Review Body on Doctors' and Dentists' Remuneration

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Forty-Third Report 2015

Chair: Professor Paul Curran

Cm 9028

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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 Sport

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

by Command of Her Majesty

March 2015

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Review Body on Doctors' and Dentists' Remuneration

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971. Its terms of reference were introduced in 1998, and amended in 2003 and 2007 and are reproduced below.

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

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

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

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

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

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

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

The members of the Review Body are:

Professor Paul Curran *(Chair)*
Lucinda Bolton
Mark Butler
John Glennie, OBE
Alan Henry, OBE
Professor Kevin Lee
Professor Steve Thompson
Nigel Turner, OBE

The Secretariat is provided by the Office of Manpower Economics.

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Summary of main conclusions and recommendations

This year, **our central recommendations are for an increase in 2015-16 in (i) basic pay of 1 per cent to the national salary scales for salaried doctors and dentists in Scotland; and (ii) pay, net of expenses, of 1 per cent for independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs) for all countries of the United Kingdom**. We have reached our conclusions on pay following detailed consideration of all of the written and oral evidence we have received from the parties, also taking into account our own analysis, covering all aspects of our remit.

Terms of reference, the remits and our recommendations

Our standing terms of reference remain unchanged, but the specific requests set out in remit letters from the Health Departments differ. Scotland sought our recommendations for all of our remit groups, whilst England, Wales and Northern Ireland sought to restrict our remit to just independent contractor GMPs and GDPs. Chapter 1 describes the remit letters in more detail.

The British Medical Association (BMA) asked us to make recommendations for all of our remit groups in each country. This left us with a dilemma. If we were to accede to the BMA's request, we would be doing so against the express request of several of the other parties. A crucial aspect of our independent advisory role is that we seek to operate with the consensual agreement of the parties: indeed there is no other durable basis on which we can operate. We would also be making recommendations with incomplete evidence, which would run contrary to the ethos of an independent, evidence-based body. On the other hand, it would undermine the rationale of a pay review body if some of the parties could indefinitely circumvent the whole process, or avoid having to respond to any recommendations, by unilaterally refusing to submit evidence.

We considered this carefully and have concluded that, whilst we understand the BMA's request, for 2015-16 we should not make recommendations for salaried doctors and dentists in England, Wales or Northern Ireland. Our reasons are set out fully in Chapter 7. Our decision for this year does not affect our view that our terms of reference allow us make pay recommendations or observations should one of the parties request it – or indeed if we simply consider it appropriate. If in future years we face the same dilemma as this year, we will consider our response accordingly. Since the 1960s, the review body process has offered all parties the benefit of independent, evidence-based recommendations, and the parties regularly assure us that they find this valuable.

Remit groups, developments in the NHS and financial context

The size of our remit groups has increased by around 1.4 per cent since last year and now consists of nearly 203,000 doctors and dentists across the United Kingdom comprising approximately:

- 48,000 full-time equivalent (FTE) consultants;
- 13,000 FTE specialty doctors, associate specialists and others;
- 64,000 FTE doctors and dentists in training;
- 49,000 headcount GMPs; 29,000 headcount GDPs; and
- 349 headcount ophthalmic medical practitioners.

We considered written and oral evidence from: the Health Departments for England, Scotland, Wales and Northern Ireland; NHS England; Health Education England; the Scottish Advisory Committee on Distinction Awards; the BMA; and the British Dental Association (BDA).

We took account of recent developments within the NHS, including the publication (in England) of the *Five Year Forward View*, the Scottish Government's *2020 Vision*, the Welsh Government's *21st Century Healthcare* programme, and Northern Ireland's *Transforming Your Care*. We noted the developments on dentistry with plans for new contractual arrangements. We also noted the negotiations on contract reform for junior doctors (United Kingdom-wide) and for consultants (England, Northern Ireland and, latterly, Wales), that stalled in October 2014.

Affordability continues to be a material issue for the NHS, and provides an ongoing challenge to meet the growth in demand for services. The picture on affordability varies by country, and appears to be particularly stark in both Northern Ireland and Wales.

Salaried doctors and dentists: recruitment, retention and motivation

There are some specialties with ongoing recruitment issues, such as emergency medicine and psychiatry, and they exist for all grades of doctors across the United Kingdom. There are also geographically-specific recruitment issues, particularly in some rural and deprived areas. Our analysis of fill rates for trainees shows that for both Scotland and England, the lack of trainees choosing a career in general practice is a cause for concern. Scotland also has problems in recruiting trainees for acute medicine and some smaller specialties such as renal medicine.

The recent negotiations on contract reform for both junior doctors and consultants were intended to address how contracts might better incentivise recruitment into the less popular specialties, so we expect to return to this issue later in the year as part of our special remit on contract reform. We do not see any current recruitment issues of concern at the undergraduate entry point level, for doctors or dentists.

Evidence drawn from staff surveys shows that the motivation of hospital doctors is holding up. This is in contrast to what we heard during oral evidence with the BMA and BDA about the low morale of doctors and dentists, reiterating what we heard during our visit programme. While hard evidence is limited, we consider that recent developments have the potential to threaten consultant morale: as far as we can see, workload appears to be increasing, pension changes are perceived as negative and our recommendations to increase incremental points by 1 per cent last year in England, Wales and Northern Ireland were not implemented. In addition, in Scotland, the consultant vacancy rate has increased and there is a continued freeze on Distinction Awards. Recruitment problems in certain specialties, such as emergency medicine, will also have implications for workload pressure. We also note the survey results on the morale and well-being of community dentists/salaried dentists report a lower level of well-being and greater levels of anxiety than the general population.

Specialty doctors and associate specialists (SAS) doctors will continue to play a pivotal role in the provision of services and we would like to see this group of doctors reflected more in the quality and quantity of evidence we receive. Given that SAS doctors were not part of the contract negotiations alongside junior doctors and consultants, we ask all parties to pay close attention to SAS doctors when submitting their evidence in future years, as we consider it important to maintain their motivation and retain their contribution.

Economic background and pay comparability

Despite the falling unemployment rate, there is little evidence of upward pressure in wages across the economy as a whole. Average earnings growth was 1.7 per cent in the three months to November 2014, although the Annual Survey of Hours and Earnings shows that those in continuous employment over the year to April 2014 had earnings growth of 4.1 per cent, compared to just 0.1 per cent for all employees. Inflation data show Consumer Prices Inflation at just 0.5 per cent in December 2014, a 14-year low, and well below the government's target

rate of 2 per cent. So whilst the economy-wide wage growth is muted, this obscures some important changes in the composition of employment and pay changes in different groups. Chapter 2 gives more detail and includes our analysis of pay comparability.

Our recommendations – Scotland

In considering the actual uplift for salaried doctors and dentists in Scotland, we firstly note the level of expectation created by the public sector pay policy in Scotland for pay awards to be within an overall cost cap of 1 per cent (excluding increments). This has in practice translated into an expectation of a uniform 1 per cent rise. Scottish Government officials confirmed during oral evidence that their public sector pay policy was affordable. We note that, despite the pressures in certain specialities, the parties in Scotland have not sought differential awards for the various salaried remit groups. We have some concerns that this approach may come under pressure in the longer term, if financial constraints continue to loom large. However, for this round, having taken account of the evidence on recruitment, retention and motivation, and weighing all these factors, our judgement is that **there should be an increase of 1 per cent in basic pay for salaried doctors and dentists in Scotland, applied to all of our salaried remit groups, across the board**.

Our recommendations – United Kingdom

We have to make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale. **We see no reason to treat them differently from other salaried doctors, and recommend that the minimum and maximum of the salary range for salaried general medical practitioners in the United Kingdom be increased by 1 per cent for 2015-16**.

Pay uplift for independent contractor GMPs and GDPs

Chapters 3 and 4 of this report set out our views on the use of the formulae for determining the uplift for independent contractor GMPs and GDPs. We have commented in previous reports on the difficulties in getting satisfactory data for these formulae to operate effectively. We have now concluded that the parties are currently unable to provide us with evidence on income and expenses to the required level of robustness and detail, and that we should therefore cease using the formulae and focus our recommendations for these remit groups on pay net of expenses. The parties should then determine how to deliver our recommended uplift (if accepted) through the annual contract negotiation process, reporting back to us in the next round. Noting the value placed on the transparency of the formulae, we provide the data we would have used to populate them at Appendix E. We would consider returning to formulae-based approaches in the future, should the parties be able to provide more robust and detailed data.

In considering pay net of expenses for independent contractor GMPs, we are concerned by the poor fill rates for general practice training: this shows (at the time of writing) that fill rates are a particular issue for both Scotland and England, especially in small towns and rural areas. At the same time, we note the action that is being taken by NHS England to address recruitment into general practice, and we were struck by the apparent agreement between the parties that the main issues were related to increasing workforce numbers, controlling workload and improving the condition of premises. Clearly not all of these issues are pay related, although we do consider that pay has a role to play in influencing career decisions. However employer staff survey evidence that we receive only focuses on hospital doctors. The evidence provided to us on the motivation of GMPs was therefore limited, and we urge the parties to give priority for the collection of better evidence in this area.

Our decision not to use the formula-based approach was influenced by a decline in GMPs' real income towards levels seen before the introduction of the new General Medical Services contract. This indicated to us that the formula has not delivered our previously-recommended increases in pay for some time, and led us to consider an increase in pay net of expenses of above 1 per cent. Our terms of reference, however, also require us to take account of affordability and the evidence here would support an increase in the 0 to 1 per cent range. On balance, **our recommendation for independent contractor GMPs in all countries of the United Kingdom is for an increase in pay net of expenses of 1 per cent**.

For independent contractor GDPs, general recruitment of dentists does not appear to be an issue, although there are undoubtedly some difficulties at a regional level. The growing number of dentists in countries operating within a fixed dental budget, combined with improvements in the dental health of the population, suggests that the dentists are all competing for a smaller slice of the available NHS income. This surplus of GDPs suggested to us a recommendation for an increase in pay net of expenses in the 0 to 1 per cent range. A similar range for our recommended uplift is suggested by the evidence on affordability. On the other hand, as with independent contractor GMPs, independent contractor GDPs have not received our intended increases in pay net of expenses for several years, because of the unsatisfactory operation of the formula. In fact, their falls in pay net of expenses have been more marked than for GMPs. This has created a much larger than anticipated decrease in average GDP income over time, and leads us towards a recommendation well above 1 per cent. **However, taking all of these factors into account, our recommendation for independent contractor GDPs in all countries of the United Kingdom is for an increase in pay net of expenses of 1 per cent**.

Looking forward, our report sets out our detailed evidence requirements for future years. The priority areas are: vacancy statistics; recruitment and retention data, by both headcount and FTE; fill rates to training; and better information on GMPs' and GDPs' earnings and expenses. If the picture on affordability continues to suggest significant pressures on NHS funding, it will be increasingly important to identify where our future pay recommendations might best be targeted. The evidence requirements set out in this report will help to inform any such recommendations.

In addition, we will be considering evidence for the special remit we have been given on contract reform for both consultants and junior doctors and expect to report by July 2015.

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OFFICE OF MANPOWER ECONOMICS
12 February 2015

Part I: Overview

CHAPTER 1: INTRODUCTION

Our purpose

1.1 As an independent review body, our main role is to provide evidence-based advice to each of the four governments on the levels of pay for our remit groups. Our independence from government is built into the review body system to ensure decisions are objective and to minimise the likelihood of workplace disruption in important public sector services. A crucial aspect to our independent advisory role is that we should seek to operate with the consensual agreement of the parties; not least because we rely on the evidence submitted to us by the parties to help inform our decision making.

Remit groups

1.2 At September 2013, our remit groups comprise approximately 202,900 doctors and dentists, a 1.4 per cent increase on the previous year and a 17.2 per cent increase over the last seven years (the period for which comparable data are available). The breakdown by group is given in Table 1.1. Further details are given at Appendix C.

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

September[1]

United Kingdom	2006	2012	2013	Change over previous year	Change between 2006 and 2013
	Full-time equivalent	Full-time equivalent	Full-time equivalent	Full-time equivalent	Full-time equivalent
Consultants[2]	37,080	46,484	47,505	2.2%	28.1%
Associate specialists/staff grades/specialty doctors	9,359	11,065	11,026	-0.4%	17.8%
Registrar group	21,267	45,448	46,449	2.2%	118.4%
Foundation house officer 1 and 2[3]	33,642	16,961	17,305	2.0%	-48.6%
Other staff[4]	3,076	2,551	2,372	-7.0%	-22.9%
Total Hospital and Community Health Services (HCHS)	**104,424**	**122,510**	**124,656**	**1.8%**	**19.4%**
	Headcount	Headcount	Headcount	Headcount	Headcount
General medical practitioners (GMPs)[5]	43,766	48,547	48,550	0%	10.9%
General dental practitioners (GDPs)[6]	24,463	28,603	29,348	2.6%	20.0%
Ophthalmic medical practitioners (OMPs)	466	376	349	-7.2%	-25.1%
Total Primary Care	**68,695**	**77,526**	**78,247**	**0.9%**	**13.9%**
Total remit group FTE HCHS + headcount primary care	**173,119**	**200,036**	**202,903**	**1.4%**	**17.2%**

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

Notes:

The table also shows our remit groups for 2006, the first year for which we have United Kingdom data following Northern Ireland's entry to our remit, data for Wales include 2005 rather than 2006 as Wales' Hospital and Community Health Services data are not available for 2006 due to data collection problems. Underlying figures for 2006 can be found in Appendix C of the 38th report 2009.

[1] Most primary care data are not as September each year, but are for the nearest time period after September: GMPs as of September 2013 in England, Wales and Scotland but as of November 2013 in Northern Ireland; GDPs as of September 2013 in Scotland, but as of March 2014 in England and Wales and as of April 2014 in Northern Ireland; OMPs as of September 2013 in Scotland but as of December 2013 in England and Wales and as of April 2014 in Northern Ireland.

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

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

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

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

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

1.3 In making our recommendations, we are guided by our standing terms of reference and consider all of the evidence submitted to us by the parties, with a focus on the need to recruit, retain and motivate suitably able and qualified people, and the financial circumstances of the governments. The governments are not bound by our recommendations: it is up to Ministers to decide how to react to this advice. Our standing terms of reference form the basis for what we do and create an expectation that we will do it. In recent years, we have received remit letters from Ministers that set out specific issues on which our advice may be sought and, as described below, the limitations on our remit have been particularly apparent this year.

1.4 In last year's report, we noted that the combination of a lengthy period of highly prescriptive pay policy and several major contractual changes affecting significant parts of our remit groups had limited the scope of our remit. As then, we continue to believe that the review body process and the interests of the parties are best served when we are able to fulfil our terms of reference without any constraints being placed on us. We believe that the parties should be able to set out their evidence without restrictions to enable us to make a full assessment and reach our conclusions. As we note later in this chapter, the British Medical Association (BMA) has submitted evidence covering the whole of the United Kingdom and has sought our recommendations for all grades in all four countries. It commented that it was increasingly concerned about our ability to exercise our independence, and that it thought that our recent recommendations reflected the United Kingdom Government's pay policy and affordability constraints. It believed strongly that we should not be constrained in this way, and asked us to consider how our previous recommendations had actually been implemented when formulating our recommendations this round. The British Dental Association (BDA) said that it continued to support an independent pay review process and supported our earlier request for an unrestricted remit.

1.5 Whilst noting these endorsements of our role as an independent pay review body, we are concerned that the restrictions placed on the review body process – in this case, by the English and Welsh governments and the Northern Ireland Executive – have limited our ability to fulfil our role as defined by our standing terms of reference. Those terms of reference enshrine the fact that we are an independent body, and set out our primary role to make pay recommendations for all of our remit groups. Of course, there may be occasions – and there have been in the past – when the parties reach agreement on pay covering one or more years and therefore do not require our recommendations; but the situation in England, Wales and Northern Ireland is that a pay outcome has been imposed by one party, without the agreement of the other parties. We therefore understand the position adopted by the BMA in seeking recommendations for all of our remit groups, in each country of the United Kingdom. Our consideration of the main pay uplift is contained in Chapter 7.

The remits for 2015-16

1.6 This year's review has been informed by both our standing terms of reference (reproduced in the opening pages of this report) and the differing remits supplied to us by the countries of the United Kingdom. The Scottish Government asked us to make recommendations for all of our remit groups. The United Kingdom Government (for the NHS in England), Welsh Government and Northern Ireland Executive sought to restrict our consideration just to independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs), while the BMA sought recommendations covering all of our remit groups in all countries. We describe the various remit letters below in more detail and they can be seen in Appendix A.

1.7 The initial guidance for this round was set by a letter from the Chief Secretary to the Treasury, Danny Alexander, dated 31 July 2014, which recorded the government's belief that the case for continued pay restraint remained strong. The letter described the approach the government had taken for 2014-15 by which all staff in the NHS either received an increase worth at least 1 per cent through incremental progression, or they were given a 1 per cent non-consolidated payment. It said that the government intended to adopt a similar approach in 2015-16 and that, as a result, we would not be required to make recommendations on a pay award for employed doctors and dentists in this pay round.

England

1.8 The letter from the Parliamentary Under Secretary of State for Health, Dr Dan Poulter, dated 26 August 2014, restated this approach, stating that following the government's announcement of a two-year pay settlement for employed doctors and dentists in England, we were not required for England to report or to make recommendations or observations for 2015-16 on: the remuneration of employed doctors and dentists; the recruitment, retention and motivation of suitably able and qualified staff; and regional/local variations in labour markets and their effects on the recruitment and retention of staff. The letter did, however, invite us to make recommendations on the appropriate uplifts for independent contractor GMPs and GDPs. It said it would particularly welcome our recommendations on what allowance should be made for independent contractor GMPs' and GDPs' pay and for practice staff pay, in the context of public sector pay policy for 2015-16. The letter said that the government would make the final decisions on the gross uplift for General Medical Services (GMS) and dental contracts in the light of our recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

Wales

1.9 The letter from the Minister for Health and Social Services in the Welsh Government, Mark Drakeford, dated 6 October 2014, took a similar approach to that in England. It said that following the Welsh Government's announcement of a pay deal in respect of employed medical and dental staff based on the same quantum as England, we were not required to report on or make recommendations for 2015-16 in Wales on: the remuneration of employed doctors and dentists; the recruitment, retention and motivation of staff; and regional/local variations in labour markets and their effects on the recruitment and retention of staff. It did, however, invite us to make recommendations on appropriate uplifts for 2015-16 for both independent contractor GMPs and GDPs. In particular, it welcomed our recommendations on what allowances should be made for independent contractor GMPs' and GDPs' pay and for practice staff pay, in the context of public sector pay policy for 2015-16. It said that the Welsh Government would make the final decisions on the gross uplift for GMS and dental contracts in the light of our recommendations.

Scotland

1.10 The letter of 13 October 2014 from Alex Neil, the (then) Cabinet Secretary for Health and Wellbeing in the Scottish Government was different to those discussed above. It outlined Scotland's Public Sector Pay Policy, which was the provision for an increase in basic pay for all staff. It said that this increase was subject to an overall cost cap of 1 per cent, although there was no assumption that this would equate to a 1 per cent uplift. As last year, the cost cap did not include pay progression. Beyond that, the letter said that it wished us to be as free as possible in considering the issues and making recommendations for 2015-16. It said that all consideration of these issues must be informed by the policy framework it had set for public sector pay in Scotland, and that it

would be important to take into account the considerable ongoing financial challenge facing NHSScotland and that any pay increase had to be affordable. The letter said that the Scottish Government's position was in complete contrast with the policies set out in the letter from the Chief Secretary to the Treasury described above. It said that Scotland's preference at this time would be to maintain one unified pay system covering the whole of the United Kingdom, but recognised that this preference would present challenges to us in putting forward recommendations, and that England's application of its pay deal in 2014-15 had already seen the widening of pay differentials between the countries. The letter asked us to make a recommendation on the uplift to the dental item-of-service fees for GDPs, and in respect of independent contractor GMPs' pay and contractual uplift. Finally, the letter invited us to give due consideration to the remuneration received by Directors of Postgraduate General Practice Education in relation to levels of pay and remuneration packages of equivalents in the private sector and comparator groups.

Northern Ireland

1.11 On 5 November 2014, Jim Wells, Minister for Health, Social Services and Public Safety in the Northern Ireland Executive, wrote to us to say that the Executive had endorsed the principle of adherence to the United Kingdom government's public sector pay policy and that the enforcement of pay growth limits was devolved to the Executive within overarching parameters set by HM Treasury. The letter said that the financial situation in Northern Ireland continued to present challenges which the Executive was seeking to manage and it was within that context that he believed that pay restraint would continue to be required for 2015-16. It said that the Northern Ireland Executive was not seeking a recommendation from us specifically in relation to salaried doctors and dentists in Northern Ireland. For independent contractor GMPs and GDPs, however, we were invited to make recommendations on appropriate uplifts. Specifically, we were asked to make recommendations on what allowance should be made for independent contractor GMPs' and dentists' pay and for practice staff in the context of public sector pay policy for 2015-16. The Northern Ireland Executive would make final decisions on the gross uplift for GMS and dental contracts in the light of our recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

Other remit correspondence

1.12 We were also aware of a letter of 21 August 2014 from Dr Mark Porter, Chair of Council to the BMA, to the Chief Secretary to the Treasury. That letter noted the approach that the government intended to follow, and commented that the Review Body had been created following the recommendation of the Royal Commission on Doctors' and Dentists' Remuneration in 1960 that such a body was necessary in order to give the medical profession "some assurance that their standards of living will not be depressed by arbitrary Government action", as well as achieving "the settlement of remuneration without public dispute". The letter said that as it was always the intention that we would ourselves initiate consideration of possible changes in remuneration, the BMA would submit evidence to us and would ask us to make recommendations on the pay of all doctors for 2015-16. Indeed, the BMA submitted evidence for the whole of the United Kingdom, and sought our common recommendation for all doctors. It said that it believed strongly that we should continue to make recommendations for all grades in all nations, but if we were not able to make recommendations for hospital doctors in England, it was imperative that this did not influence our recommendations for other groups. We address the BMA's request to make United Kingdom-wide recommendations in Chapter 7.

1.13 Some of the remit letters drew particular attention to the considerable value that the parties placed on our role as an independent pay review body. The Chief Secretary to the Treasury's letter of 31 July 2014 noted that he was strongly convinced of the role of

the pay review bodies in determining national pay awards in the public sector. The letter from Dr Dan Poulter, Minister in the Department of Health, also commented on the high value the government attached to our advice and the considerable importance of our role. In his remit letter, Jim Wells, Minister in the Northern Ireland Executive, commented that he valued our work in delivering recommendations on remuneration.

Last year's recommendations

1.14 In our 42nd Report 2014, our central recommendation was for an increase in basic pay of 1 per cent to the national salary scales for salaried doctors and dentists in 2014-15. For independent contractor GMPs, we recommended that the overall value of GMS contract payments be increased by a factor intended to result in an increase of 1 per cent to GMPs' income after allowing for movement in their expenses. We made separate recommendations for each United Kingdom country in respect of independent contractor GDPs, but each recommendation was intended to result in an increase in GDPs' income of 1 per cent after allowing for movement in their expenses. We recommended that the parties should work together to improve the quality of the evidence base that we use in our formula-based approach for both GMPs and GDPs, and to report back to us, at which time we undertook to consider whether or not to continue with the existing formula-based approach. We also recommended that the minimum and maximum of the salary range for salaried GMPs should be increased by 1 per cent, and set out our view that the GMP trainers' grant should be uplifted by 1 per cent.

1.15 In response, the **Department of Health** did not accept our central recommendation for an increase to incremental pay points of 1 per cent, and instead took an approach whereby all staff who were not eligible to receive incremental pay received a 1 per cent non-consolidated payment for 2014-15. Its imposed pay settlement for salaried staff covered both 2014-15 and 2015-16: the details of the imposed settlement for 2015-16 are set out in Chapter 7. Our recommendations for independent contractor GMPs and for the pay range for salaried GMPs were accepted, but for independent contractor GDPs, the Department of Health abated our estimate of the movement in staff costs from 2.5 per cent to 1 per cent, reducing the overall uplift to contract values from our recommended level of 1.8 per cent to 1.6 per cent. No increase was made to the GMP trainers' grant.

1.16 The **Welsh Government** also did not accept our central recommendation to increase incremental points by 1 per cent and told us that it would make an award based on the same quantum as the Department of Health, equivalent to the cost of implementing the Department of Health proposals in Wales. The recommendation relating to salaried GMPs was accepted. Our recommendation for independent contractor GMPs was also accepted, but for independent contractor GDPs, the Welsh Government abated our estimate of the movement in staff costs, reducing the overall uplift to contract values from our recommended level of 1.74 per cent to 1.47 per cent. The Minister agreed a 1 per cent uplift retrospective to April 2014 to bring the value of the GMP trainers' grant in line with that in England.

1.17 The **Scottish Government** accepted all of our recommendations in full.

1.18 The **Northern Ireland Executive** did not accept our central recommendation for a 1 per cent increase in basic pay to the salary scales for salaried doctors and dentists, saying that it was not affordable. It said that, subject to the necessary approvals, it would follow the approach in England to ensure that approximately 98 per cent of staff would receive an increase of at least 1 per cent for 2014-15. For independent contractor GMPs, it rejected our recommended increase to contract values of 0.28 per cent (intended to deliver an increase of 1 per cent in net incomes), and said that the current offer proposed was for an increase of 1 per cent for pay and practice expenses. Our recommendation for an increase of 1.76 per cent to the item-of-service feescale (intended to deliver an

increase of 1 per cent in net incomes) for independent contractor GDPs was accepted. The Northern Ireland Executive also said that it accepted our recommendation to improve the quality of the evidence base for independent contractor GMPs and GDPs: it said that whilst this was likely to mean protracted discussions with the BDA and the other Health Departments, it would work towards it. At the time of writing, the Northern Ireland Executive had not indicated what decisions it had taken with respect to our recommendation and observation on the salaried GMP pay range and the GMP trainers' grant.

Background to the current round

1.19 Last year we referred to a number of influential reports relating to patient safety and service improvement.[1] These continue to have a bearing and remain an important part of the context.

1.20 This year we were interested to note the *NHS Five Year Forward View*,[2] jointly developed by NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority, that set out those parties' views on what changes they thought necessary for the NHS in England and how it could be achieved. The report puts forward proposals for a combination of tackling demand, making efficiencies and additional funding required in order to avoid a funding gap of £30 billion by 2020-21. It also has implications for our remit groups, with a call for increased investment in primary care, an increase in the number of GMP training places and new contracting models for employing doctors. We ask the parties to keep us informed.

1.21 In addition, all four United Kingdom countries were negotiating on the contract for doctors and dentists in hospital training. The consultant contract was also under negotiation in both England and Northern Ireland, with Scotland and Wales maintaining a close interest in progress: one of the main aims of the consultant contract negotiations was to explore contractual changes to facilitate seven-day services in the interests of patients. The Welsh Government announced in July 2014 that it also intended to enter the consultant contract negotiations. However, in October 2014, the BMA announced that both the junior doctor and consultant contract negotiations had stalled. Dr Dan Poulter, Parliamentary Under Secretary of State for Health in the Department of Health, subsequently wrote to us on 30 October 2014, asking us to make recommendations and observations (for England) on the junior doctor and consultant contract reform negotiations. We subsequently received similar remit letters from the Northern Ireland Executive and the Welsh Government. The Scottish Government also wrote giving us a remit to make observations on the contract for doctors and dentists in hospital training. We will be considering evidence on this additional remit and expect to report to Ministers in the relevant countries by July 2015.

1.22 We have also noted the continuing developments in each country for dentistry, with new contractual arrangements planned. In considering our recommendations for this round, we have taken account of these and all of the other NHS developments in each of the United Kingdom countries.

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[1] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Robert Francis QC, chairman. HC 947. TSO, 2013. *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*. Department of Health, August 2013. *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. Professor Sir Bruce Keogh, July 2013. *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Health and Social Care in Northern Ireland, December 2011. *2020 Vision*. Scottish Government, 2011. *21st Century Healthcare*. Welsh Government.

[2] *NHS Five Year Forward View*. NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority, October 2014. Available from: http://www.england.nhs.uk/ourwork/futurenhs/

The evidence

1.23 We received written evidence from: the Health Departments, comprising the English Department of Health, the Welsh Government, the Scottish Government Health and Social Care Directorates and the Northern Ireland Executive Department of Health, Social Services and Public Safety; NHS England; Health Education England; the Scottish Advisory Committee on Distinction Awards; the BMA; and the BDA. In line with the remit restrictions in England, Wales and Northern Ireland, the scope of the evidence from the Department of Health, the Welsh Government and the Northern Ireland Executive was much reduced; and NHS Employers, the Advisory Committee on Clinical Excellence Awards and the Foundation Trust Network (now known as NHS Providers) opted to not submit any evidence for this round.

1.24 In addition, we heard oral evidence from: The Rt Hon Earl Howe, Parliamentary Under Secretary of State for Quality; the Department of Health; the Welsh Government; the Scottish Government; the Northern Ireland Executive; NHS England; the BMA; and the BDA. Oral evidence is a key part of our review process: it enables us to inform our views by following up and discussing issues that have arisen in the written evidence and elsewhere.

1.25 We are grateful to the parties for their time and effort in preparing and presenting evidence to us, but not all parties were able to submit to schedule. The late submission of evidence restricts our ability to test the emerging issues with the other parties during oral evidence. It is also important that all parties to the process are given sufficient time to digest and comment on each other's evidence.

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

Visits

1.27 During summer 2014, we carried out a series of visits to acute trusts, health boards and primary care organisations across the United Kingdom to meet representatives of both management and the doctors and dentists to whom our recommendations apply. We thank those organisations with whom we met in 2014 for their help in the success of our visit programme. Although the visits do not form an official part of our evidence gathering (since the evidence is by nature anecdotal), they are important in informing our views, particularly on motivation and morale, and as ever, we are grateful to those we meet for their time and for the frank opinions expressed. They are also important in allowing us to pick up issues to pursue during our oral evidence sessions.

Structure of the report

1.28 Our report consists of seven chapters: this introduction; a chapter covering economic and general considerations; chapters on GMPs, GDPs, salaried dentists, hospital doctors and dentists, and finally a chapter with our main pay recommendations. The remit letters from the parties are set out at Appendix A. The detailed pay scales that result from our recommendations are at Appendix B. Tables showing the number of doctors and dentists in the NHS in the United Kingdom are at Appendix C and Appendix D contains a glossary of terms. Appendix E gives data on income and expenses for both GMPs and GDPs and shows the latest available data that we would have used to populate the formulae we historically used for our uplift recommendations for independent contractor GMPs and GDPs. Appendix F shows a list of abbreviations and acronyms used in this report.

1.29 The overall context for this review is set out in this introductory chapter, and the individual chapters for each remit group discuss relevant issues in more detail. Our terms of reference are set out at the beginning of this report.

1.30 Data used to produce the tables and graphs in this report come from different primary sources for each of the four countries: data for England from the Health and Social Care Information Centre; for Wales, from the Welsh Government; for Scotland, from the Information Services Division, which is part of NHS National Services Scotland; and for Northern Ireland from the Department of Health, Social Services and Public Safety. Some but not all of the data are produced on a comparable basis. The data are revised yearly and revisions can be made to the historical data series going back ten years: the figures represented 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.

CHAPTER 2: ECONOMIC AND GENERAL CONSIDERATIONS

Introduction

2.1 In this chapter, we consider the current economic background and the various elements of our terms of reference in a general context for the review. A summary of our conclusions relating to economic and general considerations is at the end of this chapter.

General economic context

2.2 We are required by our terms of reference to take careful account of the economic evidence and to have regard to the Government's inflation target. The United Kingdom economy as a whole grew by 2.6 per cent in 2014, its fastest rate since 2007, and a little ahead of the forecasts available to us at the time of our last annual report. The Office for Budgetary Responsibility (OBR) has forecast a similar rate of economic growth, 2.4 per cent, for 2015 and slightly slower growth, 2.2 per cent, in 2016.[1] Inflation has fallen significantly over the last year, taken down by the falling oil price, the appreciation of sterling, and falls in food prices. The Consumer Prices Index (CPI) inflation rate was 0.5 per cent in December 2014, a 14-year low, while the Retail Prices Index (RPI) rate was 1.6 per cent. CPI inflation is expected to stay below 1.5 per cent during 2015, and below its 2 per cent target until at least 2017, while the RPI rate is forecast by the OBR to end 2015 at around 2.5 per cent, with the path dependent on interest rate rises.

2.3 The labour market has continued to perform robustly over the last year. The employment level grew by 512,000 in the year to November 2014, to reach 30.8 million, over 1 million above its pre-recession peak. Employment growth over the last year has been among full-time employees and the self-employed, with the number of part-time employees broadly stable. Much of the strong employment growth over the last four years has been driven by population growth, so that the employment rate, at 73.0 per cent, is the same as its pre-recession peak in 2008. The unemployment rate has fallen substantially over the year, to 5.8 per cent in the latest figures, down from 7.1 per cent a year earlier. There remains a significant level of 'underemployment' in the labour market, however, as a high proportion of those in employment would like to work more hours.

2.4 Despite the falling unemployment rate, there is little evidence of upward pressure in wages across the economy as a whole and average earnings growth was 1.7 per cent in the three months to November. However, the recent employment growth has been concentrated among younger workers and the low skilled, and this puts downward pressure on average earnings growth.[2] The Annual Survey of Hours and Earnings (ASHE) shows that those in continuous employment over the year to April 2014 (the same job with the same employer) had earnings growth of 4.1 per cent, compared to just 0.1 per cent for all employees. So whilst the economy-wide wage growth is muted, this obscures some important changes in the composition of employment and pay changes in different groups.

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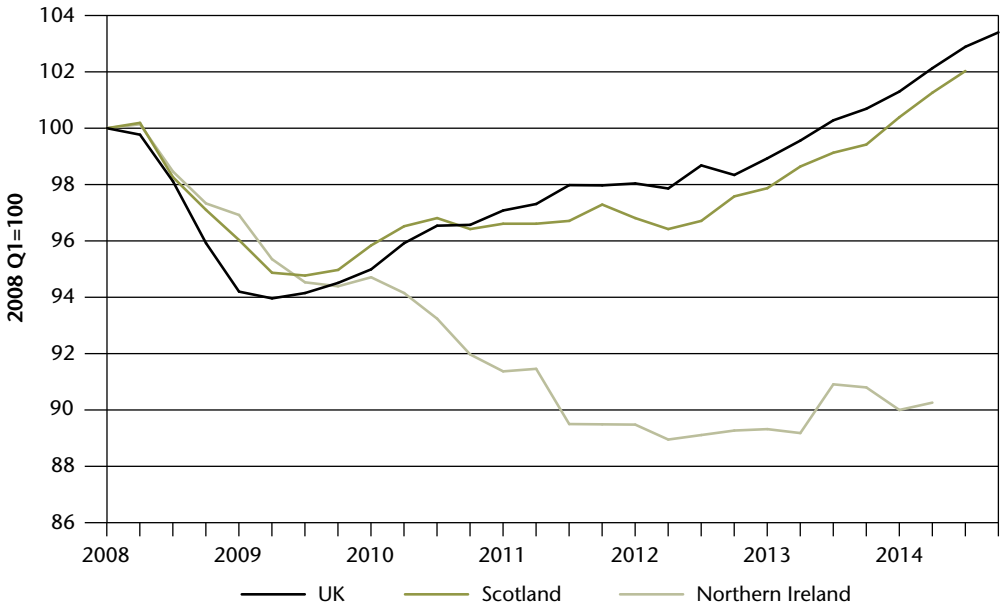
1 *Economic and Fiscal Outlook*, Office for Budgetary Responsibility, December 2014.

2 *Inflation Report*, Bank of England, November 2014.

Figure 2.1: Gross Domestic Product (GDP) level, quarterly, 2008 to 2014, United Kingdom, Scotland and Northern Ireland

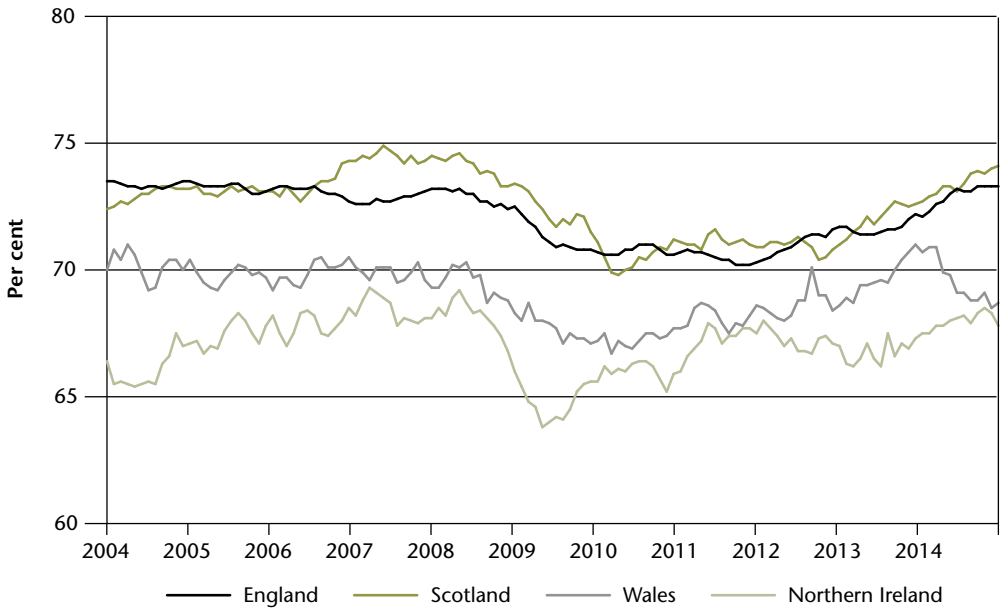


Source: ONS, Scottish Government, DETINI.

2.5 Figure 2.1 above shows how the United Kingdom economy as a whole and Scotland have regained their pre-recession size, while the Northern Ireland economy is still 10 per cent smaller. Separate Gross Domestic Product (GDP) data are not available for Wales.

2.6 Employment rates in Scotland and England are at similar levels (Figure 2.2). The Scottish employment rate was above the England rate prior to the recession (reaching a peak of 74.9 per cent in 2007, compared to a peak of 73.3 per cent in England a year earlier), when it declined more rapidly, but employment growth over the last year has taken it back above the England rate, to 74.1 per cent in the most recent figures, for the three months to November 2014, compared to 73.3 per cent in England. We note that employment rates in Wales and Northern Ireland are 68.7 per cent and 67.8 per cent respectively, suggesting a more challenging economic position.

Figure 2.2: Employment rates by country, 2004 to 2014



Source: ONS (LF3Y, LF3Z, LF42, LF5Z).

2.7 The Department of Health referred to analysis by the Office for Budget Responsibility and told us that the deficit and debt remained at unsustainable levels, with the deficit forecast to be £95.5 billion (5.5 per cent of GDP), and public sector net debt forecast to continue to rise to peak at 77.3 per cent of GDP in 2015-16, at which point the government forecast it would be spending around £59 billion on servicing its public debt. The Department said that maintaining a clear and credible path of deficit reduction, based on continued public sector spending control and public sector pay restraint, was essential to ensuring market confidence in the government's ability to get the public finances back to a sustainable position. It noted that around £164.3 billion in 2013-14 was spent on public sector pay, around half of departmental resource spending.

2.8 The Scottish Government told us that overall, the recovery in the Scottish economy was now well established and that it expected to see further strengthening throughout 2014 and into 2015. It said that recent improvements in the Scottish economy were reflected in the labour market, with encouraging trends in headline labour market indicators. It said that employment had reached its highest level on record, whilst unemployment continued to fall on an annual basis. Nevertheless, it said that challenges and legacy effects from the recession remained, including underutilisation of capacity in the labour market and subdued productivity growth. We note that parts of the economy in Scotland may be particularly affected by recent falls in the price of oil and gas.

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

2.9 We are also required by our terms of reference to take account of the funds available to the Health Departments as set out in the government's Departmental Expenditure Limits. This continued to form one of the main themes in the evidence submitted to us by the parties.

Scotland

2.10 The Scottish Government told us that the health budget had received an increase in its resource cash budget of 2.2 per cent to £11.9 billion in 2015-16. However, it said that the ageing population, new technology and the cost of drugs meant that the NHS would face considerable budget pressures. It told us that it planned to transfer £167 million from revenue to capital to support investment and provide protection of the NHS estate. The Scottish Government said that it expected NHS Boards to receive 2.4 per cent extra cash funding in 2015-16 to meet pay and non-pay pressures, with extra funding for a small number of Boards. It estimated that NHS Boards would need to deliver 3.3 per cent cash releasing efficiency savings to achieve financial balance.

England

2.11 The Department of Health said that between 2011-12 and 2013-14, NHS revenue expenditure had increased by an average 1.3 per cent per year in real terms. The Department said that the Hospital and Community Health Services (HCHS) pay bill was the largest cost pressure, accounting for around 37 per cent of the increases in revenue expenditure since 2001-02: as pay accounted for such a large proportion of NHS resources, it said that managing the pay bill was key to ensuring that the NHS lived within its funding growth. The Department said that its financial planning assessments suggested overall HCHS pay bill drift per full-time equivalent (FTE) could return to levels of around 1 per cent in 2015-16, with the gross pressure from incremental progression adding costs approaching 2 per cent of the pay bill. The Department said that there were £1.8 billion of increased revenue resources available for the NHS to meet in-year pressures, with £0.5 billion assumed to be available for pay. Achieving financial balance in 2015-16 was reliant, the Department said, on diverting activity from the acute sector, high levels of labour productivity, and a continued bearing down on the cost of procurement, drugs and pay. It concluded that this represented the biggest financial challenge in the history of the NHS.

Wales

2.12 The Welsh Government described the difficult financial challenges faced by the NHS in Wales. It said that the NHS faced a funding gap of around £1.2 billion by 2016 (out of a total NHS budget in 2015-16 of £5.81 billion, in 2013-14 prices), although if it maintained the productivity and efficiency measures already taken, the funding gap could be reduced to £221 million. It said that maintaining a focus on pay costs would be a key component of meeting the financial challenge. The Welsh Government noted £425 million of extra funding for the Welsh NHS in 2014-15 and 2015-16: in oral evidence, this additional funding was described as to "keep the lights on"; the Welsh Government said it was not in a strong position to offer a pay deal this year.

Northern Ireland

2.13 The Northern Ireland Executive did not provide us with any general evidence on NHS finances, although it did update us on funding arrangements for general dental services (GDS). It said that for the GDS budget for 2014-15, the current forecast spend was £104 million, with a £0.6 million overspend on the available budget. We were, however, acutely aware of budgetary and wider political issues within Northern Ireland widely cited in the press.

2.14 The British Dental Association (BDA) commented that it was not in a position to state whether the NHS budget in total was sufficient to meet all of its demands. It argued that the dental budget needed to increase in real terms if services were to continue to be provided to a high standard with dentists remunerated appropriately.

2.15 The British Medical Association (BMA) noted in their evidence that overall health service budgets were outside of our direct remit and influence. However, it appeared to the BMA that in recent years we had placed considerably greater weight upon affordability arguments, including the specific argument that pay restraint was required to deliver against affordability and, conversely, insufficient weight upon the impact that real terms pay cuts was having upon doctors' motivation and ability to deliver ever more care at the expense of their wellbeing and the goodwill upon which the NHS relied. The BMA went on to describe the financial difficulties facing the NHS in each country of the United Kingdom. It said that it called for a public debate on health service funding, focusing on how to reconcile increasing demand with universal and comprehensive care, without targeting the terms and conditions of the very NHS staff needed to deliver this care.

2.16 As set out in the introduction, the *NHS Five Year Forward View*[3] was published in October 2014. The report put forward proposals for the future funding of the NHS in England, noting that decisions would need to be taken by an incoming government.

2.17 Our consideration of affordability forms one strand of our deliberations, alongside (amongst others) our consideration of the need to recruit, retain and motivate doctors and dentists. We acknowledge the view of the BMA that our recent recommendations might be seen to have placed additional weight on affordability, but it has been the case that the evidence in recent years has reflected the political consensus that supports deficit reduction and this has a direct impact on the affordability of our pay recommendations. We do need to take account of the fact that pay represents a significant proportion of the NHS budget when making our recommendations. Deficit reduction is not, of course, the only objective we have in mind when formulating our recommendations. We also take account of the other factors in our remit, such as recruitment, retention and motivation, and our previous reports set out our analysis of those factors. We will continue to monitor how the present policy of public sector pay restraint impacts on those other factors and will take that into account in our future recommendations, including our recommendations for this pay round.

2.18 We note the BMA's call for a debate on health service funding, along with the *Five Year Forward View* and note that decisions on the future funding of the NHS in England will be for an incoming government. This does not, of course, fully address the issue of funding for the other countries of the United Kingdom. For our next review, we ask all countries to update us on NHS funding issues. We would also welcome evidence from the parties on any exit strategies from the current period of public sector pay restraint that might allow us to consider formulating our recommendations in order to help facilitate these; the parties were not able to offer us any such strategies during our oral evidence sessions.

2.19 Clearly, affordability continues to be a material issue for the NHS, and provides an ongoing challenge to meet the growth in demand for services. The picture on affordability varies by country, and appears to be particularly stark in both Northern Ireland and Wales.

Pay and remuneration

2.20 Levels of pay and remuneration packages for doctors and dentists are, in principle, potentially very important for recruitment and retention. In this section, we look at how doctors' and dentists' pay has changed over time, both in real terms and compared to

[3] *NHS Five Year Forward View*. NHS England, October 2014. Jointly developed by NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Available from: http://www.england.nhs.uk/ourwork/futurenhs/

the whole economy distribution of pay. We also consider how doctors' and dentists' pay compares to the private sector and to comparator groups, and look at pay drift, incremental pay and total reward issues.

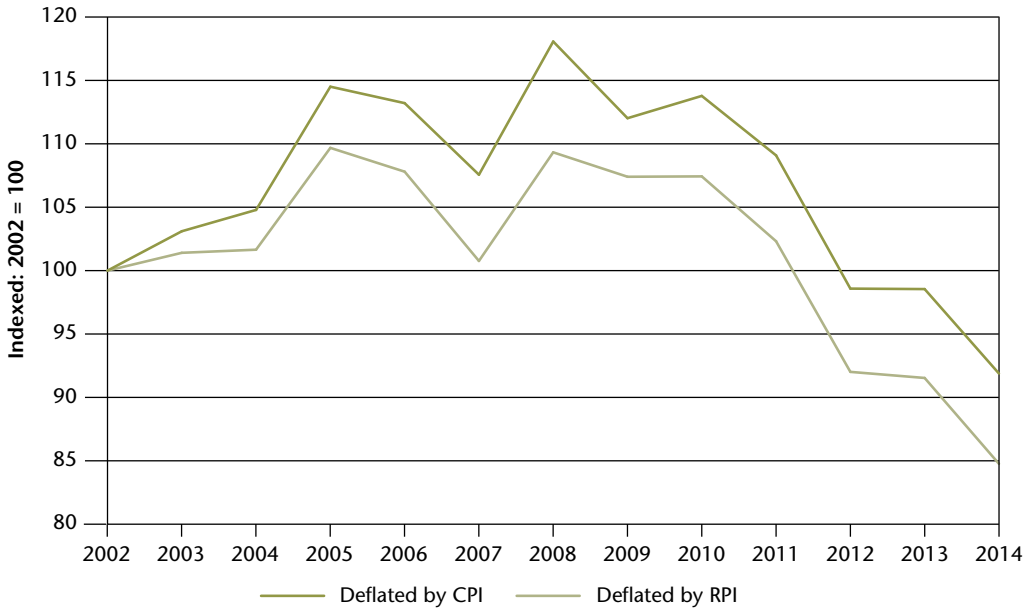
Pay levels

2.21 Figure 2.3 shows that the full-time median earnings of doctors and dentists employed in the public sector have decreased in real terms between 2002 and 2014. As CPI is generally lower than RPI, the choice of index affects the size of the decrease in real earnings. In 2012, when deflated by CPI, earnings experienced a real terms decrease of 1.4 per cent compared to 2002. In 2014, when deflated by CPI, median earnings experienced a real terms decrease of 8.1 per cent compared to 2002.

2.22 Using RPI as the deflator, in 2012, earnings experienced a real terms decrease of 8 per cent compared to 2002. Whilst in 2014, when deflated by RPI, median earnings experienced a real terms decrease of 15.2 per cent compared to 2002.

2.23 It is worth noting that the median earnings figure are influenced by the changing composition of the workforce. As shown in Table 1.1, there has been considerable growth in numbers in recent years and this shift towards new starters, taken with more early retirement, will apply a downward influence on median pay. Nevertheless, the summary plots of Figure 2.3 provide a good illustration of the impact of recent pay restraint in public sector pay.

Figure 2.3: Real terms changes in gross earnings of public sector employed doctors and dentists, April each year, 2002 – 2014



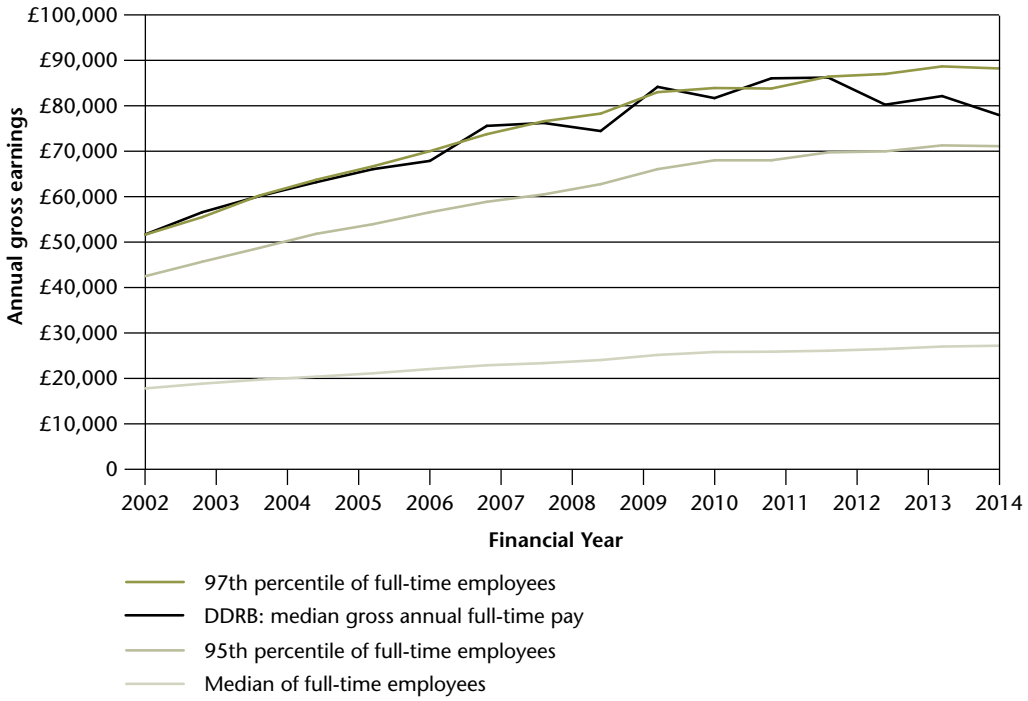
Sources: Office for National Statistics (ONS) and Office of Manpower Economics' analysis of ONS Annual Survey of Hours and Earnings' microdata.

The figures used are gross annual pay of the median all employed doctors and dentists in the public sector (i.e. excluding independent contractor general medical practitioners and general dental practitioners).

2.24 As shown in Figure 2.4, the median gross annual full-time pay for employed doctors and dentists had tended to track the 97th percentile for all full-time employees through much of 2002 – 2011 but as of 2014 this has fallen closer to the 95th percentile. The large decreases in real term earnings in 2012 and 2014 that can be seen in Figure 2.3

above can also be seen in actual earnings in Figure 2.4. ASHE data is used to monitor earnings of all employed doctors and dentists in the public sector as this gives estimates at a United Kingdom level. Although these earnings have fallen in recent years, we are told from the Department of Health's analysis of the pay bill in England, that the average earnings of doctors and dentists have increased in England (as opposed to the United Kingdom) in recent years. There could be several reasons for the mismatch between the ASHE estimates and the pay bill analysis, including sampling within ASHE and the inclusion of other countries of the United Kingdom.

Figure 2.4: Movements in earnings from the Annual Survey of Hours and Earnings, April each year, 2002 – 2014



Sources: Office for National Statistics (ONS) and Office of Manpower Economics' analysis of ONS Annual Survey of Hours and Earnings' microdata.

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

Pay comparabilities

2.25 Although pay comparability does not form part of our terms of reference, we believe it is important to assess the pay position of our remit groups relative to other groups that could be considered to be appropriate comparator professions, and against recent trends in general pay and price inflation measures, to provide a broader context. Our approach looks at both pay levels and movements. The specific comparator professions that we currently use are: legal, tax and accounting, actuarial and pharmaceutical.[4] We will consider revisiting the comparators we use once the contract reform for both junior doctors and consultants is complete and expect to return to the subject as part of our special remit on contract reform.

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

2.26 A useful source on information on comparabilities is the Higher Education Statistics Agency (HESA). This published estimates of earnings of graduates three and a half years after graduation, which equates to a doctor in specialty training in their first two years. The figures placed the first years of a career in medicine in context. Table 2.1 gives the latest estimates of earnings (as of November 2012 for 2008-09 graduates) of university first degree graduates and their employment prospects by subject. The figures show medical and dental graduates as the top earners. They also show that a very high proportion (93 per cent) of doctors and dentists are in United Kingdom work and that none are unemployed at the census point. This contrasts with those studying other subjects and subsequently working in sectors which our remit groups might consider as comparators, who earn less and for whom there is much more variability in job market outcomes. Of course, successful applicants to study medicine have amongst the highest tariff scores recorded by the Universities and Colleges Admissions Service, and might therefore be expected to be among those with the best job prospects in whichever field they chose to enter. Nevertheless, the relatively high start salary taken with the job security offered by a career in the NHS is an important consideration.

Table 2.1: Salaries and employment prospects by degree subject, United Kingdom

		Destinations of full-time first degree leavers 2011-12 and 2012-13					
First degree	**Median Salary 3½ years after leaving university (as of Nov 2012)**	**UK work**	**Overseas work**	**Combination of work and further study**	**Further study**	**Unemployed**	**Other**
Medicine & dentistry	**£40,000**	93%	0%	2%	4%	0%	0%
Veterinary science	**£30,000**	86%	3%	1%	2%	6%	2%
Engineering & technology	**£28,500**	67%	4%	3%	13%	9%	4%
Mathematical sciences	**£28,000**	53%	2%	8%	24%	9%	4%
Combined	**£27,500**	60%	3%	8%	16%	6%	7%
Subjects allied to medicine	**£26,000**	81%	1%	4%	7%	4%	2%
Computer science	**£26,000**	70%	2%	2%	9%	13%	3%
Architecture, building & planning	**£25,000**	70%	4%	5%	8%	7%	4%
Social studies	**£25,000**	62%	3%	6%	15%	9%	5%
Business & administrative studies	**£25,000**	69%	4%	6%	8%	9%	5%
Education	**£25,000**	77%	2%	4%	11%	3%	3%
Physical sciences	**£24,000**	52%	2%	5%	27%	9%	5%
Law	**£23,000**	46%	2%	11%	30%	6%	5%
Languages	**£23,000**	53%	6%	7%	21%	7%	6%
Historical & philosophical studies	**£23,000**	53%	3%	7%	23%	8%	6%
Biological sciences	**£22,000**	58%	2%	7%	20%	7%	5%
Agriculture & related subjects	**£20,500**	67%	3%	5%	11%	7%	6%
Mass communications & documentation	**£20,000**	73%	2%	3%	6%	11%	5%
Creative arts & design	**£20,000**	72%	3%	4%	8%	9%	5%
Total – Science subject areas	**£25,500**	68%	2%	5%	15%	7%	4%
Total first degree	**£24,500**	65%	3%	6%	14%	8%	5%

Source: Higher Education Statistics Agency.

2.27 Figures 2.5 and 2.6 provide more detailed analysis of doctors' and dentists' pay relative to the national distribution and other professional groups at different points in their careers. Figure 2.5 considers doctors and dentists in training (foundation house officers and specialty registrars), staff grades and specialty doctors. For these groups, our analysis has estimated the distribution of salaries on a per person basis, not an FTE basis: these salaries would tend to be lower than FTE salaries and should therefore be interpreted with that in mind. From our analysis this year, the results show that:

- median total earnings for foundation house officers (FHOs) in year one was higher than the FTE national average;
- median total earnings of FHOs in their second year were in the top 25 per cent of all United Kingdom employees but on average earned less than staff in comparator groups;
- median total earnings for specialty registrars (£53,000) were close to being in the top 10 per cent of all United Kingdom employee earnings (£54,100 or higher), but their median earnings were more than 5 per cent behind all but one of the comparator groups; and
- there were large degrees of overlap between the distributions of earnings for staff grades and specialty doctors and their comparator groups, although their median total earnings compared well to most of the comparator groups.

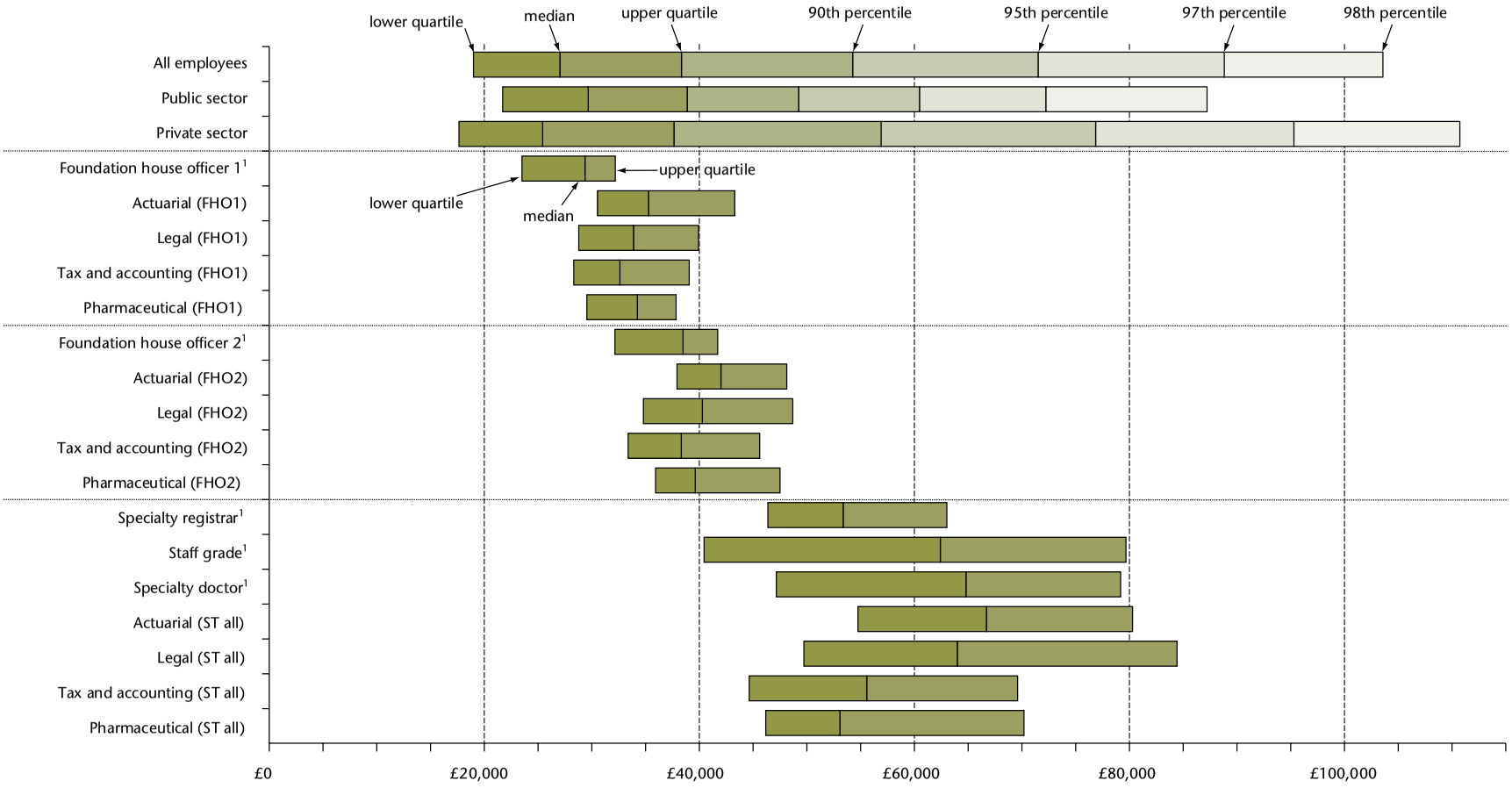
2.28 Figure 2.6 compares associate specialists, consultants, independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs) with the national pay distribution and other professional groups. Our analysis has again estimated the distribution of salaries on a per person basis, not an FTE basis, so we attach the same caveat to this analysis as in the previous paragraph. Our analysis shows that, compared with employees in the wider economy:

- median earnings per person for associate specialists were above the 95th percentile;
- median earnings (including awards) for consultants were well above all employees at the 98th percentile;
- median taxable income for independent contractors, both contractor GDPs and providing-performer GDPs were between the 97th and 98th percentiles;
- the lower quartile for independent contractor GMPs was around the 95th percentile for the wider economy; and
- the median taxable income for salaried GMPs and performer-only GDPs was around the all employees 90th percentile.

2.29 Against their specific comparators:

- associate specialists tended to earn less on average;
- consultants' median total earnings lay between the minimum and maximum anchor point earnings estimates for their comparator groups;
- median earnings of independent contractor GMPs and GDPs were similar to earnings in their comparator groups at the lower anchor point; and
- salaried GMPs and performer-only GDPs appear to earn less than members of their comparator groups.

Figure 2.5: Total earnings inter-quartile ranges of DDRB training grades, staff grades and specialty doctors 2014, compared with the national pay distribution and other professional groups, full-time rates[1]

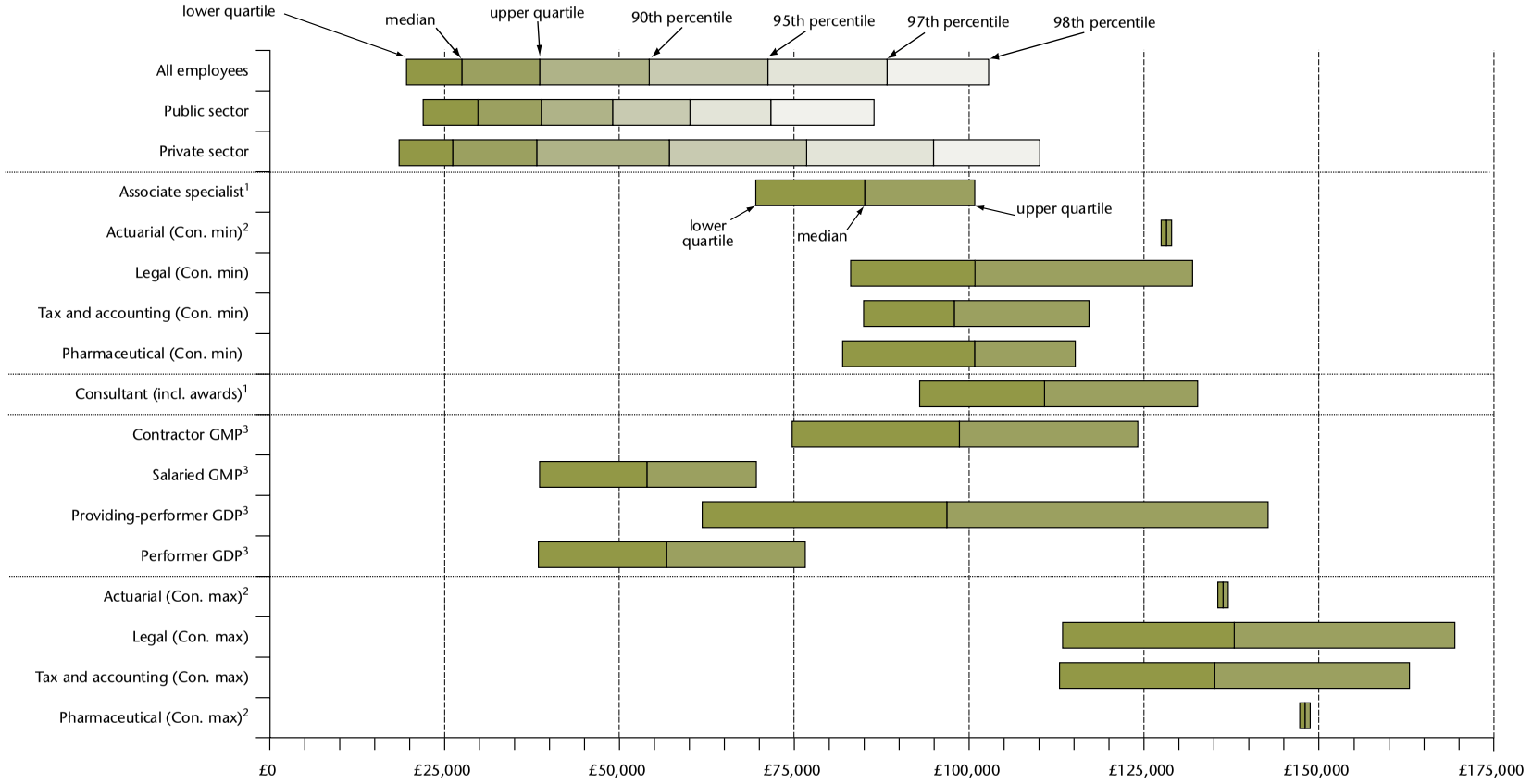


Sources: The Office for National Statistics, Health and Social Care Information Centre, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending June 2014, by headcount.

The range for specialist training (ST all) covers four distinct reference levels / job weights and the median and quartiles presented are for these four combined.

Figure 2.6: Total earnings inter-quartile ranges of consultants and equivalent grades, 2014, compared with the national pay distribution and other professional groups, full-time[1]



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

[1] Figures for hospital medical grades, contractor and salaried general medical practitioners and contractor general dental practitioners relate to total earnings in the year ending June 2014, by headcount.

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

[3] Estimated median incomes (before tax) for 2012-13 for all (both full-time and part-time) general medical practitioners and general dental practitioners (the latest available data).

2.30 In our last report, we set out our request to the parties to provide us with a greater understanding of our remit groups' earnings. We appreciate that the provision of these data is likely to be a significant undertaking, however greater granularity in earnings information would enable us to better determine where are remit groups are positioned within the overall labour market. Using the latest available annual data, for each of our remit groups within the hospital sector, we would ideally like a breakdown by age, by gender, by specialty and by country (to also include FTE and headcount figures) in order to build up a picture of the wage distribution for our remit groups. We are particularly interested in total earnings, but would welcome any additional breakdown of the components of such earnings. We would also find it helpful to be provided with anonymised sample career profiles for different specialties and grades. We set out at the end of the chapter our priorities for data and evidence.

Pay drift and incremental pay progression

2.31 Incremental pay progression is the way that the pay of staff increases as individuals move up the points of a pay scale. Table 2.2 below shows the change in the pay bill per FTE in England over the period 2009-10 to 2013-14. We note that it shows that for all HCHS doctors in England, pay bill per FTE growth was 1.2 per cent for 2013-14. We ask all Health Departments to provide us with equivalent pay drift data in future rounds.

Table 2.2: Change in costs of all Hospital and Community Health Services doctors and dentists (non-locum) staff pay bill, 2009-10 to 2013-14, England

		2009-10	2010-11	2011-12	2012-13	2013-14
1	**Pay bill per FTE Drift**	**0.3%**	**-0.7%**	**0.1%**	**0.6%**	**0.2%**
	of which:					
	Basic pay per FTE drift	*0.7%*	*0.8%*	*0.7%*	*0.7%*	*0.1%*
	Additional earnings per FTE drift impact	*-0.4%*	*-1.6%*	*-1.2%*	*-0.1%*	*0.0%*
	Total on-costs per FTE drift impact	*0.0%*	*0.1%*	*0.6%*	*-0.1%*	*0.1%*
2	**Basic pay settlement (pay uplift)**	**1.5%**	**0.4%**	**0.0%**	**0.0%**	**1.0%**
3	**Pay bill per FTE growth (1 + 2)**	**1.8%**	**-0.3%**	**0.1%**	**0.6%**	**1.2%**
4	**Average FTE growth (volume of staff)**	**3.4%**	**2.4%**	**1.8%**	**2.0%**	**1.1%**
Aggregate pay bill growth (sum of 1+2+4)		**5.3%**	**2.1%**	**1.9%**	**2.6%**	**2.3%**

Source: Department of Health's Headline Hospital and Community Health Services pay bill metrics (experimental – unpublished data).

Note: All totals are derived from unrounded figures.

2.32 Our recommendations in our last report were intended to apply to the pay points within pay scales. However, only Scotland accepted our recommendation to revalorise the pay scale points. The other countries of the United Kingdom did not increase the value of pay scale points, with the Department of Health commenting that the continuing need to support fiscal consolidation, together with the unprecedented challenge facing the NHS, meant it was unable to support our recommendations in full. For this round, the Department of Health and the Welsh Government told us that it was not seeking our recommendations on pay for salaried staff, as they both intended imposing a pay settlement whereby salaried staff would receive a non-consolidated payment of 2 per cent if they were at the top of their pay scales, except for those staff that did receive an increment in 2014-15 – they would receive a non-consolidated payment of 1 per cent. Pay scales would not be uplifted. The Welsh Government later told us during oral evidence that it hoped to hold discussions with the BMA and the BDA on how it might distribute the available funding as part of a negotiated pay settlement for 2015-16.

The Northern Ireland Executive did not seek our recommendations for salaried staff for 2015-16, although it did not indicate what approach it intended taking for salaried staff in 2015-16. Scotland told us that the cost cap for its pay policy for our remit groups did not include pay progression.

2.33 Incremental pay was being considered as part of the negotiations on contract reform for both junior doctors and consultants, so we expect to return to this issue as part of our special remit.

Total reward: pensions and other benefits

2.34 The NHS Pension Scheme continues to be a valuable recruitment and retention tool. The Department of Health told us that a new pension scheme would be introduced in April 2015 that would:

- calculate pensions using average earnings;
- calculate pension benefits based on Normal Pension Age linked to the State Pension Age; and
- would include an employer cost cap mechanism.

2.35 The Department said that public service pensions remained amongst the best available, offering guaranteed index-linked benefits protected against inflation, and that private sector workers would need to contribute over a third of their salary each year to buy an equivalent pension. It argued that higher paid NHS staff continued to pay a reasonable amount for their pension, contributing a similar proportion of their salary as other NHS staff on lower incomes once tax relief was taken into account: a doctor on a salary of £80,000 only contributed 0.66 per cent more than a nurse on £30,000, net of tax relief. The BMA said that the continuation of tiered contributions in a career average scheme undermined the principle of collective provision; and the BDA argued that tiered contribution rates had some justification against the background of promotional pay scales, but were no longer relevant following the demise of final salary schemes. In response, the Department of Health said that in the short term, 70 per cent of active pension scheme members had transitional final salary protection; and the retention of a tiered structure was therefore appropriate. It said that a commitment had been given to reconsider the contribution structure from 2019.

On behalf of the Office of Manpower Economics (which provides secretariats for all of the pay review bodies), Towers Watson undertook a study[5] of the pension benefits for a small number of illustrative career paths of individuals from across the various review bodies. The study estimated the value of the pension benefits provided by both current public sector pension schemes and by their successor schemes from April 2015. The results were not intended to provide a comprehensive assessment of the changing value of pensions but, rather, to indicate the impact of changes on illustrative career paths.

For each illustrative career path, pension benefits were valued and compared at four dates: September 2010 and 2013, and April 2015 and 2016. The methodology produced the net[6] value of employee benefits:

- over the employee's whole career (and compared this with benefits that someone with an identical career path/earnings pattern would receive from a typical private sector pension scheme: a defined benefit scheme, a defined contribution scheme, and a representative mid-level scheme); and
- over the next year of service across the employee's career.

Overall, the research concluded that public sector pension benefits across the whole public sector remain comparatively good. While the changes to public sector pensions since 2010 narrowed the gap, in general across the public sector groups studied, there remained a material difference between the net value of their pension benefits and alternative pension benefits in the private sector.

The research looked at three sample career profiles for staff within our remit groups: two based on hospital doctors (currently aged 25 and 40) and a salaried dentist (currently aged 30), although given the range of factors that would influence the results (including age, career decisions and achievement of awards), the career profiles used may not be typical. Nevertheless, for our remit groups, the study showed the importance of career path on the value of pension benefits. It highlighted the value of salary progression (the faster the salary progression, the greater the net value), although this was less of a factor in the 2015 scheme as it is a career average scheme. The importance of completed service, age and salary level at the time the 2015 scheme was introduced were also key factors. **Looking at the benefit changes between 2010 and 2013**, the change from RPI to CPI indexation in April 2011 had a significant impact on the net value of employee benefits: the indexation changes were of particular significance as they affected pension benefit entitlements in respect of past service and future service. In contrast, the subsequent changes to member contributions, member retirement ages and the move to career average benefits only affected pension benefits in respect of future service. **Looking at the 2013 to 2015-16 changes**, in general over the whole career, the changes to benefits in 2015 and 2016 were expected to have a similar impact to the changes between 2010 and 2013 for a member remaining in the scheme until retirement, although transitional arrangements would further protect some older individuals from the 2015 changes. **Reductions in private sector pension benefits** between 2010 and 2016 were less significant than the changes in the remit groups' pension benefits, but there had been very significant changes to private sector pension benefits over the preceding decade.

[5] *Comparative Pension Valuation for Review Body Remit Groups*. Office of Manpower Economics, November 2014. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370439/Report_on_results_of_comparative_pension_valuation___appendices_8_Oct_20___.pdf

[6] Pension benefits were valued net of member contributions. Other things being equal, rising member contributions would result in lower net pension value.

2.36 Responding to the study, the BDA said that increased contribution rates and reduced tax relief were leading to an increasing number of dentists opting out of the NHS Pension Scheme, and an increasing reduction in total reward to all dentists over their lifetime. It said that it could no longer be argued that doctors and dentists enjoyed a gold-plated public service pension that was the envy of the private sector. The Department of Health told us that across all staff covered by the NHS Pension Scheme, there had been an increase in membership since October 2011 of between 3.3 and 3.6 per cent, with a slight 0.3 per cent decrease from January 2014. Whilst the reasons for the slight reduction were unclear, the Department said that the reduction in the lifetime allowance might be a factor. However, it said that the NHS Pension Scheme remained a good option for investment. From the available information in the valuation data for GDPs specifically, the Department said that it had noticed a distortion of the dental practitioner numbers. It said that the reason for this had been the removal of significant numbers who should not have been included as active members as they had no or trivial earnings so were ineligible for membership. We ask the parties to keep us updated on the opt-out position for the NHS Pension Scheme.

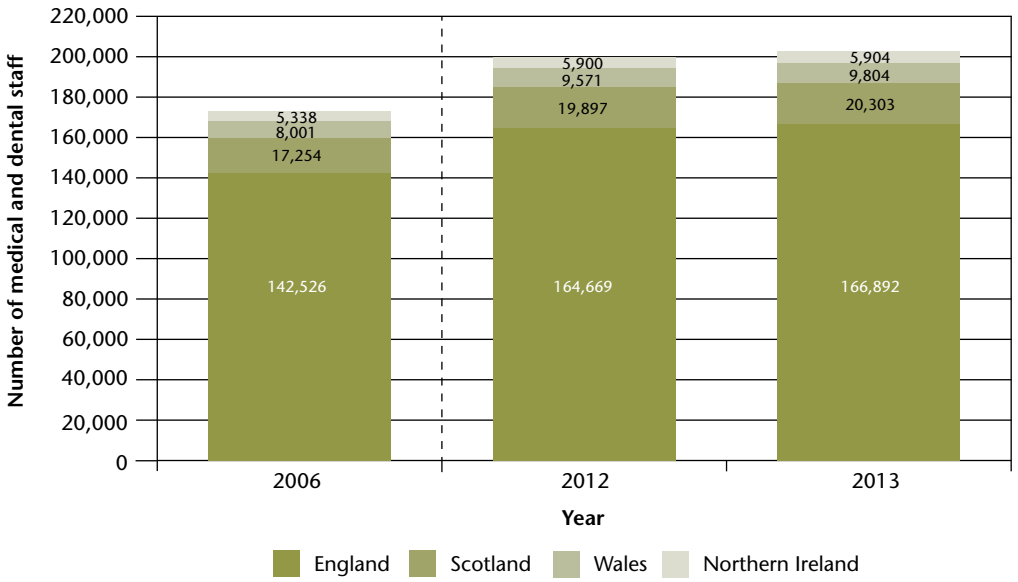
2.37 Our conclusion following reform of pensions is that the NHS Pension Scheme continues to provide significant benefits, but our remit groups will be contributing more in the future, for somewhat smaller benefits, and given the limit to the lifetime pension allowance this represents a reduction in their total reward. Private sector pension schemes may well offer more flexible total reward arrangements. Given the impact on the value of pensions by recent changes, we wish to monitor closely the impact on our remit groups' recruitment, retention and motivation, and ask the parties to keep us informed so that we can take this into account in our recommendations. As part of our special remit on contract reform, we may also wish to examine the impact of any changes to pensions arising from contractual changes for our remit groups.

2.38 We commented in our last report on the lack of any strong total reward strategies from the parties that would allow us to make our pay recommendations within a broader context. We are therefore disappointed to note the lack of such information in the evidence provided for this round, although this may in part be explained by the reduced scope of our remit for 2015-16. We ask the parties to address this evidence requirement for our next round.

Recruitment and retention

2.39 Our terms of reference require us to have regard to the need to recruit and retain doctors and dentists. Figure 2.7 below shows that the number of medical and dental staff in each country has increased over the last year, and there have been large increases since 2006 when Northern Ireland joined our remit. Our remit groups comprised approximately 203,000 in September 2013, a 1.4 per cent increase on the previous year.

Figure 2.7: Number of medical and dental staff,[1] United Kingdom, 2006 and 2012 – 2013



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

[1] Medical and dental staff are FTE Hospital and Community Health Service (HCHS) staff and headcount of primary care staff. Wales include 2005 rather than 2006 as Wales Hospital and Community Health Services data are not available for 2006 due to data collection problems.

2.40 The Scottish Government referred to the recently published Greenaway Report on the *Shape of Training*[7] as having potential to mitigate shortages at various levels in the medical supply chain. It said that the report remained subject to a great deal of discussion in Scotland and that it would take six to eight years for any improvements from implementation to manifest themselves. In the interim, the Scottish Government said it would continue to face the challenge of providing medical care at both the middle grade and consultant level. It identified immediate pressures in emergency and acute medicine. The Scottish Government said that international recruitment provided one way to address shortages in both the immediate and longer term. Commenting on vacancy levels, it said that they had increased slightly over the last year, but that they remained at a generally low level.

2.41 As the Department of Health, Welsh Government and Northern Ireland Executive did not give us a remit to report on the recruitment and retention of salaried staff, they did not offer any evidence on the general recruitment and retention picture.

2.42 The BMA commented on the continuing lack of data around vacancies and recruitment and retention. It referred to a *Telegraph* article suggesting an increase in the number of doctors planning to work in Australia and Canada. In supplementary evidence, the BMA said that many junior doctors foresaw at least an early portion of their career outside the NHS. We note from the General Medical Council's annual report on *The State of Medical*

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

Education and Practice in the United Kingdom[8] that the most recent data shows a slight drop in the numbers going to Australia and New Zealand, and that "modern medicine is global: we benefit from the skills of doctors from around the world and other nations benefit from doctors trained in the United Kingdom". Nevertheless, we would welcome evidence from the parties that analysed career movements over time, both to and from the United Kingdom, to provide better data and information about how doctors and dentists are thinking about their careers and the role of relative rewards on offer in such careers.

2.43 Based on the evidence submitted to us for this round, we do not see any current recruitment issues of concern at the undergraduate entry point level. However, there are some specialties with ongoing recruitment issues, such as emergency medicine and psychiatry and this is for all grades of doctors. There are also geographic-specific recruitment issues, particularly in some rural and deprived areas. Some of these issues should be capable of being addressed by the use of the consultant contract recruitment and retention premia, although the evidence we have been provided with in earlier reviews suggests an unwillingness by employers to use this aspect of the consultant contract in its current form. For Scotland and England, lack of trainees choosing a career in general practice is also an issue. The recent negotiations on contract reform for both junior doctors and consultants were intended to address how contracts might better incentivise recruitment into less popular specialties, so we expect to return to this issue later in the year as part of our special remit. We will, of course, wish to consider to what extent any of the recruitment issues are pay-related. We comment on the recruitment and retention evidence related to the particular remit groups within each chapter, including our analysis of the fill rates for GMP trainees in Chapter 3 and doctors and dentists in hospital training in Chapter 6.

2.44 Evidence from the parties on recruitment and retention for all of our remit groups that also takes into account headcount and FTE data, regional variations, the implications of any moves towards seven-day services, the increasing proportion of women in the workforce, and (in England) the target to increase the number of trainees choosing to enter general practice is needed in order for us to properly assess this aspect of our terms of reference. We would also welcome the parties' assessment of any implications for pay of such evidence.

Vacancy data

2.45 We urge the four Health Departments to prioritise the publication of vacancy statistics. Vacancy data are fundamental to our being able to fulfill our role as set out in our terms of reference. For our next round, we ask for an update on how plans for providing an alternative source of data on vacancies using the NHS Jobs website are proceeding. We also consider it important to our deliberations to consider the extent and cost of the use of locums to fill service gaps, broken down by specialty and grade, and ask the parties for such information for our future reviews.

[8] *The State of Medical Education and Practice in the United Kingdom Report: 2014*. General Medical Council, 2014. Available from: http://www.gmc-uk.org/publications/25452.asp

Workforce planning

2.46 The Scottish Government said it was developing a methodology and approach to produce Workforce Investment Plans to identify where future investment in the healthcare workforce was needed, to be linked to other work being progressed to deliver its 2020 Vision Route Map. It described increasing collaboration and integration across primary and secondary care. It also told us about its Reshaping the Medical Workforce Project, with service delivered by trained doctors and the implications for balancing the supply of trainees with future consultant workforce needs.

2.47 The Welsh Government told us about a range of existing guidance on workforce planning. It also foresaw a shift to providing more care locally. The Department of Health said that it had provided Health Education England with a refreshed mandate to make available 10,000 primary and community care professionals by 2020.

2.48 As recruitment and retention is a core part of our terms of reference, we ask all of the parties to keep us updated on any workforce planning issues, including any staffing targets that form part of such plans, and to consider whether any pay response is required to help shape future workforce plans. We also ask the parties to update us on how they are taking account of demographic changes in their workforce planning for all of our remit groups. We ask for future evidence to include both headcount figures and FTE estimates, broken down by gender.

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

2.49 We are required by our terms of reference to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of doctors and dentists, although the remits from the Department of Health and the Welsh Government did not require us to address this aspect in this round. Nevertheless, the BMA did ask us to address the issue of London weighting as part of our considerations this year. It said that London weighting was a cash supplement of £2,162 and had not been updated since 2005. It asked us to consider uplifting London weighting to address the very significant house price/rental and travel cost inflation in London, noting that there were around 13,000 doctors in training in the London region alone. It said that CPI inflation had risen by 26 per cent since 2005; property rental prices in London had risen by around 24 per cent since 2010; and London travel costs had risen by around 4 per cent per year since 2010.

2.50 Our previous reports have set out our view that we regard London weighting as a recruitment and retention premia issue, rather than one of cost compensation. We therefore indicated to the parties that we did not intend to revisit the decision that London weighting levels should remain at their existing levels, unless they were able to provide evidence to show that labour market conditions in London had changed. We have examined the evidence provided by Health Education England on data from the United Kingdom Foundation Programme Office, that shows that London foundation schools are oversubscribed, with many being significantly so. We heard anecdotal reports of problems in recruiting to the 'donut' around London and in other areas that might be considered as less attractive. However, any such recruitment problems would presumably not apply to foundation trainees who opt for London-based training, as we understand that they do not have a choice as to where they are posted within a rotation. On the basis of the substantive evidence, we are content not to revisit our earlier recommendation on London weighting, although we would welcome evidence from the parties if London weighting (or indeed any regional payments) has formed part of the contractual negotiations that will fall within our special remit on contract reform.

Motivation

2.51 Our terms of reference also require us to have regard to motivation, although the Department of Health, Welsh Government and Northern Ireland Executive remit letters did not require us to report on this issue for this round.

Scotland

2.52 The NHSScotland Staff Survey took place between 25 August and 6 October 2014: results were published in December 2014.[9] The survey applies to all NHS staff, including doctors, and a total of 55,077 staff responded. This represents a 35 per cent response rate and a 7 per cent increase in participation from 2013. The survey showed that in 26 out of the 29 national core questions, more staff responded positively compared to last year. The key findings for medical and dental staff included:

- 91 per cent said they were happy to go the 'extra mile' at work when required (an increase of 3 per cent since 2013);
- 61 per cent would recommend their workplace as a good place to work (a 14 per cent rise from last year);
- 77 per cent said they still intended to be working with their health board in 12 months time (up 2 per cent from 2013); and
- 69 per cent were satisfied with the sense of achievement they got from work (up 4 per cent from 2013).

2.53 The key findings for doctors in training included:

- 92 per cent said they were happy to go the 'extra mile' at work when required (up 1 per cent since 2013);
- 74 per cent would recommend their workplace as a good place to work (up 18 per cent since last year); and
- 77 per cent were satisfied with the sense of achievement they got from work (up 6 per cent from 2013).

England

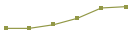
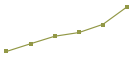
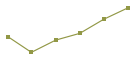
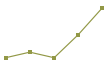
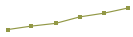
2.54 We have also examined the results of the NHS Staff Survey in England for 2013. They show that:

- for medical and dental staff as a whole, there was a slight improvement between 2012 and 2013 in average scores for staff motivation at work, reaching the highest level since the question was first asked;
- for medical and dental staff as a whole – as well as separately for consultants and training grades – there continued to be a general increasing trend in job satisfaction, but a small decrease for 'other' medical and dental staff (typically, specialty doctors and associate specialists (SAS) grades);
- since 2008, there is an upward trend in the percentage of staff working extra hours;
- the large increase in the percentage of staff suffering work-related stress over the last 12 months reported in the 2012 survey is sustained in the 2013 survey; and
- there were slight decreases for all grades between 2012 and 2013 in staff satisfaction with their level of pay.

[9] Staff Survey results for 2014 have not yet been published by England, Northern Ireland or Wales so results cannot be compared. The *NHSScotland Staff Survey 2014 National report* is available from: http://www.scotland.gov.uk/Publications/2014/12/8893/downloads

2.55 A summary of the results from the NHS Staff Survey in England over the period 2008 to 2013 is shown below in Table 2.3.

Table 2.3: Summary results from the National NHS Staff Survey, hospital medical and dental staff, England, 2008 – 2013

Measure	2008	2009	2010	2011	2012	2013	Trend[1]
Workload							
Work pressure felt by staff[2,3]	3.06	3.08	3.06	3.10	3.04	3.04	
% staff working extra hours[2]	75.0	75.3	76.8	79.4	83.5	84.3	
% staff suffering work-related stress in last 12 months[2]	22.2	25.0	24.5	23.1	32.0	32.9	
Training and appraisals							
% staff receiving job-relevant training, learning or development in last 12 months	85.5	85.2	84.6	82.5	80.5	80.9	
% staff appraised in last 12 months	74.4	78.0	79.4	81.4	87.7	89.9	
% staff having well-structured appraisals in last 12 months	29.4	31.6	34.0	35.2	37.4	43.1	
Engagement and job satisfaction							
Support from immediate managers[3]	3.53	3.55	3.56	3.61	3.57	3.62	
% staff reporting good communication between senior management and staff	29.4	27.8	31.9	34.1	30.2	34.6	
% staff able to contribute towards improvements at work	66.6	63.7	66.1	67.4	70.1	72.4	
Staff recommendation of the Trust as a place to work or receive treatment[3]		3.51	3.53	3.51	3.61	3.73	
Staff motivation at work[3]		3.97	3.94	3.94	3.95	3.99	
Staff job satisfaction[3]	3.55	3.57	3.59	3.64	3.67	3.71	

Source: National NHS Staff Survey.

Notes:

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

[2] Lower scores are better.

[3] Results are on a scale from 1 to 5.

2.56 The results in both Scotland and England suggest that doctors remain a highly motivated workforce. However, we consider that this measurement of their motivation may not be an adequate measure of their morale. We discuss this further in Chapter 6 in the section on consultants.

Northern Ireland

2.57 The Northern Ireland Executive said that it was acutely aware of issues raised by the BDA of low morale and motivation within the dental workforce, but said that it had to pursue measures to constrain GDS expenditure and reduce pressure on the budget, whilst minimising the impact on patients, practitioners and practices. It said that given the budgetary pressure, and the strong desire to introduce new contractual arrangements for practitioners, there had been little scope to address morale and motivation issues within the existing arrangements for the delivery of GDS.

Wales

2.58 The Welsh Government did not offer any motivation evidence, nor did it carry out a staff survey in the last year. We commented last year that we would like all countries to undertake staff surveys on a regular, preferably annual basis, so that we can monitor trends closely. Ideally, we would like a uniform approach by all countries to assist us with comparisons.

2.59 The BMA told us that its longer-term projects around productivity, motivation and outcomes attributable to doctors' direct intervention had been put on hold pending the resolution of the contract negotiations. We wish to record our disappointment with this decision to delay the research: given the breakdown of contract negotiations, we would ask the BMA to consider prioritising this research, which we see as potentially important intelligence for our ongoing work. The BMA also said that our recommendations appeared to place insufficient weight upon the impact of real pay cuts to doctors' motivation: we address this point earlier in the chapter in the section on affordability. The BMA also talked about the growing sense of de-professionalisation and disempowerment, and an increasing focus by management on measuring performance very narrowly as direct patient contact activity.

2.60 During our visit programme, we pick up anecdotal comments from our remit groups on the state of motivation, but it is interesting to us that the views we hear on those visits are not necessarily borne out by the results of the formal surveys that we consider in written evidence. We think it vital not to lose sight of the picture on motivation, and ask that the Health Departments do not restrict our remit or the provision of evidence for our next and future rounds. Motivation is key to delivering and leading in complex, challenging environments. We would also welcome evidence on the motivation of independent contractor GMPs and GDPs to inform our decision making. We comment further on motivation in Chapter 6.

Overall NHS strategy – 'patients at the heart'

2.61 Our terms of reference require us to have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved. The Scottish Government told us of its 2020 Vision for Health and Care in Scotland, whereby everyone should be able to live longer healthier lives at home or in a homely setting. The Department of Health told us about its priorities for the NHS: for living and ageing well and improving the standard of care throughout the NHS. It also described the refreshed mandate it had given NHS England that focused on improvements for patients. Asked how our recommendations might support this strand of our remit, the BDA said that dentists would only be able to invest in facilities,

improving patient care, if they had adequate remuneration, commenting that NHS developments and innovation required investment in people and infrastructure. The BMA focused its evidence on this aspect of our remit by noting that waiting time targets were seen (by politicians and the public) as key measures, but that they had significant staffing implications with greater workload and intensity of work for doctors, which it said had not been rewarded. Its evidence noted the decline in waiting time targets being met across the United Kingdom.

2.62 Our last report noted recent developments within the NHS that were focused on improving the link to patients. We ask the parties to consider how our pay recommendations might help facilitate those developments, perhaps through a link between motivation and patient outcomes. As we noted last year, there is a link between the number of doctors and dentists employed and the quality of services delivered to patients. We observe that the special remit on contract reform we have been given underlines the importance of better patient outcomes through the provision of seven-day services, and we intend considering evidence for that remit that will allow us to address this aspect of our terms of reference.

Legal obligations on the NHS including anti-discrimination legislation

2.63 Our terms of reference also require us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. We usually receive evidence from the Advisory Committee on Clinical Excellence Awards (ACCEA) that addresses the award distribution by gender and race, but it did not provide us with any evidence for this round: this is disappointing given that last year's evidence noted concerns about potential discrimination. The Scottish Advisory Committee on Distinction Awards (SACDA) did provide us with evidence, commenting that it believed its scheme continued to operate without discrimination on the grounds of age, gender, ethnicity, belief, type of contract, specialty or area of work, or other relevant factor. We thank SACDA for these assurances, and ask ACCEA to address this area of evidence for our next review.

2.64 Seniority payment schemes are a concern because they could be interpreted as merely rewarding staff for their length of time in post, rather than any additional experience they might bring to their work, and might therefore fall foul of age discrimination legislation. The Department of Health confirmed that the seniority pay scheme for GDPs and GMPs had both now been closed in England. The Scottish Government told us that it was reviewing GMP seniority payments, but needed to mitigate against the risk of the early exodus of senior GMPs. It said that an Allowances Review Group was currently considering GDP seniority payments. We ask the Scottish and Welsh Governments and the Northern Ireland Executive to keep us informed of any developments with their seniority payment schemes for GMPs and GDPs.

2.65 We are also interested in the views of the parties as to whether the current length of the pay scales might be age discriminatory: and if so, how they intend to address the issue. We expect to receive evidence on this aspect of our terms of reference for our special remit on contract reform for consultants, where we note the length of pay scales extends as far as 30 years in Wales.

Conclusions

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

- despite the falling unemployment rate, there is little evidence of upward pressure in wages across the economy as a whole. Whilst the economy-wide wage growth is muted, this obscures some important changes in the composition of employment and pay changes in different groups;
- affordability continues to be a material issue for the NHS, and provides an ongoing challenge to meet the growth in demand for services. The picture on affordability varies by country, and appears to be particularly stark in both Northern Ireland and Wales;
- the median gross annual full-time pay for employed doctors and dentists had tended to track the 97th percentile for all full-time employees through much of 2002 – 2011, but as of 2014 that has fallen closer to the 95th percentile, suggesting a high but declining pay position within the United Kingdom distribution of pay;
- the NHS Pension Scheme continues to provide significant benefits, but our remit groups will be contributing more in the future, for somewhat smaller benefits, and thus represents a reduction in their total reward;
- the job security offered by a career in the NHS is an important consideration;
- we do not see any issues of concern at the undergraduate entry level;
- there are some specialties with ongoing recruitment issues, such as emergency medicine and psychiatry, at all grades of doctors, and geographic-specific recruitment issues, particularly in some rural and deprived areas;
- for Scotland and England, lack of trainees choosing a career in general practice is also an issue; and
- motivation is key to delivering and leading in complex, challenging environments.

Future evidence requirements

2.67 We expect the parties' evidence to cover all elements of our terms of reference, as well as updates to issues that we have identified in previous rounds. This chapter has highlighted several areas where the evidence base is lacking and which we hope the parties can address. The priority areas for data are summarised in Table 2.4. Table 2.5 summarises our information requirements. Our secretariat would be happy to discuss these with the parties.

Table 2.4: Data requests in order of priority

Data needed	Reason (terms of reference)
Vacancy numbers in all four countries by varying workforce demographics (including FTE, specialty, grade and gender) (Health Departments; employers)	To properly understand the recruitment and retention picture and whether pay is sufficient to recruit and retain
Recruitment and retention data including: • headcount and FTE data, • regional variations, • final fill rates for trainees, and • more data on the changing workforce demographic (gender, age, grade etc) (all parties)	To understand the evolution of the workforce and to assist in assessing whether pay is sufficient to recruit and retain
Analysis of the remit groups' FTE earnings by age, gender, specialty and country, including a breakdown of the components of total earnings (all parties)	To calibrate pay with the wider labour market
Pay drift data using the same methodology as in England (health departments in Wales, Scotland and Northern Ireland)	To understand paybill costs
Regular staff survey data, with ability to make comparisons across the four countries (all parties)	To understand motivation to comparable breadth and depth across the United Kingdom
Motivation of independent contractor GMPs and GDPs across the four countries (all parties)	To understand motivation to comparable breadth and depth across the United Kingdom
Usage and cost of locums, broken down by specialty and grade (health departments; employers)	To understand the recruitment and retention picture; to inform our understanding of paybill costs
Research around productivity, motivation and the outcomes attributable to doctors' direct intervention (BMA)	To understand the link between pay and these factors

Table 2.5: Information requirements in order of priority

Information needed
Pay and total reward policies (health departments) – to provide the context to our deliberations
Opt-out position for the NHS Pension Scheme (all parties) – discussed at paragraph 2.36
Anonymised sample career profiles with related earnings (all parties) – discussed at paragraph 2.30
Impact of pensions changes on recruitment, retention and motivation (all parties) – discussed at paragraph 2.37
Workforce planning issues, including any staffing targets and demographic changes, and whether any pay response is required (all parties) – discussed at paragraph 2.48
How our pay recommendations can help facilitate NHS developments, and other issues related to the 'patients at the heart' strand of our remit (all parties) – discussed at paragraph 2.62

2.68 Finally, our terms of reference remit us to monitor legal obligations on the NHS and we welcome information in the following areas:

- evidence that addresses any discrimination issues in the consultant award schemes (all parties);
- any developments with the seniority payment schemes for GMPs and GDPs (health departments in Scotland, Wales and Northern Ireland); and
- consideration of whether the current length of the pay scales for our remit groups might be age discriminatory, and if so, how they intend addressing the issue (all parties).

Part II: Primary Care

CHAPTER 3: GENERAL MEDICAL PRACTITIONERS

Introduction

3.1 This chapter considers issues relating to general medical practice. It notes that: there are signs that the size of the general medical practitioner (GMP) workforce is not keeping pace with demand; there are issues with the pipeline to general practice from the training route; there are significant demographic changes in the composition of the workforce; and sets out our intended approach for recommending pay increases for independent contractor GMPs given our concerns with the existing formula-based approach.

3.2 The core traditional role for GMPs is the family doctor, working in the primary care sector of the NHS under one of the contracting routes: General Medical Services (GMS), Personal Medical Services (PMS) in England, Section 17C arrangements in Scotland, Alternative Providers of Medical Services (APMS), or Primary Care Trust Medical Services (PCTMS). We are concerned mainly with GMS which accounts for approximately 55 per cent of GMP practices. Doctors working under PMS, Section 17C arrangements, APMS or PCTMS contract locally with primary care organisations (PCOs).

3.3 Most doctors working in practices that hold GMS contracts are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses or managers; some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. Around 95 per cent of independent contractor GMPs' earnings come from contracts for the provision of public sector work, i.e. primary medical care services to NHS patients. Whilst doctors contribute to a defined benefit pension scheme, the balance of the costs of the scheme over members' contributions is funded by the Health Departments and is therefore very secure. Such a benefit would not typically be provided by a small business. Salaried GMPs are employed either by PCOs or by independent contractor practices. The pay range for salaried GMPs is at Appendix B.

3.4 In what follows, we provide a discussion of the labour market position of GMPs, and then a discussion of recent pay experiences and our role in these.

Recruitment and retention and the demand for GMP services

3.5 There were 48,550 (headcount) contracted GMPs in the United Kingdom in September 2013, little change compared to the previous year but around an 11 per cent increase on 2006 (Figure 3.1). NHS England told us that the average age of the workforce had reduced: in 2013, 44 per cent were under age 45, compared to 43.1 per cent in 2012.

3.6 Despite the growth in numbers achieved over the early 2000s, a common theme in the evidence was difficulties in the recruitment and retention of GMPs relative to demand and for particular areas. It is worth noting though that not all parties thought that the issue could necessarily be influenced or resolved by a contract uplift. Nevertheless, we consider that the fall in average income for GMPs each year since 2005-06 (apart from a small average increase in 2009-10) as shown in Table 3.1 may be a factor influencing the decisions of trainees when deciding whether or not to pursue a career in general practice.

3.7 The Department of Health said that it had asked Health Education England to make available 10,000 primary and community care professionals by 2020, that number to include GMPs, although no breakdown between staff groups was given. It also said that it was working with stakeholders to improve recruitment, retention and measures for return to practice, including supporting GMPs to return from career breaks. The Department was considering what changes were needed to enhance GMP training as suggested by *Shape of Training*.[1] It said that additional GMPs would help to manage pressures in primary care from an ageing population, increasing patient expectations and increasing pressures on NHS finances.

3.8 Health Education England said that it had been given a mandate to make significant progress towards 50 per cent of postgraduate doctor training places being for general practice, meaning a target of 3,250 of the 6,500 places per year by 2016. Health Education England went on to describe the lack of a compelling narrative on the future demand for GMPs, but said that according to Centre for Workforce Intelligence forecasts, if it met the 3,250 target by 2016, it would sustain moderate annual growth to the GMP workforce.

3.9 We have also noted the conclusions of the Centre for Workforce Intelligence's *In-depth Review of the General Practitioner Workforce*.[2] The report (covering England) concluded that:

- the growth in the workforce had not kept pace with the increase in the number of medical consultants or population growth;
- on a per capita basis, the number of GMPs per 100,000 had fallen to 59.6 GMPs per 100,000 (from a peak in 2009 of 61.5);
- boosting the number of GMP trainees was proving difficult, with a modest increase in applications for GMP training in the last two years, but below the peak in 2010-11;
- the workforce was becoming younger and more female;
- there was considerable geographical variation in the distribution of GMPs, with coverage especially low in the North West and North East, and
- simply increasing the supply of GMPs would not necessarily lead to a more equal distribution.

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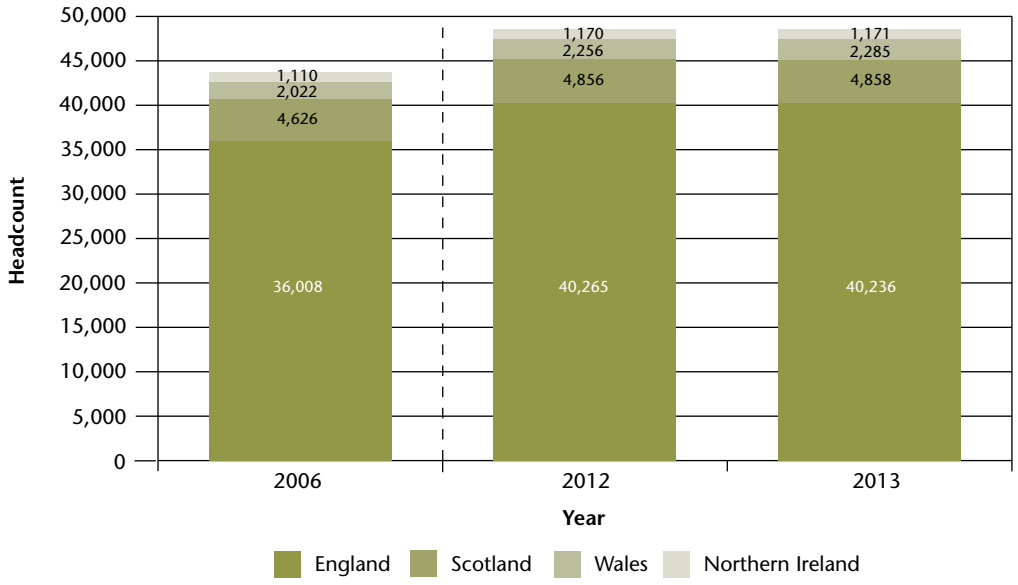
[1] *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

[2] *In-Depth Review of the General Practitioner Workforce*. Centre for Workforce Intelligence, July 2014. Available from: http://www.cfwi.org.uk/publications

Figure 3.1: Number of general medical practitioners, United Kingdom, 2006 and 2012 – 2013



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

3.10 The Scottish Government told us that at September 2013, 54 per cent of its GMP workforce was female, compared to 45 per cent in 2004. It said that in January 2013, it estimated the full-time equivalent size of the workforce to be 3,735. The Scottish Government also described 'golden hello' payments, intended to support recruitment especially in deprived and remote and rural areas in Scotland, and a new returners' programme it was setting up with NHS National Education Scotland. In supplementary evidence, the Scottish Government told us that it was providing £1.5 million over four years to test how best to sustain community hospitals that encompassed training opportunities. It also described other work to consider ways to improve the current arrangements for GMPs returning to practice. The Welsh Government said that of its GMP workforce, 23.1 per cent were aged 55+ and 46.6 per cent were female.

3.11 We have examined fill rate data for trainees: it shows that across the United Kingdom, 89.3 per cent of GMP training posts were filled, although further recruitment was underway whilst we were writing this report. The British Medical Association (BMA) said that there were significant shortages with general practice training, with a particular regional issue for GMPs everywhere other than London and the South, although its evidence did not offer an explanation for such shortages. It also said that it believed that the Welsh Government had underestimated the size of recruitment and retention issues facing general practice in Wales, commenting that the methodology to calculate FTE figures did not account for GMPs working in excess of FTE, or the increasing proportion of women in the workforce.

3.12 In oral evidence, NHS England described the actions it considered necessary to address general practice issues. It included a number of initiatives to address recruitment and retention: increasing the number of GMPs in training; incentives for GMPs to stay on and encouraging returners to practice; and options to encourage care in under-doctored areas. Alongside these measures, it stressed the importance of stabilising and increasing practice funding, including options for investing in premises and a commitment to reverse general practice's declining share of NHS funding; and measures to tackle

workload, such as building the public's understanding of wider primary care services (such as pharmacies and on-line resources) to reduce inappropriate demand. In January 2015, £10 million funding was announced by NHS England, to increase the number of GMPs and develop the roles of other primary care staff. For areas that were struggling to recruit, the funding would incentivise new GMPs by offering a further year of training in a related clinical specialty of interest. For our next review, we would welcome NHS England's assessment of how the additional funding has helped to address any recruitment issues.

3.13 We note the actions being taken in both Scotland and England to address recruitment into general practice. Clearly, this will be important for the overall NHS strategy in England, given the aim for half of all postgraduate medical training posts to be for general practice: although the Department of Health noted in its evidence that 88 per cent of its general practice training posts in England had been filled, this still suggests some 379 vacancies and represents a significant recruitment challenge, although the final position for this year was not clear as recruitment was still under way when we were writing this report. Given the actions being taken by NHS England, it is difficult for us to say whether or not any recruitment issues are pay related, but we will wish to return to this issue as part of our special remit on contract reform for junior doctors. Fill rates to general practice specialty training in both Northern Ireland (97 per cent) and Wales (100 per cent) do not suggest a problem, but in Scotland the fill rate is just 88 per cent. We ask each country to keep us updated us for our next report on what action is being taken to address any recruitment issues into general practice and for their assessment as to whether or not any such issues are pay related. We note that in some of the geographic areas that might be considered under-doctored, the relative pay for doctors (compared to the general population) would suggest that pay is not the issue affecting recruitment.

Motivation and workload

3.14 The Scottish Government said that 16.2 million consultations were carried out in 2012-13 (although did not provide a benchmark or comparator); and on working out-of-hours, GMPs aged under 35 averaged 3.5 hours per week (year to January 2013), whilst those aged 55 and over did more than double that amount. It said that 51 per cent of GMPs worked eight or more sessions per week; 36 per cent between five and seven sessions; and 13 per cent worked four or less sessions per week. The Welsh Government told us that at September 2013, the average list size was 1,568, and that there were 6.2 GMPs per 10,000 population. NHS England did not provide us with any new motivation evidence for GMPs.[3]

3.15 The BMA told us that a GMP workload survey was under way: we will, of course, be interested to learn of the results when available. The BMA said that in Wales, GMPs faced increasing workload with a limited ability to reduce many expenses. It referred to comments from the Nuffield Trust, criticising the lack of basic information about how many consultations are carried out by GMPs across the United Kingdom. It would appear that current measures of the number of consultations are based on the extrapolation of out-of-date data. We note that all of the parties indicated that they would welcome more up-to-date workload data and we support this aim to help inform our future deliberations: the parties may wish to consider some sort of measurement that also looks at the numbers of hours worked.

[3] In its evidence, NHS England referred to the results of the 7th National GP Worklife Survey, but we note that this was provided to us in evidence for the last round.

Independent contractor general medical practitioners

3.16 The GMS contract for GMPs was introduced throughout the United Kingdom on 1 April 2004. The contract is with the practice rather than with individual GMPs and allows for income under several headings, including: basic services or global sum; correction factor payments related to the Minimum Practice Income Guarantee (MPIG); enhanced services; funding administered by PCOs; and Quality and Outcomes Framework (QOF) payments. The glossary at Appendix D gives further information on aspects of the GMS contract.

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

3.18 The annual negotiations on the GMS contract were carried out separately in each United Kingdom country. The outcome of those negotiations for 2015-16 in **England** included: changes to QOF with an adjustment of point value for 2015-16 taking account of population growth and relative changes in practice list size and the deferment for one year of changes in thresholds planned for April 2015; practices are to publish average net earnings (to include contractor and salaried GMPs) relating to 2014-15, as well as the number of full and part-time GMPs associated with the published figures; the reinvestment of some enhanced services funding into the global sum; a 15 per cent reduction in total seniority payments; and NHS England and the BMA to re-examine the Carr-Hill formula with the aim of adapting the formula to better reflect deprivation. In **Scotland**, an extended set of arrangements were announced in August 2014 that would remain in place until April 2017, including: no planned major changes to QOF; golden hellos to support recruitment in deprived and remote and rural areas; further work to develop proposals on the publication of net earnings; a review of seniority payments; and a review of the variability of practice funding. At the time of writing, no agreements for Wales and Northern Ireland for 2015-16 had been announced.

3.19 Alongside the negotiations on changes to the GMS contract, we were also asked to make recommendations. The Department of Health, Welsh Government and Northern Ireland Executive all invited us to make recommendations on an appropriate uplift for independent contractor GMPs, and would particularly welcome our recommendations on what allowance should be made for GMPs' pay and for practice staff pay, in the context of public sector pay policy for 2015-16. They said that they would make the final decisions on the gross uplift for GMS contracts in the light of our recommendations and taking into account any efficiency gains obtained through the contract negotiations. The Scottish Government said it sought our recommendation in respect of GMP pay and the contractual uplift and said that it was committed to increasing its investment in general practice and that our recommendations were a helpful factor in that decision-making process.

Formula-based approach

3.20 Our last report set out in considerable detail our concerns with the existing formula-based approach to deciding the uplift for independent contractor GMPs. Our concerns included:

- our intended increases in net income not being delivered by the formula;
- the limited quality of the evidence on income and expenses available to populate the formula;
- the 'cherry picking' of the co-efficients used in the formula by the Health Departments; and
- our recommendations having only an indirect link to the actual earnings of independent contractors (Table 3.1 provides further detail).

3.21 Table 3.1 shows changes in average United Kingdom GMP income, and how those changes compare to our intended changes in income as suggested by our recommendations. It clearly shows the failure of the existing formula-based approach to deliver our intended increases in income (or pay net of expenses).

Table 3.1: GMPs' gross earnings, expenses and income, United Kingdom, 2003-04 to 2012-13

			Income			
Financial Year	**Gross Earnings £**	**Expenses £**	**£**	**Annual change %**	**Uplift intended from previous year**	**Expenses to Earnings Ratio (EER) %**
2003-04	203,613	121,595	82,019	-	-	59.7
2004-05	230,097	129,926	100,170	22.1	No recommendation	56.5
2005-06	245,020	135,016	110,004	9.8	No recommendation	55.1
2006-07	247,362	139,694	107,667	-2.1	No recommendation	56.5
2007-08	251,997	145,925	106,072	-1.5	No recommendation	57.9
2008-09	258,600	153,300	105,300	-0.7	0% (zero)	59.3
2009-10	262,700	156,900	105,700	0.4	2.2%	59.8
2010-11	266,500	162,400	104,100	-1.5	1.5%	60.9
2011-12	267,900	164,900	103,000	-1.1	0% (zero)	61.6
2012-13	271,800	169,700	102,000	-0.9	0% (zero)	62.5

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

Note: All figures in cash terms, not adjusted for inflation. Income from all sources.

3.22 We said in our last report that we had serious reservations about continuing to make recommendations using the formula as it was not delivering our intended increases in pay net of expenses, but that if the parties wished us to continue with such an approach, they should meet a series of data requirements that we set out. In essence, we required much better quality data on income and expenses so that we could make a more realistic judgement on movement in expenses. We recommended in our last report that the parties should work together to improve the quality of the evidence we use, and that progress be reported back to us for this review. We said that we would then consider whether or not to continue with the existing formula-based approach in the light of that progress.

3.23 In the evidence we received for this review, the Department of Health said that it recognised and agreed with our concerns over the formula-based uplift particularly the quality of data. It said that a key part of improving the approach to the uplift would be for increased transparency over GMP earnings in future years, to provide a richer and more timely source of information on which we could base our recommendations. It said that the government was working with NHS England and the BMA to agree how best to achieve this aim, but recognised that much of the information was not currently available.

3.24 The Scottish Government said it was discussing with the BMA the publication of GMP NHS net earnings, potentially from 2015-16, but that it had no information on the details of individual independent contractor GMP practice costs, reimbursements or expenses, nor did it currently have any means of collecting information on practice expenses. The Scottish Government said that its intent was not to impose unnecessary bureaucracy on GMPs, and it was not clear to it how it would obtain the information we required. The Welsh Government also told us that its preference was for us to continue reporting on both pay and expenses and it expressed similar concerns to the Scottish Government about the lack of current information on practice expenses and the means of collecting such information.

3.25 NHS England said it was anomalous that we were a pay review body, yet had been asked to make recommendations on expenses. It said that a better alternative would be for NHS England and the negotiating bodies to discuss and consider an appropriate uplift for expenses within future contract negotiations. It also pointed out that the future requirement for practices to publish the net earnings of GMPs would be for a combined average (mean) across both contractor GMPs and salaried GMPs, and it would be unlikely that this information (once published) would assist us in our annual recommendations for GMPs.

3.26 The BMA said it had significant concerns about the ability of the parties to provide the level of detail requested by us, noting the bureaucratic burden and cost to practices. The BMA said that the failure of the current formula to reflect expenses growth over the last few years meant that it did not wish us to continue with it. However, the BMA believed it important that we should make gross earnings recommendations as well as net, if possible. The BMA said that it was not possible to rework the formula for the current round, but that it remained committed to working with the parties to develop an alternative approach.

3.27 Our conclusion from the evidence provided to us for this review is that the data picture has not materially changed. As a result we do not have data to the required level of robustness and detail in order for us to feel confident and comfortable with using the formula-based approach. The BMA has specifically asked us not to use the formula, yet it still asks us to make both gross and net recommendations. If we are to make both gross and net recommendations, then this would require an analysis of expenses, and the parties have not provided us with the detailed evidence necessary to carry out such

an analysis. We feel that now is the time for us to cease using the formula, although we might consider returning to a formula-based approach in the future should the data picture improve.

3.28 Our recommendation last year (using the formula) was that the overall value of GMS contract payments should be increased by a factor intended to result in an increase of 1 per cent to independent contractor GMPs' net income after allowing for movement in their expenses. Using the formula, we calculated that an uplift of 0.28 per cent was required to overall GMS contract payments for 2014-15 to deliver a 1 per cent increase in net income. The Northern Ireland Executive did not follow this recommendation, but instead increased the value of GMS contract payments by 1 per cent: we have not been provided with any evidence by the Northern Ireland Executive to explain how this increase to GMS contract payments in Northern Ireland relates to any analysis of expenses. We take this as further evidence from the parties as to the failings of the current formula-based approach. Indeed, using the same weightings in our formula from our last report, we estimate that an increase in GMS contract payments of 1 per cent would (of course, if the formula worked as intended) deliver an increase in independent contractor GMPs' net income of 2.67 per cent.

3.29 We have therefore concluded that we should currently make a recommendation only on pay net of expenses. NHS England has proposed that, if we made such a recommendation, it would discuss with the BMA an appropriate uplift for expenses within future contract negotiations, and we support this general approach for all countries. Our pay net of expenses recommendation is in Chapter 7. We ask the parties to report back to us next year on the outcome of those negotiations, to include what assumptions they have made about income and expenses.

3.30 In their remit letters, the Department of Health, Welsh Government and Northern Ireland Executive asked us what allowance should be made for practice staff pay, in the context of public sector pay policy for 2015-16. Addressing increases in practice staff pay for the forthcoming year represents a different approach to that we have taken in previous reports: in particular, our formula has not sought to do that, but to recompense practices for the cost of past increases. Regrettably, we do not feel that we are in a position to address forthcoming pay increases for this group in a considered way:

- as practice staff (other than salaried GMPs) are not part of our remit group (and we therefore do not receive any evidence on their recruitment, retention or motivation – or from organisations representing them) we do not currently have an evidential base on which to make recommendations linked to their pay;
- previous evidence from the parties suggests that such staff are not, in general, appointed on *Agenda for Change* terms and conditions, so we do not consider it appropriate to use the general uplift for *Agenda for Change* staff as a proxy for the increase in staff costs; and
- even whilst such staff work mainly for the NHS, they are employed by independent contractors and should not, arguably, be subject to public sector pay policy. We recognise the counter argument that such staff's pay is ultimately funded by government.

3.31 We recognise that the Annual Survey of Hours and Earnings (ASHE) includes the costs relating to salaried GMPs. We have therefore considered whether we should take a view on the increase in staff costs that represents salaried GMPs. The original agreement between the parties for salaried GMPs was that their pay was to be guided by a salary range, but that starting pay and progression should be determined locally. Our recommendations on pay for salaried GMPs have been limited to just increasing the bottom and top points of the pay range.

3.32 We believe that consideration of practice staff costs should, like other practice expenses, form part of the annual contract negotiations, though we also note that ASHE data on actual increases in practice staff earnings, which we have used as a proxy for increases in staff's pay in our formula in recent years, appears to be affected not just by changes in rates of pay but also by changes in the number and type of staff employed by practices. These appear to us to be a proper subject for the contract negotiations. For full transparency and in case the parties find it useful, we include (at Appendix E, Table E.6) a list of the latest data that would have populated the coefficients in the formula. We are mindful of the short time for discussion between the parties to reach agreement on an alternative methodology for this year.

3.33 With the possible restructuring of pay and terms and conditions for consultants, moves to seven-day services, and plans for delivering primary care in different ways (such as envisaged by the *Five Year Forward View*), the parties might want to begin giving thought as to whether there is a need to consider how GMPs' pay could align with those new arrangements. If appropriate, we would be happy to assist in any way that the parties might find helpful.

Salaried GMPs

3.34 Last year, we recommended that the minimum and maximum of the salary range for salaried GMPs should be increased by 1 per cent. The Department of Health said that the recommendation was accepted, being most consistent with its decision for other NHS staff. It proposed in its evidence to increase the pay range by 1 per cent for 2015-16. The Welsh Government said that if we were going to make recommendations for salaried GMPs in England, it would be content for such recommendations to extend to Wales. The Northern Ireland Executive did not indicate whether it wished us to make such a recommendation for Northern Ireland. Our recommendation for salaried GMPs in 2015-16 is in Chapter 7. We also note here our request for annual evidence on the workload, hours worked, geographical variations in pay, headcount and FTE data of salaried GMPs.

Clinical Commissioning Groups

3.35 Last year, we asked the parties to keep us informed on how the new system of Clinical Commissioning Groups (CCGs) in England was affecting the income streams for GMPs. This year, NHS England told us that CCGs were to receive new powers to improve local health services, and that expressions of interest in this new work had been received from 191 CCGs (from a total of 211 CCGs). It said it would keep us abreast of any developments with a material effect on our remit, which we welcome.

General practice specialty registrars

3.36 Health Education England said that general practice specialty registrars were paid more than their hospital equivalents as part of the recruitment strategy, and that this was part of the wider issue of how to get more trainees (and qualified doctors) into currently under-doctored areas. However it said that pay was only part of the strategy. In supplementary evidence, it said that it thought that the current arrangements needed review, and that with an increasing number of trainees, the current arrangements could become unaffordable and their application potentially unfair. The evidence is, however, that the level of the supplement is set to match the average banding supplement paid in the hospital sector, the intention being that there should not be a financial disincentive for choosing general practice over a hospital specialty. Given the reduced scope of our remit, we have not been provided with evidence for junior doctors this year that would allow us to say how the average hospital banding supplement has changed. The supplement currently stands at 45 per cent. We understood that the supplement formed

part of the negotiations on the junior doctors' contract that have now stalled. Given that, we are not recommending any change to the level of the supplement, but expect to return to this issue as part of our special remit looking at contract reform for junior doctors.

General medical practitioner trainers' grant

3.37 For many years now, we have been tracking the delay in progress towards a new tariff-based system to fund education and training in general medical practice. This year, the Department of Health said that it was continuing to develop tariffs for placements, to supersede the funding currently provided through the trainers' grant. It said that it was a challenging area of work that it continued to prioritise and that a costing methodology had been completed. New arrangements were being piloted, but the Department said that it was difficult to engage with practices and get feedback. It proposed that the GMP trainers' grant should be subject to the same adjustment as the tariff that applied to placements in secondary care. The BMA initially asked for an increase in line with our overall recommendation for all doctors. In supplementary evidence, the BMA said that it was unable to comment in full on the Department of Health's proposal, as the methodology for calculating the adjustment to the secondary care placement tariff had not yet been agreed, and that it was therefore not possible to know the impact of the Department's proposal. We ask the parties to discuss this proposal further once its implications are clear and to report back to us for our next review.

Directors of Postgraduate General and Dental Education

3.38 In its remit letter, the Scottish Government asked us to give consideration to the remuneration received by Directors of Postgraduate General Practice Education in relation to levels of pay and remuneration packages of equivalents in the private sector and comparator groups. The evidence noted that the pay of Directors of Postgraduate General and Dental Education was set by the maximum point of the pay scale for GMP educators, plus 10 per cent. In supplementary evidence, the Scottish Government said that it intended to address the anomaly whereby it had not applied the 1 per cent increase to the pay of Directors of Postgraduate General and Dental Education for 2014-15 (in line with the Scottish Government's acceptance last year of our recommendation to increase the value of the pay scales for GMP educators by 1 per cent). We note that for 2015-16, the pay of Directors of Postgraduate General and Dental Education in Scotland will be uplifted in line with our recommendation for GMP educators (if accepted). We are therefore not required to consider the relative levels of pay and remuneration packages of equivalents in the private sector and comparator groups, as originally proposed. Our recommendation for salaried doctors is in Chapter 7.

Future evidence requirements

3.39 This chapter (and its related Appendix E) has highlighted areas where the evidence base is lacking and which we hope the parties can address. The data priorities are summarised in Table 3.2. Table 3.3 summarises our information requirements. Our secretariat would be happy to discuss these with the parties.

Table 3.2: Data requests in order of priority

Data needed	Reason (terms of reference)
Improved data on income and expenses[4] (all parties)	To understand the factors driving GMPs' pay and inform our pay recommendations
The outcome of negotiations to deliver our recommended increase in pay net of expenses (if accepted), to include what assumptions were made about income and expenses (all parties)	To assess how the parties will respond to our decision to cease using the existing formula-based approach and inform our pay recommendations
Annual evidence on the workload, hours worked, geographical variations in pay, headcount and FTE data of salaried GMPs (all parties)	To understand the evolution of the salaried workforce and how this impacts on the data we examine on average GMP income
Up-to-date data on consultations, to also include a measurement of hours worked (all parties)	To understand workload pressures and any implications for our pay recommendations
An explanation of any regional variations in GMPs' income (all parties)	To improve our understanding of the factors affecting average GMP pay and inform our future pay recommendations

Table 3.3: Information requirements in order of priority

Information needed
Any action being taken to address any recruitment issues in general practice and an assessment of whether such issues are pay related (NHS England/Health Departments – discussed at paragraph 3.13
An assessment of whether the recently announced £10 million funding in England has addressed any recruitment issues (NHS England) – discussed at paragraph 3.12
Progress towards publishing the income of GMPs that formed part of the agreed changes to the GMS contract in England and whether the other administrations intend taking a similar approach – discussed at paragraph 3.18
Any issues surrounding Clinical Commissioning Groups impacting on our remit (NHS England) – discussed at paragraph 3.35
Progress on reviewing the GMP trainers' grant (all parties) – discussed at paragraph 3.37

[4] Our detailed requirements were set out in paragraphs 3.26 and 3.27 of our 42nd Report 2014. Available from: https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-42nd-report-2014

CHAPTER 4: GENERAL DENTAL PRACTITIONERS

Introduction

4.1 This chapter considers issues relating to general dental practice. It notes the following: that in general, there are no recruitment and retention problems for general dental practitioners (GDPs); access to NHS services is good; there is a potential oversupply of dentists relative to dental demand; the impact of the number of dentists on average income data; and sets out our intended approach for recommending pay increases for independent contractor GDPs given our concerns with the existing formula-based approach.

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

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

4.3 In March[1] 2014, there were 29,348 GDPs (headcount) in the United Kingdom, an annual increase of 2.6 per cent and an increase of 20 per cent since 2007 (Figure 4.1). There have been increases in the number of GDPs in all United Kingdom countries between 2013 and 2014 and significant increases since 2006.

4.4 Commenting on the supply of dentists, NHS England said that workforce planning suggested an excess of supply over demand and need. It said that the intake to dental schools would be adjusted. Health Education England said that it supported the professional advice of the Chief Dental Officer for England to reduce the number of dental undergraduates, and that it was discussing any related concerns with interested parties. It said that significant improvements in population dental health were likely to reduce the future demand for dental interventions in the future, noting that the need for complete dentures in those over 65 had diminished from 28 per cent in 1978 to just 6 per cent in 2009. In its evidence, the Department of Health said Health Education England would implement a 10 per cent reduction in dental student numbers for the 2014 intake.

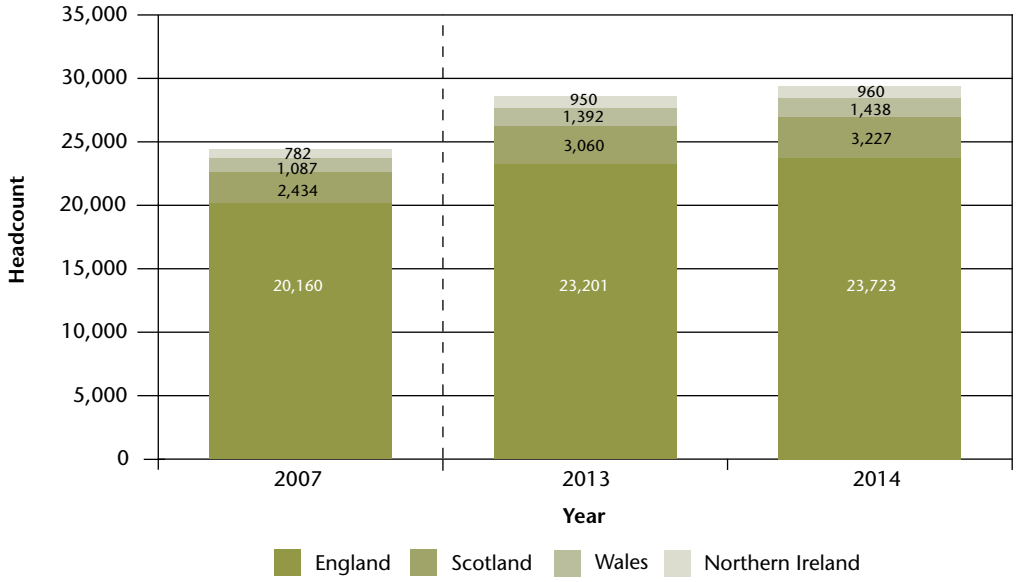
4.5 Oversupply issues were not limited to just England. The Scottish Government said that the dental student intake had been reduced in 2013-14 to ensure that Scotland had an appropriate number of dentists. It told us about a dental bursary of £4,000 per annum for students that committed to the NHS for up to five years, and that in 2013-14, 658 students were in receipt of the bursary. The Welsh Government said that it believed it had a broad balance between the supply of dentists and demand, and that it was working with Cardiff University to realign the ratio of dental undergraduates and dental care professional numbers. The Northern Ireland Executive reported that access issues that had previously been a problem had been resolved, and that the number of patient registrations was now levelling off.

4.6 The general recruitment picture across the United Kingdom appears to us to be quite healthy. We also note that both England and Wales report that dentists are ready and enthusiastic to bid for new NHS contracts. The British Dental Association (BDA)

[1] As of March 2014 in England, Scotland, Wales but as of April 2014 in Northern Ireland.

highlighted an issue with recruiting associate dentists, particularly in Wales, but we note that the pay of associates is determined by principal dentists rather than by our pay recommendations.

Figure 4.1: Number of general dental practitioners, United Kingdom, 2007 and 2013 – 2014



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

4.7 NHS England said that 95 per cent of people trying to get an appointment in the past three years (in England) were successful, and that 29.9 million patients (56 per cent of the population) were seen by an NHS dentist in the 24-month period ending June 2014: there was also a rise in NHS dental activity in England, from 88.1 million UDAs in 2012-13, to 88.7 million UDAs in 2013-14. The Scottish Government said that at March 2014, 83.7 per cent of adults and 91.5 per cent of children were NHS registered. It said that it was now focusing expenditure on certain access payments and initiatives in (mainly) remote and rural areas and islands, where dental provision continued to be relatively challenging. The Welsh Government said that 1.7 million patients were seen in the two years to June 2014 (up 3,000 on year), with an increase in UDAs of 1.2 per cent in 2013-14. It said that 90.1 per cent of patients were satisfied with the waiting time for an appointment.

Motivation and workload

4.8 NHS England said that dentists had achieved a reduction in their working hours, with the September 2014 dental working hours survey showing that dentists were working an average of 36.9 hours per week in 2013-14 compared to 39.4 hours in 2000. The Welsh Government noted that the average total working hours for dentists in Wales was 35.8 per week in 2013-14. It said that it was conscious of the concerns expressed by dentists about certain operational aspects of the contract and the perceived increase in administration. The Northern Ireland Executive told us that an overspend of £0.6 million in 2014-15 on the indicative allocation for the General Dental Services (GDS) budget was predicted: it noted that until new contractual arrangements were in place, it was unable to control the number of dentists, the number of practices, or the treatments that were carried out. It said that it remained acutely aware of the issues raised by the BDA of

low morale and motivation within the dental workforce, but said that it had to pursue measures to constrain the GDS expenditure, whilst minimising the impact on patients, practitioners and practices.

4.9 The BDA told us that the recovery in Scotland of overpayments had been extremely damaging to motivation and morale. We note that any recovery formed part of the overall pay deal for 2011-12 to 2013-14 inclusive, and that the pay deal was accepted by the BDA: nevertheless, we will continue to monitor any impact on motivation. The BDA referred to its 2013 Business Trends Survey that showed that over one third of practice owners in Scotland rated their morale as low or very low. Its evidence also highlighted the issue of 'burnout' with (it suggested) increasing pressure and stress levels for dentists. It said that life was hard for dentists, and that leaving the NHS to convert to private practice was still an option and was achievable with careful planning. We note the concerns of the BDA and will continue to monitor recruitment and retention data for any trends to suggest significant numbers of departures from the NHS.

Contractual changes

4.10 The BDA said that discussions on new contractual arrangements in England continued, albeit very slowly. NHS England said that it was seeking a consistent operating model across the country, with clear and consistent outcome measures, indicators and a single accountability framework, whilst at the same time it sought not to stifle local innovation in service and quality improvement. It said that 90 practices were involved in piloting new arrangements and that it expected new contractual arrangements to address many of the concerns of the profession and to drive further improvements in dental health. The Welsh Government also described new piloting arrangements, that moved away from UDAs to a system focused on patient care, prevention and quality. It said that practice staff and patients valued the change that the piloted arrangements had brought. The Northern Ireland Executive said that it remained committed to the development of a new stand alone contract for Northern Ireland that met the needs of practitioners and commissioners, and that would protect and improve the oral health needs of patients. It described the piloting of the new arrangements and said it would monitor any change in practitioner behaviour in moving from the current item-of-service model. We ask all of the parties to update us on any contractual changes for our next report.

Remits and the formula approach to the uplift for general dental practitioners

4.11 The Department of Health, Welsh Government and the Northern Ireland Executive all invited us to make recommendations on appropriate uplifts for independent contractor GDPs, and to make recommendations on what allowance should be made for dentists' pay and for practice staff in the context of public sector pay policy for 2015-16. They said that they would make the final decisions on the gross uplift for dental contracts in the light of our recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations. The Scottish Government said that it invited us to make a recommendation on an uplift for item-of-service fees for 2015-16: notwithstanding the ongoing difficulties with fully evidencing income and expenses, it viewed our future recommendations as a sensible frame of reference.

4.12 Tables 4.1, 4.2 and 4.3 show changes in average GDP income for England and Wales, Scotland and Northern Ireland, and how those changes compare to our intended changes in income as suggested by our recommendations. They clearly show the failure of the existing formula-based approach to deliver our intended increases in income (or pay net of expenses).

Table 4.1: Changes in England and Wales dentists' income compared to recommended/ intended increases

England and Wales	GDP (all dentists)		
Financial year	Income	change on previous year	Uplift intended from previous year
2006-07	£96,135		
2007-08	£89,062	-7.4%	3.4%
2008-09	£89,600	0.6%	2.0%
2009-10	£84,900	-5.2%	2.2%
2010-11	£77,900	-8.2%	1.5%
2011-12	£74,400	-4.5%	0% (zero)*
2012-13	£72,600	-2.4%	0% (zero)*

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

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

Note: All figures in cash terms, not adjusted for inflation. Income from all sources.

Table 4.2: Changes in Scotland dentists' income compared to recommended/intended increases

Scotland	GDP (all dentists)		
Financial year	Income	change on previous year	Uplift intended from previous year
2006-07			
2007-08			3.4%
2008-09	£85,000		2.0%
2009-10	£79,300	-6.7%	2.2%
2010-11	£73,300	-7.6%	1.5%
2011-12	£71,700	-2.2%	0% (zero)
2012-13	£68,800	-4.0%	0% (zero)

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

Note: All figures in cash terms, not adjusted for inflation. Income from all sources.

Table 4.3: Changes in Northern Ireland dentists' income compared to recommended/ intended increases

Northern Ireland	GDP (all dentists)		
Financial year	Income	change on previous year	Uplift intended from previous year
2006-07			
2007-08	£89,800		3.4%
2008-09	£90,600	0.9%	2.0%
2009-10	£86,500	-4.5%	2.2%
2010-11	£78,900	-8.8%	1.5%
2011-12	£75,800	-3.9%	0% (zero)*
2012-13	£71,600	-5.5%	0% (zero)*

Source: Income from HSCIC Dental Earnings and Expenses: Northern Ireland (various years).

* no DDRB recommendation made: Northern Ireland negotiated directly with the BDA during the pay freeze.

Note: All figures in cash terms, not adjusted for inflation. Income from all sources.

4.13 As we indicated in the chapter on general medical practitioners (GMPs), our last report set out our detailed concerns with the existing formula-based approach to determining the uplift for independent contractor GDPs. We said in that report that we had serious reservations about continuing to make recommendations using the formula as it was not delivering our intended increases in income (net of expenses) and set out a series of data requirements that the parties should meet, if they wished us to continue with the formula-based approach. In essence, we required much better data on income and expenses so that we could make a more realistic judgement on movement in expenses. We recommended in our last report that the parties should work together to improve the quality of the evidence base here, and that progress should be reported back to us for this report. We said that we would consider whether or not to continue with the formula-based approach in the light of that progress.

4.14 In the evidence received for this review, the Department of Health said that it recognised and agreed with our concerns over the uplift formula. NHS England said that it was anomalous that we were a pay review body yet had been asked to make recommendations on expenses. It said that a better alternative would be for NHS England and the negotiating parties to discuss and consider an appropriate uplift for expenses within future contract negotiations. The Northern Ireland Executive said that it supported the use of the current formula, and that it was unaware of any acceptable alternative. The BDA said that it supported the use of the formula because it included an element for expenses. It said that the fact that the formula had not prevented a fall in taxable income was probably inevitable where dentistry was not funded adequately. In oral evidence, the Welsh Government told us that it also supported the continued use of the current formula. The Scottish Government told us that it had commissioned work on dental earnings and expenses with sample data sought for 2011-12, 2012-13 and 2013-14. It hoped to complete its research by February 2015, but said that the timetable was subject to change.

4.15 Our conclusion from the evidence provided to us for this review is that the data picture has not materially changed. As a result we do not have data to the required level of robustness and detail in order for us to feel confident and comfortable with using the formula-based approach. While the BDA supports our continued use of the formula, its evidence also comments on the fall in taxable income for GDPs and requests that once the uplift amount is determined using the formula, an additional 1.5 per cent should be added year-on-year for the next ten years: both of which undermine the use of the

formula as a vehicle for delivering an intended increase in net pay. We would, however, like to put on record our thanks to the Scottish Government for its efforts in providing sample-based estimates of earnings and expenses data, that may yet bear fruit. We feel that now is the time for us to cease using the formula, although we might consider returning to a formula-based approach in the future should the data picture improve.

4.16 We have therefore concluded that we should currently make a recommendation only on pay net of expenses. This is in line with our decision this year for GMPs. NHS England has proposed that, if we make such a recommendation, it would discuss with the BDA an appropriate uplift for expenses within future contract negotiations, and we support this general approach for all countries. We ask the parties to report back to us next year on the outcome of those negotiations, to include what assumptions they have made about income and expenses. We note that the research on dental income and expenses being undertaken by the Scottish Government may help to inform such negotiations.

4.17 In their remit letters, the Department of Health, the Welsh Government and the Northern Ireland Executive asked us what allowance should be made for practice staff pay, in the context of public sector pay policy for 2015-16. Addressing increases in practice staff pay for the forthcoming year represents a different approach to that we have taken in previous reports: in particular, our formula has not sought to do that, but to recompense practices for the cost of past increases. Regrettably, we do not feel that we are in a position to address forthcoming pay increases for this group in a considered way. As set out in the chapter on GMPs, and repeated here:

- as practice staff are not part of our remit group (and we therefore do not receive any evidence on their recruitment, retention or motivation – or from organisations representing them) we do not currently have an evidential base on which to make recommendations linked to their pay;
- previous evidence from the parties suggests that such staff are not, in general, appointed on *Agenda for Change* terms and conditions, so we do not consider it appropriate to use the general uplift for *Agenda for Change* staff as a proxy for the increase in staff costs; and
- even whilst such staff work mainly for the NHS, they are employed by independent contractors and should not, arguably, be subject to public sector pay policy. We recognise the counter argument that such staff's pay is ultimately funded by government.

4.18 We believe that consideration of practice staff costs should, like other practice expenses, form part of the annual contract negotiations. We also note that Annual Survey on Hours and Earnings data on actual increases in practice staff earnings, which we have used as a proxy for increases in staff pay in our formula in recent years, appear to be affected not just by changes in rates of pay but also by changes in the number and type of staff employed by practices. Details on numbers and type of staff are proper subjects for the contract negotiations. Our recommendation on pay net of expenses is contained in Chapter 7. For full transparency and in case the parties find it useful, we include (at Appendix E, Table E.6) a list of the latest available data that would have populated the coefficients in the formulae. We are mindful of the short time for discussion between the parties to reach agreement on an alternative methodology for this year.

Future evidence requirements

4.19 The data priorities from this chapter are summarised in Table 4.4. Table 4.5 summarises our information requirements. Our secretariat would be happy to discuss these with the parties.

Table 4.4: Data requests in order of priority

Data needed	Reason (terms of reference)
Improved data on income and expenses[2] (all parties)	To understand the factors driving GDPs' pay and inform our pay recommendations
The outcome of negotiations to deliver our recommended increase in pay net of expenses (if accepted), to include what assumptions were made about income and expenses (all parties)	To assess how the parties will respond to our decision to cease using the existing formula-based approach and inform our pay recommendations

Table 4.5: Information requirements

Information needed
Developments on contractual change (all parties) – discussed at paragraph 4.10

[2] Our detailed requirements were set out in paragraphs 3.26 and 3.27 of our 42nd Report 2014. Available from: https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-42nd-report-2014

CHAPTER 5: SALARIED DENTISTS

Introduction

5.1 This chapter considers issues surrounding the various salaried dental services in each part of the United Kingdom, noting that only the Scottish Government sought pay recommendations from us this year. The British Dental Association (BDA) continues to highlight recruitment issues to the salaried services, but this is balanced by the general oversupply of dentists across the United Kingdom. The BDA also alluded to the lower levels of wellbeing and higher levels of anxiety amongst salaried dentists.

5.2 Salaried dentists work in a range of different posts, as community dentists, salaried Primary Dental Services dentists, Dental Access Centre dentists, and as salaried general practitioners in the NHS.

Recruitment and retention

Scotland

5.3 The BDA said that in Scotland confusion over the role and funding of the Public Dental Service, a *de facto* recruitment freeze with all posts requiring Scottish Government approval, combined with the lack of a clearly defined training pathway, would continue to have a serious and damaging impact on the recruitment of new staff and on the morale and retention of existing staff. We raised this issue with officials from the Scottish Government during oral evidence, and they commented that they were perplexed by the BDA's comments, and that they did not consider there to be, in general, any recruitment or retention concerns. The BDA may therefore wish to raise any concerns it does have with the Scottish Government and we ask the parties to report back to us next year on the outcome of any such discussions.

England, Wales and Northern Ireland

5.4 In line with the remit restriction for England, Wales and Northern Ireland, the Department of Health, NHS Employers, NHS England, the Welsh Government, and the Northern Ireland Executive, did not provide us with any evidence on the recruitment and retention of salaried dentists. The BDA referred to its survey of foundation dentists, that found that 3.7 per cent of respondents had found a post in community dental services after training, although it was not clear how that number related to the actual number of vacancies. It said that to ensure the long-term sustainability of the service, it needed to recruit young dentists and provide comparable rewards to those received by dentists in other parts of the professions in the health service. It also commented that if the service was to continue to be able to offer care to the most vulnerable in society, greater investment in its staff was required. It reported in England and Wales a problem with recruitment to Band B posts, noting that six posts from the thirty-five advertised were left unfilled. We also note that Health Education England reported that, with improving dental health, England could be moving to an over-supply of dentists by 2020 with a very significant over-supply by 2040 (assuming no changes made to current training plans): this comment relates to all dentists, not just salaried dentists.

Motivation and workload

5.5 Reporting from its *Survey of Community Dentist/Salaried Practitioners' Wellbeing and Working Conditions 2014*, the BDA said that it was clear that those in community/public dental services continued to report a lower level of wellbeing and greater levels of anxiety than the general population. Levels of life satisfaction, (scale 1 to 10, 1 = not at all

satisfied and 10 = completely satisfied) averaged at 6.1 compared to the United Kingdom population average of 7.4, while levels of anxiety averaged at 4.1 compared to 3.1 for the United Kingdom population. The BDA said that to ensure staff were motivated and in a position to continue to offer care, more had to be done to safeguard their wellbeing. The BDA also drew our attention to C*ommissioning Salaried Primary Dental Services,*[1] a report which outlined concerns about the impact of an overstretched workforce.

New contractual arrangements in England

5.6 The BDA reported that the Community Dental Service (CDS) had joined the service contract reform programme in England, with three sites testing a modified care pathway and IT package. The BDA said that it had contributed to the Department of Health's contract reform engagement exercise on behalf of its CDS members.

New contractual arrangements in Northern Ireland

5.7 Last year we noted that Northern Ireland Executive ministers had entered into negotiations with the BDA on a revised contract for community dentists/salaried practitioners in Northern Ireland. In this year's evidence, the BDA said it had been informed by Northern Ireland officials that finance for the new contract had yet to be agreed. The BDA said that it believed that progress towards a new contract for salaried dentists in Northern Ireland should be prioritised by the Northern Ireland Executive in order to safeguard dental services utilised by the most vulnerable in society. We hope this can be settled as a priority since salaried dentists in Northern Ireland are the final remit group for whom modernised pay, terms and conditions remain outstanding.

Pay recommendations

5.8 Our recommendation on pay for salaried dentists is contained in Chapter 7.

Future evidence requirements

5.9 The information requirement for our next review is in Table 5.1.

Table 5.1: Information requirements

Information needed
The outcome of any discussions in Scotland about recruitment and retention concerns (Scottish Government/BDA) – discussed at paragraph 5.3

[1] *Commissioning Primary Salaried Dental Services. https://www.bda.org/dentists/representation/salaried-primary-care-dentists/cccphd/Documents/commissioning_salaried_primary_dental_care_services.pdf*

Part III: Secondary Care

CHAPTER 6: HOSPITAL DOCTORS AND DENTISTS

6.1 This chapter considers issues relating to pay in the secondary care sector. It takes doctors and dentists in hospital training, consultants and specialty doctors and associate specialist (SAS) doctors in turn. Noting that only the Scottish Government and the British Medical Association (BMA) sought pay recommendations on hospital doctors from us this year, this chapter explores the United Kingdom-wide position where relevant.

DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction

6.2 In this section we consider issues relating to doctors and dentists in hospital training. We consider fill-rate data, noting with concern that in the specialties of emergency medicine, psychiatry and ophthalmology, there appears to be an ongoing problem with recruitment, resulting in staffing difficulties in hospitals across the United Kingdom. We are also aware of the contract negotiations for these grades between employers and the BMA, that were being undertaken until they stalled in October 2014, and their effect on the parameters for this report.

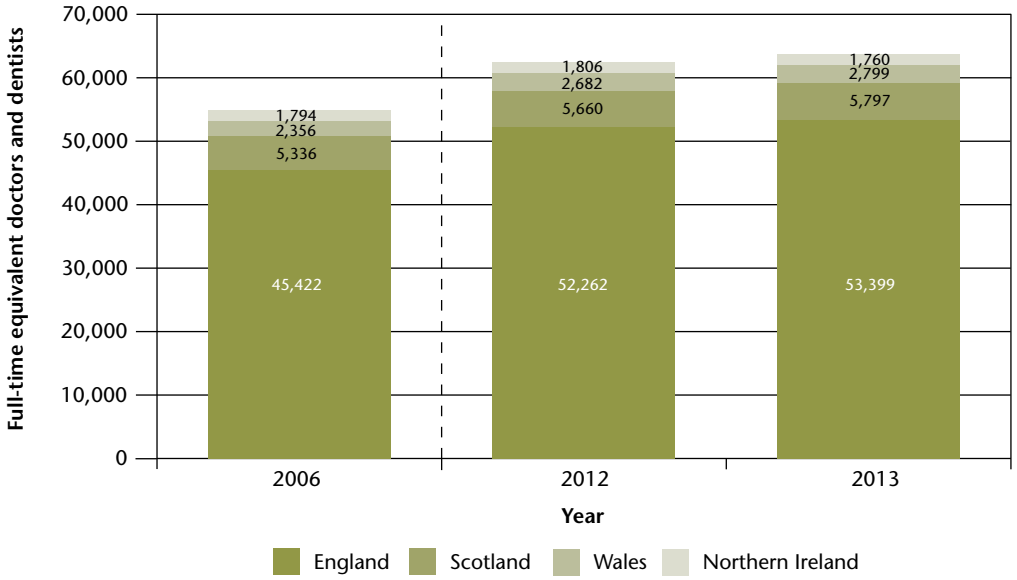
6.3 Doctors in the United Kingdom begin their hospital training in Foundation Programmes, normally a two-year, general post-graduate medical training programme, where they are known as foundation house officers (FHOs). Following this doctors can either remain in the hospital sector as specialty registrars or enter general practice via the general practice specialty registrar route.

Recruitment and retention and the demand for secondary care

United Kingdom

6.4 In September 2013 there were 63,754 doctors and dentists on a full–time equivalent (FTE) basis in hospital training (Figure 6.1) in the United Kingdom, an increase of 2.2 per cent since September 2012 and an increase of 16.1 per cent since 2006.

Figure 6.1: Number of doctors and dentists in training in the Hospital and Community Health Services, United Kingdom, 2006 and 2012 – 2013



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

6.5 We have examined data from the Universities and Colleges Admissions Service (UCAS). It shows that in 2013, there were 2.5 home applicants for each medical school place in the United Kingdom, an increase from last year's total of 2.3. We interpret this as strong evidence that at the undergraduate level, medicine continues to be seen as an attractive career. We note that the average UCAS tariff score held by home domiciled accepted applicants is 409 in 2013, down from 417 in 2012, but still above the 2011 score of 406. Women account for 55 per cent of accepted applicants in the United Kingdom. As we have previously commented, women are more likely to work part-time, and to choose specialisms conducive to part-time working. Given the potential impact on retention in specialties, particularly those less suited to part-time working, these trends are very relevant to workforce planning.

6.6 In our last report, we undertook an analysis of the fill rates for hospital trainees across the various specialties. However, because of the timing of our report, our analysis of the 2013 position was only for the first two rounds of recruitment. We therefore asked the parties to update us for this round with the final position for 2013, with a breakdown on how many vacancies were filled with training posts or with locums or other service posts. In this year's evidence, the parties did not address that evidence request in detail, although Health Education England told us that any vacancies in 2013 would have been re-advertised in 2014, together with any new posts that had become vacant or were commissioned within the year. It provided us with fill rate data for 2014 after (in general) two rounds of recruitment, but noted that further recruitment in some specialties, including emergency medicine, was ongoing.

6.7 As last year, we have looked at those specialties at the various stages (or levels) of training with more than ten posts, and fill rates that are below 50 per cent after two rounds of recruitment (Table 6.1). The table shows the total number of posts in each specialty, along with the current number of vacancies in brackets. Clearly, some of these vacancies are likely to be filled at a later stage, but our analysis from this year and last does show that amongst others, emergency medicine and psychiatry and some smaller specialties do not appear to be attracting sufficient numbers during the first two rounds of recruitment. These ongoing recruitment problems are of concern to us, particularly as when we have raised concerns in previous years about recruitment issues for particular specialites, we have been told that such issues are not pay-related.

6.8 Later this year, we will be considering an additional remit to look at contractual changes for junior doctors in all four countries: we may wish to consider the potential effect of changes for any specialty shortages, before contemplating and then considering whether or not any sort of pay response is warranted. We address issues relating to the recruitment of trainees to general practice where we also have concerns in Chapter 3 on general medical practitioners. We ask the parties to address our evidence request for fill rates on an ongoing basis

Table 6.1: United Kingdom fill rates for hospital trainees after the initial two rounds of recruitment, 2014-15

Specialty	Level	Fill rate (%)	Number of posts (vacancies)
Nuclear medicine	3	24	17 (13)
Chemical pathology	3	26	19 (14)
Emergency medicine	4	29	215 (153)
Psychiatry of learning disability	4	31	42 (29)
Ophthalmology	3	33	24 (16)
Child & adolescent psychiatry	4	49	74 (38)

Source: Health Education England.

Scotland

6.9 The Scottish Government said that Boards reported immediate service pressures exacerbated by some difficulties in recruiting trainees in some specialties. Intervention measures taken by the Scottish Government resulted in attracting three new emergency medicine trainees: the Scottish Government said it saw this as a positive result, but we note that this is unlikely to make a material difference to the recruitment of emergency medicine trainees in Scotland. Our data shows that, after the first two rounds of recruitment, Scotland's fill rate for emergency medicine level 4 trainees was just 26 per cent.

6.10 The Scottish Government told us it was working collaboratively with United Kingdom partners to better understand implications for the future training of the medical workforce raised in Professor Greenaway's *Shape of Training*[1] report and would focus on gaps in training programmes and problems of recruitment to remote areas. The Scottish Government's Strategy for Attracting and Retaining Trainees (StART) initiative had several goals to achieve by 2016: to increase overall applications by Scottish Foundation completers by 5 per cent; to increase first choice preferencing of Scottish training

[1] *Shape of Training: Securing the Future of Excellent Patient Care*. Professor David Greenaway, October 2013. Available from: http://www.shapeoftraining.co.uk/reviewsofar/1788.asp

programmes by 5 per cent; to increase fill rates of hard to fill programmes in emergency medicine, general practice, and psychiatry by 5 per cent; and to reduce gaps due to failure to fill by 5 per cent.

England, Wales and Northern Ireland

6.11 In line with the remit restriction for England, Wales and Northern Ireland, the Department of Health, Welsh Government, Northern Ireland Executive and NHS Employers did not provide us with any evidence on the recruitment, retention and motivation of doctors and dentists in hospital training.

New contract negotiations

6.12 The Heads of Terms that formed the basis of United Kingdom-wide negotiations on new contractual arrangements for junior doctors were agreed between the parties in June 2013, with negotiations beginning in October 2013. However, in October 2014, the negotiations stalled. We were subsequently issued with a remit by the Department of Health, the Welsh Government and the Northern Ireland Executive to make recommendations on new contractual arrangement for doctors and dentists in hospital training, including a new system of pay progression, with a strengthened link between pay and better quality patient care and outcomes. The Scottish Government also provided us with a remit to make observations on new contractual arrangements for doctors and dentists in hospital training, including pay progression: the Scottish Government said that it did not require the end of automatic progression, but would be willing to consider any system that was fair and equitable and offered fair reward. We will be considering evidence for this remit and we expect to report by July 2015.

CONSULTANTS

Introduction

6.13 This section looks at the consultant group, which is the main career grade in the hospital and public health service.

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

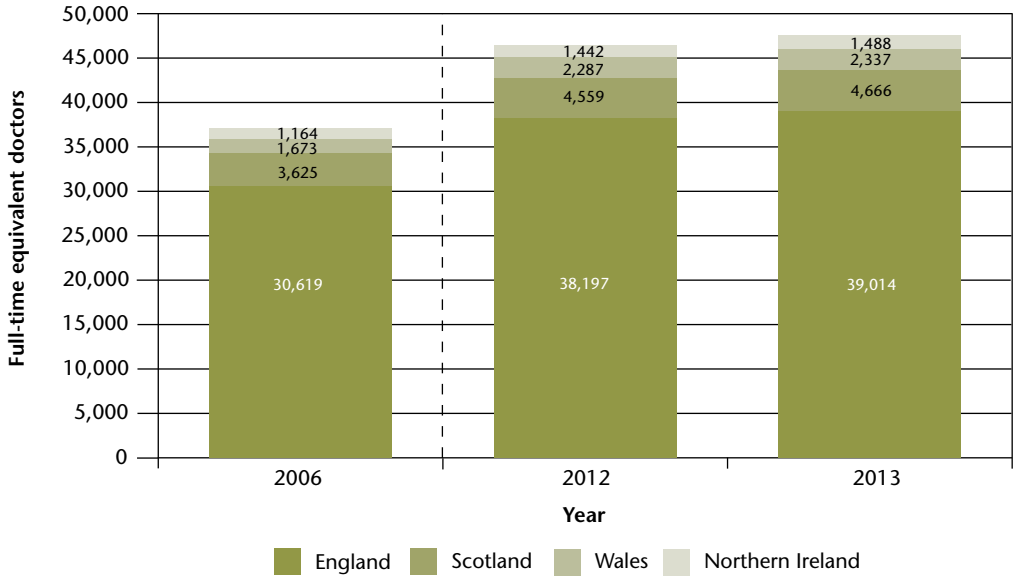
6.15 Under the 2003 contract, consultants have to agree the number of programmed activities (PAs) and supporting professional activities (SPAs) they will work. Total pay is comprised of five elements: basic pay on an eight-point scale; additional PAs/SPAs; on-call supplements; Clinical Excellence Award (CEA)/Discretionary Point/Distinction Award payments; and other fees and allowances. The current levels of payments are at Appendix B. The main differences for the 2003 contract in Wales are:

- a basic 37.5 hour working week (compared to 40 hours in the rest of the United Kingdom);
- a salary structure with seven incremental points; and
- a system of Commitment Awards to be paid every three years after reaching the maximum of the pay scale, which replaced the former Discretionary Points scheme, although consultants in Wales are also eligible for national CEAs.

Recruitment and retention

6.16 In September 2013, there were 47,505 FTE consultants, an increase of 2.2 per cent on the previous year and a 28.1 per cent increase since 2006, with the number of consultants increasing in each United Kingdom country each year between 2012 and 2013 (Figure 6.2).

Figure 6.2: Number of consultants in the Hospital and Community Health Services, United Kingdom, 2006 and 2012 – 2013



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

Scotland

6.17 The Scottish Advisory Committee on Distinction Awards (SACDA) repeated its comments from last year's evidence that suggested that consultants in Scotland were much less willing to take on quality and service improvement work on top of their normal role, a view supported by the BMA who commented in evidence this year that the lack of a higher award scheme in Scotland was making the country uncompetitive and unattractive. The Scottish Government commented last year that there was no substantive evidence to suggest that the freeze on Distinction Awards was proving detrimental to the recruitment and retention of high calibre consultants, and this year it commented that despite the freeze on Distinction Awards, Scotland had increased the number of FTE consultants by up to 10.8 per cent since September 2009. It also said that the 1 per cent increase in salary and continuation of incremental progression in 2014-15 might have had a positive impact on recruitment and retention.

6.18 In supplementary evidence, SACDA told us that it had clear evidence about consultants in their mid-career who used to compete for Distinction Awards: it said this group could not be recruited for Colleges or senior educational roles, and that this view was corroborated by the Royal Colleges in Scotland. It also noted fewer consultant applications from England for posts in Scotland and lower cross border recruitment of high calibre consultants with an award from England. We also note from the Scottish Government that the overall consultant vacancy rate at June 2014 was 6.9 per cent, an increase of 2.2 percentage points from June 2013. We comment on the freeze on Distinction Awards later in this chapter.

6.19 The BMA also drew our attention to information it had gathered following a Freedom of Information (FOI) request to all NHS Boards on Scottish consultant vacancies: it said that the responses suggested an overall consultant vacancy rate for Scotland of 11.32 per cent, of which 5.39 per cent of posts were occupied by locum doctors. There can be legitimate reasons for NHS Boards making use of locums, but locum use can also suggest an underlying recruitment problem.

England, Wales and Northern Ireland

6.20 In line with the remit restriction for England, Wales and Northern Ireland, the Department of Health, Welsh Government, Northern Ireland Executive and NHS Employers did not provide us with any evidence on the recruitment and retention of consultants. Health Education England, however, told us that it forecast an increase in the consultant population of between 3 and 4 per cent per annum. The BMA also told us that in Northern Ireland, the Health and Social Care's Workforce Vacancies survey showed 114 consultant vacancies at March 2014. We are also aware of press reports about the cost to the NHS of locums to fill rotas in emergency medicine. Later this year, we will be considering an additional remit to look at contractual changes for consultants in England, Wales and Northern Ireland: we will wish to consider the potential effect of changes on any specialty shortages before contemplating if any sort of pay response is warranted.

Motivation and workload

6.21 The BMA said that it was undertaking a study looking at Scottish consultants' perceptions of their role in the health service and the implications for patient care. We will, of course, be interested in the results of this study, when available. The BMA also drew on the results of research by the National Audit Office that showed consultants were working 1.46 direct clinical care PAs unpaid in a typical week. With other unpaid PA time, it estimated that a total of 3.34 PAs, or over 13 hours per week, were unpaid. The latest NHS Staff Survey in England showed an increase in the number of hours worked by consultants since last year.

6.22 Our view on unpaid PAs is that we recognise that many consultants exceed contractual requirements: however, we consider it to be normal practice for many professionals, including the comparators we use for consultants, to work in excess of the hours they are contracted for without additional payment, and we note that additional work above that contracted for is capable of being recognised through the various consultant reward schemes. In any case, we consider that the agreement of the number of contracted PAs/SPAs is properly an issue for job planning.

6.23 Evidence drawn from staff surveys shows that the motivation of consultants (and indeed other hospital doctors) is holding up. This is in contrast to what we heard during oral evidence with the BMA and to what we heard during our visit programme. While hard evidence is limited, we do consider that recent developments have the potential to threaten consultant morale: as far as we can see, workload appears to be increasing and pension changes are perceived as negative, alongside the non-implementation of our recommendations to increase incremental points by 1 per cent in England, Wales and Northern Ireland last year. In addition, in Scotland, the consultant vacancy rate has increased and there is a continued freeze on Distinction Awards. Recruitment problems in certain specialties, such as emergency medicine, will also have implications for workload pressure.

New contract negotiations

6.24 The Heads of Terms that formed the basis of negotiations on new contractual arrangements for consultants in England and Northern Ireland were agreed between the parties in June 2013, with the negotiations beginning in October 2013. Latterly, the Welsh Government indicated that it wished to join the negotiations. However, in October 2014, the negotiations stalled. We were subsequently issued with a remit by the Department of Health, the Welsh Government and the Northern Ireland Executive to make observations, based on information and data presented on pay-related proposals (including increments) for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way. We will be considering evidence for this remit and expect to report by July 2015. We expect this remit will allow us to consider some of the issues identified in the preceding paragraph.

6.25 The Scottish Government was not part of the contract negotiations, but told us that it had been attending the negotiations with observer status. It said that it did not wish to enter formal negotiations until it had clarity about sustainability and seven-day services. It would then look to achieve a fairer balance of remuneration at weekends and weekdays alongside other reforms to medical contracts.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

6.26 Schemes to provide consultants with some form of financial reward for exceptional achievement and contribution to patient care have been in existence since the beginning of the NHS in 1948. Since the publication of our *Review of Compensation Levels, Incentives and the Clinical Excellence and Distinction Award Schemes for NHS Consultants* in December 2012, we have been waiting for the parties to decide how to take forward our proposals on the future of the award schemes. Consideration of the future of the schemes in England and Northern Ireland was due to be taken forward as part of the consultant contract negotiations, so we expect to address this issue as part of our special remit on contract reform.

Scotland

6.27 SACDA reported that as at September 2014, there were 359 Distinction Award holders in Scotland: 30 A+; 81 A; and 248 B. It said that the number of Distinction Award holders had reduced by 37.9 per cent since 2010, and that the reduction was making it increasingly difficult for it to perform the procedures for five-yearly reviews as it relied heavily on higher award holders to carry out peer assessments. It said that there was now a significant number of specialties with no senior award holders.

6.28 The Scottish Government said that it was maintaining the freeze on new Distinction Awards, although five-yearly reviews and Discretionary Points would continue. It said that it was clear on the need to reform the scheme, and that to do nothing was not an option. Consideration on the future of the scheme would form part of any consideration of changes to the consultant contract, and would take account of the Scottish Government's aim for the delivery of person centred health provision in the context of its 2020 Workforce Vision and the delivery of seven-day services.

6.29 We noted earlier the increase in the consultant vacancy rate in Scotland, and despite the Scottish Government's commitment to the reform of the Distinction Award scheme, we are concerned about the continuing delay in taking this issue forward and its possible implications for recruitment and retention. Our 2012 report on the consultant award schemes supported the reform of the schemes, but we believe that national awards should continue to be available to recognise those consultants with the greatest sustained levels of performance and commitment to the NHS whose achievements are of national or international significance. We have also noted the concerns of SACDA.

We therefore urge the Scottish Government to proceed with its planned reform of the Distinction Award scheme, but if there is to be a delay to such reform, that it reinstate the funding to provide for new Distinction Awards in Scotland to recognise the contribution of its consultants.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

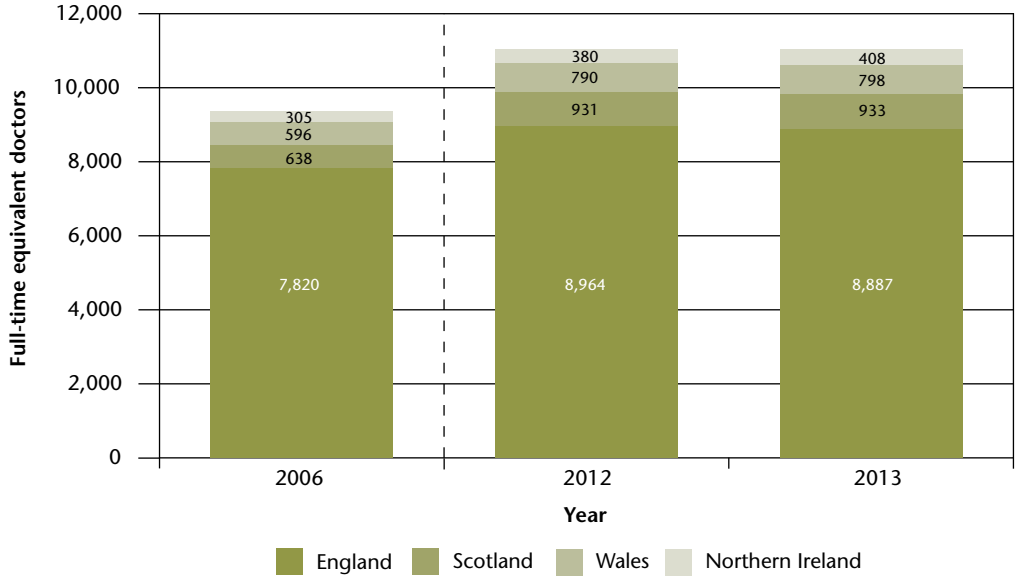
Introduction

6.30 The SAS grades are a diverse group comprised of: specialty doctors, associate specialists, staff grades, senior clinical medical officers, clinical assistants, hospital practitioners and doctors working in community hospitals. In this section, we note the small decrease in the number of FTE SAS grades, and the importance of funding for career development. Even taking into account the remit restrictions placed on us for salaried staff, the evidence we received on this group of doctors was very sparse. SAS doctors will continue to play a pivotal role in the provision of services and we would like to see this group of doctors reflected more in the quality and quantity of evidence we receive. Given that SAS doctors were not part of the contract negotiations alongside junior doctors and consultants, we ask all parties to pay close attention to SAS doctors when submitting their evidence, as we consider it important to maintain their motivation and retain their contribution to seven-day services.

Recruitment and retention

6.31 In September 2013, there were 11,026 FTE specialty doctors, associate specialists and staff grades, a decrease of 0.4 per cent on September 2012 levels but an increase of 17.8 per cent since 2006 for the United Kingdom as a whole: this decrease in 2013 was entirely due to fewer doctors in England (Figure 6.3).

Figure 6.3: Number of specialty doctors, associate specialists and staff grades in the Hospital and Community Health Services, United Kingdom, 2006 and 2012 – 2013



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

6.32 The BMA reported on a FOI request that had been made to 260 NHS organisations in England to ask about SAS vacancies that received 149 responses: it showed an average vacancy rate of 4.6 SAS doctors per organisation, with a particular problem in emergency medicine and psychiatry. It said that over the last 24 months, the average number of SAS vacancies was over 15 per organisation.

Career development issues

6.33 We have long championed the importance of funding for SAS doctors to support career development. We were therefore pleased to note the Scottish Government's support for the SAS Doctors Development Fund. We ask all of the parties to update us on any issues impacting SAS career development for our next review.

Pay recommendations

6.34 Our recommendation on pay for hospital doctors and dentists is contained in Chapter 7.

Future evidence requirements

6.35 The data priorities from this chapter are summarised in Table 6.2. Table 6.3 summarises our information requirements. Our secretariat would be happy to discuss these with the parties.

Table 6.2: Data requests in order of priority

Data needed	Reason (terms of reference)
Fill rate data for all trainees (to include general practice trainees) (all parties)	To assess recruitment and retention and help inform our pay recommendations
Evidence on SAS doctors (all parties)	To assess how all elements of our remit impact on this group of doctors and help inform our pay recommendations

Table 6.3: Information requirements in order of priority

Information needed
Developments on contractual change (all parties) – discussed at paragraphs 6.8, 6.24 and 6.25
Issues impacting SAS career development (all parties) – discussed at paragraph 6.33

CHAPTER 7: MAIN PAY RECOMMENDATIONS FOR 2015-16

The parties' proposals

7.1 In this chapter, we set out the parties' proposals for the main uplift to be awarded to each group for 2015-16, along with our recommendations. As ever, we have given careful consideration to all of the written and oral evidence we have received. The remit letters from the parties are at Appendix A. Chapter 1 covers the remits in more detail and issues specific to certain groups are addressed in the relevant chapters. For convenience the remits are summarised again very briefly below:

- the Department of Health, Welsh Government and Northern Ireland Executive only sought recommendations for independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs); and
- the Scottish Government sought recommendations for salaried doctors and dentists, as well as recommendations for independent contractor GMPs and GDPs.

7.2 The British Medical Association (BMA) said that it strongly rejected the restrictions placed upon our role and remit. It said that while the Scottish Government had implemented the recommendations in our last report in full, the explicit constraints imposed by England, Wales and Northern Ireland were both unacceptable and unnecessary. It therefore submitted evidence covering the whole of the United Kingdom and said that it was seeking a common recommendation for all doctors wherever they worked. It said that it believed strongly that we should continue to make recommendations for all grades in all nations, but that if we were not able to make recommendations for hospital doctors in England, it was imperative that this did not influence our recommendations for other groups. The BMA said that it had some concerns with the weight we placed on affordability arguments, being largely in line with public sector pay policy and asked us to consider how our recommendations had been implemented when making this year's recommendations. It argued that health services had reached a turning point, with doctors being asked to work increasingly long hours and more intensely, but without financial and other recognition. It pointed to capacity constraints in several areas, leading to worsening health service performance, recruitment difficulties, and a short-term focus on activity at the expense of finding sustainable solutions to an overall funding shortfall. It said that doctors had contributed as much as they could to sustaining and improving NHS performance, without additional investment in the service. The BMA called for a public debate on health service funding, focusing on how to reconcile increasing demand with universal and comprehensive care, without targeting the terms and conditions of the very NHS staff needed to deliver it. The BMA asked us to consider the contribution that doctors had made and continued to make in "keeping the NHS afloat" and that our recommendations should reflect that. It said that it believed that doctors merited an award in excess of inflation, but did not put forward a specific figure that it was seeking by way of a pay increase.

7.3 The British Dental Association (BDA) argued that our uplift recommendation must start to redress the fall in taxable income for GDPs over the last few years in all four countries. In terms of our pay uplift, the BDA said that its view was to ensure that GDPs' pay kept pace with inflation and that an uplift equal to the Consumer Prices Index (CPI) should be used. Its evidence noted the (then) current rate of CPI inflation of 1.5 per cent. At the time of writing, CPI is 0.5 per cent. However, once the uplift amount was determined using the dental formula, it proposed that an additional 1.5 per cent be added year on year for the next ten years to start to redress the hugely challenging situation that GDPs were in across all United Kingdom countries. The BDA also asked us to make a strong statement about the decision of some governments not to award a consolidated pay

rise to salaried dentists; and said that if we were to make a recommendation for salaried dentists in Scotland, we should recommend an increase of 3 per cent to ensure their income kept pace with inflation.

Main pay recommendations

7.4 In making our recommendations, we have taken account of our standing terms of reference, the letter from the Chief Secretary to the Treasury on public sector pay for 2015-16, the remit letters from each of the Health Departments, and the requests put to us in evidence by the parties.

7.5 The remit letters from England, Wales and Northern Ireland all sought to limit our recommendations to independent contractor GMPs and GDPs. Each letter provided varying levels of detail about the pay arrangements for doctors and dentists in training, and consultants, to be used instead.

7.6 Despite the remit restrictions placed on us by England, Wales and Northern Ireland, the BMA asked us to make recommendations covering all remit groups, in all United Kingdom countries. We have taken this request very seriously, as we do all of the requests and submissions put to us in evidence. We therefore sought evidence on salaried doctors and dentists from the parties that submit evidence to us, in order for us to make an assessment of the current picture for all of our remit groups. We did not receive any such evidence from the Department of Health, NHS Employers, the Welsh Government or the Northern Ireland Executive. We think it is also fair to say that evidence submitted by the BMA on salaried groups is not as comprehensive as in previous rounds. This may have been due to the contract negotiations for consultants and junior doctors continuing until October 2014.

7.7 We have therefore faced a dilemma. If we were to accede to the BMA's request for United Kingdom-wide recommendations, we would be doing so against the express request of several of the parties. As noted in Chapter 1, a fundamental aspect of our independent advisory role is that we seek to operate with the consensual agreement of the parties: indeed there is no other durable basis on which we can operate. We would also be making recommendations with incomplete evidence, which would run contrary to the ethos of an independent, evidence-based body. On the other hand, it would undermine the rationale of a pay review body if some of the parties could indefinitely circumvent the whole process, and avoid having to respond to any recommendations, by unilaterally refusing to submit evidence.

7.8 This is an unusual situation, and we have not previously set out our view on how we might approach it. Our standing terms of reference state that we are independent: and our central role is to make recommendations on the remuneration of doctors and dentists taking any part in the NHS, having regard to certain considerations. These do not include the need for a request from the parties. We therefore believe we have the right to set out our independent views, and submit pay recommendations or respond to specific remits, should one of the parties request it – or indeed if we simply consider it appropriate. If in future years we face the same dilemma as this year, we will consider our response accordingly. Naturally, we would provide ample opportunity for the parties to submit evidence to inform any recommendations we make.

7.9 For this year, we think it would be precipitate for us to take the step of making recommendations against the expressed desire of some of the parties, and without our previously having set out a view of our terms of reference. We have therefore concluded that for 2015-16 we should not make recommendations for salaried doctors and dentists in England, Wales and Northern Ireland. We very much hope we are not placed in this

position in future years. Since the 1960s, the review body process has offered all parties the benefit of independent recommendations, and the parties regularly assure us that they find this valuable.

7.10 Our understanding of how the pay of salaried doctors and dentists in England, Wales and Northern Ireland is being taken forward for 2015-16 is as follows:

- The Department of Health has imposed arrangements under which salaried staff in England at the top of their pay scales and who are not eligible for incremental pay will receive a non-consolidated payment of 2 per cent of pay, whilst other staff will receive incremental progression. The exception is those staff who reached the top of their pay scale in 2014-15: those staff will receive a non-consolidated payment of 1 per cent of pay for 2015-16.
- The Welsh Government told us that it hoped to hold discussions with the BMA and the BDA on how it might distribute the available funding as part of a negotiated pay settlement for 2015-16, to the same quantum as England as previously announced.
- The Northern Ireland Executive gave no indication of what approach it intended taking to pay for salaried doctors and dentists in 2015-16.

7.11 We note, with regret, the current absence of a way forward on these groups' pay in Wales and Northern Ireland, and hope the parties can shortly reach agreement, given the constraints imposed by affordability.

7.12 Before considering the uplift, we make some general observations: we note that the parties are in broad agreement that the market for doctors and dentists is a United Kingdom-based market; and that in general, our recommendations in previous reports applied to all salaried doctors and dentists, whichever country they worked in; and we comment in Chapter 2 that it has been standard practice for the value of incremental points for salaried staff to be uplifted by our recommendations.

7.13 In terms of the economic picture, despite the falling unemployment rate, there is little evidence of upward pressure in wages across the economy as a whole and average earnings growth was 1.7 per cent in the three months to November. However, the recent employment growth has been concentrated among younger workers and the low skilled, and this puts downward pressure on average earnings growth. The Annual Survey of Hours and Earnings shows that those in continuous employment over the year to April 2014 (the same job with the same employer) had earnings growth of 4.1 per cent, compared to just 0.1 per cent for all employees. So whilst the economy-wide wage growth is muted, this obscures some important changes in the composition of employment and pay changes in different groups. We are also required to consider the government's inflation target: inflation data show CPI inflation at just 0.5 per cent in December 2014, a 14-year low, and well below the government's target of 2 per cent.

7.14 Turning to our consideration of the actual uplift for salaried doctors and dentists in Scotland, we firstly note the level of expectation created by the public sector pay policy in Scotland for pay awards to be within an overall cost cap of 1 per cent (excluding increments). This has in practice translated into an expectation of a uniform 1 per cent rise. Scottish Government officials confirmed during oral evidence that their public sector pay policy was affordable. Evidence from staff surveys shows that the motivation of hospital doctors is holding up. This is in contrast to what we heard during oral evidence with the BMA and BDA about the low morale of doctors and dentists. While hard evidence is limited, we noted in Chapter 6 the factors that we consider have the potential to threaten consultant morale: as far as we can see, workload appears to be increasing, pension changes are perceived as negative, there are increases in vacancy rates, specialty shortages, such as emergency medicine; and the continued freeze on Distinction Awards. Most of these factors will also be felt by the other hospital groups

within our remit. Our analysis of recruitment for junior doctors has also identified on-going problems in recruiting to, amongst others, emergency medicine and psychiatry and some smaller specialties. We have also taken account of the survey results on the morale of wellbeing of community dentists/salaried dentists, that report a lower level of wellbeing and greater levels of anxiety than the general population.

7.15 Weighing all of these factors, our judgement is that there should be an increase of 1 per cent in basic pay for salaried doctors and dentists in Scotland. We note that despite the pressure in certain specialties, the parties in Scotland have not sought differential awards for the various salaried remit groups. We have some concerns that this approach may come under pressure in the longer term, if financial constraints continue to loom large. However, for this round we believe that the 1 per cent should apply to all of our salaried remit groups, across the board.

Recommendation 1: We recommend for 2015-16 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists in Scotland.

7.16 We make a separate recommendation for salaried GMPs, whose pay falls within a salary range rather than an incremental pay scale. Despite the restriction to our remit in England, the Department of Health told us in its evidence that it was proposing to increase the pay range for salaried GMPs in England by 1 per cent. The Welsh Government said that it was content for any recommendations we made for England to extend to Wales, although it did not offer any proposal for how to increase the pay range. The Northern Ireland Executive did not indicate whether it also sought a recommendation. In these circumstances, we make a recommendation for the pay range for salaried GMPs in all countries of the United Kingdom: we see no reason to treat them differently from other salaried doctors and recommend that the salary range for salaried GMPs be increased by 1 per cent for 2015-16.

Recommendation 2: We recommend that the minimum and maximum of the salary range for salaried general medical practitioners in the United Kingdom be increased by 1 per cent for 2015-16.

7.17 Chapters 3 and 4 of this report set out our views on the use of the formulae for determining the uplift for independent contractor GMPs and GDPs. We have concluded that the parties are currently unable to provide us with evidence on income and expenses to the required level of detail. We feel that now is the time for us to cease using the formulae, although we might consider returning to formulae-based approaches in the future should the data picture improve. For this year, we have concluded that our recommendations should therefore focus on pay net of expenses for these remit groups. The parties should then determine how to deliver our recommended uplift (if accepted) through the annual contract negotiation process, reporting back to us in the next round.

7.18 Turning first to our consideration of pay net of expenses for independent contractor GMPs, we have been concerned by the poor fill rates for general practice training: this shows (at the time of writing) that fill rates are a particular issue for both Scotland and England. At the same time, we note the action that is being taken by NHS England to address ongoing recruitment issues into general practice, and we were struck by the apparent agreement between the parties that the main issues that needed addressing in order to improve recruitment were, in the main, related to increasing workforce numbers, controlling workload and improving the condition of premises. Clearly not all of these issues are pay related, although we do consider that pay has a role to play in influencing career decisions. Employer staff survey evidence that we receive only focuses on hospital doctors. The evidence provided to us on the motivation of GMPs was therefore limited, and we urge the parties to give priority for better evidence in this area.

7.19 Our decision not to use the formula-based approach was influenced by the decline in GMPs' income, that now shows real income has returned to around the level before the introduction of the new General Medical Services contract, and indicates to us that the formula has not been working as intended. This failure to deliver the increases in pay net of expenses we previously recommended gives weight to us recommending an increase in pay net of expenses above 1 per cent for 2015-16. Our terms of reference, however, also require us to take account of affordability and the evidence here would support an increase in the 0 to 1 per cent range. On balance, our recommendation for independent contractor GMPs in all countries of the United Kingdom is for an increase in pay net of expenses of 1 per cent.

Recommendation 3: For independent contractor GMPs in all countries of the United Kingdom, we recommend an increase in pay net of expenses of 1 per cent.

7.20 For independent contractor GDPs, general recruitment of dentists does not appear to be an issue, although there are undoubtedly issues at a regional level. The number of dentists, in some countries operating within a fixed dental budget, combined with improvements in the dental health of the population, suggests that the dentists are all competing for a smaller slice of the available NHS income. This surplus of GDPs might suggest to us a recommendation for an increase in pay net of expenses in the 0 to 1 per cent range. A similar range for our recommended uplift is suggested to us by the evidence on affordability. The BDA did not conduct any research on the motivation of GDPs this year, so we are unable to take such matters into account. The BDA's evidence sought an increase in pay equal to CPI, which we note is currently 0.5 per cent, although it also sought an additional increase of 1.5 per cent for each of the next ten years. As with independent contractor GMPs, our decision to cease using a formula-based approach for determining the uplift for independent contractor GDPs has been influenced by the inability of the formula to deliver our intended increases in pay net of expenses. In fact, their falls in pay net of expenses have been more marked than for GMPs. This provides upward pressure to our recommendation well above 1 per cent. However, taking all of these factors into account, our recommendation for independent contractor GDPs in all countries of the United Kingdom is for an increase in pay net of expenses of 1 per cent.

Recommendation 4: For independent contractor GDPs in all countries of the United Kingdom, we recommend an increase in pay net of expenses of 1 per cent.

APPENDIX A – REMIT LETTERS FROM THE PARTIES

OFFICIAL

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

Review Body Members
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

31 July 2014

Dear Review Body Members

PUBLIC SECTOR PAY 2015-16

I would like to thank you for your work on the 2014-15 pay round. I am strongly convinced of the role of the pay review bodies in determining national pay awards in the public sector and appreciate the important part the pay review bodies have played over the last four years. For a number of review bodies this has included providing expert advice and oversight of wider reforms to pay policy and systems of allowances, in addition to the annual award. I am confident the changes brought about by the pay review body recommendations in these areas are making a significant contribution to the improvement and delivery of public services.

2. You will have seen that for the 2014-15 pay round there were some review body recommendations which, after careful consideration, the Government decided were unaffordable at this time. I hope you will appreciate this was a difficult decision and that the Government continues to greatly value the contribution of the pay review bodies in delivering robust, evidence-based pay outcomes for public sector workers.

OFFICIAL

3. The Autumn Statement of 2013 highlighted the important role in consolidation that public sector pay restraint has played. The fiscal forecast shows the public finances returning to a more sustainable position. However, the fiscal challenge remains and the Government believes that the case for continued pay restraint across the public sector remains strong. Reasons for this include:

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

b. Affordability: Pay restraint remains a crucial part of the consolidation plans that are continuing to help put the UK back on to 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. As you are aware, for 2014-15 the Government adopted an approach by which all staff in the NHS received at least an additional 1% of their basic pay. All staff not eligible to receive incremental pay have been given a 1% non-consolidated payment in 2014-15. Other staff will have received an increase worth at least 1% through incremental progression.

5. Unfortunately, the NHS trade unions are not prepared to negotiate an affordable alternative, although we are still open to new proposals. Therefore it is our intention to take the same approach in 2015-16. As a result, the DDRB will not be asked to make recommendations on a pay award for employed doctors and dentists in the 2015 pay round.

6. I note that the DDRB would welcome a proactive and systematic approach to considering contractual issues at an appropriate stage of the consultant and doctors in training negotiations and we will consider taking up

this offer, subject to progress in the negotiations. The Department of Health will write at an appropriate juncture with more details. They will also set out the remit for independent contractors in the usual manner.

7. I look forward to your reports, and reiterate my thanks for the invaluable contribution made by the Review Body on Doctors' and Dentists' Remuneration during the course of this Parliament.

DANNY ALEXANDER

Department of Health

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

Richmond House
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POC5 882726

Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 8, Fleetbank House
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London
EC4Y 8AE

26th August 2014

Dear Paul,

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander, on 31st July 2014 confirming the Government's approach to the 2015/16 pay round.

I should first wish to add my own thanks to that of the Chief Secretary for the robust and independent advice that the Government receives from the Review Body on Doctors' and Dentists' Remuneration (DDRB). I can assure you that we value this advice very highly and attach considerable importance to the role of the DDRB, informed as it is by expert, impartial and independent judgement. This is true even where, as in the previous review round, the continuing need for pay restraint right across the public sector to support fiscal consolidation, together with the unprecedented financial challenge facing the NHS, meant that we are not able to accept your recommendations in full.

As the Chief Secretary signalled in his letter, following the Government's announcement of a two year pay settlement for employed doctors and dentists in England, the DDRB is not required to report or to make recommendations or observations for the 2015/2016 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

This two year settlement does not apply to independent contractors.

NHS England will shortly be commencing discussions with the BMA General Practitioners Committee on potential improvements to the 2015/16 General Medical Services contract, and with the BDA General Dental Practice Committee on potential improvements to the contractual framework for general dental services. Whilst it is always possible that such discussions may result in an agreed approach to uplift, we are proceeding on the assumption that DDRB will make recommendations on uplifts for both contractor groups. If that position changes as a result of negotiations, we will of course let you know as soon as possible.

The DDRB is, therefore, invited to make recommendations on appropriate uplifts for the two contractor groups. We would particularly welcome DDRB's recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff pay, in the context of public sector pay policy for 2015/16. The Government will make the final decisions on the gross uplift for GMS and dental contracts in the light of the DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

As the Chief Secretary indicates, the case for continued pay restraint across the public sector remains strong. Whilst public finances are returning to a more sustainable position as the UK economy begins to grow again, we continue to face a considerable fiscal challenge. Pay restraint in the public sector remains a necessary part of the Government's consolidation plans, helping to ensure that public sector jobs are protected and that the quality of public sector services are supported.

This year, the Department will provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy. Separate detailed evidence will be provided by NHS England's independent primary care contractors. As always, while DDRB's remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay review round and to communicate this to you directly.

I look forward to receiving your report on independent contractors early next year.

Yours sincerely,

Dr Dan Poulter

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/MD/2335/14

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

6 October 2014

Dear Paul

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION – 2015/16 REMIT

I am writing to confirm the Welsh Government's approach in respect of the Review Body on Doctors' and Dentists' Remuneration (DDRB's) remit for 2015/16.

Following on from my announcement in March, and subsequently in July, of a pay deal in respect of employed medical and dental staff based on the same quantum as England, the DDRB is not required to report on or make recommendations for the year 2015/16 on:

- the remuneration of employed doctors and dentists
- the recruitment, retention and motivation of staff
- regional / local variations in labour markets and their effects on recruitment and retention of staff.

For the two contractor groups, General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs), the DDRB is invited to make recommendations on appropriate uplifts for 2015/16. We would also welcome, in particular, DDRB's recommendations on what allowances should be made for GPs' and GDPs' pay and for practice staff pay, in the context of public sector pay policy for 2015/16. The Welsh Government will make the final decisions on the gross uplift for GMS and dental contracts in the light of DDRB's recommendations.

The Welsh Government will shortly be commencing discussions with General Practitioners Committee (Wales) on potential changes to the GMS contract for 2015/16. Although it is possible these discussions could result in an agreed approach, we are proceeding on the basis that DDRB will make recommendations for GMPs. If that position changes as a result of negotiations we will let you know as soon as possible.

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While I value the integrity and role of the pay review bodies, the scale of the financial challenge facing the Welsh NHS remains. It is for this reason I have taken the decision to limit the monies available to fund a pay award for employed medical and dental staff during 2015/16.

Best wishes

Mark Drakeford

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

Cabinet Secretary for Health and Wellbeing
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The Scottish Government
Riaghaltas na h-Alba

In 2014 Scotland Welcomes the World

Professor Paul Curran
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13 October 2014

Dear Paul

Last year the Scottish Government's remit letter made reference to its Public Sector Pay Policy for 2014-15 which was announced by the Cabinet Secretary for Finance, Employment and Sustainable Growth on 11 September 2013. The policy is still current – extending into 2015-16 and is intended to inform considerations around pay for public sector groups in Scotland including NHSScotland staff.

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

Beyond the parameters set out above, we would again wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2015-16. You will appreciate, however, that all consideration on this issue must be informed by the policy framework which we have set for public sector pay in Scotland. It is also important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

The Scottish Government's position is in complete contrast to the policies set out in the letter of 31 July to the OME from the Chief Secretary to the Treasury, Danny

Alexander, and the further letter of 26 August from Dr Dan Poulter, Parliamentary Under Secretary of State for Health, which signalled that following on from the UK Government's announcement of a 2 year pay settlement for employed doctors and dentists in England, they would not require the DDRB to report or make recommendations or observations for the 2015-16 year on remuneration, recruitment and regional variations in labour markets for this group of staff. The Scottish Government's preference at this time would be to maintain one unified pay system which will cover the whole of the UK. I recognise that this may present challenges for the Review Body in putting forward recommendations and that England's application of the pay deal in 2014-15 will have already seen the widening of the pay differentials between our countries.

The Scottish Government would like to invite DDRB to make a recommendation on an uplift for item-of-service fees for independent dentists providing general dental services for 2015-16. As you will be aware the Scottish Government accepted the DDRB recommendation in full for 2014-15, and notwithstanding the difficulties concerning earnings and expenses, view any future recommendation as a sensible frame of reference.

For General Practitioners we again seek the DDRB's recommendation in respect of GP pay and contractual uplift. The Scottish Government is committed to increasing its investment in general practice and the DDRB's recommendation is a helpful factor in that decision-making process.

The Scottish Government also invites the DDRB to give due consideration to the remuneration received by Directors of Postgraduate General Practice Education in relation to levels of pay and remuneration packages of equivalents in the private sector and comparator groups.

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

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

ALEX NEIL

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Jim Wells MLA

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Health, Social Services and Public Safety
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Our Ref: SUB/1063/2014

Date: 5 November 2014

Dear Professor Curran

Review Body on Doctors' and Dentists' Remuneration (DDRB) Remit 2015/16

I wish to convey my thanks to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for its work on the 2014/15 pay round. My Department values the work of the pay review body in delivering its recommendations on remuneration in this important role. This is true, even where, as in the previous round we were unable to accept all your recommendation due to the exceptionally challenging financial position in which we find ourselves and HM Treasury's call for continued pay restraint

The Northern Ireland Executive has endorsed the principle of adherence to the UK Government's public sector pay policy and enforcement of pay growth limits is devolved to the Executive within the overarching parameters set by HM Treasury. The financial situation within Northern Ireland continues to present challenges which we are seeking to manage and it is within this context that I believe that pay restraint will continue to be required for 2015/16. Therefore I am not seeking a recommendation from the pay review body specifically in relation to pay for salaried doctors and dentists.

For independent contractors, the DDRB are, however, invited to make recommendations on appropriate uplifts. Specifically, DDRB are asked to make recommendations on what allowance should be made for GPs' and dentists' pay and for practice staff in the context of public sector pay policy for 2015/16. Northern Ireland will make their final decisions on the gross uplift for GMS and dental contracts in the light of the DDRB's recommendations and taking into account any efficiency gains obtained through the relevant contract negotiations.

In view of the demands placed on you to support the pay review round in the devolved administrations, and the lateness of this request, my officials would be very happy to work with you to agree a realistic timeframe for you to report on your findings for Northern Ireland.

I note that negotiations for the reform of consultants' and junior doctors' contracts and for doctors and dentists in training applying in Northern Ireland have not resulted in

agreement. However, I believe that much good work was achieved during these negotiations. Accordingly, I consider it is now appropriate to invite DDRB to make observations and recommendations that take into account the work undertaken during these negotiations.

For 2015/16, for consultants, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way ie without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, I am aware that the DDRB has been invited by the Department of Health to consider and critique proposals which they and the NHS Employers will present. Supplementary information and data reflecting the particular Northern Ireland context will also be provided.

The DDRB should also consider the following, including work already completed by the DDRB and work undertaken by the parties to the negotiations:

- the work by the DDRB on the payment of clinical excellence awards (CEAs), and the Government's response to that;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven day services.

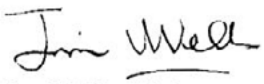
For doctors and dentists in training, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, "*a strengthened link between pay and better quality patient care and outcomes*". In doing so, DDRB should consider information submitted including:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In undertaking both strands of this work, the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should also have regard to the read-across to the work that I have asked the NHS Pay Review Body to undertake on observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

In considering your observations on seven day services, I would also wish you to consider the extent to which they would read across to other medical staff groups such as specialty doctors and associate specialists. I would expect the Review Body's observations for Northern Ireland to follow the same timetable as that for England and be included in their report in July.

My officials look forward to continued engagement with you throughout this process and I look forward to receiving your reports in due course.



Jim Wells MLA
Minister for Health Social Services and Public Safety

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

PART I: SALARY SCALES[1]

The salary scales that we recommend should apply from 1 April 2015 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	2014	2015
	£	£
Foundation house officer 1	22,976	23,205
	24,409	24,654
	25,843	26,102
Foundation house officer 2	28,497	28,782
	30,361	30,664
	32,224	32,546
Specialty registrar (full)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123

[1] Our recommended basic pay uplifts, to be applied from 1 April 2015, are applied to unrounded current salary scales (November 2007 is the base year date), with the final result being rounded up to the nearest unit.

	2014	2015
	£	£
Specialty registrar (fixed term)	30,302	30,605
	32,156	32,478
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
House officer	22,976	23,205
	24,409	24,654
	25,843	26,102
Senior house officer	28,497	28,782
	30,361	30,664
	32,224	32,546
	34,088	34,429
	35,951	36,311
	37,815	38,193
	39,678	40,075
Specialist registrar[2]	31,614	31,931
	33,180	33,512
	34,746	35,093
	36,312	36,675
	38,200	38,582
	40,090	40,491
	41,979	42,399
	43,868	44,307
	45,757	46,215
	47,647	48,123
Consultant (2003 contract)	76,001	76,761
	78,381	79,165
	80,761	81,568
	83,141	83,972
	85,514	86,369
	91,166	92,078
	96,819	97,787
	102,465	103,490

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

	2014	2015
	£	£
Discretionary Points	3,204	3,204
	6,408	6,408
	9,612	9,612
	12,816	12,816
	16,020	16,020
	19,224	19,224
	22,428	22,428
	25,632	25,632
Consultant (pre-2003 contract)[3]	63,102	63,733
	67,617	68,293
	72,133	72,855
	76,649	77,415
	81,798	82,616
Specialty doctor[4]	37,547	37,923
	40,758	41,165
	44,931	45,381
	47,168	47,640
	50,391	50,895
	53,602	54,138
	56,884	57,453
	60,168	60,770
	63,452	64,086
	66,734	67,402
	70,018	70,718

[3] Closed to new entrants.

[4] 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.

	2014	2015
	£	£
Associate specialist (2008)[5]	52,643	53,169
	56,875	57,444
	61,105	61,716
	66,693	67,359
	71,535	72,251
	73,544	74,280
	76,166	76,928
	78,788	79,576
	81,409	82,224
	84,031	84,871
	86,655	87,521
Associate specialist (pre-2008)	38,451	38,836
	42,524	42,950
	46,596	47,062
	50,668	51,175
	54,741	55,289
	58,813	59,402
	64,191	64,833
	68,852	69,541
Discretionary Points	*Notional scale*	
	70,787	71,495
	73,310	74,043
	75,833	76,592
	78,357	79,140
	80,880	81,689
	83,406	84,240
Staff grade practitioner	34,786	35,133
(1997 contract, MH03/5)	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	49,082	49,573

[5] 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.

	2014	2015
	£	£
Discretionary Points	*Notional scale*	
	51,353	51,867
	54,114	54,655
	56,876	57,444
	59,637	60,234
	62,398	63,022
	65,161	65,812
Staff grade practitioner	34,786	35,133
(pre-1997 contract, MH01)	37,547	37,923
	40,308	40,711
	43,069	43,500
	45,831	46,289
	48,592	49,078
	51,353	51,867
	54,114	54,655
	(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)	4,699	4,746
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,598	4,644
	4,864	4,913
	5,132	5,183
	5,398	5,452
	5,664	5,721
	5,930	5,989
	6,196	6,258

B. Community health staff

	2014	2015
	£	£
Clinical medical officer	33,323	33,657
	35,128	35,479
	36,932	37,301
	38,736	39,123
	40,540	40,945
	42,344	42,767
	44,148	44,589
	45,953	46,413
Senior clinical medical officer	47,089	47,560
	49,956	50,455
	52,821	53,349
	55,686	56,243
	58,553	59,138
	61,418	62,032
	64,283	64,926
	67,150	67,821

C. Salaried primary dental care staff

	2014	2015
	£	£
Dental Foundation Year 1	30,934	31,243
Dental Foundation Year 2	33,655	33,991
Public Dental Service pay scales:		
Band A: Dental Officer	38,476	38,861
	42,752	43,179
	49,164	49,656
	52,370	52,894
	55,577	56,133
	57,714	58,291
Band B: Senior Dental Officer	59,852	60,451
	61,989	62,609
	65,195	65,847
	66,799	67,467
	68,403	69,087
	70,005	70,705

	2014	2015
	£	£
Band C: Assistant Clinical Director	71,608	72,325
	73,746	74,483
	75,883	76,642
Band C: Specialist Dental Officer	71,608	72,325
	73,746	74,483
	75,883	76,642
	78,021	78,801
Band C: Clinical Director/Chief Administrative Dental Officers (Western Isles, Orkney and Shetland Health Boards)	71,608	72,325
	73,746	74,483
	75,883	76,642
	78,021	78,801
	80,158	80,960
	82,296	83,119

Part-time dental surgeon	**Sessional fee (per hour)**	
	2014	**2015**
	£	£
Dental surgeon	28.97	29.26
Dental surgeon holding higher registrable qualifications	38.43	38.81
Dental surgeon employed as a consultant	47.41	47.89

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES[6]

1. The fee for domiciliary consultations should be increased from £84.20 to £85.05 per visit. Additional fees should be increased pro rata.

2. Weekly and sessional rates for locum appointments in the hospital service should be increased as follows:

	Per week[7]		**Per notional half day**	
	2014	**2015**	**2014**	**2015**
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,010.79	1,020.91	91.89	92.81
Hospital practitioner appointment			103.51	104.55
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			90.11	91.01

[6] Our recommended basic pay uplifts, to be applied from 1 April 2015, are applied to unrounded current salary scales, with the final result being rounded up to the nearest unit.

[7] The notional half day rate multiplied by 11.

	Per week[8]		Per standard hour	
	2014	2015	2014	2015
	£	£	£	£
Specialty registrar (higher rate) appointment	900.96	910.08	18.77	18.96
Specialty registrar (lower rate) appointment	817.92	826.08	17.04	17.21
Specialist registrar appointment	900.96	910.08	18.77	18.96
Foundation house officer 2	698.88	706.08	14.56	14.71
Senior house officer appointment	784.80	792.48	16.35	16.51
Foundation house officer 1 appointment/ House officer appointment	562.08	567.36	11.71	11.82

	Per week[9]		Per session	
	2014	2015	2014	2015
	£	£	£	£
Staff grade practitioner appointment	852.50	861.00	85.25	86.10

	Per week[10]		Per programmed activity	
	2014	2015	2014	2015
	£	£	£	£
Specialty doctor appointment	861.70	870.40	86.17	87.04
Associate specialist appointment (2008)	1,171.90	1,183.60	117.19	118.36

3. The Health Department in Scotland should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

[8] 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.

[9] The per session rate multiplied by 10.

[10] The per programmed activity rate multiplied by 10.

4. The supplements payable to district directors of public health and for regional directors of public health should be increased as follows:[11]

	2014			2015		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Island Health Boards: Band E	1,853	3,674		1,872	3,711	
Band D (50,000 – 249,999 population)	3,557	7,113	8,892	3,593	7,184	8,981
Band C (250,000 – 449,999 population)	4,462	8,892	10,685	4,506	8,981	10,792
Band B (450,000 and over population)	5,337	10,685	13,782	5,390	10,792	13,920
Regional director of public health: Band A	13,782	20,006		13,920	20,207	

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

5. The supplement payable to general practice specialty registrars is 45 per cent[12] of basic salary.

6. The salary range for salaried GMPs employed by primary care organisations should be increased from £54,862 – £82,789 to £55,411 – £83,617.

General dental practitioners

7. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre should be increased from £86.33 to £87.19.

[11] Population size is not the sole determinant for placing posts within a particular band.

[12] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B2: REMUNERATION IN ENGLAND

PART I: SALARY SCALES

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

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

	2014
	£
Foundation house officer 1	22,636
	24,049
	25,461
Foundation house officer 2	28,076
	29,912
	31,748
Dental trainees in hospital posts	28,076
	29,912
	31,748
	33,584
	35,420
	37,256
	39,092
Specialty registrar (full)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175
Specialty registrar (fixed term)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693

	2014
	£
House officer	22,636
	24,049
	25,461
Senior house officer	28,076
	29,912
	31,748
	33,584
	35,420
	37,256
	39,092
Specialist registrar[1]	31,301
	32,852
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)	75,249
	77,605
	79,961
	82,318
	84,667
	90,263
	95,860
	101,451
Consultant (pre-2003 contract)[2]	62,477
	66,948
	71,419
	75,890
	80,988

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

[2] Closed to new entrants.

	2014
	£
Specialty doctor[3]	37,176
	40,354
	44,487
	46,701
	49,892
	53,071
	56,321
	59,572
	62,823
	66,074
	69,325
Associate specialist (2008)[4]	52,122
	56,312
	60,500
	66,032
	70,827
	72,816
	75,412
	78,008
	80,603
	83,199
	85,797
Associate specialist (pre-2008)	38,071
	42,103
	46,135
	50,167
	54,199
	58,231
	63,556
	68,171

[3] 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.

[4] 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.

	2014
	£
Discretionary Points	*Notional scale*
	70,086
	72,584
	75,083
	77,581
	80,079
	82,580
Staff grade practitioner	34,441
(1997 contract, MH03/5)	37,175
	39,909
	42,643
	45,377
	48,596
Discretionary Points	*Notional scale*
	50,845
	53,578
	56,313
	59,047
	61,780
	64,516
Staff grade practitioner	34,441
(pre-1997 contract, MH01)	37,175
	39,909
	42,643
	45,377
	48,111
	50,845
	53,578

	(Annual rate on the basis of a notional half day per week)
	2014
	£
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,652
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553
	4,816
	5,081
	5,344
	5,608
	5,871
	6,135

B. Community health staff

	2014
	£
Clinical medical officer	32,994
	34,780
	36,566
	38,352
	40,138
	41,925
	43,711
	45,498
Senior clinical medical officer	46,623
	49,461
	52,298
	55,135
	57,973
	60,810
	63,647
	66,485

C. Salaried primary dental care staff[5]

	2014
	£
Band A: Salaried dentist	38,095
	42,328
	48,677
	51,851
	55,026
	57,142
Band B: Salaried dentist[6]	59,259
	61,375
	64,550
	66,137
	67,724
	69,311
Band C: Salaried dentist[7, 8, 9]	70,899
	73,015
	75,131
	77,248
	79,364
	81,480

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

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

[7] 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.

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

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

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES

1. The fee for domiciliary consultations is £83.37 per visit.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[10] 2014 £	Per notional half day 2014 £
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	90.98
Hospital practitioner appointment		102.49
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)		89.22

	Per week[11] 2014 £	Per standard hour 2014 £
Specialty registrar (higher rate) appointment	892.32	18.59
Specialty registrar (lower rate) appointment	809.76	16.87
Specialist registrar appointment	892.32	18.59
Foundation house officer 2 appointment	688.80	14.35
Senior house officer appointment	773.28	16.11
Foundation house officer 1 appointment / House officer appointment	553.44	11.53

	Per week[12] 2014 £	Per session 2014 £
Staff grade practitioner appointment	844.10	84.41

	Per week[13] 2014 £	Per programmed activity 2014 £
Specialty doctor appointment	853.20	85.32
Associate specialist appointment (2008)	1,160.30	116.03

[10] The notional half day rate multiplied by 11.

[11] 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.

[12] The per session rate multiplied by 10.

[13] The per programmed activity rate multiplied by 10.

London weighting

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

Doctors in public health medicine

4. The supplements payable to directors of public and for regional directors of public health are:

	2014		
	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£
Band D	3,522	7,042	8,804
Band C	4,418	8,804	10,579
Band B	5,284	10,579	13,646
Regional director of public health: Band A	13,646	19,808	

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

5. The supplement payable to general practice specialty registrars is 45 per cent[15] of basic salary.

6. The salary range for salaried GMPs employed by primary care organisations should be increased from £54,862 – £82,789 to £55,411 – £83,617.

[14] *Thirty-Sixth Report*. Review Body on Doctors' and Dentists' Remuneration. Cm 7025. TSO, 2007. Paragraph 1.64.

[15] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B3: REMUNERATION IN WALES

PART I: SALARY SCALES

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

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

	2014
	£
Foundation house officer 1	22,748
	24,168
	25,587
Foundation house officer 2	28,215
	30,060
	31,905
Dental foundation trainees	30,132
Dental trainees in hospital posts	28,215
	30,060
	31,905
	33,750
	35,595
	37,440
	39,285
Specialty registrar (full)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175

	2014
	£
Specialty registrar (fixed term)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693
House officer	22,748
	24,168
	25,587
Senior house officer	28,215
	30,060
	31,905
	33,750
	35,595
	37,440
	39,285
Specialist registrar[1]	31,301
	32,852
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175
Consultant (2003 contract, Wales)	72,927
	75,249
	79,134
	83,646
	88,798
	91,735
	94,679

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

	2014 £
Commitment Awards[2]	3,204
	6,408
	9,612
	12,816
	16,020
	19,224
	22,428
	25,632
Consultant (pre-2003 contract)[3]	62,477
	66,948
	71,419
	75,890
	80,988
Specialty doctor[4]	37,176
	40,354
	44,487
	46,701
	49,892
	53,071
	56,321
	59,572
	62,823
	66,074
	69,325

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

[3] Closed to new entrants.

[4] 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.

	2014
	£
Associate specialist (2008)[5]	52,122
	56,312
	60,500
	66,032
	70,827
	72,816
	75,412
	78,008
	80,603
	83,199
	85,797
Associate specialist (pre-2008)	38,071
	42,103
	46,135
	50,167
	54,199
	58,231
	63,556
	68,171
Discretionary Points	*Notional scale*
	70,086
	72,584
	75,083
	77,581
	80,079
	82,580
Staff grade practitioner	34,441
(1997 contract, MH03/5)	37,175
	39,909
	42,643
	45,377
	48,596

[5] 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.

	2014 £
Discretionary Points	*Notional scale*
	50,845
	53,578
	56,313
	59,047
	61,780
	64,516
Staff grade practitioner	34,441
(pre-1997 contract, MH01)	37,175
	39,909
	42,643
	45,377
	48,111
	50,845
	53,578
	(Annual rate 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)	4,652
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553
	4,816
	5,081
	5,344
	5,608
	5,871
	6,135

B. Community health staff

	2014 £
Clinical medical officer	32,994
	34,780
	36,566
	38,352
	40,138
	41,925
	43,711
	45,498

	2014
	£
Senior clinical medical officer	46,623
	49,461
	52,298
	55,135
	57,973
	60,810
	63,647
	66,485

C. Salaried primary dental care staff[6]

	2014
	£
Band A: Salaried dentist	38,095
	42,328
	48,677
	51,851
	55,026
	57,142
Band B: Salaried dentist[7]	59,259
	61,375
	64,550
	66,137
	67,724
	69,311
Band C: Salaried dentist[8, 9, 10]	70,899
	73,015
	75,131
	77,248
	79,364
	81,480

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

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

[8] 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.

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

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

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES

1. The fee for domiciliary consultations is £83.37 per visit.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[11] 2014 £	Per notional half day 2014 £
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	90.98
Hospital practitioner appointment		102.49
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)		89.22

	Per week[12] 2014 £	Per standard hour 2014 £
Specialty registrar (higher rate) appointment	892.32	18.59
Specialty registrar (lower rate) appointment	809.76	16.87
Specialist registrar appointment	892.32	18.59
Foundation house officer 2 appointment	692.16	14.42
Senior house officer appointment	777.12	16.19
Foundation house officer 1 appointment/House officer appointment	556.32	11.59

	Per week[13] 2014 £	Per session 2014 £
Staff grade practitioner appointment	844.10	84.41

	Per week[14] 2014 £	Per programmed activity 2014 £
Specialty doctor appointment	853.20	85.32
Associate specialist appointment (2008)	1,160.30	116.03

[11] The notional half day rate multiplied by 11.

[12] 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.

[13] The per session rate multiplied by 10.

[14] The per programmed activity rate multiplied by 10.

Doctors in public health medicine

3. The supplements payable to directors of public and for regional directors of public health are:

	2014		
	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£
Band D	3,522	7,042	8,804
Band C	4,418	8,804	10,579
Band B	5,284	10,579	13,646
Regional director of public health: Band A	13,646	19,808	

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

4. The supplement payable to general practice specialty registrars is 45 per cent[15] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £54,862 – £82,789 to £55,411 – £83,617.

[15] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B4: REMUNERATION IN NORTHERN IRELAND

PART I: SALARY SCALES

The salary scales which applied on 1 April 2013 for full-time hospital and community doctors and dentists are set out below; rates of payment for part-time staff should be *pro rata* to those of equivalent full-time staff.

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

	2013
	£
Foundation house officer 1	22,636
	24,049
	25,461
Foundation house officer 2	28,076
	29,912
	31,748
Specialty registrar (full)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175
Specialty registrar (fixed term)	30,002
	31,838
	34,402
	35,952
	37,822
	39,693
House officer	22,636
	24,049
	25,461

	2013
	£
Senior house officer	28,076
	29,912
	31,748
	33,584
	35,420
	37,256
	39,092
Specialist registrar[1]	31,301
	32,852
	34,402
	35,952
	37,822
	39,693
	41,564
	43,434
	45,304
	47,175
Consultant (2003 contract, England, Scotland and Northern Ireland for main pay thresholds)	75,249
	77,605
	79,961
	82,318
	84,667
	90,263
	95,860
	101,451
Consultant (pre-2003 contract)[2]	62,477
	66,948
	71,419
	75,890
	80,988

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

[2] Closed to new entrants.

	2013 £
Specialty doctor[3]	37,176
	40,354
	44,487
	46,701
	49,892
	53,071
	56,321
	59,572
	62,823
	66,074
	69,325
Associate specialist (2008)[4]	52,122
	56,312
	60,500
	66,032
	70,827
	72,816
	75,412
	78,008
	80,603
	83,199
	85,797
Associate specialist (pre-2008)	38,071
	42,103
	46,135
	50,167
	54,199
	58,231
	63,556
	68,171

[3] 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.

[4] 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.

	2013
	£
Discretionary Points	*Notional scale*
	70,086
	72,584
	75,083
	77,581
	80,079
	82,580
Staff grade practitioner	34,441
(1997 contract, MH03/5)	37,175
	39,909
	42,643
	45,377
	48,596
Discretionary Points	*Notional scale*
	50,845
	53,578
	56,313
	59,047
	61,780
	64,516
Staff grade practitioner	34,441
(pre-1997 contract, MH01)	37,175
	39,909
	42,643
	45,377
	48,111
	50,845
	53,578

	2013 £ *(Annual rate 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)	4,652
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553
	4,816
	5,081
	5,344
	5,608
	5,871
	6,135

B. Community health staff

	2013 £
Clinical medical officer	32,994
	34,780
	36,566
	38,352
	40,138
	41,925
	43,711
	45,498
Senior clinical medical officer	46,623
	49,461
	52,298
	55,135
	57,973
	60,810
	63,647
	66,485

C. Salaried primary dental care staff[5]

	2013 £
Dental Foundation Year 1	30,628
Dental Foundation Year 2	33,321

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

	2013 £
Band 1: Community dental officer	34,964
	37,792
	40,621
	43,450
	46,279
	49,107
	51,936
	54,766
Band 2: Senior dental officer	49,962
	53,917
	57,871
	61,826
	65,780
	66,652
	67,523
Band 3: Assistant clinical director	66,392
	67,419
	68,447
	69,474
	70,502
	71,530
Band 3: Clinical director	66,392
	67,419
	68,447
	69,474
	70,502
	71,530
	72,558
	73,602
	74,630
	75,657

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

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES[6]

1. The fee for domiciliary consultations is £83.37 per visit.

2. Weekly and sessional rates for locum appointments in the hospital service are:

	Per week[7] 2013 £	Per notional half day 2013 £
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	90.98
Hospital practitioner appointment		102.49
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)		89.22

	Per week[8] 2013 £	Per standard hour 2013 £
Specialty registrar (higher rate) appointment	892.32	18.59
Specialty registrar (lower rate) appointment	809.76	16.87
Specialist registrar appointment	892.32	18.59
Foundation house officer 2 appointment	688.80	14.35
Senior house officer appointment	773.28	16.11
Foundation house officer 1 appointment/House officer appointment	553.44	11.53

	Per week[9] 2013 £	Per session 2013 £
Staff grade practitioner appointment	844.10	84.41

	Per week[10] 2013 £	Per programmed activity 2013 £
Specialty doctor appointment	853.20	85.32
Associate specialist appointment (2008)	1,160.30	116.03

[6] Which applied on 1 April 2013 unless otherwise specified.

[7] The notional half day rate multiplied by 11.

[8] 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.

[9] The per session rate multiplied by 10.

[10] The per programmed activity rate multiplied by 10.

Doctors in public health medicine

3. The supplements payable to directors of public and for regional directors of public health are:

	2013		
	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£
Band D	3,522	7,042	8,804
Band C	4,418	8,804	10,579
Band B	5,284	10,579	13,646
Regional director of public health: Band A	13,646	19,808	

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

4. The supplement payable to general practice specialty registrars is 45 per cent[11] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £54,862 – £82,789 to £55,411 – £83,617.

General dental practitioners

6. The sessional fee for part-time salaried dentists working six 3-hour sessions per week or less in a health centre is £85.48.

Community health and community dental staff (Northern Ireland)

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

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

9. 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.

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

[11] Doctors currently receiving the higher protected level of the supplement should keep their existing entitlement rather than see their pay supplement reduced.

APPENDIX B5: UNCHANGED FEES AND ALLOWANCES

Operative date

1. The levels of remuneration set out below apply from 1 April 2014. Those which apply in Scotland should remain at 2014 levels.

Hospital medical and dental staff

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

	2014
	£
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[1] should remain at current levels.

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

4. The annual values of consultant intensity payments:

	2014
	£
Daytime supplement:	1,274

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

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.

[1] 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.

The rates are set out in the table below.

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

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

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

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

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

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

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

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

* salary = F5 to F9 calculated above.

The supplements will be applied as set out below.

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

APPENDIX C: THE NUMBER OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM[1]

ENGLAND[2]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[3]						
Consultants	37,510	39,613	38,341	40,444	2.2	2.1
Associate specialists	2,995	3,364	2,773	3,116	-7.4	-7.4
Specialty doctors	5,138	5,948	5,363	6,160	4.4	3.6
Staff grades	474	587	392	477	-17.4	-18.7
Registrar group	37,964	38,866	38,858	39,921	2.4	2.7
Foundation house officers 2[4]	6,978	7,022	6,975	7,019	0.0	0.0
Foundation house officers 1[5]	6,171	6,215	6,420	6,473	4.0	4.2
Other doctors in training	45	130	30	61	-33.4	-53.1
Hospital practitioners/Clinical assistants	350	1,547	295	1,254	-15.6	-18.9
Other staff	130	300	118	244	-9.8	-18.7
Total	**97,756**	**103,190**	**99,565**	**104,778**	**1.9**	**1.5**
Hospital and Community Health Services Dental Staff						
Consultants	686	787	672	783	-2.0	-0.5
Associate specialists	128	176	108	157	-15.6	-10.8
Specialty doctors	211	410	238	447	13.1	9.0
Staff grades	17	36	12	29	-28.2	-19.4
Registrar group	525	545	549	577	4.6	5.9
Foundation house officers 2[4]	522	537	515	531	-1.4	-1.1
Foundation house officers 1[5]	58	60	52	52	-9.7	-13.3
Other doctors in training	0	0	0	0	:	:
Hospital practitioners/Clinical assistants	38	238	34	205	-10.6	-13.9
Other staff	959	1,373	894	1,268	-6.7	-7.6
Total	**3,143**	**4,070**	**3,075**	**3,968**	**-2.2**	**-2.5**

: Not applicable.

[1] An employee can work in more than one organisation, location, specialty or grade and their headcount is presented under each group but counted once in the headcount total.

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

[3] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[4] This includes senior house officers.

[5] This includes house officers.

ENGLAND[6]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**35,871**	**40,265**	**36,294**	**40,236**	**1.2**	**-0.1**
GMP providers	24,095	26,886	24,043	26,635	-0.2	-0.9
General practice specialty registrars[7]	4,138	4,426	4,093	4,404	-1.1	-0.5
GMP retainers[8]	155	321	126	284	-18.8	-11.5
Other GMPs	7,483	8,898	8,032	9,153	7.3	2.9
General dental practitioners[9,10,11]		**23,201**		**23,723**		**2.2**
General Dental Services only		18,447		19,133		3.7
Personal Dental Services only		1,924		1,877		-2.4
Mixed		1,812		1,814		0.1
Trust-led		1,018		899		-11.7
Ophthalmic medical practitioners[12]		**304**		**293**		**-3.6**
Total general practitioners		**63,770**		**64,252**		**0.8**
Total – NHS doctors and dentists		**171,012**		**172,984**		**1.2**

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

[7] General practice specialty registrars were formerly known as GMP registrars.

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

[9] This is the number of dental performers who have any NHS activity recorded against them via FP17 claim forms at any time in the year that met the criteria for inclusion within the annual reconciliation process.

[10] Data as at 31 March of the following year.

[11] Data include salaried dentists.

[12] Data as at 31 December.

WALES[13]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[14]						
Consultants	2,287	2,424	2,337	2,467	2.2	1.8
Associate specialists	356	401	334	378	-6.2	-5.7
Specialty doctors	427	529	457	556	7.1	5.1
Staff grades	7	11	7	11	0	0
Specialist registrars	1,832	1,880	1,887	1,936	3.0	3.0
Foundation house officers 2[15]	511	513	531	532	3.8	3.7
Foundation house officers 1[16]	339	339	381	383	12.6	13.0
Hospital practitioners	3	17	3	16	-2.9	-5.9
Clinical assistants	15	76	14	66	-7.5	-13.2
Other staff[17]	132	203	122	190	-7.4	-6.4
Total	**5,909**	**6,393**	**6,073**	**6,535**	**2.8**	**2.2**
General medical practitioners		**2,256**		**2,285**		**1.3**
GMP providers		1,996		2,026		1.5
General practice specialty registrars		223		233		4.5
GMP retainers		37		26		-29.7
General dental practitioners		**1,392**		**1,438**		**3.3**
General Dental Services only		988		1,040		5.3
Personal Dental Services only		197		164		-16.8
Mixed		123		149		21.1
Ophthalmic medical practitioners		**14**		**8**		**-42.9**
Total general practitioners		**3,662**		**3,731**		**1.9**
Total – NHS doctors and dentists		**10,055**		**10,266**		**2.1**

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

[14] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[15] This includes senior house officers.

[16] This includes house officers.

[17] This group consists mainly of dental officers.

SCOTLAND[18]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[19]						
Consultants	4,427	4,717	4,535	4,836	2.4	2.5
Associate specialists	323	379	285	331	-11.7	-12.7
Specialty doctors	493	685	527	736	7.1	7.4
Staff grades	67	88	66	85	-1.4	-3.4
Registrar group	3,832	3,983	3,905	4,072	1.9	2.2
Foundation house officers 2[20]	753	764	744	753	-1.2	-1.4
Foundation house officers 1[21]	989	992	1,071	1,076	8.4	8.5
Hospital practitioners	16	96	15	88	-2.8	-8.3
Clinical assistants	35	158	28	125	-19.0	-20.9
Other staff	297	675	308	704	3.7	4.3
Total	**11,231**	**12,434**	**11,485**	**12,705**	**2.3**	**2.2**
Hospital and Community Health Services Dental Staff[19]						
Consultants	132	149	131	148	-0.9	-0.7
Associate specialists	17	21	18	22	5.9	4.8
Specialty doctors	28	53	33	54	16.0	1.9
Staff grades	4	5	4	4	0	-20.0
Registrar group	38	44	32	38	-15.2	-13.6
Foundation house officers 2[20]	48	55	44	50	-8.4	-9.1
Foundation house officers 1[21]	0	0	1	1	:	:
Hospital practitioners	<1	1	<1	1	0	0
Clinical assistants	<1	1	0	0	-100.0	-100.0
Other staff	446	576	434	568	-2.7	-1.4
Total	**713**	**886**	**696**	**868**	**-2.4**	**-2.0**

: Not applicable

[18] Data as at 30 September.

[19] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[20] This includes senior house officers.

[21] This includes house officers.

SCOTLAND[22]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners		**4,856**		**4,858**		**0.0**
GMP providers		3,742		3,695		-1.3
General practice specialty registrars[23]		455		484		6.4
GMP retainers[24]		138		134		-2.9
Other GMPs		530		556		4.9
General dental services[25]		**3,060**		**3,227**		**5.5**
Principal dental practitioners		2,456		2,589		5.4
Vocational dental practitioners		179		191		6.7
Assistant dental practitioners		59		56		-5.1
Ophthalmic medical practitioners		**37**		**37**		**0**
Total general practitioners		**7,953**		**8,122**		**2.1**
Total – NHS doctors and dentists		**21,289**		**21,439**		**0.7**

[22] Data as at 30 September.

[23] General practice specialty registrars were formerly known as GMP registrars.

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

[25] Data include salaried dentists.

NORTHERN IRELAND[26]	2012		2013		Percentage change 2012 – 2013	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[27]						
Consultants	1,442	1,529	1,488	1,583	3.2	3.5
Associate specialists	139	163	132	153	-5.2	-6.1
Specialty doctors	205	257	250	309	22.4	20.2
Staff grades	37	46	25	31	-30.7	-32.6
Specialist registrars	1,256	1,281	1,218	1,244	-3.1	-2.9
Foundation house officers 1 and 2[28]	549	553	542	544	-1.3	-1.6
Hospital practitioners	39	93	15	52	-62.5	-44.1
Other staff	91	134	91	139	0.4	3.7
Total	**3,759**	**4,056**	**3,762**	**4,055**	**0.1**	**0.0**
General medical practitioners[29]		**1,170**		**1,171**		**0.1**
General dental practitioners[30]		**950**		**960**		**1.1**
Ophthalmic medical practitioners[30]		**21**		**11**		**-47.6**
Total general practitioners		**2,141**		**2,142**		**0.0**
Total – NHS doctors and dentists		**6,197**		**6,197**		**0**

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

[27] Some hospital practitioners and clinical assistants also appear as general medical practitioners, general dental practitioners or ophthalmic medical practitioners.

[28] This includes house officers and senior house officers.

[29] Data as of November.

[30] Data as at April of the following year.

APPENDIX D: GLOSSARY OF TERMS

AGENDA FOR CHANGE – the harmonised pay system in operation for the NHS. It applies to all directly-employed NHS staff with the exception of doctors, dentists and some Very Senior Managers. See *Very Senior Managers*.

ASSOCIATE DENTISTS (SCOTLAND AND NORTHERN IRELAND) – self-employed dentists who enter into a contractual arrangement, that is neither partnership nor employment, with principal dentists. Associates pay a fee for the use of facilities, the amount generally being based on a proportion of the fees earned; the practice owner provides services, including surgery facilities and staff to the associate. Associate dentists also have an arrangement with an NHS board and provide General Dental Services. The equivalent in England and Wales is performer-only dentists. See also *performer-only dentists*.

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

BASIC PAY – the annual rate of salary without any allowances or additional payments.

CARR-HILL ALLOCATION FORMULA – used to adjust the global sum total received by General Medical Services practices for a number of local demographic and other factors which may affect practice workload. For example, a practice with a large number of elderly patients may have a higher workload than one which primarily cares for commuters. See also *global sum*.

CENTRALLY FUNDED ALLOWANCES (SCOTLAND AND NORTHERN IRELAND) – centrally funded contractual payments including: rent reimbursement; reimbursement of non-domestic rates; seniority payments; recruitment and retention allowance; long-term sickness; maternity and paternity pay; continuing professional development; remote areas; vocational training; sedation; clinical audit; and non-contractual payments in kind and benefits. See also *reimbursement of practice rental costs, seniority payment*.

CLINICAL COMMISSIONING GROUPS – the groups of general medical practitioners and other healthcare professionals that have taken over commissioning from primary care trusts in England under NHS reforms.

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

COMMITMENT AWARDS – for consultants in Wales, Commitment Awards are paid every three years after reaching the maximum of the pay scale. There are a total of eight Commitment Awards. Commitment Awards replaced Discretionary Points in October 2003. See also *Discretionary Points*.

COMMITMENT PAYMENTS (SCOTLAND) – paid quarterly to dentists who carry out NHS General Dental Services and who meet the criteria for payment.

COMPARATOR PROFESSIONS – groups identified as comparator professions to those in the DDRB remit groups are: legal, tax and accounting, actuarial and pharmaceutical.[1]

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

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

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, Commitment Awards, Distinction Awards*.

DISTINCTION AWARDS – consolidated payments that provide consultants with financial reward for exceptional achievements and contributions to patient care. Now replaced by national Clinical Excellence Awards in England, Wales and Northern Ireland, but remains the current scheme in Scotland. They remain payable to existing holders until the holder retires or gains a new award. All levels of Distinction Awards are pensionable.
See also *Clinical Excellence Awards, Discretionary Points*.

DOUBLE COUNTING OF DENTISTS' GROSS EARNINGS AND EXPENSES – see *Multiple counting of dentists' gross earnings and expenses*.

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

EXPENSE SHARING ARRANGEMENT – Dentists who share expenses with other dentists, but retain their own profits.

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

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

GENERAL DENTAL PRACTICE ALLOWANCE (SCOTLAND) – an allowance, which varies according to the level of NHS commitment, introduced to retain dentists in NHS General Dental Services.

GENERAL DENTAL SERVICES CONTRACT – can be practice based, where the contract is held by an individual dentist, partnership (including limited liability partnership), company, or one individual dentist with a number of dentist performers working under the contract.

GENERAL MEDICAL PRACTITIONER TRAINER – a general medical practitioner, other than a general practice specialty registrar, who is approved by the General Medical Council for the purposes of providing training to a general practice specialty registrar.

GENERAL MEDICAL SERVICES CONTRACT – one of the types of contracts primary care organisations can have with primary care providers. It is a mechanism for providing funding to individual general medical practices, which includes a basic payment for every practice, and further payments for specified quality measures and outcomes.
See also *global sum; minimum practice income guarantee; Quality and Outcomes Framework*.

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

HEALTH SERVICE SHARE – the equivalent of NHS share, in Northern Ireland. See *NHS share*.

HOSPITAL AND COMMUNITY HEALTH SERVICES (HCHS) STAFF – consultants; doctors and dentists in training; specialty doctors and associate specialists; and others (including: hospital practitioners; clinical assistants; and some public health and community medical and dental staff). General medical practitioners, general dental practitioners and ophthalmic medical practitioners are excluded from this category.

INCORPORATED BUSINESS – both providing-performer/principal and performer-only/associate dentists are able to incorporate their business and become a director and/or employee of a limited company (Dental Body Corporate). For providing-performer/principal dentists, the business tends to be a dental practice. For performer-only/associate dentists, the business is the service they provide as a sub-contractor.

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

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

MULTIPLE COUNTING OF EXPENSES – flows of money between dentists (for example, between a principal and an associate working in the former's practice) mean that gross earnings and expenses can be double counted across the tax returns of the dental population. This will cause estimates of gross earnings and expenses for the dental population as a whole to be artificially inflated. A single sum of money can (legitimately for tax accounting purposes) be declared as gross earnings by both the principal and the associate, and also as an expense by the principal. This is explained fully in Chapter 2 of the Fortieth Report.[2]
See also *expenses to earnings ratio*.

NHS COMMITMENT – see *NHS share*.

NHS SHARE – in England, Wales and Scotland, the percentage of time devoted to NHS dentistry, as opposed to private dentistry. This is calculated from dentists' own responses to the *Dental Working Patterns Survey*, and was previously known as NHS Commitment.

PERFORMER-ONLY DENTISTS (ENGLAND AND WALES) – dentists who perform NHS activity on a contract, but do not hold the contract with the primary care organisation. The equivalent in Scotland and Northern Ireland is associate dentists. See also *associate dentists*.

PRINCIPAL DENTISTS (SCOTLAND AND NORTHERN IRELAND) – dental practitioners who are practice owners, practice directors or practice partners, have an arrangement with an NHS board, and provide General Dental Services. The equivalent in England and Wales is providing-performer dentists. See also *providing-performer dentists*.

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[2] *Fortieth Report.* Review Body on Doctors' and Dentists' Remuneration. Cm8301. TSO, 2012. Chapter 2.

PROGRAMMED ACTIVITIES – under the 2003 contract, consultants have to agree the numbers of programmed activities they will work to carry out direct clinical care; a similar arrangement exists for specialty doctors and associate specialists on the 2008 contracts. Each programmed activity is four hours, or three hours in 'premium time', which is defined as between 7 pm and 7 am during the week, or any time at weekends. A number of **SUPPORTING PROFESSIONAL ACTIVITIES** are also agreed within the job planning process to carry out training, continuing professional development, job planning, appraisal and research.

PROVIDING-PERFORMER DENTISTS (ENGLAND AND WALES) – dentists who hold a contract with a primary care organisation and also perform NHS dentistry on this or another contract. The equivalent in Scotland and Northern Ireland is principal dentists. See also *principal dentists*.

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

REVALIDATION – came into force across the United Kingdom on 3 December 2012. Licensed doctors are now legally required to demonstrate that they are keeping up to date and are fit to practise. Revalidation will usually be required every five years and will involve regular appraisals with the employer. The process will be overseen by the General Medical Council. The majority of licensed doctors in the United Kingdom will undergo revalidation for the first time by March 2016. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council.

SALARIED CONTRACTORS – general medical practitioners or general dental practitioners who are employed by either a primary care organisation or a practice under a nationally agreed model contract. See also *independent contractor status*.

SALARIED DENTISTS – provide generalist and specialist care largely for vulnerable groups. They often provide specialist care outside the hospital setting to many who might not otherwise receive NHS dental care.

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

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

SOLE TRADER (WITH HELP) – self-employed dentist who performs dental services, but also employs and/or sub-contracts other dentists to perform dental services within their sole trader business arrangement. See also *sole trader (without help)*.

SOLE TRADER (WITHOUT HELP) – self-employed dentist without other dentists working for them. See also *sole trader (with help)*.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS/SAS GRADES – doctors in the SAS grades work at the senior career-grade level in hospital and community specialties. The group comprises specialty doctors, associate specialists, staff grades, clinical assistants, hospital practitioners and other non-standard, non-training 'trust' grades. The associate specialist grade is now closed.

SUPPORTING PROFESSIONAL ACTIVITIES – see *programmed activities*.

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

VERY SENIOR MANAGERS (VSMs) – these include chief executives, executive directors (with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and requirements of the post) and other senior managers with board level responsibility who report directly to the chief executive.

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

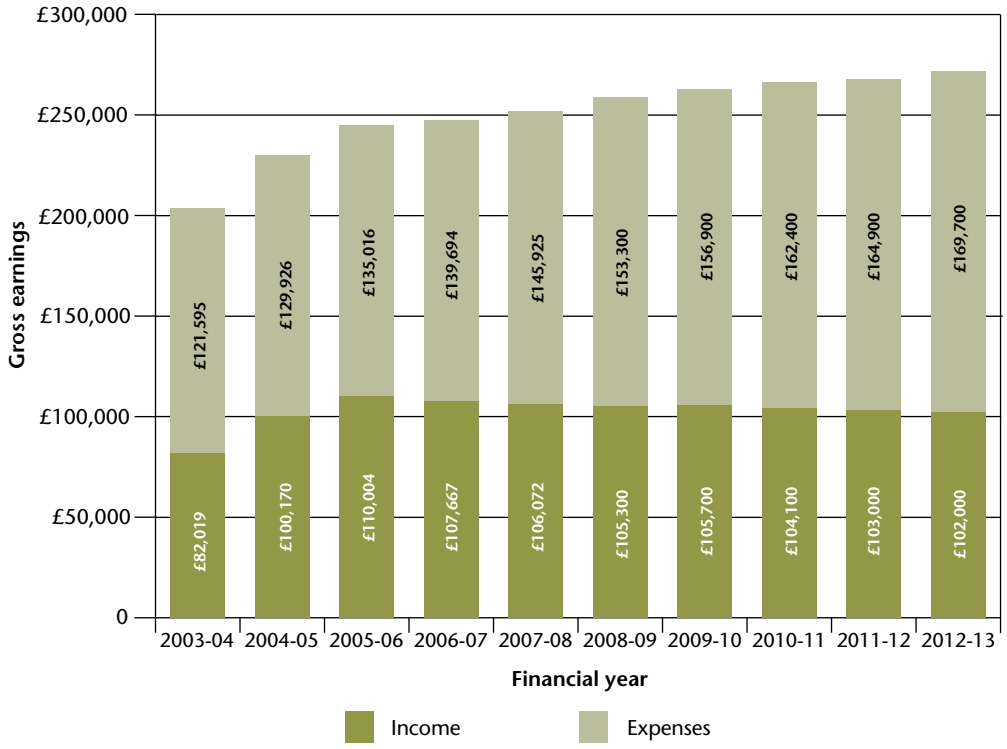
APPENDIX E: EARNINGS AND EXPENSES OF GMPs AND GDPs

E.1 This appendix sets out information on the earnings and expenses of general medical practitioners (GMPs) and general dental practitioners (GDPs), as reported by the Health and Social Care Information Centre.

The Health and Social Care Information Centre: GMP Gross Earnings and Expenses 2012-13

E.2 We include here some of the key findings from The Health and Social Care Information Centre's report on GMP Gross Earnings and Expenses 2012-13, which the parties might find helpful in their contract negotiations on expenses. The report showed that in 2012-13, average taxable income for GMPs was £102,000, with average expenses of £169,700. Average taxable income decreased by 0.9 per cent between 2011-12 and 2012-13 whilst average expenses increased by 2.9 per cent, as shown in Figure E.1 and Table 3.1 (in Chapter 3). It is important to note that these data are for headcount not full-time equivalent (FTE) and so do not account for any changes in 'part-time' working.

Figure E.1: GMPs' gross earnings: income and expenses, United Kingdom, 2003-04 to 2012-13



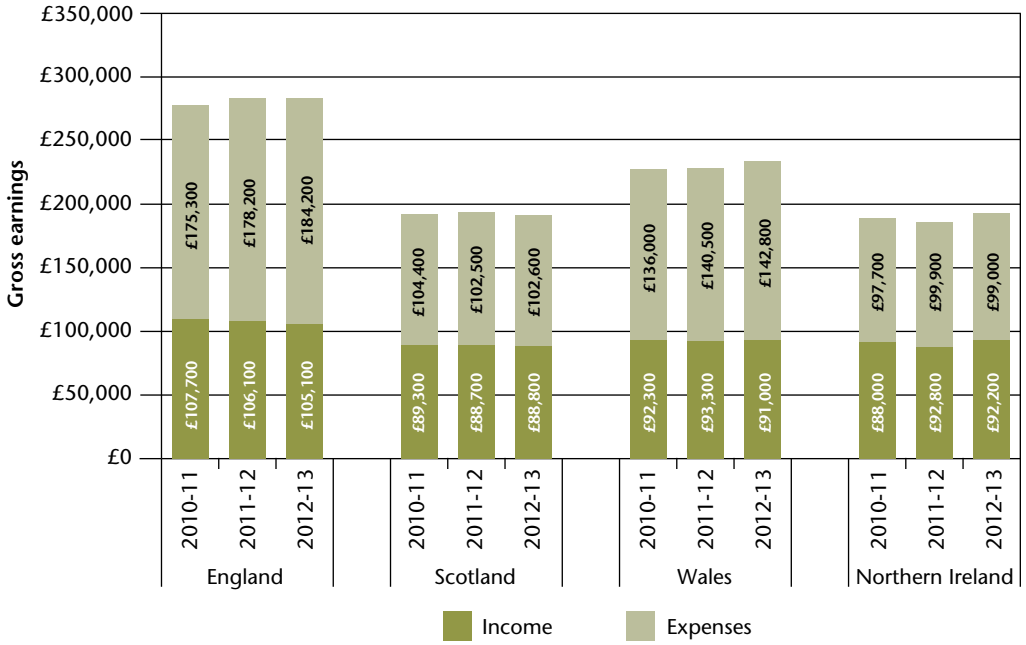
Gross earnings relate to NHS and private work.

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

E.3 Figure E.2 and Table E.1 show average taxable income and average expenses of GMPs by United Kingdom country. Table E.2 and Figure E.3 shows these data by Strategic Health Authority (SHA) area in England.

- In 2012-13, both average income and average expenses were highest in England, at £105,100 and £184,200 respectively, with the Expenses to Earnings Ratio (EER) also highest at 63.7 per cent.
- Average taxable incomes in Scotland, Wales and Northern Ireland were £88,800, £91,000 and £92,200 respectively.
- Only Northern Ireland had a decrease in average expenses, although Scotland's expenses were flat.
- Within England, average income was highest in East Midlands (£113,300) and lowest in the South West (£90,700). All but two SHA areas (East Midlands and London) saw a decrease in average taxable income between 2011-12 and 2012-13.

Figure E.2: GMPs' gross earnings: income and expenses, by United Kingdom country, 2010-11 to 2012-13



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

Table E.1: GMPs' gross earnings, expenses and income by United Kingdom country, 2011-12 to 2012-13

Country	Year	Gross Earnings	Expenses	Income Before Tax	Expenses to Earnings Ratio (EER) %
England	2011-12	£284,300	£178,200	£106,100	62.7
	2012-13	£289,300	£184,200	£105,100	63.7
	% change	*1.7*	*3.3*	*-0.9*	
Scotland	2011-12	£191,200	£102,500	£88,700	53.6
	2012-13	£191,300	£102,600	£88,800	53.6
	% change	*0.1*	*0.1*	*0.1*	
Wales	2011-12	£233,700	£140,500	£93,300	60.1
	2012-13	£233,800	£142,800	£91,000	61.1
	% change	*0*	*1.7*	*-2.4*	
Northern Ireland	2011-12	£192,600	£99,900	£92,800	51.8
	2012-13	£191,100	£99,000	£92,200	51.8
	% change	*-0.8*	*-0.9*	*-0.6*	

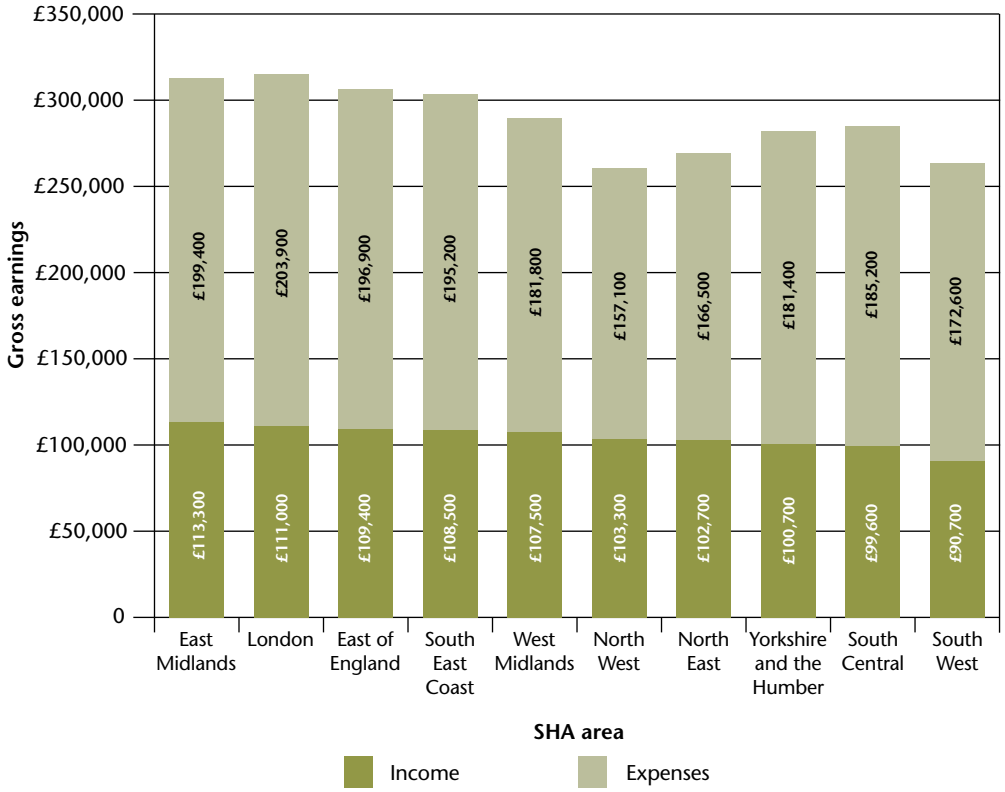
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Table E.2: Income for General/Personal Medical Services (GPMS) contractor GMPs by Strategic Health Authority (SHA) and NHS England region, 2011-12 and 2012-13

Region	Income 2011-12	Income 2012-13	Percentage change
North East SHA	£103,800	£102,700	-1.1
North West SHA	£103,900	£103,300	-0.6
Yorkshire and the Humber SHA	£103,200	£100,700	-2.4
East Midlands SHA	£112,300	£113,300	0.9
West Midlands SHA	£109,000	£107,500	-1.4
East of England SHA	£111,100	£109,400	-1.6
London SHA	£110,000	£111,000	0.9
South East Coast SHA	£111,200	£108,500	-2.4
South Central SHA	£102,200	£99,600	-2.5
South West SHA	£91,600	£90,700	-1.1
North of England region	£103,900	£102,500	-1.4
Midlands and East of England region	£110,300	£109,600	-0.7
London region	£110,000	£111,000	0.9
South of England region	£101,100	£99,200	-1.9

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

Figure E.3: GMPs' average gross earnings: income and expenses, 2012-13, by Strategic Health Authority area in England

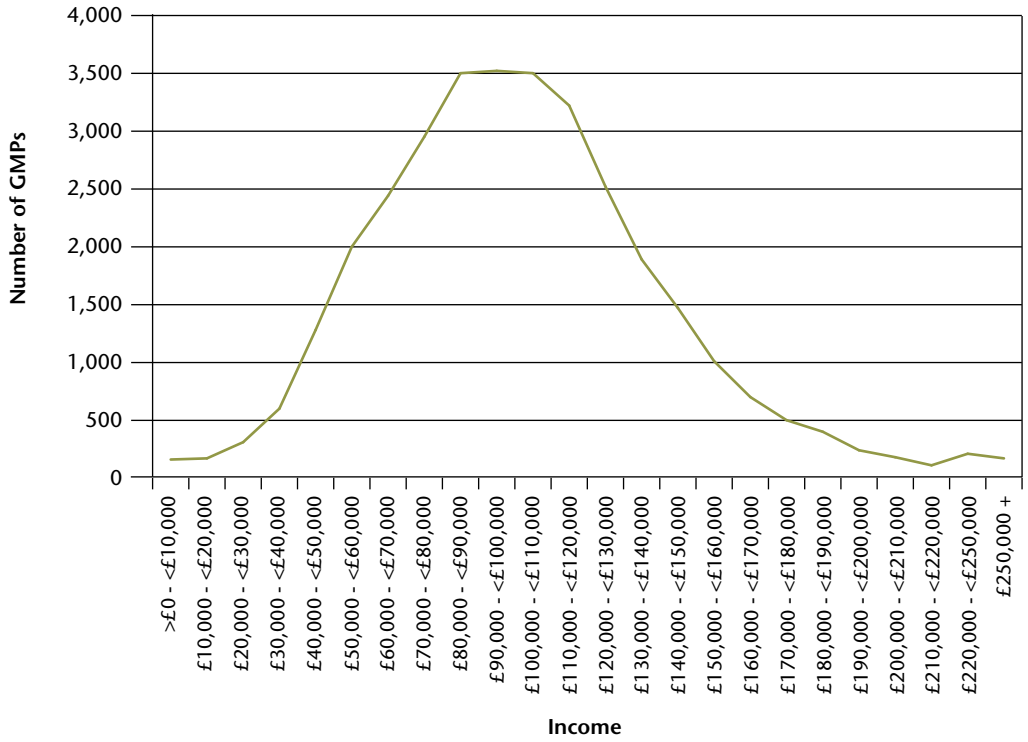


Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

E.4 There is a large amount of variability in the income of GMPs: Table E.2 and Figure E.3 show regional variations in the average income for independent contractor General/ Personal Medical Services (GPMS) GMPs. Figure E.4 shows the distribution of GMP income in the United Kingdom. We would welcome evidence explaining why variations in income occur as this information is important to our understanding of the factors influencing pay and thus, our recommendations.

E.5 For our next report, we ask NHS England to update us on what progress has been made towards publishing the income of GMPs, that formed part of the agreed changes to the GMS contract in England. We ask the other Health Departments to tell us if they intend taking a similar approach, and if so, to what timetable.

Figure E.4: Distribution of GMP income, United Kingdom, 2012-13

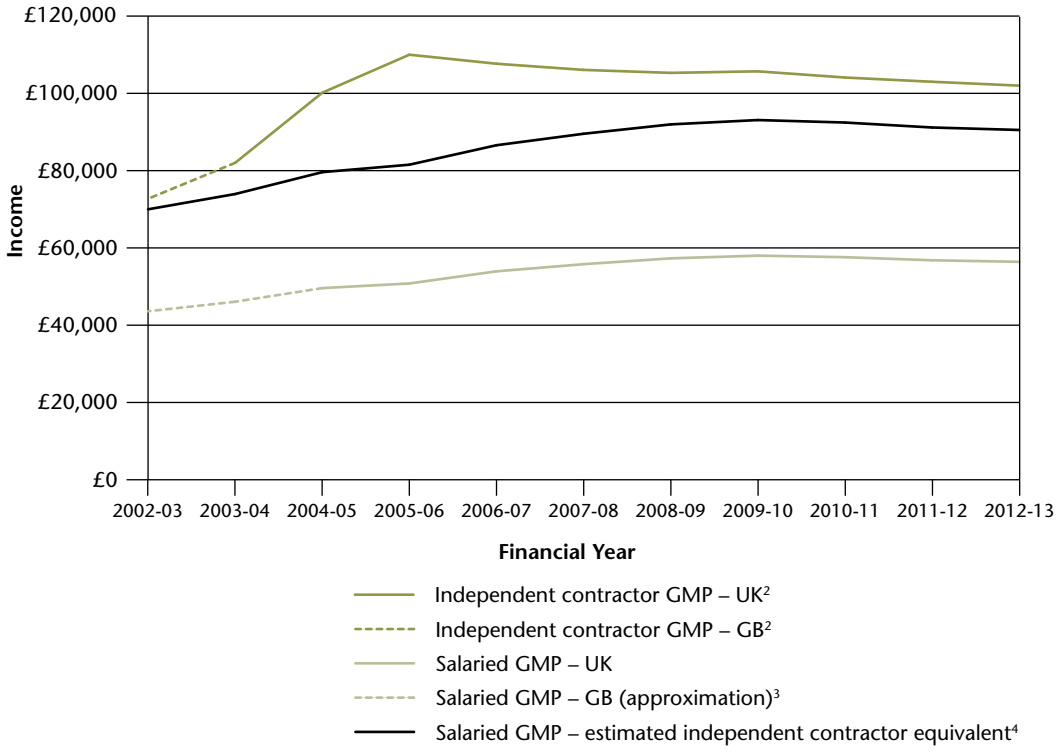


Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Key results for salaried GMPs

E.6 Average taxable income for salaried GMPs was £56,400 in 2012-13, a decrease of 0.7 per cent on 2011-12. Figure E.5 shows changes since 2002-03 in average taxable incomes. Many salaried GMPs work part-time: the average number of hours per week across all salaried GMPs (full-time and part-time) was 23.8 hours in 2006-07. As the most recent workload survey which gives information for contractors and salaried staff separately was in 2006-07, we do not know if the average amount of part-time work per week has changed since then.

Figure E.5: Income for General/Personal Medical Services (GPMS) contractor GMPs by type of GMP,[1] United Kingdom, 2002-03 to 2012-13



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

Notes:
[1] An independent contractor GMP worked an average of 38.2 hours a week in 2006-07 (incl. part-time) whilst a salaried GMP worked an average of 23.8 hours a week in 2006-07 (incl. part-time).
[2] The figures for independent contractor GMPs in 2003-04 are £82,019 for Great Britain and £81,600 for the United Kingdom.
[3] Prior to 2006-07, the figures for salaried GMPs have been produced under different methodologies in each year.
[4] A FTE figure for salaried GMPs has been estimated by grossing up salaried GMPs' income by the ratio of average hours in 2006-07 for independent contractors (ratio: 38.2/23.8 ~1.6).

The Health and Social Care Information Centre: dental earnings and expenses 2012-13

E.7 We include here some of the key findings from The Health and Social Care Information Centre's report on dental earnings and expenses, which the parties might find helpful in their contract negotiations on expenses. It is important to note that these data are for headcount rather than FTE and so do not account for any changes in 'part-time' working.

England and Wales

E.8 In 2012-13, a GDP on average had a taxable income of £72,600 and expenses of £83,500, giving an EER of 53.5 per cent (Table E.3). Providing-performer dentists[1] had average taxable income of £114,100 and expenses of £253,800 (EER 69.0 per cent); for performer-only dentists[2] the figures were £60,800 and £35,400 respectively

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

[2] A performer-only dentist performs NHS dentistry but does not hold a contract with a Primary Care Trust (PCT) or a Local Health Board (LHB).

(EER 36.8 per cent). Despite increases to average taxable incomes of providing-performer dentists (+1.2 per cent), average taxable income for all dentists decreased (-2.4 per cent). This has been driven by changes to the dentist population (fewer providing-performer and more performer-only dentists) and the decreases in average taxable income (-1.5 per cent) of performer-only dentists.

Table E.3: Average income and expenses for GDPs, England and Wales, 2010-11 to 2012-13

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Other expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
Providing-performer	2010-11	5,750	364,300	79,000	168,100	117,200	67.8
	2011-12	5,250	358,400	80,700	164,900	112,800	68.5
	2012-13	4,750	368,000	80,500	173,300	114,100	69.0
	Latest % change	*-9.5%*	*2.7%*	*-0.2%*	*5.1%*	*1.2%*	*+0.5pp*
Performer-only	2010-11	15,050	98,400	5,900	29,600	62,900	36.0
	2011-12	16,050	96,200	5,600	28,900	61,800	35.8
	2012-13	16,800	96,200	6,000	29,400	60,800	36.8
	Latest % change	*4.7%*	*0%*	*7.1%*	*1.7%*	*-1.5%*	*+1.0pp*
All dentists	2010-11	20,800	172,000	26,100	68,000	77,900	54.7
	2011-12	21,300	161,000	24,100	62,500	74,400	53.8
	2012-13	21,500	156,100	22,400	61,100	72,600	53.5
	Latest % change	*0.9%*	*-3.0%*	*-7.1%*	*-2.2%*	*-2.4%*	*-0.3pp*

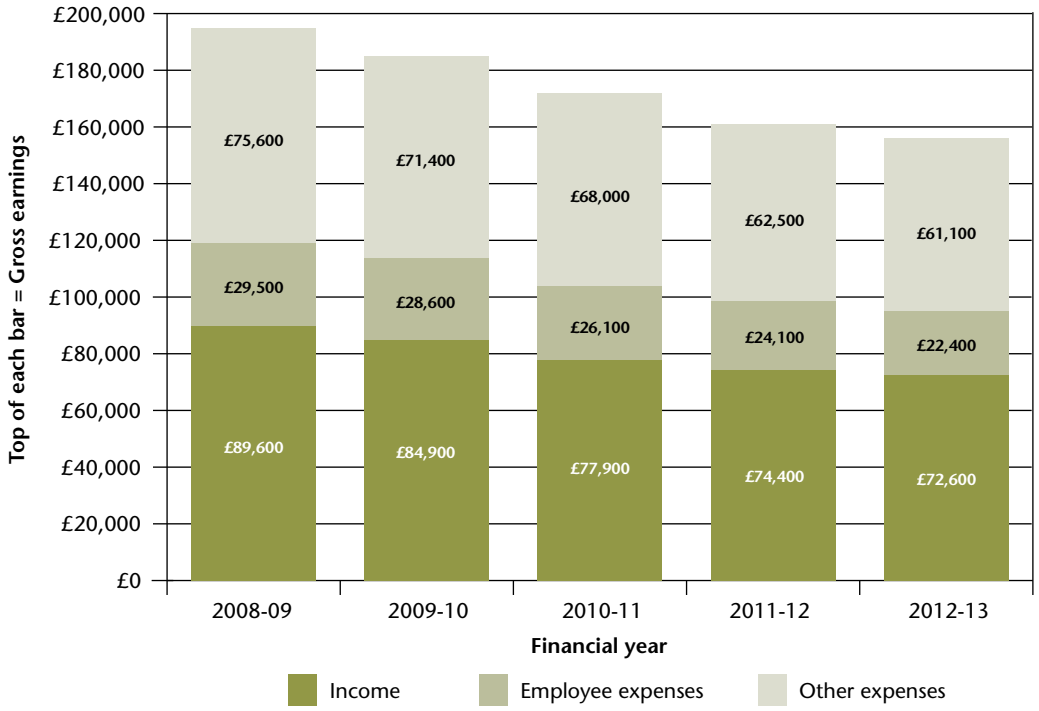
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

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

pp: percentage point change.

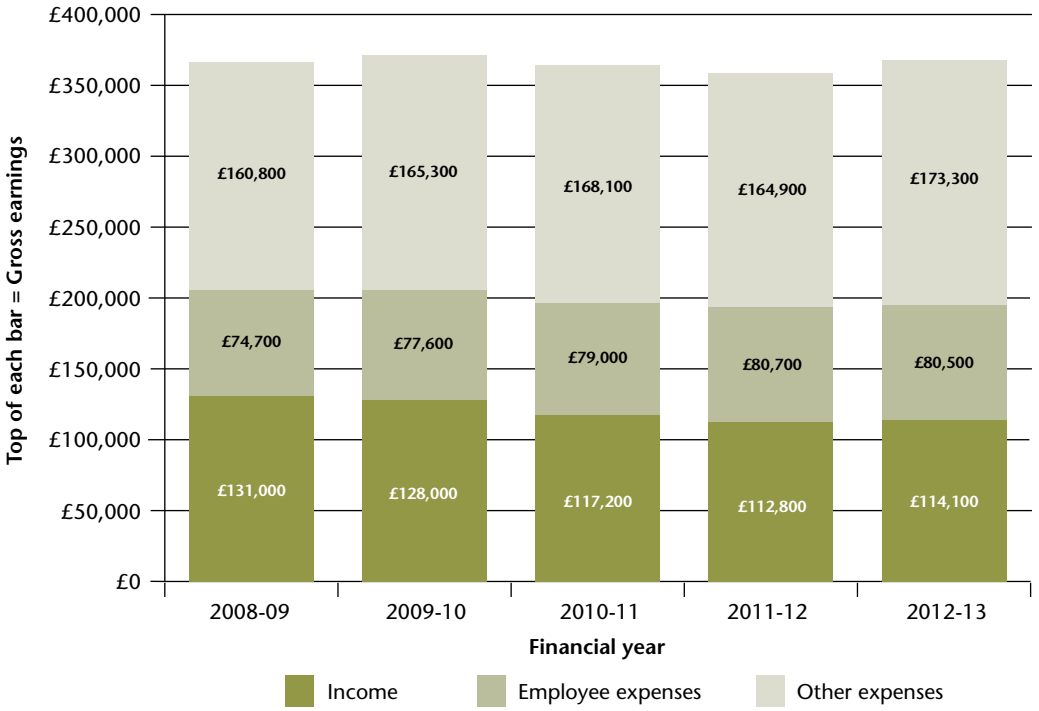
E.9 Figures E.6, E.7 and E.8 show recent trends in income and expenses in England and Wales.

Figure E.6: Gross earnings (NHS and private) for all self-employed dentists, England and Wales, 2008-09 to 2012-13



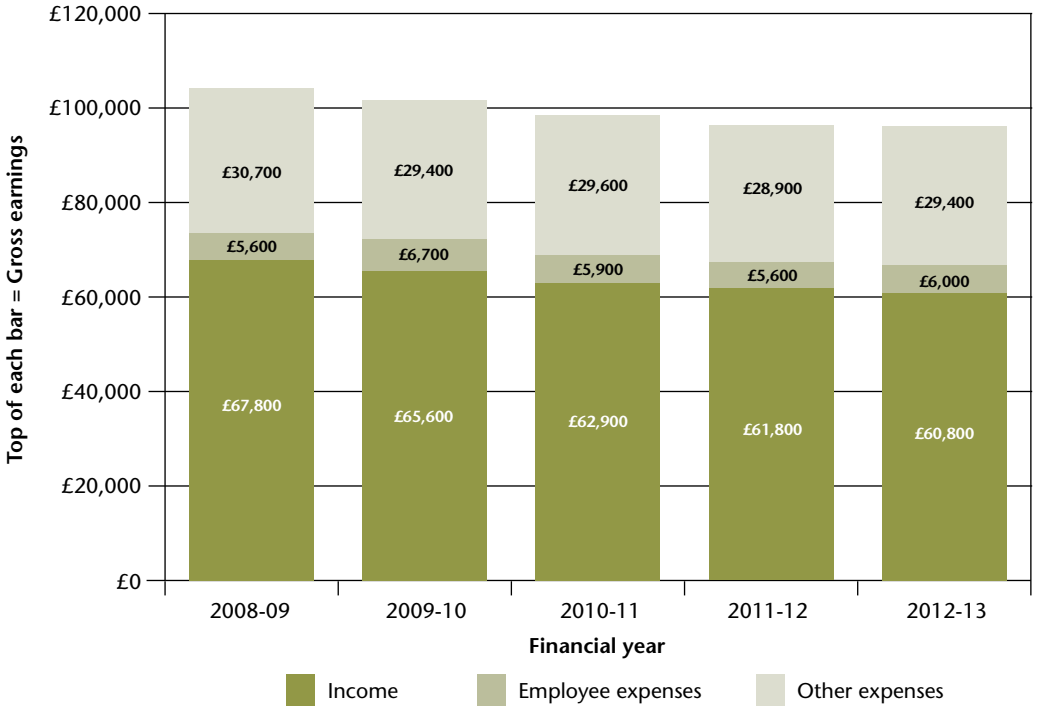
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.7: Gross earnings (NHS and private) for all self-employed providing-performer dentists, England and Wales, 2008-09 to 2012-13



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

Figure E.8: Gross earnings (NHS and private) for all self-employed performer only dentists, England and Wales, 2008-09 to 2012-13



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

Scotland

E.10 In 2012-13, a GDP in Scotland on average had a taxable income of £68,800 and expenses of £84,000, giving an EER of 55.0 per cent (Table E.4). A principal dentist had an average taxable income of £97,400 and expenses of £222,300 (EER 69.5 per cent); for associate dentists the figures were £57,200 and £27,700 respectively (EER 32.6 per cent). Average taxable income for all self-employed General Dental Services (GDS) dentists was £68,800, compared to £71,700 in 2011-12, a 4.0 per cent decrease.

Table E.4: Average income and expenses for GDPs, Scotland, 2010-11 to 2012-13

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Other expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
Principal	2010-11	700	334,700	89,300	144,300	101,100	69.8
	2011-12	700	332,900	86,200	143,800	102,900	69.1
	2012-13	650	319,600	84,000	138,300	97,400	69.5
	Latest % change	*-7.1%*	*-4.0%*	*-2.6%*	*-3.8%*	*-5.4%*	*+0.4pp*
Associate	2010-11	1,450	87,900	1,200	26,600	60,100	31.6
	2011-12	1,550	85,000	600	26,900	57,600	32.3
	2012-13	1,650	84,900	800	26,900	57,200	32.6
	Latest % change	*6.5%*	*-0.1%*	*33.3%*	*0%*	*-0.6%*	*+0.3pp*
All dentists	2010-11	2,150	167,300	29,500	64,500	73,300	56.2
	2011-12	2,250	162,400	27,300	63,400	71,700	55.8
	2012-13	2,300	152,900	24,900	59,100	68,800	55.0
	Latest % change	*2.2%*	*-5.9%*	*-8.8%*	*-6.8%*	*-4.0%*	*-0.8pp*

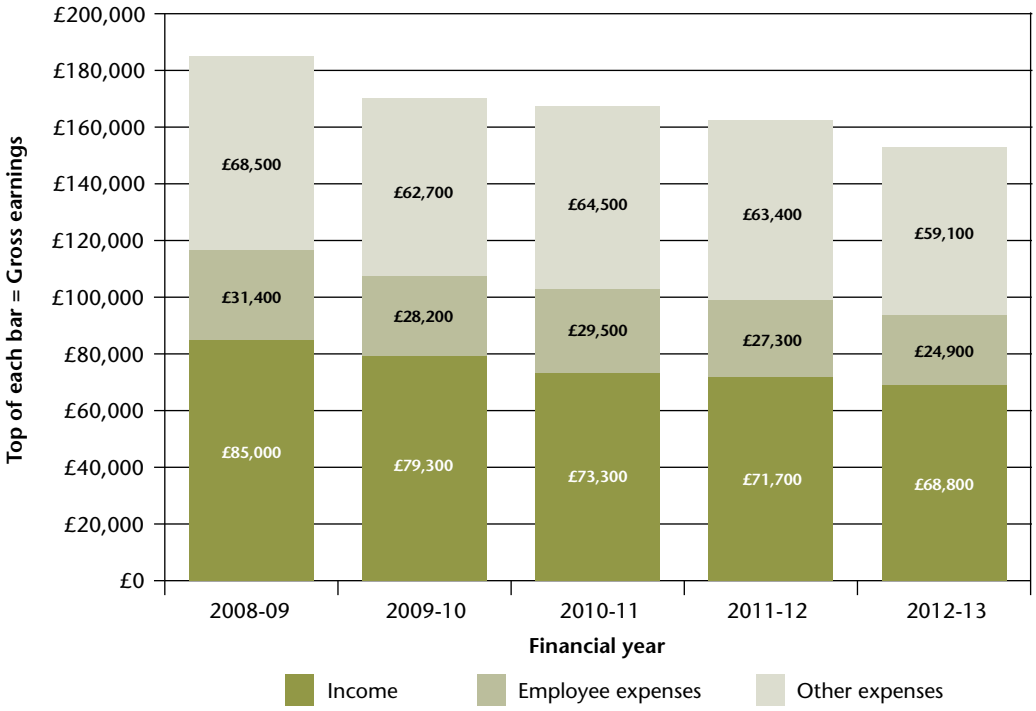
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

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

pp: percentage point change.

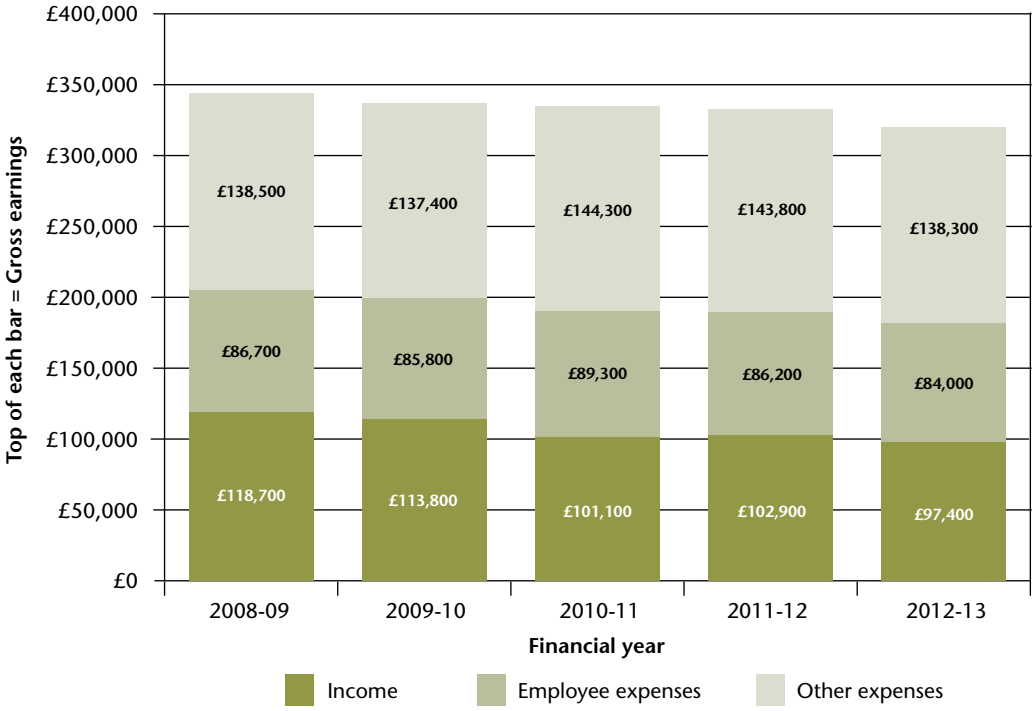
E.11 Figures E.9, E.10 and E.11 show recent trends in income and expenses in Scotland.

Figure E.9: Gross earnings (NHS and private) for all self-employed dentists, Scotland, 2008-09 to 2012-13



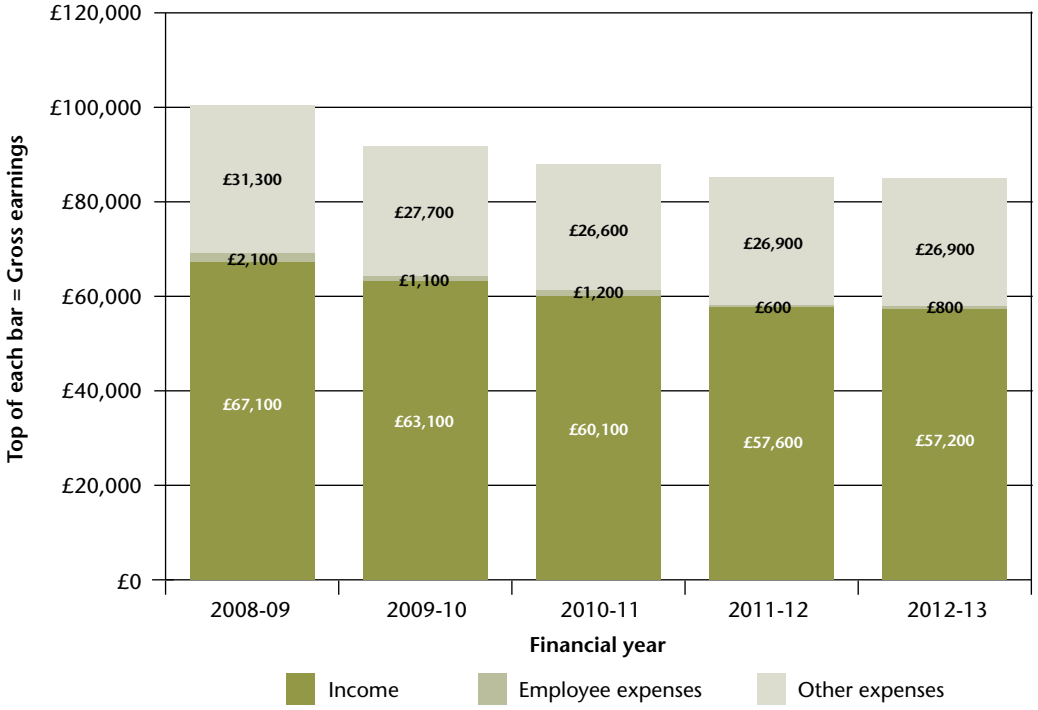
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.10: Gross earnings (NHS and private) for all self-employed principal dentists, Scotland, 2008-09 to 2012-13



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

Figure E.11: Gross earnings (NHS and private) for all self-employed associate dentists, Scotland, 2008-09 to 2012-13



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

Northern Ireland

E.12 In 2012-13, a GDP in Northern Ireland on average had a taxable income of £71,600 and expenses of £88,800, giving an EER of 55.4 per cent (Table E.5). A principal dentist had an average taxable income of £110,900 and expenses of £205,200 (EER 64.9 per cent); for associate dentists the figures were £53,000 and £33,700 respectively (EER 38.9 per cent). Average taxable income has decreased for both principal and associate dentists, and overall, since 2008-09.

Table E.5: Average income and expenses for GDPs, Northern Ireland, 2010-11 to 2012-13

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Other expenses* (£)	Income (£)	Expenses to earnings ratio (EER) (%)
Principal	2010-11	300	331,000	79,200	137,600	114,200	65.5
	2011-12	350	318,600	77,000	129,100	112,500	64.7
	2012-13	300	316,000	79,100	126,100	110,900	64.9
	Latest % change	*-14.3%*	*-0.8%*	*2.7%*	*-2.3%*	*-1.4%*	*+0.2pp*
Associate	2010-11	550	96,200	500	36,400	59,400	38.3
	2011-12	600	91,600	800	35,000	55,700	39.1
	2012-13	650	86,700	200	33,500	53,000	38.9
	Latest % change	*8.3%*	*-5.3%*	*-75.0%*	*-4.3%*	*-4.9%*	*-0.2pp*
All dentists	2010-11	900	180,100	28,600	72,600	78,900	56.2
	2011-12	900	172,000	27,800	68,400	75,800	55.9
	2012-13	950	160,400	25,500	63,300	71,600	55.4
	Latest % change	*5.6%*	*-6.8%*	*-8.3%*	*-7.5%*	*-5.6%*	*-0.5pp*

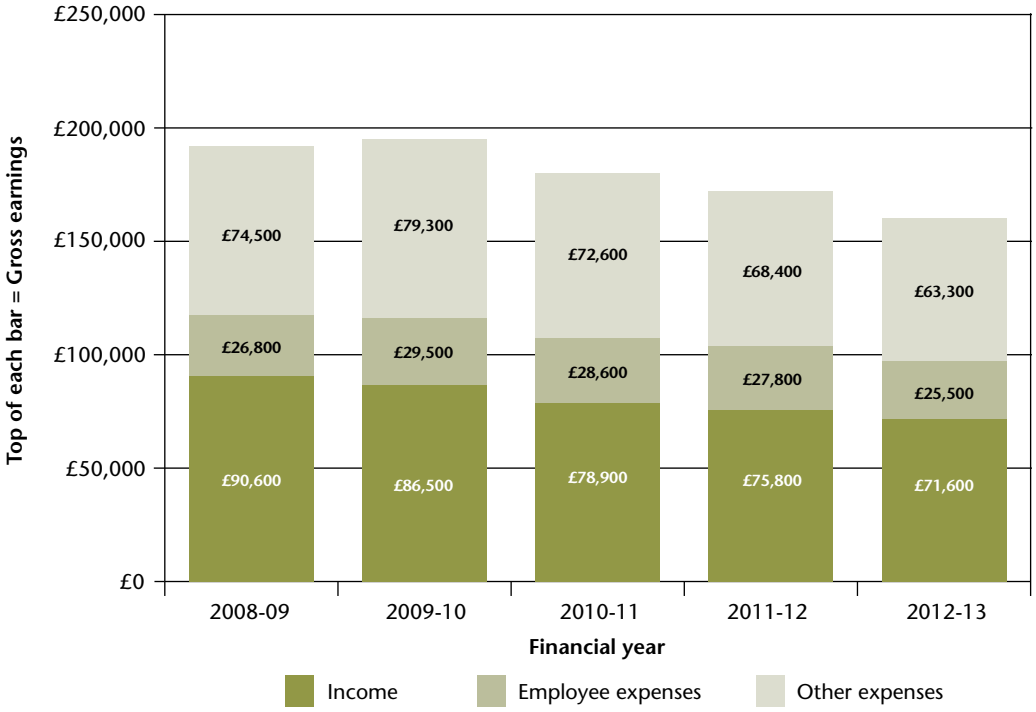
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

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

pp: percentage point change.

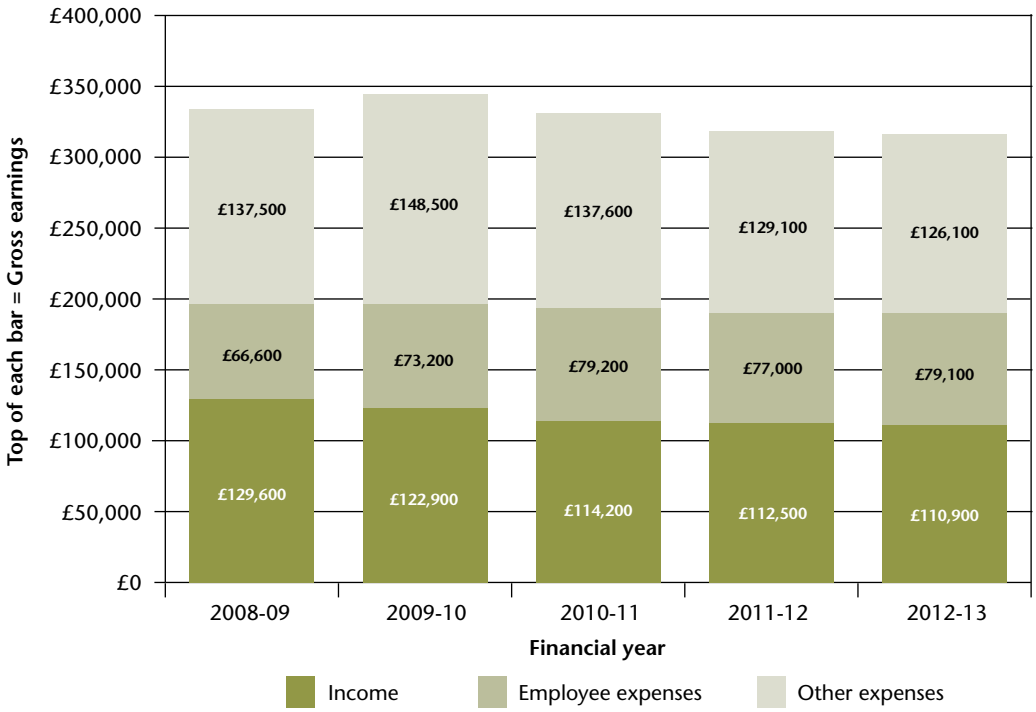
E.13 Figures E.12, E.13 and E.14 show recent trends in income and expenses in Northern Ireland.

Figure E.12: Gross earnings (NHS and private) for all self-employed dentists, Northern Ireland, 2008-09 to 2012-13



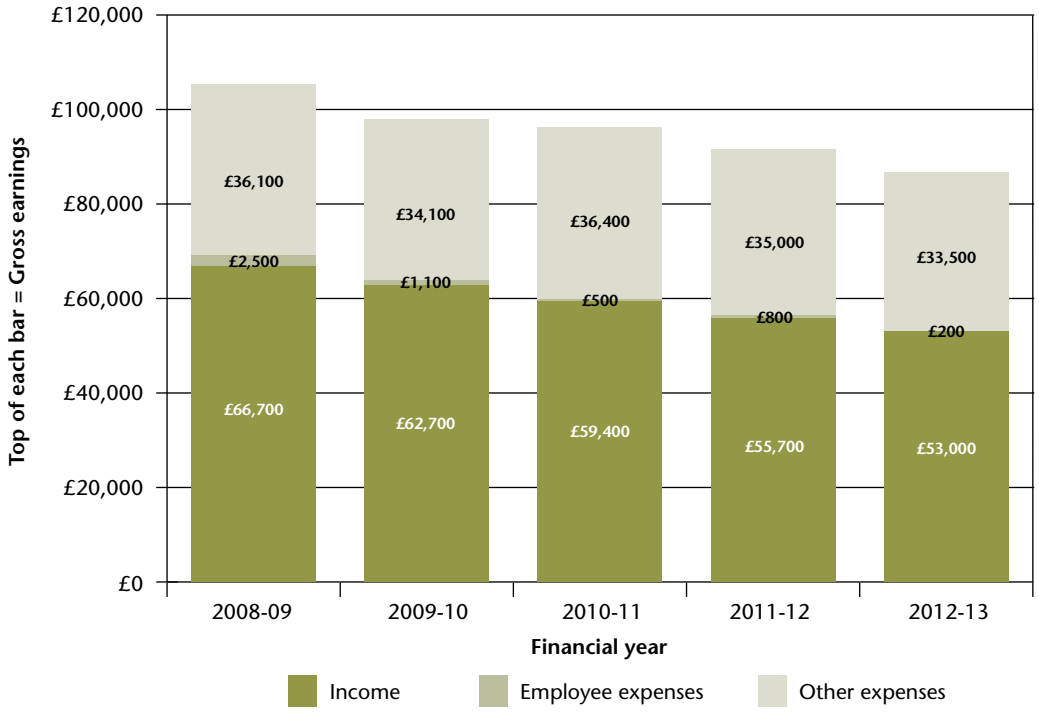
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.13: Gross earnings (NHS and private) for all self-employed principal dentists, Northern Ireland, 2008-09 to 2012-13



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

Figure E.14: Gross earnings (NHS and private) for all self-employed associate dentists, Northern Ireland, 2008-09 to 2012-13



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

Multiple counting of expenses

E.14 Our recent reports have identified the issue of "double" or "multiple counting" of dental expenses. Multiple counting artificially inflates estimates of average gross earnings, expenses and the EER, but taxable income is not affected. As we are not using a formula-based approach to our uplift recommendation this year, we have not considered this issue in depth. Had we have done so, then our working assumption (in the absence of evidence to the contrary) would be to continue with our general approach whereby the weights that we use in our formula would be derived from figures on GDPs' average earnings and expenses, complied by the Health and Social Care Information Centre using data from self-assessment tax returns, with an adjustment made to reflect the estimated effect of the multiple counting of expenses. Since the parties have not submitted any evidence to suggest an alternative approach, our likely recommendations had we have opted to use the formula-based approach would have assumed (in line with the recommendations in the last two reports) that an EER of 50 per cent should be used in each country of the United Kingdom.

Longitudinal results

E.15 For the third time, the Health and Social Care Information Centre has presented changes in income and total expenses for the cohort of dentists that had not changed dental type or contract type over the period 2009-10 to 2012-13. For all self-employed primary care dentists: the longitudinal study shows that overall, average taxable income from NHS and private dentistry fell by 2.3 per cent between 2010-11 (£81,400) and 2012-13 (£79,500). Both gross earnings and total expenses remained relatively stable over the period, decreasing 0.5 per cent and increasing 1.0 per cent respectively.

E.16 Some other changes occurred over the period of the longitudinal study that were not controlled for, including:

- changes to the rate of Value Added Tax (VAT) – VAT increased to 20 per cent in January 2011; and
- changing capital allowance – the allowance increased from £50,000 to £100,000 from April 2010 with a reduction to £25,000 from April 2012. This may have provided an incentive for small businesses to make large capital purchases in the period.

E.17 We note that these changes would influence the earnings and expenses data that we have traditionally used in our formula-based approach, and see this as further justification for our not using the formula in its current format to calculate our recommended uplift.

Table E.6: Data historically used in our formulae-based decisions for independent contractor GMPs and GDPs

Coefficient	Value
Income (GMPs) *DDRB recommendation*	1%
Staff costs (GMPs) *Annual Survey of Hours and Earnings (ASHE) 2014 (general medical practice activities)*	2.5%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2014*	2.0%
Income (GDPs) *DDRB recommendation*	1%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2014 (general dental practice activities)*	3.2%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2014*	2.0%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2014*	2.0%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2014*	1.9%
Other costs (GDPs) Scotland *RPIX for Q4 2014*	2.0%

APPENDIX F: ABBREVIATIONS AND ACRONYMS

ACCEA	Advisory Committee on Clinical Excellence Awards
A&E	Accident and Emergency
APMS	Alternative Providers of Medical Services
ASHE	Annual Survey of Hours and Earnings
BDA	British Dental Association
BMA	British Medical Association
CCG	Clinical Commissioning Group
CDS	Community Dental Service
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
DDRB	Review Body on Doctors' and Dentists' Remuneration
EER	expenses to earnings ratio
FHO	foundation house officer
FOI	Freedom of Information
FTE	full-time equivalent
GB	Great Britain
GDP	general dental practitioner
GDP	Gross Domestic Product
GDS	General Dental Services
GMP	general medical practitioner
GMS	General Medical Services
GP	general practitioner
GPMS	General/Personal Medical Services
HCHS	Hospital and Community Health Services
HESA	Higher Education Statistics Agency
HSCIC	Health and Social Care Information Centre
IT	Information Technology
LHB	Local Health Board
MPIG	Minimum Practice Income Guarantee
NHS	National Health Service
OBR	Office for Budgetary Responsibility
OME	Office of Manpower Economics

OMP	ophthalmic medical practitioner
ONS	Office for National Statistics
PA	programmed activity
PCO	primary care organisation
PCT	Primary Care Trust
PCTMS	Primary Care Trust Medical Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RPIX	Retail Prices Index excluding mortgage interest payments
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	specialty doctors and associate specialists
SHA	Strategic Health Authority
SPA	supporting professional activity
ST	specialty training
StART	Strategy for Attracting and Retaining Trainees
TSO	The Stationery Office
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UK	United Kingdom
VAT	Value Added Tax
VSM	Very Senior Manager