kingdom countries between 2006 and 2010.

Figure 1.7: Number of general dental practitioners, 2006 – 2010, United Kingdom



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

1.60 We received contrasting evidence on the recruitment and retention of GDPs from the Health Departments and the BDA. The Department of Health told us that there had been a further increase in the number of dentists working in the NHS in 2010 and that 96 per cent of people seeking an appointment with an NHS dentist in the last six months had been successful. The Welsh Government observed that there were currently more GDPs in the NHS in Wales than at any time in the past: 1,349 in the year ending March 2011 compared with 1,310 the previous year. We heard from the SGHSCD that the total number of dental students in the Scottish dental schools continued to be higher than at any time in the past decade. The DHSSPSNI claimed that Northern Ireland had more dentists per head of population than the other countries of the United Kingdom and that access to NHS dentistry was no longer a problem. Workforce reviews had concluded that Northern Ireland was training sufficient dentists to meet its needs.

1.61 On the other hand, the BDA reported a partial freeze in recruitment, which meant that the majority of practices had not recruited for NHS roles; of those that had, the BDA said that a significant proportion of practices experienced some problems with recruiting dentists into NHS work. The BDA also warned that a higher proportion of dentists than in previous years were planning to retire soon, and expressed concern about the future career prospects of dental students and those in their vocational training year, particularly in relation to increased student debt and increased competition for vocational training places for graduates from English universities.

Motivation and workload

1.62 The BDA reported that the dental *Business Trends*[16] had found that motivation and morale continued to be very low in general dental practice, and more dentists reported their morale as low or very low compared to previous years. It said that the *Practice Owner Focus Group Survey* supported these findings and identified problems with increased regulation. The BDA told us that dentists' low morale was not caused by career choice, but by the business environment, in particular, excessive administration. The dental *Business Trends* found that for dentists in England, Wales and Northern Ireland with an NHS commitment of over 75 per cent, dissatisfaction with pay, levels of autonomy and working hours had increased since 2010, but the greatest source of dissatisfaction was the pressure to achieve targets. In Scotland, pay and pressure to achieve targets were also major sources of dissatisfaction.

1.63 The BDA argued that the amount of time spent on clinical work and administrative work had increased. However, the Department of Health told us that dentists had achieved a reduction in working hours and were working an average of 37.2 hours per week in 2009-10 compared to 39.4 hours in 2000.

1.64 We note that most of these motivation issues are not capable of being addressed through pay, and therefore ask the Health Departments to consider the issues raised by the BDA when developing future policy.

1.65 Last year we noted that the Department of Health hoped to work with the BDA and NHS Employers on a joint survey of motivation and morale for future evidence. It told us that it had not been able to progress work on a joint survey, but hoped to do this for future years, although this would continue to be dependent on the availability of resources. In view of the fact that the BDA's information has again presented motivation as an issue of concern, we urge the parties to give this issue priority and to update us for our next review.

Contractual changes

1.66 We were interested to receive updates on the pilots of the new dental contracts in England and Northern Ireland. The Department of Health reported that, in August 2011, pilots were underway in 70 practices. The intention was to move towards a system based on registration, capitation and quality, focusing on prevention and outcomes. It said that the current contract left dentists on an activity treadmill with no specific rewards for high quality care or prevention, and the profession had welcomed the new approach. The DHSSPSNI told us that negotiations on a new stand-alone contract for Northern Ireland were ongoing. The general outline had been agreed, but remuneration was still under discussion. It said that the pilots would be in three stages, and were expected to start

[16] *Business trends survey 2010.* British Dental Association, 2011. Available from: http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/business-trends.aspx

within the next few months. We are interested to note from the DHSSPSNI that Northern Ireland currently has no method of restricting the number of dentists who choose to set up health service practices, but that the new contract would allow this restriction.

General dental practitioners' earnings and expenses

1.67 We are not required to make any recommendations on the pay of independent contractor GDPs during the pay freeze. We were told that the Health Departments in England, Wales and Northern Ireland would make decisions on any gross uplift for 2011-12 and 2012-13, based on the efficiency assumptions they wished to apply and the evidence on non-staff expenses. For 2011-12, England and Wales increased contract values by 0.5 per cent, and Northern Ireland increased item-of-service fees by 0.5 per cent. At the time of writing, decisions on the uplift for 2012-13 have not been taken. We ask the parties to update us on this issue in due course. For Scotland, our recommendation on dental expenses in Chapter 2 will inform the uplift for 2011-12 and 2012-13.

1.68 The NHS Information Centre published annual statistical reports on *Dental Earnings and Expenses* for 2009-10 in October 2011. The 2009-10 report for England and Wales[17] is the fourth such publication under the new contractual arrangements. Table 1.3 compares average income and expenses for all dentists with 75 per cent or more NHS share in England and Wales. On average, income and expenses both decreased between 2008-09 and 2009-10, although the expenses to earnings ratio was unchanged at 51.5 per cent.

Table 1.3: Average income and expenses for all dentists with 75 per cent or more NHS share, England and Wales, 2006-07 to 2009-10

	Taxable income	All expenses	Staff costs	Non-staff expenses	Expenses to earnings ratio
2006-07	£103,774	£107,324	£30,032	£77,292	50.8%
2007-08	£93,891	£99,589	£30,157	£69,432	51.5%
2008-09	£94,100	£100,000	£29,100	£70,900	51.5%
2009-10	£89,200	£94,900	£28,400	£66,500	51.5%
Percentage change 2008-09 to 2009-10	–5.2%	–5.1%	–2.4%	–6.2%	0.0pp

pp: percentage point change.
Source: NHS Information Centre using HM Revenue and Customs data.

1.69 The Department of Health observed that the latest data continued to be hard to compare with previous years because of changes in the way dentists paid themselves, especially the move towards personal and practice incorporation, which took profits out of the self-employed tax system and moved them into company accounts. However, it said that despite changes, it was clear that dentists continued to receive a good income.

1.70 The 2009-10 report for Scotland[18] is the second in this series. Table 1.4 compares average income and expenses for all dentists with 75 per cent or more NHS share in Scotland. We address the issue of GDPs' expenses in Scotland, in detail, in Chapter 2;

[17] *Dental earnings and expenses, England and Wales, 2009/10.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-england-and-wales-2009-10

[18] *Dental earnings and expenses, Scotland, 2009/10: experimental statistics.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-scotland-2009-10-experimental-statistics

for completeness, we include these figures here. On average, income and expenses both decreased between 2008-09 and 2009-10, while the expenses to earnings ratio reduced to 54.7 per cent.

Table 1.4: Average income and expenses for all dentists with 75 per cent or more NHS share, Scotland, 2008-09 to 2009-10

	Taxable income	All expenses	Staff costs	Non-staff expenses	Expenses to earnings ratio
2008-09	£90,500	£113,900	£40,600	£73,300	55.7%
2009-10	£85,600	£103,100	£37,500	£65,600	54.7%
Percentage change 2008-09 to 2009-10	–5.4%	–9.5%	–7.6%	–10.5%	–1.1pp

pp: percentage point change.
Source: NHS Information Centre using HM Revenue and Customs data.

1.71 The 2009-10 report for Northern Ireland[19] is the third in this series. Gross earnings figures for GDPs in Northern Ireland are provided by Health Service share, though a different definition is used to that for England and Wales: the percentage of gross earnings received from NHS work is used, a measure of money rather than time. These data were not published for the 2008-09 report due to uncertainty around how Health Service earnings were recorded, though following a consultation on this issue, data for 2008-09 and 2009-10 are provided in the latest report. Table 1.5 shows average income and expenses for all dentists with 75 per cent or more Health Service share in Northern Ireland. On average, income showed a slight decrease and expenses increased between 2008-09 and 2009-10; the expenses to earnings ratio increased to 41.3 per cent.

Table 1.5: Average income and expenses for all dentists whose Health Service earnings accounted for 75 per cent or more of their gross earnings, Northern Ireland, 2007-08 to 2009-10

	Taxable income	All expenses	Staff costs[20]	Non-staff expenses	Expenses to earnings ratio
2007-08	£65,253	£40,160	£7,593	£32,567	38.1%
2008-09	£67,900	£43,200	*	*	38.9%
2009-10	£66,400	£46,700	£8,500	£38,200	41.3%
Percentage change 2008-09 to 2009-10	–2.2%	8.1%	*	*	2.4pp

pp: percentage point change.
* 2008-09 data have not been reported in enough detail to enable analysis of expenses for dentists with 75 per cent or more Health Service share.
Source: NHS Information Centre using HM Revenue and Customs data.

19 *Dental earnings and expenses, Northern Ireland, 2009/10.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-northern-ireland-2009-10

20 Figures for Northern Ireland are not directly comparable to those for other countries because of differing contracts. In addition, associates – who tend to have low staff costs on average – form the majority of dentists whose Health Service earnings account for 75 per cent or more of their gross earnings.

Looking forward

1.72 Our examination of GDPs' expenses in Scotland has brought to light the issue of the double counting of gross earnings and expenses, and we have addressed this in depth in Chapter 2. Double counting can occur when dentistry is performed by an associate[21] working in a principal's[22] practice: where payments are made to the principal, some of that payment will be passed on to the associate. On these individuals' tax returns, the same sum of money can be declared as gross earnings by both the principal and associate, and also as an expense by the principal. When the data are aggregated, estimates of gross earnings and expenses are inflated by this double counting, though taxable income is not affected. We believe that similar issues of double counting apply in England, Wales and Northern Ireland. The issue of double counting of dentists' gross earnings and expenses across the United Kingdom means that estimates of the expenses to earnings ratio are artificially inflated. This has the potential to distort the outcomes of our formulae for uplifting dentists' contract values and item-of-service fees.

1.73 To ensure greater accuracy of the formula that we use when making recommendations on the uplift to GDPs' contract values, we consider that for recommendations in future years it will be necessary to make a fresh examination of the formula and the way in which it is applied to the different countries of the United Kingdom. In Chapter 2 we set out our information requirements, and in particular ask the parties to try and quantify the extent of double counting for dental expenses in England, Wales, Scotland and Northern Ireland for our next review.

1.74 In our next report, we expect to return to making recommendations on dental contracts and fee scales. We ask the parties to update us on these issues for our next review.

Salaried dentists

Recruitment and retention

1.75 There are approximately 1,400 salaried dentists in England, 152 in Wales, 541 in Scotland and 87 in Northern Ireland. This year, the parties have again submitted conflicting evidence on recruitment. The BDA evidence drew on a Freedom of Information request that showed that of 89 advertised posts in England, a third were not filled; while the Department of Health referred to the 2010 NHS vacancies survey that showed that vacancies of three months or more at March 2010 accounted for just 0.1 per cent of the workforce. This disparity reinforces our comments earlier in this chapter about the importance of the Health Departments ensuring that the NHS Information Centre and its equivalents provide up-to-date vacancy information, which we view as an important measure in our ongoing analysis of the workforce position.

Motivation and workload

1.76 The BDA referred to its survey of dentists working within the salaried primary dental care services in England[23] and said that the biggest issues affecting morale were the uncertainty surrounding the service and the NHS in general, inadequate staffing levels, poor leadership, ill-informed commissioning and the increased administrative burden. It also noted an increase in the number of referrals, which anecdotal evidence from our visits suggested was linked, in some cases, to the improvements in dental access. The BDA Wales said that similar motivation issues applied in Wales. The BDA Northern Ireland

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21 In England and Wales, a performer-only dentist.
22 In England and Wales, a providing-performer dentist.
23 *Salaried Primary Dental Care Service Morale Survey 2011.* British Dental Association, July 2011. Annex 6. Available from: http://www.bda.org/Images/2012-13_bda_evidence_for_england.pdf

reported that 58 per cent of dentists reported morale as low or very low and said the biggest issues affecting morale were the uncertainty surrounding the Community Dental Services, inadequate staffing levels, increased administrative burden and the need for modernisation of the estate where staff worked. We note that most, if not all, of these motivation issues are not capable of being addressed through pay, and therefore ask the Health Departments to consider the issues raised by the BDA when developing future policy.

New contractual arrangements in Scotland and Northern Ireland

1.77 The SGHSCD said that discussions continued on the merger of terms and conditions for the Community Dental Services and the Salaried General Dental Services. It reported that progress had been made on a wide range of issues, including annual leave, working hours and out-of-hours arrangements, but that remuneration remained an outstanding issue. The DHSSPSNI said that it was in continuing discussions with the BDA and that a business case setting out the potential costs of a new contract had been prepared. It added that further to some additional pay modelling work, Ministerial approval would be sought with a view to entering into negotiations with the BDA. We welcome the progress made in both Scotland and Northern Ireland on new contractual arrangements for salaried dentists as we consider such arrangements to be long overdue and ask the parties to provide us with an update for our next review.

Additional pay points for Band A staff in England

1.78 For the third year in succession, the BDA sought the addition of two incremental points to the top of the Band A pay scale, as well as the deletion of the two points at the bottom of the pay scale. However, while there continues to be a pay freeze, such action cannot be considered.

Looking forward

1.79 In our next report, we expect to return to making recommendations on the uplift to the salary scales for salaried dentists. We ask the parties to update us on this issue for our next review.

Ophthalmic medical practitioners

Recruitment and retention

1.80 There were 398 OMPs in the United Kingdom in September 2010, a decrease of 3.6 per cent (15 OMPs) on September 2009.

The sight test fee

1.81 The Department of Health told us that in 2010-11, 12.68 million sight tests were paid for by primary care trusts in England and local health boards in Wales, an increase of 1.1 per cent over the previous year. Within those figures, the proportion of sight tests carried out by OMPs was 0.3 per cent, down from last year's proportion of 0.4 per cent. Our *Thirty-Sixth Report* records our earlier recommendation[24] that we believe a unified sight test fee for OMPs and optometrists is appropriate, set in negotiation between the Health Departments and representatives of both OMPs and optometrists. The Department of Health said that discussions on the sight test fee would take place

[24] Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth Report.* Cm 7025. TSO, 2007. Paragraph 6.2. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

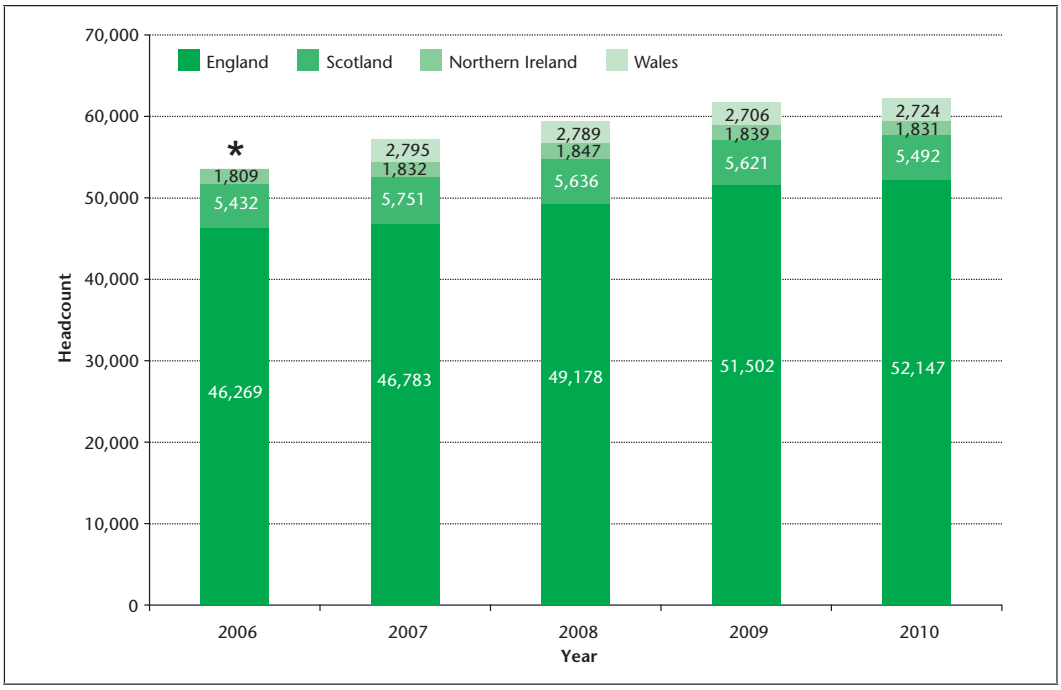
with representatives of the professions on the implementation of government pay policy. It also told us that the *Health and Social Care Bill*, currently before Parliament, had proposed that commissioning of the NHS sight testing service in England should be the responsibility of the NHS Commissioning Board, following the abolition of primary care trusts.

Doctors and dentists in hospital training

Recruitment and retention

1.82 In September 2010 there were 62,194 doctors and dentists in hospital training (Figure 1.8), an increase of 0.9 per cent in the United Kingdom as a whole since September 2008, but this masks decreases in Scotland (-2.3 per cent) and Northern Ireland (-0.4 per cent).[25]

Figure 1.8: Number of doctors in training in the Hospital and Community Health Services, 2006 – 2010, United Kingdom



Sources: NHS Information Centre, Information Services Division Scotland, StatsWales, Department of Health, Social Services and Public Safety in Northern Ireland.
* Data for Hospital and Community Health Services staff in Wales not available for 2006.

1.83 There were 2.4 applicants for each United Kingdom medical school place in 2010, up from 2.2 the previous year. We note that there continues to be a more than adequate supply of good quality applicants to study medicine, which we interpret as strong evidence that medicine is still seen as an attractive career. Women account for 55 per cent of accepted applicants, so we welcome the assurances given by the Department of Health that any related workforce planning issues are being addressed.

[25] Because of changes made in 2010 to the way in which headcount staff in HCHS are counted in England – effectively removing instances of double counting – comparisons between 2009 and 2010 data should be made with caution. This does not affect full-time equivalent data or primary care, or other United Kingdom countries. The overall effect of removing double counting is estimated to reduce the published total HCHS medical and dental headcount by around 1.5 per cent in 2009, though the impact is likely to be different for individual grades and has not been published in this form.

1.84 We note the BMA's concern that the rise in applicants this year may be as a result of the forthcoming increase in tuition fees; we will monitor the position next year. The BMA also suggested that the impact of the increase in tuition fees on workforce planning and medical students' aspirations needed to be carefully monitored and invited us to take an active part in such work. We would expect the Health Departments to take the lead on any such work and ask the parties to keep us informed of any developments in the normal submission of evidence.

1.85 The BMA told us that its research indicated that junior doctors were most likely to consider moving abroad and leaving the NHS if they were unable to find accredited training or career posts in the future. The Department of Health said that the Foundation Programme was oversubscribed in 2011 and for the first time had a reserve list, although ultimately all eligible applicants were placed on the Programme. Specialty training achieved high fill rates with only one specialty, psychiatry, achieving less than 94 per cent. It commented that it did not envisage a shortage of junior doctors and that there was evidence of oversupply in certain specialties compared to future demand. By contrast, the Welsh Government said that the last year continued to present difficulties in recruiting doctors, and it described initiatives to improve recruitment, including funding for training courses and professional qualifications and assistance with accommodation for those arriving new to Wales from overseas. The SGHSCD told us that modelling on the numbers of juniors currently in training showed that if it continued to train doctors in the same numbers, over the next five years the supply of trained doctors would outstrip demand. It said that while recruitment in 2011 generally went well, it acknowledged ongoing difficulties with some posts, particularly in paediatrics, emergency medicine and general practice. The DHSSPSNI said that there was a strong trend for local graduates to be successful in gaining a place on the Foundation Programme, but that there were vacancies in specialty training, mainly in emergency medicine and core surgery; it hoped to fill such vacancies through locums and successful visa applicants.

1.86 The BMA said that certain specialties had failed to expand sufficiently to meet demand and were experiencing workforce difficulties, drawing our attention to low fill rates for specialty training in both psychiatry and emergency medicine. It asked us to review the use of recruitment premia to address long-term shortage specialties and geographical locations. In line with the pay freeze, we consider it inappropriate for us to give this issue substantial consideration this year. We note, however, that none of the Health Departments supports the use of recruitment premia for specialty training posts, although the Welsh Government told us that individual health boards are able to introduce their own arrangements for additional payments for hard-to-fill posts under certain conditions. We ask the Welsh Government to update us for our next review on the extent of the use of these freedoms along with an assessment of their effectiveness, and for the other Health Departments to give further consideration as to whether similar arrangements might be beneficial to them.

Motivation

1.87 The Department of Health said that the *2010 NHS staff survey*[26] showed the score for job satisfaction for doctors and dentists in hospital training had increased in the last year. The BMA said that the level of satisfaction had improved significantly since 2008, noting 2008 as the low point associated with the introduction of the *Modernising Medical Careers* training programme, particularly relating to the problems with the electronic recruitment and selection tool.

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[26] *2010 NHS staff survey.* Care Quality Commission, March 2011. Available from: http://webarchive.nationalarchives.gov.uk/20110718105843/http:/www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2010.cfm

New contractual arrangements

1.88 The Department of Health said that it had received NHS Employers' scoping study on new contractual arrangements for hospital trainees and was giving it careful consideration with the devolved administrations. It said that it expected to publish the study in due course and would welcome our views on NHS Employers' recommendations. We will, of course, be happy to provide our comments when the study is published.

Looking forward

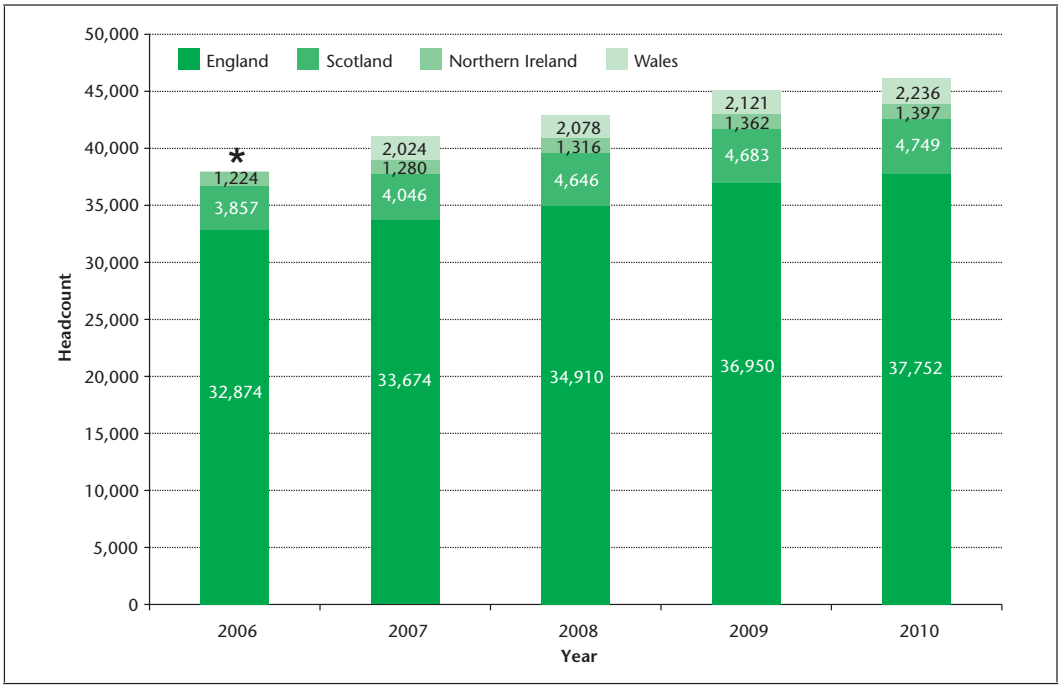
1.89 In our next report, we expect to return to making recommendations on the salary scales for doctors and dentists in hospital training and the banding supplements that are applied to basic pay. We ask the parties to update us on these issues for our next review.

Consultants

Recruitment and retention

1.90 In September 2010 there were 46,134 consultants, an increase of 2.3 per cent on the previous year, with the number of consultants increasing in each United Kingdom country every year between 2006 and 2010 (Figure 1.9).[27]

Figure 1.9: Number of consultants in the Hospital and Community Health Services, 2006 – 2010, United Kingdom



Sources: NHS Information Centre, Information Services Division Scotland, StatsWales, Department of Health, Social Services and Public Safety in Northern Ireland.
* Data for Hospital and Community Health Services staff in Wales not available for 2006.

[27] Because of changes made in 2010 to the way in which headcount staff in HCHS are counted in England – effectively removing instances of double counting – comparisons between 2009 and 2010 data should be made with caution. This does not affect full-time equivalent data or primary care, or other United Kingdom countries. The overall effect of removing double counting is estimated to reduce the published total HCHS medical and dental headcount by around 1.5 per cent in 2009, though the impact is likely to be different for individual grades and has not been published in this form.

Motivation

1.91 In general, we do not have any cause for concern regarding the motivation of the consultant group. The *2010 NHS staff survey*[28] showed that consultants tended to be, on average, the grade most satisfied with freedom to choose their own method of working and with their level of pay, but they tended to be least satisfied with support from immediate managers. Furthermore, consultants, on average, had higher feelings of work pressure than other grades and were most likely to be working extra hours. We are conscious that while this survey took place after the announcement of the pay freeze, it predated the first year of the pay freeze taking effect, the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom. We will be monitoring closely the impact of these changes on the motivation of our remit groups and ask the parties to update us on this issue for our next review.

Consultant contract

1.92 We note from the SGHSCD that there had been some discussions during 2011 between the Management Steering Group of Scottish employers and the BMA Scotland, which aimed to agree terms of reference for negotiations on consultant terms and conditions. However, it told us that negotiations were currently on hold as the BMA Scotland felt unable to proceed due to the significant uncertainties over pay and pensions. We ask the parties to update us on this issue for our next review.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

1.93 Our *review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*, carried out at the request of the four United Kingdom Health Departments, was submitted to Ministers on 7 July 2011. At the time of writing, the report has not yet been published, but we look forward to receiving the views of the parties on our proposals, in due course.

1.94 In the light of the pay freeze, we did not receive any requests from the awarding bodies to increase the number of awards; ACCEA explicitly stated that it had made no such proposal, pending the outcome of our *review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants.*

1.95 We heard from ACCEA that it expected to hold a renewals round for awards in England and Wales in 2012, but was awaiting an announcement from the Department of Health on whether there would be a new national awards round. It reported that in the 2010 and 2011 awards rounds, Ministers had held the total number of new awards in England at 300, which was less than the levels seen in previous years. Also, that following clear recommendations from Ministers and the main ACCEA committee, and the analysis from the 2011 round, it would discontinue the 'year's grace' from the 2012 round forward. This meant that consultants who made unsuccessful applications for the renewal of an award at the end of the fourth year would no longer be permitted to make a further renewal application the following year.

1.96 For Scotland, SACDA told us that for the 2011-12 awards round, the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy had proposed that there should be no new Distinction Awards, no increase in their value and no

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[28] *2010 NHS staff survey.* Care Quality Commission, March 2011. Available from: http://webarchive.nationalarchives.gov.uk/20110718105843/http:/www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2010.cfm

progression through the awards scheme in 2011-12 pending the outcome of our *review of the compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*, although the five-yearly reviews would continue as normal.

1.97 The national and local schemes were frozen in Northern Ireland, which the DHSSPSNI reported had saved £1 million on national awards during 2010-11. In response to concerns that we expressed last year, the DHSSPSNI also confirmed that the levels of funding for the various award schemes did not form part of contractual arrangements.

Looking forward

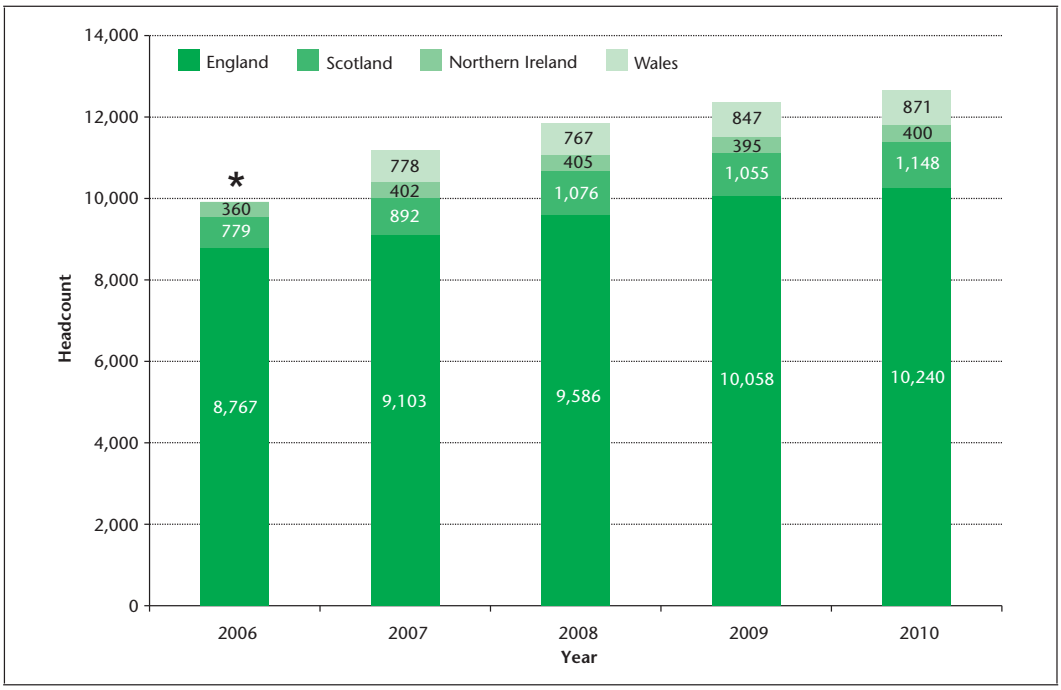
1.98 In our next report, we expect to return to making recommendations on the uplift to consultants' pay and on the consultants' award schemes. We ask the parties to update us on these issues for our next review.

Specialty doctors and associate specialists

Recruitment and retention

1.99 In September 2010 there were 12,659 associate specialists, staff grades and specialty doctors, an increase of 2.5 per cent on September 2009 levels for the United Kingdom as a whole, and numbers increased in all countries (Figure 1.10).[29]

Figure 1.10: Number of staff grades, associate specialists and specialty doctors in the Hospital and Community Health Services, 2006 – 2010, United Kingdom



Sources: NHS Information Centre, Information Services Division Scotland, StatsWales, Department of Health, Social Services and Public Safety in Northern Ireland.
* Data for Hospital and Community Health Services staff in Wales not available for 2006.

[29] Because of changes made in 2010 to the way in which headcount staff in HCHS are counted in England – effectively removing instances of double counting – comparisons between 2009 and 2010 data should be made with caution. This does not affect full-time equivalent data or primary care, or other United Kingdom countries. The overall effect of removing double counting is estimated to reduce the published total HCHS medical and dental headcount by around 1.5 per cent in 2009, though the impact is likely to be different for individual grades and has not been published in this form.

Motivation and career progression

1.100 The BMA reminded us of its own survey[30] that showed staff grades and specialty doctors had the lowest level of satisfaction among all doctors, and highlighted the lack of opportunities for career progression caused by the closure of the associate specialist grade and the decrease in higher specialist training opportunities.

1.101 The Department of Health told us that the *2010 NHS staff survey*[31] showed job satisfaction within the specialty doctor grade and for associate specialists was high, but that the score had marginally decreased over the last year. The score for intention to leave jobs had increased slightly over the previous year's score. The Department of Health said that recurrent annual funding of £12 million, uprated for inflation, had been provided for specialty doctor career support, training and continuing professional development. The SGHSCD said that the Scottish Medical Training Board had been persuaded that more should be done to improve access to training and development opportunities for the SAS doctor group, and that it was looking at current and planned policies for top-up training for Certificate of Eligibility for Specialist Registration (CESR) application and the appraisal process for SAS doctors in terms of identified training needs. However, the DHSSPSNI told us that continuing financial constraints meant it was unable to provide additional funding to support career development, training and continuing professional development for SAS doctors. While we appreciate that the Health Departments are operating within financial constraints, we wish to stress to all countries the importance of ensuring that the investment in the new SAS contracts is not wasted and that the benefits of the new contracts are fully realised: ongoing career development was seen by the parties as an important aspect of the new contract and therefore should not be ignored.

1.102 The BMA reminded us that we had previously enquired about the potential discrimination in associate specialists securing consultant posts via the CESR process and said that the General Medical Council had commissioned research about the perceptions of the CESR routes, including perceptions about the relative ease or difficulty of progression for CESR doctors compared with CCT doctors. The Department of Health told us that it was contributing to this research. We will be very interested to learn of the findings of this research.

New contractual arrangements

1.103 All four Health Departments reported on the progress made to move those SAS doctors who wished to, across to their new contracts. We recorded our concern last year with the lack of progress in Northern Ireland, and are therefore pleased to note that assimilation to the new contracts in that country is expected to be completed by the end of the financial year. We note that the Department of Health has not provided us with an updated estimate on the costs on the new contractual arrangements and ask for these data to be included with the evidence for our next review.

Looking forward

1.104 In our next report, we expect to return to making recommendations on the salary scales for SAS grade doctors. We ask the parties to update us on this issue for our next review.

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[30] Staff and Associate Specialist Committee. *Survey of SAS doctors' workload and career progression.* British Medical Association, October 2010. Available from: http://www.bma.org.uk/images/sasdoctorsworkloadsurveyresultsoct2010_tcm41-201172.pdf

[31] *2010 NHS staff survey.* Care Quality Commission, March 2011. Available from: http://webarchive.nationalarchives.gov.uk/20110718105843/http:/www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2010.cfm

Conclusions

1.105 The main conclusions that we draw from our monitoring round for 2012 are:

- the growth in staff numbers, together with the currently available information on vacancy rates, gives us no real cause for concern on recruitment and retention grounds. However, the loss of the HCHS and GMP vacancy surveys for England, with no immediate alternative source of data, has a detrimental impact on the evidence base to enable us to assess changes in recruitment and retention, both important elements of our remit;
- the main surveys of NHS HCHS staff and from the BMA did not give us any real cause for concern regarding motivation, but the BDA provided evidence of a continuing decline in morale among GDPs, particularly those with a high NHS commitment. We are conscious that while these surveys took place after the announcement of the pay freeze, they predated the first year of the pay freeze taking effect, the proposed changes to the NHS Pension Scheme and the various NHS reforms across the United Kingdom;
- we recognise from the evidence that affordability continues to dominate the thinking of many employers. The Health Departments emphasised: the need for tight control of public spending, including pay, in England; the considerable budget pressures in Scotland; and the very tight public expenditure position in Northern Ireland;
- we note that, yet again, efficiency savings have been applied to our formulae for the contract uplifts for GMPs and GDPs. We reiterate our general view that while requiring cash-releasing efficiency savings may be an appropriate way to achieve cost discipline in a government department or agency that is not subject to market forces, GMPs and GDPs operate small businesses in competitive markets and have an incentive to achieve whatever efficiency savings are possible. We therefore believe that it is both unnecessary and inappropriate to include efficiency savings in our funding formulae for GMPs and GDPs as the impact of efficiency savings will become apparent, albeit with a time lag, in the data used in the formulae. If the Health Departments continue to think it appropriate to impose a requirement on independent contractor GMPs and GDPs to make efficiency savings, then we believe that any such requirement should be a contractual matter, rather than abating our recommended increases; and
- the relative position of total earnings for the majority of our remit groups has declined slightly since 2010, when measured against comparator professions. Although there are some slight differences between the various grades, the median total earnings of most categories in our remit group are within the top decile when compared with all full-time employees in the wider economy. The median gross annual full-time pay for employed doctors and dentists has remained around the 97th percentile for all full-time employees.

1.106 We expect the parties to provide us with updates to issues that we have indentified in previous rounds, such as any developments on new contractual arrangements for junior doctors and the new dental contract pilots in England. 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[32] including recruitment, retention, motivation, affordability, economic evidence, 'patients at the heart' and the legal obligations of the NHS;

[32] Our terms of reference can be found on page iii at the beginning of this report.

- the parties to update us on issues relating to the pay and other allowances for the doctors and dentists within our remit group;
- information on the relative position of total earnings for our remit groups, measured against comparator professions;
- the Health Departments to take steps to ensure that the NHS Information Centre and its equivalents provide up-to-date vacancy information for HCHS staff and GMPs, as this is an important measure in our ongoing analysis of the workforce position;
- the Health Departments to take steps to ensure that the NHS Information Centre and its equivalents provide data on full-time equivalents in addition to headcount data for all our remit groups;
- the SGHSCD to update us on progress towards its aim of a health service predominantly delivered by trained doctors;
- the parties to update us on changes to pension arrangements;
- an update to the measurement of the average amount of part-time work per week undertaken by salaried GMPs;
- information on how the new system of CCGs in England will operate in practice, in particular, what it will mean to be a member of the groups and the effect on income streams for GMPs;
- an update on the review looking at the GMP trainers' grant;
- an update on the proposed joint survey between the Department of Health, NHS Employers and the BDA on motivation and morale;
- the parties to update us on any decisions to uplift the contracts and fee scales for independent contractor GDPs in 2012-13;
- an update on new contractual arrangements for salaried dentists in both Scotland and Northern Ireland;
- an update on the information relating to applications to medical and dental school;
- the parties to update us on any work looking at the impact of the increase in tuition fees on workforce planning and medical students' aspirations;
- the Welsh Government to provide information on the extent of the use of the freedoms of health boards to introduce their own arrangements for additional payments for hard-to-fill specialty training posts, along with an assessment of their effectiveness; and for the other Health Departments to give further consideration as to whether similar arrangements might be beneficial to them;
- the SGHSCD to update us on any changes to consultants' terms and conditions;
- the parties to submit their views on our report looking at compensation levels, incentives and the Clinical Excellence and Distinction Award schemes, once it is published;
- an update on the General Medical Council's research into perceptions of the CESR routes; and
- the Department of Health to provide an update on the costs of the new SAS contractual arrangements.

CHAPTER 2: GENERAL DENTAL PRACTITIONERS' EXPENSES IN SCOTLAND

Introduction

2.1 In her letter of October 2011 (see Appendix A), the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy sought our recommendations in relation to dental practice expenses of independent contractors in the General Dental Services (GDS) in Scotland. The letter noted that:

> *"The system for Primary Care Dentistry in Scotland is different from England and has not been considered by DDRB in depth for some time. We would find it helpful if DDRB could carry out a detailed consideration and assessment of all the changes that have been made to practitioners' earnings and expenses in Scotland and make recommendations as appropriate for both 2011-12 and 2012-13."*

2.2 Our specific remit covers all independent contractor general dental practitioners (GDPs) in primary care who are contracted to provide NHS dental services in Scotland. As at 31 March 2011, there were 2,581 non-salaried dental practitioners registered to provide NHS treatment in Scotland, an increase of 73 (2.9 per cent) on 31 March 2010. The remuneration system for the GDS in Scotland is primarily based on item-of-service fees for adults and children, capitation and some continuing care payments. There are also centrally funded allowances available to dentists.[1]

The evidence

2.3 We received evidence relating to GDPs' expenses in Scotland from the Scottish Government Health and Social Care Directorates (SGHSCD) and the British Dental Association's (BDA's) Scottish Dental Practice Committee (SDPC). The main evidence can be read in full on the parties' websites (see Appendix D) and further information about the evidence received, including oral evidence, can be found in Chapter 1.

The uplift in 2010-11

2.4 Our approach to pay recommendations for GDPs has been based on a formula, which attempts to ensure that dentists' own remuneration and their practice expenses are both provided for. At the time we submitted our *Thirty-Ninth Report*,[2] we did not have sufficient data on expenses in Scotland to allow us to make a distinct recommendation for that country. We recommended that fee scales in Scotland should be adjusted to take account of expenses, but that if the parties did not have sufficient evidence to enable them to make such adjustments, the adjustment we identified as being appropriate for 2010-11 in England and Wales should be used instead.

2.5 In Scotland, as in England and Wales, the decision was taken by Ministers to abate our recommended uplift of 1.44 per cent to the gross earnings base of GDPs by applying a prospective efficiency assumption of 1 per cent on expenses, leading to a gross uplift of 0.9 per cent. In Northern Ireland, a further abatement was made, leading to a gross uplift of 0.5049 per cent.[3]

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1 A similar arrangement exists in Northern Ireland. In England and Wales, primary care organisations hold budgets for dental services for their areas which are specified in terms of units of dental activity. Primary care organisations agree contract values with providers for a particular level of service.

2 Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report.* Cm 7837. TSO, 2010. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

3 See Appendix G to this report, paragraph 9.

Dentistry in Scotland

2.6 The SGHSCD told us that, since the launch in 2005 of *an action plan for improving oral health and modernising NHS dental services in Scotland*,[4] the payment system for independent contractors had changed markedly and was now completely different from the system used in England and Wales. GDS dentists received a range of direct payments, including fees, a General Dental Practice Allowance, rent reimbursement and commitment payments (see Table 2.1). Additional funding had been made available under the Scottish Dental Access Initiative to assist dentists to open new practices, extend existing practices and comply with the requirements of decontamination and the *Disability Discrimination Act*.

2.7 Typically NHS payments were 80 per cent item-of-service fees and 20 per cent allowances. In order to be eligible for the whole range of allowances a practitioner needed to meet a commitment of registering 500 patients (of whom 100 had to be fee-paying adults) and have gross annual NHS earnings of at least £50,000.

2.8 The SGHSCD told us that the General Dental Practice Allowance had been introduced in 2005-06 and payments had increased over the years. The initial increase was due to the introduction of the 12 per cent payment on top of gross fees for practitioners committed to the NHS. In addition, during 2007-08, a new category of partial commitment had been introduced to recognise that some practitioners, although not meeting the full commitment levels, were still providing a valuable level of NHS care: this group was eligible to earn an additional 9 per cent of their gross fees. The remainder of practitioners who were neither fully nor partially committed were eligible for a 6 per cent payment of their gross fees.

2.9 The SGHSCD said that rent reimbursement payments had been fairly steady, though following the re-assessment of rents in 2009, payments had increased, which was likely to be due to a combination of re-assessments and new practices opening.

[4] *An action plan for improving oral health and modernising NHS dental services in Scotland.* Scottish Executive, 2005. Available from: http://www.scotland.gov.uk/Publications/2005/03/20871/54813

Table 2.1: Direct payments and benefits in kind for General Dental Services dentists, Scotland, 2005-06 to 2010-11

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000
Contractual payments						
Fees (item-of-service, continuing care, capitation)[1, 2]	178,997	188,320	198,713	219,804	229,830	242,916
General Dental Practice Allowance[1, 2]	15,422	21,644	22,832	25,578	28,029	29,094
Rent reimbursement[1, 4]	3,440	7,901[6]	6,637	6,147	7,458	8,140
Commitment[1, 4]	4,269	4,305	4,943	5,402	5,639	5,651
Seniority[1, 4]	1,620	1,627	1,624	1,701	1,634	1,695
Reimbursement of non-domestic rates[1, 4]	1,564	1,614	1,661	1,457	1,558	1,639
Recruitment and retention[1]	773	1,145	1,328	1,320	1,535	1,635
Long-term sickness, maternity and paternity[1, 4]	784	701	941	906	909	1,207
Continuing professional development[1, 4]	994	960	967	1,191	1,168	1,020
Remote areas[1]	449[7]	645	662	668	979	769
Vocational training practice[1]	661	902	1,045	720	635	582
Sedation practice[1]	63	101	127	106	103	107
Clinical audit[1]	492	68	118	301	108	68
Deprived areas[1]	–	2,750	2,900	–	–	–
Non-contractual payments and benefits in kind						
Scottish Dental Access Initiative[1]	1,213	1,298	1,283	3,449	3,374	5,460
NHS Education for Scotland (Vocational Training Recruitment Allowance[1] and START[3])	506	597	597	751	762	874
NHS boards clinical and special wastes[3]	–	984	1,038	1,055	857	841
NHS National Services Scotland (General Dental Services information management and technology system)[3]	–	1,969[8]	1,777[8]	557[8]	319	422
Practice improvements[1]	5,000	2,500	2,500	–	–	–
Decontamination practice improvements[1]	–	–	5,000	5,000	–	–
Vocational training (trainee salaries and trainer grant)[1, 5]	6,117	7,038	7,768	8,161	8,260	8,553
Total	**222,364**	**247,069**	**264,461**	**284,274**	**293,157**	**310,673**

Sources: Information Services Division Scotland, Practitioner Services Division, Scottish Government, NHS Education for Scotland.

Notes:

1. Direct payment.
2. Payments directly affected by changes in the fee scale.
3. Benefits in kind.
4. Payments indirectly affected by changes in fees.
5. Estimate.
6. Includes 2005-06 rent reimbursement reconciliation payments made in 2006-07.
7. Revised to remove general practice improvement funding which is now recorded in practice improvements line.
8. Includes initial start up costs, e.g. provision of equipment, and some NHS National Services Scotland support costs which cannot be identified and removed in the time available.

Business arrangements and workforce profile

2.10 Evidence from the SGHSCD and the SDPC highlighted a number of business arrangements for dental practices, including: single-handed practices; partnerships involving more than one practice owner; arrangements between practice owners and self-employed associates; and limited companies (Dental Bodies Corporate).

2.11 The SDPC told us that, in an associateship, the practice owner provided services to the associate, including surgery facilities and staff. The associate paid the practice owner for the use of the facilities. The practice owner also provided the associate with patients, equipment, materials and staff assistance. The associate normally paid for the use of the facilities monthly, the amount generally based on a proportion of fees earned: the BDA's *Business Trends*[5] survey showed that the mean percentage was 49.8 per cent in the United Kingdom, but focus groups suggested that many practice owners had decreased their associates' percentages or were considering doing so. Associates were self-employed, rather than being employees of practice owners. We are aware that there are a variety of ways in which associates' gross earnings and expenses can be recorded, which can cause problems with the interpretation of the data. We discuss this further in paragraphs 2.15 to 2.17.

2.12 The BDA's *Business Trends*[6] survey found that over half (51 per cent) of dental practices in Scotland operated as sole traders, 27 per cent as partnerships, 15 per cent as limited companies, and 7 per cent operated under an expense sharing arrangement. On average, there were 2.8 full-time equivalent GDPs, 4.0 full-time equivalent dental nurses, 0.5 full-time equivalent practice managers and 1.0 full-time equivalent receptionists in dental practices in Scotland. The BDA also provided survey data on the pay of dental care professionals.

Earnings and expenses

2.13 The SDPC told us that its research into practice costs had shown that practices in Scotland and Northern Ireland were most likely to report costs above expectations: 65 per cent of respondents to its survey reported that practice costs had exceeded expectations, as against 36 per cent reporting costs in line with expectations. The SDPC also told us that its research showed that practices in Scotland reported higher laboratory expenses than practices elsewhere in the United Kingdom, though this was not quantified.

Earnings statistics

2.14 In October 2011, the NHS Information Centre published HM Revenue and Customs (HMRC) data on dentists' earnings in Scotland for the financial year 2009-10, based on a sample of around 250 principal and 700 associate dentists.[7] These data were referred to by the parties in written evidence. These data are experimental,[8] the 2009-10 data being the second year in which data in this format have been produced; and are not comparable to data for other United Kingdom countries because of differences in dental

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5 *Business trends survey 2010*. British Dental Association, 2011. Available from: http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/business-trends.aspx

6 *Business trends survey 2010*. British Dental Association, 2011. Available from: http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/business-trends.aspx

7 *Dental earnings and expenses, Scotland, 2009/10: experimental statistics.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-scotland-2009-10-experimental-statistics

8 Experimental statistics are new official statistics that are undergoing evaluation, in keeping with the United Kingdom Statistics Authority's *Code of Practice for Official Statistics*.

contracts across the United Kingdom. Table 2.2 compares the average income and expenses of GDPs in the two financial years available. Several factors make comparisons between the two years difficult.[9]

Table 2.2: Average gross earnings, expenses, taxable income and expenses to earnings ratio for self-employed General Dental Services dentists, by dental type, Scotland, 2008-09 and 2009-10

Dental Type	Financial year	Average (£)			Expenses to earnings ratio
		Gross Earnings	Expenses	Taxable Income	
Principal[10]	2008-09	343,900	225,200	118,700	65.5%
	2009-10	337,000	223,200	113,800	66.2%
Associate[11]	2008-09	100,500	33,400	67,100	33.2%
	2009-10	91,900	28,800	63,100	31.3%
All dentists	2008-09	184,800	99,900	85,000	54.0%
	2009-10	170,200	90,900	79,300	53.4%

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

The impact of double counting on the expenses to earnings ratio

2.15 In the *Dental earnings and expenses, Scotland, 2009/10* statistical report, the NHS Information Centre noted that:

> *"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. The extent of this double counting is difficult to quantify, but is thought to be relatively widespread since a majority of payments for NHS dentistry in Scotland are made to principal dentists: in cases where that dentistry was actually provided by an associate working in the principal's practice, some of that payment will be passed on to the associate. This means that a single sum of money can be declared as gross earnings by both the principal and associate, and also as an expense by the principal. Estimates of taxable income are not affected."*[12]

2.16 There are a number of ways in which principals can pass on payments to associates who carry out General Dental Services in their premises, and the way in which these payments can be recorded on self-assessment tax returns can vary. For example, a

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9 *Dental earnings and expenses, Scotland, 2009/10: experimental statistics.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-scotland-2009-10-experimental-statistics
Paragraph 1.28 of the statistical report notes that: *"particularly, it should be noted that the primary sample used in the 2009-10 analyses (1,000) is greater than that which was used in 2008-09 (800), and not all of those from the 2008-09 sample feature in the 2009-10 sample. The majority (approximately 300 of 350) of new entrants to the sample were associate dentists."*
Page 6 notes that: *"when making comparisons between earnings and expenses results for 2008-09 and 2009-10 it should be kept in mind that this is only the second year for which these statistics have been produced, and that the sample used for 2009-10 was notably larger than the sample used for 2008-09. In some cases, it is possible that differences in the results between 2008-09 and 2009-10 reflect the increased sample size, rather than any real change in earnings and expenses."*

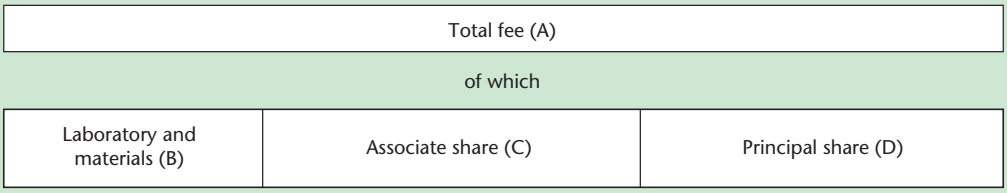
10 A dental practitioner who is also an owner, director, or partner of a dental practice, has an arrangement with an NHS board, and provides General Dental Services.

11 A dental practitioner who is self-employed and enters into an arrangement with a principal dentist, that is neither partnership nor employment. Also has an arrangement with an NHS board and provides General Dental Services.

12 *Dental earnings and expenses, Scotland, 2009/10: experimental statistics.* NHS Information Centre, October 2011. Paragraphs 1.16-1.17. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-scotland-2009-10-experimental-statistics

patient who receives treatment from an associate dentist, at the principal's premises, would pay a fee to the principal (the practice owner). The principal deducts any expenditure on laboratory work and materials, then passes on a percentage of the remainder (usually 50 to 55 per cent) to the associate. In their self-assessment tax return, the principal declares the entire fee in their gross earnings; in their expenses, they declare the expenditure on laboratory work and materials, as well as the money passed to the associate. The associate's tax return includes the money passed from the principal within gross earnings. This sum is therefore counted twice, across two separate tax returns. This is illustrated in Figure 2.1.

Figure 2.1: Illustrative transaction between principals and associates



The principal declares the entire fee (A) as gross earning, and (B)+(C) as expenses. The remainder (D) is the principal's taxable income.

The associate declares (C) as gross earnings, with no expenses. The sum (C) is therefore reported on two separate tax returns, and is therefore double counted in the aggregated data.

Alternatively, the associate could declare (B)+(C) as gross earnings, with expenses of (B). The sum (B)+(C) is therefore double counted in the aggregate data.

2.17 The accounting practices and consequent tax returns are valid for the individual dentist, but when aggregated the issue of double counting causes estimates of gross earnings and total expenses, and consequently the expenses to earnings ratio, to be artificially inflated. We consider how to account for double counting later in this chapter.

The formula for 2011-12 and 2012-13

2.18 Our formula represents an 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. However, since the coefficients and the input prices used in the formula are based on published data, they are by their nature retrospective. This means that there is a time lag between the change in input prices or input coefficients, and the impact on the uplift figure. This should provide an incentive to practices to pursue cost-effective delivery. It is of course the case that our approach may under or over-estimate what has actually been happening to the true level of expenses. However, in the long run, we expect under and over-estimates to feed through the data on income and expenditure and therefore to be taken into account in future years.

2.19 The SDPC supported the retention of a formula-based approach to increasing item-of-service fees, and believed the formula used in our *Thirty-Ninth Report*[13] should be used to calculate a figure to ensure that dentists did not receive a cut in their taxable income in 2011-12 or 2012-13. The SDPC provided the following evidence on the change in practice expenses:

[13] Review Body on Doctors' and Dentists' Remuneration. *Thirty-ninth report.* Cm 7837. TSO, 2010. Paragraphs 4.62-4.78. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

- the SDPC argued that broad measures of inflation were not an accurate reflection of the rates of inflation faced by GDPs. The prices of metals had continued to rise, affecting the price of laboratory fabricated items. Dentists had reported to the SDPC that the item-of-service fees for laboratory fabricated items were insufficient to meet rising costs and placed an extra financial burden on practices that were working hard to deliver high quality patient care;
- many staff employed by GDPs earned less than £21,000 and so fell under the protected category of those public sector employees who would receive a pay award of £250. The SDPC believed there were not enough dental care professionals available; consequently, practice owners would be under pressure to award at least £250 to their staff, and to fund the additional National Insurance contributions of 1 per cent from April 2011, in order to remain competitive in the employment market. The SDPC told us that BDA research during 2010 had shown that the average percentage increase in dental nurses' wages during 2009-10 in Scotland was 3.5 per cent;
- all GDPs were faced with increasing General Dental Council registration costs. The whole clinical team now had to be registered and those costs were frequently met by the practice owner. The compulsory continuing professional development requirements resulted in additional staff training costs, and reduced time available for revenue generating activities;
- dentistry continued to be a particularly fast-moving industry with rapid technological change due to the fact it needed to keep pace with clinical innovations and increasing patient expectations. Equipment and machinery needed regular updating and could quickly become out of date and in need of replacement, leading to a high level of depreciation at a substantial cost to dental practitioners; and
- the annual running costs associated with decontamination requirements could be as high as the initial start-up costs. The additional annual local decontamination unit cost for a three-surgery practice could be as high as £50,000.

2.20 The SDPC recommended that the formula used to increase item-of-service fees should reflect an expenses to earnings ratio of 56.1 per cent. It said that this ratio had been developed and agreed by the Dental Rates Study Group,[14] and had been recognised and consistently used over time for the purposes of DDRB evidence.

2.21 Using a formula-based approach, the SDPC suggested that a minimum increase of 2.39 per cent in item-of-service fees was required in 2011-12,[15] and 2.5 per cent in 2012-13, to ensure that dentists did not receive a cut in their taxable income.

2.22 The SGHSCD noted that the DDRB formula for England and Wales included premises costs. In Scotland, practitioners committed to the NHS could apply for both rates and rental payments to be reimbursed. These payments totalled £9.8 million in 2010-11 (see Table 2.1). In SGHSCD's view, applying the England and Wales formula to fees in Scotland was flawed.

2.23 In oral evidence, the SGHSCD told us that the maintenance costs of local decontamination units would be lower than the SDPC had suggested, provided that the manufacturers' guidance was adhered to.

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[14] The expenses to earnings ratio of 56.1 per cent has been in existence since at least 1991-92, which was the last year in which the Dental Rates Study Group used evidence on expenses to determine the uplift to item-of-service fees.

[15] The SDPC additionally provided an amended formula which included its estimate of the likely changes in staff costs, including an increase of £250 and an additional 1 per cent for employers' National Insurance contributions. The outcome of this formula was 2.48 per cent.

2.24 We note the broad support of the parties in continuing with a formula-based approach, and consider that the formula for Scotland should utilise, where appropriate, data specific to Scotland. Our formula involves weighting together the increase in the practitioners' personal remuneration and the increase in GDPs' expenses. The weights that have been used in the formula for England and Wales in recent years have been based on HMRC data for these countries; now that data for Scotland are available, we derive the weights for net income and staff costs in the formula using these data.

2.25 As noted above, we are aware that transactions between principal dentists and associates occur frequently, and that the same sums of money can be recorded on two tax returns. At the level of the individual, this is entirely rational, but when aggregated this double counting causes estimates of gross earnings and total expenses, and consequently the expenses to earnings ratio, to be artificially inflated, which could lead to inaccurate weights being applied in our formula. In the next section, we discuss how best to account for this.

Our approach to quantifying double counting of earnings and expenses

2.26 By multiplying the data in Table 2.2 above for average earnings and expenses for 2009-10 by the dental population in Scotland, estimates of total self-employment income and expenses can be obtained, as shown in Table 2.3. However, the aggregate gross earnings and expenses for all dentists (£357.4 million and £190.9 million respectively) are thought to be inflated by an unknown amount of double counting.

Table 2.3: *Aggregate* gross earnings, expenses, taxable income and expenses to earnings ratio for self-employed General Dental Services dentists, by dental type, Scotland, 2009-10

Dental Type	Estimated Population	Aggregate (£million)			Expenses to earnings ratio
		Gross Earnings	Expenses	Taxable Income	
Principal	670	225.8	149.5	76.2	66.2%
Associate	1,430	131.4	41.2	90.2	31.3%
All dentists	2,100	357.4	190.9	166.5	53.4%

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

The sum of individual items does not equal the totals because of rounding.

2.27 One approach to quantifying double counting would be to assume that *all* NHS payments are made to principals, who then pass on part of that money to associates. It follows that associates' aggregate gross earnings (£131.4 million) would be drawn entirely from principals' aggregate expenses. However, we reject this approach, as the aggregate gross earnings for principals are lower than the total expenditure on NHS General Dental Services in Scotland.[16]

2.28 In the *Dental earnings and expenses, Scotland, 2009/10* statistical report, the NHS Information Centre provides a detailed breakdown of the average expenses incurred by principals and associates. Aggregated figures based on these data are shown in Table 2.4. 'Other' expenses, highlighted in the table, comprise direct costs such as laboratory and materials, most of the costs of associate dentists to principal dentists, and other costs.[17] It follows that double counting could be expressed as the remainder of 'other' expenses, after accounting for laboratory and material costs.

[16] Table 2.1 shows that total expenditure on NHS General Dental Services in Scotland in 2009-10 was £293.2 million.

[17] Other costs also include: advertising, promotion and entertainment costs, bad debts, alternative finance payments, interest for businesses with turnover less than £70,000 and expenses for businesses where a more detailed breakdown is not available. See: *Dental earnings and expenses, Scotland, 2009/10: experimental statistics.* NHS Information Centre, October 2011. Tables 21 and 22, note 3. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-scotland-2009-10-experimental-statistics

Table 2.4: Detailed expenses breakdown for self-employed General Dental Services dentists, by dental type, Scotland, 2009-10

Dental Type	Aggregate (£million)							
	Total Expenses	Office and General Business	Premises	Employee	Car and Travel	Interest	Other	Net Capital Allowance
Principal	149.5	9.6	11.3	57.5	0.9	1.7	61.4	7.2
Associate	41.2	4.4	3.3	1.6	0.7	0.1	30.2	1.0

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

2.29 Based on data from the National Association of Specialist Dental Accountants and Lawyers, we estimate that in England and Wales, laboratory and materials costs each comprise 10 per cent of total expenses. Reported total expenses for principals in Scotland (which are believed to include an element of double counting) come to £149.5 million. It could therefore be assumed that aggregate expenditure by principals on laboratory work and materials was £29.9 million in total. The remainder of 'other' expenses – £31.5 million – could be used as an estimate of double counting; logically, this same sum should be deducted from principals' aggregate expenses and gross earnings.

2.30 Estimates of expenditure on laboratory work and materials had however been derived directly from the previous, inflated figure for total expenses. Revised estimates of expenditure on these items can be calculated from the revised total expenses, leading to a revised – higher – estimate of double counting, which in turn leads to a further revision of total expenses. By following this approach to its conclusion, a final estimate of double counting of £39.3 million can be calculated.[18] The impact on aggregate gross earnings and expenses is shown in Table 2.5.

Table 2.5: *Adjusted aggregate* gross earnings, expenses, taxable income and expenses to earnings ratio for self-employed General Dental Services dentists, Scotland, 2009-10

All dentists	Aggregate (£million)			Expenses to earnings ratio
	Gross Earnings	Expenses	Taxable Income	
Original reported data	357.4	190.9	166.5	53.4%
Double counting	–39.3	–39.3	0	
Revised estimates	318.1	151.6	166.5	47.6%

Source: Office of Manpower Economics calculations based on NHS Information Centre and HM Revenue and Customs data.

2.31 The revised estimate of the expenses to earnings ratio is subject to a number of caveats:

- *Dental earnings and expenses, Scotland, 2009/10* are experimental statistics: that is, new official statistics that are undergoing evaluation;
- data on average earnings and expenses for dentists in Scotland are based on a sample of dentists (approximately 250 principals and 700 associates in 2009-10);
- dental practitioners are able to incorporate their businesses[19] and become a director and/or an employee of a limited company (Dental Body Corporate). Dentists' taxable income from employment or dividend income, and expenses incurred by the limited company, are not reflected in the statistics, which rely solely on self-employment earnings and expenses declared in self-assessment tax returns. We have assumed in our analysis that the average earnings and expenses of self-employed dentists in Scotland are identical to those who have incorporated their businesses;

[18] By making successive revisions to the estimates of total expenses and double counting, a pattern of a convergent geometric series with common ratio 0.2 emerges: total expenses are calculated as (£149.5 million – £61.4 million) ÷ 0.8 = £110.2 million, and the estimate of double counting is obtained via subtraction.

[19] Both principal and associate dentists are able to incorporate their businesses (for principal dentists, the business tends to be a dental practice; for associate dentists, the business is the service they provide as a sub-contractor).

- the HMRC data include all self-employment earnings and expenses, relating to both NHS and private work. It is not possible to obtain separately earnings relating to NHS dentistry, though the statistical report does provide information on the earnings and expenses of dentists who spend at least 75 per cent of their time on NHS dentistry (see Table 1.4). Average earnings and expenses for dentists reporting a high NHS share are similar to the total dental population, so we are content to use figures relating to the latter; and
- some reimbursements against specific expenses (for example, rent and rates reimbursements) could be used to net off the expenses; the 'true' expense could therefore be higher. In oral evidence, the SDPC told us that, in their experience, these expenses were not netted off by dentists.

2.32 However, these same caveats also apply to the original reported data. We are confident that the expenses to earnings ratio implied by the aggregated HMRC data is too high, but acknowledge that the revised estimate in Table 2.5 may not accurately reflect double counting. It is not possible from the evidence available to estimate the true figure with a high degree of precision. We have concluded that, in the absence of definitive data, it is appropriate to use an expenses to earnings ratio of 50 per cent for our 2011-12 and 2012-13 recommendations.

Formula coefficients[20]

2.33 Based on the above assumptions, taxable income is 50 per cent of gross earnings for dentists in Scotland. However, the Scottish Government has drawn to our attention that a number of allowances and reimbursements are paid to dentists in Scotland, as shown in Table 2.1. We think it would be inappropriate for the uplift to item-of-service fees to be influenced by changes in the discretionary allowances provided by the Scottish Government. We have identified a number of allowances in Table 2.1 which in our view the formula should discount:[21] in total these accounted for 10.1 per cent of expenditure on NHS General Dental Services in Scotland in 2009-10. Expressing income as a percentage of non-reimbursed gross earnings gives 50 per cent ÷ 0.899 = 55.6 per cent. We use this figure as the income coefficient in our formula.

2.34 According to Table 2.4, expenditure by dentists on employees (dental nurses, practice managers, receptionists, and salaried dentists, hygienists and other dental care professionals) was £59.1 million in 2009-10, which accounts for 35.5 per cent of total expenses,[22] equivalent to 17.8 per cent of gross earnings or 19.7 per cent of non-reimbursed gross earnings.

2.35 For the formula for Scotland, we have chosen to follow the approach used for the England and Wales formula, in which we split the remaining 65 per cent of total expenses into laboratory costs, materials and other costs. We do not have data which relates specifically to expenditure by dentists in Scotland on laboratory work and materials, and so we apply the same weighting to these items as was used in the most recent formula for England and Wales: 10 per cent of expenses for each of these items, equivalent to 5 per cent of gross earnings or 5.6 per cent of non-reimbursed gross earnings. Other costs are the remaining 13.5 per cent of gross earnings.

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[20] Our formula coefficients for both the 2011-12 and the 2012-13 uplift are based on earnings and expenses data for 2009-10.

[21] 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; and clinical audit; and non-contractual payments in kind and benefits such as Scottish Dental Access Initiative payments.

[22] This is consistent with an expenses to earnings ratio of 50 per cent: under this approach, an estimate of £24.4 million is assumed for double counting, resulting in adjusted total expenses of £166.5 million.

Pay and price measures

2.36 For the pay and price measures for the expenses elements in the formula (staff costs, laboratory costs, materials and other costs), we use the most recent pay and price data for the 2012-13 uplift, and data from 12 months earlier for the 2011-12 uplift:

- for staff costs, we continue to use data from the *Annual Survey of Hours and Earnings (ASHE)*, but for the *dental practice activities* industrial classification. This includes a sample of all employees (i.e. excluding self-employed contractors and associates) within this industry. It therefore relates to dental nurses, receptionists, hygienists (if salaried), practice managers, other dental care professionals and any salaried dentists. In our view, these statistics capture more accurately the pay of dental practice employees than the measure used previously, which was more broadly based.[23] The change in median gross hourly pay in the *dental practice activities* sector was minus 0.8 per cent in 2010 and plus 0.4 per cent in 2011;
- the SDPC has suggested that we take into account the increase in employers' National Insurance contributions from 12.8 per cent to 13.8 per cent, which was effective from April 2011. In our view, such a change will become apparent in due course in the earnings and expenses data and reflected in the formula coefficients, so we do not make a prospective adjustment for this factor. This is consistent with our approach for other expense items;
- 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 increases for the last quarter of 2010 and 2011 were 4.7 per cent and 5.3 per cent respectively; and
- for all other costs, we also use RPIX. This is because dentists receive reimbursements for rent and non-domestic rates, and these elements have already been accounted for by expressing the formula coefficients as a percentage of non-reimbursed gross earnings.

2.37 Taking all these factors into account, the formula calculations for 2011-12 and 2012-13 are set out in Table 2.6 and Table 2.7 respectively.

Table 2.6: Dental formula for Scotland, 2011-12

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.6%	0% *Scottish Government public sector pay policy*	0%
Staff costs	19.7%	–0.8% *Annual Survey of Hours and Earnings (dental practice activities) 2010*	–0.16%
Laboratory costs	5.6%	4.7% *RPIX 2010 Q4*	0.26%
Materials	5.6%	4.7% *RPIX 2010 Q4*	0.26%
Other costs	13.5%	4.7% *RPIX 2010 Q4*	0.64%
		Total	**1.00%**

[23] We have previously used the *healthcare and related personal services* occupational classification, which includes nursing auxiliaries and assistants; ambulance staff (excluding paramedics); dental nurses; houseparents and residential wardens; and care assistants and home carers. Dental nurses comprise just over 3 per cent of total employee jobs in this occupational group.

Table 2.7: Dental formula for Scotland, 2012-13

Formula element	Weight (A)	Pay and price data and source (B)	Contribution to uplift (A * B)
Net income	55.6%	0% *Scottish Government public sector pay policy*	0%
Staff costs	19.7%	0.4% *Annual Survey of Hours and Earnings (dental practice activities) 2011*	0.08%
Laboratory costs	5.6%	5.3% *RPIX 2011 Q4*	0.29%
Materials	5.6%	5.3% *RPIX 2011 Q4*	0.29%
Other costs	13.5%	5.3% *RPIX 2011 Q4*	0.72%
		Total	**1.38%**

2.38 We have been asked to make a recommendation that item-of-service fees in Scotland are increased by a factor intended to result in no increase to GDPs' net income after allowing for movement in expenses. Our dental formula gives an overall percentage rise of 1.00 per cent in 2011-12 and 1.38 per cent in 2012-13. Therefore, we recommend that an uplift of 1.00 per cent be applied to item-of-service fees in Scotland for 2011-12, and a further compound increase of 1.38 per cent be applied for 2012-13. The parties should agree the effective dates of these increases.

We recommend that an uplift of 1.00 per cent be applied to item-of-service fees in Scotland for 2011-12, and a further compound increase of 1.38 per cent be applied for 2012-13. The parties should agree the effective dates of these increases.

2.39 The specific remit on dental expenses in Scotland has given us the opportunity to revisit the methodology for our formula, and we have found that adjustments for double counting of earnings and expenses, as well as reimbursements and allowances, have a substantial impact on the coefficients used in our formula. In the absence of definitive data, we have used our judgement to construct a formula that is appropriate. We welcome the parties' views on our approach.

2.40 The particular issue of double counting is not confined to dentists in Scotland: the NHS Information Centre has identified that it causes distortions to the statistics in England and Wales,[24] and in Northern Ireland.[25] In England and Wales in particular, this practice could be widespread since the introduction of new contractual arrangements in 2006, because all payments for NHS dentists are made to the providing-performer dentist (or the corporate body) which holds the contract under which the dentistry is performed; all payments to performer-only dentists in respect of NHS work could therefore be double counted in tax returns. We ask the parties to quantify the extent to which dentists' gross earnings and expenses are double counted in each United Kingdom country, and provide us with this information for our next review.

[24] *Dental earnings and expenses, England and Wales, 2009/10.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-england-and-wales-2009-10

[25] *Dental earnings and expenses, Northern Ireland, 2009/10.* NHS Information Centre, October 2011. Available from: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-earnings-and-expenses-northern-ireland-2009-10

2.41 For the 2012-13 round, we ask the parties to provide better estimates of the expenses to earnings ratio, and associated formula coefficients, that could be used in our formulae for dentists in each country. These estimates could be based on more detailed analysis of the HMRC data we have used, or could alternatively take the form of a survey of a representative sample of dental practices, including corporate bodies. We also ask the parties to provide information on why dentists might choose to incorporate their businesses, particularly in relation to remuneration.

Conclusions

2.42 The main conclusions that we draw on GDPs' expenses in Scotland are:

- we note the broad support of the parties in continuing with a formula-based approach, and consider that the formula for Scotland should utilise, where appropriate, data specific to Scotland;
- we are aware that transactions between principal dentists and associates occur frequently, and that the same sums of money can be recorded on two tax returns. At the level of the individual, this is entirely rational, but when aggregated this double counting causes estimates of gross earnings and total expenses, and consequently the expenses to earnings ratio, to be artificially inflated, which could lead to inaccurate weights being applied in our formula. We have considered how best to account for this, and have concluded that, in the absence of definitive data, it is appropriate to use an expenses to earnings ratio of 50 per cent for our 2011-12 and 2012-13 recommendations;
- we have identified a number of allowances which in our view the formula should discount: in total these accounted for 10.1 per cent of expenditure on NHS General Dental Services in Scotland in 2009-10;
- taking all factors into account, the formula calculations for 2011-12 and 2012-13 are set out in Table 2.6 and Table 2.7 respectively. Our dental formula gives an overall percentage rise of 1.00 per cent in 2011-12 and 1.38 per cent in 2012-13;
- the specific remit on dental expenses in Scotland has given us the opportunity to revisit the methodology for our formula, and we have found that adjustments for double counting of earnings and expenses, as well as reimbursements and allowances, have a substantial impact on the coefficients used in our formula. In the absence of definitive data, we have used our judgement to construct a formula that is appropriate; and
- the particular issue of double counting is not confined to dentists in Scotland: the NHS Information Centre has identified that it causes distortions to the statistics in England and Wales, and in Northern Ireland. In England and Wales in particular, this practice could be widespread since the introduction of new contractual arrangements in 2006, because all payments for NHS dentists are made to the providing-performer dentist (or the corporate body) which holds the contract under which the dentistry is performed.

2.43 The evidence requirements that we have identified in this report for our next review are for:

- the parties' views on our approach to the formula for Scotland;
- the parties to quantify the extent to which dentists' gross earnings and expenses are double counted in each United Kingdom country;

- better estimates of the expenses to earnings ratio, and associated formula coefficients, that could be used in our formulae for dentists in each country; and
- the parties to set out the benefits to dentists who choose to incorporate their businesses, particularly in relation to remuneration.

APPENDIX A

THE REMIT LETTERS

UNCLASSIFIED

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

Prof Alasdair Smith, AFPRB Chair

Ron Amy OBE, DDRB Chair

Jerry Cope, NHSPRB Chair

Dr Peter Knight CBE, PSPRB Chair

STRB Chair

Bill Cockburn CBE, SSRB Chair

20 June 2011

Dear Alasdair, Ron, Jerry, Peter, Bill and Chair

PUBLIC SECTOR PAY 2012-13

I would like to thank the Review Bodies for your work on the 2011-12 pay round. The Government greatly values the independent and expert view that the Review Bodies provide.

2. Given that we remain in the exceptional circumstance of a cross-public sector pay freeze, I am now writing – as I did last year - to set out how the Government proposes that the Review Bodies should approach the 2012-13 round. As you know, at the June 2010 Budget, the Government announced a two-year pay freeze from 2011-12 for public sector workforces where the

UNCLASSIFIED

Government is responsible for setting pay, except for those earning a full-time equivalent of £21,000 or less, where the Government announced it would seek increases of at least £250 per year.

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

- 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.

- 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 Government therefore remains of the view that the 2012-13 pay round should proceed in line with the approach agreed for 2011-12 – with the Review Bodies making recommendations in relation to those earning £21,000 or less. Further details on the practicalities for this round are set out in the Annex to this note.

5. As you will be aware, Lord Hutton published his final independent report on the future of public service pensions, on 10 March 2011 and the Government has accepted Lord Hutton's recommendations for reform of public service pensions as a basis for consultation with public sector workers, trades unions and others. One of these recommendations was that the Government should

make clear to Review Bodies that they should consider how public service pensions affect total reward. The Government will return to this issue as part of the overall response to Lord Hutton's report, in advance of the 2013-14 round.

6. However, independent research by the IFS in February suggested that, overall, there remains a public sector pay premium over the private sector, adjusting for the relevant skills and experience – and Lord Hutton concluded that these remain significantly more generous than private sector pensions, on average. Given this evidence, the Government is clear that any changes to pensions, including the proposed increase in contributions from 2012-13, do not justify upwards pressure on pay.

7. I found our meeting last year very helpful, so I would be delighted to meet you to discuss the issues set out above, review developments since last year and consider any specific matters that you wish to raise.

DANNY ALEXANDER

Pay round in 2012-13

Overall approach

For the second year of the freeze - the 2012-13 pay round - the pay review body process should proceed as in 2011-12, with the exception of the School Teachers Review Body, where I recognise that a two year recommendation has been made and therefore do not expect an additional remit on this matter. Specifically:

- For those groups of workers paid above £21,000, the Government will not submit evidence or seek recommendations on pay uplifts. It will however, provide information about recruitment, retention and other aspects of the affected workforces as appropriate. The Government may ask the Review bodies to consider specific issues, other than a general pay uplift that lie within their terms of reference; and
- For those groups of workers paid £21,000 or less, the Government will look to the Pay Review Bodies to provide recommendations on uplifts. The Government will submit evidence for these groups in the Autumn in the usual way, covering the usual factors, ensuring that it is in line with the policy on pay announced at June 2010 Budget.

Because of the varied positions of the Review Body remit groups, officials will again discuss in more detail with the Review Body secretariats, and where appropriate with the Devolved Administrations, before the relevant Secretary of State writes to Review Bodies about their remit, if any, for 2012-13.

Treatment of Employees earning £21,000 or less

Definition of employees earning £21,000 or less:

- This should be determined on the basis of basic salary of a full-time equivalent employee, pro-rated on the basis of the hours worked, using the standard number of hours per week for that organisation.
- Part-time workers with an FTE salary of less than £21,000 should receive a pro-rata increase on the basis of the number of hours worked.
- The £21,000 is based on the normal interpretation of basic salary and does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

Size of Increase:

It is for the Review Bodies to recommend on the size of the uplift for those earning £21,000 or less, though the Government will seek an uplift of at least £250. When considering their recommendations, Review Bodies may want to consider:

- the level of progression pay provided to the workforce;
- affordability;
- the potential for payments to be more generous for those on the lowest earnings; and
- how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper.

From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

DH Department of Health

Ron Amy OBE
Chair
Review Body on Doctors' and Dentists' Remuneration
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London
SW1A 2NS

Tel: 020 7210 3000
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22 AUG 2011

Dear Ron,

As you are aware, the Chief Secretary to the Treasury, Danny Alexander, has now written to you and the other Pay Review Body Chairs to confirm that the Government's approach to the 2012/13 pay round will be the same as to the 2011/12 round. Like Danny, I am very grateful for the independent and expert work the independent review body undertakes and I am sure this is shared by both employers and staff side representatives.

As with last year, we will not be submitting evidence but instead will provide information about motivation, recruitment, retention and other aspects of the affected workforces.

As you will no doubt recall, on the specific question of GMPs and GDPs which we discussed last year, I decided:

- based on the financial and economic position; and
- the continued need for reduction in public sector expenditure (including the 2-year pay freeze already announced by the Chancellor in the budget for all workers earning over £21,000 a year);

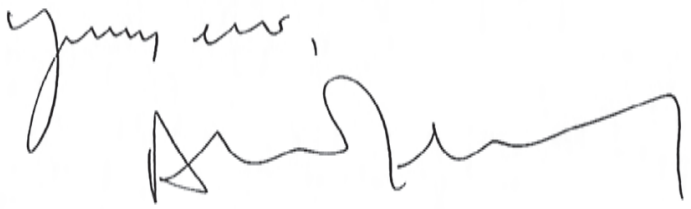
that it would not be necessary for the DDRB to make any recommendations on the need for any earnings or contract uplifts for independent contractor GMPs and GDPs in England. I continue to hold this view and confirm that the Government will make the decisions on any gross uplift, based on the efficiency assumption that we wish to apply and the evidence on non-staff expenses. Therefore, as with last year, there is no requirement to ask DDRB to play a role in the remuneration of independent contractor GMPs and GDPs for the financial year 2012/13.

We believe we have everything necessary from your past recommendations on the formulae to take forward discussions with relevant professional bodies. We remain determined to secure continued efficiencies from the investments in independent contractor GMPs and GDPs, and therefore, will reach our decisions based on the progress we can make in those negotiations.

I am aware that the DDRB makes recommendation for the whole of the United Kingdom. It is for each of the devolved administrations to make their own decision on their approach to this year's pay review round and to communicate this to you. My officials have been closely in touch, and remain closely in touch, with their counterparts in the other countries and will do all they can to support you in handling the consequences of any different approaches taken by each country.

I am copying this letter to Nicola Sturgeon, Edwin Poots, Lesley Griffiths and representatives of the BMA, BDA and NHS Employers.

Yours ever,



ANDREW LANSLEY CBE

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref MB/LG/6255/11

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

18th September 2011

Dear Mr Amy,

Following the Chief Secretary to the Treasury's confirmation of the Government's approach to the 2012/13 pay round, I am writing to confirm that the Welsh Government's stance on the pay of NHS doctors and dentists in Wales will be the same as for the 2011/12 pay round i.e for those groups of workers paid above £21.000 the Welsh Government will not submit evidence or seek recommendations on pay uplifts but will instead provide information about recruitment, retention and other aspects of the affected workforce as appropriate.

On the specific question of general medical practitioners (GMPs) and general dental practitioners(GDPs) the Welsh Government are taking the same approach as England as set out in Andrew Lansley's letter of 22 August ie that decisions on any gross uplift will be based on the efficiency assumption that we wish to apply and the evidence on non-staff expenses.

I am copying this letter to the Secretary of State for Health and the respective Ministers in the devolved administrations and representatives of the staff side and NHS Employers

Yours Sincerely

Lesley Griffiths

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Michael McGimpsey MLA

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN RÒNA
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MANNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

Mr Ron Amy OBE
Chair
Doctors and Dentists Review Body
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Our Ref: SUB/943/2010

4th October 2010

Dear Mr. Amy,

In his recent letter to you the Rt Hon Andrew Lansley CBE, Secretary of State for Health outlined his position in relation to providing evidence to the DDRB in the 2011/12 pay round; this is in light of the two year pay freeze. He also indicated that each of the Devolved Administrations would be writing to you separately confirming their own approach.

I can confirm that the two-year pay freeze for public sector workers announced in the emergency budget on 22 June will apply in the 2011/2012 and 2012/2013 years to Health and Social Care staff groups governed by the Doctors and Dentists Review Body. Northern Ireland will be providing information rather than evidence to the DDRB to enable you to undertake your role in 2011/12. This will include an update on our junior doctor recruitment position and constraints that we faced this year in relation to meeting the DDRB recommendations in full. We will however have some difficulty in meeting the deadline for submitting all information as our final position on funding will not be clarified until mid to late October at the earliest. I will however ask my officials to liaise with your Secretariat on this issue to ensure that information is provided at the earliest opportunity thus ensuring minimum disruption to your timetable.

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

Yours sincerely,

Michael McGimpsey

Michael McGimpsey MLA
Minister for Health Social Services and Public Safety

Deputy First Minister and Cabinet Secretary for Health,
Wellbeing and Cities Strategy

Nicola Sturgeon MSP

T: 0845 774 1741
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The Scottish Government

Ron Amy OBE
Chair
Doctors' and Dentists' Review Body (DDRB)
Kingsgate House
66-74 Victoria Street
LONDON
SW1E 6SW

9 October 2011

Dear Ron

In his letter of 22 August 2011, the Rt Hon Andrew Lansley CBE MP, Secretary of State for Health outlined his position in relation to providing evidence to the Doctors' and Dentists' Review Body (DDRB) in the 2012-13 pay round, the second year of a two-year freeze. He also indicated that each of the Devolved Administrations would write to you separately confirming their own approach and I am now in a position to provide you with this information for Scotland.

As you are aware, setting a remit for the DDRB process in Scotland for 2012-13 has been delayed by the timetable of the Spending Review. The Scottish Government has now considered the implications of the settlement for Scotland and has set a public sector pay policy for 2012-13 which was announced by the Cabinet Secretary for Finance, Employment and Sustainable Growth on 21 September.

The Scottish public sector pay policy sets out that pay will again be frozen (zero percent basic award) for all staff earning more than £21,000. Scotland will therefore provide information rather than evidence to the DDRB this year. We do not seek any pay recommendations from the DDRB for 2012-13.

As with last year, we will not submit evidence but rather provide information about motivation, recruitment, retention and other aspects of the affected workforces.

On the specific question of general medical practitioners (GMPs) and general dental practitioners (GDPs), I can also confirm that the Scottish Government's view is that it will not be necessary for the DDRB to make any recommendations on the need for any earnings or contract uplifts for independent contractor GMPs or GDPs in Scotland.

However, there is one area in which I would welcome the DDRB's recommendations and that is in relation to dental practice expenses of independent contractors in the General Dental Services. The system for Primary Care Dentistry in Scotland is different from England and has not been considered by DDRB in depth for some time. We would find it helpful if DDRB could carry out a detailed consideration and assessment of all the changes that have been made to practitioners' earnings and expenses in Scotland and make recommendations as appropriate for both 2011-12 and 2012-13. We will provide further details in the information we submit to DDRB by the deadline date of 28 October.

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.

Best wishes

Nicola

NICOLA STURGEON

APPENDIX B

THE DETAILED PAY SCALES

PART I: SALARY SCALES

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

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

	England and Northern Ireland[1]	Scotland and Wales
	£	£
Foundation house officer 1	22,412	22,523
	23,811	23,928
	25,209	25,334
Foundation house officer 2	27,798	27,936
	29,616	29,763
	31,434	31,589

	United Kingdom
	£
Specialty registrar (full)	29,705
	31,523
	34,061
	35,596
	37,448
	39,300
	41,152
	43,003[2]
	44,856[2]
	46,708[2]

[1] 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.

[2] To be awarded automatically except in cases of unsatisfactory performance.

	United Kingdom
	£
Specialty registrar (fixed term)	29,705
	31,523
	34,061
	35,596
	37,448
	39,300

	England and Northern Ireland	Scotland and Wales
	£	£
House officer	22,412	22,523
	23,811	23,928
	25,209	25,334
Senior house officer	27,798	27,936
	29,616	29,763
	31,434	31,589
	33,251	33,416
	35,069	35,243
	36,887[3]	37,070[3]
	38,705[3]	38,896[3]

	United Kingdom
	£
Specialist registrar[4]	30,992
	32,526
	34,061
	35,596
	37,448
	39,300
	41,152
	43,003[5]
	44,856[5]
	46,708[5]

[3] To be awarded automatically except in cases of unsatisfactory performance.
[4] The trainee in public health medicine scale and the trainee in dental public health scale are both the same as the specialist registrar scale.
[5] To be awarded automatically except in cases of unsatisfactory performance.

	England, Scotland and Northern Ireland
	£
Consultant (2003 contract, England, Scotland	74,504
and Northern Ireland for main pay thresholds)	76,837
	79,170
	81,502
	83,829
	89,370
	94,911
	100,446

Clinical Excellence Awards[6]	*England and Northern Ireland*[7]
	£
	2,957
	5,914
	8,871
	11,828
	14,785
	17,742
	23,656
	29,570
	35,484[8]

	Scotland[10]
	£
Discretionary Points[9]	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632

6 Local level Clinical Excellence Awards (CEAs) in England and Northern Ireland. For national CEAs, see Part II of this Appendix.

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

8 Level 9 CEAs are only made at national level in Northern Ireland.

9 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.

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

	Wales
	£
Consultant (2003 contract, Wales)	72,205
	74,504
	78,350
	82,818
	87,918
	90,827
	93,742

Commitment Awards[11]	*Wales*[12]
	£
	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632

	United Kingdom
	£
Consultant (pre-2003 contract)[13]	61,859
	66,285
	70,712
	75,138
	80,186

[11] Awarded every three years once the basic scale maximum is reached.
[12] Commitment Awards for levels 2 – 8 are multiples of the level 1 award (x2, x3, x4, x5, x6, x7 and x8).
[13] Closed to new entrants.

	United Kingdom
	£
Specialty doctor[14]	36,807
	39,955
	44,046
	46,239
	49,398
	52,546
	55,764
	58,983
	62,201
	65,419
	68,638
Associate specialist (2008)[15]	51,606
	55,754
	59,901
	65,378
	70,126
	72,095
	74,665
	77,235
	79,805
	82,375
	84,948

[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
	£
Associate specialist (pre-2008)	37,694
	41,687
	45,678
	49,670
	53,663
	57,655
	62,927
	67,496
Discretionary Points	*Notional scale*
	69,392
	71,866
	74,339
	76,813
	79,286
	81,762
Staff grade practitioner	34,100
(1997 contract, MH03/5)	36,807
	39,514
	42,221
	44,928
	48,115
Discretionary Points	*Notional scale*
	50,342
	53,048
	55,755
	58,462
	61,169
	63,877
Staff grade practitioner	34,100
(pre-1997 contract, MH01)	36,807
	39,514
	42,221
	44,928
	47,634
	50,342
	53,048

	United Kingdom *(Annual rates on the basis of a notional half day per week)* £
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,606
Hospital practitioner (limited to a maximum of five half	4,508
day weekly sessions)	4,769
	5,031
	5,291
	5,552
	5,813
	6,074

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

B. Community health staff

	United Kingdom £
Clinical medical officer	32,667
	34,435
	36,204
	37,972
	39,741
	41,509
	43,278
	45,048
Senior clinical medical officer	46,161
	48,971
	51,780
	54,589
	57,399
	60,208
	63,017
	65,827

C. Salaried primary dental care staff[16]

	England and Wales
	£
Band A: Salaried dentist	37,718
	41,909
	48,195
	51,338
	54,481
	56,576
Band B: Salaried dentist	58,672[17]
	60,767
	63,910
	65,482
	67,054
	68,625
Band C: Salaried dentist[18]	70,197[19, 20]
	72,292
	74,387
	76,483
	78,578
	80,674

	Scotland and Northern Ireland
	£
Dental Foundation Year 1	30,324
Dental Foundation Year 2	32,991

16 These scales also apply to salaried dentists working in Personal Dental Services.
17 Salary point is the entry level to Band B but 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 Salary point is the entry level to Band C but 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 and Northern Ireland
	£
Band 1: Community dental officer[21]	34,618
	37,418
	40,219
	43,020
	45,821
	48,621
	51,422[22]
	54,223[22]
Band 2: Senior dental officer	49,468
	53,383
	57,298
	61,214
	65,129
	65,992[22]
	66,854[22]
Band 3: Assistant clinical director	65,734
	66,752
	67,769
	68,786
	69,804[22]
	70,822[22]
Band 3: Clinical director	65,734
	66,752
	67,769
	68,786
	69,804
	70,822
	71,839
	72,874
	73,891[22]
	74,908[22]

[21] Points 2 – 8 on this scale form the Advanced Practitioner Training Grade in Scotland.
[22] Performance-based increment.

	Scotland
	£
Chief administrative dental officer of Western Isles,	57,732
Orkney and Shetland Health Boards	61,322
	64,912
	68,501
	72,874
	73,891[22]
	74,908[22]

Part-time dental surgeon	**Scotland and Northern Ireland** *Sessional fee (per hour)* £
Dental surgeon	28.40
Dental surgeon holding higher registrable qualifications	37.67
Dental surgeon employed as a consultant	46.48

PART II: FEES AND ALLOWANCES

Operative date

1. The current levels of remuneration set out below operate from 1 April 2010.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards for consultants and academic general medical practitioners (GMPs) are as follows.

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

3. The annual values of distinction awards for consultants[23] are as follows.

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

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

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

	From 1 April 2010
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 new payment system was introduced in summer 2005 for flexible trainees working less than 40 hours of actual work per week, where basic pay is calculated as follows:

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

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 is £81.72 per visit.

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

	Per week £	Per notional half day £
Associate specialist, senior hospital medical or dental officer appointment	990.88	90.08
Hospital practitioner appointment		101.47
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)		88.34

	Per week £	Per standard hour £
Specialty registrar (higher rate) appointment	883.20	18.40
Specialty registrar (lower rate) appointment	801.60	16.70
Specialist registrar appointment	883.20	18.40
Foundation house officer 2 appointment:		
England, Wales and Northern Ireland	681.60	14.20
Scotland	684.96	14.27
Senior house officer appointment:		
England, Wales and Northern Ireland	765.60	15.95
Scotland	769.44	16.03
Foundation house officer 1 appointment / House officer appointment:		
England, Wales and Northern Ireland	548.16	11.42
Scotland	551.04	11.48

	Per week £	Per session £
Staff grade practitioner appointment	835.70	83.57

	Per week £	Per programmed activity £
Specialty doctor appointment	844.80	84.48
Associate specialist appointment (2008)	1148.80	114.88

[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.

London weighting

12. 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

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

	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£
Island Health Boards: Band E			
(under 50,000 population)	1,816	3,601	
District director of public health (director of public health in Scotland/Wales):			
Band D (District of 50,000 – 249,999 population)	3,487	6,972	8,717
Band C (District of 250,000 – 449,999 population)	4,374	8,717	10,474
Band B (District of 450,000 and over population)	5,232	10,474	13,511
Regional director of public health: Band A	13,511	19,612	

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

14. The supplement payable to GMP specialty trainees is 45 per cent[29] of basic salary.

15. The salary range for salaried GMPs employed by primary care organisations is £53,781 to £81,158.

General dental practitioners (Scotland and Northern Ireland)

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

[27] See Review Body on Doctors' and Dentists' Remuneration. *Thirty-sixth report.* Cm 7025. TSO, 2007. Paragraph 1.64. Available from: http://www.ome.uk.com/DDRB_Main_Reports.aspx

[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.

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

Level 1 payment	£135 per quarter
Level 2 payment	£456 per quarter
Level 3 payment	£588 per quarter
Level 4 payment	£704 per quarter
Level 5 payment	£822 per quarter
Level 6 payment	£934 per quarter
Level 7 payment	£1,055 per quarter
Level 8 payment	£1,173 per quarter
Level 9 payment	£1,289 per quarter
Level 10 payment	£1,406 per quarter

Community health and community dental staff (Northern Ireland)

18. The teaching supplement for assistant clinical directors in the community dental service is £2,437 per year.

19. The teaching supplement payable to clinical directors in the community dental service is £2,753 per year.

20. The supplement for clinical directors covering two districts is £1,780 per year and the supplement for those covering three or more districts is £2,841 per year.

21. The allowance for dental officers acting as trainers is £1,949 per year.

APPENDIX C

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

ENGLAND[1]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[2]						
Consultants	33,875	36,040	35,128	37,016	3.7	2.7
Associate specialists	3,020	3,375	3,222	3,634	6.7	7.7
Specialty doctors	2,600	3,047	4,008	4,687	54.2	53.8
Staff grades	2,820	3,183	1,173	1,362	–58.4	–57.2
Registrar group	36,235	36,638	37,055	37,672	2.3	2.8
Foundation house officers 2[3]	7,519	7,474	7,068	7,120	–6.0	–4.7
Foundation house officers 1[4]	6,465	6,362	6,179	6,212	–4.4	–2.4
Other doctors in training	0	0	63	139	–	–
Hospital practitioners/Clinical assistants	698	2,333	509	2,147	–27.0	–8.0
Other staff	66	167	162	374	146.6	124.0
Total	**93,298**	**98,619**	**94,566**	**99,877**	**1.4**	**1.3**
Hospital and Community Health Services Dental Staff[2]						
Consultants	778	910	653	736	–16.1	–19.1
Associate specialists	115	161	121	176	5.2	9.3
Specialty doctors	92	166	154	311	67.9	87.3
Staff grades	95	126	40	70	–57.3	–44.4
Registrar group	464	470	473	486	1.9	3.4
Foundation house officers 2[3]	531	556	532	547	0.2	–1.6
Foundation house officers 1[4]	2	2	28	28	1300.0	1300.0
Other doctors in training	0	0	0	0	–	–
Hospital practitioners/ Clinical assistants	105	408	52	317	–50.2	–22.3
Other staff	1,119	1,543	1,017	1,442	–9.1	–6.5
Total	**3,301**	**4,342**	**3,070**	**4,035**	**–7.0**	**–7.1**

1 Data as at 30 September unless otherwise specified.
2 The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.
3 This includes senior house officers.
4 This includes house officers.
5 GMP specialty trainees were formerly known as GMP registrars.
6 GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.

ENGLAND[1]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**39,211**		**39,409**		**0.5**	
GMP providers	27,194		27,036		–0.6	
GMP specialty trainees[5]	3,780		3,880		2.6	
GMP retainers[6]	468		419		–10.5	
Other GMPs	7,985		8,319		4.2	
General dental practitioners[7, 8, 9]	**22,003**		**22,799**		**3.6**	
General Dental Services only	15,961		17,287		8.3	
Personal Dental Services only	2,644		2,164		–18.2	
Mixed	1,896		1,997		5.3	
Trust-led	1,502		1,351		–10.1	
Ophthalmic medical practitioners[10]	**344**		**330**		**–4.1**	
Total general practitioners	**61,558**		**62,538**		**1.6**	
Total – NHS doctors and dentists	**164,519**		**166,450**		**1.2**	

7 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.
8 Data as at 31 March of the following year.
9 Data include salaried dentists.
10 Data as at 31 December.

WALES[11]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[12]						
Consultants	1,983	2,072	2,080	2,179	4.9	5.2
Specialty doctors	189	216	292	362	54.3	67.6
Associate specialists	249	273	40	47	–84.0	–82.8
Staff grades	270	309	364	412	35.1	33.3
Specialist registrars	1,762	1,801	1,794	1,832	1.8	1.7
Foundation house officers 2[13]	482	486	468	469	–3.0	–3.5
Foundation house officers 1[14]	341	342	341	342	0.0	0.0
Hospital practitioners	6	31	5	23	–25.0	–25.8
Clinical assistants	26	121	16	80	–37.7	–33.9
Other staff	10	18	5	10	–55.8	–44.4
Total	**5,319**	**5,669**	**5,404**	**5,756**	**1.6**	**1.5**
Hospital and Community Health Services Dental Staff[12]						
Consultants	45	49	51	57	13.6	16.3
Specialty doctors	11	22	14	32	25.2	45.5
Associate specialists	12	18	6	7	–54.2	–61.1
Staff grades	8	9	9	11	19.9	22.2
Registrar group	21	22	27	28	30.8	27.3
Foundation house officers 2[13]	55	55	53	53	–3.6	–3.6
Foundation house officers 1[14]	0	0	0	0	–	–
Hospital practitioners	0	2	0	2	1.0	0.0
Clinical assistants	4	28	2	18	–35.6	–35.7
Other staff	88	118	88	122	–1.1	3.4
Total	**244**	**323**	**250**	**330**	**2.5**	**2.2**

[11] Data as at 30 September unless otherwise specified.
[12] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.
[13] This includes senior house officers.
[14] This includes house officers.

WALES[11]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners		**2,156**		**2,253**		**4.5**
GMP providers		1,940		1,991		2.6
GMP specialty trainees[15]		161		215		33.5
GMP retainers[16]		55		47		–14.5
General dental practitioners[17, 18]		**1,310**		**1,349**		**3.0**
General Dental Services only		817		967		18.4
Personal Dental Services only		300		201		–33.0
Mixed		147		127		–13.6
Ophthalmic medical practitioners[19]		**21**		**16**		**–23.8**
Total general practitioners		**3,487**		**3,618**		**3.8**
Total – NHS doctors and dentists		**9,479**		**9,704**		**2.4**

15 GMP specialty trainees were formerly known as GMP registrars.
16 GMP retainers are practitioners who provide service sessions in general practice. The practitioner undertakes the sessions as an assistant employed by the practice. A GMP retainer is allowed to work a maximum of 4 sessions of approximately half a day per week.
17 Data include salaried dentists.
18 Data as at 31 March of the following year.
19 Data as at 31 December.

SCOTLAND[20, 21]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[22]						
Consultants	4,189	4,538	4,303	4,599	2.7	1.3
Associate specialists	231	278	276	320	19.9	15.1
Staff grades	436	538	204	260	–53.3	–51.7
Specialty doctors	140	184	355	507	152.6	175.5
Registrar group	3,650	3,766	3,624	3,744	–0.7	–0.6
Foundation house officers 2[23]	782	799	819	825	4.6	3.3
Foundation house officers 1[24]	962	963	824	827	–14.4	–14.1
Hospital practitioners	26	120	22	104	–14.9	–13.3
Clinical assistants	116	411	67	267	–42.2	–35.0
Other staff	153	317	239	537	55.4	69.4
Total	**10,687**	**11,806**	**10,732**	**11,887**	**0.4**	**0.7**
Hospital and Community Health Services Dental Staff[22]						
Consultants	117	145	131	150	12.1	3.4
Associate specialists	16	20	14	18	–7.7	–10.0
Staff grades	20	28	12	16	–41.2	–42.9
Specialty doctors	4	7	18	27	394.4	285.7
Registrar group	34	39	42	48	26.3	23.1
Foundation house officers 2[23]	46	53	43	47	–5.5	–11.3
Foundation house officers 1[24]	1	1	1	1	0.0	0.0
Hospital practitioners	2	8	1	3	–52.2	–62.5
Clinical assistants	11	48	10	41	–1.9	–14.6
Other staff	392	482	435	534	10.9	10.8
Total	**641**	**812**	**708**	**871**	**10.5**	**7.3**

[20] Data as at 30 September.
[21] An employee can work in more than one board / region / specialty or grade and is presented under each group but counted once in the total.
[22] The table contains full-time equivalent and headcount medical and dental staff in post. Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.
[23] This includes senior house officers.
[24] This includes house officers.

SCOTLAND[20, 21]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners		**4,929**		**4,960**		**0.6**
GMP providers		3,800		3,775		–0.7
GMP specialty trainees[25]		465		503		8.2
GMP retainers[26]		162		164		1.2
Other GMPs		510		527		3.3
General dental practitioners[27]		**2,847**		**2,940**		**3.3**
General dental practitioners		2,737		2,742		0.2
Vocational dental practitioners		160		185		15.6
Assistant dental practitioners		51		62		21.6
Ophthalmic medical practitioners		**26**		**30**		**15.4**
Total general practitioners		**7,802**		**7,930**		**1.6**
Total – NHS doctors and dentists		**20,420**		**20,688**		**1.3**

[25] GMP specialty trainees were formerly known as GMP registrars

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

[27] Data include salaried dentists.

NORTHERN IRELAND[28]	2009		2010		Percentage change 2009-2010	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical and Dental Staff[29]						
Consultants	1,289	1,362	1,317	1,397	2.2	2.6
Associate specialists	95	110	108	125	13.7	13.6
Staff grades	242	285	231	275	–4.5	–3.5
Registrar group	1,305	1,324	1,288	1,311	–1.3	–1.0
Foundation house officers 1 & 2[30]	515	515	520	520	1.0	1.0
Hospital practitioners	94	172	88	159	–6.2	–7.6
Other staff	79	125	79	121	0.8	–3.2
Total	**3,619**	**3,893**	**3,632**	**3,908**	**0.4**	**0.4**
General medical practitioners[31]		**1,156**		**1,160**		**0.3**
General dental practitioners[31, 32]		**837**		**885**		**5.7**
Ophthalmic medical practitioners[31]		**22**		**22**		**0.0**
Total general practitioners		**2,015**		**2,067**		**2.6**
Total – NHS doctors and dentists		**5,908**		**5,975**		**1.1**

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

APPENDIX D

THE INFORMATION/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 Department of Health, Social Services and Public Safety in Northern Ireland; NHS Employers; the Advisory Committee on Clinical Excellence Awards; the Scottish Advisory Committee on Distinction Awards; the British Medical Association; and the British Dental Association and its Scottish Dental Practice Committee. The main evidence can be read in full on the parties' websites.

Information from the Department of Health

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130878

Information from the Welsh Government

http://www.wales.nhs.uk/sites3/page.cfm?orgid=433&pid=59175

Information/evidence from the Scottish Government Health and Social Care Directorates

http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nhsworkforce/pay

Information from the Department of Health, Social Services and Public Safety in Northern Ireland

http://www.dhsspsni.gov.uk/non_medical_ddrb_information_from_northern_ireland__2012_13.pdf

Information from NHS Employers

http://www.nhsemployers.org/PayAndContracts/AnnualPayReview/Pages/201213DoctorsandDentists.aspx

Information from the Advisory Committee on Clinical Excellence Awards

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_132256.pdf

Information from the Scottish Advisory Committee on Distinction Awards

http://www.shsc.scot.nhs.uk/upload/file/national_committee_services/sacda/news/2011_ddrb_evidence_41st_report_final.pdf

Information from the British Medical Association

http://www.bma.org.uk/employmentandcontracts/pay/ddrbev201213.jsp

Information/evidence from the British Dental Association and its Scottish Dental Practice Committee

http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/ddrb/index.aspx

APPENDIX E

PAY COMPARABILITY

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

Table E.1: Anchor points used for pay comparability

Anchor point	Hay reference level
Foundation house officer 1	14
Foundation house officer 2	15
Specialty registrar (years 1 and 2)	16
Specialty registrar (years 3 onwards)	17 – 19
Consultant on the scale minimum	20
Consultant on the scale maximum (with the upper quartile* Clinical Excellence Award)	21

Source: Office of Manpower Economics.
* In 2011 this was a level 5 local Clinical Excellence Award.

Data issues

E.2 It should be noted that, whilst PA Consulting have proposed anchor points which cover sub-sections of the specialty registrar group, median basic salary and median total earnings are not available for these subgroups. Consequently Figures E.3 and E.4 provide estimates of total earnings (namely, by multiplying the pay scale value by the average banding supplement for specialty registrars, 43 per cent).

E.3 Hay Group has provided medians for reference levels rather than for anchor points. For Figure E.4 the medians of the comparator groups are the median of three reference points (17 to 19) combined.

E.4 In addition, Hay Group has provided data for pharmaceutical posts for all reference levels rather than from specialty registrar year 3 onwards. PA Consulting stated that pharmaceutical physicians followed the medical path up until this point and that they would not exist as a profession prior to year 3 of specialty training. Therefore, whilst all these points have been included, they should be treated with caution as it is not clear whether these posts exist in the industry because doctors move into posts at a lower reference level when starting this career or whether this category includes posts which did not have that early training.

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

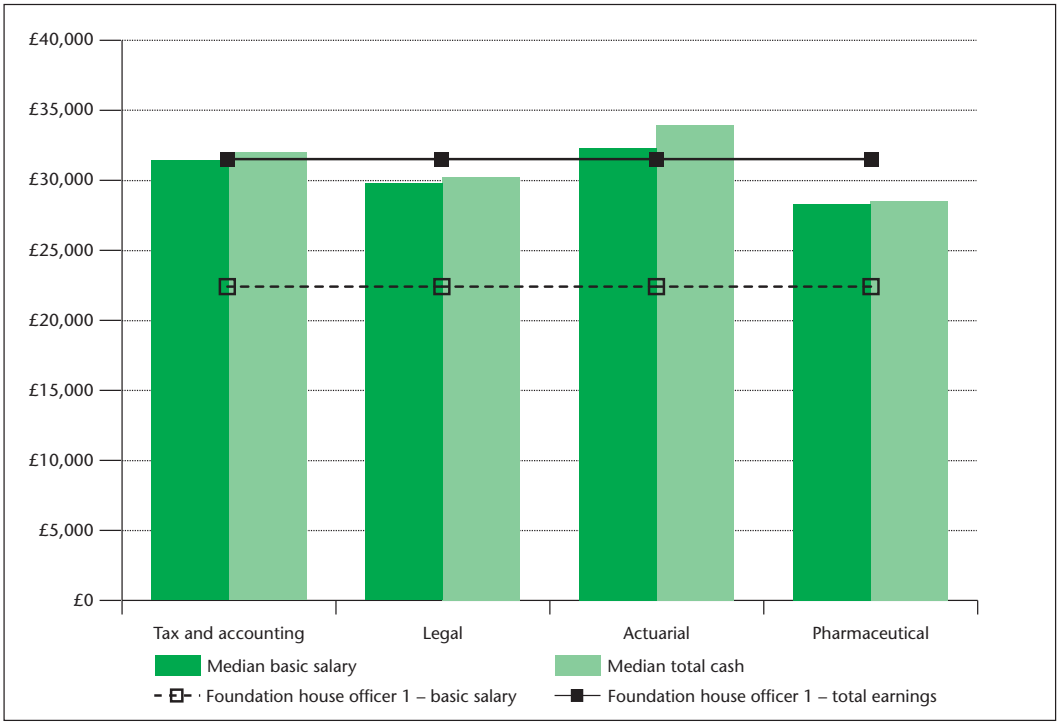
Pay comparability by anchor point

Foundation house officer 1

E.5 This first anchor point is for the first year of training following medical school. This is the first year of a two-year foundation course and builds upon the knowledge, skills and competences acquired in undergraduate training. Successful completion of this year will lead to registration with the General Medical Council. This anchor point aligns with graduate entry, although the undergraduate course is longer for medicine than for most other subjects. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E.1.

E.6 The median basic salary for foundation house officers in year 1 is well below that of the median basic salary of comparator groups. Median total earnings are broadly comparable to comparator groups, as a result of banding supplements.

Figure E.1: Foundation house officer, year 1 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2011



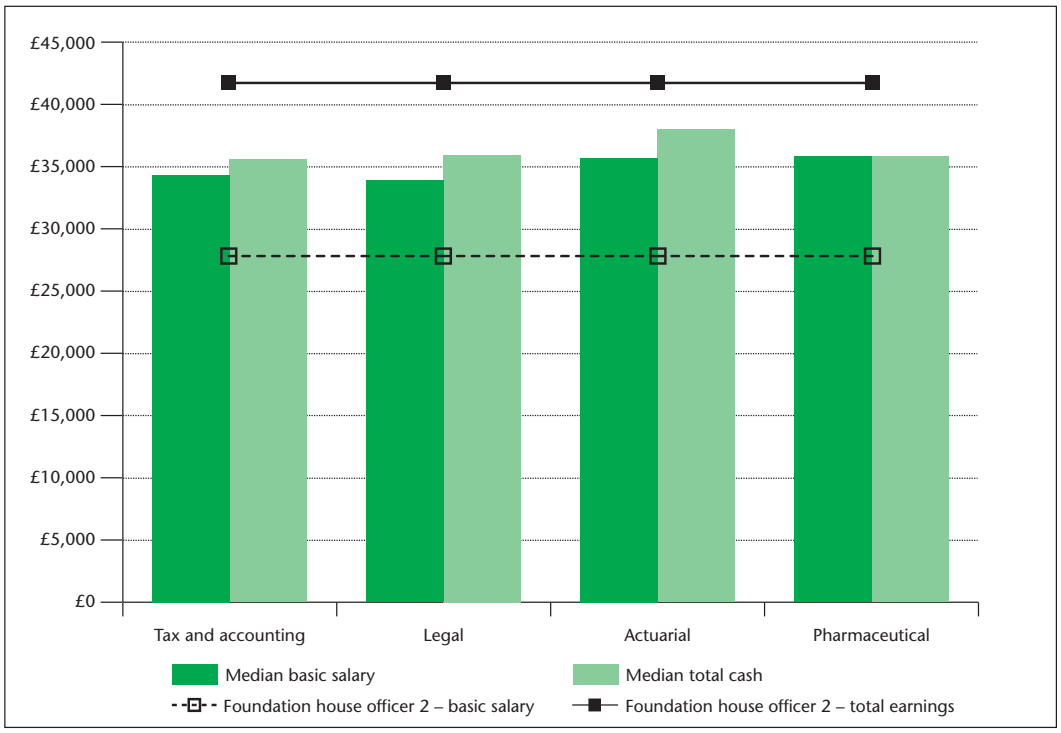
Sources: NHS Information Centre and Hay Group.

Foundation house officer 2

E.7 This anchor point marks the second and final year of the foundation course. This year focuses on training in the assessment and management of acutely ill patients. At the end of this year, doctors and dentists in training must undergo competitive entry to obtain a place on the specialty training run-through. A comparison of the median basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure E.2.

E.8 Total earnings for foundation house officers in their second year put them well ahead of their comparators: although their median basic salary is still below that of the other professions, banding supplements provide them with a median total income greater than that of their private sector cohort by about 16 per cent (except actuarial, for which the differential is about 10 per cent), but the gap has narrowed since 2009.

Figure E.2: Foundation house officer, year 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2011

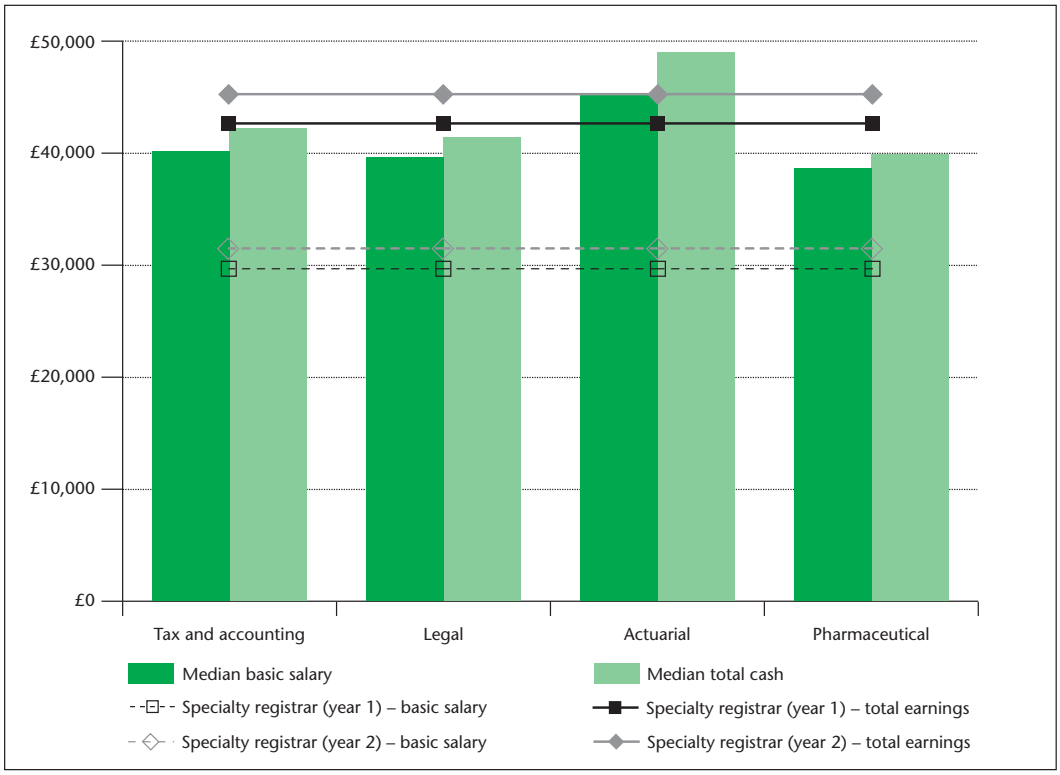


Sources: NHS Information Centre and Hay Group.

Specialty training 1 and 2

E.9 Doctors in their first two years of specialty training similarly receive basic salaries considerably lower than those of their comparators (Figure E.3). Median total earnings including banding supplements remain competitive with total cash paid to the comparator groups, but the difference (which formerly favoured specialty registrars over the private sector) has been eroded year-on-year since 2008.

Figure E.3: Specialty training years 1 and 2 – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2011

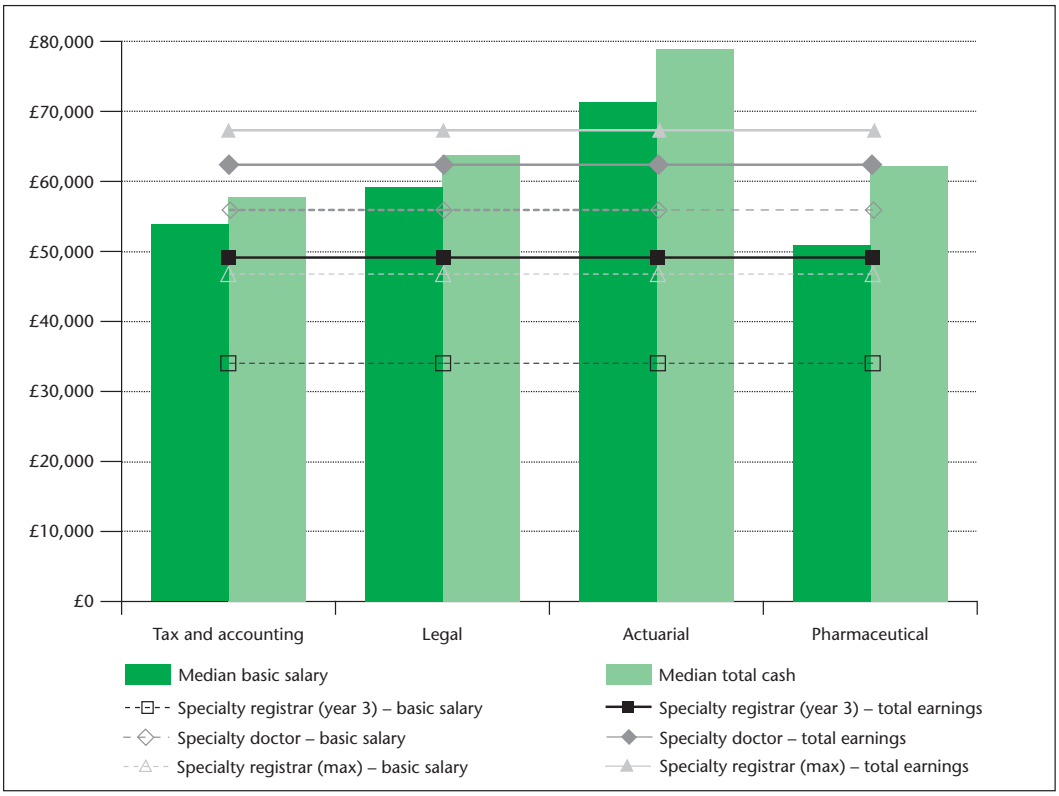


Sources: NHS Information Centre and Hay Group.

Specialty training 3 and onwards

E.10 Registrars in their third year of specialty training are required to complete Royal College membership exams; this year is also used as the anchor point for the new specialty doctor grade. Salaries and total earnings for comparator occupations cover a wide range,[2] but median total earnings of the relevant medical grades typically compare well with those of the private sector comparators (Figure E.4), though as for other training grades the relative position has worsened in recent years.

Figure E.4: Specialty training years 3 and onwards and specialty doctors – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2011



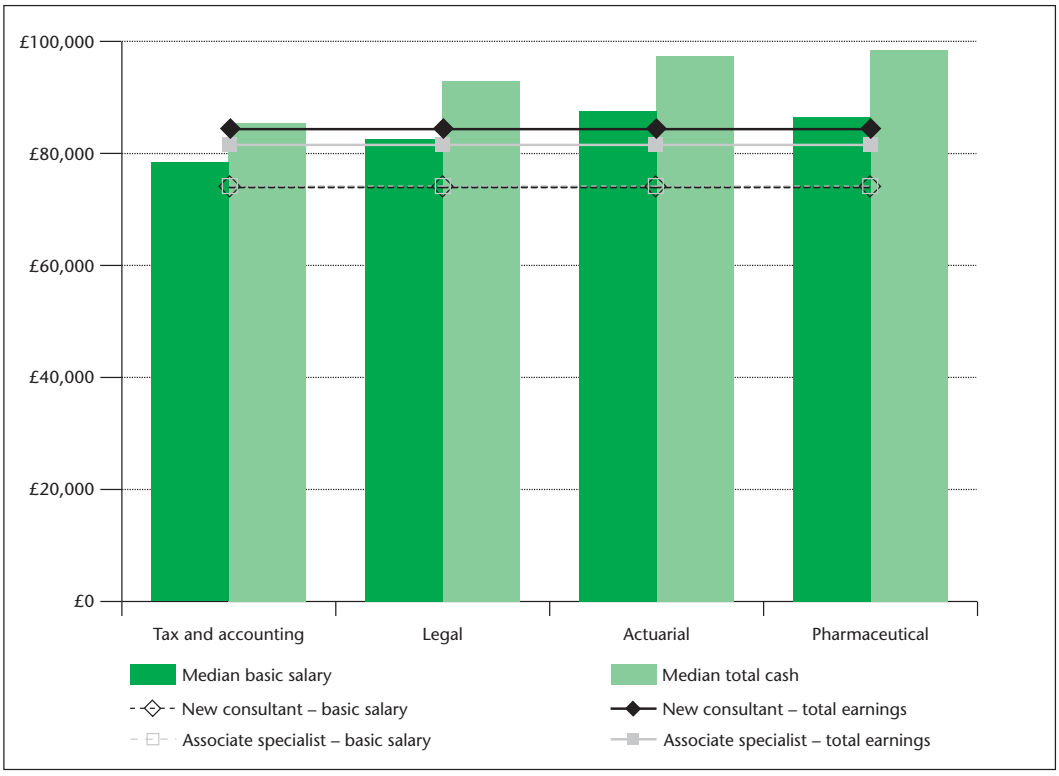
Sources: NHS Information Centre and Hay Group.

[2] This is because the comparator occupations at this anchor point span 3 Hay reference levels.

Consultant (minimum)

E.11 Entry to the consultant grade requires a formal qualification (i.e. membership of one of the Royal Colleges). Median basic salary and total earnings for newly qualified consultants are both lower than those seen in the comparator groups. Associate specialists, who are also linked to this anchor point, also have lower median incomes than employees in the comparator groups (Figure E.5). The relative position of both grades has worsened slightly since 2010.

Figure E.5: Newly qualified consultant (on the minimum of the scale), and associate specialist – median basic salary and median total earnings against median basic salary and median total cash for comparator professions, 2011

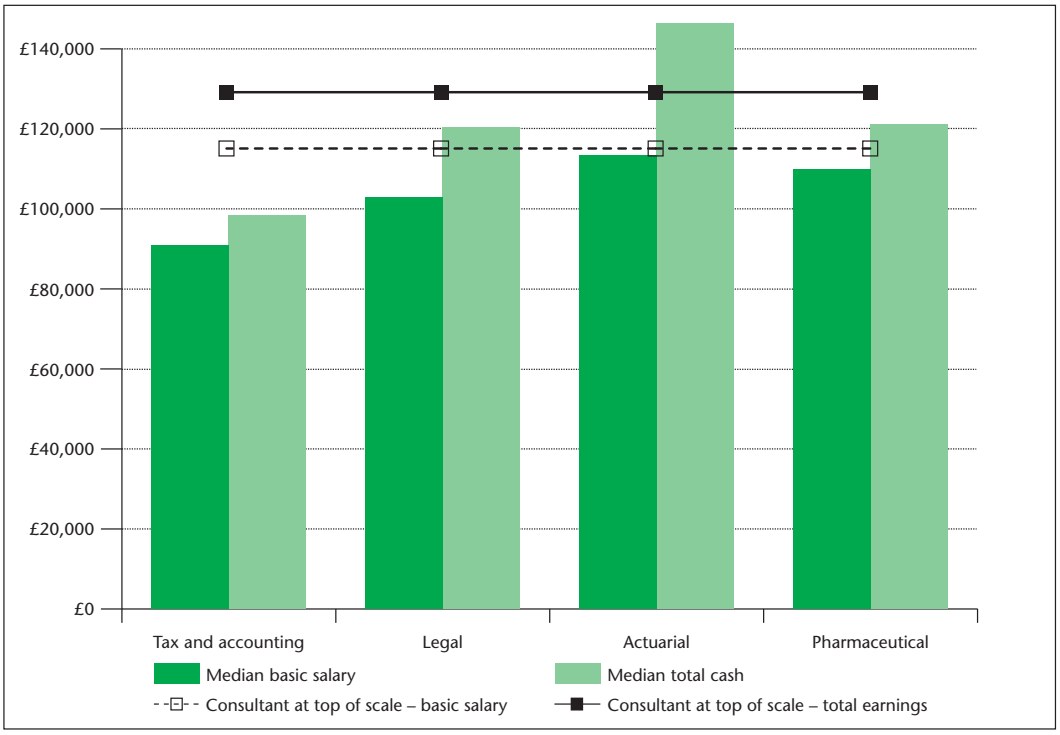


Sources: NHS Information Centre and Hay Group.

Consultant (maximum)

E.12 There is a (generally) accepted gap between the skills and responsibilities of newly qualified consultants and their more experienced counterparts. The final anchor point identified by PA Consulting is a consultant with at least 19 years' experience (and therefore at the scale maximum), with a level five Clinical Excellence Award – worth £14,785, and considered to be the upper quartile number of Clinical Excellence Awards. An experienced consultant's basic salary is higher than those for the comparator groups with similar job weights, and total earnings are higher than for three of the comparator groups (Figure E.6), though as with other grades their relative position has worsened since 2010.

Figure E.6: Experienced consultant (at the scale maximum, with level 5 Clinical Excellence Award) – basic salary and total earnings against median basic salary and median total cash for comparator professions, 2011



Sources: NHS Information Centre and Hay Group.

APPENDIX F

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
Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants (2011)	Not yet published

APPENDIX G

DDRB MONITORING ROUND 2011 – LETTER TO MINISTERS

THE REVIEW BODY ON
DOCTORS' AND DENTISTS' REMUNERATION

DDRB

OFFICE OF MANPOWER ECONOMICS
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Direct Telephone Line 020-7215 8413

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Rt. Hon. Andrew Lansley CBE MP, *Secretary of State for Health, Department of Health*

Edwina Hart MBE OStJ AM, *Minister for Health and Social Services, Welsh Assembly Government*

Nicola Sturgeon MSP, *Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Scottish Government*

Michael McGimpsey MLA, *Minister for Health, Social Services and Public Safety, Northern Ireland Executive*

7 February 2011

Dear Secretary of State,

DDRB MONITORING ROUND – 2011

Introduction

1. The Chief Secretary of the Treasury wrote to me on 26 July 2010 setting out the Government's approach to public sector pay in the context of the fiscal consolidation, in which he confirmed the approach announced in the Emergency Budget for a two year public sector pay freeze from 2011-12 for public sector workforces earning in excess of £21,000 per annum on a full-time equivalent basis ("the pay freeze"). The Health Ministers for each country subsequently wrote to us stating that due to the pay freeze we are not required to make recommendations on the remuneration of doctors and dentists, including independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs), in the United Kingdom for 2011-12. All doctors and dentists have full-time equivalent earnings of more than £21,000 and are therefore subject to the pay freeze.

2. We note from NHS Employers that employers in the NHS have welcomed the pay freeze. On the other hand, the British Medical Association (BMA) wished to place on record its view that it was inappropriate for the government to restrict the Review Body with instructions about the pay freeze. It believed that our remit obliged us to take into account both the funds available to the Health Departments (as set out in the government's

Departmental Expenditure Limits) and the government's inflation target. The BMA observed that the government had prevented consideration of any structural issues surrounding the pay of doctors and dentists. The British Dental Association (BDA) also expressed disappointment at the government's decision not to require us to report for two years. It said that at a time of uncertainty for dentists, during which primary care trusts would be abolished, the preservation of the Review Body process was important for the profession.

3. In the context of the revised remit we will continue to monitor recruitment, retention and motivation and other relevant matters. To this end we invited the parties to submit any information they considered appropriate in order for us to carry out this role. As required by our remit we also wished to ensure that we were taking account of the legal obligations on the NHS, including anti-discrimination legislation, and asked the parties to draw to our attention any relevant matters.

4. Annex A contains a supporting paper which looks at economic and general considerations as well as considering each of our remit groups.

Recruitment, retention and motivation

5. The need to recruit, retain and motivate doctors and dentists is part of our terms of reference. Motivation is of particular interest to us because it can provide an early indication of recruitment and retention problems. We address these topics in more detail at Annex A, but our view is that the overall picture does not give us any cause for concern, although the BDA information does show signs of deterioration in dentists' motivation, and the BDA and Department of Health have provided contrasting information on recruitment into the salaried dental services. We will continue to maintain an interest in these matters during the pay freeze and in particular to note any effect of the pay freeze on recruitment and retention, and to monitor the impact of the pay freeze on motivation and other changes in the NHS through the results of staff surveys. However, as yet it is too early for any trends to be identified.

Basic salary scales for foundation house officers (FHOs)

6. Our recommendation for an increase of 1.5 per cent to the basic salary scales for FHO1s and FHO2s was not accepted in either England or Northern Ireland, where the respective governments chose to limit the increase to 1 per cent. In response to this the BMA asked us to recommend that the government equalise salaries across the United Kingdom by

raising basic salaries in both England and Northern Ireland. We expect that the forthcoming contractual negotiations on a new contract for junior doctors will be United Kingdom wide, and that such negotiations will provide an opportunity for the agreement of the same pay scales across all countries of the United Kingdom.

Last year's recommendation for the uplift for general dental practitioners in Northern Ireland

7. Our recommendations on the uplift for GDPs' contract values follow a formula-based approach, which takes into account recent increases in operating costs. Our most recent report recommended an increase of 1.44 per cent in contract values in England and Wales; this was intended to deliver a zero increase in net income for GDPs. We recommended that, if the parties in Scotland and Northern Ireland did not have sufficient evidence to enable them to make adjustments to the fee scales to account for expenses, each fee scale item should be increased by 1.44 per cent; this was intended to deliver a zero increase in net income.

8. We note that the Secretary of State for Health in England took the decision to abate our recommended uplift of 1.44 per cent to the gross earnings base for GDPs by applying a prospective efficiency assumption of 1 per cent on expenses, leading to a gross uplift of 0.9 per cent. Ministers in Wales and Scotland followed the same approach, uplifting contract values and fee scale items respectively by 0.9 per cent.

9. In Northern Ireland, the figure of 0.9 per cent was multiplied by an assumed average expenses to earnings ratio of 56.1 per cent, leading to an uplift of 0.5049 per cent for GDPs in this country. We do not think this approach appropriate, as our recommendation for an increase to the feescale of 1.44 per cent (notwithstanding the decision by governments to reduce this to 0.9 per cent) already took account of an expenses to earnings ratio of 51.5 per cent. The approach taken will have the effect of requiring GDPs in Northern Ireland to make greater efficiency savings in their operating costs in order to maintain their levels of net income, than will be the case in other countries in the United Kingdom.

Clinical Excellence Awards, distinction awards and discretionary points

10. We have been asked by the United Kingdom Health Departments to carry out an independent review to look at compensation levels, incentive systems and the Clinical Excellence and Distinction Awards schemes for NHS consultants and to submit our

recommendations to Ministers by July 2011. In the light of this review we have kept our comments in the Annex brief.

Your sincerely,

Ron Amy OBE
Chairman
Review Body on Doctors' and Dentists' Remuneration

The Annex to the letter is available at:
http://www.ome.uk.com/DDRB_Main_Reports.aspx

APPENDIX H

GLOSSARY OF TERMS

ASSOCIATE DENTISTS (SCOTLAND) – 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.*

CENTRALLY FUNDED ALLOWANCES (SCOTLAND) – 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; and clinical audit; and non-contractual payments in kind and benefits such as Scottish Dental Access Initiative payments. A similar arrangement exists in Northern Ireland. See also *recruitment and retention allowance, reimbursement of practice rental costs, remote area allowance, sedation allowance, seniority payment, Scottish Dental Access Initiative payment.*

CLINICAL COMMISSIONING GROUPS – the groups of general medical practitioners and other healthcare professionals that are planned to take 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 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 group are: legal, tax and accounting, actuarial and pharmaceutical.[1]

DENTAL BODIES CORPORATE – limited companies operating dental practices. See also *incorporated business (Scotland).*

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.*

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, Distinction Awards.*

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

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 – the estimates of the expenses to earnings ratio are artificially inflated, which has the potential to distort the outcomes of the formula for uplifting dentists' contract values and item-of-service fees. This is explained fully in Chapter 2 of this report. See also *expenses to earnings ratio.*

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

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

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 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.*

INCORPORATED BUSINESS (SCOTLAND) – both principal and associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For principal dentists, the business tends to be a dental practice. For 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.*

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

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 is associate dentists. See also *associate dentists.*

PRINCIPAL DENTISTS (SCOTLAND) – 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 is providing-performer dentists. See also *providing-performer dentists.*

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 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.

RECRUITMENT AND RETENTION ALLOWANCE (SCOTLAND) – available to all new dentists. Recipients must undertake to provide the full range of General Dental Services to all categories of NHS patients during each of the three years following receipt of the first payment.

REIMBURSEMENT OF PRACTICE RENTAL COSTS (SCOTLAND) – paid to dental practices who meet the NHS commitment criteria.

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

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 PRIMARY DENTAL CARE SERVICES – these were developed predominantly in response to the need for services which could complement the independent contractor General Dental Services. They are an important part of primary care dentistry, providing generalist and specialist care largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care.

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

SCOTTISH DENTAL ACCESS INITIATIVE PAYMENT – grants for the establishment of new NHS dental practices, or the purchase or expansion of existing NHS dental practices, in areas where access to general dental services remains poor.

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

SENIORITY PAYMENT (SCOTLAND) – paid to reward dentists over the age of 55, who stay within the NHS and continue to undertake NHS dentistry.

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.

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 I

ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CESR	Certificate of Eligibility for Specialist Registration
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
DHSSPSNI	Department of Health, Social Services and Public Safety in Northern Ireland
GDP	general dental practitioner
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
HCHS	Hospital and Community Health Services
HMRC	Her Majesty's Revenue and Customs
MPET	Multi-Professional Education and Training
MPIG	minimum practice income guarantee
NHS	National Health Service
OMP	ophthalmic medical practitioner
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
PCO	primary care organisation
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
SDPC	Scottish Dental Practice Committee
SGHSCD	Scottish Government Health and Social Care Directorates

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