Review Body on Doctors' and Dentists' Remuneration

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Forty-Fourth Report 2016

Chair: Professor Sir Paul Curran

Cm 9211

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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 2016

Cm 9211

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at
Office of Manpower Economics
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2-6 Salisbury Square
London
EC4Y 8JX
www.gov.uk/government/organisations/office-of-manpower-economics

Print ISBN 9781474129855
Web ISBN 9781474129862

ID 03031602 03/16 54290 19585

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

Review Body on Doctors' and Dentists' Remuneration

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

The Review Body on Doctors' and Dentists' Remuneration is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health, Wellbeing and Sport 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 Sir Paul Curran *(Chair)*
Lucinda Bolton
John Glennie, OBE
Alan Henry, OBE
Mehrunnisa Lalani[1]
Professor Kevin Lee
Professor James Malcomson[2]
Nigel Turner, OBE

The Secretariat is provided by the Office of Manpower Economics.

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[1] Mehrunnisa Lalani was appointed to the Review Body by the Parliamentary Under Secretary of State for NHS Productivity from 1 August 2015.

[2] Professor James Malcomson was appointed to the Review Body by the Parliamentary Under Secretary of State for NHS Productivity from 1 August 2015.

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Executive Summary

1. This year, **our central recommendations for 2016-17 are for (i) an increase in basic pay of 1 per cent to the national salary scales for salaried doctors and dentists for all countries of the UK; and (ii) an increase, of 1 per cent in pay, net of expenses, for independent contractor general medical practitioners (GMPs) and general dental practitioners (GDPs) for all countries of the UK**. We have reached these conclusions following detailed consideration of all of the written and oral evidence we have received from the parties, as well as taking into account our own analysis, covering all aspects of our remits.

2. In addition, **we have concluded that we should not target our recommendations for 2016-17 on the basis of recruitment and retention. Issues do exist in some specialties and locations and unless the parties provide evidence that other approaches are working, we think that there could be merit in testing a targeted pay approach in future years to see whether that was more effective. We also note that funds set aside for the pay uplift could be used differently to alleviate workload pressures.**

3. For this year, we are satisfied that the evidence on affordability, the evidence on relevant earnings increases, the subdued levels of inflation, and the recruitment and retention data all pointed in a roughly equivalent direction. We are making recommendations accordingly. If in future years, the evidence suggests a different conclusion, we do not consider that government messages on affordability constrain us from making recommendations we think are right, in the round.

Remits and the pay round process

4. This year's review has been informed by both our standing terms of reference and the differing remits supplied to us by the countries of the UK. This year, recommendations were sought for all of our remit groups. For England and Northern Ireland, we were asked also to consider the case for targeting to support recruitment and retention. None of the parties supported targeting in their evidence to us. We are conscious that this report comes close to the start of a new UK Parliament. The UK government has set out its approach to public sector pay over the next four years. We are conscious also that this report comes close to elections in Scotland, Wales and Northern Ireland, where pay policies were for one year only. Our recommendations relate to existing contracts only.

5. Due to the Spending Review (published on 25 November 2015), the evidence from all the health departments was late, which limited the ability of the other parties to comment. It is vital that evidence is provided in a timely fashion and shared to enable all parties to comment and to enable us to fully examine the proposals being put forward. The Northern Ireland Executive did not provide us with a remit and evidence until early February. We concluded that it would not be appropriate to delay our main report to the other parties, and neither was it practical to run a bespoke process specifically for the Northern Ireland Executive and still deliver recommendations to them before the start of the pre-election period. We are evidence-based in our approach and took the decision that we had sufficient evidence from all parties in order to make recommendations for Northern Ireland. This is not a position we were comfortable with, nor would we wish to carry out a remit on such a limited timescale again.

6. This year the size of our remit groups increased by around 1.6 per cent and now amounts to just over 206,000 doctors and dentists across the United Kingdom. Over the last eight years our remit groups have increased by 19 per cent, driven mainly by an increase in the consultant workforce. Our remit groups comprise approximately:

- 49,000 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; 30,000 headcount GDPs; and
- 320 headcount ophthalmic medical practitioners.

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

Context to this report

8. There are significant changes in all four UK countries in the way health services are being delivered. The *Five Year Forward View* in England, *Our Plan for a Primary Care Service in Wales,* the Scottish Government's *2020 Vision for Health and Social Care,* and the recently published consultation document *Health and Social Care reform and transformation – getting the structures right* in Northern Ireland all seek to address to varying degrees the integration of health and social care, new contracting models in primary care, seven-day services and further devolution of funding decisions.

9. In 2014, we were given a special remit to consider proposals for contract reform for both consultants and doctors and dentists in training. We made observations and recommendations on this for both sets of doctors,[1] submitting our report[2] in July 2015. As we write this report, negotiations on the consultant contract are underway in both England and Northern Ireland. All four UK countries have been involved in negotiations on the new contract for doctors and dentists in training; not all have taken the same approach to those negotiations. In England an industrial dispute has ensued, which was ongoing at the time we submitted our report. Our hope was that the parties would reach a negotiated settlement and we are disappointed that agreement has not yet proved possible. At the time of writing, a "best and final" offer had been rejected by the BMA, and the Department of Health had announced an intention to proceed without agreement with the new contract in England. The effects on recruitment, retention and motivation; on the continued existence of a national UK-wide contract; and on our other remit groups are not clear and we will be watching closely in future pay rounds. We note also that the relatively low morale we encountered on our visit programme was not just confined to junior doctors in England.

Recruitment, retention and motivation

10. There are ongoing problems with recruiting doctors into some specialties, such as chemical pathology, emergency medicine, psychiatry, acute medicine and general practice. Some of these problems appear to be UK-wide; others are more localised; however, certain geographic locations have greater difficulties than others, such as rural areas far from a medical school or other natural supply of doctors, and areas with fewer economic opportunities. At present because the relevant data has not been collected there is no single coherent picture on hard-to-fill specialties, consultant vacancies and

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[1] For doctors and dentists in hospital training, we made recommendations for England, Wales and Northern Ireland and observations for Scotland. For consultants, we made observations for England, Wales and Northern Ireland.

[2] *Contract Reform for Consultants and Doctors & Dentists in Training – Supporting Healthcare Services Seven Days a Week.* Review Body on Doctors' and Dentists' Remuneration. Cm 9108. Available from: https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week

locum use in any of the countries, or UK-wide; however, the trends are worrisome, with consultant vacancy rates in emergency medicine and psychiatry mirroring problems with fill rates at the training level. The consensus that the market for doctors and dentists is UK-wide continues to hold amongst the parties.

11. The role of pay in recruitment and retention is not straightforward and the evidence we have seen claims that the issues in some specialties are mainly due to supply problems which would not necessarily be solved by pay. However we note that shortage specialties, including general practice, are not new and that certain locations have ongoing recruitment and retention difficulties. We would like to see evidence that the non-pay initiatives in train are actually being effective, and we do not rule out pay changes as offering a possible solution in the future.

12. Motivation data shows two things: the intrinsic motivation of our remit groups to deliver high quality patient care, set against increasing workload pressures which are having a negative effect. The Staff Survey results in England are, broadly speaking, holding up, although we note that the survey whose results were available to us was carried out in autumn 2014 and predates the current breakdown in industrial relations: in Scotland more recent results are in general on a downward trend. Both the BMA and BDA cited low morale affecting their members and highlighted that workforce issues are tied in with the wider service aspirations in each country. The BMA said that the junior doctors' industrial action was likely to have a negative effect on the morale of all of our remit groups. The annual pay uplift, upon which we recommend, was, in the current context, an important signal of their value.

13. As we said last year, specialty doctors and associate specialists (SAS) doctors are an important part of the NHS workforce and continue to play a pivotal role in the provision of services and we would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive.

Economic background, pay comparability and affordability

14. Headline economic indicators and wider wage settlements are relatively buoyant, particularly the employment rate at 74 per cent, as at November 2015. There is some evidence of upward pressure on wages across the economy as a whole and average annual rate of earnings growth was 2.4 per cent in the three months to October 2015, although commentators have started to question whether this will be maintained through 2016. Inflation is forecast to remain low, at or around an annual rate of 1 per cent. Economic growth is steady, with 2.4 per cent growth forecast by the Office for Budgetary Responsibility in 2016. The picture does vary across the UK countries; employment rates for Wales and Northern Ireland for example have lagged behind England and Scotland.

15. Affordability and delivery of efficiency savings continue to be a key focus of all of the health departments. It is clear that pay restraint offers a relatively effective way of meeting the efficiency challenge, although all countries have other initiatives in train to support Trusts and Health Boards since pay restraint alone would not deliver all of the required savings. This being the case, the onus of making transformational change, whilst maintaining service levels falls largely on the NHS workforce and our remit groups as clinical leaders.

Pay comparability and Total Reward

16. Our analysis of our remit groups' earnings and pay comparability shows that the pay of GMPs and GDPs continues to decline in absolute terms and relative to comparator professions. This is of concern to us, as it could, coupled with the motivation and workload issues in general practice, affect recruitment and retention negatively.

However, average income before tax for GMPs is still above the 97th percentile for full-time employees. We note that FTE income data is not available for GMPs. Similarly, our analysis shows that consultants' total earnings have been and remain consistently above the 98th percentile.

17. The recent changes in the NHS pension scheme continue to play out, along with the increase in National Insurance contributions in April 2016 for both contracted-out employees and their employers. We recognise that the NHS pension remains an important part of the total reward package. We feel that further flexibility within the reward package for those who leave the pension scheme is needed to reduce the number of early departures. For recruitment and retention reasons we will continue to monitor the impact of changes to the NHS Pension Scheme.

Our recommendations

18. In considering the request for targeting to support recruitment and retention, we note several contextual factors that point us away from recommending targeting this year. Critically, we do not have strong-enough evidence to counter the consensus view given to us by all the parties, namely that to differentiate the pay award risks demotivating a large part of our remit groups. We therefore concluded that we should not target our recommendations for 2016-17. There is also an apparent consensus between the parties that a targeted pay response is not appropriate for serious national supply shortages in certain specialties. We are not entirely persuaded by this; however we note that the issues are complex. Unless the parties provide evidence that other approaches are working, as indicated in paragraph 2 above we think that there could be merit in testing a targeted pay approach in future years to see whether that is more effective.

19. In considering the uplift for all our remit groups, we note that wider economic measures remain muted, with the rise in the Consumer Prices Index (CPI) for example at 0.2 per cent in the year to December 2015, and forecast to reach 1 per cent in the second half of 2016. Earnings for those in the top 10 per cent of all earnings, which we consider to be a more appropriate comparison for our remit groups, increased by just 0.9 per cent in the year to April 2015. In relation to motivation, we note that the public sector pay policy has created a level of expectation amongst our remit groups, and that the parties were unanimous in their view that any award below 1 per cent would be demotivating. To go against this would require very strong evidence. In terms of affordability, we understand that all Health Departments have been funded for a 1 per cent increase in pay for the workforce. We do not see compelling evidence for differential awards by country. **We are therefore recommending for 2016-17 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists in the UK.** Individuals on incremental pay scales who have not yet reached the maximum scale point, will continue to be eligible for incremental progression, according to agreed criteria.

20. We consider that no member of our salaried remit groups should see a fall in their earnings in relation to the basic pay scale and relative to a full-time post. **We therefore recommend that those members of our remit groups who received a 2 per cent non-consolidated payment in 2015-16 and who have not since moved on to a new pay scale point should, in 2016-17, receive a non-consolidated payment equivalent to 1 per cent of their basic earnings alongside our main pay recommendation**.

21. We have to make a separate recommendation for salaried GMPs whose pay falls within a salary range rather than an incremental pay scale. **We recommend that the minimum and maximum of the salary range for salaried GMPs in the UK be increased by 1 per cent for 2016-17.**

22. Chapter 5 also includes some more detailed recommendations. Firstly, that **for 2016-17 the trainers' grant should be increased by 1 per cent in line with our main pay recommendations for GMPs**; secondly, that **for 2016-17, the rate for GMP appraisers should remain at £500**; thirdly, that **for 2016-17, the supplement payable to general practice specialty registrars should remain at 45 per cent of basic salary**; and finally that **for 2016-17, the value of the awards for consultants – Clinical Excellence Awards, Discretionary Points and Distinction Awards – should increase in line with our main pay recommendation of 1 per cent**.

23. We find ourselves no further forward in getting a more robust data set to support a formula-based approach for GMPs or GDPs. In these circumstances, the concerns set out in our previous reports still hold and we have concluded that we should again this year make a recommendation on pay net of expenses. For the next pay round we suggest that the parties discuss expenses to an earlier timetable. Ideally we would like the parties to reach an agreed position. However, if the parties are unable to do so we would be open to arbitrating where appropriate, provided we received firm propositions from the parties backed by sufficient evidence. If improved evidence is not forthcoming then we would reserve the right to refuse. We note that in England, agreement was reached in February 2016 between NHS England and the BMA on a contract uplift for GMPs that took account of the rise in expenses and we welcome this development. **Our recommendation for independent contractor GMPs in all countries of the UK is for an increase in pay, net of expenses, of 1 per cent. Our recommendation for independent contractor GDPs in all countries of the UK is also for an increase in pay, net of expenses, of 1 per cent.**

24. **We also observe that the parties in all four UK countries have the option to make the provision of expenses data a mandatory requirement of new GMP and GDP contracts.**

Looking forward

25. We note two key principles that we see as guiding our future role alongside our standing terms of reference. These are the principles of *fairness* and of taking a *longer term view.* We seek to find a balance between the interests of our remit groups, of their employers, of the taxpayer, and of patients, in a context where the NHS, as employer, occupies a dominant position in the market. We are also conscious that members of our remit groups require a long period of training, and many of them expect to work in the NHS for their whole careers, so their long-term position on pay, relative to other professional groups, must be relevant to our thinking.

26. This year's review highlights several wide-ranging issues that will shape our approach over the coming years. It is a time of great change within the NHS. The moves towards integration of health and social care, new contracting models in primary care, seven-day services and further devolution of funding decisions are all in train to varying degrees in the different parts of the UK, which are also taking different approaches to the development of the general medical services (GMS) contract. This divergence in approach is likely to continue. The workforce implications are not yet clear, but are unlikely to mean a one-size-fits-all model. At the same time, we see signs of a generational shift within the remit groups, with newer members making different career choices to their predecessors and seeking a different relationship with their employers. We would like all the parties to provide us with evidence on how the new models of care, and new contracts, will affect our remit groups, and particularly any implications for their pay or job weighting. We believe that pay responses may need to be differentiated, given that affordability constraints and the desire to transform services both seem likely to remain for the medium to longer term.

27. The UK government's stated intention is to implement a further four years of average annual wage growth of no greater than 1 per cent. Given this intention, we need to think beyond single years and how the long-term pay and conditions of our remit groups relate to those elsewhere in the labour market. Certainly we cannot assume that good retention figures published to date and apparently reasonable motivation in any one year reflect a sustainable position among our high-performing remit groups. To help ensure that our remit groups see their pay is fair, and to provide ourselves with a point of reference with which we might judge annual pay round evidence, we have given early thought to the possible role of what we describe as "benchmark pay factors". We welcome views on these.

28. We understand that the parties and key information providers in each country are already trying to agree workforce data collection processes and definitions. We support this since, given the scale of the challenge facing the NHS, we feel that the debate should be about what the numbers are telling us and what the solutions should be, not about whether the numbers are right. We look forward to improved vacancy, turnover and attrition data for the next round.

PROFESSOR SIR PAUL CURRAN (*Chair*)
LUCINDA BOLTON
JOHN GLENNIE, OBE
ALAN HENRY, OBE
MEHRUNNISA LALANI
PROFESSOR KEVIN LEE
PROFESSOR JAMES MALCOMSON
NIGEL TURNER, OBE

OFFICE OF MANPOWER ECONOMICS
24 February 2016

CHAPTER 1: INTRODUCTION

Our purpose and the review body process

1.1 The Review Body on Doctors' and Dentists' Remuneration (DDRB) was formed in 1971 as an independent body, with its primary role being to advise Ministers on the remuneration of doctors and dentists taking any part in the National Health Service. Our independence from government is built into our terms of reference to ensure our decisions are objective.

1.2 An important rationale for our creation was the inherent difficulty in deciding on the right pay levels for these remit groups. Doctors and dentists undergo lengthy training, have high levels of commitment to patients, and the UK labour market for these groups remains dominated by the NHS, which is by far the largest single employer. Given this situation, we, like our predecessors, need to ensure that our remit groups are not unreasonably disadvantaged relative to other professional groups, because of their inherent unwillingness to leave their profession and the shortage of alternative employers. We keep this very much in mind when considering our report and recommendations in line with our standing terms of reference.

1.3 A crucial part of the review body process is its transparency, and this includes the requirement that the parties share their evidence with each other so that they are able to comment on and interrogate the submissions. However, we value the ability to deliberate on the various issues raised by the parties in private, and we understand that the parties value the opportunity to provide their views to us in oral evidence in private to enable the free and frank exchange of views. Given this, our aim is to be absolutely clear about what has informed our recommendations in our report, which gives our final views on the issues raised by all the parties, the rationale for our decision-making and a summary of all the evidence provided.

Remit groups

1.4 At September 2014, our remit groups comprise approximately 206,100 doctors and dentists, a 1.6 per cent increase on the previous year and a 19 per cent increase over the last eight years (the period for which comparable data are available), compared to UK population growth of 0.8 per cent on the previous year and 6.2 per cent over the last eight years. The breakdown by group is given in Table 1.1. The figures here show the effects of the previous expansion of medical and dental school places that are now feeding into growing numbers of registrars, consultants, general medical practitioners (GMPs) and general dental practitioners (GDPs). Further details, including the country-specific breakdowns and an infographic of our remit groups and their pay systems, 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**	**2013**	**2014**	**Change over previous year**	**Change between 2006 and 2014**
	Full-time equivalent	**Full-time equivalent**	**Full-time equivalent**	**Full-time equivalent**	**Full-time equivalent**
Consultants[2]	37,080	47,505	49,294	3.8%	32.9%
Specialty doctors/ associate specialists/staff grades	9,359	11,026	11,184	1.4%	19.5%
Registrar group	21,267	46,449	47,087	1.4%	121.4%
Foundation house officer 1 and 2[3]	33,642	17,305	17,162	-0.8%	-49.0%
Other staff[4]	3,076	2,372	2,466	4.0%	-19.8%
Total Hospital and Community Health Services (HCHS)	**104,424**	**124,656**	**127,193**	**2.0%**	**21.8%**
	Headcount	**Headcount**	**Headcount**	**Headcount**	**Headcount**
General medical practitioners (GMPs)[5]	43,766	48,573	48,962	0.8%	11.9%
General dental practitioners (GDPs)[6]	24,463	29,297	29,580	1.0%	20.9%
Ophthalmic medical practitioners (OMPs)	466	349	320	-8.3%	-31.3%
Total Primary Care	**68,695**	**78,219**	**78,862**	**0.8%**	**14.8%**
Total remit group FTE HCHS + headcount primary care	**173,119**	**202,875**	**206,055**	**1.6%**	**19.0%**

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

Notes:

1. Most primary care data are not as September each year, but are for the nearest time period after September: GMPs as of September 2014 in England, Wales and Scotland but as of October 2013 in Northern Ireland; GDPs as of September 2014 in Scotland, but as of March 2015 in England and Wales and as of April 2015 in Northern Ireland; and OMPs as of September 2014 in Scotland but as of December 2014 in England and Wales and as of April 2015 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. From 2014 in Northern Ireland it also includes GP trainees and GP educators.

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.

1.5 In making our recommendations, we are guided by our standing terms of reference and consider all of the evidence submitted to us in time 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.

1.6 In last year's report, we expressed concern that the restrictions placed on the review body process – by the English and Welsh governments and the Northern Ireland Executive to restrict our recommendations to independent contractor GMPs and GDPs – 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. We noted that the situation in England, Wales and Northern Ireland meant that the pay outcome for salaried doctors and dentists would effectively be imposed by one party, without the agreement of the other parties. We therefore understood the position adopted by the British Medical Association (BMA) in seeking recommendations for all of our remit groups, in each country of the UK. Our decision last year not to provide recommendations against the express request of the BMA does not affect our view that our terms of reference allow us to make pay recommendations or observations should one of the parties request it, or indeed if we simply consider it appropriate. 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.

The remits for 2016-17

1.7 We are conscious that this report comes close to the start of a new UK Parliament. The UK government has set out its proposed approach to public sector pay between now and 2020, and signalled overall constraints on the funding available over these four years. 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 UK. This year, recommendations were sought for all of our remit groups. We describe the various remit letters below in more detail and they can be seen in Appendix A.

1.8 The BMA told us that it was becoming increasingly concerned about our ability to exercise our independence. It asked that we not be constrained by any remits we might receive this year when making our recommendations, and additionally that we challenge the affordability part of our standing remit. Affordability is part of our terms of reference and we do, of course, pay very careful attention to the government's evidence in this area. However, we make our recommendations based on all the evidence we receive in the round. If the evidence points us sufficiently strongly to make particular recommendations, we do not consider that we are constrained from making such recommendations by guidance letters from government.

1.9 The initial guidance for this round was given by a letter dated 19 August 2015 from the Chief Secretary to the Treasury, Greg Hands, which served to set out the UK Government's Public Sector Pay Policy. The letter recorded the government's belief that, whilst the deficit and debt were being reduced, there was a continuing need to ensure restraint in public sector pay. Without such restraint, reductions would need to come from other areas of spend, resulting in negative impacts on public services and jobs. It said that the pay policy would help to protect the jobs of thousands of front line public sector workers, and that the government had funded public sector workforces for a pay award of 1 per cent a year for four years from 2016-17. The letter added that the government expected pay awards to be applied in a targeted manner to support the delivery of public services, and to address recruitment and retention pressures. The letter

remarked this might mean that some workers could receive more than 1 per cent while others could receive less, and that there should not be an expectation that every worker would receive a 1 per cent award.

England

1.10 The letter from the Parliamentary Under Secretary of State for NHS Productivity, Lord Prior of Brampton, dated 6 November 2015, reaffirmed this approach, and invited us to consider the case for targeting to support recruitment and retention and to make our recommendations within an average of 1 per cent for employed doctors. It said that pay recommendations for 2016-17 should be based on existing contracts only. For independent contractor GMPs and GDPs, it said that it would welcome our views as to how an overall pay uplift of an average of 1 per cent could be applied to improve recruitment and retention.

Wales

1.11 The letter from the Minister for Health and Social Services in the Welsh Government, Mark Drakeford, dated 16 December 2015, asked us to make recommendations for medical and dental staff. For GMPs and GDPs, it said it would welcome our views on how an overall pay uplift could be applied. The letter said that any recommendation should take into account the Chancellor's 2015 budget statement that public sector pay would increase by 1 per cent a year for four years from 2016-17 and within the context of NHS Wales' financial position.

Scotland

1.12 The letter of 22 December 2015 from Shona Robison, the Cabinet Secretary for Health, Wellbeing and Sport in the Scottish Government referred to its Public Sector Pay Policy for 2016-17, of which the key features of DDRB interest were an overall 1 per cent cap on the cost of the increase in basic pay for those earning £22,000+ and a continuation of the commitment to no compulsory redundancies. It asked us to be as free as possible in considering the issues and making recommendations, but said that it would be important to take into account the considerable on-going financial challenges facing NHSScotland at the present time, and that any pay increase had to be affordable. The letter noted that an exercise to collect robust information on the expenses of GDPs had resulted in a disappointing response, and asked us to consider how such information might be provided in the future. For GMPs, it asked for our recommendation in respect of GMP pay and contractual uplift.

Northern Ireland

1.13 We wrote to the Northern Ireland Executive in December 2015 to seek clarity on both the recommendations in our 2015 Report and their wishes for the current round. We subsequently received a remit letter dated 3 February 2016 from Simon Hamilton, Minister for Health, Social Services and Public Safety asking us to consider the case for targeting to support recruitment and retention and seeking recommendations for salaried doctors and dentists. For GDP and GMS contractors, our views were sought on how an overall pay lift could be applied.

Other remit views

1.14 The BMA was also concerned about the late submission of evidence by some of the other parties. It said that this gave the other parties considerable time to comment on its evidence, but that the BMA had very limited time to review theirs. It said that this blatant disregard of the timetable cast serious doubt amongst its membership as to value

of the process, and our ability to make genuinely independent recommendations. The British Dental Association (BDA) also commented on the late remits issued by the Health Departments. It said that with an expectation of high quality evidence submission, it was vital that we were given remits in a timely fashion to ensure that non-governmental parties could deliver appropriate and tailored evidence to meet the deadline and consider the remit. The BDA said it continued to believe in an independent pay review process and supported an unrestricted remit.

1.15 We have sympathy with the BMA and BDA in their criticisms of late submission of remits and evidence. We understand that this has largely been as a result of the Spending Review, whose results were not announced until 25 November 2015, considerably later than the normal date for the submission of evidence of 30 September 2015. We regret the inconvenience that this caused to the parties and are grateful for the work they have put in to comment within shortened timetables. We have ensured that all the parties have been given a right of reply to all the evidence we have taken into account, and have considered all views as part of our deliberations for this round as far as possible. We are expecting that the next pay round will revert to the normal timetable, and would ask all parties to submit evidence for our next round – and to make it available to all of the other parties – in good time. As the BMA and BDA have said, this is important to maintain confidence in the review body process.

Last year's recommendations

1.16 In our 43rd Report 2015, 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 Scotland in 2015-16. We decided not to make any recommendations for salaried doctors and dentists in England, Wales and Northern Ireland, although we did recommend that the minimum and maximum points of the pay range for salaried GMPs should be increased by 1 per cent. For independent contractor GMPs, we recommended that in all four countries of the UK, there should be an increase in pay net of expenses of 1 per cent. For independent contractor GDPs, we also recommended that in all four countries of the UK, there should be an increase in pay net of expenses of 1 per cent.

1.17 In response, the **Department of Health** accepted our pay recommendations, increasing the minimum and maximum points of the pay range for salaried GMPs by 1 per cent. The detail of how it sought to uplift GMP and GDP pay is set out in Chapter 3.

1.18 Similarly, the **Welsh Government** said that minimum and maximum of the pay range for salaried GMPs had been increased by 1 per cent. The approach taken by the Welsh Government to the uplift for GMPs and GDPs is described in Chapter 3.

1.19 The **Scottish Government** accepted and implemented all of our recommendations in full.

1.20 At the time of writing, we had not been formally told of the **Northern Ireland Executive**'s response to the recommendations in our last report.

Contract reform

1.21 In 2014, we were given a special remit to consider contract reform for both consultants and doctors and dentists in training. We made observations and recommendations on this for both sets of doctors, submitting our report[1] in July 2015. As we write this report, negotiations on the consultant contract are underway in both England and Northern

[1] *Contract Reform for Consultants and Doctors & Dentists in Training – Supporting Healthcare Services Seven Days a Week*. Review Body on Doctors' and Dentists' Remuneration. Cm 9108. Available from: https://www.gov.uk/government/publications/contract-reform-for-consultants-and-doctors-and-dentists-in-training-supporting-healthcare-services-seven-days-a-week

Ireland. All four UK countries have been involved in the negotiation on the new contract for doctors and dentists in training; not all have taken the same approach to those negotiations. We cannot ignore the industrial dispute in England that was ongoing at the time of writing and discuss this further at paragraph 1.34 below.

1.22 New dental contracts are also in train in both England and Northern Ireland and we address this in Chapter 3, which also notes contractual changes for GMPs, both in terms of the current GMS contract and for GMPs working in federations. We understand also that a Scotland-specific GMS contract is being considered.

Approach to the current round

1.23 The influential reports relating to patient safety and service improvement across the four countries continue to have a bearing and remain an important part of the context.[2]

1.24 The recommendations contained within this report are being made at a time of great change in the NHS. We note that the jointly developed *NHS Five Year Forward View*[3] is guiding the service in England, and that its spending and efficiency assumptions were borne out in the Spending Review settlement. The implications of the *Five Year Forward View* for our remit groups, particularly the call for increased investment in primary care, an increase in the number of GMP training places and new contracting models for employing doctors, are covered in the appropriate sections of this report, as relevant. Overall, the workforce implications of the changes are not yet apparent and much store is being set in the new models of care 'vanguard' initiative, which is due to deliver findings in 2016. Vanguard sites have been selected in England to deliver health and social care in a more integrated manner. Indeed, better integration of health and social care formed a common theme in the evidence we received from each country.

1.25 The Welsh Government published *Our plan for a primary care service for Wales up to March 2018*[4] which set out the aim for a more "social" model of health, with people being able to receive the care they need in a coordinated way from integrated multi-professional health and social care teams. Similarly, the Scottish Government's *2020 Vision for Health and Social Care* aimed to integrate health and social care. The Public Bodies (Joint Working) (Scotland) Act 2014 required Health Boards and Local Authorities in Scotland to integrate adult health and social care services, resulting in integration schemes being submitted to the Scottish Government by April 2015. The Scottish Government told us that the process of approval for the integration schemes was almost complete.

1.26 The Northern Ireland Executive said that a consultation document *Health and Social Care reform and transformation – Getting the structures right* had been published in December 2015, and it described plans to transform the health and social care system to make it more streamlined and to reduce complexity. Separately, a Panel had been announced to lead a debate on the best configuration of health and social care services in Northern Ireland.

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[2] *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.

[3] *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/

[4] *Our Plan for a Primary Care Service for Wales up to March 2018*. Welsh Government, November 2014. Available from: http://www.wales.nhs.uk/sitesplus/documents/986/Our%20Plan%20for%20Primary%20Care%20in%20Wales%20up%20to%20March%202018.pdf

1.27 Our report is being written in the run-up to elections in Wales, Scotland and Northern Ireland. While in England a pay policy has been set out by HM Treasury covering the period 2016-17 through to 2019-20, the forthcoming elections mean that pay policy in Wales, Scotland and Northern Ireland has only been set out for one year. Clearly, the outcome of the elections and subsequent pay policy will form an important backdrop to our future considerations.

1.28 In the light of all these changes, we have set out in this report our recommendations for what we consider necessary for 2016-17, but alongside that we have also put forward our views on the issues that we believe will need to be monitored over the longer term.

The evidence

1.29 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 Department of Health, Social Services and Public Safety in Northern Ireland; NHS Employers; NHS England; Health Education England; the Advisory Committee on Clinical Excellence Awards; the BMA; and the BDA. The Scottish Advisory Committee on Distinction Awards and NHS Providers opted to not submit any evidence for this round.

1.30 In addition, we heard oral evidence from: Lord Prior of Brampton, Parliamentary Under Secretary of State for NHS Productivity; Shona Robison, Cabinet Secretary for Health, Wellbeing and Sport in the Scottish Government; the Department of Health; the Scottish Government; the Welsh Government; NHS England; NHS Employers; Health Education 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.

1.31 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.

1.32 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

1.33 Given the special remit on contract reform, we carried out a truncated programme of three visits to acute trusts and health boards in England and Scotland 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 2015 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 they provide 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.

1.34 Our visits in 2015 took place during September and October, after we submitted our report on contract reform. This was before the BMA balloted junior doctors in England on the prospect of industrial action, following the announcement by the Department of Health to proceed to contract implementation for August 2016, and before NHS Employers worked up the detail on the pay implications of the proposed reform.

We encountered a very high level of apprehension from the junior doctors that we met on what the proposals would mean for them individually. The debate intensified as the visit programme proceeded and we felt this was clear evidence of an anxious medical workforce at least in the trusts we visited. We discuss the implications for the morale of junior doctors in Chapter 4. We note that the parties chose to present the contract reform proposals for junior doctors in very different ways and that our July 2015 report was cited by the parties, again in different ways. Our hope was that the parties would reach a negotiated settlement and we are disappointed that agreement has not yet proved possible. At the time of writing, a "best and final" contract offer had been rejected by the BMA and the Department of Health had announced an intention to proceed in England without agreement.

Structure of the report

1.35 Our report consists of six chapters: this introduction giving the overall context for this review; the pay context and an overview of our terms of reference; primary care doctors and dentists; hospital doctors and dentists; our main pay recommendations for 2016-17; and finally a chapter setting out the key issues that we believe will need to be monitored and considered over the coming years. 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 UK and an info-graphic on the numbers on each pay system 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 expenses formula we historically used for our uplift recommendations for independent contractor GMPs and GDPs. Appendix F gives the results of our analysis of pay comparability, Appendix G shows the total earnings distribution for some of our remit groups and Appendix H shows a list of abbreviations and acronyms used in this report.

1.36 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 and Health Education England; 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: PAY CONTEXT AND OVERVIEW OF TERMS OF REFERENCE

Introduction

2.1 In this chapter, we consider the wider economic and labour market context, and the pay and remuneration of doctors and dentists including comparisons with other professions. We then examine the evidence against each of our terms of reference. Where possible the evidence and commentary are split out by country, otherwise the information is for the UK. This chapter serves to build up a picture of the range of issues of relevance to our consideration of the pay for our remit groups in the later chapters.

General economic and wider labour market context

2.2 In this section we consider the macroeconomic picture, including inflation and employment trends that provide important context to considering pay rates. We are required by our terms of reference to have regard to the Government's inflation target and deal with it here as it is part of the macroeconomic picture.

2.3 The UK economy as a whole grew by 2.2 per cent in 2015. The Office for Budgetary Responsibility (OBR) has forecast a rate of economic growth of 2.4 per cent for 2016 and slightly faster growth, 2.5 per cent, in 2017.[1]

2.4 The Government's inflation target is 2 per cent. Inflation has remained low but stable over the last year, prices for transport costs, food and non-alcoholic beverages and (to a lesser extent) recreational and cultural goods and services have had a downward pull on the rate of inflation. These have been counterbalanced by an upward pull from price movements for other goods and services, most notably restaurant and hotel bills, and education costs such as university tuition fees. The Consumer Prices Index (CPI) annual inflation rate was 0.2 per cent in December 2015, while the Retail Prices Index (RPI) rate was 1.2 per cent. CPI inflation is expected to increase during 2016 as the oil prices falls of a year ago drop out of the 12-month comparison. The Bank of England forecasts annual CPI inflation to rise to 0.7 per cent in March, reaching 1 per cent in the second half of 2016. The RPI rate is forecast by the OBR to end 2016 at around 2.3 per cent, with the path dependent on interest rate rises.

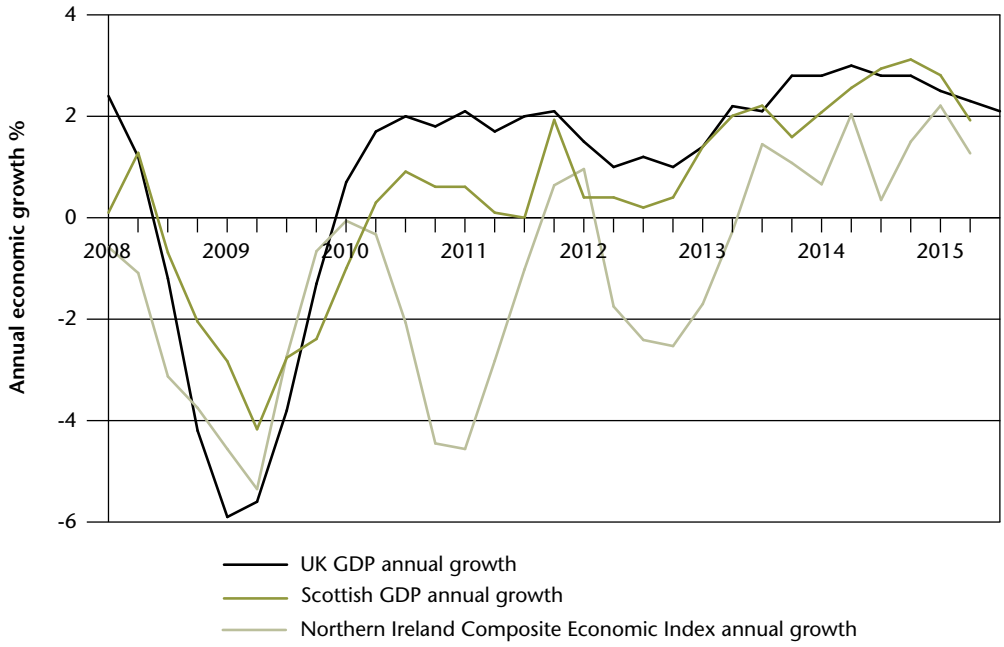
2.5 The labour market has continued to perform robustly over the last year. The employment level grew by 588,000 in the year to November 2015, to reach 31.39 million. The employment rate has risen by 1 percentage point over the year to 74.0 per cent, the highest since comparable records began in 1971. The unemployment rate has fallen over the same period to 5.1 per cent in the latest figures, down from 5.8 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.

2.6 With the falling unemployment rate, there is increasing evidence of upward pressure in wages across the economy as a whole and average earnings growth was 2.4 per cent in the three months to October 2015, although commentators have started to question whether this will be maintained through 2016. The Bank of England said in November 2015 that it expects wage growth to be volatile in the near term, due to the timing of bonus payments. Beyond that, wage growth is expected to pick up, further outstripping productivity growth, as the tightening labour market results in pay pressures and companies find it increasingly difficult to find staff. The Annual Survey of Hours and Earnings (ASHE) shows that the median gross weekly earnings for full-time employees increased over the year to April 2015 by 1.8 per cent, compared to 0.2 per cent between

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

2013 and 2014. Similar increases were seen in the public and private sectors with increases of 1.8 per cent and 1.6 per cent respectively. Of most relevance to our remit groups, earnings at the top decile were up 0.9 per cent over the year to April 2015 for full-time employees.

Figure 2.1: Annual growth in Gross Domestic Product (GDP), quarterly, 2008 to 2015, United Kingdom, Scotland and Northern Ireland

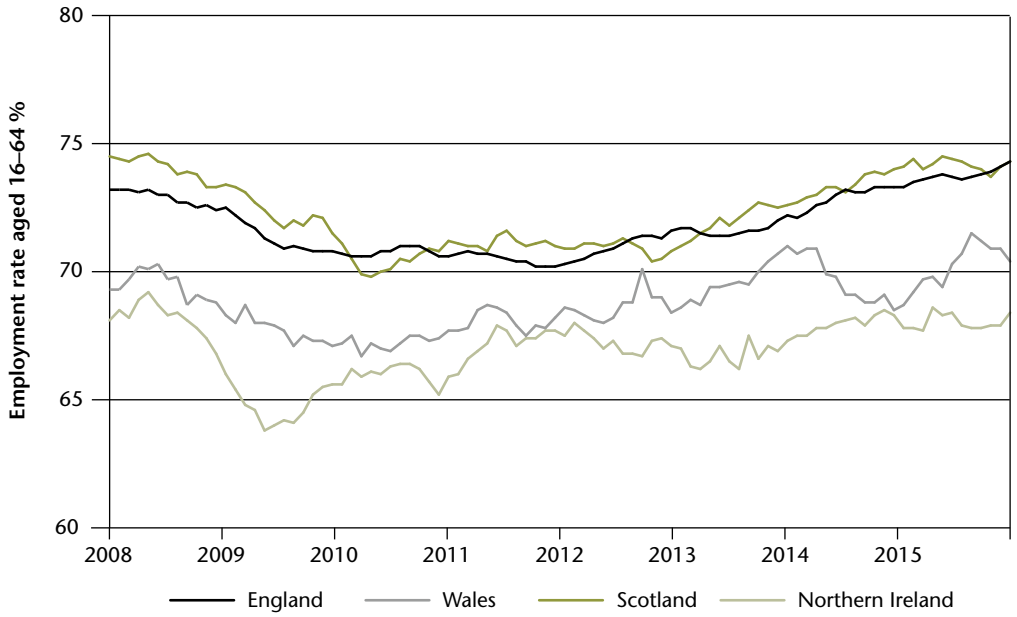


Sources: ONS, Scottish Government, DETINI.

2.7 Figure 2.1 above shows that economic growth in Scotland has kept pace with the UK over the last two years, although the recently revised UK data shows that the UK as a whole had stronger growth in 2010 to 2012 than Scotland. Northern Ireland saw a triple-dip recession with positive, but relatively slow growth over the last two years. Separate Gross Domestic Product (GDP) data are not available for Wales.

2.8 Employment rates in Scotland and England are at similar levels (Figure 2.2). Employment rates for Wales, and particularly Northern Ireland, have lagged behind England and Scotland. Northern Ireland was hit sharply by the recession, then saw an initial recovery, but employment has grown less than in the other countries recently, and is currently at 68.4 per cent. The employment rate in Wales grew significantly between mid-2014 and mid-2015, but has dropped in recent months, to 70.4 per cent in the three months to October 2015.

Figure 2.2: Employment rates by country, 2008 to 2015



Sources: ONS, Labour Force Survey (LF3Y, LF3Z, LF42, LF5Z).

2.9 The Department of Health referred to analysis by the Office for Budget Responsibility and told us that since 2010 the deficit had halved as a share of GDP and the national debt was forecast to fall in 2015-16 for the first time since 2001-02. However debt stood at its highest share of GDP since the late 1960s and the deficit remained among the highest in advanced economies. The Department said that when further spending reductions were required to complete the repair of the public sector finances, a policy of pay restraint made a significant contribution to protecting jobs and maintaining public services.

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

2.10 Our terms of reference require us to take account of the funds available to the Health Departments as set out in the Departmental Expenditure Limits. This continued to form one of the main themes in the evidence submitted to us by the parties.

England

2.11 The Department of Health said that the Spending Review made provision for England to have £10 billion per annum more in real terms by 2020-21 than in 2014-15, with £6 billion a year available in the first year so that the plans in the *Five Year Forward View* could be fully funded to deliver seven-day services. The Department of Health said that NHS England was investing £2.1 billion in 2016-17 into a Sustainability and Transformation Fund: £1.8 billion for sustainability including support to bring the provider trust sector back to financial balance; and £0.3 billion for the transformation element, including support for the ongoing development of new models of care and policy commitments such as seven-day services and general medical practitioner (GMP) access. Local councils were given powers to increase social care funding through a new 2 per cent Council Tax precept. The *Five Year Forward View* also noted a funding gap of £30 billion by 2021, so efficiency savings are still required.

2.12 The Department said that the affordability of the workforce required a balance of pay and reward sufficiently attractive to enable the recruitment and retention of a high quality workforce and maintain good industrial relations. It said that Trusts spent around 60 per cent of their funding on pay, so contract reform was crucial to ensuring the workforce was affordable and sustainable. During oral evidence, Lord Prior noted the level of health spending relative to GDP was lower than that in similar countries. In that context he commented that the target the NHS had set itself to deliver £22 billion of efficiencies (equivalent to 2 per cent to 3 per cent per annum) by 2020-21 was a very ambitious one. Productivity gains would also form an important part of delivering efficiency savings: the Department of Health referred to the *Review of Operational Productivity in NHS providers*[2] by Lord Carter of Coles which found that the NHS could save up to £5 billion a year by making better use of staff, medicines and by deploying its buying power more effectively. Lord Carter's report also suggested making more efficient use of the hospital estate, noting that current running costs per area (£/m^2) varied between £105 and £970.

2.13 NHS England explained to us in supplementary evidence that the *Five Year Forward View*, upon which the Spending Review settlement was based, included pay assumptions as part of its modelling of the £30 billion funding gap. They said that those assumptions included both real terms pay growth and incremental drift. For 2016-17, its pay assumption was for a 2.4 per cent increase; the figure rose to 2.7 per cent from 2018-19 onwards.

2.14 We have also noted the independent assessment of where the Spending Review leaves the NHS and social care provided by the Nuffield Trust/The Health Foundation/The King's Fund.[3] The report noted that total health spending in England would rise by £4.5 billion in real terms between 2015-16 and 2020-21 and that additional investment was to be front-loaded, but commented that much of the money would be absorbed by dealing with deficits among NHS providers and by additional pension costs. It said that the impact of a further period of pay restraint was unclear, with the service already struggling to recruit and retain enough staff, very high expenditure on agency staff and low staff morale.

2.15 The British Dental Association (BDA) commented that the dental budget for England remained fixed and that dentistry was nationally commissioned within that fixed budget.

2.16 The British Medical Association (BMA) highlighted that commentators including the Chartered Institute of Public Finance and Accountancy, the Nuffield Trust, King's Fund and the Health Foundation had uniformly agreed that both the quantification of the shortfall highlighted by the *Five Year Forward View*,[4] and the proposals to address it were extremely optimistic.

Wales

2.17 The Welsh Government said that its total budget had faced successive reductions since 2010, and that by 2015-16, it was around 10 per cent lower in real terms than it was in 2010-11, a reduction of more than £1.5 billion. It said that NHS Wales continued to face rising costs, increased demand, an ageing population, a growth in the number of people with chronic conditions and spending cuts on other services, such as social services. Following the Spending Review, the Welsh Government said that its revenue budget had

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[2] *Review of Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations.* Lord Carter of Coles, February 2016. Available from: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals#history

[3] *The Spending Review: What Does It Mean For Health and Social Care?* Nuffield Trust/The Health Foundation/The King's Fund, December 2015.

[4] *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/

received a 4.5 per cent real terms cut over the next four years. The draft budget included an additional £260 million revenue funding for health in 2016-17, but Ministers were yet to decide how to target the funding in 2016-17 to deliver and transform NHS services. The Welsh Government said that the affordability of any pay award had to be managed within the context of a reducing real-terms budget.

Scotland

2.18 The Scottish Government told us that the full extent of funding available to NHS Scotland for 2016-17 would be confirmed when the budget bill was published in February 2016 (not published at the time of writing), but its planning assumption was that NHS Boards would have 1.7 per cent additional cash funding in 2016-17 to meet pay and non-pay pressures, with a small number of Boards receiving additional funding. It said that the financial position for 2016-17 would be challenging and would again require NHS Boards to deliver and retain efficiencies. In oral evidence Scottish Government officials confirmed that the efficiency savings required by NHS Boards would likely be in the order of 3 per cent to 5 per cent for 2016-17.

Northern Ireland

2.19 The Northern Ireland Executive said its approach to financial planning in 2016-17 had been aimed at identifying all available opportunities and options that could be deployed in seeking to manage a challenging financial position, whilst also prioritising and securing the delivery of reform and transformation. It said that it had sought to secure financial balance for existing services before the consideration of new service developments, reviewing existing services to ensure that they were efficient and effective. It said that options available to address unmet need from within its budget were limited without impacting negatively on the levels of service provision. The Northern Ireland Executive said that all options for achieving savings would have to be considered, including the continued application of pay restraint.

2.20 Commenting on the UK as a whole, the BMA said that the NHS continued to show increasing signs of financial stress across the whole system. It asked us to think more broadly about the funding requirements of the health service from a more "bottom up" approach of what reward and remuneration was needed to recruit, retain and motivate doctors for them to be able to deliver the highest quality care and contribute to sustained service redesign, and not a "top down" recommendation driven by financial constraints. It noted that health spending in the UK accounted for a lower proportion of GDP than comparable countries (9.3 per cent of GDP in 2012 against the EU average of 9.9 per cent), and referred to the severe deficits reported by Trusts in England for this year. The BMA said that the financial situation was unsustainable and a consequence of insufficient budgets was that doctors were being asked to work increasingly longer hours and more intensely. It accepted that the overall health budgets were outside our direct control but challenged us to consider the impact of pay controls on the ability of the NHS to deliver safe care and recruit, retain and motivate sufficient staff to deliver the current service, let alone any aspirations to extend access.

Pay drift and incremental pay progression

2.21 Incremental pay progression is the way that the pay of staff increases as individuals move up the points of a pay scale. Table 2.1 below shows the change in the pay bill per full-time equivalent (FTE) in England over the period 2010-11 to 2014-15. We note that it shows that for all Hospital and Community Health Services (HCHS) doctors in England, pay bill growth per FTE was 1.0 per cent for 2014. Only the Department of Health in England provided data on this to us.

Table 2.1: Change in costs of all Hospital and Community Health Services doctors and dentists (non-locum) staff pay bill, 2010-11 to 2014-15, England

		2010/11	2011/12	2012/13	2013/14	2014/15
1	**Pay bill per FTE Drift**	**-0.7%**	**0.1%**	**0.6%**	**0.2%**	**0.9%**
	of which:					
	Basic pay per FTE drift	*0.8%*	*0.7%*	*0.7%*	*0.1%*	*0.6%*
	Additional earnings per FTE drift impact	*-1.6%*	*-1.2%*	*-0.1%*	*0.0%*	*0.4%*
	Total on-costs per FTE drift impact	*0.1%*	*0.6%*	*-0.1%*	*0.1%*	*-0.1%*
2	**Basic pay settlement (pay uplift)**	**0.4%**	**0.0%**	**0.0%**	**1.0%**	**0.1%**
3	**Pay bill per FTE growth (1 + 2)**	**-0.3%**	**0.1%**	**0.6%**	**1.2%**	**1.0%**
4	**Average FTE growth (volume of staff)**	**2.4%**	**1.8%**	**2.0%**	**1.1%**	**2.0%**
Aggregate pay bill growth (sum of 1+2+4)		**2.1%**	**1.9%**	**2.6%**	**2.3%**	**3.0%**

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

Note: All totals are derived from unrounded figures

Our comments

2.22 The affordability of the NHS across the UK continues to be a key consideration and we recognise the difficult challenges in each country. We were interested to note the pay assumptions that fed into the quantification in the *Five Year Forward View*. It is apparent that the maintenance of a public sector pay policy of 1 per cent over four years would go a long way towards helping Trusts in England to meet their demanding efficiency targets. The same conclusion can be drawn for Scotland and Wales. It is also clear that pay restraint offers a relatively effective way of meeting the efficiency challenge, although all countries have other initiatives in train to support Trusts and Health Boards as pay restraint alone would not deliver all of it. This being the case, the onus of making transformational change, as well as maintaining service levels, would fall largely on the NHS workforce and our remit groups as clinical leaders. We return to this 'ask' of our remit groups in our discussion of our other terms of reference later in this chapter and in Chapters 5 and 6.

2.23 The front-loading of investment for the NHS in England is likely to mean that the affordability position will become increasingly acute in subsequent years, a point highlighted to us in oral evidence by Lord Prior. We note the forthcoming elections in Wales, Scotland and Northern Ireland and await the outcomes, including future decisions on public sector pay policy within those countries.

2.24 Incremental pay progression was being considered as part of the negotiations on the relevant contract reforms for both junior doctors and consultants, so we wait to learn the outcome of those negotiations.

2.25 Our response to the BMA's challenge to take a "bottom up" approach to our recommendations is contained in Chapters 5 and 6 where we weigh up all the factors and outline the 'benchmark pay factors' that might contribute to such an approach.

Pay and remuneration

2.26 In this section, we look at how doctors' and dentists' pay has changed over time, and how it compares to the distribution of pay across the whole UK economy. This section is looked at on a UK-wide basis due to the data sources currently at our disposal. We also consider how doctors' and dentists' pay compares to the private sector and to comparator groups, and total reward issues.

Pay levels

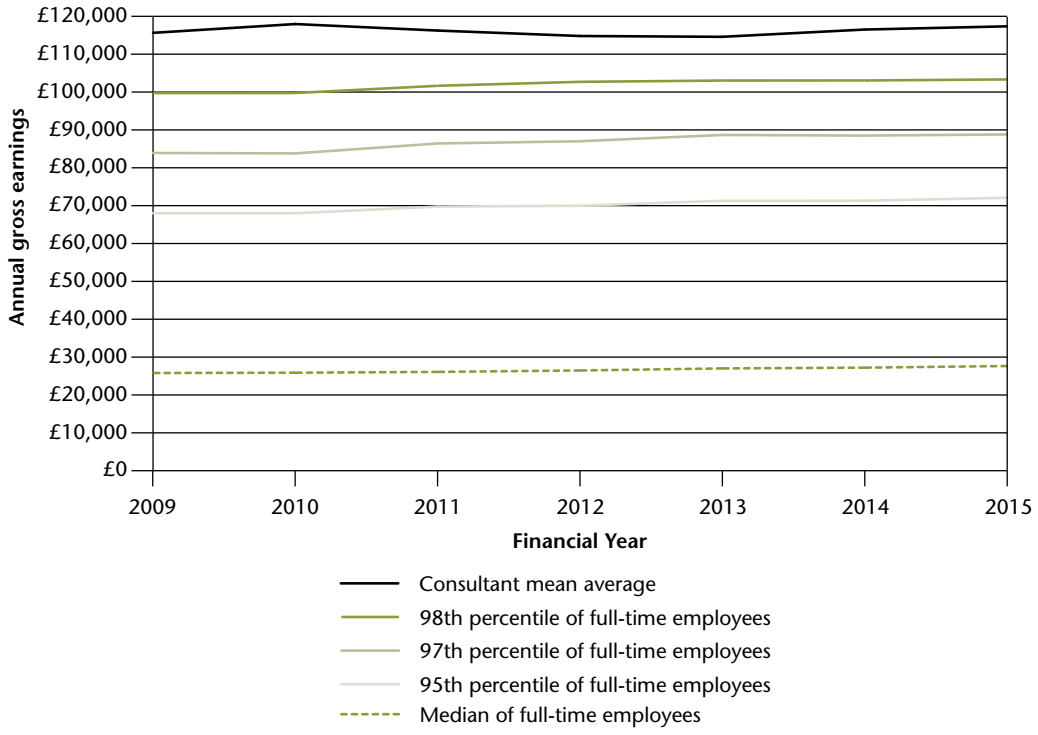
2.27 Appendix G shows the estimated total earnings for some of our hospital remit groups in the year to September 2015; and the estimated total earnings distribution for GMPs in 2013-14.

2.28 Figures 2.3 to 2.6 show how the mean total earnings per head of various staff groups compare to the median, 90th, 95th, 97th and 98th percentile of full-time employees' earnings in the wider economy over the last seven years, based on the Annual Survey of Hours and Earnings.

2.29 Over this time period, consultants' total earnings have been consistently above the 98th percentile. Specialty doctors' and associate specialists' average earnings have increased over the period. The average earnings of the registrar group have been largely unchanged, and are now at about the 90th percentile. For the Foundation years 1 and 2, their mean average earnings have increased slightly and are between the median and 90th percentile.

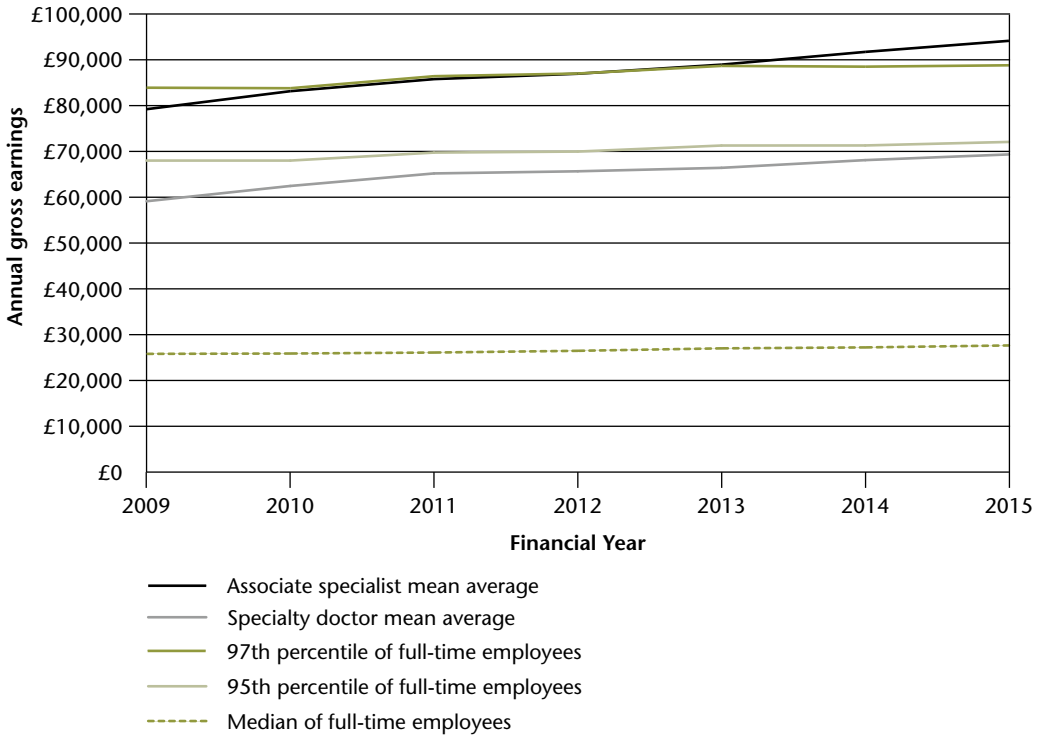
2.30 With the exception of the specialty doctor and associate specialist grades we have seen the average pay increase only slightly, whilst the 90th, 95th and 97th percentiles have increased at a faster rate.

Figure 2.3: Consultant average total earnings compared to full-time employees percentiles, England



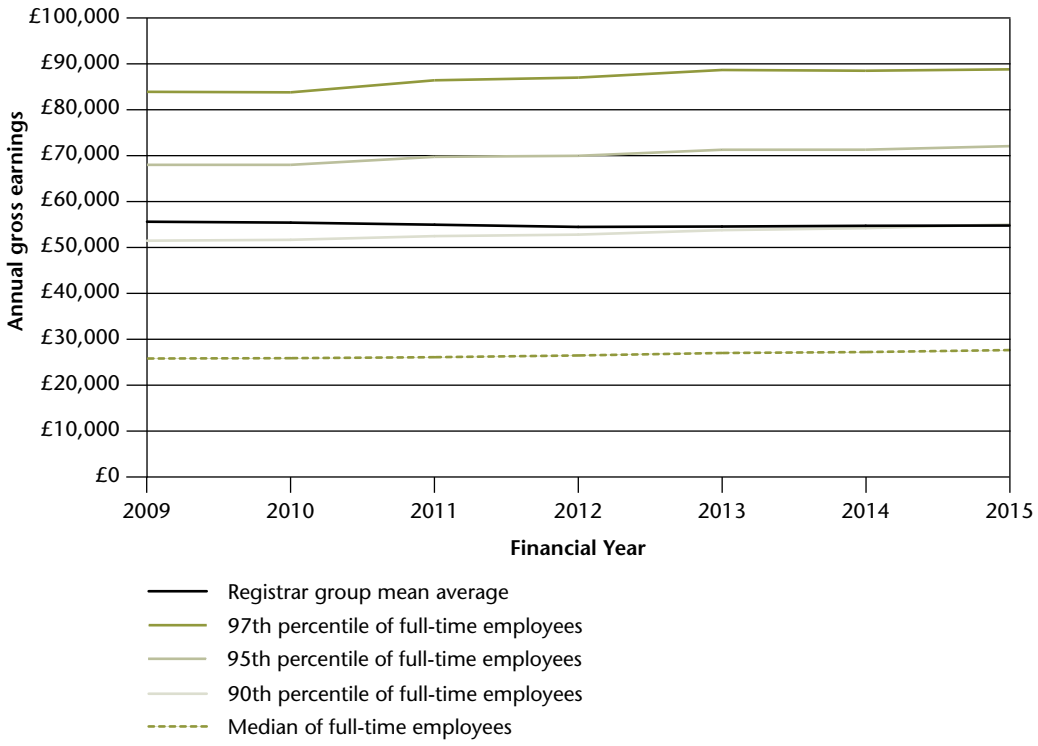
Sources: Health and Social Care Information Centre, Office for National Statistics (Annual Survey of Hours and Earnings).

Figure 2.4: Associate specialist and specialty doctor average total earnings compared to full-time employees percentiles, England



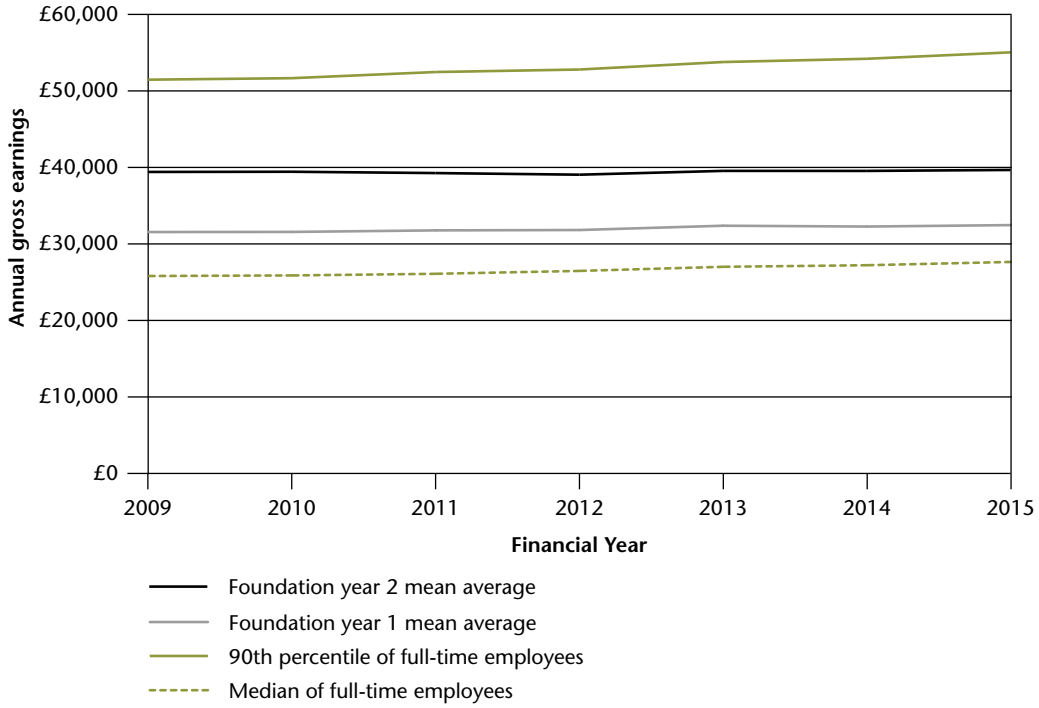
Sources: Health and Social Care Information Centre, Office for National Statistics (Annual Survey of Hours and Earnings).

Figure 2.5: Registrar group average total earnings compared to full-time employees percentiles, England



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

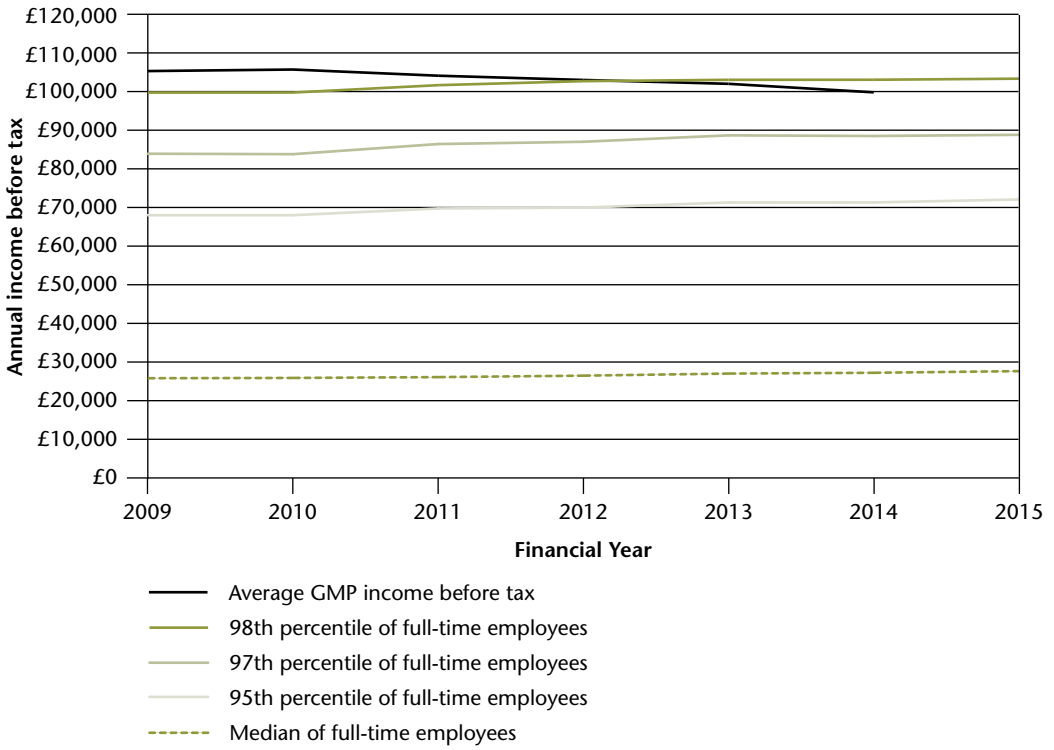
Figure 2.6: Training grades average total earnings compared to full-time employees percentiles, England



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

2.31 As shown in Figure 2.7, the average income before tax for GMPs has been falling since 2010. Whilst it has fallen below the 98th percentile, it is still above the 97th percentile for full-time employees.

Figure 2.7: GMP income before tax compared to full-time employees percentiles, UK



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

Pay comparabilities

2.32 Although pay comparability does not form an explicit 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.[5] We are due to revisit the comparators we use.

2.33 A useful source of information on comparabilities is the Higher Education Statistics Agency (HESA). HESA 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. Degrees in medicine typically take longer than other subjects: as a result, medical graduates would typically be a slightly older age group than the comparator groups. The figures placed the first years of a career in medicine in context. Table 2.2 gives the latest estimates of earnings (as of November 2014 for 2010-11 graduates) of university first degree graduates and their employment prospects by subject. For job weighted comparators, see Figures 2.8 and 2.9. 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 were in work in the UK and that less than 1 per cent of respondents were unemployed at the survey point. This contrasts with those studying other subjects and subsequently working in sectors which our remit groups might consider as comparators,

[5] 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.

who earned less and for whom there is much more variability in job market outcomes. We consider that the relatively high starting salary taken with the job security offered by a career in the NHS is an important consideration.

Table 2.2: Salaries and employment prospects by degree subject, United Kingdom

		Destinations of full-time first degree leavers 2011-12 to 2013-14					
First degree	**Median salary 3½ years after leaving university (as of Nov 2014)**	**UK work**	**Overseas work**	**Combination of work and further study**	**Further study**	**Unemployed**	**Other**
Medicine & dentistry	**£40,000**	93%	<1%	2%	5%	<1%	<1%
Veterinary science	**£32,000**	89%	4%	1%	2%	3%	2%
Engineering & technology	**£30,000**	68%	3%	4%	13%	8%	4%
Mathematical sciences	**£28,500**	53%	2%	8%	25%	8%	5%
Architecture, building & planning	**£27,500**	74%	4%	6%	7%	6%	4%
Computer science	**£27,000**	73%	2%	3%	8%	11%	3%
Combined	**£27,000**	57%	5%	8%	18%	6%	6%
Subjects allied to medicine	**£26,000**	83%	1%	3%	7%	3%	2%
Social studies	**£25,500**	64%	3%	6%	15%	7%	6%
Business & administrative studies	**£25,000**	69%	4%	6%	8%	8%	5%
Physical sciences	**£24,500**	52%	2%	5%	27%	8%	5%
Law	**£24,000**	49%	2%	11%	29%	5%	4%
Languages	**£24,000**	55%	6%	7%	19%	7%	6%
Historical & philosophical studies	**£24,000**	55%	3%	7%	22%	7%	6%
Education	**£24,000**	76%	2%	4%	13%	3%	3%
Biological sciences	**£22,000**	59%	2%	7%	20%	6%	5%
Agriculture & related subjects	**£21,000**	67%	3%	6%	10%	7%	7%
Mass communications & documentation	**£21,000**	75%	2%	3%	6%	9%	5%
Creative arts & design	**£21,000**	74%	3%	4%	7%	8%	5%
Total – Science subject areas	**£26,000**	69%	2%	5%	14%	6%	4%
Total first degree	**£25,000**	66%	3%	5%	14%	8%	5%

Source: Higher Education Statistics Agency (HESA).

2.34 Figures 2.8 and 2.9 provide a more detailed analysis of doctors' and dentists' pay relative to the national distribution and other professional groups at different points in their careers. Figure 2.8 considers doctors and dentists in training (foundation house officers (FHOs) and specialty registrars), staff grades and specialty doctors. For these groups, we 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 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 UK 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 UK employee earnings (£55,000 or higher), but their median earnings were more than 15 per cent behind all but two 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.

2.35 Figure 2.9 compares associate specialists, consultants, independent contractor 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 all full-time employees in the UK wider economy:

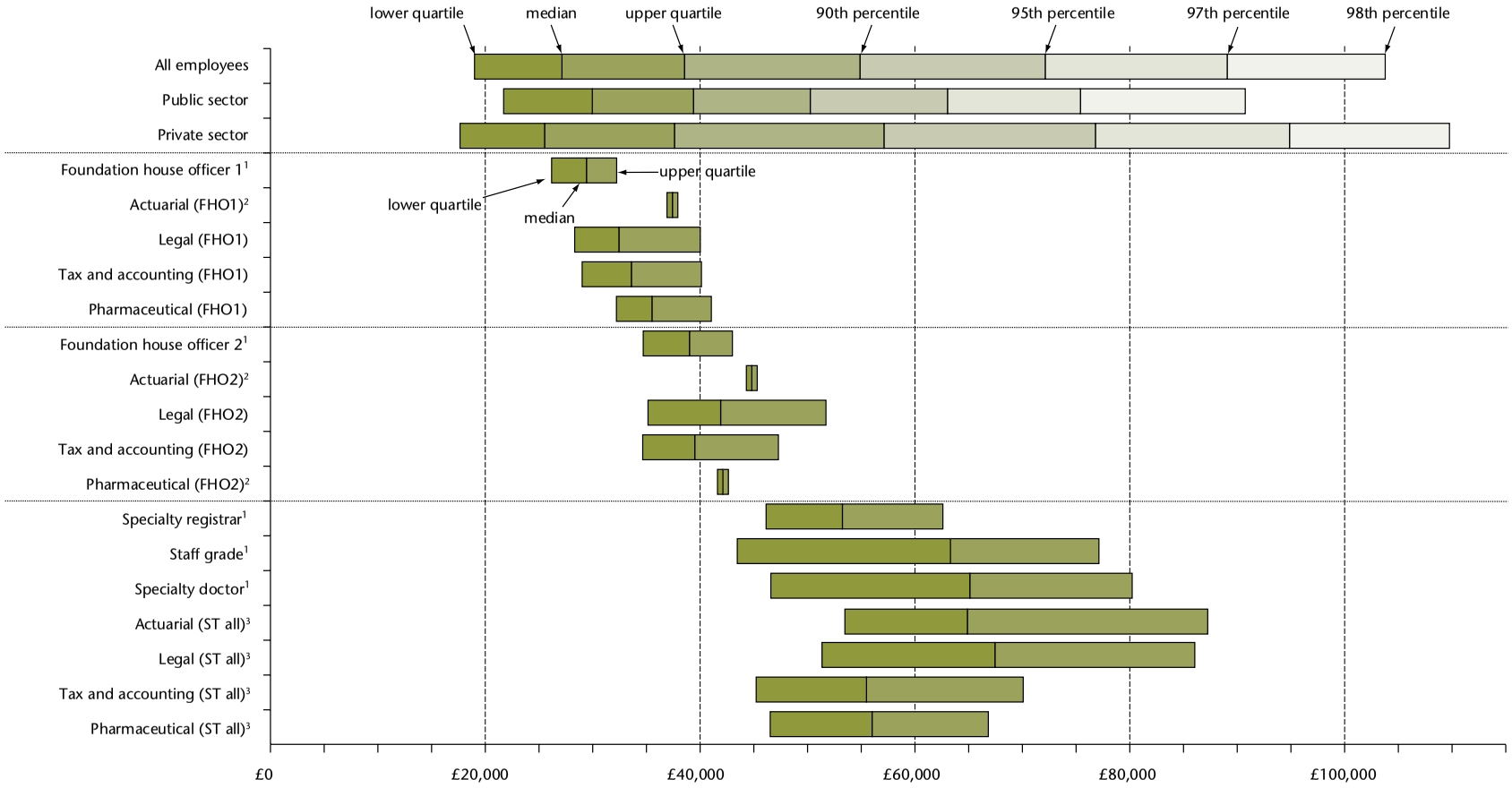
- median earnings per person for associate specialists were above the 95th percentile;
- median earnings (including awards) for consultants were well above the 98th percentile;
- median taxable income in 2013-14 for independent contractors, both contractor GDPs and providing-performer GDPs were between the 2014-15 97th and 98th percentiles;
- the lower quartile for independent contractor GMPs in 2013-14 was slightly higher than 95th percentile in 2014-15 for the wider economy; and
- the median taxable income for salaried GMPs and performer-only GDPs in 2013-14 was around the all employees 2014-15 90th percentile.

2.36 Against their specific comparators:

- associate specialists tended to earn less on average;
- consultants' median total earnings were between the minimum and maximum anchor point earnings estimates for their comparator groups;
- although above the 97th percentile for full-time employees, median earnings of independent contractor GMPs and providing-performer GDPs were lower than earnings in their comparator groups; and
- salaried GMPs and performer-only GDPs tended to earn less than members of their comparator groups.

2.37 Appendix E gives more detail on the income and expenses of GMPs and GDPs.

Figure 2.8: Total earnings inter-quartile ranges of DDRB training grades, staff grades and specialty doctors 2015, compared with the national pay distribution and other professional groups, full-time rates[1]



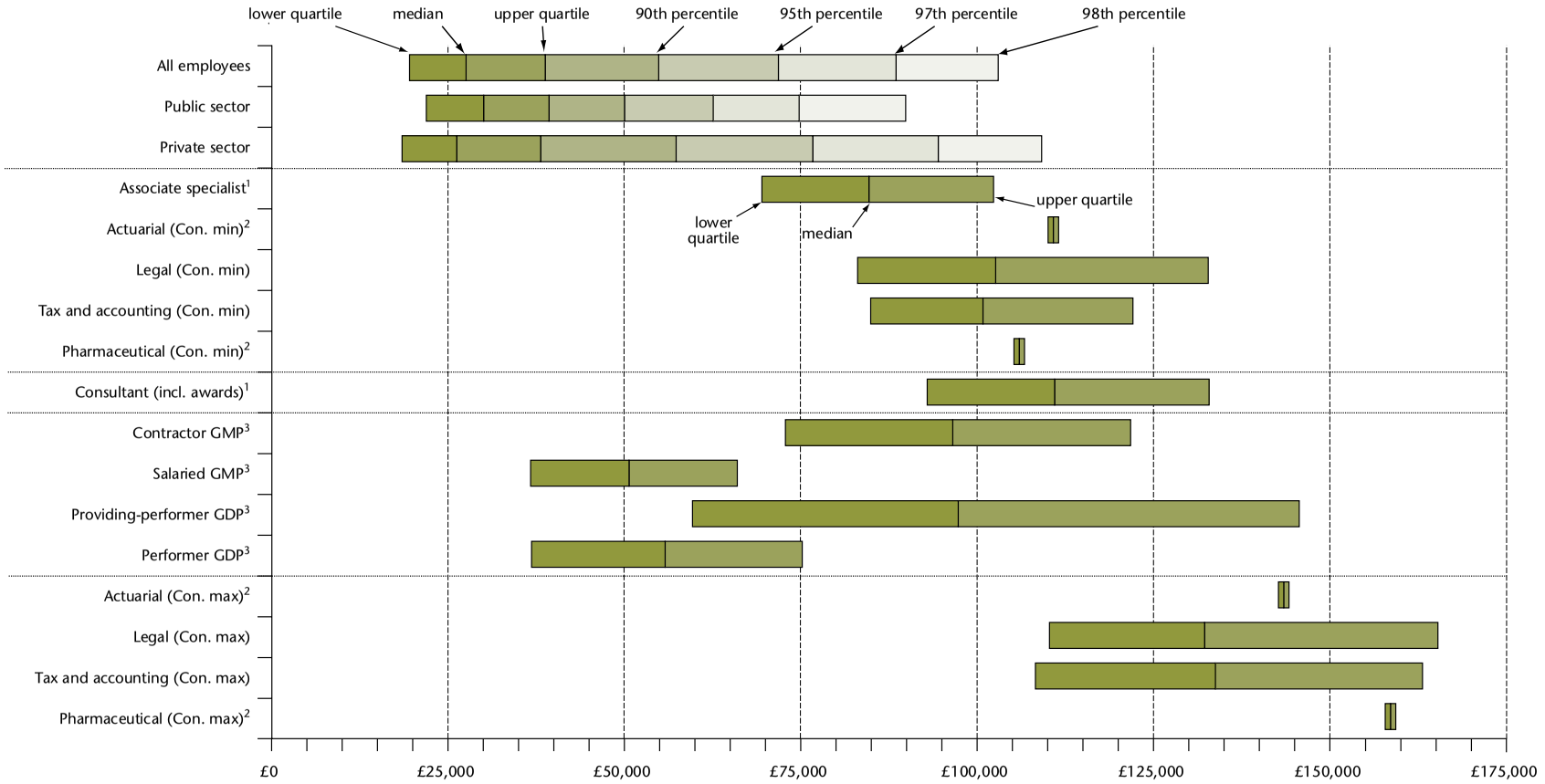
Sources: The Office for National Statistics, Health and Social Care Information Centre, NHS Employers and Hay Group.

[1] Figures for hospital medical grades relate to total earnings in the year ending September 2015, by headcount.

[2] A range is not always available for these groups at this salary level. A 'notional' range of £1,000 is used in order to illustrate the median.

[3] 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 2.9: Total earnings ranges of consultants and equivalent grades, 2015, 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 relate to total earnings in the year ending September 2015, 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 incomes (before tax) for 2013-14 for all (both full-time and part-time) general medical practitioners and general dental practitioners (the latest available data).

Our comments

2.38 Our recent reports have 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 our remit groups are positioned within the overall labour market and how far pay might be a factor in recruitment and retention. 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. If possible, we would like statistical distributions which gave an indication of the spread of earnings, in addition to means or medians such as the Health and Social Care Information Centre's basic and total earnings grapher tool. We would also find it helpful to be provided with anonymised sample career profiles for different specialties and grades. We consider the position of our remit groups' pay further in Chapter 5.

Total reward: pensions and other benefits

2.39 NHS Employers told us that the overall reward package in the NHS remained competitive and included a generous pension scheme. They said that in addition to benefits offered through national terms and conditions, employers had the opportunity to offer flexible benefits to suit local business needs and workforce priorities. They added that external factors could impact on how reward was perceived and valued by staff, such as changes to taxation and national insurance. Total reward statements helped to raise awareness of the value and range of benefits available through the NHS. Members of the NHS Pension Scheme could be liable for tax if their pension savings breached the annual or lifetime allowance. They also noted that the removal of contracting out and the National Insurance rebate had significant financial implications for employers, and that discussions with HM Treasury were being undertaken. NHS Employers said that from April 2016, NHS Pension Scheme members would no longer receive a 1.4 per cent National Insurance rebate and employers would need to raise awareness of why that was the case.

2.40 The Scottish Government said that the NHS Pension Scheme was an integral part of the NHS remuneration package and an invaluable recruitment and retention tool. It said that 2015-16 contribution rates would remain unchanged until March 2019, and that scheme membership remained broadly consistent.

2.41 The Northern Ireland Executive said that a review was due to commence in April 2016 on how the provisions of The Public Service Pensions Act (Northern Ireland) 2014 would affect public sector pension scheme members.

2.42 The BMA said that the abolition of the State Second Pension and the ending of contracting out would mean that members would pay full National Insurance contributions. The BDA said it would investigate the impact of increased contributions on recruitment, retention and motivation for next year's evidence.

Our comments

2.43 As we noted last year, 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. 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, although we note the comments from NHS Employers that locally designed benefits can also be agreed in England. As many of our remit groups are likely at some stage to come

up against either the annual or lifetime allowance (or both), we consider it important that appropriate support and advice is made available to help individuals manage their pensions. We feel that further flexibility within the reward package, for those who leave the pension scheme, is needed to reduce the number of early departures. For example, it may be possible to consider whether the employer's pension contribution could be used to fund a salary supplement in the event that a member of pension scheme hits the lifetime allowance. From 2015, the final salary pension scheme moved to a career average scheme for most members, although we note that GMPs and GDPs have long been members of a career average scheme. We have also noted that the ending of contracting out will result in an increase to National Insurance contributions for the scheme members. We will monitor the impact of pension changes on our remit groups. The Total Reward package continues to be of great interest in our consideration of pay.

Overall NHS strategy – 'patients at the heart'

2.44 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.

England

2.45 NHS Employers said that the *Five Year Forward View* was based on a vision of new models of care to better suit the needs of patients, which meant ensuring that patients had access to seven-day services where this made a difference to clinical outcomes. It said that this would need a well-trained, well-motivated, modern and flexible workforce, and that pay and contract reform was central to this aim.

2.46 The Department of Health said that it was committed to ensuring that patients received the hospital care they needed, seven days a week, by 2020, with hospitals staffed so that the quality of care was the same every day of the week. It noted four priority standards[6] linked to the reduction of the risk of weekend mortality: time to consultant review; access to diagnostics; access to consultant-directed interventions; and on-going review. It said that it intended establishing headline metrics on mortality to measure outcomes from seven-day services.

Wales

2.47 During oral evidence, the Welsh Government commented that good positive staff engagement was related to better quality patient care, and that being valued by colleagues and managers led to greater engagement. It said that pay was unlikely to be dominant, but would be part of the package of feeling valued.

Scotland

2.48 In oral evidence, Scottish Government officials noted the importance of contract reform in ensuring that the right people were in the right place at the right time to support service delivery for patients.

2.49 In relation to the UK as a whole, the BMA noted that NHS performance continued to deteriorate when measured against waiting times, cervical cancer screening and the volume of antibiotics prescribed in primary care. It said that the situation was unsustainable without investment and recruitment, arguing for the need to compensate staff for their efforts in maintaining quality at the personal expense of their workloads and

[6] https://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/

work-life balance. The BDA said that primary care dentists were most strongly motivated by patient care, and that a full pay award was required to maintain good standards of patient care and enable practice investment.

Our comments

2.50 The NHS Constitution in England, Patient Rights Act 2011 in Scotland, the Core Principles of NHS Wales and Quality 2020 strategy in Northern Ireland all provide the basis for patient-centred care in each country. Each country is looking to transform the way health care is delivered through its own initiatives and priorities; these may include new models of care, greater integration of health and social care, different skill-mix, seven-day services and a generalised push to provide care in community settings close to home in order to improve patient outcomes and patient experience. This would therefore involve new ways of working for our remit groups, but we note that one size would not fit all. A great deal of change is clearly taking place in all health systems across the UK as outlined in Chapter 1 and discussed further in Chapter 6 in relation to how this will affect our remit groups.

2.51 Evidencing a direct link between pay and patient outcomes is difficult, given the intrinsic motivation of our remit groups to provide high quality patient care. In taking this element of our terms of reference into account, we instead focus on the link between pay and staff engagement. Staff engagement is increasingly being cited as a factor in good patient care[7] and patient outcomes. A pay system should reward both quality of care and productivity and the evolution of performance pay in the proposed consultant contract is an example of how this may be addressed in the health context.

2.52 At present our pay uplift recommendation (when accepted and implemented) appears to be a signal of the value placed on staff, and in the context of pay restraint and the changes being sought, a relatively more important factor supporting staff engagement. Given how critical the workforce is in delivering the transformation required, maintaining staff engagement will be increasingly important. The 'patients at the heart' aspect of our terms of reference links closely to the requirement for us to consider motivation, and we note the staff survey results that show 81 per cent of the medical and dental workforce in hospitals in England in autumn 2014 said that they felt satisfied with the quality of work and patient care that they are able to deliver. In Scotland, the survey carried out in August – September 2015 showed 63 per cent of the equivalent workforce felt able to do their job to a standard they were personally pleased with (see Table 2.4). We will continue to monitor how changes in the way that our remit groups are working affects their level of engagement. We discuss the role of pay in relation to staff engagement further in Chapter 5 in consideration of our pay recommendations.

2.53 In relation to GMPs and GDPs, we note that both the BMA and the BDA have argued that our pay awards should factor in allowing practices to invest in better services for patients. Practice investment is, in our view, a matter for negotiation between policy makers and independent practitioners: our focus is on pay. Whilst the issues are linked through the uplift to contract values/fee scales, we do not see it as our role through our pay recommendations to make adequate provision for practice investment.

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[7] See for example *Culture and Behaviour in the English National Health Service: overview of lessons from a large multi-method study.* West *et al*, 2013. BMJ Quality and Safety, Volume 23, Issue 2. Available from: http://qualitysafety.bmj.com/content/23/2/106.

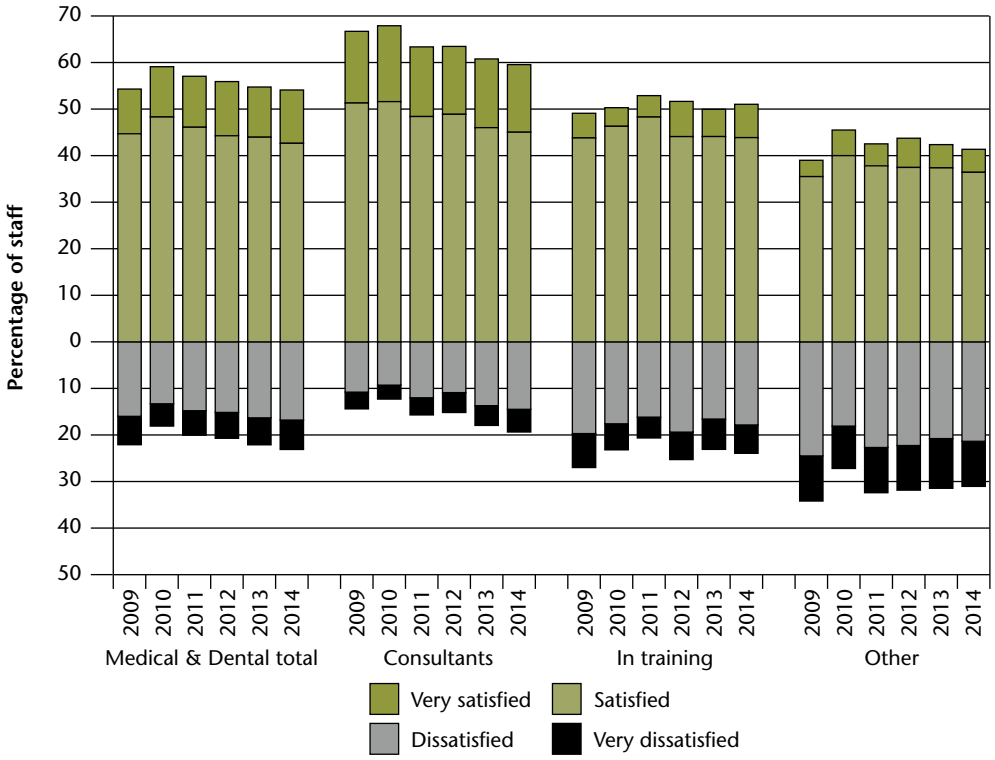
Motivation

2.54 Our terms of reference also require us to have regard to motivation. The results of the latest surveys of NHS staff in England and Scotland were provided to us in evidence. These surveys cover staff working within the hospital sector and as this spans doctors in training, SAS grades and consultants, we consider this here. We deal with motivation data in relation to GDPs and GMPs in the UK in Chapter 3, and the recent announcement of a review of junior doctors' morale is addressed in Chapter 4.

England

2.55 We examined the results of the latest available NHS Staff Survey in England for 2014, conducted in autumn 2014 for our hospital remit groups with results published in early 2015.[8] The survey had a 42 per cent response rate in 2014, down from 49 per cent in 2013. Figure 2.10 shows that both satisfaction[9] and dissatisfaction[10] with the level of pay were broadly similar to 2013 levels. The biggest change was for consultants, where there had been an increase (from 17.9 per cent to 19.4 per cent) in the percentage dissatisfied[11] with their pay.

Figure 2.10: HCHS staff satisfaction with their level of pay, England, 2009 – 2014



Source: National NHS Staff Survey.

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

[8] The results of the 2015 NHS Staff Survey in England were published on 23 February 2016, the day before we submitted this report. The parties were therefore unable to consider and submit evidence relating to the 2015 NHS Staff Survey in time for this report.

[9] Answering that they were satisfied or very satisfied with their level of pay.

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

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

2.56 Other findings from the survey show that:

- There was little change between 2013 and 2014 in average scores for feelings of work pressure, job satisfaction and staff motivation at work across all medical staff groups.
- For each staff group (except other staff which remained at 2013 levels), the percentage who agreed that they had worked extra hours had decreased between 2013 and 2014 although the level was still high. The percentage of consultants who agreed that they had received job relevant training, learning or development over the last 12 months had increased slightly whilst the percentage of doctors/dentists in training who agreed had decreased slightly.
- The percentage of staff who agreed that they had received an appraisal in the last 12 months increased for all staff groups except doctors/dentists in training (slight decrease). Further, the percentage of staff who agreed to having had a well-structured appraisal also increased for each staff group (although still less than half).
- In 2014 in each staff group the percentage of doctors/dentists who agreed that they were satisfied with the quality of work and patient care they are able to deliver and who agreed that their role makes a difference to patients remained broadly similar to 2013 levels.

2.57 A summary of some of the results from the NHS Staff Survey in England over the period 2009 to 2014 is shown in Table 2.3.

2.58 In its written evidence, the Department of Health said that the staff satisfaction results in the NHS Staff Survey were reasonably high despite the pressures on staff. It highlighted the results of the Friends and Family Test, which showed the extent to which an employee would advocate their Trust as a place to receive care and a place to work, and that their Trust had care of patients as its top priority. It said that whilst the results varied across the service, the overall trend was positive with 62 per cent saying they would recommend their Trust as a place to work (unchanged from 2014-15), and 79 per cent recommending their Trust as a place to receive treatment (up from 76 per cent in 2014-15). During oral evidence, Lord Prior said that the Department was far from complacent on staff engagement, commenting that NHS Staff Survey results were not as high as they should be. He also said that within hospital trusts, he was concerned that morale was affected by bullying, and added to by the lack of progression for Black and Minority Ethnic (BME) doctors. Noting the intrinsic motivation of doctors to deliver the best possible services for patients, the Minister commented on the importance of also being fair to doctors in decisions on their pay.

Table 2.3: Summary results from the National NHS Staff Survey, hospital medical and dental staff, England, 2009 – 2014

Measure	2009	2010	2011	2012	2013	2014	Trend[1]
Workload							
Work pressure felt by staff [2,3]	3.08	3.06	3.10	3.04	3.04	3.04	
% staff working extra hours[2]	75.3	76.8	79.4	83.5	84.3	83.2	
% staff suffering work-related stress in last 12 months[2]	25.0	24.5	23.1	32.0	32.9	32.3	
Training and appraisals							
% staff receiving job-relevant training, learning or development in last 12 months	85.2	84.6	82.5	80.5	80.9	80.9	
% staff appraised in last 12 months	78.0	79.4	81.4	87.7	89.9	91.6	
% staff having well-structured appraisals in last 12 months	31.6	34.0	35.2	37.4	43.1	44.0	
Engagement and job satisfaction							
Support from immediate managers[3]	3.55	3.56	3.61	3.57	3.62	3.65	
% staff reporting good communication between senior management and staff	27.8	31.9	34.1	30.2	34.6	36.9	
% staff able to contribute towards improvements at work	63.7	66.1	67.4	70.1	72.4	72.0	
Staff recommendation of the Trust as a place to work or receive treatment[3]	3.51	3.53	3.51	3.61	3.73	3.75	
Staff motivation at work[3]	3.97	3.94	3.94	3.95	3.99	3.99	
Staff job satisfaction[3]	3.57	3.59	3.64	3.67	3.71	3.72	
Harassment, bullying and abuse							
% staff personally experiencing harassment, bullying or abuse at work in the last 12 months from…							
Patients/service users, their relatives or other members of the public[2]				34.7	32.8	32.1	
Managers/team leader or other colleagues[2]				22.6	21.3	21.5	

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.

Wales

2.59 The Welsh Government did not offer any new evidence on motivation, but referred again to the results of the last Staff Survey carried out for NHS Wales in 2013.

Scotland

2.60 The NHS Scotland Staff Survey took place between August and September 2015: results were published in December 2015.[12] The survey covered all NHS staff, including doctors, and a total of 60,681 staff responded. This represents a 38 per cent response rate and a 3 per cent increase in participation from 2014. The key findings for medical and dental staff included:

- 90 per cent said they were happy to go the 'extra mile' at work when required (a decrease of 1 per cent since 2014);
- 58 per cent would recommend their workplace as a good place to work (a 3 per cent decrease from last year);
- 76 per cent said they still intended to be working with their health board in 12 months' time (down 1 per cent from 2014); and
- 65 per cent were satisfied with the sense of achievement they got from work (down 4 per cent from 2014).

2.61 The key findings for doctors in training included:

- 92 per cent said they were happy to go the 'extra mile' at work when required (no change since 2014);
- 71 per cent would recommend their workplace as a good place to work (down 1 per cent since last year);
- 60 per cent said they still intended to be working with their health board in 12 months' time (down 4 per cent from 2014); and
- 76 per cent were satisfied with the sense of achievement they got from work (down 1 per cent from 2014).

2.62 Table 2.4 below analyses responses to similar questions asked in the staff surveys in Scotland and England.

[12] The *NHSScotland Staff Survey 2015 National report* is available from: http://www.gov.scot/nhsscotlandstaffsurvey2015nationalreport

Table 2.4: Comparison between England (2014) and Scotland (2015) survey results

Country	2014/2015 staff survey wording	In training (%)	Medical / Dental (%)
Scotland:	In the last 12 months, have you had a Knowledge and Skills Framework (KSF) development review, performance review, appraisal, Personal Development Plan meeting or equivalent?	91	89
England:	Percentage of staff appraised in last 12 months	82	92
Scotland:	I get the help and support I need from colleagues	89	83
England:	The support I get from my work colleagues	86	84
Scotland:	I can meet all the conflicting demands on my time at work	51	34
England:	I am unable to meet all the conflicting demands on my time at work (for comparison, this is the level of disagreement)	32	28
Scotland:	There are enough staff for me to do my job properly	47	25
England:	There are enough staff at my place of work for me to do my job properly	46	34
Scotland:	I am able to do my job to a standard I am personally pleased with	76	63
England:	Staff feeling satisfied with the quality of work and patient care they are able to deliver	84	81
Scotland:	I would recommend my workplace as a good place to work	71	58
England:	Staff recommendation of the trust as a place to work or receive treatment (an average score between 1 and 5 was then scaled to 100%)	76	75
Scotland:	I have a choice in deciding what I do at work	31	41
England:	The freedom I have to choose my own method of working	59	66

Source: National NHS Staff Surveys (England 2014 and Scotland 2015)

2.63 The BMA told us that in the Scottish Government's analysis of the outcome of the staff survey, it had underplayed the need for improvement. The BMA said that the survey showed significant discontent across all doctors on lack of involvement in decision making.

Northern Ireland

2.64 The Northern Ireland Executive said that the Health and Social Care Staff Survey reports were currently being finalised, so was unable to share the results with us at the time of writing.

2.65 Commenting in general on the UK, the BMA hypothesised that increased locum use was due to pay restraint on permanent staff and a deteriorating work-life balance. During oral evidence, it argued that years of below-inflation pay increases had an impact on doctors, making them feel under-valued. It suggested that this had given rise to a perfect storm of unrest, noting the recent junior doctors' industrial action. Commenting on the proposal

for targeting of our pay recommendations, the BDA said that targeting a group to receive less than 1 per cent following years of pay restraint would have a crushing effect on morale and retention. We address targeting in Chapter 5 of this report.

Our comments

2.66 We note the decreasing survey response rate which may mean that results are less representative of the population as a whole. The English Staff Survey data predates the current difficulties with industrial relations. We will wish to monitor closely the results by staff group in future rounds. From the evidence we have, workload pressure is evident, and we note the comparison between the medical and dental workforce in hospitals in England and Scotland in Table 2.4. In Scotland, only 34 per cent said that they felt able to meet all the conflicting demands on their time at work, whilst in England 48 per cent said they were unable to meet all the conflicting demands on their time, with only 28 per cent disagreeing. Just under a third of hospital grades in England report suffering from work-related stress, a situation unchanged in comparison to the previous three years of the survey. Over 80 per cent report working extra hours, again broadly unchanged since 2011. We note that nearly 20 per cent of consultants in England say that they are dissatisfied with their pay, an increase on the previous year. We also note that in England, 21.5 per cent of our HCHS remit groups report bullying by managers, team leaders or other colleagues.

2.67 The 2014 staff survey results in relation to appraisals, training and staff motivation at work in England are on a positive upwards trend although we will monitor the evidence closely for any signs of change. We note again that numbers having well-structured appraisals are low which causes us concern. The findings are less positive in Scotland and we note the decrease in those satisfied with the sense of achievement they got from work between 2014 and 2015. We do not have staff survey data for equivalent groups in Wales since 2013. Overall, the evidence on motivation shows signs of problems, particularly in Scotland, but also workload pressures in England which show no clear sign of abating. As highlighted in the preceding section on 'patients at the heart', the intrinsic motivation of our remit groups remains fundamental to the provision of patient care. We link this to the remarks made in oral evidence about the need for our remit groups to be treated fairly.

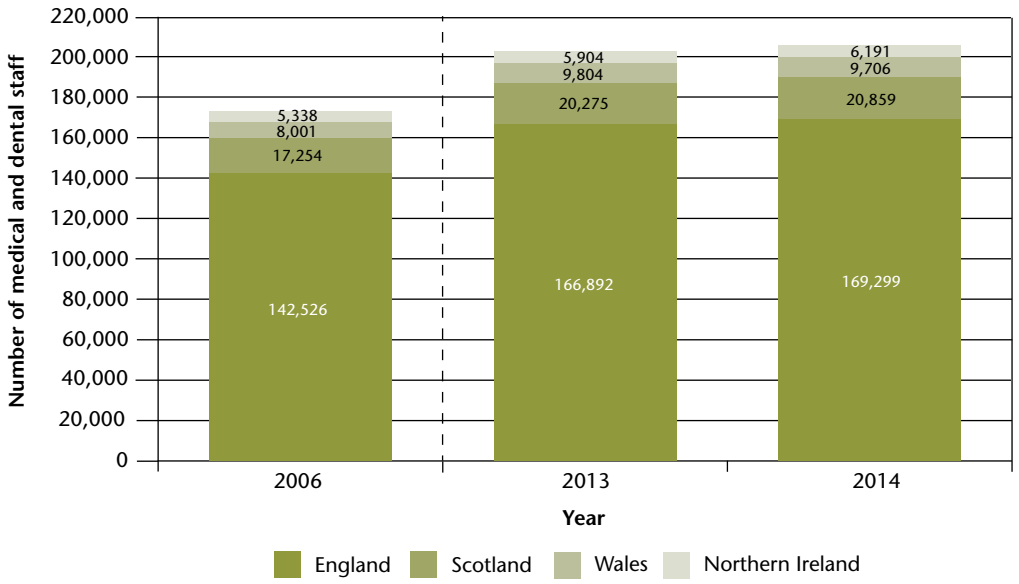
2.68 We deal with the motivation of GMPs and GDPs in Chapter 3 and discuss this in relation to all groups in Chapter 5 in consideration of our pay recommendations.

2.69 We pick up anecdotal comments on the state of motivation during our visit programme. We comment on the issues raised from this year's visits in Chapter 1.

Recruitment and retention

2.70 Our terms of reference require us to have regard to the need to recruit and retain doctors and dentists. This section describes the general recruitment and retention picture based on the latest available data; issues specific to remit groups are covered in Chapters 3 and 4. Figure 2.11 below shows the number of medical and dental staff in each country. Our remit groups comprised approximately 206,100 in September 2014, a 1.6 per cent increase on the previous year, although Wales had a small decline in numbers.

Figure 2.11: Total number of medical and dental staff[1], United Kingdom, 2006 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, 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.

England

2.71 The Department of Health said that it was committed to a self-sustaining workforce and a reduction in the demand for migrant labour. Whilst the Department was able to make use of the Shortage Occupation List (SOL) when there was a shortage in the UK and European Economic Area for certain occupations, it said that it was committed to a reduction in the number of professions on the SOL each year. At present, it said that there were 19 roles on the list including doctors and consultants specialising in emergency medicine and clinical radiology.

2.72 NHS Employers told us that 52 per cent of the respondents to its survey (that formed the basis of its evidence submission) often relied on locums. Reasons given for locum use were: shortages and general recruitment and retention issues; gaps in training, fill rates, rota gaps and national shortages; variations in workload and acuity; and sickness, annual and maternity leave. They noted that a consultation was underway on introducing price caps so that trusts were not permitted to pay more than 55 per cent above national rates for locums. NHS Employers said that recruitment and retention remained generally good except in areas of known labour market shortages, but that such shortages mostly could not be addressed simply by higher pay levels, but needed adjustments over time to training commissions. Health Education England told us that in their view there were signs that junior doctors were starting to choose location over specialty.

2.73 The BMA referred to a small survey of 43 Human Resource Directors by the Smith Institute that showed 63 per cent of respondents being 'unsure' if they had enough staff to meet demand, with 85 per cent finding recruitment 'very or fairly difficult' (although these survey results related to the entire NHS workforce, rather than being specific to our remit groups). It said that around two-thirds of respondents felt that the NHS "pay squeeze" had 'some or significant impact' on recruitment and retention, was

bad for morale, and would increasingly impact on the future ability to recruit and retain staff. The BMA said that it shared our concerns around the lack of data on recruitment, retention and workload. It noted that data on job advertisements was being used as a proxy for vacancies in England, which it welcomed as a baseline to allow it to make more evidenced comments about recruitment in the future, but said that this was not a comprehensive vacancy measure. The BMA said that it believed that the pay policy in England would lead to further and significant problems of recruitment and retention on top of those already experienced in many specialties and locations.

Wales

2.74 The Welsh Government said that over the last seven years, NHS Wales' total workforce numbers had remained relatively stable, with the largest increase in staffing numbers being for consultants (at 19.3 per cent). It said that agency and locum costs in Wales continued to increase, but saw this as no different to the rest of the UK. It acknowledged that the use of agency staff provided an essential means of increasing staffing levels to manage short term peaks in demand to maintain the quality of patient care. During oral evidence, BMA Wales said that pay for doctors working in Wales needed to align with that in England in order to support recruitment and retention.

Scotland

2.75 The Scottish Government said that although it was committed to no compulsory redundancies, it was right for Boards to look critically at service delivery at a time of tightening public sector budgets. It said that Boards could recruit using both the UK-wide and Scotland-only Shortage Occupation Lists, noting that psychiatry, anaesthetics and paediatrics were Scotland only. It also described recruitment initiatives it had conducted in the Netherlands and Spain. During oral evidence, BMA Scotland suggested that location and specialty were both important in terms of recruitment.

Northern Ireland

2.76 The BMA said that in Northern Ireland, the overall medical FTE vacancy rate was 5.3 per cent of which over 60 per cent were long-term vacancies. In oral evidence, BMA Northern Ireland said that whilst Northern Ireland had tended to fill vacancies internally, it was now seeing greater transfer of doctors across the UK.

2.77 In relation to the UK as a whole, the BMA said that it had lobbied the Migration Advisory Committee (MAC) to add GMPs to the shortage occupation list, but it had not been successful, making it harder still to recruit non-EU doctors to general practice. Indeed, the MAC's Annual Report 2014-15 noted that the Department of Health had also asked that GMPs be added to the shortage list but the MAC did not see any evidence suggesting that there was a shortage of medical students who could continue into general practice. Therefore, the MAC considered that any shortage of GMPs could potentially be overcome by changing the incentive structure of GMPs compared with other medical roles, in order to encourage more take-up on GMP training programmes. Overall, the MAC considered that more should be done to recruit GMPs from within existing routes.

Workforce data

England

2.78 The Department of Health said that it was working with the Health and Social Care Information Centre, Health Education England (HEE) and others to improve the evidence base. It said that it expected the publication of such information to provide more meaningful information on vacancies by occupation group and by region across primary

and secondary care. It also described other data, such as the Workforce Minimum Data Set to be collected from all providers of NHS funded care, to include tables on turnover, staff movements, reasons for leaving and information on absences and vacancies for staff working in the hospital sector and in general practice.

Wales

2.79 The Welsh Government was unable to provide the latest vacancy rate for consultants. It said that it was working with NHS Wales to agree a simple definition of an active vacancy as well as a mechanism for reporting this regularly as part of a wider dashboard of indicators from the next financial year.

Scotland

2.80 The Scottish Government said that it was collecting evidence about vacancies and fill rates through the National Primary Care Workforce Survey. It also said a Short Life Working Group had been set up to consider how to improve the recording and reporting of vacancy details by NHS Boards.

Workforce planning

England

2.81 HEE told us that it had now established a workforce planning process that brought together in one place decisions on: planning the future medical (and non-medical) workforce; investment in training/education of existing staff; local needs and national priorities; and national workforce priorities alongside wider system/strategic goals. It said that its Second Workforce Plan for England had been published in December 2014 and included 13 local plans, shaped to form a national plan. Work was now underway to understand the workforce implications of the *Five Year Forward View*.

Wales

2.82 The Welsh Government said that a robust understanding of the staff needed to deliver high quality care was essential in making sure that patients could access services and that organisations matched their funding to priorities. It said that responsibility for planning the appropriate workforce sat with local health boards.

Scotland

2.83 The Scottish Government said that its 2020 Workforce Vision committed to flexible approaches to workforce planning to deliver the right people at the right time and in the right place. It said that it was for Health Boards to plan workforces according to local needs and circumstances, but at the national level to gather information and intelligence to support Ministers in a strategic workforce agenda for NHSScotland. The Scottish Government had a role in determining intake numbers to medicine and dentistry and numbers at some points of the medical supply chain beyond undergraduate education.

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

2.84 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. NHS Employers said that the Cities and Local Government Devolution Bill would allow the devolution of powers to cities and counties. They said that it was not yet clear what the implications would be for the NHS workforce in England, but supported the view that

there needed to be more scope in national agreements for employers to tailor packages to meet local needs. They said that this could mean that in future, pay and condition changes in both the NHS and local government in England might need to be considered together. We ask the parties to keep us in touch with developments.

2.85 As last year, the BMA asked us to address the issue of London weighting as part of our considerations this year. It noted the very significant house price/rental and travel cost inflation in London. It did not agree with our view that London weighting was a recruitment and retention premia issue, rather that it was to address the disproportionate costs of living in London.

Our comments

2.86 We note that any increase in the workforce increases the potential for a better work-life balance for our remit groups, which we support. The 2015 OECD Health Statistics publication says that 28.7 per cent of UK doctors were foreign-trained (above the OECD average of 17.3 per cent but in line with other English-speaking countries). Migration of doctors is a phenomenon that affects all OECD countries. Whilst we do not see any sign of the UK's historical reliance upon overseas doctors reducing, we note the aspiration of the Department of Health for England to become self-sufficient and the recent publication of Health Education England's third workforce plan in December 2015. That report noted that HEE was considering the part played in delivering services by SAS and trust grade doctors as well as doctors in training. HEE said that only by openly and explicitly acknowledging the whole medical workforce and their supporting multi-professional teams would it be able to make sensible decisions on the levels of structured post-graduate medical education to commission for future consultant and GMP supply.

2.87 In the shorter term however, we note that there is an increasing reliance on locum doctors.

2.88 Our previous reports have set out our view that, as we regard London weighting as a recruitment and retention premia issue, rather than one of cost compensation, we did not intend to revisit our earlier decision that London weighting levels should remain at their existing levels, unless the parties are able to provide evidence to show that labour market conditions in London had changed. The BMA did not offer any such evidence and we therefore believe that our earlier recommendation on London weighting should stand.

2.89 Specific recruitment and retention issues are examined in Chapters 3 and 4, and Chapter 5 draws upon all of the evidence in relation to the targeting aspect of our remit this year. We ask the parties to provide evidence on the extent to which they consider pay to be a relevant factor in any recruitment or retention issues. We also note the current developments on workforce data in Chapter 6.

Legal obligations on the NHS including anti-discrimination legislation

2.90 Finally, 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.

England

2.91 The Advisory Committee on Clinical Excellence Awards (ACCEA) told us that its analysis of application rates for Clinical Excellence Awards (CEAs) showed that women were less likely to apply. It said that the distribution of awards by ethnicity reflected the findings of gender distribution, with Black and Minority Ethnic (BME) awards more heavily weighted at the lower levels of awards. ACCEA said that it was not in a position to provide a

robust explanation for the disappointing data on gender, where progress towards more proportionate recognition seemed to have been reversed, or for the continuing failure to see improvements in relation to BME consultants. It described action taken by ACCEA to try and address the problem, including making presentations to specific groups to encourage applications, open competition for award committees and training for new and existing members.

2.92 During oral evidence with the Department of Health, Lord Prior also highlighted his concern about the lack of progression for BME doctors.

Wales

2.93 The Welsh Government told us that the seniority payment scheme for GDPs remained available, subject to qualifying conditions, to both new applicants and existing recipients in Wales. During oral evidence, Welsh Government officials said that the seniority scheme for GDPs in Wales was being reviewed, but that any amendments to current arrangements would need to wait until contractual changes were made. They said that they were concerned that changing the scheme might impact retention.

Scotland

2.94 The Scottish Advisory Committee on Distinction Awards did not provide us with any evidence this year.

Our comments

2.95 We thank ACCEA for its evidence on the CEA scheme and for the information on the action it has taken to try and address the under-representation of both women and BME holders of awards. Given that action, we are content to continue to recommend on the value of CEAs. In relation to the seniority payment scheme in Wales, we commented last year that such schemes could be a concern as 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. We ask the parties to keep us informed on any discriminatory issues that might arise from the pay structures on which we recommend. For our next round, we ask ACCEA and SACDA to provide evidence on the extent that the award schemes are operating without discrimination. We also ask the parties to submit relevant evidence to us to highlight any concerns about progression for BME doctors, noting that the operation of pay structures is for employers.

2.96 We are also interested in the views of the parties in all countries as to whether the current length of the pay scales might be age discriminatory: and if so, how they intend to address the issue, perhaps as part of the current contract reform negotiations.

CHAPTER 3: PRIMARY CARE DOCTORS AND DENTISTS

GENERAL MEDICAL PRACTITIONERS

Introduction

3.1 This section considers issues relating to general medical practice. It notes that: there are plans underway to increase the number of general medical practitioners (GMPs); workload is affecting motivation; and there are new models of care and changes in skill mix within practices. It also gives our view on the GMP trainers' grant, the rate for GMP appraisers and the GMP specialty registrar supplement.

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 56 per cent of GMP practices. Doctors working under PMS, Section 17C arrangements, APMS or PCTMS contract locally with primary care organisations (PCOs).

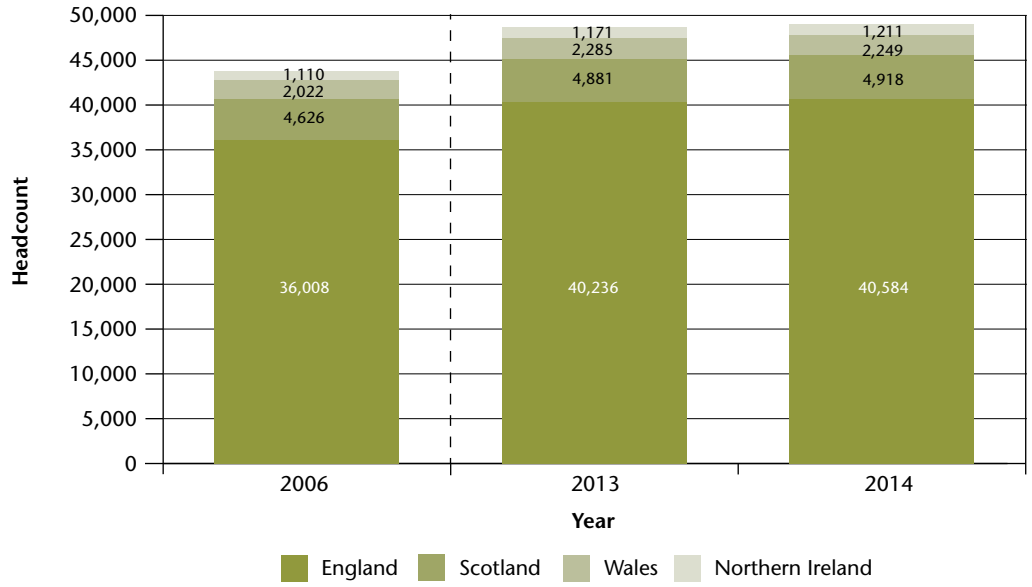
3.3 Most doctors working in practices that hold GMS contracts are independent contractors – self-employed people running their own practices as small businesses, usually in partnership with other GMPs and sometimes others such as practice nurses or managers; some practices belong to sole practitioners and some to companies which employ salaried doctors to staff them. Our previous report noted that 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.

Recruitment and retention

3.4 There were 48,962 (headcount) GMPs in the UK in September[1] 2014; an increase of 0.8 per cent compared to the same period in 2013 (Figure 3.1). Within these in Great Britain, the number of GMP specialty registrars (Figure 3.2) increased by 1.9 per cent.

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

Figure 3.1: Number of general medical practitioners, United Kingdom, 2006 and 2013 – 2014

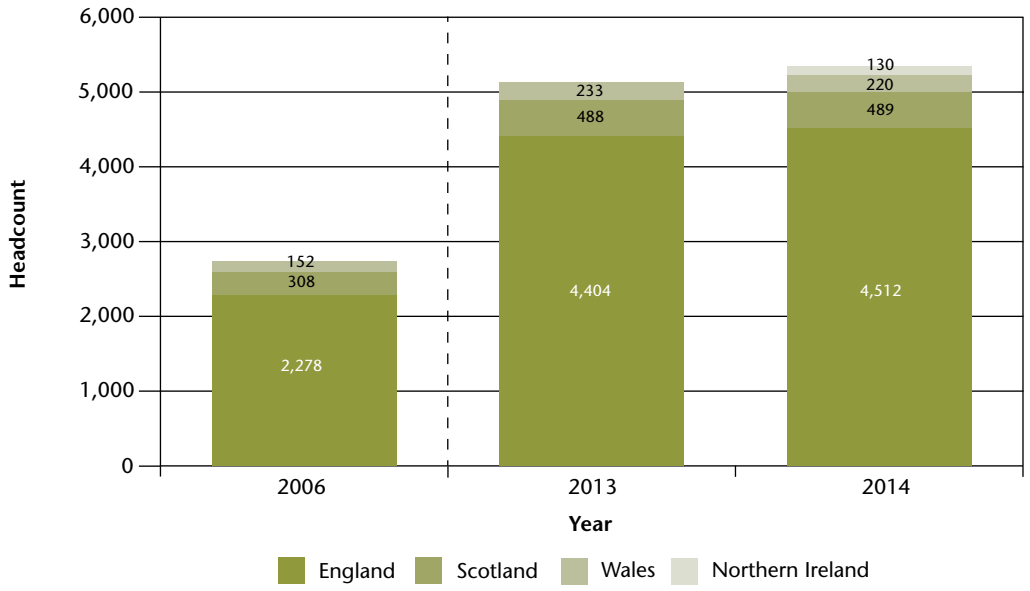


Sources: The Health & Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety.

United Kingdom

3.5 We have noted the *F2 Career Destination Report 2015* by The UK Foundation Programme Office. The report noted a wide variation in the percentage of survey respondents from different UK foundation schools that went on to GMP training: from 10.8 per cent in North West Thames; to 30.8 per cent in Leicestershire, Northamptonshire and Rutland.

Figure 3.2: Number of general practice specialty registrars, United Kingdom,[1] 2006 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.
[1] Northern Ireland only started collecting information on GP trainees from 2014 and therefore these figures are not available in earlier years.

England

3.6 Women account for 49.9 per cent of the GMP workforce in England. Health Education England (HEE) told us that it had been increasing the number of training posts since 2013, with the aim of reaching its target of 3,250 trainees entering GMP training by August 2016. It said that the drop in fill rate to GMP training was a result of the greater number of posts being advertised rather than a significant drop in acceptances. It described other initiatives to improve recruitment: a Return to Practice scheme, a national Induction and Refresher scheme, and GMP specific recruitment events using various communication channels and media. Other initiatives to support 2016 recruitment included: the creation of a twice yearly recruitment exercise for August and February intakes; offering more localised posts to attract applicants where location was important; and offering general practice themed foundation year 2 posts.

3.7 Both NHS England and HEE referred to the 'New Deal' or 'Ten Point Plan' for increasing recruitment and retention in general practice. NHS England told us that it was working with HEE to deliver 5,000 additional GMPs by 2020, with responsibility for achieving 1,000 of these additional GMPs through return to practice and retention initiatives. It said that the Ten Point Plan was introducing carefully targeted measures to address the geographical recruitment and retention challenges in some areas of England, which it felt were better suited to solving the problem than a contract uplift or our recommendations. It said that a targeted bursary scheme, designed to encourage trainees to work in hard-to-recruit areas was planned to be launched in early 2016. In response to a suggestion that we might target our award at aspects of the Ten Point Plan, NHS England said that it did not think that appropriate this year. NHS England acknowledged a lack of vacancy rate data for general practice, but said that from September 2015, the Health and Social Care Information Centre (HSCIC) had started to collect information on vacancies, and that the data would be published in March 2016. We will, of course, be interested to learn of these results.

3.8 The British Medical Association (BMA) referred to a survey by *Pulse* (a publication for GMPs in the UK) that found that 9 per cent of full-time equivalent positions were unfilled, compared to a 6 per cent vacancy rate from the previous year. It said that it was taking longer to recruit partners, with almost one in five roles taking more than a year to fill, compared to one in ten the previous year. It also said that the GP National Recruitment Office showed 632 out of 3,124 training posts in GMP surgeries had not yet been filled. The BMA drew on its on-line Omnibus survey of a broadly representative panel of member doctors, where it asked what factors would make general practice more attractive to medical students: staffing levels and assurances of increased funding were the top ranked responses, with a majority opinion that financial incentives would help with recruitment. It said that schemes to incentivise doctors to undertake GMP training using new funding, such as those being explored through the Ten Point Plan, would be welcome. It said that GMP trainees could be offered additional remuneration, for relocation costs or to cover student loans or to train, in certain parts of the UK.

Wales

3.9 The Welsh Government said that at September 2014, there were 2,006 GMPs in Wales, 20 fewer than the previous year, but 190 more than in 2004. Female practitioners accounted for 48.6 per cent of the workforce; and the number of practitioners aged 55+ had remained steady over the last five years, with around 23 per cent falling into this age band. A primary care workforce plan backed by £4.5 million of new funding included actions to expand the GP retainer scheme, reimbursement of medical school fees when a newly-qualified doctor committed to a career in general practice and a national recruitment campaign to promote the benefits of a career in Wales.

Scotland

3.10 The Scottish Government told us that the GMP workforce was 53 per cent female in 2014, compared to 45 per cent in 2004. It said that £2.5 million had been made available over three years to assist with recruitment and retention, with work underway as to how best to use the funding. In addition, the GMP returners' scheme had been re-launched with ring-fenced funding: the scheme was likely to expand over the next couple of years, depending on demand. The Scottish Government also reported from a survey by NHS Western Isles: of 30 FTE GMP posts, the survey found 7 – 8 FTE vacancies, with 3 posts remaining vacant after 2 or more years. Four further vacancies were anticipated within the next year. In addition, five of the 12 GMPs currently undertaking out-of-hours sessions wanted to stop doing so. Reasons cited by GMPs for wanting to leave included workload, changes to the pension scheme and reaching retirement age. Of the 22 GMPs to respond to the survey, 14 were aged 50+. The Scottish Government also said that GMP training numbers would be increased from 300 to 400 per year, starting next year, increasing the number of GMPs entering the workforce from 2019 onwards.

3.11 The BMA referred to its quarterly vacancy study of GMP practices in Scotland, that found that nearly a quarter of the 588 respondents reporting at least one vacancy, with 43 per cent unable to secure locum cover on at least one occasion in May 2015.

Northern Ireland

3.12 The Northern Ireland Executive said that applications for GMP training posts were always high and that in the latest recruitment round, there were 185 applicants for 6 places. It said that following a review of the GMP workforce in Northern Ireland, in January 2016 the Minister had announced a funding investment to create 20 additional GMP places to 85 a year from 2016-17. It said that a recent review of GMPs who gained a Certificate of Completion of Training (CCT) in Northern Ireland between August 2010 and August 2015 showed that the majority of CCT holders were practising in Northern Ireland.

3.13 The Northern Ireland Executive said that it had the oldest GMP workforce in the UK, with over a quarter of its GMPs aged over 55. Women account for 47.3 per cent of the GMP workforce in Northern Ireland. The Northern Ireland Executive said that it was working with stakeholders to consider options to support recruitment and retention for the workforce.

3.14 The BMA (Northern Ireland) told us that the fill rate for GMP training posts was 100 per cent, but said that this did not mean that there were no recruitment and retention workforce challenges. It said that Northern Ireland had a lower number of GMPs per 100,000 patients than elsewhere in the UK and therefore needed more GMPs trained to meet the workforce gap: it estimated that Northern Ireland required 111 more GMP training places per year, compared to the current 65.

3.15 We have examined fill rate data for GMP trainees: it shows that in 2015, 88 per cent of UK GMP trainee places were filled, although there is some variation by country and region (see Table 3.1 below). Northern Ireland filled all of their places, whilst Scotland filled 79 per cent and Wales 87 per cent. Within Scotland, recruitment was more challenging in the West where the fill rate was just 70 per cent. The overall rate for England was 89 per cent, however the North East (62 per cent) and East Midlands (69 per cent) had low fill rates. The East of England, Kent, Surrey and Sussex, the South West and Thames Valley regions filled 100 per cent of their places with the London fill rate at 99 per cent.

Table 3.1: 2015 Recruitment of General Practice Specialty Training 1 places

	Places	Filled	Fill rate
England	3,117	2,769	89%
Northern Ireland	65	65	100%
Scotland	302	239	79%
Wales	125	109	87%
UK	**3,609**	**3,182**	**88%**

Source: Health Education England.

Our comments

3.16 As noted above, fill rates for GMP training across the UK are between 79 per cent in Scotland, and 100 per cent in Northern Ireland, whilst the 89 per cent fill rate for England masks some low fill rates of 62 per cent in the North East and 69 per cent in the East Midlands. We would be interested in any analysis by the parties of why a greater proportion of trainees in some foundation schools than others choose a career in general practice.

3.17 We commented last year that the fall in average income for GMPs might be a factor influencing the decisions of trainees when deciding whether or not to pursue a career in general practice. That view is borne out by the BMA's Omnibus survey that found increased funding for general practice to be one of the main factors that would influence trainees to look at general practice as an attractive career option. Appendix E gives detail on how GMPs' income net of expenses has changed over the last year, and it continues to follow a downward trend, despite the Health Departments' acceptance of our recommendations that GMPs' income should increase in recent years. We are concerned about this, and it highlights the issues around the operation of the expenses formula, to which we return later in this chapter.

3.18 We note the separately funded initiatives being taken forward in both Scotland and England to address recruitment into general practice. Chapter 5 includes our consideration as to whether our pay recommendations could helpfully target these initiatives.

3.19 We asked NHS England to explain the fall in GMPs' income, and it attributed part of the fall to the decrease in patients per FTE GMP. Given the link between practice funding and capitation payments, we note that plans to increase the number of GMPs, particularly when such expansion might outstrip the growth in patients, could have further negative implications for pay. For future rounds, we would welcome evidence on any pay modelling that the parties may have carried out in order to inform this issue.

Motivation and workload

England

3.20 NHS England reported on the 8th National GP Work Life Survey. It found that on a 7 point scale, overall job satisfaction was at 4.1 in 2015, down from 4.5 in 2012. NHS England suggested that the fall in job satisfaction could be due to workload increases, with an ageing patient population with more complex health needs. Average hours worked had reduced from 41.7 hours per week to 41.4.

Wales

3.21 The Welsh Government said that its primary care workforce plan included strategies to stabilise core sections of the workforce by supporting people who wanted to return to practice or work part-time; explored how training and working in general practice could be encouraged in the areas of greatest need; and communicated the opportunities afforded by general practice in Wales.

Scotland

3.22 The Scottish Government said that it was working in partnership with the BMA to jointly develop practical measures to support the delivery of service. Its recent decision to remove the Quality and Outcomes Framework (QOF) was seen to be positive by the BMA, reducing workload and bureaucracy. The Blueprint for General Practice, produced by the Royal College of General Practitioners, set out five overarching recommendations to strengthen primary care: 11 per cent of the NHS budget to be invested in general practice; increasing the GMP workforce and additional practice nurses; reducing bureaucracy; allowing time for GMPs to innovate and develop new models of care; and investment in practices.

Northern Ireland

3.23 The Northern Ireland Executive said that a Review Group had been tasked to look at workload, and was undertaking a survey of practices to explore activity trends since the introduction of the GMS contract in 2004. The work would also estimate the volume and growth in practice consultations.

3.24 The BMA offered comments covering the whole of the UK. It said that its 2015 survey of GMPs had received over 15,000 responses, and showed workload to be verging on unmanageable with insufficient funding to address the issue. Less than half of GMPs said they were able to recommend their career path. 93 per cent of respondents felt that their workload had impacted negatively on the quality of care; and 68 per cent reported significant but manageable stress, with 16 per cent reporting unmanageable stress. The survey found that GMPs wanted to provide continuity of care, with increased funding, longer consultation times and a reduction in bureaucracy. The BMA also referred to the

8th National Work Life Survey that found the lowest job satisfaction score since 2001. The BMA said it had been working with the Northern Ireland Executive to look at pressures on GMP workload, and concluded that there needed to be 46 additional GMPs trained each year to meet gaps in the workforce. During oral evidence, the BMA was keen to impress upon us its belief that separate additional investment for practice staff would be welcomed: it did not, however, want such investment to be at the expense of a general contract uplift.

Our comments

3.25 We note the impact that perceived excessive workload is having on motivation and the potential for this to create a negative image of general practice, especially for trainees, which will not help with recruitment and retention. The balance between pay and non-pay factors is not well understood and better information is needed to do so. We also note the findings of the National Audit Office in their recent study of access to general practice in England,[2] which found that the Department of Health and NHS England do not have up-to-date data to estimate the number of consultations and recommended that NHS England improve the data it collects on demand and supply in general practice. Our focus is on the pay of GMPs, although additional practice investment to help with workload is ultimately interlinked with the pay of GMPs, as all funding impacts on the profitability of practices and thus income. This aspect of the GMS contract is however an area for the parties to negotiate on.

Independent contractor general medical practitioners

3.26 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 Primary Care Organisations (PCOs); and QOF payments. The glossary at Appendix D gives further information on aspects of the GMS contract.

3.27 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.

3.28 The annual negotiations on the GMS contract are carried out separately in each country. At the time of writing, the outcome of those negotiations for 2016-17 in **England** had just been announced. The agreement between NHS England and the BMA was for £220 million to be invested in the contract to cover expenses and an intended 1 per cent net pay uplift, an increase in the item-of-service fee for vaccinations and immunisations, and an increase to the value of a QOF point as a result of a Contactor Population Index adjustment. The 1 per cent net pay uplift would be revisited, should we recommend a higher increase for 2016-17. In **Scotland**, a period of stability was agreed until March 2017, with a commitment to address wider issues for a potential new or revised contract for implementation after April 2017, and QOF would be dismantled with transitional quality arrangements put in place for 2016-17. In **Wales**, similar to Scotland, a period of stability was agreed until March 2017. The changes to the contract, in addition to making further reductions in QOF and implementing the second year of the cluster network development programme, also included a commitment to address the sustainability of practices. From 2015-16, £40 million was made available recurrently

[2] National Audit Office, "Stocktake of access to general practice in England", HC 605, Session 2015-16, 27 November 2015

to health boards to support the delivery of the primary care plan for Wales, including £6 million allocated directly to primary care clusters to implement local priorities. In addition, through this new investment, over 40 clinical pharmacists had been recruited to work within primary care clinical teams. At the time of writing, no agreement for **Northern Ireland** for 2016-17 had been announced, although the Northern Ireland Executive did report on a five-year initiative that would see additional investment in 2016-17 of £2.55 million, rising to £14 million per year in 2020-21, to put close to 300 pharmacists in practices by 2021. It said that additional non-recurrent funding of £190,000 for 2015-16 had also been agreed to provide support for GP Federations; and £50,000 non-recurrent funding in 2015-16 to support leadership and management training.

Our comments

3.29 Our consideration of the formula-based approach for determining the pay of independent contractor GMPs appears later in this chapter, in parallel with consideration of the formula-based approach for independent contractor general dental practitioners (GDPs). The pay data that we examine covers all sources of income. The data is income before tax, net of expenses. We also note that from April 2016 in England, practices must publish on their websites the average earnings derived from the GMS contract for GMPs working in the practice.

Salaried GMPs

3.30 NHS England told us that whilst salaried GMP recruitment and retention was a problem in some areas of England, it would not necessarily be influenced or resolved through a contract uplift. The BMA said that salaried GMPs were one of our remit groups and were an important element in determining overall expenses. It said that this supported its belief that we should make gross recommendations on independent contractor GMPs' pay.

Our comments

3.31 We address this point later in this chapter in the section on the formula-based approach, but note here that we only recommend on the bottom and top point of the pay range for salaried GMPs: where individual salaried GMPs are placed within that range, or how they progress within the range, is for local determination. Our recommendation for 2016-17 for the salaried GMP pay range is in Chapter 5.

Changes in skill mix

3.32 The Department of Health said that it was committed to the expansion of the physician associate role within primary care as part of a broader change in skill mix. It said that a physician associate was a healthcare professional who, while not a doctor, worked to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical/practice team, under defined levels of supervision. It said that training to become a physician associate generally required a science-related first degree followed by two years of further training.

3.33 HEE told us that it had commissioned 205 physician associate training posts this year. Their duties included: taking medical histories; performing examinations; diagnosing illnesses; analysing test results; and developing management plans. It said that by 2017, it expected to see real improvements in patient care from having these roles.

3.34 We understand from the Department of Health that central information on the rates of pay for physician associates is not held, but that they should be employed under Agenda for Change terms and conditions. Recent advertisements on NHS Jobs showed salary

ranges on offer between £31,000 and £45,000 with £50,000 being an outlier. It said that whilst these figures indicated similarity with the earnings of junior doctors at various stages of their training, physician associates did not have the same level of lifetime earnings potential as junior doctors.

3.35 The BMA, however, said that physician associates were being recruited on a salary of £50,000, and that this was of significant concern. It said that they were not doctors and did not have the same level of training as doctors, and that to achieve the same level of salary would take a UK trained doctor ten or so years. It asked us to consider the impact on motivation and retention of this development.

Our comments

3.36 The BMA was unable to offer us any evidence to enable us to consider the impact of the salary levels of physician associates on motivation and retention. Given the expansion of this role, we would, of course, be happy to consider such evidence in future rounds. We would also welcome evidence on any other skill mix innovations insofar as they might affect our remit groups, such as the wider use of nurse practitioners or clinical pharmacists.

Clinical Commissioning Groups

3.37 NHS England told us that over 70 per cent of Clinical Commissioning Groups (CCGs) had taken on an increased role in the commissioning of GMP services from April 2015, including 63 that had successfully been delegated commissioning responsibilities. It said that CCGs had greater influence over the way primary care funding was being invested for local populations.

Our comments

3.38 We ask the parties to keep us informed on how the transfer of primary care commissioning to CCGs in England is affecting the income streams and workload of GMPs. We would welcome clarification as to whether or not any such income derived from CCG work would always be shown in practice accounts, and thus in the average income reported by practices in their annual accounts.

Access to GMP services and *Five Year Forward View*

3.39 NHS England said that the Prime Minister's Challenge Fund aimed to improve access to GMP services and offer more convenience, with: more evening and weekend appointments; video, email and telephone consultations; health apps; and more integrated services. 37 'vanguard' pilot schemes were underway involving 1,400 practices covering 10.6 million patients. The Fund was backed by £100 million investment and a further £25.5 million from the Primary Care Infrastructure Fund. A new voluntary seven-day services contract was also being offered to GMPs working in federations covering at least 30,000 patients. NHS England said that subject to our recommendations being accepted for regular GMS contracts, it envisaged seven-day contracts being treated equitably, as currently happened with PMS and APMS contracts. NHS England said that new care models included proposals for new staffing models, with GMPs working alongside consultants.

Our comments

3.40 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, the parties must begin to consider how the pay of GMPs and other parts of the medical workforce would align with those new arrangements. We are alert to how the role of our remit

groups might change, particularly those of salaried doctors including hospital doctors and practice holders in primary care. If appropriate, we would be happy to assist in any way that the parties might find helpful. We would also be interested to learn more about the take-up of the new seven-day services contract in evidence for the next round.

GMP trainers' grant and GMP appraisers

3.41 The BMA brought two issues to our attention: the GMP trainers' grant, which currently stood at £7,751, which it believed should be increased at least in line with the overall contract recommendation; and the GMP appraiser contract, that it said had not been increased from its £500 value since appraisal was introduced in 2004.

3.42 In relation to the GMP trainers' grant, the Department of Health said that it continued to work with the BMA and others to develop a tariff based approach to funding clinical placements in practices for medical students and trainees. It said that during 2015, it had been working with practices to better understand the costs incurred with having medical students and trainees on placement with them.

Our comments

3.43 We note that progress on the development of the new tariff based approach has been very slow: our 2007 report noted the start of work, following an independent review of GMP trainers' pay in 2006. Given the slow progress, we agree with the BMA that the GMP trainers' grant should be uplifted in line with our main pay recommendation for GMPs: both recommendations are contained in Chapter 5.

3.44 NHS England told us North Central and East London had a reappointment process to improve the quality of appraisers. It said that at the standard rate of £500 per appraisal, it offered the opportunity to existing appraisers to go through an assessment centre. NHS England reported that there had been no issues with take up. Further, when new appraisers were recruited there were consistently large numbers of applicants, sufficient for needs. It said that it was not aware of any recruitment problems for GMP appraisers in any area of the country.

Our comments

3.45 On the basis that, in NHS England's view, there are sufficiently large numbers of applicants, we are content for the £500 rate for GMP appraisers to stand, although we will wish to keep the rate under review and would welcome further evidence if the parties consider the rate needs adjusting. Our recommendation is in Chapter 5.

General practice specialty registrars

3.46 NHS England said that it was keen that the level of the GMP specialty registrar supplement (currently 45 per cent) should not cause any disincentives for juniors to train as GMPs. It said that it would like to be able to clearly state to GMP trainees that nobody should be disadvantaged as a result of any changes. HEE told us filling GMP training posts was its highest priority, and it said that recruitment premia were needed for some hard-to-fill locations, but that others including Kent, Surrey and Sussex needed no further incentive. The BMA said that the current supplement was vitally important in maintaining recruitment, and that it would be disastrous for trainee numbers if pay for GMP trainees was not equitable with other speciality trainees.

Our comments

3.47 We note that the future of the supplement formed part of the proposals on the new junior doctors' contract. We are not suggesting any change to the current level of the supplement. Our recommendation is in Chapter 5.

GENERAL DENTAL PRACTITIONERS

Introduction

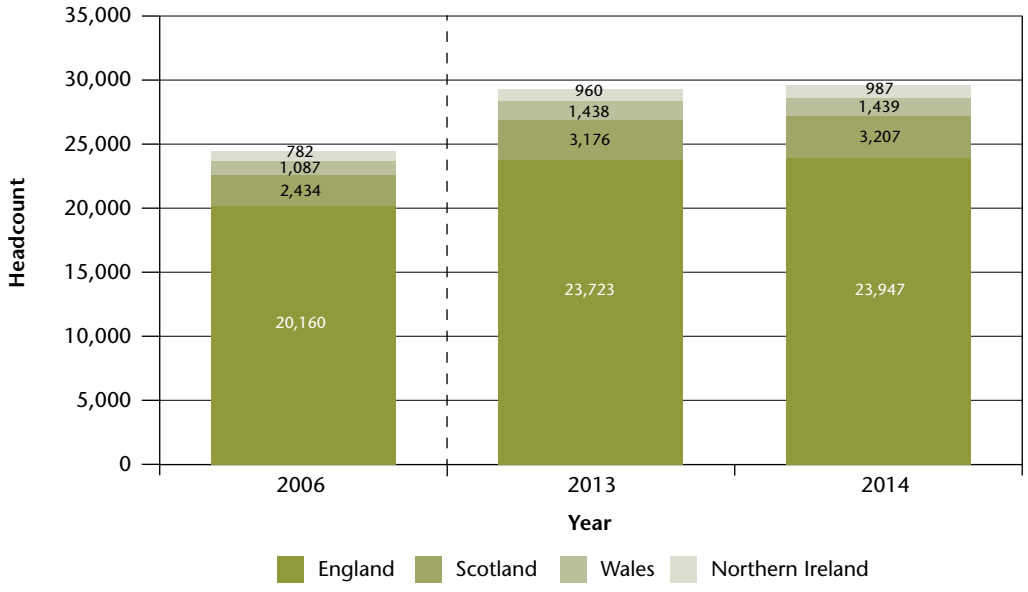
3.48 This section considers issues relating to general dental practice. It notes that: recruitment of GDPs remains healthy; new motivation evidence will provide a helpful benchmark; and contract reform is underway in England and Northern Ireland.

3.49 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

3.50 In 2015,[3] there were 29,580 GDPs (headcount) in the UK, and an annual increase of 1.0 per cent (Figure 3.3). There have been increases in the number of GDPs in all UK countries in the latest year.

Figure 3.3: Number of general dental practitioners, United Kingdom, 2006 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.

[3] As of March 2015 in England and Wales but as of April 2015 in Northern Ireland and September 2014 in Scotland.

England

3.51 NHS England said that there were 23,947 dentists in England in 2014-15, an increase of 224 over the previous year. It said that the number of dentists was a relatively weak indicator of supply: the number of patients and the amount of NHS service was more important, and that both continued to rise. Despite this, it also drew our attention to the Centre for Workforce Intelligence analysis of workforce needs that concluded that all scenarios examined showed an excess of supply over demand/need. NHS England said that recommendations to adjust dental school numbers would be made soon. It said that dentists were ready and enthusiastic to bid for NHS contracts and that 95 per cent of patients seeking NHS appointments in the last three years had been successful.

3.52 In oral evidence, we asked the BDA about the workforce analysis carried out by the Centre for Workforce Intelligence. The BDA said that: the forecasting of workforce was not an exact science, and that there had been dental school closures in earlier years only to be followed by shortages soon after; the cohort of dentists from other EU countries could leave quickly given an upturn in their home country economies; and that with an ageing population still with their own teeth, there could be an increased demand on dental services in the future.

Wales

3.53 The Welsh Government said that 1,439 dentists were providing primary dental care in Wales equating to 4.7 dentists per 10,000 population. It said that Health Boards continued to report little shortage of takers for new or expanded contracts when offered, noting that in general, it took longer to fill posts in the more rural areas of North and West Wales. It said that the last workforce review (in October 2012) had concluded that Wales was likely to have a broad balance between supply and demand in the short and medium term. The Welsh Government said that it was working to realign the ratio of dental undergraduate and Dental Care Professional trainees over the next 2 – 3 years. The BDA noted problems with recruiting associates in Wales, which it suggested was due to the relatively low UDA values in Wales.

Scotland

3.54 The Scottish Government said that there had been a significant increase in the number of GDPs since the Dental Action Plan in 2005, resulting in a decision to reduce the dental student intake from 2013-14. 'Golden hello' payments were available in certain designated areas, and Remote Area Allowances for practices with less than 0.5 people per hectare. Scottish Dental Access Initiative funding was also available for areas with poor general dental services (GDS) availability. It said that vocational dental practitioner numbers remained high and that it was seeing an unprecedented number of dental graduates that it said was likely to continue for the foreseeable future. It told us that a dental bursary of £4,000 per annum is available for graduates committing to Scotland for five years, and that 626 were currently in payment: given the changing workforce landscape, it was reviewing the bursary scheme.

3.55 The BDA offered some general comments on recruitment and retention. It reported on its 2015 Business Trends Survey that found that around 25 per cent of respondents were intending to sell their practices in the next 12 months, and that it showed an average staff turnover rate of 13 per cent. It said that 35 per cent of practice owners intended retiring in the next five years, and that 5.9 per cent of owners and 6.9 per cent of associates wanted to leave dentistry in the next five years and work in a different sector.

Our comments

3.56 Despite the sobering comments emerging from the BDA's 2015 Business Trends Survey, the current overall recruitment picture for dentistry looks healthy. We have noted that in England, there is no shortage of GDPs willing to bid for new dental work. Whilst noting the BDA's comments that workforce planning is something of an inexact science, we have not been provided with any strong evidence to suggest that the Centre for Workforce Intelligence conclusions of an oversupply are unreliable. Practice owners (or providing-performer dentists) determine the pay of associate dentists (or performer-only dentists). We are therefore unable to directly influence the pay of associates in order to try and address recruitment issues, such as those identified by the BDA in Wales. We understand that associate dentists make local arrangements with practice owners for what percentage of UDA values they will earn, typically around 50 per cent. Given the competitive nature for GDS contracts under the commissioning system, we would expect contract values and their associated UDA values – and thus the pay for associates – to find their own level, taking into account the demand for associate dentists.

Motivation and workload

England

3.57 NHS England told us that HSCIC data showed that in 2013-14, average hours worked per week were 36.9, compared to 39.4 in 2000. It said that HSCIC had also collected information on the motivation and morale of dentists: the results showed that performer-only dentists were more motivated and had higher morale than providing-performer dentists. The question 'I feel my pay is fair' produced the lowest result of the motivation questions, with 24.2 per cent of providing-performers responding 'agree' or 'strongly agree', and 29.4 per cent of performer-only dentists. 64.7 per cent of performer-only and 54.4 per cent of providing-performers either 'agreed' or 'strongly agreed' to the question 'I feel good about my job as a dentist'. NHS England said that it was working with the profession to address key issues with the way dentistry was delivered, and that it hoped that the new dental contract being piloted would benefit both dentists and patients by focusing on prevention and outcomes rather than the number of interventions.

Wales

3.58 The Welsh Government said that average total working hours for dentists in Wales was 35.8 hours a week in 2013-14, compared with 37 in England. It said that it remained conscious of the concerns expressed by dentists about certain operational aspects of the contract and perceived increases in administration, and that it was working with the profession to consider new and improved ways of working.

Scotland

3.59 The Scottish Government did not provide us with any specific motivation evidence on dentists, although the BDA did address the issue (below).

Northern Ireland

3.60 The BDA stressed that the decision by Ministers in Northern Ireland to reject our recommendation for an increase in pay of 1 per cent net of expenses had created anxiety amongst dentists, leading to poor morale and motivation for the dental profession in Northern Ireland. It said that this could be addressed in part through remuneration and sought a clear recommendation from us for 2016-17.

3.61 The BDA also reported on the HSCIC analysis of motivation and morale. It noted the average morale results for 2013-14 for all dentists, shown below in Table 3.2. The BDA commented that the lower morale results for practice owners was a cause for concern given the rise in expenses and the falls in income. It said that dentistry was becoming a very difficult profession in which to run a business and deliver high quality healthcare. Commenting on Scotland, the BDA said that the HSCIC report illustrated a direct correlation between low morale and motivation with dentists with higher levels of NHS commitment; and also a correlation between low morale and motivation and those practitioners working longer hours.

Table 3.2: Average morale (%) results,* 2013-14 for all GDPs

Country	Practice owner	Associate
England and Wales	27.2	42.7
Northern Ireland	14.4	25.6
Scotland	22.4	38.5

* percentage of dentists who recorded their morale as 'very high' or 'high'

Our comments

3.62 We welcome the new evidence on the motivation and morale of dentists provided by the HSCIC which we hope will provide a useful benchmark. The results are particularly low for Northern Ireland, and we note that in that country, there was a severe delay in responding to the recommendations in our Forty-Second Report relating to the uplift for 2014-15 (the BDA tells us a delay of 12 months); and the BDA also tells us that for 2015-16, Ministers rejected our recommendation from our Forty-Third Report for an increase in pay net of expenses of 1 per cent. The Northern Ireland Executive's evidence did not address GDPs.

Contractual changes

3.63 The BDA said that contract reform in England had slowly evolved into the prototype stage, with models based on variable blends of UDAs, capitation and quality payments. It said that it remained fully engaged in the reform process but that it thought that including UDAs in the contract was a mistake. The BDA said that widespread change to the contract would not be in place until 2018-19 on current timelines. In Northern Ireland, negotiations towards a new contract were also continuing with pilots in place, but it did not believe new arrangements were imminent.

Our comments

3.64 Given the evidence on the motivation of dentists noted above, particularly in Northern Ireland, it will be important for the parties to continue to work closely with the profession on new contractual developments. We ask the parties to update us for our next review.

SALARIED DENTISTS

Introduction

3.65 This section considers issues relating to salaried dentists in each part of the United Kingdom, noting that only the Scottish Government sought pay recommendations from us last year for salaried dentists. The BDA continues to highlight recruitment difficulties within the salaried services.

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

Recruitment and retention

England and Wales

3.67 The BDA presented evidence based on Freedom of Information requests to 68 community dental services in England and Wales. It reported that vacancies as a percentage of headcount were as follows: Band A (6 per cent); Band B (5 per cent); Band C Clinical (10 per cent); and Band C Managerial (2 per cent). During oral evidence, the BDA said that the Band C Clinical vacancies required specialist skills, so were not open to all existing Band B dentists; this could suggest that increasing the supply of suitably trained staff is the appropriate solution, rather than pay. The BDA said that inability to recruit would lead to the eventual erosion of the workforce, and an increase in stress and pressure on those remaining to a level where retention would become a significant problem. The BDA reported that the majority of dentists working within the Community Dental Services (CDS) had reached the top of their salary scale with no opportunity for progression unless successfully applying for another post. The BDA said that the likely outcome of further reductions in staff numbers was that experienced staff with established skills in treating vulnerable and challenging patients would depart leaving services bereft of clinical leaders to effect service changes.

3.68 On the other hand, NHS Employers reported that in England only a small number of employers were reporting recruitment difficulties, but they were working to improve their intelligence on salaried dentists (or community dentists) with the BDA through a renewed joint negotiating committee. The Department of Health told us that NHS England was conducting a review of all salaried dental contracts to ensure that provision was mapped against local need. It said that it was not aware of any specific difficulties in filling vacancies.

3.69 The Welsh Government reported that there were 164 (103.5 FTE) dentists working in the CDS in Wales. This was a decrease of 4 (2.9 FTE) over the previous year. It said that the CDS provided dentistry to vulnerable people in Wales and also delivered health promotion programmes including the Welsh Government's *Designed to Smile* child dental health improvement scheme.

Scotland

3.70 The BDA reported that in Scotland there had been changes to the Public Dental Services (PDS), with restructuring of services, reduction in sites and downsizing of staffing. As a result, it said that recruitment has been challenging, with posts in many areas designed on the basis of one year appointments. An ageing workforce profile and lack of specialist training (including Special Care Dentistry) had potential, it believed, to lead to a workforce skills crisis, thus impacting recruitment and retention.

3.71 The Scottish Government reported that information recently provided from clinical directors of the Public Dental Service was that there were no recruitment and retention problems within the service; indeed they quoted the clinical lead from one of the island boards saying that: '*Recruitment has been much easier in recent times; previously we would have no suitable applicants for jobs, that is no longer the case'.*

3.72 The Scottish Government said that fixed term contracts (an issue raised by the BDA) were not used routinely within NHS Scotland; they were used only during periods of known organisational change: as Scottish NHS Boards were working through the rebalancing of the PDS:GDS clinical provision they were then requesting fixed-term posts to give them flexibility of manoeuvre.

3.73 The Scottish Government said that the main specialties within the Scottish Public Dental Service were paediatric dentistry (of which it believed there was adequate training provision) and special care dentistry (SCD). It said that many of those on the SCD specialist list were 'grandparented' onto the list through past experience and not all of them were currently working as specialists. The Scottish Government said that it would work in partnership with the PDS and NHS Education for Scotland to look at the SCD workforce requirements and any training pathways to deliver such a workforce.

Motivation and workload

England and Wales

3.74 The BDA quoted evidence from its survey provided in last year's submission that reported around 39 per cent of community dentists experiencing high levels of job stress compared with just 15 per cent of British workers in general, and suggested that it had worsened since due to regulation and service change, adding to an already fraught environment. However, it said that loyalty to the CDS remained high. The BDA said it did not conduct research into morale and motivation this year, but that it intended to do so again in 2016.

General Dental Council Annual Retention Fee

3.75 The BDA reported the increase in the contractually necessary Annual Retention Fee by the General Dental Council from £576 to £890. It said that for the majority of staff in England and Wales (at the top of their scales), there was no increment to help absorb this increase.

New contractual arrangements

England

3.76 The BDA reported working with the Department of Health to develop a new contract for the CDS in England. It said that any new contract might have the same potential effect for the CDS workforce as for general practice: increased use of skill mix and increasing costs.

Northern Ireland

3.77 The BDA reported that negotiations for a new contract for CDS dentists in Northern Ireland had stalled. It said that it had been informed in October 2015 that the additional resources and funding required to implement a new contract was not available. The BDA said that community dentists were frustrated that after five years of attempting to modernise their terms and conditions to align with the rest of the UK, they were still waiting for a new contract. The BDA was concerned that any future delay would see Northern Ireland fall further behind the rest of the UK which could lead to further problems of recruitment, retention, and morale of community dentists.

Our comments

3.78 We acknowledge that the general picture on recruitment and retention of salaried dentists is positive but we note the apparent lack of progress in Northern Ireland towards a new contract. The BDA is intending to carry out new research into the morale of salaried dentists, and we look forward to receiving it for our next round, particularly on how it is changing over time. We will also wish to be updated on how contractual reform is being taken forward.

FORMULA-BASED APPROACH TO THE UPLIFT FOR INDEPENDENT CONTRACT GMPS AND GDPS

3.79 Our recent reports have rehearsed in great detail our ongoing concerns with the formula-based approach to the uplifts for independent contractor GMPs and GDPs. Our concerns include:

- 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, given the current model where pay is an embedded element of a wider contract for services.

3.80 As a result, we took the decision last year to abandon the use of the formula, and to instead make recommendations on our intended increase in *pay net of expenses*. It was therefore incumbent on the parties to discuss expenses in order for them to ascertain what gross increase was necessary in order to deliver our recommended increase in pay (assuming that the Health Departments accepted our recommendation). We did not rule out returning to a formula-based approach to the uplifts, should the data picture improve.

Developments since our last report

3.81 Last year's report recommended an increase in pay of 1 per cent net of expenses for both GMPs and GDPs. We were also mindful of the short time following the submission of last year's report for discussion between the parties on an alternative method for considering expenses, so we included a list of the data that would have populated the coefficients in the formula, had we chosen to use it.

3.82 We understand that in England and Wales, the Health Departments used the formula approach for calculating the uplift for both GMPs and GDPs, but for the coefficient representing staff costs the figures from the Annual Survey of Hours and Earnings (ASHE) were replaced by 1 per cent because this was the government's target figure for the public sector pay increases. The Scottish Government also used the formulae, but used Scotland specific data, and did include the ASHE data for the calculation. At the time of writing, the Northern Ireland Executive had not confirmed the approach taken for 2015-16. The BDA and BMA both explained to us that they did not feel involved in the use of the formulae, feeling that they were imposed rather than negotiated. They both suggested that we should be part of a 'tripartite' approach to expenses discussions. All parties expressed their desire for us to remain involved in the formulae, citing the value of our independent view giving the parties a common starting point for discussions.

3.83 In this year's evidence, the Scottish Government empathised with our viewpoint that led to us to abandon the formula. In relation to GDPs, it noted that the annual report on the earnings and expenses of independent contractor GDPs from the HSCIC had a

number of material problems that made it problematic as a source of information for the formula. The Scottish Government felt it would be more appropriate to have dedicated information from practices that were predominantly NHS and had therefore contracted for a professional corporate financial advisory firm to survey dental practices for earnings and expenses information. Unfortunately, the survey resulted in only 7 practices agreeing to provide information. The Scottish Government concluded that there was little prospect of better engagement in the future without a substantial redesign of how to get the required information.

3.84 The BDA said that our abandonment of the formula was a major disappointment. It said that it believed the HSCIC data to be robust for the weighting in the formula, and thought that we added value by providing a clear statement of how much dental fees and contract values should change each year. The BMA accepted and agreed that the formula to determine the gross earnings uplift was not fit for purpose. However, it said that its preference was for some kind of national formula, and it believed that a crude 'rule of thumb', coupled with consideration of one-off pressures, made it possible to recommend a gross earnings increase. It said that as staffing expenses included salaried GMPs, it made it very difficult to agree an overall expenses uplift without knowing our recommendation for this group.

Our approach for 2016-17

3.85 In the case of contractor GMPs and GDPs we are recommending within a complex contractual environment. Although pay is a significant cost, it is not covered specifically in these contracts. We would like to be as helpful as we feel we can be, given our desire for our recommendations to be evidence-based and likely to deliver the intended uplifts if implemented. We are extremely grateful to the Scottish Government for its attempts to obtain practice account data for GDPs. In oral evidence, the BDA suggested that the poor response rate to the survey may have been due to its very detailed nature. This sounds like a problem that could be addressed through a simpler approach. However, for this year we find ourselves no further forward in getting a more robust data set to support a formula-based approach for GMPs or GDPs. In these circumstances, we have concluded that this year we should again make a recommendation on pay net of expenses.

3.86 As last year, we note that the timing of our report submission does not allow the parties much time for deliberation on expenses. We are therefore again including (at Appendix E) the latest data that would have populated the formulae for both GMPs and GDPs, had we used the formulae-based approach. It is for the parties to decide whether to use a formula and what elements they put into it. However, we observe that it would be inconsistent with any formula approach if one of its elements was arbitrarily changed because it appeared to give the "wrong" answer. We see no objective justification for a Health Department to have substituted their own preferred 1 per cent figure for the actual ASHE data while claiming to operate the formula last year; such an approach is not operating the formula.

3.87 From the next pay round, we suggest that the parties discuss expenses to an earlier timetable using the indices at Appendix E and our recommendations as a common starting point, or perhaps through 'open book accounting'[4] to establish an agreed baseline and approach. Ideally, we would like the parties to reach an agreed position on expenses when they come to us in evidence: our recommendations on pay would then supplement such an agreement. In response to the calls by the BDA and BMA for us to be part of a 'tripartite' approach to these expenses discussions, if the parties are unable to reach an agreement on expenses, then we would be open to arbitrating, where appropriate. In order for us to arbitrate, the parties would have to provide us with firm

[4] See for example *Open Book Accounting: How to Deliver and Demonstrate Value for Money in the Public Sector*. Chartered Institute for Public Finance and Accountancy, 2013.

propositions and improved evidence, so that we can choose between the propositions presented. Otherwise the situation will be no different than before and we would reserve the right to refuse.

3.88 The BMA has said that because salaried GMPs are one of our remit groups, it is difficult to agree an overall expenses uplift without knowing our recommendation for this group. As noted earlier, we only recommend on a minimum pay range for salaried GMPs: where GMPs are placed within (or indeed, above) that range, and how they progress through the range, is for local determination. Our recommendations are one of many influences on the pay of individual salaried GMPs; and we do not think that this should form an insurmountable barrier to the parties being able to discuss expenses. Indeed, if the negotiation has reached the point where it is simply awaiting our recommendations, then there is still enough time for these to be applied in time for the 1 April contract start-date.

Expenses information

3.89 In evidence for this round, we asked the parties to indicate what they felt were the main unavoidable non-reimbursed cost drivers facing NHS practices, in order of magnitude. The response from the BDA is set out below in Table 3.3.

Table 3.3: BDA cost driver information

BDA list of costs drivers, in order of magnitude
Staff costs (dental nurses, receptionists, practice managers, hygienists, therapists)
Mortgage/rent costs (except in Scotland)
Infection control and decontamination costs
Laboratory, materials and consumables; costs of regulation (including indemnity costs)
Costs of regulation
Utility costs
IT software and maintenance costs
Equipment and equipment maintenance

3.90 The BMA said that it was not possible to rank cost drivers due to the lack of detail; and in any case, it questioned whether it would be the same expenses that created pressures each year. Table 3.4 presents the costs it felt were creating pressures this year and last.

Table 3.4: BMA costs pressure information

Key cost pressures in 2015	Key cost pressures in 2014
Medical indemnity costs	Postage
National insurance contributions	Electricity and gas

3.91 We ask the parties to take this information into account in deliberations on expenses, and report back to us for our next review. We note that in England, agreement was reached in February 2016 between NHS England and the BMA on a contract uplift for 2016-17 that also took into account the rise in practice expenses. We welcome this development. For our part, whilst this year we have concluded that we should again make recommendations on pay net of expenses for both GMPs and GDPs, we intend giving further thought as to whether an alternative approach might be of benefit. We also

observe that the parties in all four UK countries have the option to make the provision of expenses data a mandatory requirement of new GMP and GDP contracts and return to this in Chapter 5.

3.92 The Scottish Government has asked us to consider how expenses information for GDPs might be provided in the future, given the disappointing response from GDPs to its recent survey on practice expenses. We believe that the Scottish Government is in a better position to consider this and that they are able to obtain support of survey design and best practice from statistical colleagues or the Office for National Statistics survey specialists. It might be useful if the survey design and information needed to be collected could be discussed and agreed by all the parties (to include OME and the BMA/BDA) and then a targeted, shorter survey (leading to a higher response rate) could be run. It could be cost effective for all four countries to commission this jointly, using a sampling approach, and OME would be happy to advise. Ultimately, we consider the onus should be on the parties to resolve the issue of expenses.

3.93 Appendix E in this report gives detailed information on the earnings and expenses of GMPs and GDPs, as reported by the HSCIC that the parties might find helpful in their discussions on the uplift. Our recommendation on the uplift for both GMPs and GDPs is in Chapter 5.

CHAPTER 4: HOSPITAL DOCTORS AND DENTISTS

4.1 Our report *Contract reform for consultants and doctors & dentists in training – supporting healthcare services seven days a week*[1] was published in July 2015. Contract reform negotiations continue to form a backdrop to our pay considerations of several of our salaried remit groups. Our remit this year is for pay recommendations for those on existing contracts.

4.2 This chapter examines the issues specific to hospital doctors and dentists. The motivation data in Chapter 2 provides important context to this.

DOCTORS AND DENTISTS IN HOSPITAL TRAINING

Introduction

4.3 In this section we consider issues relating to doctors and dentists in hospital training. We consider fill-rate data, noting an on-going problem with recruitment into emergency medicine, psychiatry and chemical pathology; and we look at the career destinations of junior doctors where the choices being made at the point of speciality training are changing, a development we feel the parties should keep a close eye on. Recruitment to general practice specialty training is dealt with in Chapter 3.

4.4 Doctors in the UK 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 training, doctors can either remain in the hospital sector as specialty registrars or enter general practice via the general practice specialty registrar route.

4.5 The current junior doctor contract is based on an incremental pay scale, with additional payment to recognise the out-of-hours and intensity of rotas for individual doctors, known as the banding supplements. For this round, we are only making recommendations on the current contract.

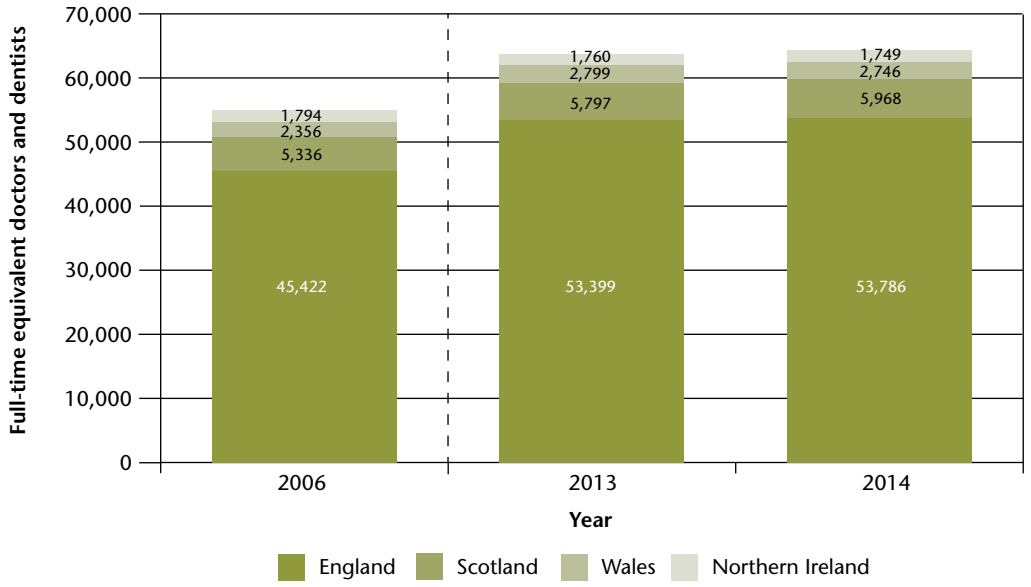
Recruitment and training choices

United Kingdom

4.6 In September 2014 there were 64,248 doctors and dentists on a full–time equivalent (FTE) basis in hospital training (Figure 4.1) in the UK, an increase of 0.8 per cent since September 2013 and by 17.0 per cent since 2006.

[1] *Contract Reform for Consultants and Doctors and Dentists in Training – Supporting Healthcare Services Seven Days a Week*. Review Body on Doctors' and Dentists' Remuneration. Cm 9108. TSO, July 2015.

Figure 4.1: Number of doctors and dentists in training in the Hospital and Community Health Services, United Kingdom, 2006 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 in Northern Ireland.

Undergraduates

4.7 We have examined data from the Universities and Colleges Admissions Service (UCAS). It shows that in 2014, the ratio of applications to accepted applicants for Pre-clinical medicine was 9.4, down slightly from the equivalent ratio in 2013 of 9.6. Comparisons on the total number of applicants are not counted by UCAS from 2014, only the number of applications; hence a direct comparison is not possible. Women account for 56.1 per cent (4,300) of accepted applicants for Pre-clinical medicine in the UK in 2015 compared with 55.7 per cent (4,280) in 2014, the equivalent figures for Pre-clinical dentistry being 62.6 per cent (685) in 2015 and 65.4 per cent (705) in 2014. NHS Employers (in England) reported that applications to medical schools remained high and were of high quality candidates as measured by school examinations.

Our comments

4.8 On the latest available evidence, the ratio of applicants to study medicine suggests that at undergraduate level, medicine continues to be seen as an attractive career. 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.

Trainees

4.9 We have noted the *F2 Career Destination Report 2015* by the UK Foundation Programme Office, which analysed the destinations of foundation house officers (F2s) at the end of their post-graduate training (normally two years). The report included a table that gave a year on year comparison of F2 career destinations (Table 4.1). It notes that in 2015 only 52 per cent of the qualified F2 junior doctors progressed to core or specialty training in the UK compared to 71.3 per cent in 2011; an increase in the number of trainees taking a career break (13.1 per cent in 2015 compared to 4.6 per cent in 2011), and an

increase in the number of doctors taking up a UK service appointment (9.2 per cent in 2015 compared to 2.3 per cent in 2011). The report said that a targeted study would be required to understand the reasons for the increase in the proportion of doctors taking a career break. We also refer to F2s in relation to general medical practitioner training in Chapter 3.

Table 4.1: F2 career destinations year on year comparison

Destinations for F2 doctors – year on year comparison	2015	2014	2013	2012	2011
Specialty training in UK – run-through training programme	24.0%	29.5%	29.9%	33.5%	34.0%
Specialty training in UK – core training programme	26.0%	26.8%	29.6%	30.5%	34.0%
Specialty training in UK – academic programme	1.3%	1.6%	1.5%	1.6%	1.5%
Specialty training in UK – FTSTA	0.1%	0.2%	0.2%	0.8%	1.1%
Specialty training in UK – deferred for higher degree	0.0%	0.1%	0.2%	0.1%	0.1%
Specialty training in UK – deferred for statutory reasons	0.5%	0.3%	0.5%	0.5%	0.5%
Sub-total for specialty (incl. GP) training in UK	***52.0%***	***58.5%***	***64.4%***	***67.0%***	***71.3%***
Locum appointment for training (LAT) in UK	0.5%	0.5%	0.6%	0.7%	0.4%
Service appointment in UK	9.2%	5.6%	3.5%	3.3%	2.3%
Other appointment in UK (e.g. anatomy demonstrator, higher education)	5.5%	6.1%	2.3%	1.9%	3.0%
Still seeking employment as a doctor in the UK	8.6%	8.4%	7.6%	7.4%	6.3%
Specialty training outside UK	0.4%	0.3%	0.6%	1.1%	0.8%
Other appointment outside UK	6.1%	3.9%	4.8%	6.6%	7.4%
Still seeking employment as a doctor outside the UK	4.3%	5.1%	6.5%	5.5%	3.7%
Not practising medicine – taking a career break	13.1%	11.3%	9.4%	6.1%	4.6%
Not practising medicine – permanently left profession	0.3%	0.3%	0.3%	0.2%	0.1%
Total signed off, known destinations	**100%**	**100%**	**100%**	**100%**	**100%**

Note: FTSTA = Fixed Term Specialty Training Appointment

Source: UK Foundation Programme Office

4.10 The BMA hypothesised that increased locum use (which would include service appointments) could be due to pay restraint and/or a deteriorating work-life balance. We asked NHS Employers for their views on this during oral evidence: in response they said that it was not solely due to levels of pay and speculated that it could be that some F2s felt they had not yet had sufficient experience to progress on to specialty training; or that some F2s were taking up trust posts while waiting for the right specialty training post in the locality of their choice, since junior doctors might be more selective about the trust and locality in which they wished to work and live. NHS Employers agreed that there was considerable variation between F2 destinations from each foundation school and they were working with Health Education England, NHS England and the General Medical Council to get an improved understanding of the issue.

4.11 NHS Employers suggested that dramatic increases in applications for Certificates of Current Professional Status (CCPS) which are necessary in order to work abroad were related to BMA campaigning activity and the General Medical Council had noted that the vast majority of candidates retained their Responsible Officer at NHS Trust status which suggested that the doctors concerned were not planning immediate migration. It said

that a 2013 study by the UK Medical Careers Research Group suggested that doctors proportionately were no more likely to migrate than previous generations, but that more detailed research was needed to confirm this.

Our comments

4.12 We have not been provided with more recent evidence and therefore the 2013 study results referred to above may be out of date. We were very interested to note the conclusions of the *F2 Career Destination Report 2015* by the UK Foundation Programme Office, and the increase in the number of doctors choosing not to move on to specialty training, but taking career breaks or other service appointments. The report said that a targeted study would be required to understand the reasons for the increase in the proportion of doctors taking a career break, and we would encourage the parties to carry out such research. We would also welcome evidence on why junior doctors are choosing to take up service appointments, rather than training posts: this may be relevant to recruitment and retention and help us in our consideration of targeting. It will be important to understand how changing workforce demographics will impact workforce planning, and to monitor how the changing employment proposition and attraction of a medical career is affecting the decisions of junior doctors. We will continue to monitor the position.

England

4.13 We have also undertaken an analysis of fill rates for hospital trainees across the various specialties in England (as noted earlier, fill rates to general practice are dealt with in Chapter 3). 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 (Table 4.2); and we also looked at specialties that have more than 30 vacancies. The table shows the total number of posts in each specialty, along with the current number of unfilled posts following final rounds of recruitment making the data difficult to compare with the previous year when fill rates were given following just two rounds of recruitment.

Table 4.2: England fill rates for hospital trainees following the final rounds of recruitment, 2015

Specialties with fill rates below 50% and more than 10 posts			
Specialty	**Fill rate (%)**	**Number of posts**	**Unfilled**
Chemical pathology	22.7%	22	17
Genito-urinary medicine	42.4%	33	19
Psychiatry of learning disability	47.2%	36	19

Specialties with over 30 vacancies			
Specialty	**Fill rate (%)**	**Number of posts**	**Unfilled**
Emergency medicine (All)	77.5%	448	101
Core psychiatry training	81.6%	419	77
Paediatrics	86.1%	468	65
General psychiatry	75.0%	136	34

Source: Health Education England.

4.14 NHS Employers said that, for public health training posts, the lower commitment to out-of-hours working (and therefore lower pay) had not affected recruitment which had fill rates of 97 per cent in 2013, and 100 per cent in 2014 and 2015. In oral evidence, Health Education England suggested that junior doctors were beginning to choose location over specialty.

Wales

4.15 The Welsh Government did not provide us with any data on fill rates for 2015.

Scotland

4.16 The Scottish Government said that the *Scottish Shape of Medical Training Transitions Group* made annual recommendations on core, run through and specialty training numbers. The Scottish Government reported an overall fill rate for recruitment in Scotland for foundation, core and specialty training of 89 per cent. Particular areas of concern were anaesthesia (fill rate 78 per cent) and emergency medicine (24 per cent). Other areas of concern included psychiatry, geriatric medicine, clinical oncology, and rheumatology.

4.17 The Scottish Government was continuing to work with Scottish and UK partners to understand implications for training outlined in Professor Greenaway's *Shape of Training* report published in October 2013. Key issues were:

- Strategic management of gaps in training.
- Supply and demand for the NHS Scotland workforce.
- Attractiveness of Scotland as a place to train and work.
- Perceived erosion of professionalism in medicine.
- Alignment with the Scottish Government's existing StART (Strategy for Attracting and Retaining Trainees) initiative.

4.18 The Scottish Government said that StART had recently commissioned work to gain insights into what informed trainees' choices at the key career transitions.

4.19 Separately to the evidence provided by the Scottish Government, we have noted analysis of fill rates carried out by the Scottish Shape of Training Group, dated August 2015. This analysis showed the following fill rates by Scottish region (Table 4.3), and identified acute, emergency and geriatric medicine as hard-to-fill specialties. The table shows the number of posts filled/total number of posts (fill rate %).

Table 4.3: Scottish fill rates by NHS Education for Scotland (NES) region for hard-to-fill specialties, 2015

Specialty	NES Region				All
	East	North	SE	West	
Acute medicine	0/3 (0%)	0/4 (0%)	0/2 (0%)	2/12 (17%)	2/21 (9.5%)
Emergency medicine	0/2 (0%)	1/2 (50%)	2/3 (67%)	2/14 (14%)	5/21 (23%)
Geriatric medicine	0/4 (0%)	3/4 (75%)	3/3 (100%)	4/12 (33.3%)	10/23 (43%)

Source: Scottish Shape of Training Transition Group.

Northern Ireland

4.20 The BMA provided us with information on fill rates in Northern Ireland at August 2015. Across Northern Ireland there was an 88.81 per cent fill rate for specialty training. Table 4.4 below shows those specialties with more than ten vacancies.

Table 4.4: Northern Ireland fill rates for hospital trainees at August 2015

Specialties with more than 10 vacancies			
Specialty	**Fill rate (%)**	**Number of posts**	**Unfilled**
Core psychiatry training	71.74%	46	13
Obstetrics and gynaecology	74.19%	93	24
Core surgical training	76.40%	89	21
Paediatrics	89.91%	109	11
Core medical training	90.34%	145	14

Source: BMA.

Our comments

4.21 It is difficult for us to make comparisons from year to year: the data we receive is not in the same format each year, is incomplete for some countries, and because of the timing of our report, does not always tell the final picture on fill rates after all rounds of recruitment are complete. Nevertheless, looking across the years our analysis shows that several specialties including chemical pathology, emergency medicine, psychiatry and acute medicine have an ongoing problem with recruitment, although the picture varies by country. These ongoing recruitment problems are of concern to us, particularly as when we have raised concerns in previous years about recruitment issues for particular specialties, we have been told that such issues are not pay-related. For our next round, we ask the parties to provide a more detailed analysis of the causes of hard-to-fill specialties, broken down by region in each country, and evidence on how the gaps from low fill rates are covered, including by adjustments to pay. We would also welcome evidence on whether it is actually the case that junior doctors are choosing location over specialty, and if so, the reasons for this.

Motivation

Our comments

4.22 We comment in Chapter 1 on the state of junior doctors' motivation we encountered during our visit programme in September and early October 2015. The issues raised by junior doctors were not confined to those in England. As we were considering issues that informed this report, junior doctors took industrial action in England. This action followed a ballot that had the support of 98 per cent of junior doctors. Given how the mood changed during our visit programme, it seemed to us that the situation may have been exacerbated by poor communication and lack of engagement from employers, as well as a feeling of not being valued (which as we noted in our visits, may be UK-wide and not just about contract reform). We note that it has been announced that Professor Dame Sue Bailey, Chair of the Academy of Medical Royal Colleges, will lead an independent review of junior doctors' experience of their NHS training and employment to better understand and deal with the long-standing issue of low morale amongst junior doctors in England. We very much welcome and support this action.

CONSULTANTS

Introduction

4.23 This section looks at the consultant group, which is the main career grade in the hospital and public health service. It notes that despite the growth in the consultant workforce, there are some specialties and locations that continue to have significant recruitment problems; and reports on the various consultant award schemes across the UK.

4.24 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 current 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.

4.25 Following our special remit report on contract reform, the BMA is negotiating on the consultant contract in both England and Northern Ireland. The Welsh Government told us that it had maintained observer status and would reflect on the outcome of the discussions. The Scottish Government told us that it was not seeking to reform the consultant contract via negotiation until it had a clearer idea of what the sustainable shape of seven-day services in Scotland would look like. We have only been asked to make recommendations on the existing contracts.

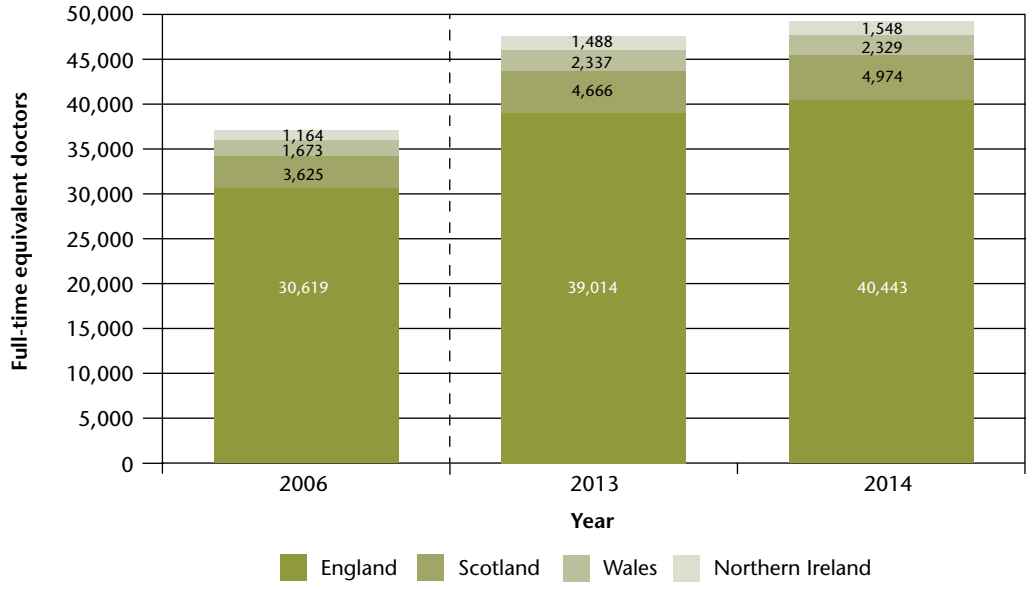
4.26 Under the 2003 contract, consultants have to agree the number of programmed activities (PAs) and supporting professional activities (SPAs) they will work. Total pay is comprised of five elements: basic pay on an eight-point scale; additional PAs/SPAs; on-call supplements; Clinical Excellence Award (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

4.27 In September 2014, on a full-time equivalent (FTE) basis, there were 49,294 consultants, an increase of 3.8 per cent on the previous year (Figure 4.2).

Figure 4.2: Number of consultants in the Hospital and Community Health Services, United Kingdom, 2006 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.

England

4.28 Data from Health Education England showed shortfall against establishment by group varying between 4 per cent and 11 per cent; but these group totals masked variations by specialty (26 per cent for acute and general internal combined; 23 per cent for chemical pathology; and 17 per cent for rehabilitation medicine). It also showed variation by geography: for example, chemical pathology had vacancies from 10 per cent in the South of England to 25 per cent in the North of England.

Wales

4.29 The Welsh Government said that consultants were the only group of staff increasing their numbers annually. It said that while there was a large increase from 2009 to 2012, the percentage increase in staff in post numbers had slowed in recent years.

4.30 The BMA said that a Freedom of Information request to Welsh health boards and trusts showed a 6.8 per cent vacancy rate, with 10.5 per cent of the consultant headcount being locums. In response, the Welsh Government said that at November 2014, it estimated that locums accounted for 9.34 per cent of the consultant workforce. The Welsh Government was unable to provide the vacancy rate.

Scotland

4.31 The Scottish Government said that a 'reasonable' proportion of consultants continued to practice beyond age 55. It said that total consultant vacancies were up 100.8 FTE to 447.5 FTE at the end of June 2015. Of those vacancies, 259.5 FTE were vacant for less than 6 months. It said that the overall vacancy rate was 8.3 per cent, but said that as the consultant establishment had risen by 353.5 FTE, increases in vacancies were to be expected. The Scottish Government said that recruitment problems to some specialties were not unique to Scotland, as there was a worldwide problem. Its evidence noted

vacancies in emergency medicine (23.8 FTE); anaesthetics (35 FTE); clinical radiology (36.8 FTE); geriatric medicine (24 FTE); the psychiatry specialties (52.1 FTE); general surgery (26 FTE); and paediatrics (26.2 FTE).

4.32 The BMA commented that the trend of an increase in total vacancy rates in Scotland was worsening, also noting the 8.3 per cent rate. The BMA said that it believed that the official vacancy figures understated the true position in Scotland, and that continuing recruitment and retention problems were manifesting in increased temporary staffing costs for the Scottish NHS, noting that spending on locum doctors increased by 22 per cent during 2014-15, compared to a 15 per cent increase for all staff groups. It also referred to a report by the Academy of Medical Royal Colleges and Faculties in Scotland that found that 46 per cent of recruitment panels in 2014 had been cancelled due to a lack of applicants. The BMA said that the 9:1 approach to consultant workplans in Scotland (9 PAs/1 SPA) made Scotland uncompetitive and unattractive, not only in the UK market for consultants, but also internationally.

Northern Ireland

4.33 The Northern Ireland Executive provided vacancy rates for consultants. Firstly, for current vacancies (which it defined as a post that at March 2015 the organisation was actively trying to fill) there were 112 (headcount) vacancies, equivalent to a 6.8 per cent FTE vacancy rate. For long-term vacancies (defined as a post advertised prior to December 2014 but still unfilled at March 2015, and where the organisation was still actively trying to fill it), there were 75 (headcount) vacancies, equivalent to a 4.6 per cent FTE vacancy rate. It also provided information on vacancies by region, noting that the highest vacancy rate for both current and long-term vacancies was in the Western Health and Social Care Trust. Radiology was the specialty with the most vacancies (16 FTE current vacancies, 14 FTE of which were long-term).

Our comments

4.34 Despite the growth in the consultant population, there are some specialties and regions with significant ongoing problems in recruiting sufficient numbers of staff. For some of these specialties, such as psychiatry and emergency medicine, there are also problems with fill rates at the training level, suggesting that workforce supply issues are not likely to be solved in the near future. We note that the facility to use Recruitment and Retention Premia (RRPs) in the consultant contract is not widely used by employers: whilst we understand this when there is an overall shortage in the supply of a particular specialty, it should not preclude employers from using RRPs to encourage recruitment to address local shortages that may be related to the attractiveness of working in a particular region. We would encourage the parties to discuss and agree the rules surrounding the use of RRPs so that they can be used more flexibly. Chapter 5 includes our consideration of whether targeting might help to address particular specialties.

Motivation and workload

4.35 Our analysis of motivation of all HCHS staff (including consultants) is contained in Chapter 2.

4.36 The BMA referred to a report by the Academy of Medical Royal Colleges in Scotland that warned of a loss of leadership, poor staff morale, a 'defective culture', disconnected clinical staff and management, inappropriate targets and poor accountability mechanisms. It also told us of research commissioned by BMA Scotland that revealed that consultants were feeling deprofessionalised, disengaged and demoralised. The

BMA noted a potential vicious circle of workforce gaps caused by recruitment problems putting more stress on the system, with increased pressure on the remaining staff making it harder for them to provide a good level of care to patients.

Clinical Excellence Awards, Distinction Awards and Discretionary Points

4.37 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 forms part of the consultant contract negotiations, so we wait to see the outcome of those discussions.

England

4.38 The Advisory Committee on Clinical Excellence Awards (ACCEA) told us that the 2015 award round was underway, with results due in early 2016. It said that at July 2015, the number of national award holders accounted for 7.14 per cent of the consultant population. Ministers had asked for the number of new awards to be capped at 300 for the 2015 round. Chapter 2 includes further information on the operation of the award scheme as part of our consideration of any discrimination concerns.

Scotland

4.39 The Scottish Government told us that the freeze of distinction awards continued. Whilst it had noted our urging for the reform of the scheme in Scotland and the reinstating of funding, it said that the Cabinet Secretary had made clear the need to reform the scheme, but that any review of the scheme should form part of consultant contract negotiations in the context of its 2020 Workforce Vision and the development of sustainable seven-day services.

Northern Ireland

4.40 The BMA explained that no awards had been made in Northern Ireland since 2010, even though applications for new awards had been sought in 2012-13. It said that the lack of awards devalued the consultant workforce.

Our comments

4.41 We set out our concerns in our last report that the delay in the reform of the consultant award scheme in Scotland had the potential to further damage recruitment and retention. We have noted that the Scottish Government is committed to reform of the scheme, but that it does not wish to do so until it takes forward wider contract reform. We continue to believe that national awards should be available to recognise those consultants with the greatest sustained level of performance and commitment to the NHS whose achievements are of national or international significance. This is, of course, for Ministers to decide, but we note that the vacancy rate has continued to rise in Scotland: we consider that the freeze on distinction awards could form part of the reason for that increase. We also note that the staff survey results in Scotland suggest that motivation is becoming more of an issue, and a properly funded award scheme could go some way to addressing this.

4.42 The values of the consultant awards have been held back in recent years, in line with pay restraint. We believe that the value of the awards should also increase in line with our main pay recommendation for consultants. This should apply to Clinical Excellence

Awards, Discretionary Points, Distinction Awards and Commitment Awards. Our recommendation is in Chapter 5 alongside our treatment of those in receipt of non-consolidated payments in this and other remit groups.

SPECIALTY DOCTORS AND ASSOCIATE SPECIALISTS

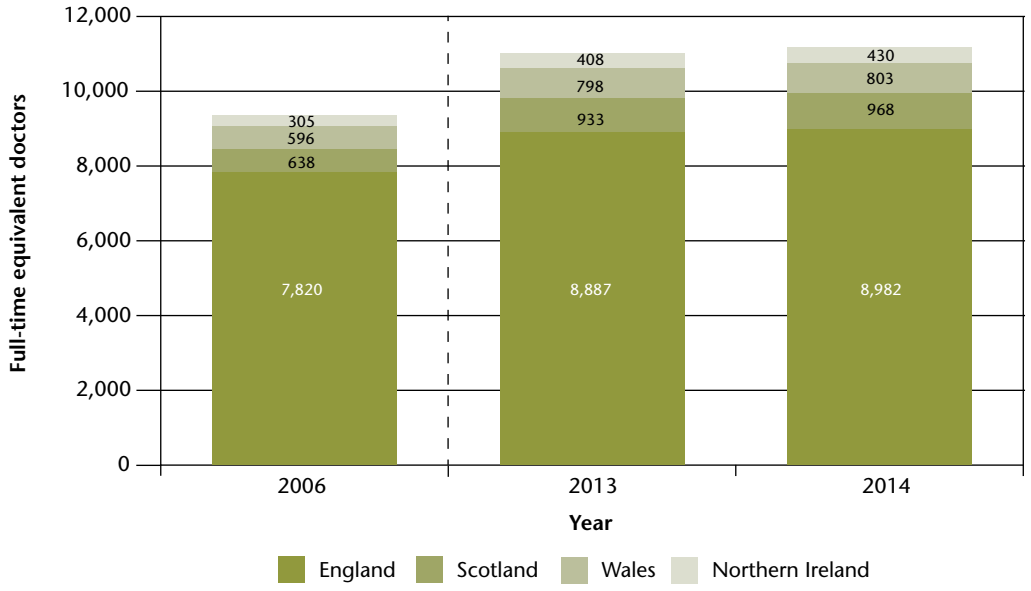
Introduction

4.43 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: continued growth across the UK in the SAS population; and the actions taken to encourage career development for this important group of doctors.

Recruitment and retention

4.44 In September 2014, on an FTE basis, there were 11,184 specialty doctors, associate specialists and staff grades (SAS grades), an increase of 1.4 per cent on September 2013 levels for the UK as a whole; all countries had increases in the FTE number of SAS (Figure 4.3).

Figure 4.3: Number of specialty doctors, associate specialists and staff grades in the Hospital and Community Health Services, United Kingdom, 2006 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 in Northern Ireland.

England

4.45 NHS Employers told us that there were some national shortages for SAS doctors that mirrored consultant specialties, and as a result, locally agreed on-call arrangements had been made more financially generous.

Northern Ireland

4.46 The Northern Ireland Executive provided vacancy rates for specialty doctors/staff grades. Firstly, for current vacancies (which it defined as a post that at March 2015 the organisation was actively trying to fill) there were 59 (headcount) vacancies, equivalent

to a 12.0 per cent FTE vacancy rate. For long-term vacancies (defined as a post advertised prior to December 2014 but still unfilled at March 2015, and where the organisation was still actively trying to fill it), there were 41 (headcount) vacancies, equivalent to a 8.6 per cent FTE vacancy rate.

Motivation and career development issues

England

4.47 NHS Employers reported on survey findings that showed that 82 per cent of SAS doctors believed that they were working at a level appropriate to their competence and experience, but that only 67 per cent felt they received due recognition of their contribution. They concluded that the survey showed that further progress remained both possible and necessary. NHS Employers also described a Charter for SAS doctors published in December 2014, that promoted a supportive environment to enable SAS doctors to work to the best of their ability. They said that it was an important piece of work intended to address the perception that there was a lack of opportunity for career progression. They described workshops to identify barriers and solutions to effective development, opportunities for SAS leadership roles and the sharing of good practice.

Scotland

4.48 The Scottish Government described its SAS Doctors Development Fund that was available for individual personal development and provided SAS doctors with enhanced skills and experience. It said that the Fund had been well received and was a clear signal of its on-going commitment to support SAS doctors.

4.49 The BMA referred to its July 2015 survey of SAS doctors across the UK that reported on the lack of opportunity to take on additional roles and responsibilities, and on the majority of SAS doctors being asked to give up SPA time to take on clinical duties.

Our comments

4.50 Given the BMA's survey results, we welcome the action taken in both England and Scotland via the Charter for SAS doctors and the SAS Doctors Development Fund. We have long championed the importance of funding for SAS doctors to support career development. We ask all of the parties to update us on any issues impacting SAS career development for our next review and to learn of the effects of the Charter and any other actions impacting SAS grades. As we noted last year, SAS doctors are an important part of the NHS workforce and continue to play a pivotal role in the provision of services. We would like to see this group of doctors given equal consideration and reflected more in the quality and quantity of evidence we receive.

Pay recommendations

4.51 Our recommendations on pay for hospital doctors and dentists are contained in Chapter 5.

CHAPTER 5: MAIN PAY RECOMMENDATIONS FOR 2016-17

Introduction

5.1 In this chapter, we set out the parties' proposals for the main uplift for our remit groups for 2016-17, along with our recommendations. It also includes our consideration of targeting. As always, 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 describes the remits in more detail and issues specific to certain groups are addressed in the relevant chapters. The four-year timescale for the announced public sector pay policy, at least in England, provided important context to our deliberations.

Targeting

5.2 The letter of 19 August 2015 from the Chief Secretary to HM Treasury confirmed the government's public sector pay policy is to fund public sector workforces for an average annual pay award of 1 per cent for four years from 2016-17, noting that the government expects pay awards to be applied in a targeted manner to support the delivery of public services, and to address recruitment and retention pressures. It said that this might mean that some workers could receive more than 1 per cent while others could receive less: there should not be an expectation that every worker would receive a 1 per cent award.

5.3 The remit letter of 6 November 2015 from Lord Prior at the Department of Health invited us to consider the case for targeting to support recruitment and retention and to make recommendations within an average of 1 per cent for employed doctors. It also welcomed our view as to how an overall pay uplift of an average 1 per cent could be applied to improve recruitment and retention for GMPs and GDPs.

5.4 Remit letters from the Welsh and Scottish Governments did not ask us to address directly the issue of targeting. However, the remit letter of 3 February 2016 from Simon Hamilton, Minister for Health, Social Services and Public Safety in the Northern Ireland Executive asked us to consider the case for targeting to support recruitment and retention and to make recommendations for salaried doctors and dentists. Its evidence asked that we take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland. It also asked us to consider how an overall pay uplift for GMPs and GDPs could be applied.

The parties' views

5.5 In the evidence provided to us for this round, all parties recommended against targeting for 2016-17. In summary the key reasons put forward for this were:

- the lack of an evidence base, with the need for better data on supply, vacancies and the link to pay;
- the demotivational impact on some of our remit groups of an award that was below expectations; and
- the available money for targeting (1 per cent of current paybill) did not give enough scope for meaningful targeting.

Our approach

5.6 In the absence of any of the parties making a case for targeting, we approached the issue by considering whether there may be a case to target by remit group, by specialty or by geography. This involved examining the recruitment and retention evidence to identify firstly where there may be issues and secondly whether these issues could be resolved with a targeted pay response. Chapters 2, 3 and 4 summarise this evidence and

demonstrate that there are recruitment and retention difficulties in all three categories in all four countries of the UK. However in considering whether the evidence pointed to targeted pay being a solution we drew the following conclusions:

- Although we might in theory target our annual pay recommendations, in the main our recommendations are to pay scales that apply to all doctors and these pay scales do not differentiate by specialty or geography, areas we might wish to target. For GMPs, practice income is not directly linked to our pay recommendations but is reliant on allocations made to practices by a variety of funding streams.
- Trusts and health boards in each country are already in some cases using local flexibilities to address recruitment, retention or returner issues, or have this option available to them but have decided not to use it. In particular, the consultant contract includes a facility to pay recruitment and retention premia (RRPs). For contractor GMPs, shortages are being addressed via the separately funded Ten Point Plan in England and other initiatives in the rest of the UK, and Scotland is addressing dental recruitment problems via a "Golden Hello" scheme and a Scottish Dental Access Initiative. We note that GDPs in England and Wales are in essence competing for work in a market-driven process, with locally agreed contract values. Salaried GMPs and associate/providing-performer dentists agree their pay locally with practice owners.
- Contract reform is intending to address specific shortages using a revised pay system: in particular the junior doctor contract proposals include the use of flexible pay premia to address hard-to-fill vacancies by specialty and geography. The evidence for our remit on contract reform suggested that RRPs would remain a local flexibility as part of the consultant contract.
- There is an apparent consensus between the parties that a targeted pay response is not appropriate for serious national supply shortages in certain specialties this year. We are not entirely persuaded by this; however, we note that the issues are complex. Unless the parties provide evidence that other approaches are working, we think that there could be merit in testing a targeted pay approach in future years to see whether that is more effective.

5.7 Setting these conclusions alongside the consensus view given to us by all the parties – namely that to differentiate the pay award risks demotivating some of our remit groups – we have concluded that we should not target our recommendations for 2016-17. However, given that there are recruitment and retention issues which are concentrated in certain specialties and locations, we would not preclude targeting in future years. Given the pressure on affordability over the next four years, the evidential basis for a targeted pay response needs to be high to avoid unintended consequences. We set out in Chapter 6 our thoughts on the type of evidence that we think would be necessary to inform such decisions.

Observation 1: We have concluded that we should not target our recommendations for 2016-17 on the basis of recruitment and retention. Issues do exist in some specialties and locations and unless the parties provide evidence that other approaches are working, we think that there could be merit in testing a targeted pay approach in future years to see whether that is more effective. We also note that funds set aside for the pay uplift could be used differently to alleviate workload pressures.

Pay proposals

5.8 The Department of Health's written evidence did not propose a specific figure for this year's uplift, but as noted above, its remit letter invited us to consider the case for targeting to support recruitment and retention and to make recommendations within

an average of 1 per cent for employed doctors. It also welcomed our view on how an overall pay uplift of an average 1 per cent could be applied to improve recruitment and retention for GMPs and GDPs. As its evidence said that it did not believe there was currently the evidence base to support targeting, we have taken this to mean an across-the-board 1 per cent increase for all staff in England. This view was reinforced during oral evidence, when Lord Prior argued that 1 per cent was 'credible' for 2016-17, but it would be important to keep a close eye on what was happening with private sector settlements and recruitment/retention over the longer term. He also referred to the need to treat our remit groups fairly, noting that this was a hard criterion to measure. Even when faced with evidence on Trust deficits, he did not support the case for a zero award in 2016-17.

5.9 NHS Employers said that they favoured a 1 per cent increase for all staff. NHS England did not propose a figure, but asked us to consider what uplift, if any, was appropriate.

5.10 The Welsh Government's written evidence also did not specify a figure for 2016-17. In oral evidence, officials said that any award would be unaffordable, but that no rise at all would result in the workforce becoming demotivated. They also expressed a desire to harmonise pay for doctors in Wales with that in England.

5.11 The Scottish Government set out its public sector policy: an overall 1 per cent cap on the cost of the increase in basic pay, with additional protections for the lower paid (none of our remit groups). It said that our remit groups would be expecting an increase of 1 per cent.

5.12 The Northern Ireland Executive said that our pay recommendation should take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland. It said that all options for achieving savings would have to be considered, including the continued application of pay restraint.

5.13 The British Medical Association (BMA) did not propose a specific figure for this year's uplift, but said that doctors should be treated in line with the wider economy where pay settlements were running at higher than the public sector pay cap. Its written evidence noted pay settlements averaging 2 per cent. It argued that a lower increase for doctors would impact recruitment and retention as alternative jobs became relatively more attractive. It asked us to take a more "bottom up" approach looking at what reward and remuneration was needed to recruit, retain and motivate doctors for them to be able to deliver high quality care and contribute to sustainable service redesign, rather more than a "top down" recommendation driven by financial constraints.

5.14 The British Dental Association (BDA) said that 1 per cent was meagre compared to private sector pay growth. Its evidence stated that GDPs should receive at least 1 per cent, and that a 1 per cent increase was necessary for all salaried dentists.

Treatment of Northern Ireland

5.15 In their evidence, both the BMA and the BDA sought recommendations covering all remit groups in all UK countries. The Northern Ireland Executive only provided us with a remit letter on 3 February 2016: and its main written evidence on 8 February 2016. We comment in Chapter 1 on the need for the parties to submit their evidence on time, in order to allow us to carry out an inclusive, transparent and evidence-based process.

5.16 Given the very late submission of evidence by the Northern Ireland Executive, we have concluded that it would not be appropriate to delay our main report to the other parties, and neither was it practical to run a bespoke process specifically for the Northern Ireland Executive and still deliver recommendations to them before the start of the pre-election period. We are evidence-based in our approach and took the decision that we had

sufficient evidence from all parties in order to make recommendations for Northern Ireland. This is not a position we were comfortable with, nor would we wish to carry out a remit on such a limited timescale again.

Main pay recommendations

5.17 For clarity, we are recommending on existing contracts only. As ever, we have been guided by the evidence in formulating our pay recommendations. The BMA has sought a more "bottom up" approach looking at what reward and remuneration was needed to recruit, retain and motivate doctors for them to be able to deliver high quality care and contribute to sustainable service redesign, rather more than a "top down" recommendation driven by financial constraints. We have taken this suggestion very seriously, and explored this proposal with each of the parties (including the BMA), asking them to point to any specific part of the evidence base to support their pay proposals. The BMA's case centred around a fair treatment of our remit groups relative to comparators. It also highlighted the recent industrial action as symptomatic of the current state of morale. Lord Prior also referred to the need to treat our remit groups fairly. We consider what this may mean for our future role in Chapter 6.

5.18 Looking first at the wider economy, we note that Consumer Prices Index (CPI) of inflation at December 2015 was 0.2 per cent, and was forecast to reach 1 per cent in the second half of 2016. The Annual Survey of Hours and Earnings showed that the median gross weekly earnings for full-time employees increased by 1.8 per cent in the year to April 2015, although earnings at the top decile (which we consider to be a more appropriate comparison for our remit groups) increased by just 0.9 per cent over the same period.

5.19 In relation to motivation, we note the results of staff surveys in England and Scotland. The results in England are, broadly speaking, holding up, although we note that the most recent staff survey was carried out in autumn 2014 and predates the current breakdown in industrial relations: whilst in Scotland their more recent results are in general on a downward trend. We note that the public sector pay policy has created a level of expectation amongst our remit groups, and that the parties were unanimous in their view that any award below 1 per cent would be demotivating. To go against this would require very strong evidence.

5.20 In terms of affordability, we understand that all Health Departments have been funded for a 1 per cent increase in the paybill. The Department of Health believes 1 per cent to be credible in England, and the Scottish Government told us that 1 per cent was expected by the workforce. The Welsh Government said in oral evidence that any pay increase was unaffordable, but that it would be concerned about the effect on motivation of a zero award. The Northern Ireland Executive asked us to consider the specific financial context of Northern Ireland. As noted above, the Northern Ireland Executive's evidence arrived too late for us to interrogate further, although we note that it has not provided any detailed information on the 2016-17 financial position. On that basis we had to assume that the 1 per cent coming out of the Spending Review fed through to the Northern Ireland Executive in its consequential settlement.

5.21 We did consider differential recommendations by country. However, we do not see a case for this principally because the consensus that there is a UK-wide market for doctors and dentists continues to hold amongst the parties. On that basis, we do not seek to exacerbate disparities in pay between the countries. In addition, affordability and pay policy in each country is not markedly different for our remit groups for this year, although clearly Wales (and we infer Northern Ireland) are in very difficult financial circumstances. However, our line of reasoning in relation to the demotivational impact of differentiating the award holds here.

5.22 We have therefore concluded that the evidence for this year is pointing us towards a 1 per cent pay recommendation. As noted earlier, we have concluded that targeting is not appropriate for 2016-17. Our recommendations are therefore for a base increase of 1 per cent in 2016-17 to the national salary scales for salaried doctors and dentists in all four UK countries; an increase of 1 per cent to the top and bottom points on the pay range for salaried GMPs in the UK; and an increase in pay, net of expenses, of 1 per cent in 2016-17 for both independent contractor GMPs and GDPs in all countries of the UK. Individuals on incremental pay scales, who have not reached the maximum scale point, will also be eligible for incremental progression according to the agreed criteria. For this year, we are satisfied that the evidence on affordability, the evidence on relevant earnings increases, the subdued levels of inflation, and the recruitment and retention data all pointed in a roughly equivalent direction. We are making recommendations accordingly. If in future years, the evidence points us to a different conclusion, we do not consider that government messages on affordability constrain us from making recommendations we think are right, in the round.

Recommendation 1: We recommend for 2016-17 a base increase of 1 per cent to the national salary scales for salaried doctors and dentists in the UK.

Recommendation 2: We recommend that the maximum and minimum of the salary range for salaried GMPs in the UK be increased by 1 per cent for 2016-17.

Recommendation 3: For independent contractor GMPs in all countries of the UK, we recommend an increase in pay, net of expenses, of 1 per cent for 2016-17.

Recommendation 4: For independent contractor GDPs in all countries of the UK, we recommend an increase in pay, net of expenses, of 1 per cent for 2016-17.

5.23 Chapter 3 includes our consideration of issues relating to primary care, where we set out our thoughts on the GMP trainers' grant, the rate for GMP appraisers and the level of the general practice specialty registrar supplement. Chapter 4 notes our comments on the consultant award schemes, and we also make a recommendation relating to the value of the awards.

Recommendation 5: For 2016-17, the GMP trainers' grant should be increased by 1 per cent in line with our main pay recommendation for GMPs.

Recommendation 6: For 2016-17, the rate for GMP appraisers should remain at £500.

Recommendation 7: For 2016-17, the supplement payable to general practice specialty registrars should remain at 45 per cent of basic salary.

Recommendation 8: For 2016-17, the value of the awards for consultants – Clinical Excellence Awards, Discretionary Points, Distinction Awards and Commitment Awards – should increase in line with our main pay recommendation of 1 per cent.

5.24 As discussed in Chapter 3, given that changes are in train to GMP and GDP contracts in all four countries, we observe that in re-formulating these, provision of expenses data could become a mandatory requirement. This would be a clear step forward in addressing the long-standing problems with the expenses formulae for these groups. Clearly, a mandatory requirement such as this must avoid creating undue bureaucracy and care will be needed in order to avoid over-specifying the expenses data to be supplied, through close working with the BMA and BDA.

Observation 2: We observe that the parties in all four countries have the option to make provision of expenses data a mandatory requirement of new GMP and GDP contracts.

Treatment of those with non-consolidated payments in previous years

5.25 We have also given thought to the treatment of those members of our remit groups in England, Wales and Northern Ireland that as a result of the pay policy adopted by governments in those countries, received non-consolidated payments in 2014-15 and 2015-16. We understand that the intention is (subject to our recommendations being accepted) to implement an uplift consolidated into the pay scale points. This would, however, mean that those members of our remit group that were already at the top of their respective pay scales in 2014-15, and who therefore received a 2 per cent non-consolidated payment in 2015-16, will see a reduction in their basic pay related earnings for 2016-17 as their non-consolidated payment would not be repeated. We consider that no member of our salaried remit groups should see a fall in their earnings in relation to the basic pay scale and relative to a full-time post. We therefore recommend that those members of our remit groups who received a 2 per cent non-consolidated payment in 2015-16 and who have not since moved on to a new pay scale point should, in 2016-17, receive a non-consolidated payment equivalent to 1 per cent of their basic earnings alongside our main pay recommendation.

Recommendation 9: We recommend that those members of our remit groups who in 2015-16 received a 2 per cent non-consolidated payment and who have not since moved on to a new pay scale point should, in 2016-17, receive a non-consolidated payment equivalent to 1 per cent of their basic earnings alongside our main pay recommendation.

5.26 Given the four-year timescale for pay policy, the following chapter sets out our views on key issues that we believe will need to be considered over the coming years.

CHAPTER 6: LOOKING FORWARD

6.1 This final chapter considers three related topics: forthcoming developments in contracts and services which will affect our remit groups; long-term pay outcomes; and pay data requirements. All of these will shape our approach in the coming years. Before so doing however, we would like to establish two key principles that we see as guiding our future role alongside our standing terms of reference. These are the principles of *fairness* and of taking a *longer-term view*.

6.2 "Fairness" is, in our view, inherent in our terms of reference. We seek to find a balance between the interests of our remit groups, of their employers, of the taxpayer, and of patients. In this context we note two factors that, while relevant throughout the public sector, apply particularly strongly to our remit groups. First, our remit groups have a strong intrinsic motivation to practise their profession, but that does not preclude a perceived sense of unfairness adversely affecting their motivation. Second, they work in a sector where a single employer – the NHS – retains a dominant market position. In other words, those who train as doctors or dentists do so primarily because they have a strong urge to practise medicine or dentistry, and those who wish to do so in the UK will have to work for the NHS for much of their careers and accept the terms that the NHS offers. Normal market mechanisms, whereby employees who do not like their employers' offer can readily leave to do similar work for a different employer on terms they believe are more favourable, are much less available in this sector. Being "fair" to our remit groups means we need to take these factors into account, in assessing the data such as resignation rates. Feeling that they are treated fairly makes a real difference to our remit groups, and we are very conscious of this.

6.3 Linked to the need to ensure fairness is the importance of taking a longer-term view on pay. Members of our remit groups require a long period of training, and many of them expect to work in the NHS for their whole careers. Their long-term position relative to other professional groups is relevant to our thinking. This does not mean that we see our role as maintaining a particular set of "differentials"; we would echo the comments of the very first DDRB report from 1971:

> "Doctors and dentists should not have a fixed place in a changing world. Their financial position may rise in relation to some occupations, and fall in relation to others. Equally, there can be no permanent relationship between the earnings of different groups in the two professions". (First Report, 1971, para 52)

Whilst differentials should not be fixed, we do take account of the position of our remit groups relative to the wider economy. But simply thinking year-to-year, or even over the timescale of a particular public sector pay policy, cannot be sufficient when considering these remit groups.

Evolution of career expectations, services and contracts

6.4 We are very conscious that this is a time of great change within the NHS, in all countries of the UK. The moves towards integration of health and social care, new contracting models, seven-day services and further devolution of funding decisions are all in train to varying degrees in the different countries. Moreover, each country is taking a different approach to the development of the general medical services contract, and this divergence in approach is likely to continue. We note that in England, new voluntary seven-day service contracting models have been launched, and that pilot dental contracting schemes are already in operation in both England and Northern Ireland.

6.5 The workforce implications of all these changes are not yet clear but are unlikely to mean a one-size-fits-all model. In this sense, they reflect an apparent trend towards greater variety in the career plans of young medical and dental students; the different choices now being made at the end of foundation training appear to suggest a change in career pathways, especially the large increase in those opting to defer specialty training in recent years. It is possible that the newer and younger members of the workforce have a different attitude to their work, expecting a better work-life balance and greater flexibility; certainly they carry greater financial debts than their predecessors at the start of their careers, which may be changing their view of incentives.

6.6 In this context, we would like all the parties to provide us with evidence on how the new models of care, and new contracts, will affect our remit groups, and particularly any implications for their pay or job weighting. This will need detailed attention, especially when doctors from different remit groups (or indeed any new grades that may be under consideration) are working closely together. In time it may be conceivable that the parties may wish to provide us with evidence on salaried hospital doctors working in primary care settings. We note the changing demographic composition of our remit groups and would welcome any evidence on the implications of this for pay.

6.7 Around 50 per cent of the general medical practitioner (GMP) workforce are now female and this may link to the expansion of the salaried model in general practice. We already makes recommendations on the minimum and maximum of the salaried GMP pay scale, but does not examine recruitment and retention and motivation to the same level of detail as for hospital doctors. If the parties would find this helpful we would be willing to take evidence on these. In similar fashion to the different choices being made at the end of foundation training, the decision to choose salaried posts tells us something about how career expectations and structures are changing. Pay and the mechanisms to channel pay, particularly in primary care, must respond to this.

Long-term pay outcomes

6.8 The financial crisis of 2008 and the government's commitment to improve the country's fiscal position has resulted in five years of public sector pay restraint. The UK government's stated intention is to implement a further four years of average annual wage growth of no greater than 1 per cent in the public sector. Comparisons between doctors' and dentists' pay and private sector pay are not straightforward, as much depends on the chosen comparators and timeframe. However, we do feel that we need to think beyond single years and how the pay and conditions of our remit groups relate to those elsewhere in the labour market. Certainly we cannot assume that good retention figures and apparently reasonable motivation in any one year reflect a sustainable long-term position among our high-performing remit groups.

6.9 Whilst we do not think differentials should be fixed, we have given early thought to the possible future role of what we describe as "benchmark pay factors" at different career stages to provide ourselves with a benchmark with which to compare annual pay round evidence. These could provide a means to look at pay over time, to ensure a perception of fairness and consideration of long-term recruitment and retention objectives. These benchmark pay factors could be used to monitor the extent to which pay might be moving out of line compared with what might have been expected in the absence of a tightly constrained public sector pay policy.

6.10 Benchmark pay factors relating to perceptions of fairness or short-run factors, potentially include a measure of price inflation; wage inflation in other public sector groups and elsewhere in the NHS; short-term recruitment and retention signals such as vacancy rates (depending on definition), changes in part-time working, changes in retirement patterns, or changes in return-to-work patterns.

6.11 Long-run influences on benchmark pay levels, relating to career choice recruitment and retention, could potentially include specific points in the national pay distribution, suitably adjusted to take into account the remit group's age profile; value of the total reward package; pay in comparator professions at equivalent levels of seniority and job weight; productivity achievements, measured using specific job evaluation weights for the remit group, or based on aggregate NHS outcomes.

6.12 We would welcome the views of the parties on these factors and any others they think would be relevant.

Pay settlements, data requirements and measurement issues

6.13 We very much welcome the progress being made in England and Scotland on the provision of better workforce data. This is critical to good decision-making by the health system, as well as to our consideration of pay recommendations and the merits of targeting. A large number of organisations provide us with such information, for which we are grateful. Table 6.1 sets out the high level indicators that we consider necessary to monitor this important workforce, as well as to inform both our deliberations on targeting and our wider remit. This table is not intended as an exhaustive list: it is intended to be a guide. We note that many of these data are already available, but reliable vacancy data are one of the key gaps at present and will be an important part of the future evidence base for the system as a whole not just for us. NHS Improvement (which is being formed from the integration of Monitor and the Trust Development Authority in England) will be key in the provision of some of our data requirements. Table 6.1 also lists relevant bodies in Wales, Scotland and Northern Ireland that may already collect relevant data.

6.14 We understand that the parties and key information providers in each country are already trying to agree data collection processes and definitions and we support this, since given the scale of the challenge facing the NHS, we feel that the debate should be about what the numbers are telling us and what the solutions should be, not about whether the numbers are right.

6.15 As recruitment and retention is a core part of our terms of reference, we ask all of the parties to continue to keep us updated on any workforce planning issues, including any staffing targets that form part of such plans, and to explicitly 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. Specifically, we ask for future evidence to include both headcount figures and full-time equivalent (FTE) estimates, broken down by gender.

6.16 In recent reports we have set out our ongoing concerns with the formula-based approach we have until recently used to decide the uplift for independent contractor GMPs and general dental practitioners. As noted elsewhere in this report and in line with our commitment to make evidence-based recommendations, we have asked the parties to improve the evidence that we receive on practice expenses, should they wish us to give this issue further consideration.

Table 6.1: DDRB – Workforce monitoring data

This table is intended to give an indication of the types of data we consider necessary for our pay deliberations, including whether to target pay, and where these data might come from. It is not exhaustive. Other sources of information and evidence are available across the DDRB terms of reference.

	Location	Staff Group (Primary Care and Hospital Groups)	Specialty (including general practice)
Source of new recruits	% UK training routes % Non-EEA % EEA Source: GMC/GDC registrations ***tbc***	% UK training routes % Non-EEA % EEA Source: GMC/GDC registrations	% UK training routes % Non-EEA % EEA Source: GMC/GDC registrations
Quality of new UK trainees	UCAS tariff at under-graduate entry Source: UCAS; HESA	UCAS tariff at under-graduate entry Source: UCAS; HESA	UCAS tariff at under-graduate entry Source: UCAS; HESA
Career choices by doctors in training	% going to core training % career break % locum % trust posts Source: UKFPO ***tbc***	% going to core training % career break % locum % trust posts Source: UKFPO	
International migration patterns		Numbers applying for CCPS Source: GMC/GDC Retention rates in destination countries Source: GMC/GDC equivalent	Numbers applying for CCPS Source: GMC Retention rates in destination countries Source: GMC/GDC equivalent
Leavers and joiners	% leaving rate (excluding internal transfers to another trust/board) % joining rate (excluding internal transfers to another trust/board) Source: HSCIC/Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments	% leaving rate (excluding internal transfers to another trust/board) % joining rate (excluding internal transfers to another trust/board) Source: HSCIC/Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments	% leaving rate (excluding internal transfers to another trust/board) % joining rate (excluding internal transfers to another trust/board) Source: HSCIC/Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments
Reasons for leaving	HSCIC/Workforce Minimum Dataset (England) ***Pending; not collected in Scotland, Wales, Northern Ireland***	HSCIC/Workforce Minimum Dataset (England) ***Pending; not collected in Scotland, Wales, Northern Ireland***	HSCIC/Workforce Minimum Dataset (England) ***Pending; not collected in Scotland, Wales, Northern Ireland***
Numbers eligible to return to NHS workforce – clinical		Total number on GMC/ GDC registers, less those employed by the NHS Source: GMC/GDC Registers, HEE, Health Departments	
Vacancy rates	To a consistent definition. Source: Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments. ***No consistent definition in place***	To a consistent definition. Source: Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments. ***No consistent definition in place***	To a consistent definition. Source: Workforce Minimum Dataset (England) ***Pending***; Information Services/Health Departments. ***No consistent definition in place***

	Location	Staff Group (Primary Care and Hospital Groups)	Specialty (including general practice)
Annual workforce planning assumptions	Shortfall against demand; priority training areas Source: HEE, NHS Education for Scotland, NHS Wales Shared Services Partnership, Workforce Planning Unit DHSSPSNI	Shortfall against demand; priority training areas Source: HEE, NHS Education for Scotland, NHS Wales Shared Services Partnership, Workforce Planning Unit DHSSPSNI	Shortfall against demand; priority training areas Source: HEE, NHS Education for Scotland, NHS Wales Shared Services Partnership, Workforce Planning Unit DHSSPSNI
Locum use and rates	Data on locum expenditure by location, staff group and shift type; range of rates paid Source: NHS Improvement (England); NHS England (primary care); Health Departments. ***Not consistently collected***	Data on locum expenditure by location, staff group and shift type; range of rates paid Source: NHS Improvement (England); NHS England (primary care) ***tbc***; Health Departments. ***Not consistently collected***	Data on locum expenditure by location, staff group and shift type; range of rates paid Source: NHS Improvement (England); NHS England (primary care) ***tbc***; Health Departments. ***Not consistently collected***
Wider labour market trends and economic indicators	Wage settlements, employment rates, inflation Source: OBR; ONS	Wage settlements, employment rates, inflation Source: OBR; ONS	Wage settlements, employment rates, inflation Source: OBR; ONS

See Appendix H for Abbreviations and Acronyms.

APPENDIX A: REMIT LETTERS FROM THE PARTIES

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

Jerry Cope (NHSPRB); Paul Curran (DDRB); Peter Knight (Prison Services RB); David Lebrecht (Police/NCA PRB); Martin Read (SSRB); Patricia Rice (STRB); John Steele (AFPRB)

c/o Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London EC4Y 8JX

19th August 2015

Dear Jerry, Paul, Peter, David, Martin, Patricia and John,

PUBLIC SECTOR PAY 2016-17

Thank you for your work on the 2015-16 pay round. It is clear to me that the pay review bodies play an invaluable role in making independent, evidence-based recommendations on public sector pay, as well as providing expert advice and oversight in relation to wider reforms to pay policy and allowances. I am grateful to you and your colleagues for the careful thought you give to this work, and look forward to receiving your advice and recommendations during the 2016-17 pay round and beyond.

2. Savings from public sector pay and workforce reform made a significant contribution to reducing the deficit over the course of the last Parliament, saving around £8bn. The new government's Summer Budget last month set out that a further £20 billion of consolidation in public sector spending will be required to deliver a surplus by 2019-20. Whilst the deficit and debt are being reduced, the government will need to continue to ensure restraint in public sector pay. Without

such restraint, reductions would need to come from other areas of spend, resulting in negative impacts on public services and jobs. At a time of difficult decisions, the government's pay policy will help to protect the jobs of thousands of front line public sector workers.

3. As you will have seen, the government announced at Budget it will fund public sector workforces for a pay award of 1% a year for four years from 2016-17. The government expects pay awards to be applied in a targeted manner to support the delivery of public services, and to address recruitment and retention pressures. This may mean that some workers could receive more than 1% while others could receive less; there should not be an expectation that every worker will receive a 1% award. The relevant departments will submit in their evidence to you proposals covering the needs of their different workforces.

4. The Budget also set out that the government will continue to examine pay reforms and modernise the terms and conditions of public sector workers. This will include a renewed focus on progression pay, and considering legislation where necessary to achieve the government's objectives. Over the course of the Parliament, I look forward to the pay review bodies playing an important role in advising the government on how best to achieve pay reforms.

5. The relevant Secretaries of State will write to you shortly with a detailed remit covering these points and I look forward to receiving your recommendations.

With best wishes,

GREG HANDS

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Paul Curran
Chair, Doctors and Dentists Review Body
Email to cliff.wilkes@bis.gsi.gov.uk

6th November, 2015

Dear Paul,

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Greg Hands, on 19 August 2015 confirming the Government's approach to pay awards in the public sector for 2016/2017. I do apologise for the long delay in writing to you.

I am grateful for the invaluable work you and your members carry out on behalf of all those that participate in the pay review process. The government has made it clear that pay restraint in the public sector continues to be a crucial part of its plans to reduce the deficit. I appreciate that this presents particular challenges, but your expertise, impartial and independent judgement is vital as employers and staff respond to the unprecedented challenges facing the NHS.

The Government has announced that it will fund annual pay awards in the public sector at an average of one per cent in each of the next four years (2016/2017 to 2019/2020). In his letter to you, the Chief Secretary to the Treasury also asked that you consider how an award might be targeted to support recruitment and retention.

Employed Doctors and Dentists

I invite the Review Body on Doctors' and Dentists' remuneration to consider the case for targeting to support recruitment and retention and to make recommendations within an average of one per cent for employed doctors.

I would like to thank you and your members for your work on the special reports on the reform of consultant and junior doctor employment contracts. The BMA have agreed to re-enter talks on the reform of consultant contracts with new contracts implemented by 1 April 2016 and existing staff given the option to transfer to the new contract from 1 April 2017.

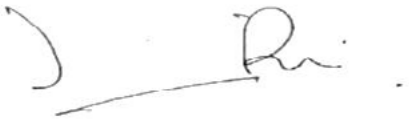
The BMA decided not to re-enter talks on the reform of the junior doctor contract. We have asked NHS Employers to continue work to introduce a new junior doctor contract from 1 August 2016. They will continue to engage with all relevant stakeholders, including the BMA as they develop and implement a new contract.

Pay recommendations for 2016/2017 should be based on existing contracts only.

Independent Contractors

For general medical practitioners and general dental practitioners, the Government would welcome the views of the Review Body on Doctors' and Dentists' remuneration as to how an overall pay uplift of an average of one per cent could be applied to improve recruitment and retention.

As always, whilst your 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 round and to communicate this to you directly.



DAVID PRIOR

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The Rt Hon Simon Hamilton MLA
Minister for Health, Social Services and Public Safety
Northern Ireland Executive
Stormont Castle
Stormont Estate
Belfast BT4 3TT

1st December 2015

Dear Minister,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION: 2016 PAY ROUND

The Review Body on Doctors' and Dentists' Remuneration (DDRB) was asked by your predecessor to provide recommendations on independent contractor general medical practitioners and general dental practitioners for 2015/16. We submitted our report and recommendations in February 2015.

The pay round for 2016/17 is now underway and the DDRB is keen to understand what the Northern Ireland position is, in respect of our last recommendations and whether you will seek recommendations on the pay of doctors and dentists for 2016/17.

I and the DDRB members would be most grateful for an update. While our terms of reference do not require us to have a remit from governments in order to report and make recommendations, it would be helpful to us to know the NI government's position.

Yours sincerely,

Professor Paul Curran
Chair, DDRB

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/MD/1410/15

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

16 December 2015

Dear Professor Curran,

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION – REMIT 2016/17

I am writing to confirm the Welsh Government's approach in respect of the DDRB's remit for 2016-17, and as such, request that the Review Body provides recommendations in respect c staff engaged on medical and dental terms and conditions. For general medical practitioners and general dental practitioners, the Welsh Government would also welcome the views of th Review Body as to how an overall pay uplift could be applied.

Any recommendation should take into account the Chancellor's 2015 budget statement that public sector pay will increase by 1% a year for 4 years from 2016-17 and within the context NHS Wales financial position, as set out in the written and oral evidence.

To this end, please note that the Welsh Government will be aiming to submit written evidenc by 21 December, followed with oral evidence on 11 January 2016.

My officials will be happy to work with your secretariat to ensure you have all relevant supporting information is made available.

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

Yours sincerely,

Mark Drakeford

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

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
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Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

T: 0300 244 4000
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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014

Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
8th Floor
Fleetbank House
2-6 Salsbury Square
LONDON EC4Y 8JX

22 December 2015

Dear Prof Curran

Further to the letters that the Doctors' and Dentists' Review Body has received from the Chief Secretary to the Treasury, Greg Hands, on 19 August 2015 and Lord Prior on 6 November 2015, I am writing to confirm the Scottish Government's remit to the Doctors' and Dentists' Review Body for employed doctors and dentists for the 2016 pay round.

The Cabinet Secretary for Finance, Constitution and the Economy announced the Scottish Government's Public Sector Pay Policy for 2016-17 on 16 December 2015. This is a single year policy and sets out the parameters for pay increases for staff. A copy of the policy is available here.

With regard to DDRB interests, the main features of this policy are:

- An overall 1 per cent cap on the cost of the increase in basic pay for those earning £22,000 or more.
- A continuation of the commitment to No Compulsory Redundancies.

You will appreciate that all consideration on this issue by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland for 2016-17. It is 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.

At the request of DDRB, the Scottish Government commissioned an exercise to collect more robust information on the expenses of independent GDPs in order to support the pay review process. The response to this exercise has been disappointing. In view of our mutual difficulties with respect to this commission, the Scottish Government requests DDRB to consider how this information may be provided in the future, and on what basis the Scottish Government should proceed with making an award for 2016-17.

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.

I would like to take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to 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.

Yours sincerely,

Shona Robison

SHONA ROBISON

BB0018DEC2015
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FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY

Department of
Health, Social Services and Public Safety
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Professor Paul Curran
Chair, Doctors and Dentist Review Body
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London
EC 4Y 8JX

Our Ref: COR/1796/2015

Date: 3 February 2016

Dear PROFESSOR CURRAN

Thank you for your letter of 1 December 2015. The Department of Health, Social Services and Public Safety (DHSSPS) greatly values the contribution of the Doctors and Dentists Pay Review Body in delivering robust, evidence based pay outcomes for public sector workers.

I write to confirm the approach of my Department in respect of the Pay Review Body's remit for 2016-17.

I would ask that you consider the case for targeting to support recruitment and retention and to make recommendations for salaried doctors and dentists. Any recommendation should take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland which will be set out in the written evidence.

For GDP and GMS contractors, my Department would also welcome your views as to how an overall pay lift could be applied.

To this end, please note that my Department will be aiming to submit written evidence by 5 February. My officials will be happy to work with your secretariat to ensure that you have all relevant supporting information to inform your review.

Yours sincerely

Simon

SIMON HAMILTON MLA

APPENDIX B1: DETAILED RECOMMENDATIONS ON REMUNERATION IN ENGLAND

PART I: SALARY SCALES[1]

The salary scales that we recommend should apply from 1 April 2016 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

	2015	2016
	£	£
Foundation house officer 1	22,636	22,862
	24,049	24,289
	25,461	25,716
Foundation house officer 2	28,076	28,357
	29,912	30,211
	31,748	32,066
Dental trainees in hospital posts	28,076	28,357
	29,912	30,211
	31,748	32,066
	33,584	33,920
	35,420	35,774
	37,256	37,628
	39,092	39,483
Specialty registrar (full)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647

[1] Our recommended basic pay uplifts, to be applied from 1 April 2016, 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.

	2015	2016
	£	£
Specialty registrar (fixed term)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
House officer	22,636	22,862
	24,049	24,289
	25,461	25,716
Senior house officer	28,076	28,357
	29,912	30,211
	31,748	32,066
	33,584	33,920
	35,420	35,774
	37,256	37,628
	39,092	39,483
Specialist registrar[2]	31,301	31,614
	32,852	33,180
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647
Consultant (2003 contract, England for main pay thresholds)	75,249	76,001
	77,605	78,381
	79,961	80,761
	82,318	83,141
	84,667	85,514
	90,263	91,166
	95,860	96,819
	101,451	102,465

[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.

	2015	2016
	£	£
Consultant (pre-2003 contract)[3]	62,477	63,102
	66,948	67,617
	71,419	72,133
	75,890	76,649
	80,988	81,798
Specialty doctor[4]	37,176	37,547
	40,354	40,758
	44,487	44,931
	46,701	47,168
	49,892	50,391
	53,071	53,602
	56,321	56,884
	59,572	60,168
	62,823	63,452
	66,074	66,734
	69,325	70,018
Associate specialist (2008)[5]	52,122	52,643
	56,312	56,875
	60,500	61,105
	66,032	66,693
	70,827	71,535
	72,816	73,544
	75,412	76,166
	78,008	78,788
	80,603	81,409
	83,199	84,031
	85,797	86,655
Associate specialist (pre-2008)	38,071	38,451
	42,103	42,524
	46,135	46,596
	50,167	50,668
	54,199	54,741
	58,231	58,813
	63,556	64,191
	68,171	68,852

[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.

[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.

	2015	2016
	£	£
Discretionary Points	*Notional scale*	
	70,086	70,787
	72,584	73,310
	75,083	75,833
	77,581	78,357
	80,079	80,880
	82,580	83,406
Staff grade practitioner	34,441	34,786
(1997 contract, MH03/5)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,596	49,082
Discretionary Points	*Notional scale*	
	50,845	51,353
	53,578	54,114
	56,313	56,876
	59,047	59,637
	61,780	62,398
	64,516	65,161
Staff grade practitioner	34,441	34,786
(pre-1997 contract, MH01)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,111	48,592
	50,845	51,353
	53,578	54,114
Clinical Excellence Awards	2,957	2,986
	5,914	5,972
	8,871	8,958
	11,828	11,944
	14,785	14,930
	17,742	17,916
	23,656	23,888
	29,570	29,860
	35,484	35,832

	2015	2016
	£	£
	(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)	4,652	4,699
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553	4,598
	4,816	4,864
	5,081	5,132
	5,344	5,398
	5,608	5,664
	5,871	5,930
	6,135	6,196

B. Community health staff

	2015	2016
	£	£
Clinical medical officer	32,994	33,323
	34,780	35,128
	36,566	36,932
	38,352	38,736
	40,138	40,540
	41,925	42,344
	43,711	44,148
	45,498	45,953
Senior clinical medical officer	46,623	47,089
	49,461	49,956
	52,298	52,821
	55,135	55,686
	57,973	58,553
	60,810	61,418
	63,647	64,283
	66,485	67,150

C. Salaried primary dental care staff[6]

	2015	2016
	£	£
Band A: Salaried dentist	38,095	38,476
	42,328	42,751
	48,677	49,164
	51,851	52,370
	55,026	55,576
	57,142	57,714
Band B: Salaried dentist[7]	59,259	59,851
	61,375	61,989
	64,550	65,195
	66,137	66,798
	67,724	68,401
	69,311	70,004
Band C: Salaried dentist[8, 9, 10]	70,899	71,608
	73,015	73,745
	75,131	75,883
	77,248	78,020
	79,364	80,158
	81,480	82,295

[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 should be increased from £83.37 to £84.20 per visit. Additional fees should be increased *pro rata*.

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

	Per week[11]		Per notional half day	
	2015	2016	2015	2016
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	1,010.79	90.98	91.89
Hospital practitioner appointment			102.49	103.51
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			89.22	90.11

	Per week[12]		Per standard hour	
	2015	2016	2015	2016
	£	£	£	£
Specialty registrar (higher rate) appointment	892.32	900.96	18.59	18.77
Specialty registrar (lower rate) appointment	809.76	817.92	16.87	17.04
Specialist registrar appointment	892.32	900.96	18.59	18.77
Foundation house officer 2 appointment	688.80	695.52	14.35	14.49
Senior house officer appointment	773.28	780.96	16.11	16.27
Foundation house officer 1 appointment/ House officer appointment	553.44	559.20	11.53	11.65

	Per week[13]		Per session	
	2015	2016	2015	2016
	£	£	£	£
Staff grade practitioner appointment	844.10	852.50	84.41	85.25

	Per week[14]		Per programmed activity	
	2015	2016	2015	2016
	£	£	£	£
Specialty doctor appointment	853.20	861.70	85.32	86.17
Associate specialist appointment (2008)	1,160.30	1,171.90	116.03	117.19

[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.

London weighting

3. The value of the London zone payment[15] is unchanged at £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:

	2015			2016		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,522	7,042	8,804	3,557	7,113	8,892
Band C	4,418	8,804	10,579	4,462	8,892	10,685
Band B	5,284	10,579	13,646	5,337	10,685	13,782
Regional director of public health: Band A	13,646	19,808		13,782	20,006	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

5. The supplement payable to general practice specialty registrars is 45 per cent[16] of basic salary.

6. The salary range for salaried general medical practitioners (GMPs) employed by primary care organisations should be increased from £55,411 – £83,617 to £55,965 – £84,453.

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

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

APPENDIX B2: DETAILED RECOMMENDATIONS ON REMUNERATION IN WALES

PART I: SALARY SCALES[17]

The salary scales that we recommend should apply from 1 April 2016 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

	2015	2016
	£	£
Foundation house officer 1	22,636	22,862
	24,049	24,289
	25,461	25,716
Foundation house officer 2	28,076	28,357
	29,912	30,211
	31,748	32,066
Foundation house officer 1 (pre-2015 contract)	22,748	22,976
	24,168	24,409
	25,587	25,843
Foundation house officer 2 (pre-2015 contract)	28,215	28,497
	30,060	30,361
	31,905	32,224
Dental foundation trainees	30,132	30,434
Dental trainees in hospital posts	28,215	28,497
	30,060	30,361
	31,905	32,224
	33,750	34,088
	35,595	35,951
	37,440	37,815
	39,285	39,678

[17] Our recommended basic pay uplifts, to be applied from 1 April 2016, 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.

	2015	2016
	£	£
Specialty registrar (full)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647
Specialty registrar (fixed term)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
House officer	22,748	22,976
	24,168	24,409
	25,587	25,843
Senior house officer	28,215	28,497
	30,060	30,361
	31,905	32,224
	33,750	34,088
	35,595	35,951
	37,440	37,815
	39,285	39,678
Specialist registrar[18]	31,301	31,614
	32,852	33,180
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647

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

	2015 £	2016 £
Consultant (2003 contract, Wales)	72,927	73,656
	75,249	76,001
	79,134	79,925
	83,646	84,482
	88,798	89,686
	91,735	92,653
	94,679	95,626
Commitment Awards[19]	3,204	3,236
	6,408	6,472
	9,612	9,708
	12,816	12,944
	16,020	16,180
	19,224	19,416
	22,428	22,652
	25,632	25,888
Specialty doctor[20]	37,176	37,547
	40,354	40,758
	44,487	44,931
	46,701	47,168
	49,892	50,391
	53,071	53,602
	56,321	56,884
	59,572	60,168
	62,823	63,452
	66,074	66,734
	69,325	70,018
Associate specialist (2008)[21]	52,122	52,643
	56,312	56,875
	60,500	61,105
	66,032	66,693
	70,827	71,535
	72,816	73,544
	75,412	76,166
	78,008	78,788
	80,603	81,409
	83,199	84,031
	85,797	86,655

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

[20] 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.

[21] 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.

	2015	2016
	£	£
Associate specialist (pre-2008)	38,071	38,451
	42,103	42,524
	46,135	46,596
	50,167	50,668
	54,199	54,741
	58,231	58,813
	63,556	64,191
	68,171	68,852
Discretionary Points	*Notional scale*	
	70,086	70,787
	72,584	73,310
	75,083	75,833
	77,581	78,357
	80,079	80,880
	82,580	83,406
Staff grade practitioner	34,441	34,786
(1997 contract, MH03/5)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,596	49,082
Discretionary Points	*Notional scale*	
	50,845	51,353
	53,578	54,114
	56,313	56,876
	59,047	59,637
	61,780	62,398
	64,516	65,161
Staff grade practitioner	34,441	34,786
(pre-1997 contract, MH01)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,111	48,592
	50,845	51,353
	53,578	54,114

	(Annual rates on the basis of a notional half day per week)	
	2015	**2016**
	£	**£**
Clinical assistant (part-time medical and dental officer appointed under paragraphs 94 or 105 of the Terms and Conditions of Service)	4,652	4,699
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553	4,598
	4,816	4,864
	5,081	5,132
	5,344	5,398
	5,608	5,664
	5,871	5,930
	6,135	6,196

B. Community health staff

	2015	**2016**
	£	**£**
Clinical medical officer	32,994	33,323
	34,780	35,128
	36,566	36,932
	38,352	38,736
	40,138	40,540
	41,925	42,334
	43,711	44,148
	45,498	45,953
Senior clinical medical officer	46,623	47,089
	49,461	49,956
	52,298	52,821
	55,135	55,686
	57,973	58,553
	60,810	61,418
	63,647	64,283
	66,485	67,150

C. Salaried primary dental care staff[22]

	2015	2016
	£	£
Band A: Salaried dentist	38,095	38,476
	42,328	42,751
	48,677	49,164
	51,851	52,370
	55,026	55,576
	57,142	57,714
Band B: Salaried dentist[23]	59,259	59,851
	61,375	61,989
	64,550	65,195
	66,137	66,798
	67,724	68,401
	69,311	70,004
Band C: Salaried dentist[24, 25, 26]	70,899	71,608
	73,015	73,745
	75,131	75,883
	77,248	78,020
	79,364	80,158
	81,480	82,295

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

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

[24] 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.

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

[26] 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 should be increased from £83.37 to £84.20 per visit. Additional fees should be increased *pro rata*.

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

	Per week[27]		Per notional half day	
	2015	2016	2015	2016
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	1,010.79	90.98	91.89
Hospital practitioner appointment			102.49	103.51
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			89.22	90.11

	Per week[28]		Per standard hour	
	2015	2016	2015	2016
	£	£	£	£
Specialty registrar (higher rate) appointment	892.32	900.96	18.59	18.77
Specialty registrar (lower rate) appointment	809.76	817.92	16.87	17.04
Specialist registrar appointment	892.32	900.96	18.59	18.77
Foundation house officer 2 appointment	688.80	695.52	14.35	14.49
Senior house officer appointment	773.28	780.96	16.11	16.27
Foundation house officer 1 appointment/ House officer appointment	553.44	559.20	11.53	11.65

	Per week[29]		Per session	
	2015	2016	2015	2016
	£	£	£	£
Staff grade practitioner appointment	844.10	852.50	84.41	85.25

	Per week[30]		Per programmed activity	
	2015	2016	2015	2016
	£	£	£	£
Specialty doctor appointment	853.20	861.70	85.32	86.17
Associate specialist appointment (2008)	1,160.30	1,171.90	116.03	117.19

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

[28] 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.

[29] The per session rate multiplied by 10.

[30] 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:

	2015			2016		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,522	7,042	8,804	3,557	7,113	8,892
Band C	4,418	8,804	10,579	4,462	8,892	10,685
Band B	5,284	10,579	13,646	5,337	10,685	13,782
Regional director of public health: Band A	13,646	19,808		13,782	20,006	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[31] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,411 – £83,617 to £55,965 – £84,453.

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

APPENDIX B3: DETAILED RECOMMENDATIONS ON REMUNERATION IN SCOTLAND

PART I: SALARY SCALES[32]

The salary scales that we recommend should apply from 1 April 2016 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

	2015	2016
	£	£
Foundation house officer 1	23,205	23,437
	24,654	24,900
	26,102	26,363
Foundation house officer 2	28,782	29,070
	30,664	30,971
	32,546	32,872
Specialty registrar (full)	30,605	30,911
	32,478	32,803
	35,093	35,444
	36,675	37,042
	38,582	38,968
	40,491	40,896
	42,399	42,823
	44,307	44,750
	46,215	46,677
	48,123	48,605
Specialty registrar (fixed term)	30,605	30,911
	32,478	32,803
	35,093	35,444
	36,675	37,042
	38,582	38,968
	40,491	40,896
House officer	23,205	23,437
	24,654	24,900
	26,102	26,363

[32] Our recommended basic pay uplifts, to be applied from 1 April 2016, 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.

	2015	2016
	£	£
Senior house officer	28,782	29,070
	30,664	30,971
	32,546	32,872
	34,429	34,773
	36,311	36,674
	38,193	38,575
	40,075	40,476
Specialist registrar[33]	31,931	32,250
	33,512	33,847
	35,093	35,444
	36,675	37,042
	38,582	38,968
	40,491	40,896
	42,399	42,823
	44,307	44,750
	46,215	46,677
	48,123	48,605
Consultant (2003 contract)	76,761	77,529
	79,165	79,956
	81,568	82,384
	83,972	84,812
	86,369	87,233
	92,078	92,998
	97,787	98,765
	103,490	104,525
Discretionary Points	3,204	3,236
	6,408	6,472
	9,612	9,708
	12,816	12,944
	16,020	16,180
	19,224	19,416
	22,428	22,652
	25,632	25,888

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

	2015	2016
	£	£
Consultant (pre-2003 contract)[34]	63,733	64,370
	68,293	68,976
	72,855	73,583
	77,415	78,189
	82,616	83,442
Specialty doctor[35]	37,923	38,302
	41,165	41,577
	45,381	45,834
	47,640	48,116
	50,895	51,404
	54,138	54,679
	57,453	58,028
	60,770	61,377
	64,086	64,727
	67,402	68,076
	70,718	71,425
Associate specialist (2008)[36]	53,169	53,701
	57,444	58,018
	61,716	62,333
	67,359	68,033
	72,251	72,973
	74,280	75,023
	76,928	77,697
	79,576	80,371
	82,224	83,046
	84,871	85,720
	87,521	88,397
Associate specialist (pre-2008)	38,836	39,224
	42,950	43,379
	47,062	47,533
	51,175	51,687
	55,289	55,842
	59,402	59,996
	64,833	65,482
	69,541	70,236

[34] Closed to new entrants.

[35] 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.

[36] 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.

	2015	2016
	£	£
Discretionary Points	*Notional scale*	
	71,495	72,210
	74,043	74,784
	76,592	77,358
	79,140	79,932
	81,689	82,506
	84,240	85,082
Staff grade practitioner	35,133	35,485
(1997 contract, MH03/5)	37,923	38,302
	40,711	41,118
	43,500	43,935
	46,289	46,752
	49,573	50,069
Discretionary Points	*Notional scale*	
	51,867	52,386
	54,655	55,202
	57,444	58,019
	60,234	60,836
	63,022	63,652
	65,812	66,471
Staff grade practitioner	35,133	35,485
(pre-1997 contract, MH01)	37,923	38,302
	40,711	41,118
	43,500	43,935
	46,289	46,752
	49,078	49,568
	51,867	52,386
	54,655	55,202
Distinction Awards		
B award	31,959	32,278
A award	55,924	56,483
A+ award	75,889	76,648

	2015	2016
	£	£
	(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)	4,746	4,793
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,644	4,691
	4,913	4,962
	5,183	5,235
	5,452	5,506
	5,721	5,778
	5,989	6,049
	6,258	6,321

B. Community health staff

	2015	2016
	£	£
Clinical medical officer	33,657	33,993
	35,479	35,834
	37,301	37,674
	39,123	39,514
	40,945	41,355
	42,767	43,195
	44,589	45,035
	46,413	46,877
Senior clinical medical officer	47,560	48,036
	50,455	50,960
	53,349	53,883
	56,243	56,805
	59,138	59,730
	62,032	62,652
	64,926	65,575
	67,821	68,499

C. Salaried primary dental care staff

	2015	2016
	£	£
Dental Foundation Year 1	31,243	31,556
Dental Foundation Year 2	33,991	34,331
Public Dental Service pay scales:		
Band A: Dental officer	38,861	39,250
	43,179	43,611
	49,656	50,152
	52,894	53,423
	56,133	56,694
	58,291	58,874
Band B: Senior dental officer	60,451	61,055
	62,609	63,235
	65,847	66,505
	67,467	68,142
	69,087	69,778
	70,705	71,412
Band C: Assistant Clinical Director	72,325	73,048
	74,483	75,228
	76,642	77,408
Band C: Specialist dental officer	72,325	73,048
	74,483	75,228
	76,642	77,408
	78,801	79,589
Band C: Clinical Director/Chief Administrative Dental Officers	72,325	73,048
(Western Isles, Orkney and Shetland Health Boards)	74,483	75,228
	76,642	77,408
	78,801	79,589
	80,960	81,769
	83,119	83,950

Part-time dental surgeon	**Sessional fee (per hour)**	
	2015	**2016**
	£	**£**
Dental surgeon	29.26	29.55
Dental surgeon holding higher registrable qualifications	38.81	39.20
Dental surgeon employed as a consultant	47.89	48.36

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES[37]

1. The fee for domiciliary consultations should be increased from £85.05 to £85.90 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[38]		Per notional half day	
	2015	2016	2015	2016
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,020.91	1,031.14	92.81	93.74
Hospital practitioner appointment			104.55	105.59
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			91.01	91.92

	Per week[39]		Per standard hour	
	2015	2016	2015	2016
	£	£	£	£
Specialty registrar (higher rate) appointment	910.08	919.20	18.96	19.15
Specialty registrar (lower rate) appointment	826.08	834.24	17.21	17.38
Specialist registrar appointment	910.08	919.20	18.96	19.15
Foundation house officer 2	706.08	712.80	14.71	14.85
Senior house officer appointment	792.48	800.64	16.51	16.68
Foundation house officer 1 appointment/ House officer appointment	567.36	573.12	11.82	11.94

	Per week[40]		Per session	
	2015	2016	2015	2016
	£	£	£	£
Staff grade practitioner appointment	861.00	869.60	86.10	86.96

	Per week[41]		Per programmed activity	
	2015	2016	2015	2016
	£	£	£	£
Specialty doctor appointment	870.40	879.10	87.04	87.91
Associate specialist appointment (2008)	1,183.60	1,195.50	118.36	119.55

[37] Our recommended basic pay uplifts, to be applied from 1 April 2016, are applied to unrounded current salary scales, with the final result being rounded up to the nearest unit.

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

[39] 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.

[40] The per session rate multiplied by 10.

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

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

4. The supplements payable to district directors of public health and for regional directors of public health should be increased as follows:[42]

	2015			2016		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Island Health Boards: Band E	1,872	3,711		1,890	3,748	
Band D (50,000 – 249,999 population)	3,593	7,184	8,981	3,629	7,255	9,071
Band C (250,000 – 449,999 population)	4,506	8,981	10,792	4,551	9,071	10,900
Band B (450,000 and over population)	5,390	10,792	13,920	5,444	10,900	14,059
Regional director of public health: Band A	13,920	20,207		14,059	20,409	

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[43] of basic salary.

6. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,411 – £83,617 to £55,965 – £84,453.

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 £87.19 to £88.07.

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

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

APPENDIX B4: DETAILED RECOMMENDATIONS ON REMUNERATION IN NORTHERN IRELAND

PART I: SALARY SCALES[44]

The salary scales that we recommend should apply from 1 April 2016 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

	2015	2016
	£	£
Foundation house officer 1	22,636	22,862
	24,049	24,289
	25,461	25,716
Foundation house officer 2	28,076	28,357
	29,912	30,211
	31,748	32,066
Specialty registrar (full)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647
Specialty registrar (fixed term)	30,002	30,302
	31,838	32,156
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
House officer	22,636	22,862
	24,049	24,289
	25,461	25,716

[44] Our recommended basic pay uplifts, to be applied from 1 April 2016, 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.

	2015	2016
	£	£
Senior house officer	28,076	28,357
	29,912	30,211
	31,748	32,066
	33,584	33,920
	35,420	35,774
	37,256	37,628
	39,092	39,483
Specialist registrar[45]	31,301	31,614
	32,852	33,180
	34,402	34,746
	35,952	36,312
	37,822	38,200
	39,693	40,090
	41,564	41,979
	43,434	43,868
	45,304	45,757
	47,175	47,647
Consultant (2003 contract, Northern Ireland for main pay thresholds)	75,249	76,001
	77,605	78,381
	79,961	80,761
	82,318	83,141
	84,667	85,514
	90,263	91,166
	95,860	96,819
	101,451	102,465
Consultant (pre-2003 contract)[46]	62,477	63,102
	66,948	67,617
	71,419	72,133
	75,890	76,649
	80,988	81,798

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

[46] Closed to new entrants.

	2015	2016
	£	£
Specialty doctor[47]	37,176	37,547
	40,354	40,758
	44,487	44,931
	46,701	47,168
	49,892	50,391
	53,071	53,602
	56,321	56,884
	59,572	60,168
	62,823	63,452
	66,074	66,734
	69,325	70,018
Associate specialist (2008)[48]	52,122	52,643
	56,312	56,875
	60,500	61,105
	66,032	66,693
	70,827	71,535
	72,816	73,544
	75,412	76,166
	78,008	78,788
	80,603	81,409
	83,199	84,031
	85,797	86,655
Associate specialist (pre-2008)	38,071	38,451
	42,103	42,524
	46,135	46,596
	50,167	50,668
	54,199	54,741
	58,231	58,813
	63,556	64,191
	68,171	68,852

[47] 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.

[48] 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.

	2015	2016
	£	£
Discretionary Points	*Notional scale*	
	70,086	70,787
	72,584	73,310
	75,083	75,833
	77,581	78,357
	80,079	80,880
	82,580	83,406
Staff grade practitioner	34,441	34,786
(1997 contract, MH03/5)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,596	49,082
Discretionary Points	*Notional scale*	
	50,845	51,353
	53,578	54,114
	56,313	56,876
	59,047	59,637
	61,780	62,398
	64,516	65,161
Staff grade practitioner	34,441	34,786
(pre-1997 contract, MH01)	37,175	37,547
	39,909	40,308
	42,643	43,069
	45,377	45,831
	48,111	48,592
	50,845	51,353
	53,578	54,114

	2015	2016
	£	£
	(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)	4,652	4,699
Hospital practitioner (limited to a maximum of five half day weekly sessions)	4,553	4,598
	4,816	4,864
	5,081	5,132
	5,344	5,398
	5,608	5,664
	5,871	5,930
	6,135	6,196

B. Community health staff

	2015	2016
	£	£
Clinical medical officer	32,994	33,323
	34,780	35,128
	36,566	36,932
	38,352	38,736
	40,138	40,540
	41,925	42,344
	43,711	44,148
	45,498	45,953
Senior clinical medical officer	46,623	47,089
	49,461	49,956
	52,298	52,821
	55,135	55,686
	57,973	58,553
	60,810	61,418
	63,647	64,283
	66,485	67,150

C. Salaried primary dental care staff[49]

	2015	2016
	£	£
Dental Foundation Year 1	30,628	30,934
Dental Foundation Year 2	33,321	33,655
Band 1: Community dental officer	34,964	35,313
	37,792	38,170
	40,621	41,027
	43,450	43,885
	46,279	46,742
	49,107	49,599
	51,936	52,455
	54,766	55,313
Band 2: Senior dental officer	49,962	50,462
	53,917	54,456
	57,871	58,450
	61,826	62,444
	65,780	66,438
	66,652	67,319
	67,523	68,198
Band 3: Assistant clinical director	66,392	67,056
	67,419	68,093
	68,447	69,131
	69,474	70,169
	70,502	71,207
	71,530	72,246
Band 3: Clinical director	66,392	67,056
	67,419	68,093
	68,447	69,131
	69,474	70,169
	70,502	71,207
	71,530	72,246
	72,558	73,283
	73,602	74,338
	74,630	75,376
	75,657	76,414

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

Part-time dental surgeon	Sessional fee (per hour)	
	2015	2016
	£	£
Dental surgeon	28.68	28.97
Dental surgeon holding higher registrable qualifications	38.05	38.43
Dental surgeon employed as a consultant	47.41	47.89

PART II: OTHER RATES OF PAY, FEES AND ALLOWANCES[50]

1. The fee for domiciliary consultations should be increased from £83.37 to £84.20 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[51]		Per notional half day	
	2015	2016	2015	2016
	£	£	£	£
Associate specialist, senior hospital medical or dental officer appointment	1,000.78	1,010.79	90.98	91.89
Hospital practitioner appointment			102.49	103.51
Clinical assistant appointment (part-time medical and dental officer appointment under paragraphs 94 or 105 of the Terms and Conditions of Service)			89.22	90.11

	Per week[52]		Per standard hour	
	2015	2016	2015	2016
	£	£	£	£
Specialty registrar (higher rate) appointment	892.32	900.96	18.59	18.77
Specialty registrar (lower rate) appointment	809.76	817.92	16.87	17.04
Specialist registrar appointment	892.32	900.96	18.59	18.77
Foundation house officer 2	688.80	695.52	14.35	14.49
Senior house officer appointment	773.28	780.96	16.11	16.27
Foundation house officer 1 appointment/ House officer appointment	553.44	559.20	11.53	11.65

	Per week[53]		Per session	
	2015	2016	2015	2016
	£	£	£	£
Staff grade practitioner appointment	844.10	852.50	84.41	85.25

	Per week[54]		Per programmed activity	
	2015	2016	2015	2016
	£	£	£	£
Specialty doctor appointment	853.20	861.70	85.32	86.17
Associate specialist appointment (2008)	1,160.30	1,171.90	116.03	117.19

[50] Our recommended basic pay uplifts, to be applied from 1 April 2016, are applied to unrounded current salary scales, with the final result being rounded up to the nearest unit.

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

[52] 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.

[53] The per session rate multiplied by 10.

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

Doctors in public health medicine

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

	2015			2016		
	Minimum	Top of range[1]	Exceptional maximum[2]	Minimum	Top of range[1]	Exceptional maximum[2]
	£	£	£	£	£	£
Band D	3,522	7,042	8,804	3,557	7,113	8,892
Band C	4,418	8,804	10,579	4,462	8,892	10,685
Band B	5,284	10,579	13,646	5,337	10,685	13,782
Regional director of public health: Band A	13,646	19,808		13,782	20,006	

Notes:

[1] High performers can go above this as long as they do not exceed the exceptional maximum.

[2] This is the exceptional maximum of the scale.

General medical practitioners

4. The supplement payable to general practice specialty registrars is 45 per cent[55] of basic salary.

5. The salary range for salaried GMPs employed by primary care organisations should be increased from £55,411 – £83,617 to £55,965 – £84,453.

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 should be increased from £87.19 to £88.07.

Community health and community dental staff (Northern Ireland)

7. The teaching supplement for assistant clinical directors in the community dental service should be increased from £2,486 to £2,511 per year.

8. The teaching supplement payable to clinical directors in the community dental service should be increased from £2,808 to £2,836 per year.

9. The supplement for clinical directors covering two districts should be increased from £1,815 to £1,833 per year and the supplement for those covering three or more districts should be increased from £2,898 to £2,927 per year.

10. The allowance for dental officers acting as trainers should be increased from £1,988 to £2,008 per year.

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

APPENDIX B5: OTHER FEES AND ALLOWANCES

Operative date

1. The levels of remuneration set out below apply from 1 April 2016.

Hospital medical and dental staff

2. The annual values of national Clinical Excellence Awards (CEAs) for consultants and academic GMPs should be increased as follows:

	2015	2016
	£	£
Bronze (Level 9):	35,484	35,832
Silver (Level 10):	46,644	47,110
Gold (Level 11):	58,305	58,888
Platinum (Level 12):	75,796	76,554

3. The annual values of Distinction Awards for consultants[56] should be increased as follows:

	2015	2016
	£	£
B award:	31,959	32,278
A award:	55,924	56,483
A+ award:	75,889	76,648

4. The annual values of consultant intensity payments should be increased as follows:

	2015	2016
	£	£
Daytime supplement:	1,274	1,287

	England, Scotland and Northern Ireland		Wales	
	2015	2016	2015	2016
	£	£	£	£
Band 1:	960	970	2,213	2,235
Band 2:	1,913	1,932	4,426	4,470
Band 3:	2,860	2,889	6,637	6,704

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.

[56] 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.

Total salary = salary* + salary* X { 0.5 / 0.4 / 0.2 }

* 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 NHS[1]

ENGLAND[2]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[3]						
Consultants	38,341	40,444	39,748	41,929	3.7	3.7
Associate specialists	2,773	3,116	2,552	2,857	-8.0	-8.3
Specialty doctors	5,363	6,160	5,682	6,526	5.9	5.9
Staff grades	392	477	352	418	-10.2	-12.4
Registrar group	38,858	39,921	39,317	40,460	1.2	1.4
Foundation house officers 2[4]	6,975	7,019	7,012	7,056	0.5	0.5
Foundation house officers 1[5]	6,420	6,473	6,318	6,373	-1.6	-1.5
Other doctors in training	30	61	40	96	31.9	57.4
Hospital practitioners/Clinical assistants	295	1,254	239	1,013	-19.1	-19.2
Other staff	118	244	128	246	8.9	0.8
Total	**99,565**	**104,778**	**101,388**	**106,638**	**1.8**	**1.8**
Hospital and Community Health Services Dental Staff						
Consultants	672	783	695	811	3.4	3.6
Associate specialists	108	157	101	149	-6.5	-5.1
Specialty doctors	238	447	285	519	19.3	16.1
Staff grades	12	29	11	26	-13.1	-10.3
Registrar group	549	577	530	555	-3.6	-3.8
Foundation house officers 2[4]	515	531	518	536	0.7	0.9
Foundation house officers 1[5]	52	52	51	51	-1.9	-1.9
Other doctors in training	0	0	0	0	:	:
Hospital practitioners/Clinical assistants	34	205	30	172	-11.5	-16.1
Other staff	894	1,268	893	1,268	-0.1	0.0
Total	**3,075**	**3,968**	**3,113**	**4,011**	**1.2**	**1.1**

: 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 (GMPs), general dental practitioners (GDPs) or ophthalmic medical practitioners.

[4] This includes senior house officers.

[5] This includes house officers.

ENGLAND[6]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners	**36,294**	**40,236**	**36,920**	**40,584**	**1.7**	**0.9**
GMP providers	24,043	26,635	23,763	26,183	-1.2	-1.7
General practice specialty registrars[7]	4,093	4,404	4,175	4,512	2.0	2.5
GMP retainers[8]	126	284	116	262	-7.5	-7.7
Other GMPs	8,032	9,153	8,865	9,885	10.4	8.0
General dental practitioners[9,10,11]		**23,723**		**23,947**		**0.9**
General Dental Services only		19,133		19,625		2.6
Personal Dental Services only		1,877		1,799		-4.2
Mixed		1,814		1,658		-8.6
Trust-led		899		865		-3.8
Ophthalmic medical practitioners[12]		**293**		**267**		**-8.9**
Total general practitioners		**64,252**		**64,798**		**0.8**
Total – NHS doctors and dentists		**172,984**		**175,430**		**1.4**

[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]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[14]						
Consultants	2,337	2,467	2,329	2,463	-0.4	-0.2
Associate specialists	334	378	306	347	-8.6	-8.2
Specialty doctors	457	556	492	590	7.7	6.1
Staff grades	7	11	6	9	-20.3	-18.2
Specialist registrars	1,887	1,936	1,832	1,890	-2.9	-2.4
Foundation house officers 2[15]	531	532	573	577	8.1	8.5
Foundation house officers 1[16]	381	383	341	342	-10.5	-10.7
Hospital practitioners	3	16	2	12	-21.2	-25.0
Clinical assistants	14	66	11	77	-19.1	16.7
Other staff[17]	122	190	120	196	-1.8	3.2
Total	**6,073**	**6,535**	**6,011**	**6,503**	**-1.0**	**-0.5**
General medical practitioners		**2,285**		**2,249**		**-1.6**
GMP providers		2,026		2,006		-1.0
General practice specialty registrars		233		220		-5.6
GMP retainers		26		23		-11.5
General dental practitioners		**1,438**		**1,439**		**0.1**
General Dental Services only		1,040		1,092		5.0
Personal Dental Services only		164		126		-23.2
Mixed		149		141		-5.4
Ophthalmic medical practitioners		**8**		**7**		**-12.5**
Total general practitioners		**3,731**		**3,695**		**-1.0**
Total – NHS doctors and dentists		**10,266**		**10,198**		**-0.7**

[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]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Health Services Medical Staff[19]						
Consultants	4,535	4,836	4,847	5,160	6.9	6.7
Associate specialists	285	331	297	344	4.3	3.9
Specialty doctors	527	736	592	794	12.2	7.9
Staff grades	66	85	22	31	-66.5	-63.5
Registrar group	3,905	4,072	4,140	4,308	6.0	5.8
Foundation house officers 2[20]	744	753	856	863	15.0	14.6
Foundation house officers 1[21]	1,071	1,076	883	885	-17.6	-17.8
Hospital practitioners	15	88	12	73	-22.1	-17.0
Clinical assistants	28	125	21	74	-26.0	-40.8
Other staff	308	704	345	792	11.9	12.5
Total	**11,485**	**12,705**	**12,014**	**13,240**	**4.6**	**4.2**
Hospital and Community Health Services Dental Staff[19]						
Consultants	131	148	127	144	-2.7	-2.7
Associate specialists	18	22	15	19	-17.4	-13.6
Specialty doctors	33	54	42	76	27.2	40.7
Staff grades	4	4	<1	1	-83.3	-75.0
Registrar group	32	38	58	63	79.8	65.8
Foundation house officers 2[20]	44	50	30	33	-30.4	-34.0
Foundation house officers 1[21]	1	1	1	1	0.0	0.0
Hospital practitioners	<1	1	<1	1	25.0	0.0
Clinical assistants	0	0	0	0	:	:
Other staff	434	568	410	526	-5.4	-7.4
Total	**696**	**868**	**685**	**850**	**-1.6**	**-2.1**

: 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]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
General medical practitioners		**4,881**		**4,918**		**0.8**
GMP providers		3,727		3,722		-0.1
General practice specialty registrars[23]		488		489		0.2
GMP retainers[24]		133		118		-11.3
Other GMPs		543		598		10.1
General dental services[25]		**3,176**		**3,207**		**1.0**
Principal dental practitioners		2,589		2,661		2.8
Vocational dental practitioners		191		166		-13.1
Assistant dental practitioners		56		62		10.7
Other dentists (non-hospital)		1,441		1,421		-1.4
Ophthalmic medical practitioners		**37**		**35**		**-5.4**
Total general practitioners		**8,094**		**8,160**		**0.8**
Total – NHS doctors and dentists		**21,411**		**21,729**		**1.5**

[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, community dentists and public dental service dentists.

NORTHERN IRELAND[26]	2013		2014		Percentage change 2013 – 2014	
	Full-time equivalents	Headcount	Full-time equivalents	Headcount	Full-time equivalents	Headcount
Hospital and Community Medical and Dental Staff[27]						
Consultants	1,488	1,583	1,548	1,644	4.0	3.9
Associate specialists	132	153	125	145	-5.1	-5.2
Specialty doctors	250	309	284	346	13.4	12.0
Staff grades	25	31	21	26	-17.0	-16.1
Specialist registrars	1,218	1,244	1,211	1,242	-0.6	-0.2
Foundation house officers 1 and 2[28]	542	544	538	540	-0.7	-0.7
Hospital practitioners	15	52	21	44	40.5	-15.4
Other staff	91	139	233	362	155.3	160.4
Total	**3,762**	**4,055**	**3,982**	**4,349**	**5.8**	**7.3**
General medical practitioners[29]		**1,171**		**1,211**		**3.4**
General dental practitioners[30, 31]		**960**		**987**		**2.8**
Ophthalmic medical practitioners[30]		**11**		**11**		**0.0**
Total general practitioners		**2,142**		**2,209**		**3.1**
Total – NHS doctors and dentists		**6,197**		**6,264**		**1.1**

[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.

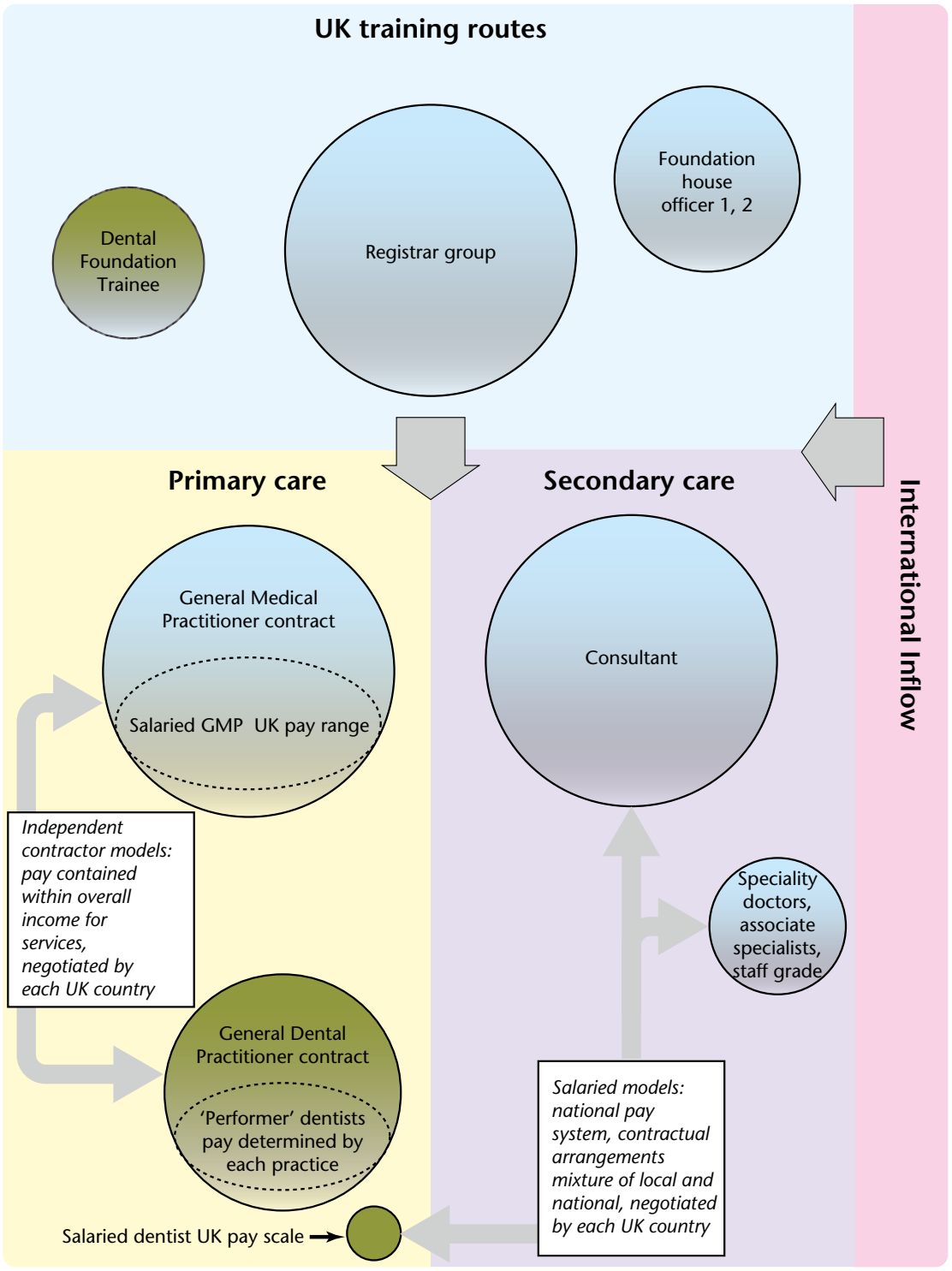
[28] This includes house officers and senior house officers.

[29] Data as of November.

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

[31] It is possible for someone to be a dentist at one location and an assistant at another location so the final total will not represent individual people.

Map of UK doctors' and dentists' pay system



All circles are proportionate to the FTEs of each group except for the dental foundation training.

Source: 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, (2014).

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.

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*.

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.

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

DENTAL PERFORMERS – those who carry out dental work; that is, individual general dental practitioners. See also *performer-only dentists, associate dentists, principal dentists, providing-performer dentists.*

DENTAL PROVIDERS – those with whom primary care organisations agree contract values for a particular level of service. They can be practices, individual dentists or companies. See also *performer-only dentists, associate dentists, principal dentists, providing-performer dentists.*

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.*

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 for 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.*

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.

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.* See also *expenses to earnings ratio.*

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

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

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

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

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.

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.

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.

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.

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.

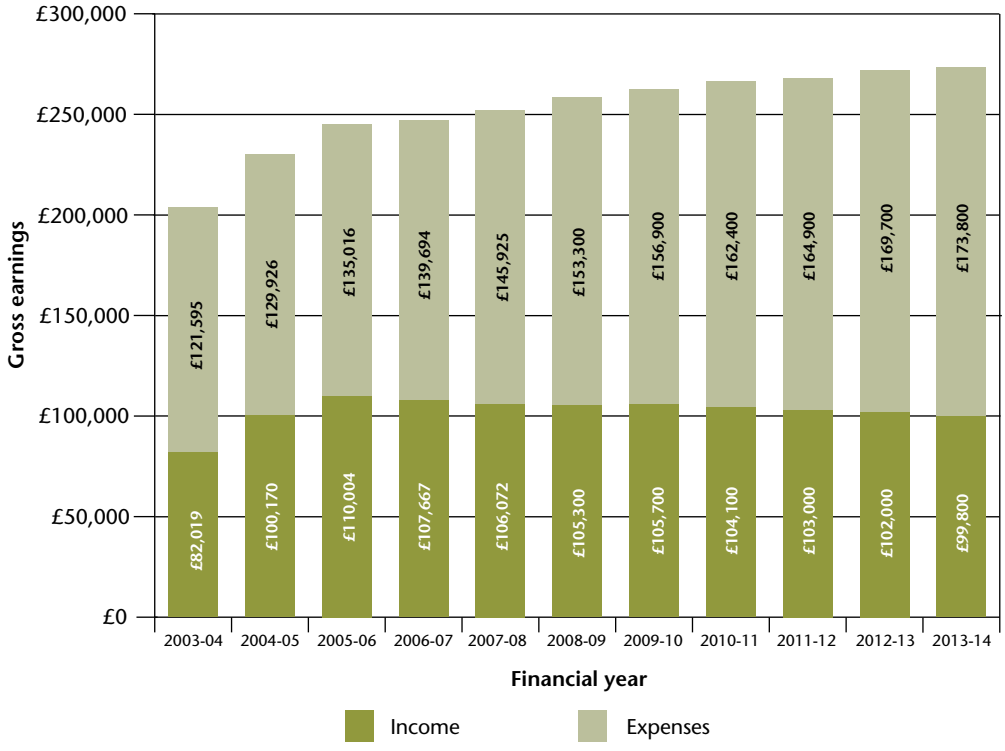
APPENDIX E: EARNINGS AND EXPENSES OF GMPs AND GDPs

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 2013-14

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 2013-14, which the parties might find helpful in their contract negotiations on expenses. The report showed that in 2013-14, average gross earnings were £273,600 and average expenses were £173,800 giving an expenses to earnings ratio (EER) of 63.5 per cent. Average taxable income for contractor GMPs was £99,800, a decrease of 2.2 per cent on 2012-13 and was the first time that, in cash terms, income had fallen below £100,000 since 2003-04. This decrease at the UK level was entirely driven by decreases in England. Expenses have generally been increasing at a faster rate than gross earnings and therefore the EER has been increasing over recent years: see Figure E.1 and Table E.1 for further details.

Figure E.1: GMP contractors' gross earnings: income and expenses, United Kingdom, 2003-04 to 2013-14



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

Notes: Gross earnings relate to NHS and private work.

Not adjusted for inflation.

Table E.1: GMP contractors' gross earnings, expenses and income, United Kingdom, 2003-04 to 2013-14

Financial Year	Gross Earnings £	Total Expenses £	Income £	Income Annual change %	Income Change from 2003-04 %	Expenses to Earnings Ratio (EER) %
2003-04	201,600	120,100	81,600	-	-	59.6
2004-05	230,100	129,900	100,200	22.8	22.8	56.5
2005-06	245,000	135,000	110,000	9.8	34.8	55.1
2006-07	247,400	139,700	107,700	-2.1	32.0	56.5
2007-08	252,000	145,900	106,100	-1.5	30.0	57.9
2008-09	258,600	153,300	105,300	-0.8	29.0	59.3
2009-10	262,700	156,900	105,700	0.4	29.5	59.8
2010-11	266,500	162,400	104,100	-1.5	27.6	60.9
2011-12	267,900	164,900	103,000	-1.1	26.2	61.6
2012-13	271,800	169,700	102,000	-0.9	25.0	62.5
2013-14	273,600	173,800	99,800	-2.2	21.7	63.5

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

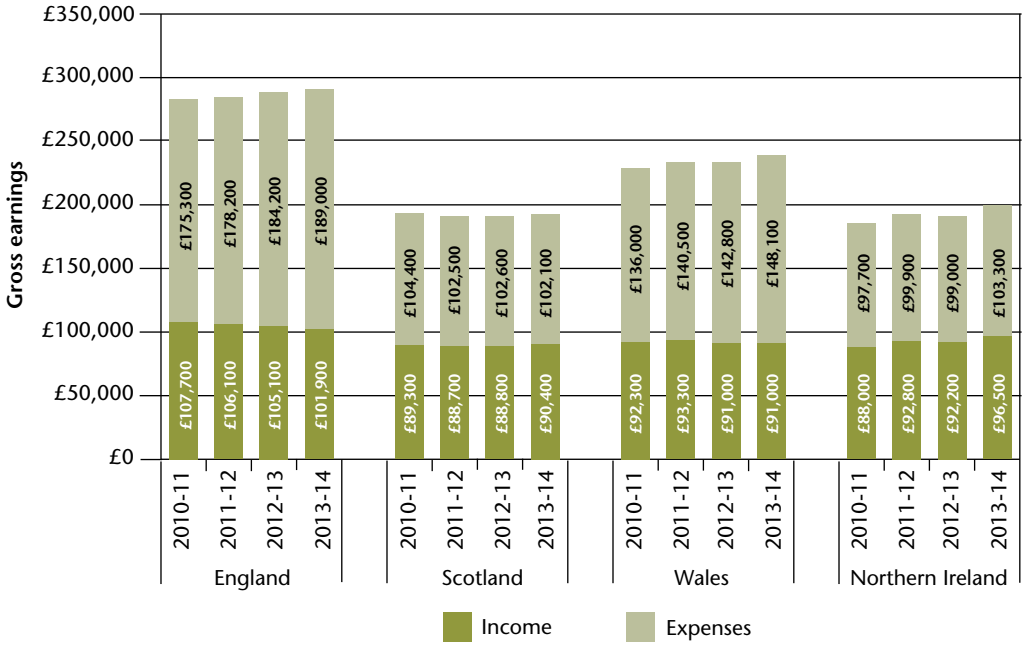
Note: Not adjusted for inflation.

E.3 Figure E.2 and Table E.2 show average taxable income and average expenses of contractor GMPs by UK country. Table E.3 and Figure E.3 show these data by NHS England regions. It is the first time the data have been available at regional level since the abolition of Strategic Health Areas and therefore no trend data exists.

- In 2013-14, both average income and average expenses were highest in England, at £101,900 and £189,000 respectively, with the EER also highest at 65.0 per cent. However the only contractor GMPs to experience a decrease in income were those in England.
- Average taxable incomes in Scotland, Wales and Northern Ireland were £90,400, £91,000 and £96,500 respectively.
- Within England, average income was highest in the East (£110,700) and lowest in the South West (£86,300).
- Whilst the reasons for variability between regions are unknown, another one-off piece of analysis by HSCIC[1] concluded that there is a statistically significant link between areas of deprivation and some GMPs EER in both 2011-12 and 2012-13 data. It showed that in more deprived areas some GMPs had smaller EERs than elsewhere (i.e. expenses were smaller in relative terms to gross earnings). However, specific groups of GMPs which appear to show no correlation at all between earnings and expenses and deprivation are salaried GMPs, non-dispensing GMPs, GMPs in urban practices and single-handed GMPs. For these groups, deprivation had no relationship with their EER.

[1] http://www.hscic.gov.uk/catalogue/PUB17057/GP%20Earnings%20by%20Deprivation%20Score%20England%202011-12%20and%202012-13%20V1.0.pdf

Figure E.2: GMP contractors' gross earnings: income and expenses, by United Kingdom country, 2010-11 to 2013-14



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

Note: Not adjusted for inflation.

Table E.2: GMP contractors' gross earnings, expenses and income by United Kingdom country, 2012-13 to 2013-14

Country	Year	Gross Earnings	Expenses	Income	Expenses to Earnings Ratio (EER) %
England	2012-13	£289,300	£184,200	£105,100	63.7
	2013-14	£290,900	£189,000	£101,900	65.0
	% change	0.5	2.6	-3.1	
Scotland	2012-13	£191,300	£102,600	£88,800	53.6
	2013-14	£192,400	£102,100	£90,400	53.0
	% change	0.6	-0.5	1.8	
Wales	2012-13	£233,800	£142,800	£91,000	61.1
	2013-14	£239,100	£148,100	£91,000	61.9
	% change	2.2	3.7	0.0	
Northern Ireland	2012-13	£191,100	£99,000	£92,200	51.8
	2013-14	£199,800	£103,300	£96,500	51.7
	% change	4.5	4.4	4.7	
United Kingdom	2012-13	£271,800	£169,700	£102,000	62.5
	2013-14	£273,600	£173,800	£99,800	63.5
	% change	0.7	2.4	-2.2	

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

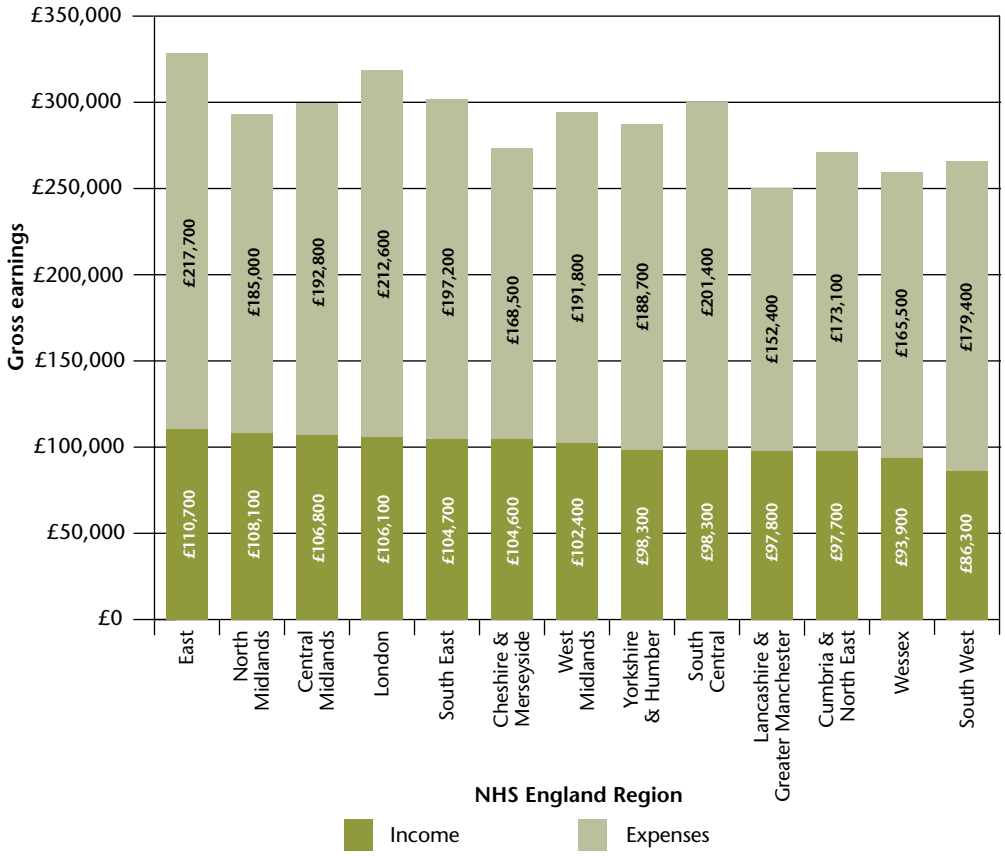
Note: Not adjusted for inflation.

Table E.3: Income for General/Personal Medical Services (GPMS) contractor GMPs by NHS England region, 2013-14

NHS England region	Expenses £	Income £	EER %
East	217,700	110,700	66.3
North Midlands	185,000	108,100	63.1
Central Midlands	192,800	106,800	64.4
London	212,600	106,100	66.7
South East	197,200	104,700	65.3
Cheshire & Merseyside	168,500	104,600	61.7
West Midlands	191,800	102,400	65.2
Yorkshire & Humber	188,700	98,300	65.7
South Central	201,400	98,300	67.2
Lancashire & Greater Manchester	152,400	97,800	60.9
Cumbria & North East	173,100	97,700	63.9
Wessex	165,500	93,900	63.8
South West	179,400	86,300	67.5
NHS England commissioning region			
North of England Region	172,700	99,200	63.5
Midlands and East of England Region	197,000	107,100	64.8
London region	212,600	106,100	66.7
South of England Region	187,600	96,400	66.1

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

Figure E.3: GMP contractors' average gross earnings: income and expenses, 2013-14, by NHS England region

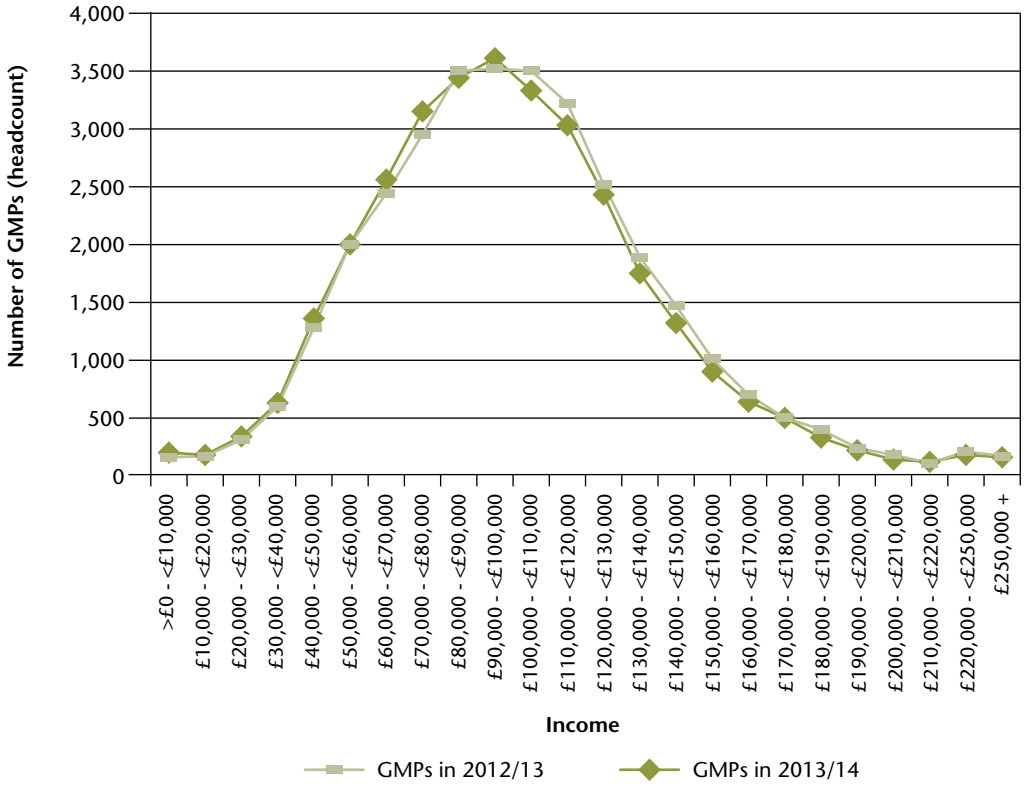


Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

E.4 NHS England suggested that the fall in GMP pay in England was due to two main factors: GMPs working fewer hours per week on average; and a reduction in the number of patients per GMP. Whilst hours worked and patient numbers per FTE GMP are important factors in pay, there are other ways to earn income. Additionally the figures do not differentiate between salaried and provider GMPs, so any differences in workload would not be apparent.

E.5 There is a large amount of variability in the income of GMPs: Table E.3 and Figure E.3 shows regional variations in the levels of average income for independent contractor GPMS GMPs. Figure E.4 shows the distribution of GMP income in the United Kingdom and shows decreases in average income across the distribution of earnings.

Figure E.4: Distribution of GMP contractors' income before tax, United Kingdom, 2012-13 and 2013-14



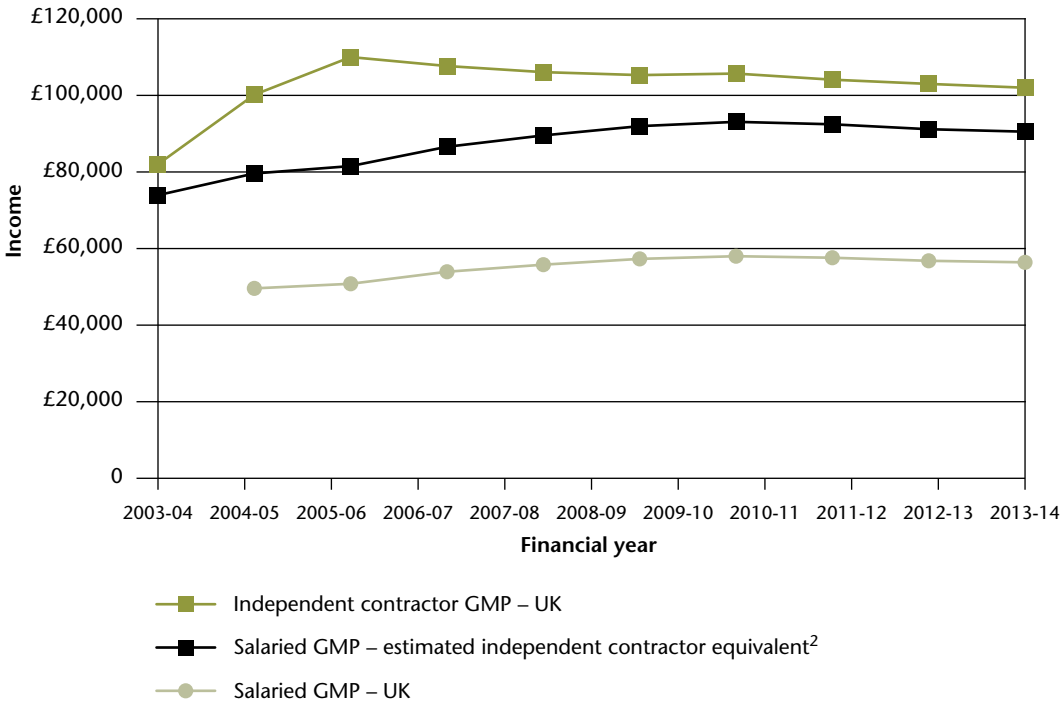
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Note: Not adjusted for inflation.

Key results for salaried GMPs

E.6 Average taxable income for salaried GMPs was £54,600 in 2013-14, a decrease of 3.3 per cent on 2012-13. 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 extent of part-time working has changed since then.

Figure E.5: Income for General/Personal Medical Services (GPMS) contractor GMPs by type of GMP,[1] United Kingdom, 2003-04 to 2013-14



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. 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).

3. Not adjusted for inflation.

The Health and Social Care Information Centre: dental earnings and expenses 2013-14

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 2013-14, a GDP on average had a taxable income of £71,700 and expenses of £83,400, giving an EER of 53.8 per cent (Table E.4). Providing-performer dentists[2] had average taxable income of £115,200 and expenses of £259,800 (EER 69.3 per cent); for performer-only dentists[3] the figures were £60,600 and £38,500 respectively (EER 38.8 per cent). Despite increases to average taxable incomes of providing-performer dentists (+1.0 per cent), average taxable income for all dentists actually decreased (-1.2 per cent). This has been driven by changes to the dentist population (fewer

[2] A providing-performer dentist holds a contract with a NHS England Area Team/Local Health Board and also performs NHS dentistry on this or another contract.

[3] A performer-only dentist performs NHS activity on a contract, but does not hold a contract with a NHS England Area Team/Local Health Board themselves.

providing-performer and more performer-only dentists) and the decreases in the average taxable income (-0.4 per cent) of performer-only dentists.

E.9 For providing-performer dentists, average taxable income increased with the percentage of time spent on NHS dentistry, with those dentists spending at least 75 per cent of their time on NHS dentistry earning an average taxable income of £119,600 in 2013-14. The opposite pattern was shown for performer-only dentists, where the lowest average taxable income of £60,900 was earned by those who spent at least 75 per cent of their time on NHS dentistry, and the highest taxable income of £70,000 was earned by those who spend less than 25 per cent of their time on NHS dentistry. One potential explanation for these trends could be that performer-only dentists may retain a higher percentage of the fees generated by performing private dentistry than they do for NHS dentistry (i.e., providing-performer dentists may take a lower proportion of the private fees).

Table E.4: Average income and expenses for GDPs, England and Wales, 2008-09 to 2013-14

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	EER (%)
Providing-performer	2008-09	6,783	366,500	74,700	160,800	131,000	64.3
	2009-10	6,250	370,900	77,600	165,300	128,000	65.5
	2010-11	5,750	364,300	79,000	168,100	117,200	67.8
	2011-12	5,250	358,400	80,700	164,900	112,800	68.5
	2012-13	4,750	368,000	80,500	173,300	114,100	69.0
	2013-14	4,350	375,000	81,700	178,100	115,200	69.3
	Latest % change	*-8.4%*	*1.9%*	*1.5%*	*2.8%*	*1.0%*	*+0.3pp*
Performer-only	2008-09	12,853	104,000	5,600	30,700	67,800	34.9
	2009-10	14,050	101,700	6,700	29,400	65,600	35.5
	2010-11	15,050	98,400	5,900	29,600	62,900	36.0
	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
	2013-14	17,150	99,000	6,700	31,800	60,600	38.8
	Latest % change	*2.1%*	*2.9%*	*11.7%*	*8.2%*	*-0.4%*	*+2.0pp*
All dentists	2008-09	19,636	194,700	29,500	75,600	89,600	54.0
	2009-10	20,300	184,900	28,600	71,400	84,900	54.1
	2010-11	20,800	172,000	26,100	68,000	77,900	54.7
	2011-12	21,300	161,000	24,100	62,500	74,400	53.8
	2012-13	21,500	156,100	22,400	61,100	72,600	53.5
	2013-14	21,500	155,100	21,900	61,500	71,700	53.8
	Latest % change	*0.0%*	*-0.7%*	*-2.2%*	*0.7%*	*-1.2%*	*+0.3pp*

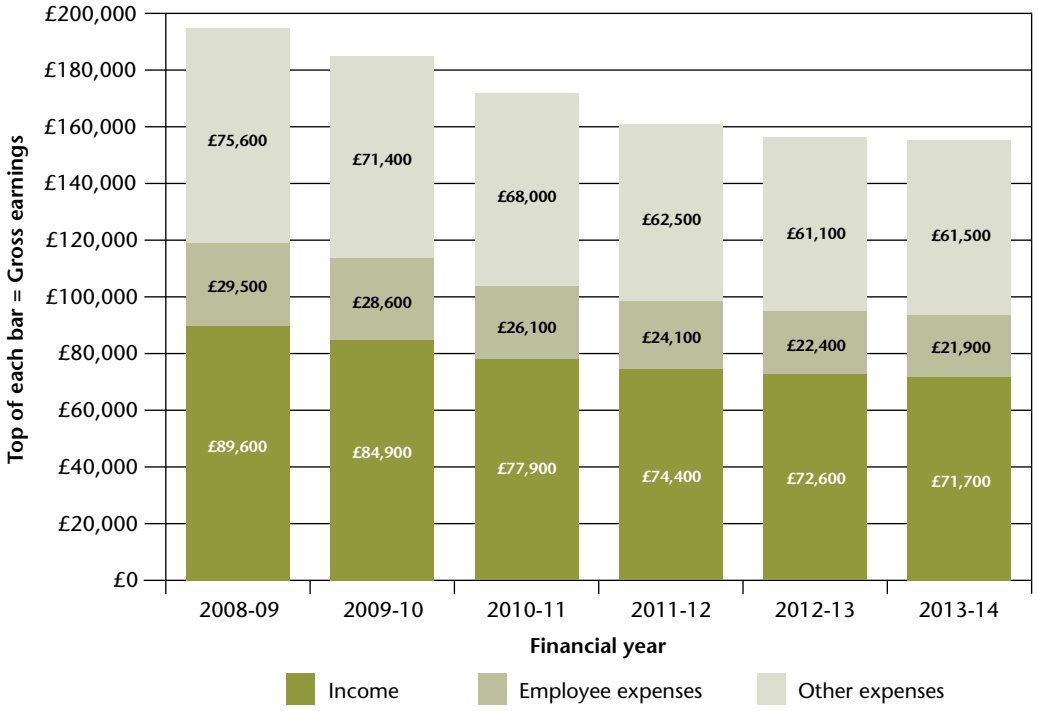
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

* 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.

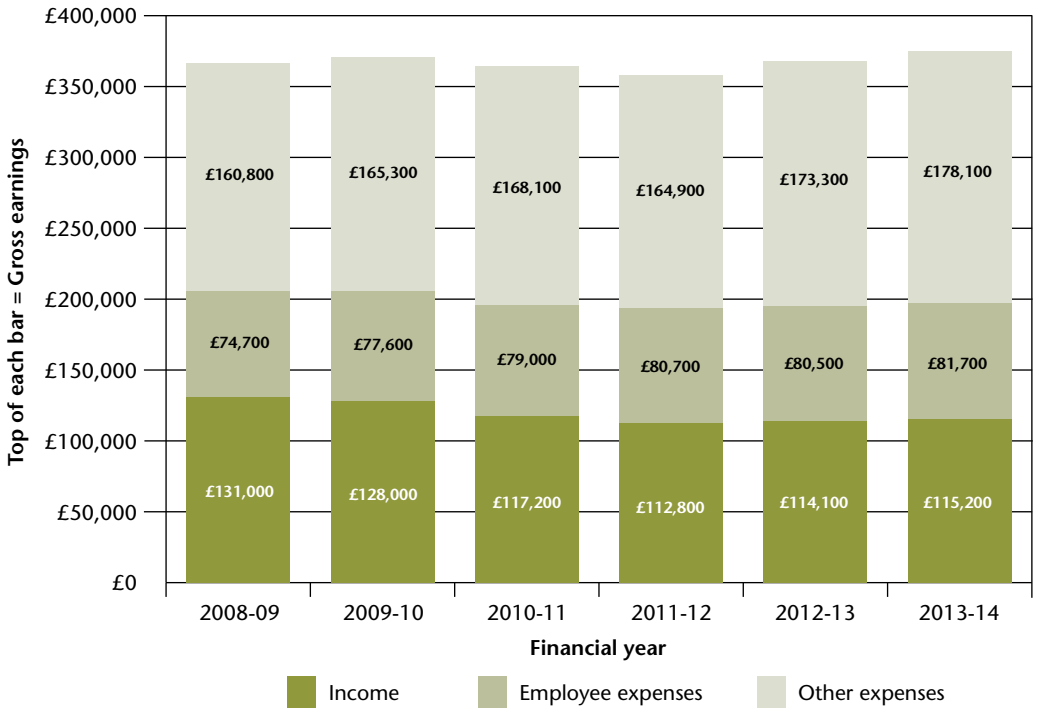
E.10 Figures E.6, E.7 and E.8 show recent trends in income and expenses in England and Wales.

Figure E.6: Gross earnings (NHS and private) for self-employed dentists, England and Wales, 2008-09 to 2013-14



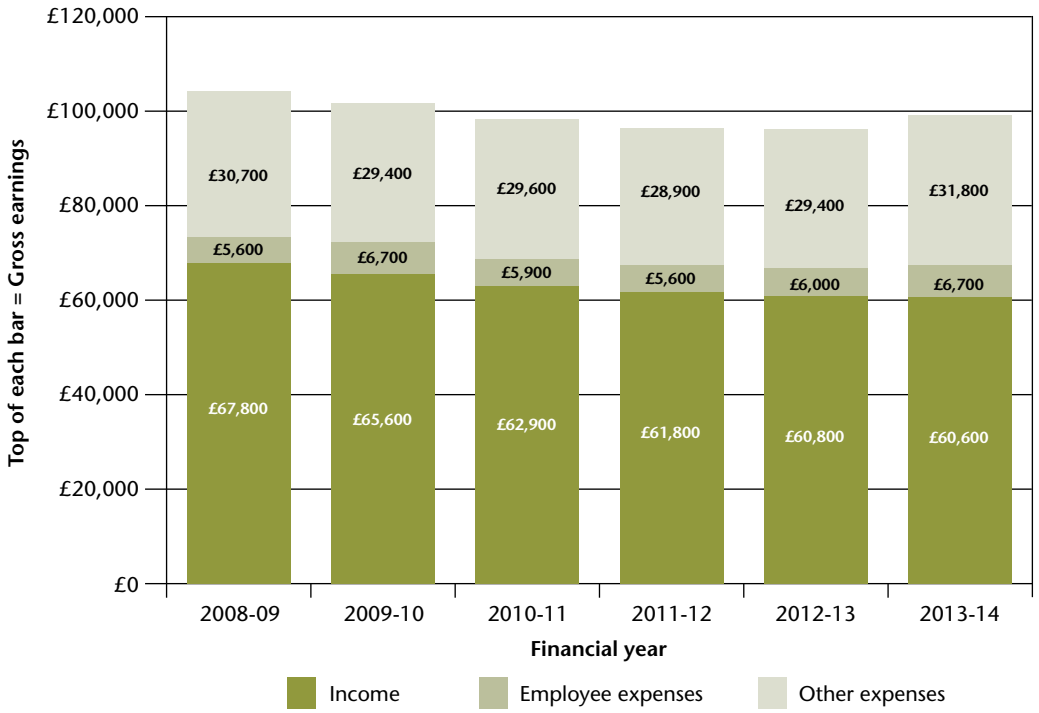
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.7: Gross earnings (NHS and private) for self-employed providing-performer dentists, England and Wales, 2008-09 to 2013-14



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

Figure E.8: Gross earnings (NHS and private) for self-employed performer only dentists, England and Wales, 2008-09 to 2013-14



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

Scotland

E.11 In 2013-14, a GDP in Scotland on average had a taxable income of £68,000 and expenses of £85,800, giving an EER of 55.8 per cent (Table E.5). A principal dentist[4] had an average taxable income of £98,400 and expenses of £231,900 (EER 70.2 per cent); for associate[5] dentists the figures were £56,200 and £28,700 respectively (EER 33.8 per cent).

Table E.5: Average income and expenses for GDPs, Scotland, 2008-09 to 2013-14

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	EER (%)
	2008-09	699	343,900	86,700	138,500	118,700	65.5
	2009-10	650	337,000	85,800	137,400	113,800	66.2
	2010-11	700	334,700	89,300	144,300	101,100	69.8
Principal	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
	2013-14	650	330,300	85,000	146,900	98,400	70.2
	Latest % change	*0.0%*	*3.3%*	*1.2%*	*6.2%*	*1.0%*	*+0.7pp*
	2008-09	1,318	100,500	2,100	31,300	67,100	33.2
	2009-10	1,450	91,900	1,100	27,700	63,100	31.3
	2010-11	1,450	87,900	1,200	26,600	60,100	31.6
Associate	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
	2013-14	1,650	84,900	600	28,100	56,200	33.8
	Latest % change	*0.0%*	*0.0%*	*-25.0%*	*4.5%*	*-1.8%*	*+1.2pp*
	2008-09	2,017	184,800	31,400	68,500	85,000	54.0
	2009-10	2,100	170,200	28,200	62,700	79,300	53.4
	2010-11	2,150	167,300	29,500	64,500	73,300	56.2
All dentists	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
	2013-14	2,300	153,900	24,300	61,500	68,000	55.8
	Latest % change	*0.0%*	*0.6%*	*-2.4%*	*4.1%*	*-1.1%*	*+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.

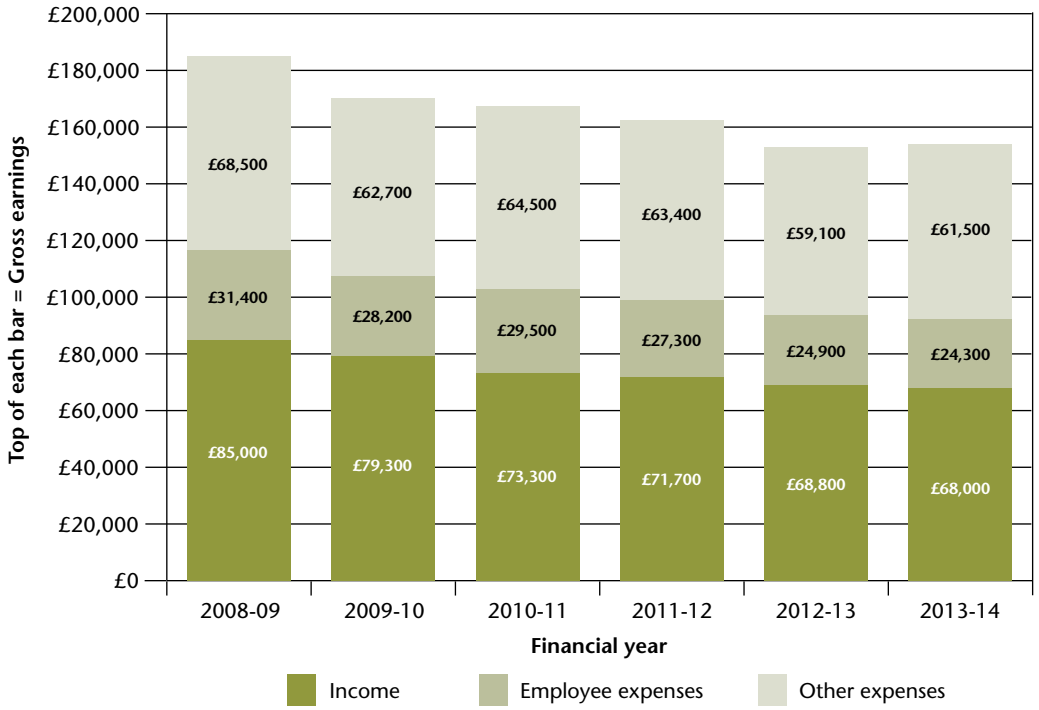
pp: percentage point change.

[4] A dental practitioner who is also an owner, director, or partner of a dental practice, has an arrangement with an NHS Board to provide primary care dental services.

[5] A dental practitioner who is self-employed and enters into an arrangement with a principal dentist that is neither partnership nor employment. Also has an arrangement with an NHS Board and provides primary care dental services.

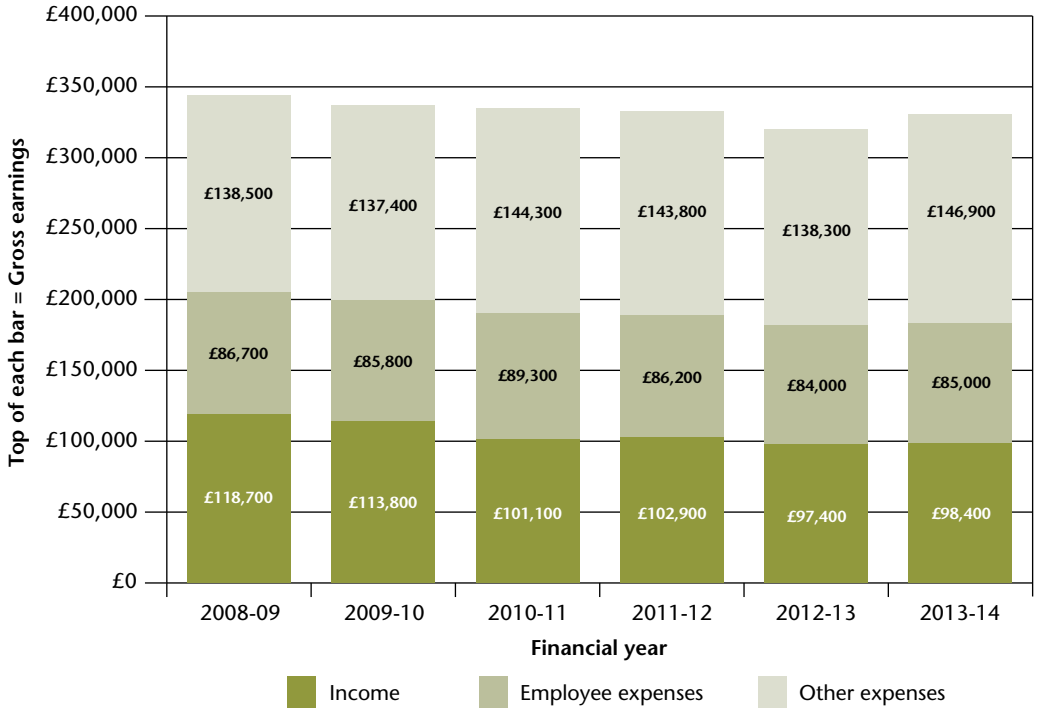
E.12 Figures E.9, E.10 and E.11 show recent trends in income and expenses in Scotland.

Figure E.9: Gross earnings (NHS and private) for self-employed dentists, Scotland, 2008-09 to 2013-14



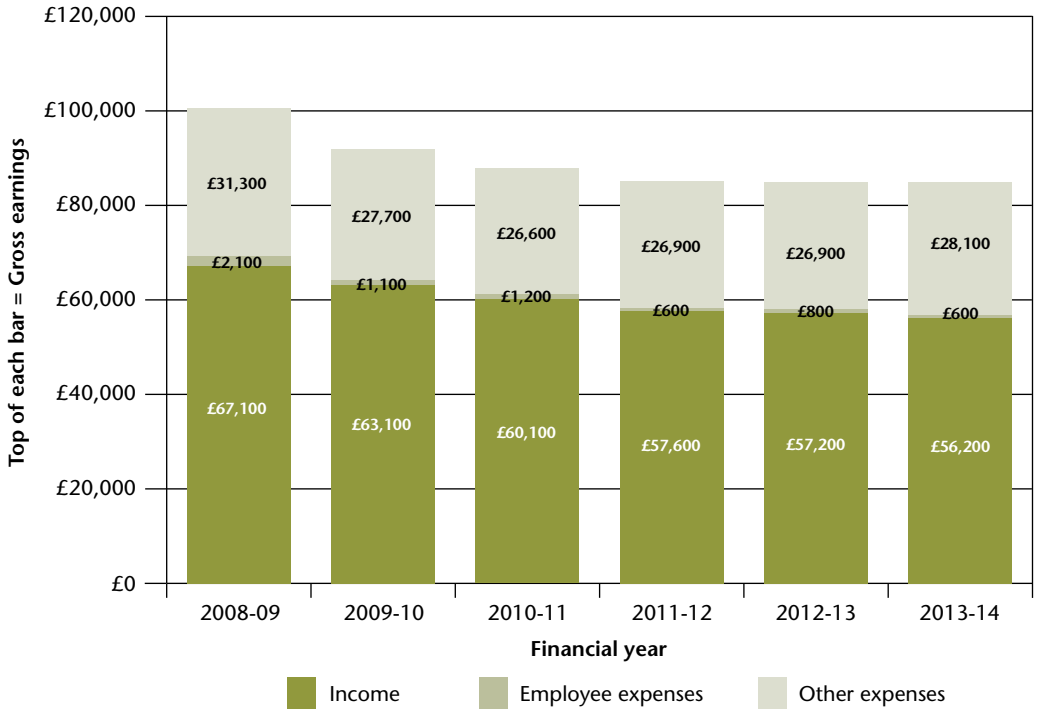
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.10: Gross earnings (NHS and private) for self-employed principal dentists, Scotland, 2008-09 to 2013-14



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

Figure E.11: Gross earnings (NHS and private) for self-employed associate dentists, Scotland, 2008-09 to 2013-14



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

Northern Ireland

E.13 In 2013-14, a GDP in Northern Ireland on average had a taxable income of £71,400 and expenses of £91,100, giving an EER of 56.0 per cent (Table E.6). A principal[6] dentist had an average taxable income of £112,500 and expenses of £223,100 (EER 66.5 per cent); for associate[7] dentists the figures were £54,200 and £35,500 respectively (EER 39.6 per cent).

[6] A dental practitioner who is also an owner, director, or partner of a dental practice, holds a dental surgeon (DS) number, and also performs primary care dental services.

[7] A dental practitioner who is self-employed and enters into an agreement with a principal dentist that is neither partnership nor employment. Holds a dental surgeon (DS) number and performs primary care dental services.

Table E.6: Average income and expenses for GDPs, Northern Ireland, 2008-09 to 2013-14

Dental type	Year	Estimated population*	Gross earnings (£)	Employee expenses* (£)	Non-employee expenses* (£)	Income (£)	EER (%)
Principal	2008-09	319	333,700	66,600	137,500	129,600	61.2
	2009-10	350	344,600	73,200	148,500	122,900	64.3
	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
	2013-14	300	335,600	76,900	146,200	112,500	66.5
	Latest % change	*0.0%*	*6.2%*	*-2.8%*	*15.9%*	*1.5%*	*+1.6pp*
Associate	2008-09	522	105,300	2,500	36,100	66,700	36.7
	2009-10	500	97,900	1,100	34,100	62,700	36.0
	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
	2013-14	700	89,700	700	34,800	54,200	39.6
	Latest % change	*7.7%*	*3.5%*	*250.0%*	*3.9%*	*2.2%*	*+0.7pp*
All dentists	2008-09	840	191,900	26,800	74,500	90,600	52.8
	2009-10	850	195,300	29,500	79,300	86,500	55.7
	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
	2013-14	950	162,500	23,300	67,800	71,400	56.0
	Latest % change	*0.0%*	*1.3%*	*-8.6%*	*7.1%*	*-0.2%*	*+0.6pp*

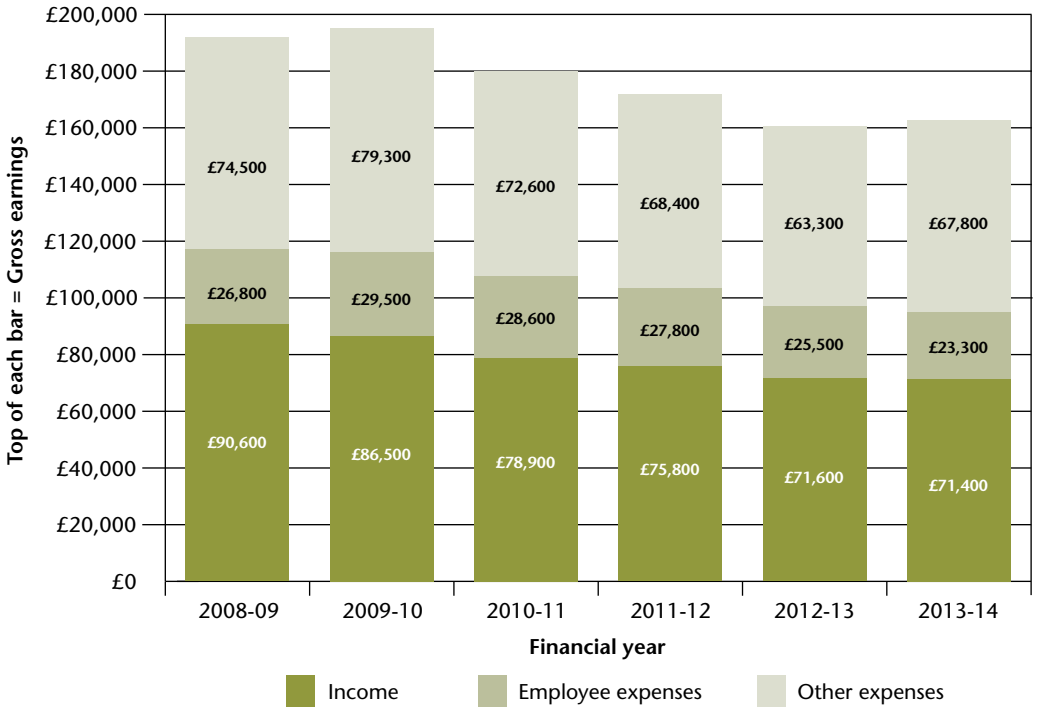
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

* 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.

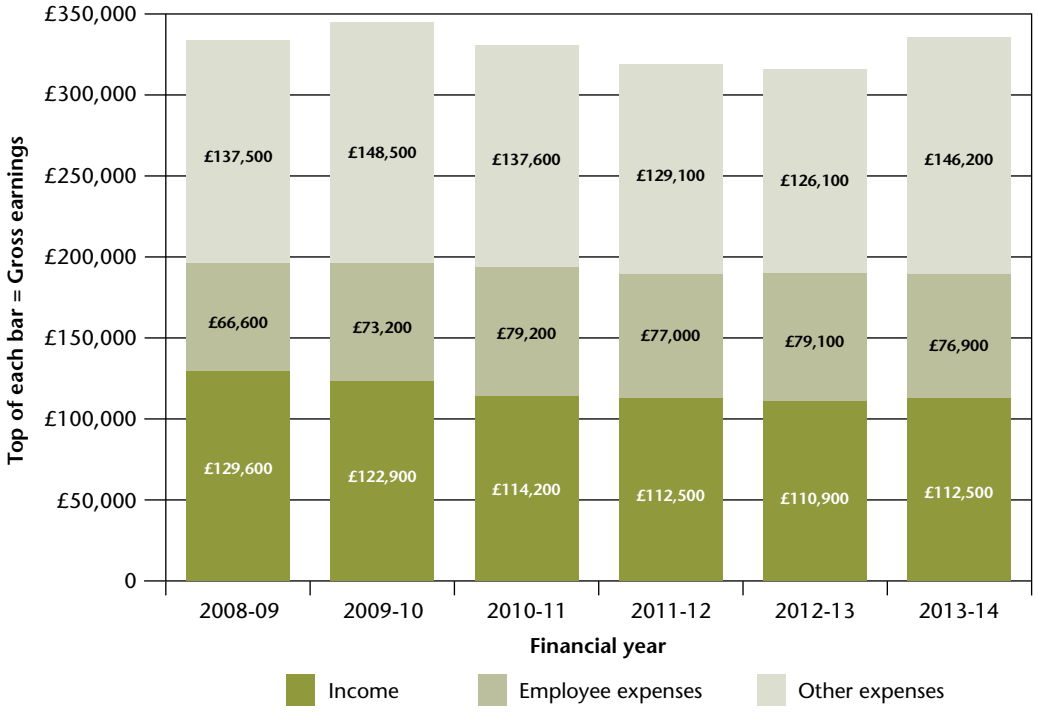
E.14 Figures E.12, E.13 and E.14 show recent trends in income and expenses in Northern Ireland.

Figure E.12: Gross earnings (NHS and private) for self-employed dentists, Northern Ireland, 2008-09 to 2013-14



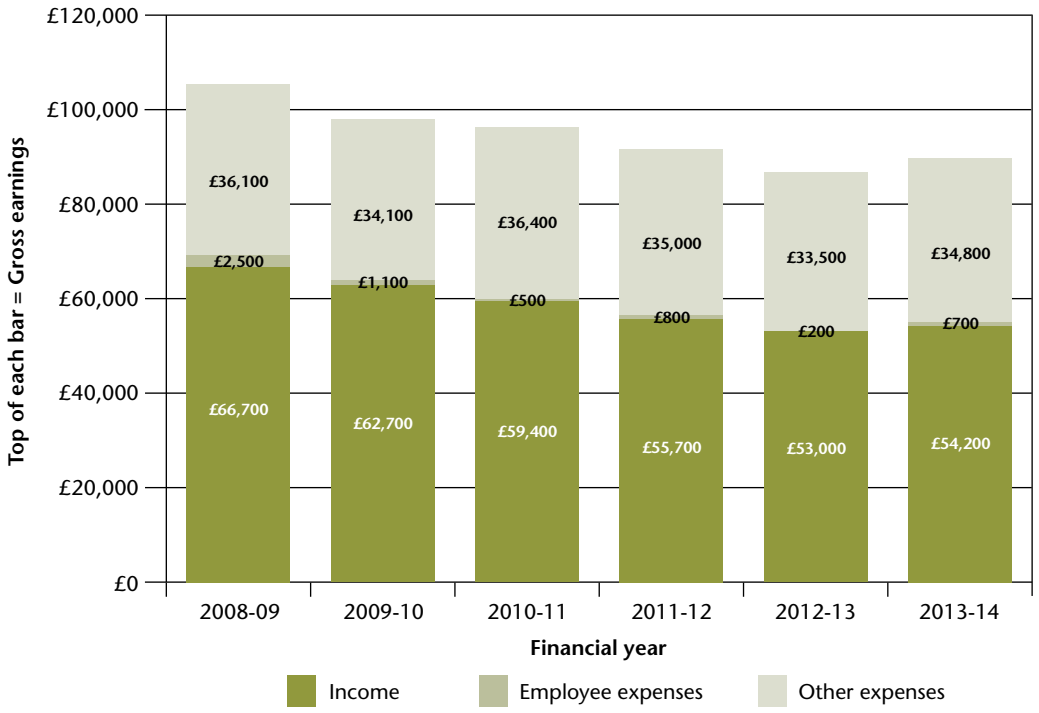
Source: The Health & Social Care Information Centre using Her Majesty's Revenue and Customs data.

Figure E.13: Gross earnings (NHS and private) for self-employed principal dentists, Northern Ireland, 2008-09 to 2013-14



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

Figure E.14: Gross earnings (NHS and private) for self-employed associate dentists, Northern Ireland, 2008-09 to 2013-14



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

Multiple counting of expenses

E.15 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, our working assumption (in the absence of evidence to the contrary) would have been 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, compiled 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 our earlier reports) that an EER of 50 per cent should be used in each country of the UK.

The data historically used in our formula-based decisions for independent contractor GMPs and GDPs

E.16 Whilst we are not making formula-based recommendations for independent contractor GMPs and GDPs, we set out below in Table E.7 the data that would have populated the formula. Given our ongoing concerns with the reliability of the formula, we do not consider it appropriate this year to adjust the weightings of the coefficients in the formula. When we last considered this issue, the coefficients and their weightings for dentists were based on data that covered all dentists, regardless of the time devoted to NHS work: as noted in our 2012 report, average earnings and expenses for dentists

reporting a high NHS share were similar to the total dental population. If we were using the formula this year, then we would wish to examine whether that case remained sound. The parties may wish to consider this point as part of their discussion of expenses and the uplift.

Table E.7: Data historically used in our formula-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) 2015 (general medical practice activities)*	-1.9%
Other costs (GMPs) *Retail Prices Index excluding mortgage interest payments (RPIX) for Q4 2015*	1.1%
Income (GDPs) *DDRB recommendation*	1%
Staff costs (GDPs) England, Scotland, Wales, Northern Ireland *ASHE 2015 (dental practice activities)*	1.5%
Laboratory costs (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2015*	1.1%
Materials (GDPs) England, Scotland, Wales, Northern Ireland *RPIX for Q4 2015*	1.1%
Other costs (GDPs) England, Wales, Northern Ireland *Retail Prices Index (RPI) for Q4 2015*	1%
Other costs (GDPs) Scotland *RPIX for Q4 2015*	1.1%

APPENDIX F: PAY COMPARABILITY

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

Table F.1 Anchor points used for pay comparability

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

Source: Office of Manpower Economics.

* In 2015 this was a level 4 local Clinical Excellence Award.

Data issues

F.2 It should be noted that, whilst PA Consulting has proposed anchor points which cover sub-sections of the specialty registrar group, mean basic salary and mean total earnings are not available for these subgroups. Consequently, Figures F.3 and F.4 provide estimates of total earnings (namely, by multiplying the pay scale value by the average banding supplement for specialty registrars, 43.7 per cent).

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

Pay comparability by anchor point

Foundation house officer 1

F.4 This first anchor point is for the first year of training following medical school. This is the first year of a two-year foundation course and builds upon the knowledge, skills and competences acquired in undergraduate training. Successful completion of this year will lead to registration with the General Medical Council. This anchor point aligns with graduate entry, although the undergraduate course is longer for medicine than for most other subjects. A comparison of earnings for doctors and dentists at this anchor point with external professions is given as Figure F.1.

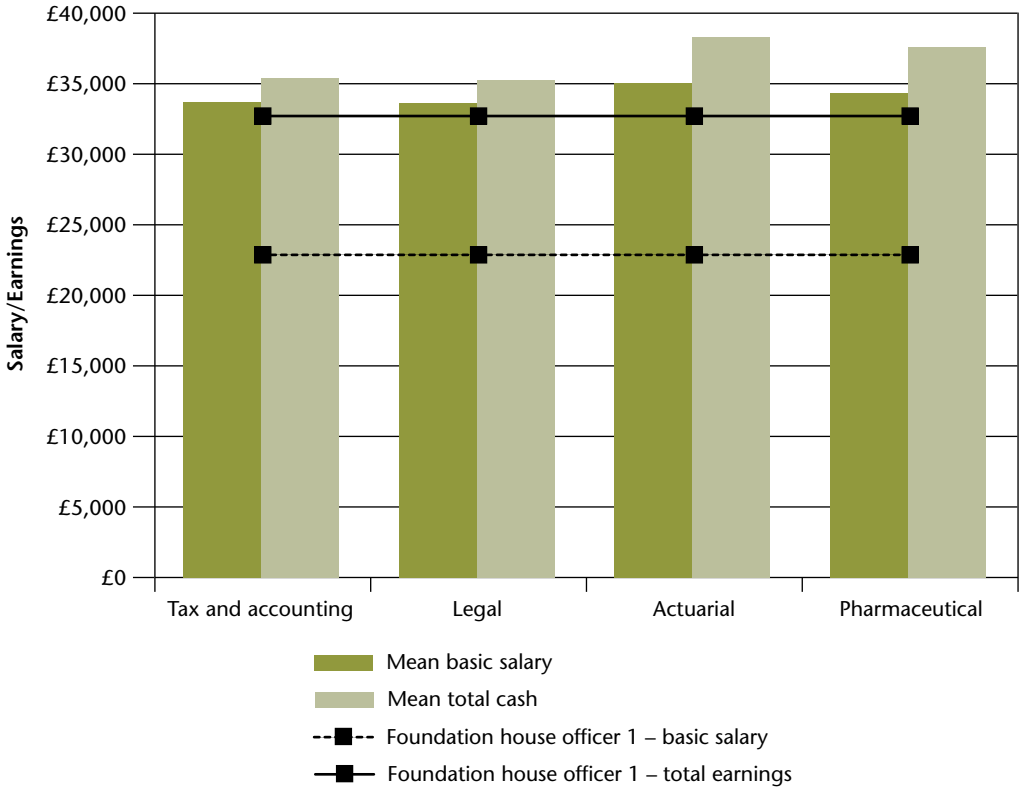
F.5 The mean basic salary[2] for foundation house officers in year 1 was well below that of the mean basic salary of comparator groups. Mean total earnings[3] were also down in relation to comparator groups. In the last two years, earnings for foundation house officers in year 1 were below that of all their comparator groups.

[1] The pay comparators were identified in the report: PA Consulting Group, *Review of pay comparability methodology for DDRB salaried remit groups*. Office of Manpower Economics, 2008.

[2] Mean annual basic pay per FTE.

[3] Mean annual basic pay per FTE plus mean annual non-basic pay per person.

Figure F.1: Foundation house officer, year 1 – mean basic salary and mean total earnings against mean basic salary and mean total cash for comparator professions, 2015



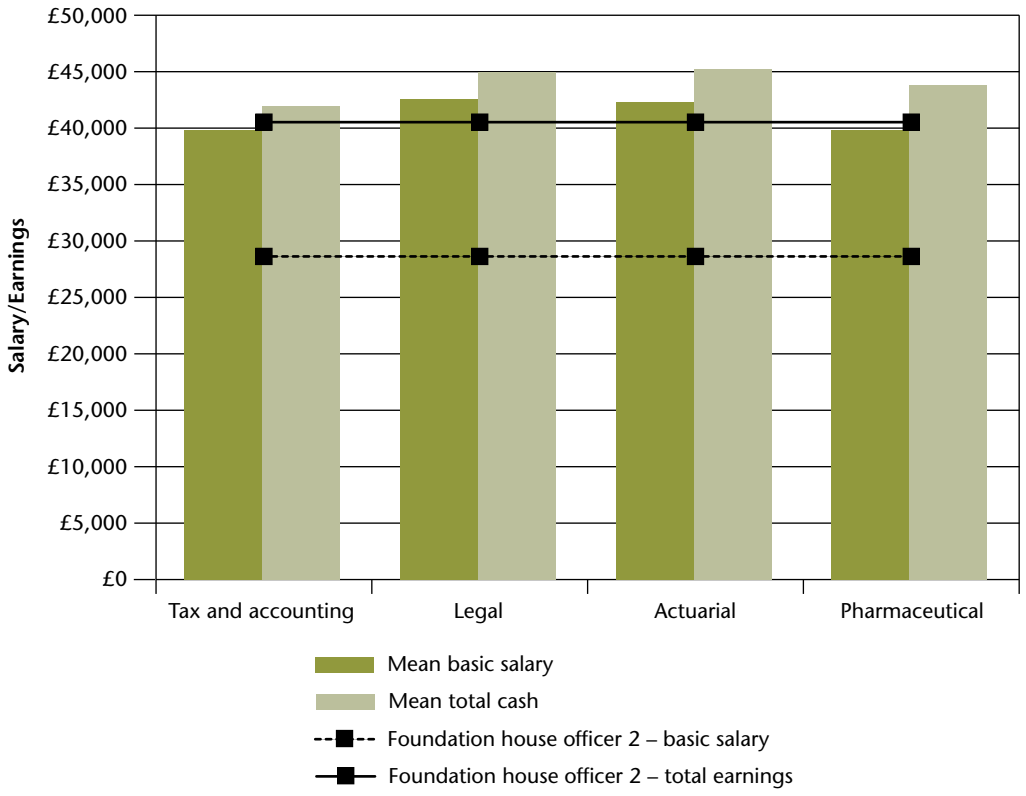
Sources: Health and Social Care Information Centre and Hay Group.

Foundation house officer 2

F.6 This anchor point marks the second and final year of the foundation course. This year focuses on training in the assessment and management of acutely ill patients. At the end of this year, doctors and dentists in training must undergo competitive entry to obtain a place on the specialty training run-through. A comparison of the mean basic salary and total earnings for doctors and dentists at this anchor point with external professions is given as Figure F.2.

F.7 In 2015, total earnings for foundation house officers in their second year were below that of their comparators. In the latest year, mean total earnings for foundation house officers in their second year were slightly behind all their comparators, although their mean basic salary was still well below that of the other professions.

Figure F.2: Foundation house officer, year 2 – mean basic salary and mean total earnings against mean basic salary and mean total cash for comparator professions, 2015

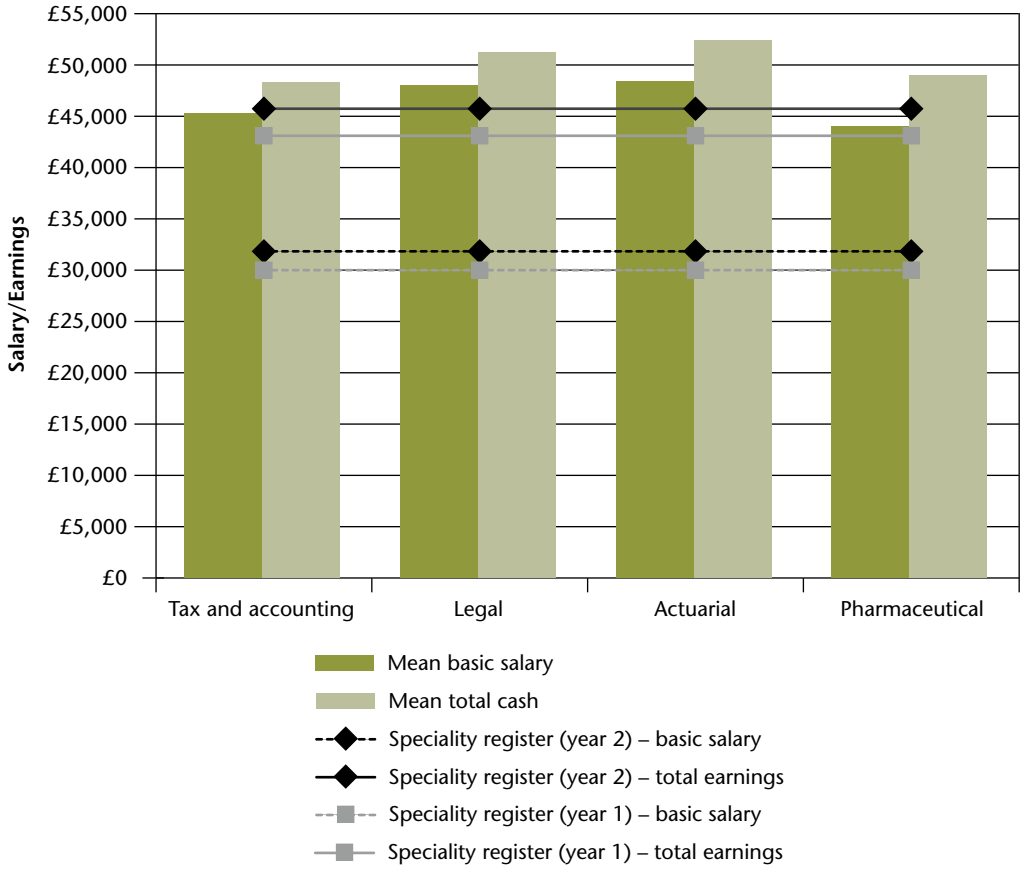


Sources: Health and Social Care Information Centre and Hay Group.

Specialty training 1 and 2

F.8 Doctors in their first year of specialty training receive both basic and total earnings considerably lower than those of their comparators (Figure F.3). Mean total earnings including banding supplements for second year registrars were slightly behind the total cash paid to all the comparator groups. In the last three years specialty registrar salaries have started to fall behind their comparator groups especially specialty registrars in their first year.

Figure F.3: Specialty training years 1 and 2 – basic salary[4] and estimated total earnings[5] against mean basic salary and mean total cash for comparator professions, 2015



Sources: NHS Employers and Hay Group.

Specialty training 3 and onwards

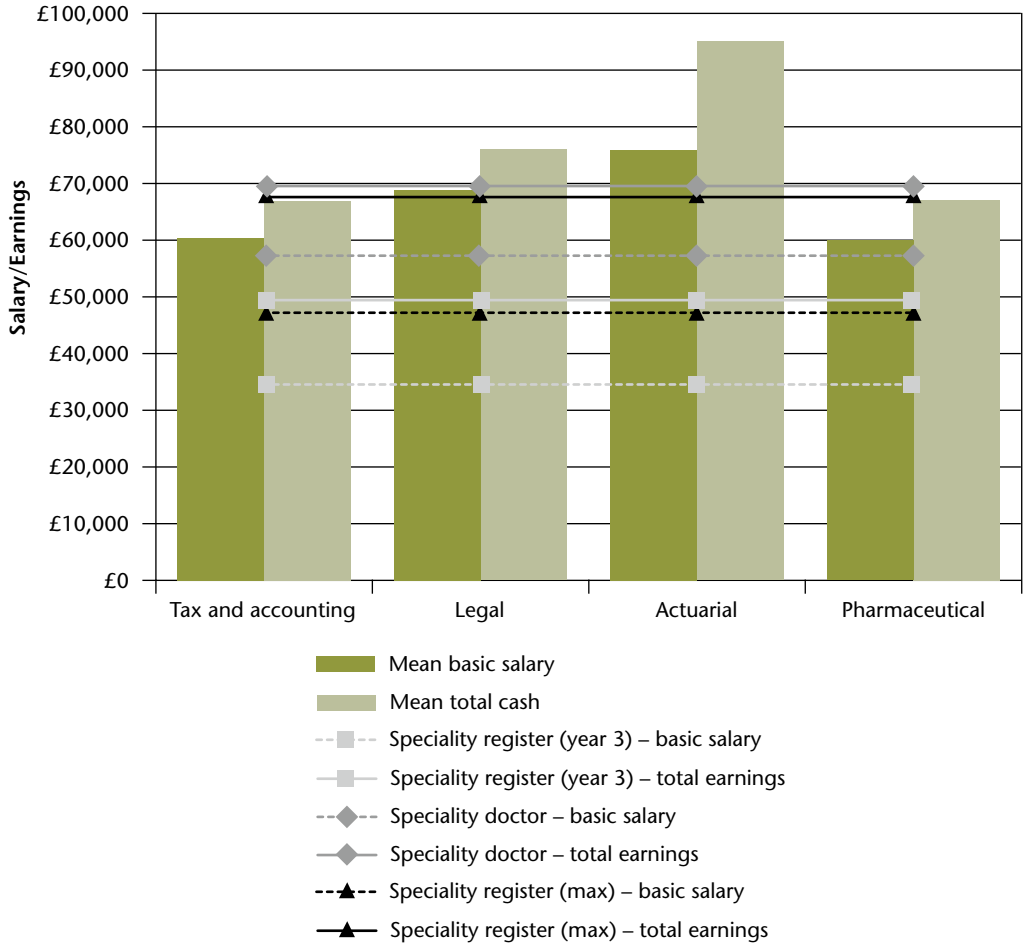
F.9 Registrars in their third year of specialty training are required to complete Royal College membership exams; this year is also used as the anchor point for the specialty doctor grade. Salaries and total earnings for comparator occupations cover a wide range.[6] Even at the salary scale maximum, registrars' basic salaries were significantly lower than that of the comparator groups (Figure F.4). Mean total earnings of specialty doctors and maximum salaries of Specialty training year 3 (ST3s) were very similar and were broadly comparable to mean total cash earnings in the tax and accounting and pharmaceutical groups but were significantly behind total cash earnings in the actuarial sector.

[4] Based on salary scale minimum.

[5] Based on salary scale minimum plus estimated supplement proportions.

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

Figure F.4: Specialty training year 3 and onwards and specialty doctors – basic salary[7] and estimated total earnings[8] against mean basic salary and mean total cash for comparator professions, 2015



Sources: Health and Social Centre Information Centre, Hay Group and NHS Employers.

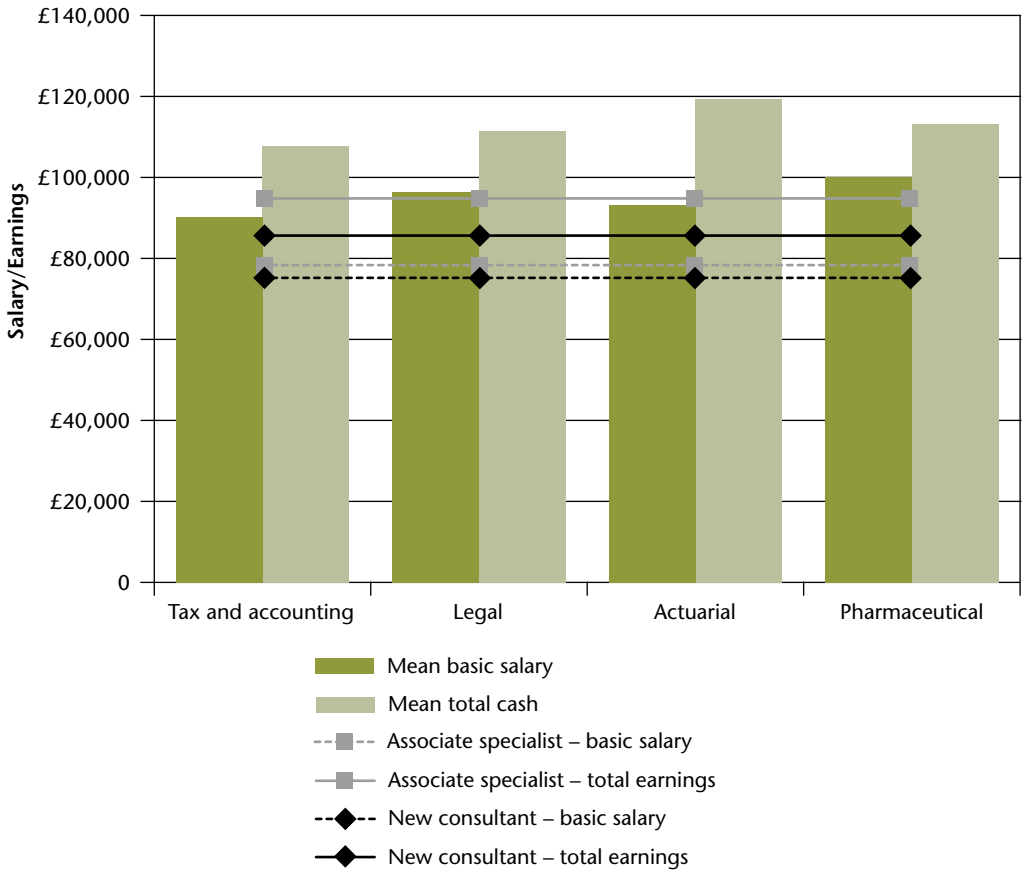
Consultant (minimum)

F.10 Entry to the consultant grade requires a Certificate of Completion of Training. Basic salary and total earnings for newly qualified consultants were both lower than those generally seen in the comparator groups. Associate specialists, who were also linked to this anchor point, faired a little better than new consultants in terms of comparisons in mean basic earnings and total earnings but are still behind those of their comparator groups (Figure F.5). Total earnings for both consultants (min) and associate specialists have been lower than the comparator groups in the last 5 years.

[7] All specialty registrar estimates are based on salary scales. The figure for specialty doctors is the estimated mean annual basic pay per FTE.

[8] All Specialty registrar estimates are based on salary scales plus estimated supplement proportions. 'Specialty doctors' is the estimated mean annual basic pay per FTE plus mean annual non-basic pay per person.

Figure F.5: Newly qualified consultant (on the minimum of the scale), and associate specialist – basic salary[9] and total earnings[10] against mean basic salary and mean total cash for comparator professions, 2015



Sources: Health and Social Centre Information Centre, Hay Group and NHS Employers.

Consultant (maximum)

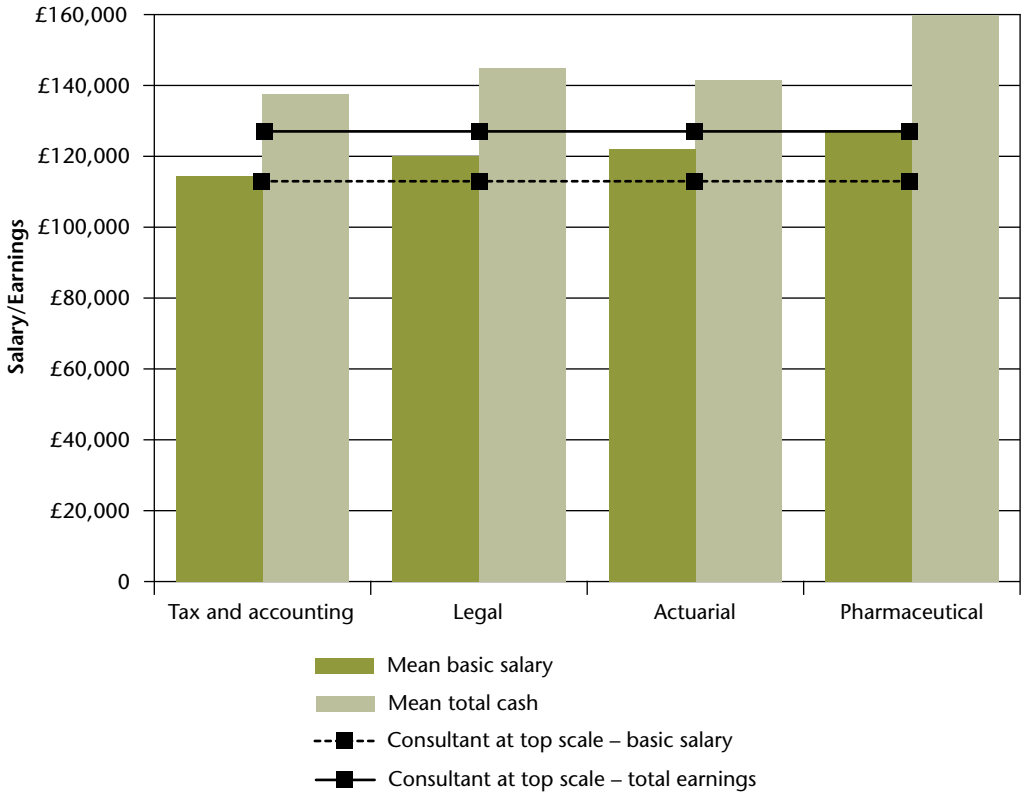
F.11 There is a (generally) accepted gap between the skills and responsibilities of newly qualified consultants and their more experienced counterparts. The final anchor point identified by PA Consulting is a consultant with at least 19 years' experience (and therefore at the scale maximum), with a level four clinical excellence award (CEA) – worth £11,828, and considered to be the upper quartile[11] number of CEAs. An experienced consultant's basic salary was broadly comparable with three comparator groups in Figure F.6, though their total earnings were consistently lower than all the comparator groups. Their relative position has worsened over the last years.

[9] Consultant estimates are based on salary scale minimum. Associate Specialists is the estimated mean annual basic pay per FTE.

[10] Consultant estimates are based on salary scale minimum and an average of 11.4 Programmed Activities. Associate Specialists is the estimated mean annual basic pay per FTE plus mean annual non-basic pay per person.

[11] This is based on all consultants, i.e. including those consultants without a CEA.

Figure F.6: Experienced consultant (at the scale maximum, with Level 4 CEA) – basic salary[12] and total earnings[13] against mean basic salary and mean total cash for comparator professions, 2015



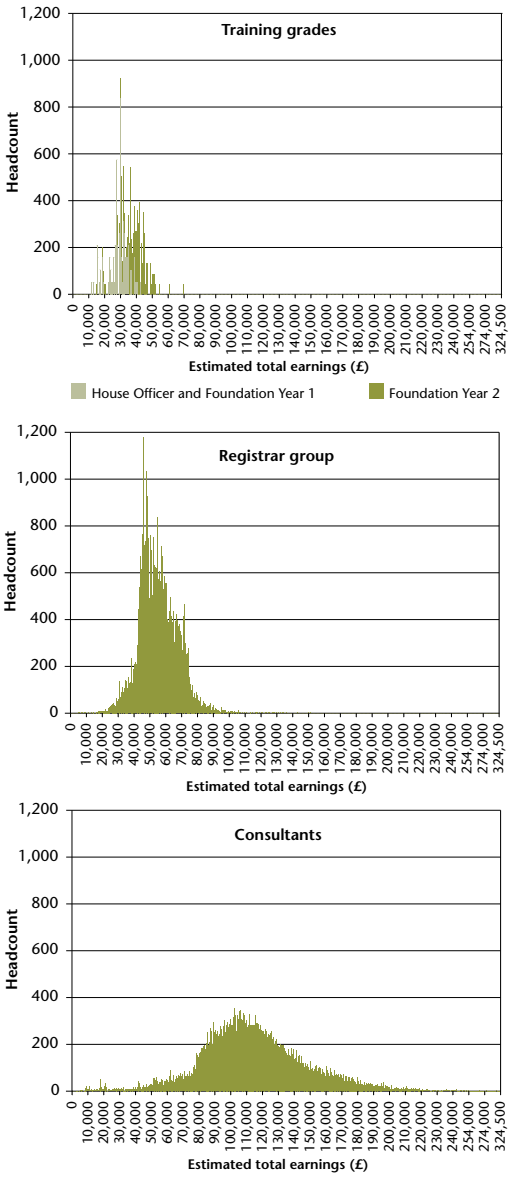
Sources: Hay Group, NHS Employers and Advisory Committee on Clinical Excellence Awards.

[12] Consultant estimates are based on salary scale maximum and a level 4 CEA.

[13] Consultant estimates are based on salary scale maximum and a level 4 CEA and an estimate of 11.4 Programmed Activities.

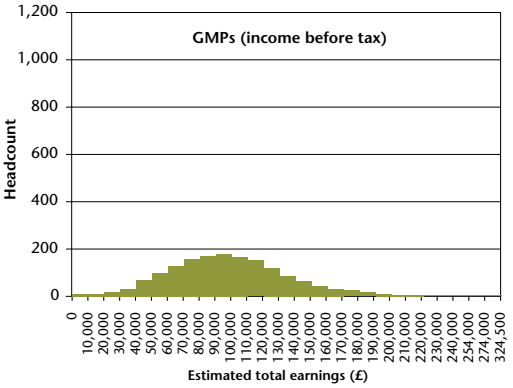
APPENDIX G: TOTAL EARNINGS DISTRIBUTION

Figure G.1: Estimated Total Earnings Distribution for some staff groups, England, Year to September 2015



Source: OME Analysis of Health and Social Care Information Centre Data.

Figure G.2: Estimated Total Earnings Distribution for GMPs, UK, 2013-14



Source: OME Analysis of Health and Social Care Information Centre using Her Majesty's Revenue and Customs data.

APPENDIX H: 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
AWE	Average Weekly Earnings
BDA	British Dental Association
BMA	British Medical Association
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CCPS	Certificate of Current Professional Status
CDS	Community Dental Service
CEA	Clinical Excellence Award
CPI	Consumer Prices Index
Con.	Consultant
CT 1-3	Junior doctor, later stages in training (core training)
DDRB	Review Body on Doctors' and Dentists' Remuneration
DETINI	Department of Enterprise, Trade and Investment in Northern Ireland
DHSSPS	Department of Health, Social Services and Public Safety (Northern Ireland)
DHSSPSNI	Department of Health, Social Services and Public Safety Northern Ireland
DS	Dental surgeon
EEA	European Economic Area
EER	Expenses to earnings ratio
F1	Foundation house officer Year 1
F2	Foundation house officer Year 2
FHO	Foundation house officer
FOI	Freedom of Information
FT2	Foundation Training Year 2
FTE	Full Time Equivalent
FTSA	Fixed Term Specialty Training Appointment
GDC	General Dental Council
GDP	Gross Domestic Product
GDP	General dental practitioner

GDS	General Dental Services
GMC	General Medical Council
GMP	General medical practitioner
GMS	General Medical Services
GP	General Practitioner
GPMS	General/Personal Medical Services
HCHS	Hospital and Community Health Services
HEE	Health Education England
HESA	Higher Education Statistics Agency
HSCIC	Health and Social Care Information Centre
LAT	Locum appointment for training.
MAC	Migration Advisory Committee
MLA	Member of the Legislative Assembly (Northern Ireland)
MP	Member of Parliament
MPIG	Minimum Practice Income Guarantee
MSP	Member of the Scottish Parliament
NHS	National Health Service
NI	Northern Ireland
OBR	Office of Budget Responsibility
OECD	Organisation for Economic Co-operation and Development
OME	Office of Manpower Economics
ONS	Office for National Statistics
PA	Programmed Activity
PCTMS	Primary Care Trust Medical Services
PDS	Public Dental Services
PMS	Personal Medical Services
QOF	Quality and Outcomes Framework
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SACDA	Scottish Advisory Committee on Distinction Awards
SAS	Specialty doctors and associate specialists
SCD	Special Care Dentistry
SOL	Shortage Occupation List

SPA	Supporting Professional Activity
ST	Specialist training
StART	Strategy for Attracting and Retaining Trainees (Scotland)
TSO	The Stationery Office
UCAS	Universities and Colleges Admissions Service
UDA	Unit of Dental Activity
UK	United Kingdom
UKFPO	UK Foundation Programme Office

ISBN 978-1-4741-2985-5