

ies Report

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Office of Manpower Economics: Review of DDRB Pay Comparability Methodology: Final Report

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Executive Summary

Introduction

- This report sets out the findings from a review carried out by the Institute for Employment Studies (IES) on behalf of the Office of Manpower Economics (OME) for the Doctors' and Dentists' Remuneration Review Body (DDRB) of the methods currently used to make pay comparisons with other occupations and professions.
- The aims of the review have been to assess if the current methodology remains fit for purpose, to recommend any necessary updating, changes and improvements, as well as to extend the coverage to primary care doctors and dentists.
- The last major review of this methodology was by the PA Consulting Group in 2008.

Stakeholder Views

- We interviewed 12 key stakeholders from relevant bodies including the GMC, BMA, BDA and NHS Employers.
- There were some significant variations in the perceived value of the pay comparison exercise, possibly indicating different views on the purpose.
- Interviewees agreed that pay comparisons need to be carried out in a robust and sound manner, and some change to the existing methodology would be desirable.
- Some felt that the process should be simplified and just average earnings of sections of the economy and other broad categories of work used, to avoid 'cherry picking' occupations.
- Probably the majority favoured a more detailed exercise. Some wanted additional occupations included, others wanted more complex methodologies used and comparisons with overseas' doctors and dentists.
- There was general support for the existing anchor points/levels.

- However, almost all saw the need to produce separate descriptors and levels, and some different/additional matching occupations, for GPs and GDPs.
- There was little interest shown in the detailed role profiles, far more in the occupations to match with and the right levels to compare across.
- All four existing occupations compared with were supported, particularly the legal and pharmaceutical sectors.
- Almost all interviewees gave us suggestions for additional occupations. Most saw merit in introducing some additional occupations introducing better matching occupations, or in using large/broad national earnings and private/public sector samples.
- We heard less than we might have anticipated about the potential difficulties of comparing across UK-based occupations, such as different pension values. The job security of doctors relative to other occupations was mentioned by some.
- Views on the relevance of overseas comparisons were divided, although all recognised the difficulties of making such comparisons.

Doctor and Dentist Views

- We repeated and updated PA Consulting's social cohort analysis, interviewing 10 dentists on British Dental Association (BDA) committees, five doctors on committees of the British Medical Association (BMA); and we received responses to an on-line survey from 162 committee members through the Academy of Medical Royal Colleges (AOMRC).
- The purpose of these consultations was to detail our understanding of the medical/dental career paths and solicit views on occupations to benchmark.
- Key findings included:
 - Doctors and dentists still primarily see their careers as vocational, a 'career-for-life'.
 - Pay and rewards are not why most people go into and stay in these professions, but they provide an important return on the lengthy investment required in their education/training, and an indication of their professional standing/status in society and their local communities.
 - Career paths have changed little since the last review carried out by PA.

-
- However the pressures on medical professionals and their earnings and lifestyle have increased markedly – increased workloads, higher property prices etc.
 - Most supported the need to compare with other occupations, and reported declines in earnings in general practice.
 - The existing comparisons were supported, particularly with the pharma industry (as an employer of medical professionals) and with lawyers (because of their lengthy training and levels of expertise, and as they commonly operate in partnerships).
 - The existing anchor points were also supported, as was the development of new anchors and comparisons for doctors and dentists in general practice.
- In terms of the criteria for selecting comparable occupations, these were primarily based on education/experience, and responsibilities and risks managed.
 - The most commonly favoured additional occupations to use were vets, pilots, company/partnership leaders and owners, and university academics and leaders.
 - Overseas comparisons were seen as an essential component of any future exercise by the vast majority of respondents.

Literature Review on External Practice

- There is a general UK and public sector trend towards employers placing a stronger emphasis on external market data rather than internal job evaluation methods in determining pay levels.
- This has seen less reliance placed on detailed job descriptions and job evaluation as pay determination methods and more prominence given to external market comparisons, with:
 - direct job and occupational comparisons through tailored surveys in some cases;
 - in the public sector also using broad national ONS categories and external survey databases, rather than making detailed comparisons with specific occupations/jobs, partly to avoid debate over the occupations and the dangers of ‘cherry picking’;
 - comparisons on more of a total rewards/package, not just a pay level, basis, but generally using quite simple methodologies to do this.

- This might imply that:
 - there may be further scope to utilise national datasets in the comparability work that the DDRB undertakes in its annual report;
 - the original PA role profiles are no longer really required;
 - international comparisons are possible and are important due to the growth in the evident flows particularly between English-speaking countries.

Career Paths, Inflows and Outflows

- We have reviewed available data on mature joiners and leavers from the medical and dental professions to help to indicate comparator occupations.
- While there is more and more accurate data on these movements now available, the information on the destination occupations of leavers in particular is still frustratingly poor.
- Although there has been significant growth in the numbers of medical and dentistry students temporarily taking breaks from their studies, all of the indications are that these continue, for today's students as much as in the past, to be very largely a 'career for life', decided on at a relatively early stage in people's lives.
- Apart from the numbers going overseas and those moving into clinical academia, which clearly support overseas and UK academic pay comparisons, it is hard to justify the choice of specific occupations to compare earnings with solely on the basis of data on career outflows and inflows.
- These findings might also support arguments for more generic comparisons with managerial/professional and high earning occupational categories, rather than specific occupations.

Career Paths and Anchor Points

- We propose the use of briefer summary descriptors of the anchor points in each medical and dental career path, with an overview of the career paths provided in the table below. We have produced these for the existing hospital doctor and dentist career paths, supporting (along with all our stakeholders) the retention of the current six anchor points used.
- We have also produced new descriptors in the same format for the GP and GDP career paths, on account of the different sets of skills and competencies required. We propose

five anchor points in each of these. We also in chapter 7 provide more detailed justifications for the choice of anchor point in each career path.

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice Doctors	4. General Dental Practice Dentists	Survey match levels
Consultant - experienced		Managing Partner/ Principal GP	Principal/Practice Owner Dentist	Hay level 21
Consultant - newly qualified	Associate Specialist	Partner GP	Partner/Providing- Performer Dentist	Hay level 20
ST3+	Speciality Doctor	Salaried GP	Associate/Performer Specialist Dentist	Hay level 19
			Associate/Performer Dentist	Hay Level 18
		Registrar GP	Hay level 17	
ST 1&2		GP Specialist Trainee		Hay level 16
F2			Foundation Dentist/ Vocational Dental Practitioner	Hay level 15
F1				Hay level 14

NB: The exact positioning of the roles relative to each other and the Hay survey levels would need to be confirmed after discussion with Hay Group and possibly also job evaluation.

Occupations, Markets and Data for the Comparisons

- We have carried out a detailed analysis of possible comparators. Our selection criteria have focused on job, skill and career comparability; stakeholder and doctor/dentist support; and pay data availability.
- This analysis leads to the conclusion that:
 - There is a strong case for including architects (used previously in these comparisons) for all roles; and vets for the practice-based roles;
 - Higher education also has a very strong case for inclusion based on the number of academic medical teaching and research roles;

- We provide draft anchor point descriptions in Chapter 8 for these three occupations/careers paralleling the medical/dental career paths;
 - Looking at wider categorisations, using the same criteria supports the inclusion of overseas medical/dental remuneration comparisons;
 - As well as the use of large company managers/leaders for the higher anchor points in hospital-based career paths; and small company owners/managers for the practice-based roles.
- We also in Chapter 8 suggest pay data sources for the three new occupations and for these broad senior management comparisons, as well as suggesting how the data sources for the current four occupations could be enhanced and extended.

Recommendations Summary

1. **Clarify the Purpose of the Comparisons.** The prime purpose of these comparisons for doctors and dentists appears to be not in order to set their exact rate of pay in line with these markets, but seems rather to be to inform these decisions and help to ensure that remuneration is set and seen to be fair and appropriate. As such, there are risks in stretching the comparisons to many other specific occupations and roles, or increasing the number of anchor levels.
2. **Adopt Summary Descriptors for Describing and Anchoring Roles in Each Medical/Dental Career Path.** Comparisons across these medical and dental roles and with other professions will best be facilitated by brief summary descriptions of each anchor level in terms of the common features and factors that will be key to matching, such as level of qualification, years of required experience and scale of responsibility/risk . More specific detail just confuses and obscures.
3. **Adopt Five Anchor Points in the New GMP Career Path and Five in the GDP Career Path.** We have set out the career paths for GPs and GDPs on this basis in Chapter 7 and drafted/edited the existing role profiles and anchor points in a similar format. These anchors can be matched into the equivalent level in the external databases such as Hay which are used.
4. **Carry Out More Detailed Job Analysis to Confirm Relativities Across the Career Paths and into the External Database(s).** It is recommended that the internal relativities between medical and dental career paths, which has the potential to be a controversial area, are confirmed by a more detailed points factor job evaluation exercise, using either the Hay system or possibly the NHS job evaluation system. If this is seen as too expensive/time-consuming then it is recommended that at least a meeting should be held with Hay consultants to carry out this exercise.

5. **Continue to Focus on and Enhance the Market Data for the Current Four Professions.** It is recommended that the OME examine and profile these markets in more detail and broaden the sources of data, particularly to cover legal partnerships, and employer models which better fit with roles based in general practice (although pay survey data for SMEs is unfortunately poor). We suggest some additional sources in Chapter 8 and recommend that these are confirmed in meetings with the suggested suppliers, which can also be used to confirm the job matching of the anchor points at the appropriate survey level.
6. **Selectively Extend the Matching Occupations.** In chapter 8 we analyse many different potential occupations to include on the basis of the criteria of job and career comparability and pay data availability. On this basis it is recommended that the comparisons are extended to include vets for GPs and GDPs, relevant Higher Education roles for hospital-based doctors and dentists, and architects possibly for all four medical and dental career paths, or at least for the practice-based roles.
7. **Continue to Make More of the Improving National Datasets and Trend Analyses.** It is recommended that the greater use of this data evident in the 2017 report should be continued. The analysis of trends over time and changes in relative positioning of medical/dental earnings is a key aspect of this analysis.

We also recommend use of the more generic samples from the survey provider datasets, such as the Hay general all private sector and public sector employer samples, at the equivalent survey levels. We recommend using their datasets for larger companies (includes over 200 employers) for hospital-based roles and smaller companies (123) for the practice roles at the top two anchor points.

8. **Carry Out Overseas Comparator Studies.** Ideally the comparisons would look at the most relevant countries in terms of doctor and dentists movements to/from the UK and cover; the remuneration method and structure, salary levels, other cash payments, major benefits, contractual terms, and with adjustments for cost of living/purchasing power and exchange rates. Therefore this type of study might perhaps best be carried out every three to four years to help to allay the costs.
9. **Reflect Total Rewards.** Carry out a simple adjustment where possible on the market total cash data to reflect different pension values, as is already done by some of the other Review Bodies in their comparisons. This appears to be reasonably straightforward to achieve with the Hay market data. As already stated, it is not recommended that any adjustment is made to reflect the full employment of doctors.

1 Introduction

This report sets out the findings and recommendations from a review carried out by the Institute for Employment Studies (IES) for the Doctors' and Dentists' Remuneration Review Body (DDRB) of the methods currently used to make pay comparisons with other occupations and professions.

Although not specifically required to make external market comparisons, for many years the DDRB has compared the earnings for its remit groups with relevant external professions, in order to inform its reports and help to address its brief to consider the most appropriate and effective methods for recruiting, retaining and motivating doctors and dentists.

The **current comparison method** was established following the last major review of these comparisons undertaken in 2008 by PA Consulting. Currently comparisons are made using a slightly abbreviated version of the method recommended in 2008, with:

- Comparisons made at six levels mirroring the medical training and career structure: FHO 1, FHO 2, Speciality Registrar, Associate Specialist, Consultant and Senior Consultant; GPs have been slotted into the comparisons at the consultant level although neither they nor dentists were included in PA Consulting's original analysis;
- Market data used for comparison from four occupations, with the information all drawn from Hay Group's remuneration databases: actuaries, lawyers, accountants and pharmaceutical industry professionals; four of the occupations recommended by PA are not currently compared with: architects, teachers, management consultants and pilots.

In addition pay levels and ranges for these core roles are compared with current national average earnings information and the trends since 2010 are plotted, and the effects of price inflation on real incomes is also analysed, with both showing declines for most of the roles in recent years. Data on graduate earnings comparing medicine and dentistry graduates with other subjects is also considered in the DDRB's latest annual report.

The **aims of this review** are to assess if the current methodology remains fit for purpose, to recommend any necessary updating, changes and improvements, as well as extending the review to cover primary care doctors and dentists. There was no assumption of the

need for a major overhaul to the methodology and indeed almost all of the stakeholders consulted as part of the review supported the core of the current approach. But they also saw the value in reviewing and updating it.

The **project stages** involved in the work have been as follows:

- Planning and drafting of a project methodology report;
- Key stakeholder interviews with representative training and regulatory bodies;
- Doctor and dentist consultations;
- An external literature review;
- Reviewing the currently defined career paths and relevant benchmarking anchor points, and extending these to cover GPs and dentists;
- Researching, defining and confirming market comparators and sources;
- Recommending the future methodology for comparison.

The **remainder of this report** is organised as follows:

- Section 2 presents a summary of our stakeholder interview findings, drawing out the implications for the level and direction of change required to the current approach.
- Section 3 covers the main findings from our research with a sample of doctors and dentists, which focused on the key stages and job differentiators in their career paths and what they regarded as the most comparable and relevant alternative careers.
- Section 4 presents the evidence from our literature review, which has focused on how other employers determine pay levels and undertake these types of pay comparability studies - overseas and in other professions, and particularly where the comparisons are not straightforward.
- Section 5 covers the information and evidence we have gathered on the career paths of doctors and dentists as to where they come from and go to, indicating relevant and potential comparator occupations to benchmark.
- Section 6 describes the updated and new career paths and anchor points for benchmarking externally which we have developed.
- Section 7 contains the occupations we have considered for inclusion in the comparison exercise, and recommends three additional ones to use, along with the potential sources of market remuneration information.

- Section 8 contains an overall critique of the existing methodology.
- Section 9 draws conclusions from the earlier sections and summarises and presents the recommended future methodology, professions to include in comparisons and data sources.

We would like to thank all of those who helped us with this work and in particular Tony Wilkins and colleagues at the OME, Penny Whitehead and Tom King at the British Dental Association, Claire Coomber at the Academy of Medical Royal Colleges (AOMRC), Andy Knapton at the General Medical Council, Ellie Bullard at the Royal College of General Practitioners and Andrew Lloyd-Kendall at the British Medical Association.

2 Stakeholder Interview Findings

2.1 Introduction

The purpose of these semi-structured interviews was to solicit the views of those with a key stake in and knowledge of the existing pay comparability methodology, regarding:

- The purpose and value of the exercise;
- Strengths and weaknesses of the existing process;
- Job contents and career paths of doctors and dentists and any changes in them;
- The labour market context for these roles and views on any pay, recruitment and retention pressures/challenges and reasons for them;
- Any required changes and improvements to the methodology.

Interviews were carried out with the following:

- Penny Whitehead, Head of Policy and Research, British Dental Association
- Andy Knapton, Data Modelling Manager, General Medical Council
- Bernard Horan, Section Head, NHS Digital
- Rob Rowell, Pay/Negotiations Analyst, Ellie Pattinson, Head of Medical Pay, Geoff Winnard, Assistant Director Agenda for Change/Employee Relations, NHS Employers
- Andrew Lloyd-Kendall, Head of Research, British Medical Association
- David Pyper, Senior Client Partner, David Smith, Business Leader, Korn Ferry Hay Group
- John Stock, Health Education England
- Professor Sir Paul Curran, Chair DDRB
- Helen Stokes-Lampard, Chair of Council, Royal College of General Practitioners.

2.2 Key Findings

2.2.1 Overview

- There were some significant variations evident amongst the interviewees in terms of the perceived value of this sort of pay comparison exercise which the DDRB carries out, ranging from:
 - Very useful in helping to understand the current staffing and morale situation; to
 - Fairly irrelevant, in terms of the lack of any practical effect of the exercise in setting rates of pay in the context of the one per cent cap, or influencing career choices in what is perceived to be a strong vocation with a comparatively low level of 'outflow';
 - Interviewees questioned 'Do they really want to be an accountant or lawyer instead?' and perceived these medical and dental careers to be 'a vocation'.

Most interviewees did appear to agree however:

- That there is an issue of worsening morale and engagement in the medical profession, a 'profession not at ease' as the GMC referred to it; this is causing more, if still a minority, of doctors and dentists to consider their futures and explore avenues such as employment overseas;
- That the causes of this disquiet are not primarily pay-related in absolute terms, and that even the recent junior doctors' dispute over their new contracts was not primarily about pay and financial reward (although dentist-in-practice earnings we heard have been falling). They relate rather to factors such as resource constraints, increasing workloads and excessive working hours, service restructuring, lack of perceived recognition, etc. A number referred to particular morale difficulties at speciality doctor level but again this was largely held to be down to non-financial factors. A number of interviewees also referred to the relative pay position of doctors and dentists compared to other professions falling back in recent years at a number/most of the benchmarked levels.

2.2.2 Labour market situation

Any staff shortages were not primarily perceived to be down to money or relative earnings by our interviewees. GPs, psychiatrists and A&E were all mentioned as areas of difficulty in some parts of the UK. Partly we were told this is down to speciality choices within the profession – attempts are being made to make the GP career more attractive as a result, and to match the additional earnings opportunities of doctors in hospital. Partly

it is driven by lack of supply – hence there was general welcoming of the recent announcement of the increase in trainee doctor numbers.

Also we were told that there are problems for recruiting and retaining GPs and dentists in rural areas and places with no direct hospital training link. Greater numbers don't appear yet in the statistics to be actually moving overseas, but most interviewees said interest in exploring this had grown, particularly since the Brexit vote.

A significant minority of trainees, we were told, are now not proceeding from Foundation training straight into speciality training, although the vast majority of those only seem to be taking a temporary break.

The attraction of working overseas was seen to be partly based on lifestyle and partly on more attractive working conditions, for example longer time to spend on each patient. Again, some interviewees pointed this out as a part of a wider generational phenomenon affecting other professions and supporting comparisons with those similarly affected. Travel overseas, a break from intense training, and a wish to get more practical work experience before progressing their careers were all cited as reasons for this trend.

Almost all interviewees agreed that this exercise does need to be carried out and as such, done in a sound and rigorous fashion. Those with a more detailed knowledge of the existing process were generally supportive of the methodology and its robustness, for example in terms of the quality of role profiles and choice of anchor points, but felt that it should be undertaken in the more detailed manner originally recommended by PA, rather than as currently takes place, reinstating all of the comparisons that were originally recommended, such as with architects for example.

The majority were also in support of more extensive comparisons, with a larger number of relevant occupations included, and some supporting the undertaking of an overseas earnings' comparison. While interviewees generally held that the existing comparator professions were good ones, the sense was that a wider range of occupational data would be more robust and prevent a risk of 'cherry picking' and comparing with high paying or low paying occupations in the comparisons.

2.2.3 The Roles and Career Paths

Regarding job contents and career paths, there was near unanimity that these have not changed in any significant way since 2008. Those who knew the detail of the PA role profiles and anchor points felt that they remained relevant and there had been little change in the job content at the anchor levels, even if the volume of work had increased.

Interestingly, most people also felt that future developments and changes, such as in technology, would similarly not radically change this pattern of training and career development in the profession, although a number mentioned the moves to make medical

training more integrated and flexible and emphasise some of the common components across all of the various specialities (described in a recent BMA report). New roles such as physician associates were also mentioned, as well as the shift in the overall distribution of GPs from practice partners to salaried GPs, particularly for female doctors.

The trainee and junior roles, it was felt, were relevant across all the medical and dental career paths and the current anchor points also applied to hospital-based dentists.

However, different role profiles and career paths were required, it was felt, for GPs and dentists in general practices thereafter, with their own descriptors and levels, and people in those areas also supported some additional occupations used just for these roles. The roles were seen as being different to hospital-based work, with a greater managerial component being particularly important to reflect and also the risks and responsibilities of partnership and leadership. Some interviewees mentioned that medicine was in fact becoming more specialised, despite the periodic attempts at greater integration.

Most supported benchmarking these roles at two to three levels:

- Newly qualified and typically operating as a self-employed contractor;
- A seasoned fully experienced GP/GDP operating either as a partner in a practice or as a salaried GP;
- Some thought that this higher level, or possibly a third level, should cover the managing partner of a large practice where the management task, responsibility and risk were seen as significantly greater.

Partner roles were seen as being larger because of the management responsibility and risks involved, and also because the move from salaried to partner status was generally seen as a promotion in terms of moving into a bigger role. A number also mentioned the impact on the workforce of growing feminisation.

Some interviewees felt that the original two levels of consultant matched externally should continue to be used, rather than the single level used in the 2016 DDRB annual report, and this was indeed reinstated in the 2017 report which was published as this review was underway.

2.2.4 Comparator Occupations and Careers

Everyone recognised the difficulties in benchmarking the medical and dental professions with other occupations, due to factors such as:

- Differences in the structuring of reward, for example in terms of the relative emphasis on base pay/bonus/pension, of lifetime patterns of earnings and of employment structures – employee, partner, self-employed contractor, etc.

- In terms of overseas comparisons, significant variations in tax and social security systems affecting net pay and standard of living, and also wide variations in the job contents of doctors and dentists in other countries, for example in the balance of specialist and generalist, hospital and community-based roles, variations in the relationships to other medical areas such as physiotherapy and pharmacy etc.

There was near unanimous support for continuing with those occupations currently used in the comparisons- accountants, lawyers, actuaries and pharmaceutical professionals. This was seen to be on the basis of their professional status and standing, the academic calibre of recruits, the length and investment required in training and work experience, and for GPs and GDPs the delivery of services through a predominantly partner-owned practice model. Medical professionals were also employed by law firms and pharmaceutical companies.

Other occupations that might be compared with and mentioned by at least one interviewee included: management and professional roles in higher education (mentioned by most due to the obvious read across in teaching hospitals), engineers, pilots (the most disputed one, with some seeing them as an excellent comparator and others as a poor one), senior civil servants and other public sector leaders, management consultants; finance professionals, and also vets (again mentioned by a number and regarded as the most comparable from a training and skills perspective particularly for those in practice-based work).

Factors referred to in justifying these choices included: equivalent periods of training required, similar types and levels of skill and competence, equivalent levels of responsibility and particularly in operating in 'life or death' situations.

Private sector NHS suppliers and employers of doctors and dentists were not seen as useful comparators, either because the numbers employed are so small, or because these employers attempt to replicate NHS terms in order to be able to recruit. Even in dentistry we were told that most dentists do a majority of NHS work.

A number of the interviewees also saw value in varying the sample of occupations and roles compared with at different levels of medics' careers (as originally recommended by PA), and for different medical and dental roles. A number for example, mentioned some different comparators being relevant only for GDPs and GMPs, such as vets and opticians. There was also some questioning as to whether the slotting in that has been made of GPs at the consultant level in the most recent DDRB comparisons was in fact appropriate – some felt the GP role was not as large given that they took approximately half the time (five years) to become fully qualified compared to a hospital consultant.

A number of interviewees pointed to the considerably improved data now available compared to 2008 with which to consider the sources of medical recruits and alternative peer career paths, as well as the characteristics and motivations of doctors and dentists,

through NHS Digital's establishment, moving all trusts onto the ESR system, the NHS Staff Survey, etc. However, a number of interviewees mentioned that data available was less robust for the GP than for the hospital medical workforce, and also areas such as reported reasons for leaving stats were collected by individual trusts and so may not be robust in all cases. The numbers actually entering and leaving the profession mid-career, some interviewees also pointed out, remains tiny.

Two people mentioned the value of more specific comparisons being made with remuneration for Agenda for Change staff in the NHS, given the obvious interactions and the ability of the job evaluation system to cover all types of work.

We were told:

- 'The comparisons need to be with a good range of other high intellectual calibre professions';
- 'Being a GP is much more like running your own business'.

2.3 Chapter Summary and Implications

Our 12 interviewees appeared in agreement that however it is done, pay comparisons need to be carried out in a robust and sound manner, and that some change to the existing pay comparability methodology would be desirable. But there was disagreement over the direction of that change:

More Detailed Comparisons	< Current Method >	Continue Simplifying Comparisons
<ul style="list-style-type: none"> • More levels, more professions • Total rewards • Overseas comparisons 		<ul style="list-style-type: none"> • More generic comparisons, average earnings, general management, etc.

Some felt that given the market positioning does not in reality influence pay setting for these groups in the NHS that the process should be simplified and just average earnings and perhaps general management and other broad categories of work used in the comparisons, with a focus on relative positioning and year on year changes.

The majority however, favoured more detail being required to do this exercise fully, at least to return to the fuller coverage of occupations recommended by PA. Some favoured more occupations being included, such as higher education, and others wanted more complex methodologies employed, so as to compare the full rewards package between these occupations and also potentially, to compare take-home earnings with overseas posts.

The logic for varying the matching occupations by level and specialisation was generally supported. There was little questioning of and general support for the existing anchor points/levels and all agreed that the training levels applied across all areas of medicine. However, almost all saw the need to produce separate descriptors and levels, and possibly some different/additional matching occupations, for GPs and GDPs. Given the difficulties of matching, nobody argued for a greater number of career levels being used, other than to return to the two levels of consultant recommended by PA (there had originally been three). There was also little interest shown in the detailed role profiles, far more in the occupations to match with and the right levels to compare across.

Views on the relevance and value of any overseas comparisons were more divided, although all recognised the difficulties of making such comparison on a consistent basis. Any comparison exercise would need to be thorough and recognise differences in job contents, working hours etc., so possibly done as a different/separate exercise (as the OME have in fact done in the past for specific aspects of the reward package)

The value of regional UK comparisons was mentioned by a number of interviewees, not primarily in terms of UK country variations (although Northern Ireland for example has its own medical and dental agency), but to highlight difficulties in recruiting/retaining staff in rural areas and possibly to support the case for greater NHS pay differentiation.

We perhaps heard less than we might have anticipated about the potential difficulties of comparing across UK-based occupations, such as different pension values and variations in employment status. The full employment situation and job security of doctors relative to other occupations was mentioned however by a number.

All the existing occupations compared with were supported, particularly the law and pharmaceutical sector, and almost all interviewees gave us suggestions for additional occupations that could be used. Most saw merit in broadening the occupations used – either in terms of introducing better matching occupations, or in terms of avoiding the ability to ‘cherry pick’ in making comparisons on too narrow a basis, by using broad samples and/or comparing more dimensions of the rewards package, such as pensions’ value.

3 Doctor and Dentist Consultation Findings

3.1 Methodology

An important input into this review has been to consult with a sample of doctors and dentists themselves regarding the comparability issues under consideration. While we can and have looked at national statistics on flows into and out of medical professions, consulting with these professionals themselves has been important in grounding our thinking on actual comparators and methods of comparison in real individual people and examples, helping to develop, detail and illustrate our thinking and hopefully thereby ensuring that the review exercise has credibility with these communities.

The purpose of this aspect of our research has been two-fold:

- To consider job content and career paths of the participants and their peers, in order to update the current descriptions of the anchor/benchmark levels of doctors that are used when matching them with other professions and to produce new anchors for dentists and GPs.
- To solicit views on the most relevant comparator occupations and professions – other careers they might have considered, roles that their peers from university are now filling in other professions, occupations with similar skill sets and demands.

In the last review PA carried out telephone interviews with a sample of 20 doctors in different roles and at different stages in their careers to obtain this input. Given the time and cost pressures on doctors and dentists at the moment this has proved more challenging to organise. However, we have managed to obtain the input by two slightly different but complementary research methods:

- For dentists, we carried out structured 30-minute telephone interviews with a sample of 10 dentists who are members of the General Dental Practice Committee and the Young Dentists' Committee at the British Dental Association. Interviews were completed in the last week of May 2017. The GDPC is made up of 'high street' dentists who are a mix of associates, practice-owners and also former practice-owners nearing retirement. The Young Dentists' Committee is made up of dentists who have qualified within the last 10 years and is cross-profession (GDPs, hospital, community etc.).

- For doctors, we sent out in the last week of May an online questionnaire asking similar questions to The Academy's Trainee Doctors' Group at the Academy of Medical Royal Colleges (AOMRC). We received 162 responses which we have analysed, with the majority being from speciality registrars and trainees. The Academy's Trainee Doctors' Group is a forum for Trainee representatives of all Medical Royal Colleges and Faculties to come together and a number of the Colleges also asked their own equivalent committees to take part.
- Subsequently, we also asked these same questions in telephone interviews to five BMA committee members from the junior doctors', the SAS doctors', the consultants' and the GPs' committees.

The research questionnaires we used are contained in the Appendix.

While not a statistically representative or stratified sample of these professions, nonetheless the structuring of these committees and coverage of trainees and younger doctors and dentists means that we have been able to get input from a nicely mixed sample of professionals working in different settings and at different stages in their careers, providing us with some rich primary research findings. We are extremely grateful to them for their time in this, and particularly to the BDA, BMA and AOMRC for allowing us to access their members in this way.

3.2 Dentist Consultation

3.2.1 Respondents

Our 10 respondents provided a good range of experience and dental roles. In terms of years of post-qualification experience the breakdown was as follows:

- 3-7 years: 2 respondents
- 8-10 years: 1 respondent
- 11-20 years: 2 respondents
- More than 20 years: 5 respondents.

Seven were male and three were female.

In terms of their roles:

- Three were specialists predominantly based in hospital; four were the owners or partners in practices, two were associates in practices and one was based at a

university. A number had mixed roles, for example practice owner and part-time lecturer at a dental school.

- The majority (70 per cent) were based in urban settings and 70 per cent of GDPs were in smaller practices. One practice was totally private work, one NHS only and the rest were mostly NHS work. One practice had been taken over by a corporate chain.

3.2.2 Jobs and Career Paths

Although held to be a very varied profession, the majority of respondents described themselves as having followed one of the two main career paths for dentists:

- A year's foundation training followed by becoming an associate (performer only) working in practice; then becoming a partner or the owner of a practice or practices (providing-performer); and then in a couple of cases, selling up and becoming associates again, prior to their retirement;
- Another year's training followed by acceptance onto specialist training and progression up to a hospital consultant role.

Again, a couple had had spells working in both practice and hospitals and two had either worked or qualified overseas. Although characterised by an increasing variety of roles, such as practice owner with a specialism, the respondents felt that these two paths were sufficiently different to warrant separate profiling for the purpose of pay comparison with other professions.

On further questioning, the career path for hospital-based dentists and specialists was described as closely akin to that of doctors and the existing anchor points were seen as sensible points at which to make comparisons for dentists as well as for the other medical specialities.

For the practice-based roles, the two levels of associate and partner were seen as being the key career anchor points. Although the clinical skills were seen as being the most difficult to master early in your dental career, the major difference between these two roles and with the hospital career path was held by all respondents to be the requirement for management and leadership skills. These were described as having become an increasingly important and time-consuming aspect of the role over the last decade. It encompasses everything we were told from financial management and financing to practice mergers, staff recruitment and motivation and dealing with employment legislation to purchasing, IT, patient management and dealing with CQC inspections.

Respondents said:

- 'The practice used to almost manage itself but now you need to look at the costs and the details every week, be more business minded';
- 'You continue to provide clinical leadership but the business aspects take over';
- 'The management component is the big differentiator...you have to learn it as you go along'.

Interestingly, every one of our respondents mentioned that the traditional career in general practice was now increasingly under threat, with indebted students facing a future of less remunerative and more time-consuming and time-pressured roles in partnerships, as NHS costs and payments continue to be squeezed, and property prices, litigation and other risks increase. Dental students today were described as placing more emphasis on work-life balance and more likely to prefer self-employment and to work overseas. The new dental contract was also held to be likely to worsen the earnings situation in the future.

The other essential and important skill sets mentioned were the interpersonal ones of patient care and interaction, which was seen as one of the big attractions of working in general practice. Again some interviewees questioned if the public and community service motivations were as strong for today's trainees as it had been and was for them.

3.2.3 Personal Career Experience

Respondents all described dentistry as a vocation and most had made the decision to pursue dentistry or a medical career by age 15/16 years. Half mentioned that they had either had parents working in the NHS or had met and been influenced positively by a dentist at this age. Four respondents, however, described the reward package as being an important parallel influence, given that it was an obviously challenging career in terms of the training requirements and job and work demands, and they were therefore concerned about the influence of the perceived decline in personal rewards in practice on the future career choices of young people.

Respondents said:

- 'I always wanted to be a dentist'
- 'It's a vocation'
- 'My parents were both in the NHS'
- 'The (financial) rewards do drive the career choice of many dentists'

- 'Earnings now vary widely, morale is gloomy generally'.

Other careers that the respondents had originally considered were:

- Doctor: 5 cases
- Vet: 2 cases
- Law: 2 cases
- Accountant and engineer: 1 case each.

In terms of their career intentions for the next 3-5 years, most respondents envisaged staying and progressing in their current area of dentistry and their responses largely reflected their age/level of experience, with:

- Three planning to reduce working hours or retire;
- Three planning to develop their experience in their current role;
- Two hoping to progress to a more senior role in their current area;
- One hoping to move to another speciality of dentistry and 1 envisaging shifting their practice to all private work.

None were planning to leave dentistry or go overseas and the vast majority of their friends and peers from university were still practicing dentistry in the UK, or had become academic dentists or retired after doing so. But when asked, again becoming a doctor was the most common response of alternative careers to move into, with moving to an academic post/or lecturing being the next most common response.

Seven respondents, however, had or would consider working as a dentist overseas and nine had peers or colleagues whom had done so, with Australia and New Zealand most frequently cited, but also the Middle East, USA and Asia. The motivations to do so were unanimously not seen as being primarily financial but a combination of a more attractive lifestyle and less time/financial pressure so as to be able to practice dentistry more effectively/enjoyably. The majority of moves were described as temporary, with people returning after developing their experience and a break. But some respondents worried that the movement of UK dentists overseas risked becoming larger and more permanent.

Respondents said:

- 'It's a different lifestyle'
- 'They want to escape the pressures here';

- 'It's quite specialised so there are a limited number of other jobs you can do and even other countries that you can practice in'.

3.2.4 External comparisons

Many of the respondents commented as to how difficult it is to compare dentistry with other occupations. When doing so however they felt the following were the most important factors in their work to reflect (ranked in order of ratings on a 3-point scale):

- Similar levels of qualifications and experience (by far the highest ranked);
- Equivalent levels of risk;
- Similar skills and competencies;
- Similar levels of responsibility and decision making;
- Professional status;
- Other factors mentioned included leadership skills and intelligence required.

Looking at it from the choice of occupations to compare with, the order of factors in terms of importance was as follows:

- The skills demanded and challenge of the work;
- The variety and autonomy in the work;
- The professional standing and reputation of the occupation;
- The opportunities to develop and progress;
- The likely workload and working hours;
- The earnings and rewards on offer;
- The associated lifestyle;
- The working environment.

The existing four comparator occupations were generally endorsed by our respondents, and generally rated and supported more highly than any of the alternative occupations we asked respondents to consider. The legal profession and then the pharmaceutical industry were rated as the most comparable, some way ahead of accountants and then actuaries.

We also provided respondents with a list of 17 other potential comparator occupations and asked them to suggest any others they thought relevant. By some way the two most highly rated occupations were:

- Veterinary medicine, followed by;
- Small business partners/leaders.

These were rated almost on a par with the existing occupations used. Others rated as very or partly relevant by four or five respondents were:

- Relevant academic and senior university roles;
- Pilots;
- Opticians;
- Engineers;
- Teachers.

Medical roles overseas and at home were also listed by a third of respondents each. Management consulting, banking, IT, Civil Service leadership roles, science and surveying also received mentions.

3.3 Doctor Consultation

3.3.1 Respondents

We received 162 usable questionnaire responses to our survey from members of the Academy of Medical Royal Colleges (AOMRC) with the majority (92 per cent) being completed by hospital-based speciality trainees and registrars. Some five per cent worked in research or academic medicine and three per cent in general practice/community health. The breakdown in terms of post-graduate experience is shown in Table 3.1. The five BMA Committee members we interviewed ranged from a speciality trainee to the managing partner in a GP practice.

Table 3.1: Experience Profile of Survey Respondents

	Frequency	Per cent
Less than 3 years	3	2
3 - 4 years	28	17
5 - 9 years	91	56
10 - 20 years	40	25
More than 20 years	0	0

3.3.2 Jobs and Careers

In terms of our respondents own career plans for the next 3–5 years, the majority (84 per cent) envisaged developing their experience in their current role and progressing in their current area of work to a more senior role. Some 10 per cent anticipated moving to part-time or reduced working hours.

However other alternative career paths and plans included:

Table 3.2: Alternative Career Paths and Plans of Survey Respondents

	Per cent
Leave the UK to work in medicine overseas	12
Moving to an academic/research post	7
Leave medicine to work in a different occupation	4
Leave the NHS to work in the private sector	3
Move into another speciality/area of medicine	2
Become a contractor/locum	2

The four per cent considering other occupations mentioned the City of London, medical technology and medical writing. Reasons for doing so included:

- ‘The pressure, stress and uncertainty of the future’;
- ‘One (an occupation) that respects me as a person’;
- ‘One that pays me my worth’.

Amongst our telephone interviewees, relative earnings were felt to have declined for GPs and the pressures and demands increased significantly, with one commenting that ‘for ambitious top graduates today, there are easier ways to make far more money’. Examples were also cited of salaried GPs not wanting to take on partner roles because of the extra risks and responsibilities involved for comparatively little extra pay and a worsening of terms such as maternity pay.

The majority of our respondents also knew peers and former colleagues who had left medicine and had moved in the following directions:

Table 3.3: Destination of Peers and Colleagues Leaving Medicine

	Per cent
Left the UK to work in medicine overseas	95
Moved into another speciality/area of medicine	84
Left medicine to work in a different occupation	75
Left the NHS to work in the private sector	50

UK medical earnings in our interviews were described as being up to 50% behind those in comparable occupations and countries such as Australia, where the workload and lifestyle was also generally held to be far better.

3.3.3 External Comparisons

When determining which occupations to compare with, our doctor respondents rated very similar characteristics as being most relevant and important to consider as our dentists questioned, with the following factors most commonly rated as very important across the sample:

Table 3.4: Most Important Factors Determining choice of Comparator Occupations

	Per cent
Similar levels of responsibility and decision making	91
Level of risk	84
Similar levels of qualifications and experience	77
Similar skills and competencies	58
Professional status	53

Factors which would actually influence their decision to move included:

Table 3.5: Factors that would Influence Respondents' Decision to Leave Medicine

	Per cent
Likely workload and working hours	78
The earnings and rewards on offer	74
The working environment and lifestyle	74
The opportunities to develop and progress	66
The variety and autonomy in the work	63
The skills and challenge in the work	61
Professional standing and reputation of the occupation	29

The doctors had more varied views on the relevance of the four occupations currently compared with, although like the dentists they also thought lawyers and pharma roles were the more appropriate, with the proportion seeing them as very relevant being as follows:

Table 3.6: Proportion of Respondents Rating Current Occupations as Very Relevant

	Per cent
Lawyers	50
Pharmaceutical industry managers and professions	21
Actuaries	17
Accountants and tax professionals	16

In terms of the 17 other professions which we provided as possible comparators, these predominantly hospital-based doctors surveyed had some very different views to the predominantly practice-based dentists, with the proportions rating them as very relevant as follows:

Table 3.7: Possible Comparator Professions Rated as Very Relevant by Respondents

	Per cent
Medical roles overseas	72
Pilots	56
Large private sector leadership/professional roles	39
Vets	37
Finance and banking	37
Management consultancy	30
University roles	19
The Civil Service	19
Engineering	19
Science professionals	15
IT and technology roles	14
Architects	13
Opticians	9
Small business leaders	8
School teaching/leadership	6
Journalism	2
Surveyors	1

Pilots were seen as relevant because of the complexity of the job and the similar demands and disruptions of shift work. Other roles mentioned included air traffic controllers, MPs and private sector doctors. The overseas comparisons favoured were generally those in countries with similar funding models, with Australia, Canada and New Zealand most frequently cited. The BMA's GPs we spoke to, like the dentists, tended towards wanting to compare with partnership roles in other professions such as lawyers and vets. There was strong support generally for increasing the number of comparative professions and occupations.

3.4 Chapter Summary and Implications

Although reflecting on differences in their training and particularly in the organisation of their current roles and rewards (partners in SMEs for most of the dentists, versus NHS employees for most of the doctors) there were some marked similarities in the views of the doctors and dentists consulted during this research for our review:

- Doctors and dentists primarily see their careers as vocational, with their career choice made at a relatively early stage, and for most it is, and they feel will continue to be, a 'career-for-life'.
- Pay and rewards are therefore not why most people go into and stay in these professions, but they are an important return on the lengthy investment that doctors and dentists make in their education and training, and an indication of their professional standing and status in society and their local communities.
- Career paths have changed little since the last review carried out by PA; however most anticipated more change in the future, particularly in general practice with the growth of the salaried GP workforce and the spread of corporate chains in dentistry;
- However the pressures on medical professionals and their earnings and lifestyle have increased markedly, encouraging growing numbers to look at alternatives, particularly overseas. Overseas comparison with medical roles was seen as an essential component of any future exercise by the vast majority of respondents.
- Most supported the comparison with other relevant occupations, even if they were critical of the 1 per cent cap and reported decline in earnings in general practice.
- The existing comparisons were largely supported, particularly with the pharmaceutical industry (as they are an employer of medical professionals) and with lawyers (both because of their lengthy training and levels of expertise, and also because they operate in partnerships as a common organisational model).
- The existing anchor points were also supported, as was the development of new anchors and comparisons for doctors and dentists in general practice. The roles and anchors were seen as being pretty straightforward to specify at 2-3 levels in each.

In terms of the criteria we should consider in selecting comparable occupations, these were very similar between these populations and our original stakeholders, with just some minor differences in emphasis. The criteria we presented them, which had been informed by our stakeholder interviews, were prioritised as follows:

Table 3.8: Rankings of Criteria for Selecting Comparator Occupations by Doctors and Dentists

Dentists	Doctors
Qualifications, training and experience	Responsibilities and risks
Responsibilities and risks	Qualifications, training and experience
Skills and competencies (clinical/technical)	Skills and competencies (clinical/technical)
Professional standing/status	Professional standing/status
Leadership/management	

And in terms of the occupations seen as most relevant, again there was lot of commonality between doctors and dentists (and with the original stakeholder interviewees), with differences largely reflecting the practice-based operations of most of the dentists consulted.

The priority occupations in order of preference were as follows:

Table 3.9: Rankings of New Occupations to Include in the Comparisons by Doctors, Dentists and Stakeholder Interviewees

Dentists	Doctors	Stakeholder Interviews
Vets	Pilots	University academics/leaders
Small business leaders/ partners	Large private company leaders/ senior professionals	
University academics/ leaders	Vets	Engineers, pilots, Senior Civil Servants, Finance and banking roles, management consulting, vets (for practice-based roles)
Opticians	Finance and banking	
Pilots	Management consulting	
Engineers; school teachers/leaders	University academics/leaders; engineers; Civil Service roles	

4 Literature Review: Relevant Pay Determination and Comparability Methods

4.1 Introduction

All of the stakeholders we have consulted in this review have commented as to the difficulties of comparing doctors and dentists' pay with other occupations, as well as the relatively large numbers for whom the profession is seen as a genuine career for life. However, our various stakeholder consultations have confirmed the benefits in this review of looking both at how medical pay is set in other countries as well as in other relevant professions, with the learning designed to support a critique of and improvement to the UK method used by DDRB.

The main aims of our external literature review therefore have been to:

- Examine current approaches and external trends in pay comparability methodologies;
- Examine the pay determination and comparability methods of overseas' doctors and dentists, in order to highlight how comparability studies are made there and the issues linked to performing international remuneration comparisons;
- Determine if there is any relevant learning around how other professions conduct pay comparability studies.

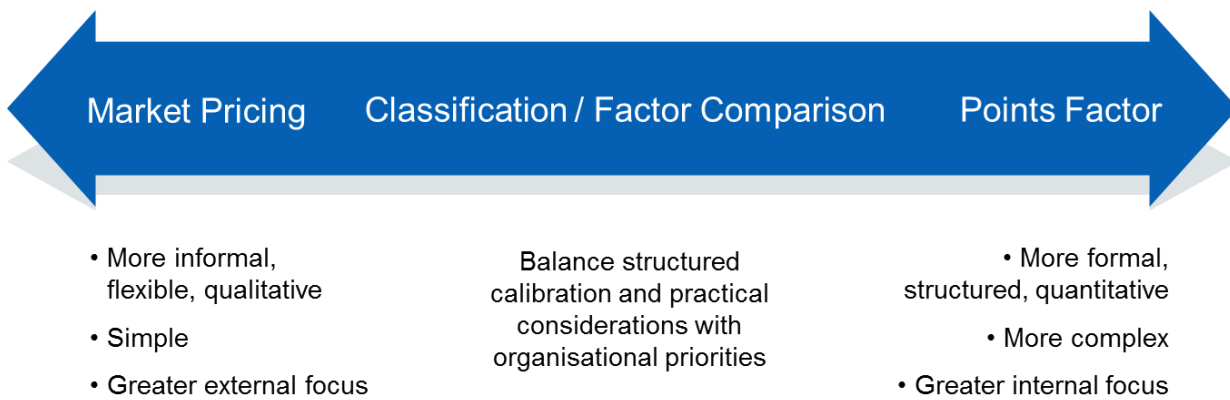
4.2 Definition and Trends

Pay comparability "*focuses on the processes through which organisations classify and reward jobs*" and compare them with the pay and rewards in other relevant organisations (Findlay et al, 2013:4). Pay comparison methods vary considerably and are based on data of varying degrees of robustness. Within comparator professions, and more broadly across the private and parts of the public sector, there have been moves to more external market/survey-driven rather than purely internal job evaluation-driven pay determination approaches, or a combination of job evaluation and market surveys within looser job 'classification' or 'levelling' approaches (Armstrong and Cummins, 2008). The overall trend in pay comparability methods has also been described as being towards a

“more pragmatic adaptation rather than revolution; for simplification rather than complexity” (Armstrong and Cummins, 2008: online). The DDRB’s recent approach of essentially slotting medical jobs in at the appropriate job level within Hay Group’s survey database appears to fit this evolution in approach.

In practice we are seeing traditional job evaluation and market-driven approaches to pay comparability often emerging as combined and complementary, rather than alternative approaches, as represented by Aon Hewitt’s spectrum of approaches model below (Figure 4.1). The direction of travel for many UK employers on the model has been from right to left, and market surveys are paying an increasingly influential role in pay determination, with job evaluation playing a simpler, more supportive and defensive role.

Figure 4.1: Aon Hewitt’s spectrum of pay comparability approaches



Source: Aon (2013), Aon Client Seminar on Job Levelling

Given the changing nature of jobs and increasingly varied and changeable skill demands, it is becoming less accepted that one pay comparison method, be that job evaluation or one single pay survey database, will capture and reflect this changing landscape. Marsden stated (Marsden, 2002) that, in most cases, an agreed yet broad approach to job classification will be needed in pay comparability exercises ‘to reduce the natural idiosyncrasy of jobs and help to identify contours of similarity and equivalence’.

There have also been moves to fewer and more generic role profiles, which have replaced multiple detailed job descriptions, particularly in sectors such as technology and finance where jobs can change rapidly and professionals often have considerable scope to personally shape their roles. Large corporate organisations nowadays typically benchmark their professional and managerial jobs into the job catalogues of the major international pay survey houses, for example, Hay and Willis Towers Watson, in order to remove complexity and the need to develop their own job descriptions and job evaluation methods.

The descriptors used to benchmark jobs and anchor points for the comparisons are tending to be briefer and to emphasise common factors, rather than the detailed occupational-specific aspects of work. However, age and service criteria for job matching have become much less popular as benchmarking criteria, largely on account of the legislation on age discrimination and a risk in some occupations that they may reinforce gender pay gaps as men on average tend to have longer service records. It used to be very common to produce 'age curves' of salary information in surveys covering engineers, lawyers and other professions, and chart pay progression over a career in these occupations. Now this is rare and so while individual levels of job and anchor points are compared between organisations, comparable rates of pay and/or career progression are typically impossible to compare in this way.

A survey by Xpert HR found that 95 per cent of respondents are now using market-linked pay comparisons in some form. UK medical and dental staff are interesting for having no internal job evaluation or measurement approach to compare and value jobs, while for the bulk of NHS jobs under Agenda for Change this is the main way in which jobs are placed into pay bands using the NHS job evaluation system.

Employers are also becoming more likely to use external market data to establish the pay levels of jobs internally and using surveys to cover more of their workforce. World at Work found that more than one-third of organisations match at least 80 per cent of their jobs to survey sources; and nearly 70 per cent of organisations match at least 60 per cent of their jobs (World at Work, 2015).

This survey by World at Work (2015) highlighted the growing trend in the use of market pricing to evaluate job worth. More than four fifths (88 per cent) of organisations have an established method for determining pay comparability with market pricing outpacing other pay comparability methods (between 68 per cent to 74 per cent of organisations depending on job category) (World at Work, 2015). Similarly high up among the reward priorities of UK reward professionals in a 2016 survey was 'benchmarking salaries against the market' (three-quarters of survey respondents – Xpert HR, 2016). World at Work found that more than one-third of organisations match at least 80 per cent of their jobs to survey sources; and nearly 70 per cent of organisations match at least 60 per cent of their jobs (World at Work, 2015).

Despite regular forecasts of the 'death of job evaluation' however, the majority of large UK organisations continue to employ some method of internal job evaluation and comparison with points factor schemes still being the most common. Reported reasons for this include the need for defence against equal pay claims, the inability to match unique jobs externally, and the need for more accurate internal measurement and justification for placements in grading structures (Xpert HR, 2016).

The PA methodology is a good example of this intermediate classification-style approach to measurement and matching which is typically associated with broader and market-

related salary bands in individual employers. Armstrong and Brown (2001) found that the majority of employers' experiences with such approaches had been positive, particular for professional groups, and supporting moves to more flexible and integrated working and less hierarchical organisations and behaviours. However, potential downsides experienced included over-complexity from trying to provide both internal and external matching, and a failure to achieve either objective of internal equity and external competitiveness in pay determination in the desire to achieve both. Thus while the PA approach is extremely effective in matching into the Hay market database at the appropriate generic level, it is much less effective at for example, assessing whether or not the core GP role is the same size of job as the entry level consultant post.

4.3 Pay Comparability in other Professions

The majority of the professional bodies of the comparable professions conduct salary surveys amongst their members. For example, the Law Society conducts earnings surveys of corporate in-house solicitors and separately for solicitors in private practice. These member surveys illustrate how pay comparisons are made within the professions. For example, among lawyers, accountants and architects pay is compared at key benchmark levels of post-qualification experience (PQE) up to and including salaried partners or partners/directors/sole principals. Organisations also analyse pay by practice size and region, which generally emerge from correlation analysis to be key determinants of pay levels. Beyond member salary surveys, recruitment consultants focusing on these professions also conduct their own market surveys for pay comparability purposes; although with varying degrees of robustness.

The large survey houses such as Xpert HR, Hay and Willis Towers Watson (WTW), supply market data and now actually run the surveys for the major professional institutes, with WTW for example running the Keypad survey for the large accounting firms. The 'magic circle' law firms (the five leading law firms headquartered in London) also participate in salary surveys. Salaries and pay rises up to three years post-qualification experience at these magic circle firms are generally shared, however, further up the career ladder and particularly at partner levels, pay levels and rises become less uniform and are more rarely released into the public domain (The Lawyer, 2015). Pay becomes much more profit-based and performance-driven.

This review could find little evidence of comparator professions looking outside of their own profession to benchmark pay, other than for entry level staff/new graduates. The largest law firms for example look at their direct competitors and at in-house legal roles in their clients and wider corporate sector, but rarely at other professions. At the junior levels, as for doctors and dentists, pay determination is focused on ensuring a supply of quality entrants and on ensuring minimum salary levels.

In relation to the latter, for example, from January 2016, all RIBA Chartered Practices are required to pay at least the Living Wage Foundation UK Living Wage, or where applicable the London Living Wage, to new architecture entrants working within the practice (RIBA, 2016). In the legal profession, the Solicitors Regulation Authority set a regulatory minimum salary for trainees, until this obligation was abolished in 2014 and replaced with a requirement that firms pay trainees at least the national hourly minimum wage. Prior to this, firms were required to pay their trainee solicitors at least £18,590 if they were in Central London, and £16,650 elsewhere (Law Society, 2016). The Law Society now recommends a minimum salary for trainees, “as a matter of good practice”, that providers of training contracts should pay trainees £20,913 in London and £18,547 outside of London. This recommended minimum salary is based on a 35 hour week at the Living Wage level plus the average yearly Legal Practice Course repayment. The Legal Practice Course is a pre-requisite for qualifying as a solicitor (Law Society, 2016). There is, however, considerable variation in salary ranges for newly qualified and more senior or experienced solicitors (Phillips, 2013).

One of the reasons that cross-professions’ pay comparisons, except at junior levels, seem to be comparatively rare may be that the variations between professions seem to be growing.

Research, for example, by Machin and Bell looking at the last 40 years of earnings for a range of professionals highlighted a stark division between the ‘uber professions’ still in the top 5 per cent of earners, including finance professions and doctors, who’s earnings had continued to grow faster than average earnings; and other middle class professionals such as engineers, academics, teachers and architects, the ‘cling ons’, who’s relative pay and living standards have fallen back. The huge jump in City workers’ pay was linked to the growth in the value of financial transactions, while *The Financial Times* which sponsored the study noted ‘the finding that doctors have consistently matched the earnings trajectory of City workers may prove more controversial, raising questions about the impact of the spending Labour lavished on the National Health Service under Tony Blair’ and explained they believed by the new contracts negotiated in 2004.

4.4 Pay Comparability in the Public Sector, PRB Groups and other Hard-to-Compare Roles

Since pay was devolved to individual departments in the mid-1990s, the public sector illustrates the general UK trends towards greater use of market data to establish pay levels and support greater flexibility in pay. This is illustrated for example by the move to relatively wide pay bands for the Senior Civil Service, and adoption of multiple location-based pay ranges in the Ministry of Justice, and recently the move to Trade-based variations in pay ranges in the Army’s new pay structure. The Cabinet Office/Civil Service Employee Policy now purchases market data for use by departments on a cost-

effective basis, from Hay Group for general managerial and professional roles, and from Radford for cyber and technology roles.

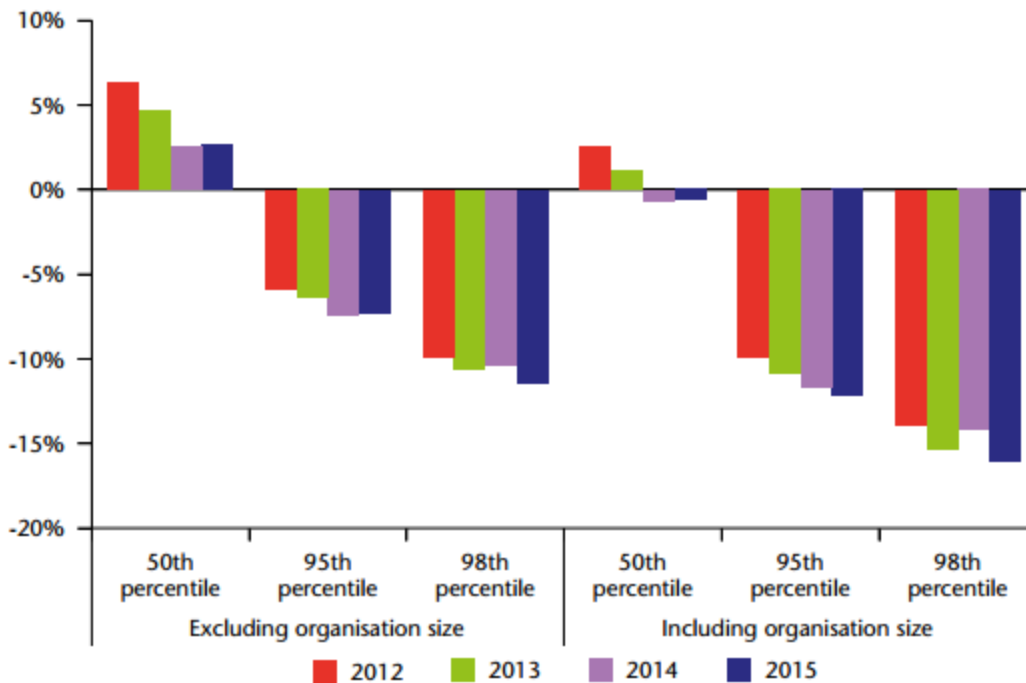
A stronger emphasis on fairness and internal relativities in a context of still high levels of unionisation, and the continuing threat of equal pay claims, have meant that detailed job evaluation continues to play an important role in public sector pay determination, but less strongly than in the past and generally now in conjunction with market data.

Pay comparability methods across the Pay Review Body Groups vary considerably, with only the Armed Forces and Prison Service Pay Review Bodies having a duty to undertake these comparisons, but the rest doing so to help to inform their recommendations.

Examples include:

- The Senior Salary Review Body (SSRB) which in its 2016 report focused on comparisons of higher earners in public and private sectors, rather than making specific occupational comparisons, and also made detailed adjustments to salary comparisons to consider both the trend in real take home earnings (taking account of price inflation) and total rewards comparisons involving pension valuations.

Figure 4.2: Adjusted average difference in hourly pay between public and private sector workers, excluding and including organisation size, as a percentage of private pay, 2012-2015

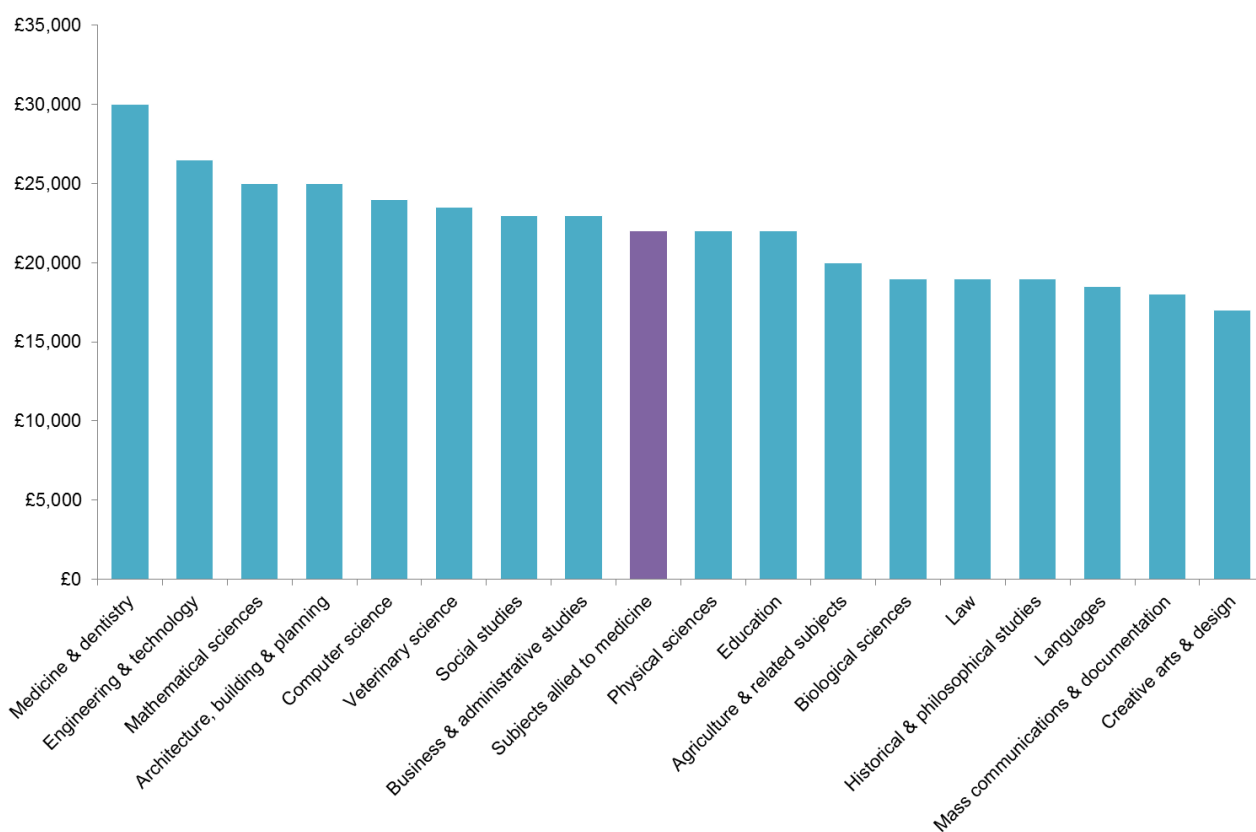


Source: OME, 2016

The SSRB concluded that the public sector at the 98th percentile of national earnings is between 11 per cent and 16 per cent behind the private sector and that the addition of pension reduces but does not eliminate this gap.

- The NHS Pay Review Body similarly focuses on ONS public and private sector average hourly earnings comparisons, noting a gap in favour of the private sector by 5.5 per cent, rather than using detailed occupational analysis. It also looks at pay levels and movement for the human health and social work category of the ONS earnings data. And for the first time this year they included comparative data from the Destinations of Leavers from Higher Education Survey (DLHE) showing that median starting salaries for graduates from non-medical health degree courses were roughly the same as the mean of distribution (£22,000) of graduate starting salaries.

Figure 4.3: Median starting salary by one-digit Standard Occupational Code, UK 2014/15



Source: OME, 2016

- The Prison Service Pay Review Body commissioned a specific pay comparison study with the private sector carried out by IDS and contained in its 2016 report, using a general sample of private sector employers. It concluded that pay levels and packages for lower graded officers in the private sector were less generous than for those in the public sector. But pay and reward levels for senior staff were generally more generous

in the private sector than in the public sector, and included additional benefits such as private medical insurance, a company car and bonuses.

Table 4.1: Base salary private sector comparison: National excluding London – Market Facing Pay Model

Nat'l exc. London private sector MFP					NOMS 2015	NOMS 2015
Grade	Band	UQ	Med	LQ		
	11				£74,848	
Grade 6	10	£94,648	£81,918	£71,976	£66,170	LQ-
Grade 7	9	£81,081	£70,383	£61,470	£60,108	LQ-
	8				£46,930	
SEO	7	£55,846	£49,519	£43,860	£40,247	LQ-
HEO	6	£41,935	£37,003	£32,240	£33,680	Med-LQ
	5				£28,491	
EO	4	£33,147	£28,478	£25,000	£24,975	LQ-
AO – L11	3	£25,000	£21,819	£19,125	£19,566	Med-LQ
AO – L10		£23,451	£20,777	£18,168		Med-LQ
AA	2	£18,932	£17,320	£15,526	£15,916	Med-LQ

Source: OME, 2016a

Generally therefore across these various public sector groups we have seen:

- Less reliance in recent years on detailed job descriptions and job evaluation as pay determination methods, unless the comparisons are particularly difficult due to the unique nature of jobs – hence the continuing reliance of the Armed Forces Pay Review Body on a points factor job evaluation approach to support their market comparisons – see below.
- More prominence given to external market comparisons, but generally using quite general ONS categories and survey databases (e.g. public vs. private sector) or breakdowns, (e.g. higher earning categories), rather than detailed comparisons with specific occupations or jobs. Where this is required then specific tailored surveys are intermittently carried out.
- Comparisons on more of a total rewards/package not just a pay level basis, although this is generally undertaken in a fairly simple way, adjusting most commonly for pension values, rather than through carrying out detailed and costly total rewards surveys.

The methodologies used for other occupations which are hard to compare and where the state is the major employer are also interesting to consider. For Armed Forces’ personnel

jobs are evaluated using a tailored internal points factor system (similar to the NHS one) which is converted to points in the job evaluation system and then generic private sector market pay level data drawn off for various ranges/levels of points from general industry databases. The data is adjusted to reflect the higher valuation of pension in the Armed Forces compared to the private sector, and an 'X factor' adjustment is also made to reflect the unique features of army life, such as potentially being shot at.

4.4.1 The Example of MPs

MPs are another fairly unique job in the public sector and also one where remuneration has been highly controversial in recent years. From 2004 pay comparability was carried out by a method involving a detailed job analysis and PwC points factor job evaluation, supporting comparison with the pay of similar-sized jobs in the public sector - SCS pay band 1/1A, mid-sized council Divisional Director, Head Teacher (mid-sized secondary school), Police Chief Superintendent, Armed Forces (1 Star Officer), and Directors of subsidiary companies (turnover between £100m- £500m). The sample of comparators was changed in 2007 and a target of 85 per cent of their average pay determined. The SSRB in 2007 also compared levels of UK MPs' pay with that in other European countries, although it noted that "precise comparisons are near impossible because the roles and job weights of members of parliament in different countries vary considerably depending on factors such as the number of voters represented, whether the system is unicameral or bicameral, and whether members represent a defined constituency or are elected on a party list".

A review in 2008 by Sir John Baker however, was concerned of the danger of 'cherry picking' particular occupations and he recommended linking MPs' salaries to changes in the Public Sector Average Earnings Index each year as being fairer, easy to understand, and less affected by disproportionate salary movements in one selected occupation

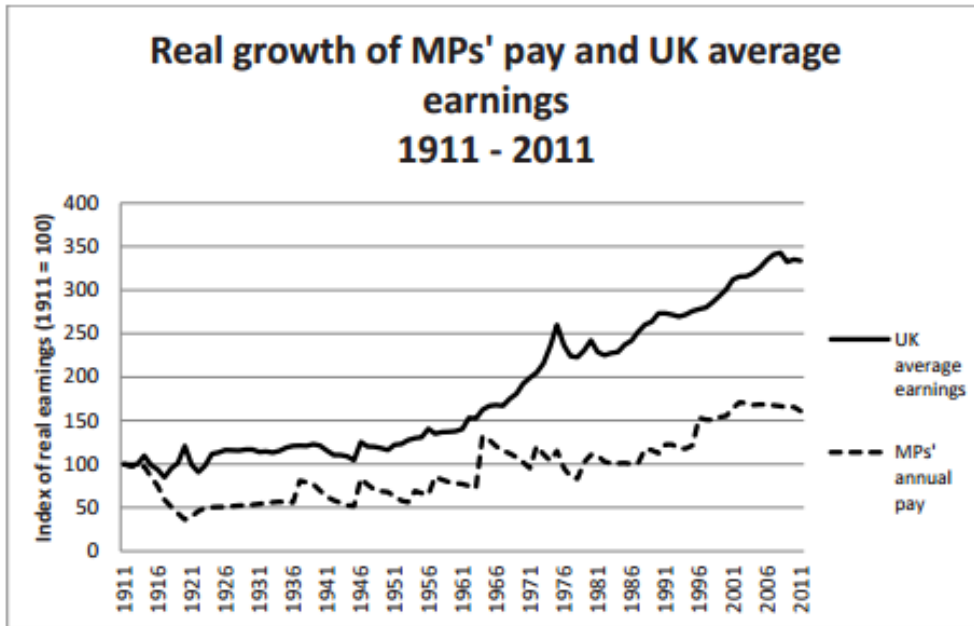
Following the expenses scandal in 2011 a detailed market review and stakeholder consultation exercise was undertaken by the body established to determine and control their remuneration, IPSA, published in 2012 (*Reviewing MPs' Pay & Pensions: A Consultation October 2012*). To some extent this repeated the debate over the value of specific occupational comparisons versus the use of more generic earnings indices to help to set MPs pay and pay increases. In that report, the SSRB noted concerns about mechanically linking pay levels for MPs with another occupation, stating "MPs' pay should not be set mechanically but by a judgement based on a range of factors, not all of which can be readily quantified".

IPSA agreed 'but consider it useful to look at information on other occupations' pay to provide a broad context for determining an appropriate salary'. They looked at MPs earnings in other countries and also against a wide range of other occupations suggested to them, including Council Leaders and Chief Executives of local authorities, Army

Privates, Senior Social Workers, Lawyers, Chief Probation Officers, Managing directors of small and medium sized companies. They also included General Practitioners (GPs) and CEOs of NHS Hospital Trusts.

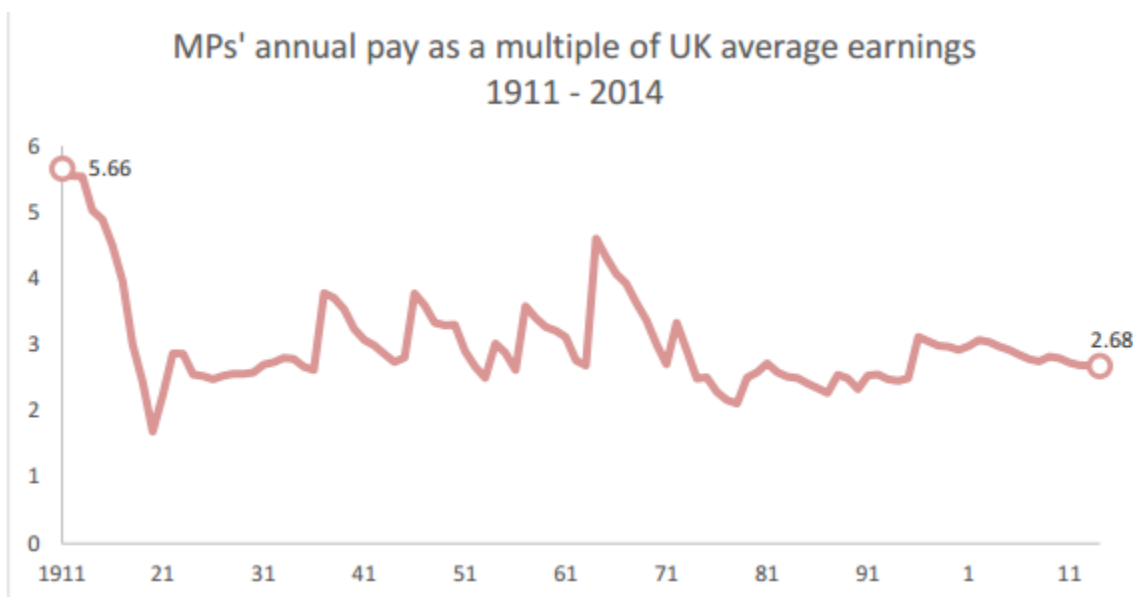
IPSA also compared MPs' remuneration to UK average earnings over the previous century noting an average ratio of approximately three times.

Figure 4.4: MPs' pay and UK Average Earning 1911-2011



Source: IPSA - Reviewing MPs' Pay & Pensions: A Consultation, October 2012

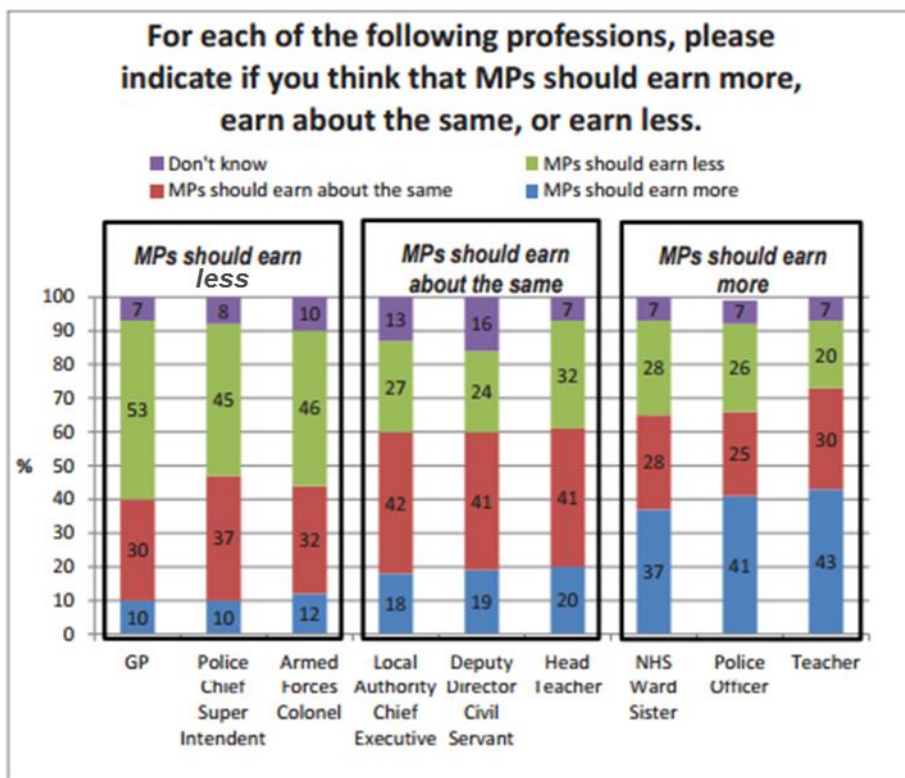
Figure 4.5: MPs' pay as a multiple of average earnings since 1911



Source: IPSA - *MPs' Pay in the 2015 Parliament: A Consultation*, June 2015

They also presented some interesting analyses of surveys of where the public felt MPs' pay should be positioned relative to certain relevant occupations (*MPs' Pay In The 2015 Parliament A Consultation*: June 2015):

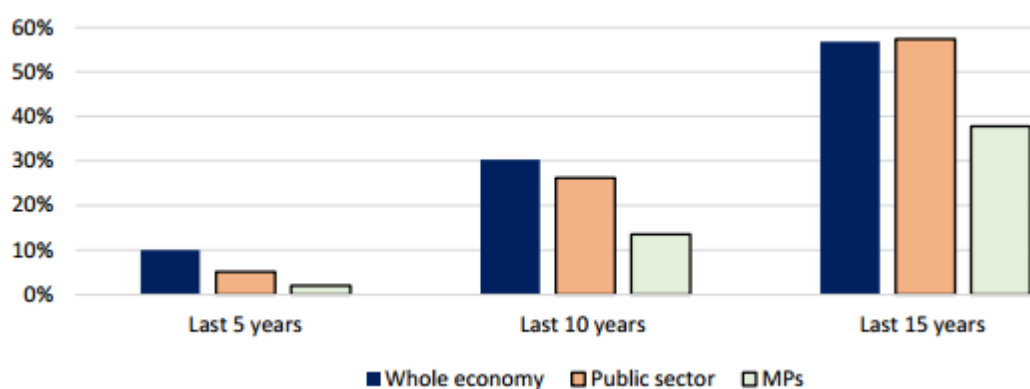
Figure 4.6: Public views on comparing MPs' pay to other occupations



Source: IPSA - *Reviewing MPs' Pay & Pensions: A Consultation*, October 2012

In 2013 changes were proposed by IPSA that were finally implemented in 2015, involving a one-off adjustment to MPs' pay from £67,060 to £74,000 a year, to restore the historic ratio with average earnings of three times. The relative pay decline for MPs with lower average pay awards was illustrated in the graph below. Comparison with general or specific senior professional roles was specifically rejected and IPSA noted that there was no evidence that the relative decline in pay had affected the quality or quantity of applicants. Thereafter, they proposed to link changes in MPs' pay to their constituents' pay across the country by indexing it to public sector average earnings movement (a late change to the original proposal of average earnings across the economy as a whole, driven largely by the continuing 1 per cent pay award cap across the public sector).

Figure 4.7: Pay increase across the economy, in the public sector and for MPs over the last 5, 10 and 15 years (to March 2015)



Source: IPSA - MPs' Pay in the 2015 Parliament: Final Report, July 2015

4.5 UK National datasets

UK Government-produced statistics also offer sources of earnings comparability for doctors and dentists against the comparator professions, and as just noted, other PRBs have been making increasingly extensive use of this improving base of information, both in addition and as an alternative to specific occupation comparisons. In its latest report, the DDRB presented data which provided important context to its consideration of pay. It included:

- Analysis of average (mean) total earnings per head of various staff groups compared 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 data from ASHE and NHS Digital.
- Analysis of the Higher Education Statistics Agency (HESA) Destination of Leavers from Higher Education (DLHE) statistics of earnings of first degree graduates six months after graduation. This analysis helped place the earnings of a career in medicine into context by analysing doctors' and dentists' pay relative to the national distribution and other professional groups at different points in their careers.

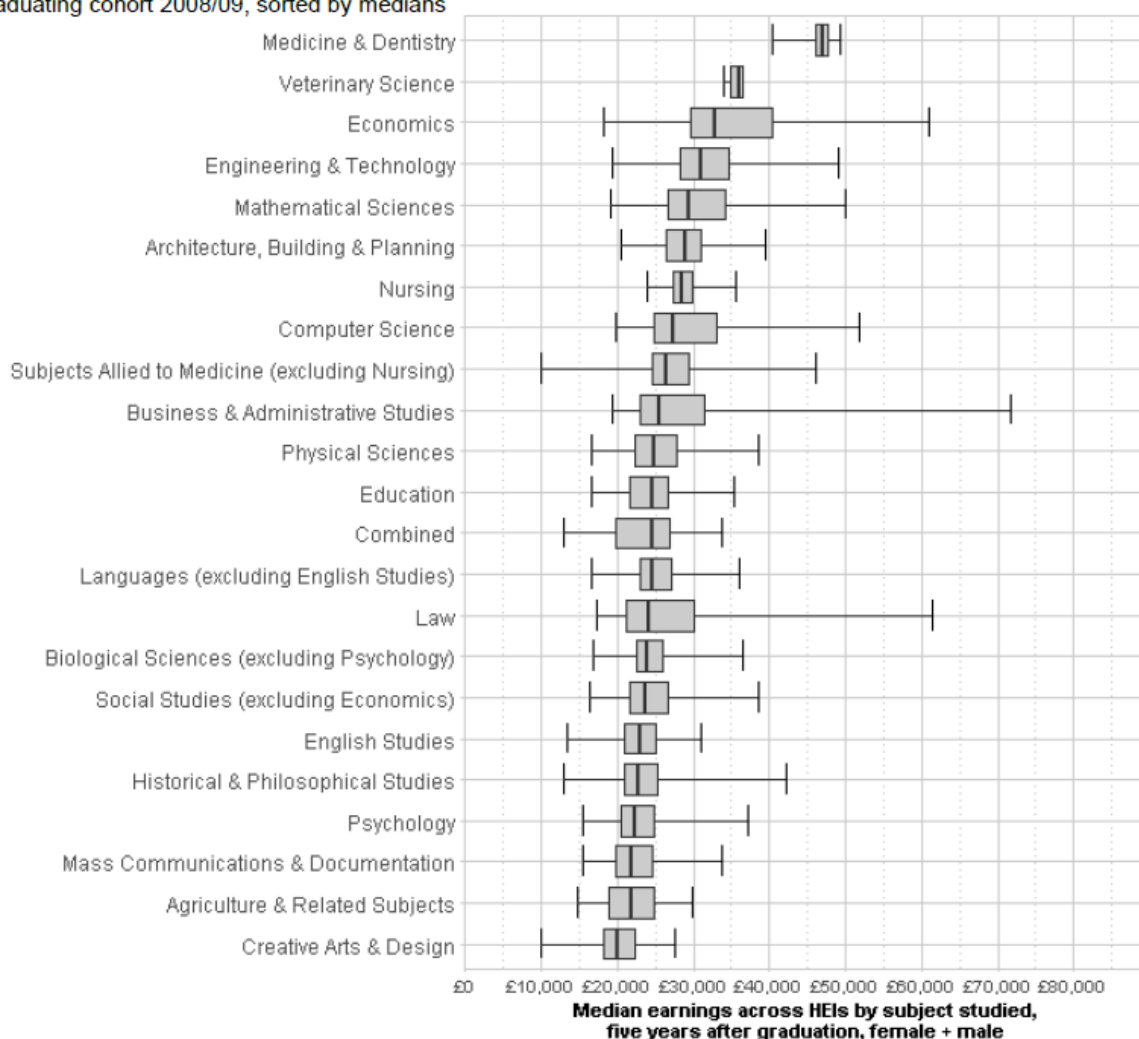
In addition, other datasets provide further context for doctors' and dentists' pay. The Department for Education recently released the first full set of subject and institutional Longitudinal Education Outcomes (LEO) data. This highlights the wide variation in earnings potential of graduates between subjects. The data enables analysis of how much graduates of different courses at different universities are earning one, three, five, or ten years after graduating. The data can also be broken down by graduate characteristics including prior school attainment.

With relevance to this review, the LEO data shows that five years after graduation, 'medicine and dentistry' graduates had the highest median annualised earnings (£46,500); followed by 'Economics' (£37,500) and 'Veterinary science' (£36,500). For the other comparators, 'Law' is shown at £25,000. Also of note is that within medicine and dentistry, the lowest quartile of earnings five years after graduation was higher than the median of all other subjects (DfE, 2017) with pay in a narrow range of £40,300 to £49,200 due to the national determination of pay – see Figure 4.8 below.

Figure 4.8: Distribution of median annualised earnings across HEIs for each subject area five years after graduation

(minimum, lower quartile, median, upper quartile, maximum).

Graduating cohort 2008/09, sorted by medians



Source: DfE, 2013

The data also examines the median annualised earnings of graduates by attainment group (prior attainment at 'A' level). Due to the entry requirements of UK medical schools, it can confidently be assumed that medical graduates would be within the highest attainment grouping (360 points). Five years after graduation, the median annualised earnings of

graduates in this group were £35,500, £7,500 (26 per cent) higher than the median earnings of graduates in the next prior attainment grouping (300-359 points) (DfE, 2016).

In its recent report for the OME, The Institute of Fiscal Studies (IFS) used prior attainment level as an indicator of worker quality. IFS used data from the Destination of Leavers from Higher Education (DLHE) survey to take individuals' Universities and Colleges Admissions Service (UCAS) Tariff Points Score on entry to higher education as a main measure of educational achievement (a proxy for worker quality) and then examined the average educational achievement of individuals in major public sector occupations six months after graduating¹; there being significant evidence to suggest that workers with higher levels of educational achievement also have higher levels of earnings.

The results showed that new doctors have a median UCAS tariff percentile of close to the 86th percentile amongst all higher education leavers- the highest of the professions examined and there was no evidence of substantial declines in educational attainment across the occupation over time (relative to those employed in other sectors) and therefore little evidence that public sector pay changes to date have affected the quality of new recruits (IFS, 2017). The report stated that average wages for doctors aged 21–30 are relatively high, placing them at around the 80th percentile amongst all graduates in the same age bracket. However, from a higher starting point, the rate of pay increase for medicine and dentistry graduates was slower than in many other professions – see table below.

Table 4.2: Levels and Growth in Graduate Earnings after Graduation

Subject	Prior attainment ¹	1 year	3 years	5 years	Per cent growth
Medicine & Dentistry	360 points	35,500	43,500	47,000	32.4
Subjects allied to medicine	360 points	23,000	31,500	37,000	60.9
Biological sciences	360 points	14,500	24,500	29,500	103.4
Veterinary science	360 points	26,000	32,000	36,500	40.4
Agriculture & related subjects	360 points	15,000	x	x	-
Physical sciences	360 points	16,500	28,500	33,000	100.0
Mathematical sciences	360 points	20,500	32,500	41,000	100.0
Computer science	360 points	18,000	37,000	42,500	136.1
Engineering & technology	360 points	22,000	32,000	39,000	77.3
Architecture, building & planning	360 points	21,000	27,500	30,000	42.9
Social studies (excluding economics)	360 points	17,000	26,000	32,000	88.2
Economics	360 points	21,500	36,000	48,000	123.3

¹ The sample was limited to those aged between 21 and 25 and graduating between 2006–07 and 2014–15.

Subject	Prior attainment ¹	1 year	3 years	5 years	Per cent growth
Law	360 points	14,500	28,500	37,500	158.6
Business & administrative studies	360 points	17,500	32,000	42,500	142.9
Mass communications & documentation	360 points	14,000	23,000	26,500	89.3
Languages	360 points	15,000	24,000	29,500	96.7
Historical & philosophical studies	360 points	14,500	25,500	31,500	117.2
Creative arts & design	360 points	12,500	19,500	24,500	96.0
Education	360 points	18,500	24,500	28,000	51.4
Combined	360 points	19,500	26,500	30,000	53.8

Source: UCEA, 2017

The Annual Survey of Hours and Earnings (ASHE), now in its thirteenth year, produced by the Office for National Statistics (ONS), also provides data that can be used for benchmarking medical professionals and the existing comparator professions. The Department of Health used ASHE data in its evidence to the DDRB in October 2016, to analyse movements in medical earnings compared with other high-earning professions. The approach identified the highest-earning professions in 2011, using the median gross annual pay figures, and assessed how those figures had changed by 2015. The comparisons indicated that doctors had “broadly maintained their rank position amongst the very highest earners, although relative gaps had been modestly affected by pay restraint” (DoH, 2016:41).

Table 4.3 shows the mean annual gross pay figure higher than £55,000 for 2011 and the median figure for 2015, and also the average for all employees. The DoH stated that the evidence showed that “in both years the median for medical practitioners was 4th highest amongst the 2011 top six, after Chief executives & senior officials, Aircraft pilots & engineers, and Marketing & sales directors, and more than 2.9 times the average for all employees in the UK, despite the fact that medical practitioners is the only group in the table to include junior trainees” (DoH, 2016:42).

The evidence also included analysis of each four-digit occupation code group with a published 70th percentile annual gross pay figure higher than £70,000 for 2011 and 2015; showing that in both years the 70th percentile pay figure for Medical Practitioners was in the top three occupation groups (Chief Executives and senior officials; Medical Practitioners and Marketing and sales directors) and around three times the figure for all UK employees (DoH, 2016).

Table 4.3: Mean annual gross pay of the UK highest earning professions in 2011 and 2015

Occupation	Mean annual gross pay £pa		Number of jobs
	2011	2015	
Chief executives and senior officials	71,515	80,871	67,000
Aircraft pilots and flight engineers	66,810	84,592	10,000
Marketing and sales directors	64,515	68,338	144,000
Medical practitioners	62,621	65,843	164,000
Information technology and telecommunications directors	57,924	61,082	29,000
Senior police officers	56,903	61,841	11,000
All employees	21,100	22,487	21,634,000

Source: DoH, 2016

There are further ONS earnings data cuts which could be useful for DDRB to include to provide context to its consideration of doctors' and dentists' pay. For example:

- Movement in the earnings of the 'professional occupations' major occupational group in SOC 2010 – in which the general nature of the qualifications, training and experience include a 'degree or equivalent qualification, with some occupations requiring postgraduate qualifications and/or a formal period of experience-related training.'
- Movement in the earnings of the 'Managers, directors and senior officials' major occupational group in SOC 2010 – in which the general nature of the qualifications, training and experience include 'a significant amount of knowledge and experience of the production processes and service requirements associated with the efficient functioning of organisations and businesses'.
- Movement in earnings among the Level 4 skill, sub-major groups of SOC 2010 which includes: corporate managers and directors; Science, research, engineering and technology professionals; Health professionals; Teaching and educational professionals; Business, media and public service professionals.
- Movement in earnings levels between the public and private sectors at the 90th, and 95th and 98th percentiles of full-time employees' earnings.

Comparisons of professions on criteria beyond earnings, in areas such as rates of job movement and progression, vacancies and unemployment levels is much harder, with the ONS data in these areas generally broken down by Standard Industrial Classification rather than Standard Occupational Classification.

4.6 Overseas pay determination and comparability

Traditionally, doctors in OECD countries have been remunerated via:

- *Salary*: determined based on qualifications and seniority, with salary scales usually set within the country or varying by region or by health facility (Fujisawa and Lafortune, 2008).
- *Fee-for-service*: whereby doctors' earnings are determined by the volumes, types and prices of the services provided. Across most countries, fees-for-services are negotiated between the health care purchasers (e.g. Health Ministries/health insurers) and the doctors providing them. In some countries, e.g. France, individual doctors have some flexibility to set fee levels. Fees can be fixed within a country (e.g. Canada) or by insurance funds (e.g. Austria). Several countries have introduced a ceiling on the maximum number and types of services that fee-for-service doctors can claim in any one year (e.g. Canada and Germany) (Fujisawa and Lafortune, 2008).
- *Capitation*: whereby doctors are paid a certain amount for each patient registered with them in return for a commitment to provide care for a defined period of time. Remuneration is therefore impacted by the number of patients and the amount paid per patient, which is normally negotiated between health care purchasers and providers. In OECD countries, capitation has been mainly used to pay GPs and several countries have imposed a ceiling on the total number of patients per GP to ensure patients are not underserved (e.g. the Czech Republic, Denmark and Hungary) (Fujisawa and Lafortune, 2008).

However, in the context of increases in the international migration of doctors; easier access to information about better job opportunities and rising healthcare costs (Fujisawa and Lafortune, 2008), there has been a growing trend in many countries to explore new remuneration systems for doctors, combining the traditional methods with new types such as pay for performance, in attempt to attract and retain doctors, whilst controlling costs (Ibid.). For example, there is evidence in the United States that the use of performance incentives linked to care quality, patient satisfaction and resource use is increasing, alongside a decline in the use of productivity/per item incentives (Chien et al, 2014).

In UK general practice, mixed payment methods are commonly used, typically combining capitation and fee-for-services and with partner, salaried employee and self-employed contractual arrangements. Remuneration methods for GPs in the United States vary significantly, including capitation, fee-for-services, salary and performance-based payments (Fujisawa and Lafortune, 2008). Payment methods also vary for specialists; with most paid on a fee-for-service basis in countries such as Canada, France, and the United States. However, some other countries (e.g. Denmark, Finland etc.) alongside the

UK, pay specialists a salary, although as in the UK some specialists may earn additional income from private practices on a fee-for-service basis (Fujisawa and Lafortune, 2008).

It is these different methods of remuneration and various income sources used overseas which make international comparisons of doctors' remuneration difficult.

A study of international models of pay determination for medical and dental consultants, conducted for OME by Capita in 2011, highlighted some key points of relevance for our current review:

- Whilst models of pay determination for senior medical staff vary across countries, there are some broad similarities which can be categorised. For example, The Republic of Ireland, New Zealand, and Australia operate a national or State level framework, "matching government involvement in healthcare policy and funding, where collective negotiation and/or periodic independent review sets the main pay rates and terms/conditions. In contrast, the USA and Canada report a higher level of individualised or local pay determination" (Capita, 2011:4).
- Most countries operate forms of additional payments for out-of-hours' work, management responsibilities and recruitment and retention supplements.
- The USA and Canada report attempts to move payment methods away from fee-for-service to 'blended' approaches or new models.
- There was strong evidence of flows of doctors between English-speaking countries; in particular from New Zealand to Australia and from Canada to the USA. Better career opportunities and pay rates were reported as contributing factors in these 'two major flows' (Capita, 2011:4).

These findings highlight the complexity of making international pay comparisons for doctors, in addition to the fact that in some countries the distinction between salaried and self-employed doctors has become increasingly blurred, as some salaried doctors may have a separate practice and some self-employed doctors may receive part of their payment through salaries (OECD 2011:66).

The OECD Health Database offers the most comprehensive source of comparable data on health systems across OECD countries and includes remuneration of salaried and self-employed GPs and salaried specialists. The 2016 statistics (from 2013 data) show that the remuneration levels of GPs and specialists vary greatly, with specialists pay being 3.44 times the average wage in the UK; compared with 3.22 times in Ireland (values for other English-speaking countries were not available). Among GPs, salaried income is 1.69 in the UK, ranging up to over four times the average wage (4.36) in Luxembourg. The OECD stated that in many OECD countries, "the income gap between general practitioners and specialists has widened over the past decade, reducing the financial attractiveness of

general practice". (OECD 2011:66). It has been found that generally specialists' remuneration is higher in countries where they are self-employed and paid by fee-for-services; compared with countries where they are paid salaries. In countries where self-employed and salaried specialists coexist, the earnings of self-employed specialists tend to be substantially higher than for salaried specialists (Fujisawa and Lafortune, 2008).

In summary, there is evidence that despite the different remuneration methods used for doctors and dentists overseas; international comparisons are possible and are an important due to the evident flows between English-speaking countries. However, as highlighted by the Capita review, such comparisons are difficult because of the differences in how the healthcare systems operate; the limited available data and different national sources; and the increasing use of mixed payment methods. As such, international comparisons, using a common currency, need to be detailed exercises and therefore probably conducted only at intervals e.g. every three to four years.

4.7 Chapter Summary and Implications

The DDRB has carried out market comparisons for doctors and dentists for many years and illustrates the general UK trend towards employers placing a stronger emphasis on external market data rather than internal job evaluation methods in determining pay levels.

Generally across these various public sector groups we have seen:

- Less reliance on detailed job descriptions and job evaluation as pay determination methods.
- More prominence given to external market comparisons, with direct occupational comparisons and tailored surveys in some cases.
- Often also using national ONS categories and survey databases (e.g. public vs. private sector) or breakdowns, (e.g. higher earning categories' comparisons), or broad sector and occupational comparisons (e.g. Hay general industry database), rather than detailed comparisons with specific occupations or jobs, partly to avoid debate over the occupations and avoid the dangers of 'cherry picking'.
- Comparisons on more of a total rewards/package, not just a pay level, basis, but generally using quite simple methodologies to do this, for example simple pension value formula adjustments to pay levels.

It could be argued that with improvements in the national datasets available and given the comparison methods of other PRBs, there may be scope to further utilise these datasets in the comparability work that the DDRB undertakes in its annual report.

The PA method facilitates effective matching into the appropriate responsibility level of Hay's salary survey databases. However the original role profiles are no longer really required for this, nor to match into any additional databases selected as the survey providers have generally improved their job catalogues and matching descriptors. But nor are they really detailed enough to determine the relative positioning of different roles, for example how different dental and GP posts should be placed relative to the original descriptions for hospital-based positions.

There is also evidence that despite the different remuneration methods used for doctors and dentists overseas, international comparisons are possible and are important due to the evident flows particularly between English-speaking countries, which massively outweigh movement into and from other occupations (see next chapter). They were generally supported, sometimes strongly, by all the stakeholders we consulted (see Chapter 2). However, as highlighted by the Capita review, such comparisons are difficult because of the differences in how the healthcare systems operate; the limited available data and different national sources; and the increasing use of mixed payment methods. As such, international comparisons, using a common currency, need to be detailed exercises and therefore probably realistically could be conducted only at intervals, for example every three to four years.

5 Career Paths, Inflows and Outflows

Employers generally define their labour market competitors and set competitive market pay levels based on knowing:

- Where existing staff come from;
- What other organisations their staff consider joining;
- Which organisations and occupations staff are lost to.

Although medicine and dentistry very much continue to be lifetime careers and vocations, with comparatively small numbers of leavers and most of those going overseas, and high barriers to entry for joiners, nonetheless this information is vital to identifying occupations and organisations to include in external comparisons. PA carried out such analysis in 2008. Now, with better national datasets available, we have been able to update and extend this to help to indicate the most relevant labour markets and professions to compare the medical and dental professions with.

5.1 Entry data

The first report of the BMA's cohort study of 2006 medical graduates, as part of a 10-year longitudinal study of the career paths of 435 doctors, provided baseline information of interest in medicine and career choice. The study found that 15 per cent of the doctor cohort had been in full-time permanent employment before entering medical school, with almost a fifth of male cohort doctors having been employed full-time before entering medical school, compared with 13 per cent of female cohort doctors. The types of previous employment ranged from medical-related occupations such as nurse, midwife, dentist, pharmacist and clinical research scientist to non-medical related occupations such as financial analyst, builder, waitress, software engineer, police officer, lifeguard and a professional footballer (BMA, 2007).

As part of our review, contact was made with the Medical Schools Council, of which the 33 undergraduate medical schools in the UK are members to attempt to access any data on the alternative career paths applicants took before transferring to medicine. Unfortunately, however, the Medical Schools Council do not undertake any analysis of this nature. UCAS was also contacted to determine whether it held data on the previous

occupation of mature entrants to medical school, but they do not hold previous occupation data within its analytical data service. We also approached individual UK medical schools in an attempt to obtain this data. One of the largest medical schools in the UK was able to supply the background data of its applicants and it showed that the previous occupations of mature (aged 24 years and over) entrants in the last three years included consultancy, finance; pharmacy and science (see below).

Table 5.1: Previous occupation of mature medical school entrants (2014-2017) at one UK medical school

Year of entry	Age on entry	Previous occupation
2016	31	RAF paramedic
2016	26	Business consultant
2016	24	Student/parent/office intern
2015	39	Investment banker
2015	33	Science researcher
2015	25	Student, then work experience or volunteering
2015	24	Student, then work experience or volunteering
2015	24	Student, then work experience or volunteering
2015	24	Student, then work experience or volunteering
2015	24	Pharmacist
2014	27	Carer for family members
2014	25	Student, then work experience or volunteering
2014	24	Finance

Source: Undergraduate Admissions Office (UK Medical School)

NHS Digital holds recruitment data, including the recruitment sources for new general medical practice joiners. The most recent data (2015-2016) shows that outside of general practice and the NHS, the other most common routes for those already in employment were education/training and the private sector (see Table 5.2). For about half, however, the sources are unknown.

Table 5.2: Recruitment sources for new general medical practice joiners, April 2015- March 2016, England, Provisional Experimental Statistics

Recruitment Source	Headcount
Abroad - EU Country	3
Abroad - Non EU Country	13
Armed Forces	21
Education Sector	221
Education/Training	755
General Practice	4,941
NHS Organisation	3,912
No Employment	778
NQ - First Qualification	35
NQ - Further Qualification	9
Other Private Sector	1,286
Other Public Sector	404
Prison Service	15
Private Health/Social Care	269
Return to Practice	268
Self Employed	161
Social Services	13
Third Sector	19
Unknown	12,159
Total	25,045

Source: NHS Digital, 2016

Data from UCAS shows that in 2014/15, 89.7 per cent of medical and allied subject graduates went directly into employment (UCAS, online) and according to data from HESA, the industry destinations of full-time medicine and dentistry first degree leavers entering employment in the UK (degree 2011/12 to 2013/14) across all UK HEPs was dominated by Human health and social work activities, with some also going to Education and Public administration and defence industries (HESA, 2015) - see Table 5.3. This would tend to support making pay comparisons with general and specific public sector earnings databases.

Table 5.3: Industry destinations of full-time medicine and dentistry first degree leavers entering employment in the UK (degree 2011/12 to 2013/14) across all UK HEPs

	Headcount)
All UK HEPs	
Standard Industrial Classification	
Agriculture, forestry and fishing	0
Mining and quarrying	0
Manufacturing	0
Electricity, gas, steam and air conditioning supply	0
Water supply, sewerage, waste management and remediation activities	0
Construction	5
Wholesale and retail trade; repair of motor vehicles and motorcycles	5
Transport and storage	0
Accommodation and food service activities	5
Information and communication	0
Financial and insurance activities	5
Real estate activities	0
Professional, scientific and technical activities	5
Administrative and support service activities	5
Public administration and defence; compulsory social security	20
Education	30
Human health and social work activities	6,950
Arts, entertainment and recreation	0
Other service activities	0
Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use	0
Activities of extraterritorial organisations and bodies	0
Unknown	10
Total	7,040

Source: HESA DLHE, 2015

5.2 Exit data

The BMA, General Medical Council, NHS Digital and the NHS Staff Survey and UK Medical Careers Research Group are all sources of destination data for doctors and dentists leaving the NHS.

Firstly, the stability index is useful for looking at staff retention in the NHS. The stability index is the percentage of staff there at the start and remaining in that employment during a certain period. Retention statistics for NHS staff in Trusts and CCGs, in England in 2016 showed that the stability index for NHS Hospital and Community Health Services Doctors was 59.6 per cent. In addition, the turnover rate for NHS Hospital and

Community Health Services Doctors between 30 Sep 2009 and 30 Sep 2016 was 40.4 per cent (NHS Digital, 2017).

The BMA highlight that “retention is increasingly an issue in some specialties; almost half of the orthopaedic consultants appointed in Scotland in the last five years have subsequently left to work elsewhere, mostly outside Scotland” and across all specialties, the BMA, has highlighted recruitment issues in the remote and rural geographies (BMA, 2016a). The BMA report that Welsh vacancy rates have not been officially published since 2011 (Ibid.), however, data from local health boards and trusts in Wales from March 2015 indicated a consultant vacancy rate of 6.8 per cent, with considerably higher rates in some health boards and trusts (BMA, 2016b).

The annual NHS Staff survey also provides some proxy indicators of intention to leave, as research has demonstrated clear links between levels of engagement (for the purposes of this defined as a mixture of how motivated staff are, how much they are able to suggest and implement improvements, and how prepared they are to speak positively about their organisation) and a range of outcomes including staff turnover (Dawson and West, 2016). The 2016 survey showed that all ‘medical/dental staff’ had an overall engagement scale score (out of five) of 3.9, compared with an overall NHS staff engagement score of 3.79. Levels of staff motivation among ‘medical and dental staff’ were 4.04, compared with 3.92 for all NHS staff (NHS Staff Survey, 2016); indicating that levels of engagement and motivation among the medical/dental workforce in the NHS are, relatively, not strong indicators of intention to leave the profession.

The BDA’s Associate Survey 2016 showed that over the next five years some 13 per cent of associate dentists intend to leave the profession through retirement; nine per cent intend to leave dentistry to work in different sector or industry (10 per cent of heavily NHS-committed associates); and five per cent intend to leave the UK to work overseas (BDA, 2016). Again, unfortunately there is no detail available on the targeted sector or industry. Responses are shown in Table 5.4. Respondents could choose more than one option.

Table 5.4: Associate dentist career intentions for the next five years

	All associates in England, Scotland, Wales and NI	NHS >75 per cent	NHS <75 per cent
Become a community dentist	2	3	2
Become a hospital dentist	4	4	3
Become a practice owner	18	18	16
Continue working in current role	44	47	42
Develop new specialist skills	29	34	21
Increase the proportion of NHS/HS work I do	2	2	2
Increase the proportion of private work I do	33	40	24
Leave dentistry to work in different sector or industry	9	10	6
Leave the UK to work overseas	5	5	5
Reduce the number of hours I work	26	28	23
Retire from general dental practice	13	10	17

Source: BDA Associates Survey, as cited in BDA, 2016. Reproduced with permission from the British Dental Association.

Similarly for practice owners, almost a third intend to retire in the next five years (30 per cent) ; five per cent intend to leave dentistry to work in a different sector or industry and three per cent intend to leave the UK to work overseas(see Table 5.5) (BDA, 2016). Respondents could choose more than one option.

Table 5.5: Practice owners career intentions for the next five years

	All practice owners in England, Scotland, Wales and NI	NHS >75 per cent	NHS <75 per cent
Acquire additional practices or contracts	10	10	10
Become a community dentist	0	0	0
Become a hospital dentist	0	1	0
Continue working in current role	41	37	44
Develop new specialist skills	13	11	14
Increase the proportion of NHS/HS work I do	1	2	1
Increase the proportion of private work I do	27	35	21
Leave dentistry to work in different sector or industry	5	5	4
Leave the UK to work overseas	3	3	3
Reduce the number of hours I work	31	31	31
Retire from general dental practice	30	28	31
Sell my practice and become an associate	18	18	18
Expand my practice	16	12	18

Source: BDA Associates Survey 2016, , as cited in BDA,2016. Reproduced with permission from the British Dental Association.

In addition, the Dental Working Hours, Motivation Analysis 2015/16 Report, produced by NHS Digital, which explores the relationship between the motivation and morale of self-employed primary care dentists and their working patterns based on the Dental Working Patterns Survey, highlighted that half of dentists surveyed said they often think about leaving the profession (NHS Digital, 2016b).

The GMC collects data from doctors who leave the profession, through answers to exit questionnaires sent to doctors giving up their licence to practise, however this data is not comprehensive. Doctors' reasons for leaving the workforce also change with age. The majority of doctors aged under 50 years old who are giving up a licence to practise are leaving to go overseas. Interestingly, this is occurring among both UK graduates (65 per cent) and non-UK graduates (87 per cent). This highlights the importance of conducting international comparisons of pay. The majority of doctors aged over 50, leave the GP or Specialist Registers to retire (86 per cent UK Graduates; 73 per cent non-UK graduates) (GMC, 2016).

Table 5.6 shows the breakdown of doctors leaving the NHS in the period 2015-2016. It highlights the recent trend for doctors in their second year of foundation training (F2) not to proceed immediately to the first year of specialty training. The GMC's national training survey found that 26.1 per cent of F2 doctors intended to take a break from training after completing foundation training, and 3.5 per cent were considering giving up medicine. The large majority of doctors planning to take a break (86.5 per cent) gave work-life

balance as the reason (cited in GMC, 2016). In the 2016 UK Foundation Programme Office annual report, it showed that 15.4 per cent of F2 doctors completing their AFP F2 year in August 2016 were taking a career break and 1.2 per cent were permanently leaving the profession (Foundation Programme, 2016).

In 2015, only 65.7 per cent of F2 doctors who completed foundation training made an immediate application to the first round of specialty training places; which was a decline from previous years e.g. in 2012, 77.7 per cent of F2 doctors made an immediate application to the first round of specialty training places. The particular reasons for this decline, however, are not clear (GMC, 2016), although the vast majority do appear to return to continue their training.

Table 5.6: NHS Hospital and Community Health Services Doctors, leaving the NHS, in NHS Trusts and CCGs in England in the period Oct 2015- Oct 2016

	Number
Doctors in training:	12,021
Of which:	
Specialty Registrar	6,682
Core Medical Training	1,553
Core Dental Training	340
Foundation Doctor Year 2	3,001
Foundation Doctor Year 1	452

Source: NHS Digital, 2017a

Exit data is also available from the BMA 10-year longitudinal study of the career paths of 430 doctors who graduated from UK medical schools in 2006. The study showed that nine years after graduation, 42 per cent of doctors plan to practise overseas either temporarily (29.8 per cent) or permanently (11.7 per cent); with 10 per cent having applied for a Certificate of Good Standing with a view to working overseas. Figures from the GMC, showed that between 2008 and 2014, an average of 2,852 Certificates of Good Standing were issued annually between 2008 and 2014 – totalling 19,522 (cited in BMA, 2016b); highlighting the evidence that doctors are internationally mobile and therefore overseas comparisons of doctors pay should be considered.

Some five per cent of cohort doctors in the BMA study also indicated that they are planning to leave general practice to work in a completely different industry (outside medicine); however further details were not provided. About 10 per cent of cohort doctors also indicated that they see themselves working in an academic post or working outside medicine in five years' time (BMA, 2016).

The destination of leavers from the general medical practice workforce is available in experimental statistics produced by NHS Digital. Data from the period 2015-2016 shows that whilst the majority of leavers remain in general practice (leaving to move to another

practice) or remain within the NHS; of interest to our review is that 178 moved abroad; 339 changed careers; and 242 moved into the education sector or education/training (see Table 5.7), again supporting overseas comparisons and comparisons with the Higher Education sector by the DDRB.

Table 5.7: General Medical Practice Workforce: leavers from the workforce by destination on leaving, April 2015- March 2016, England (Provisional experimental statistics)

Destination on Leaving	Headcount
Abroad - EU Country	50
Abroad Non - EU Country	128
Armed Forces	5
Career Change	339
Death in Service	47
Education/Training	148
Education Sector	94
Emigration	36
General Practice	1,908
NHS Organisation	2,845
No Employment	1,308
Other Private Sector	438
Other Public Sector	99
Prison Service	14
Private Health/Social Care	196
Retirement	446
Return to Practice	36
Self Employed	184
Social Services	12
Unemployed	240
Unknown	8,481
Total	16,918

Note: Leavers data based on information supplied from 5,016 GP practices. Leavers include those moving between GP practices.

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NHS Digital have also produced experimental statistics on the reasons given for leaving among all Doctors in Training in the NHS. Of interest to our review is that only a small number (11 doctors) in the period 2015-2016, cited voluntary resignation due to the offer of better reward packages elsewhere; however unfortunately, data is not available on the exact destinations of these leavers (see Table 5.8).

Table 5.8: Reason for Leaving of all Doctors in Training that have left the NHS, in NHS Trusts and CCGs between June 2015 and June 2016

Reason For Leaving	Headcount
Bank Staff not fulfilled minimum work requirement	7
Death in Service	15
Dismissal – Capability	5
Dismissal – Conduct	3
Dismissal - Some Other Substantial Reason	9
Dismissal - Statutory Reason	1
Employee Transfer	40
End of Fixed Term Contract	4,348
End of Fixed Term Contract - Completion of Training Scheme	1,160
End of Fixed Term Contract - End of Work Requirement	144
End of Fixed Term Contract - External Rotation	1,862
End of Fixed Term Contract – Other	391
Has Not Worked	4
Merged Organisation - Duplicate Record	1
Pregnancy	1
Redundancy – Compulsory	1
Retirement - Ill Health	1
Retirement Age	3
Voluntary Resignation - Adult Dependants	9
Voluntary Resignation - Better Reward Package	11
Voluntary Resignation - Child Dependants	8
Voluntary Resignation – Health	21
Voluntary Resignation - Incompatible Working Relationships	2
Voluntary Resignation - Lack of Opportunities	7
Voluntary Resignation - Other/Not Known	929
Voluntary Resignation – Promotion	107
Voluntary Resignation – Relocation	243
Voluntary Resignation - To undertake further education or training	73
Voluntary Resignation - Work Life Balance	72
Unknown	3,505

Notes: Turnover data is based on headcount and shows people leaving active service, this would include those going on or returning from maternity leave or career break, for example. More than one reason for leaving may be recorded per person. Doctors in Training include the following grades: Specialty Registrar, Core Medical Training, Core Dental Training, Foundation Doctor Year 1 and Foundation Doctor Year 2.

Source: NHS Digital, 2016a. Copyright © 2016, Re-used with the permission of the Health and Social Care Information Centre, also known as NHS Digital. All rights reserved.

Similar statistics are produced on the reasons for leaving among the general medical practice workforce. Within this workforce in the period 2015-2016, some 445 GPs cited voluntary resignation due to the offer of better reward packages elsewhere; however this

is less informative for our review as this would include moves between GP practices (see Table 5.9).

Table 5.9: General Medical Practice Workforce: Leavers from the Workforce by Reason for Leaving, April 2015- March 2016, England, (Provisional Experimental Statistics)

Reason for Leaving	Headcount
Bank staff not fulfilled minimum work requirement	28
Death in Service	46
Dismissal – Capability	87
Dismissal – Conduct	80
Dismissal - Some Other Substantial Reason	38
Dismissal - Statutory Reason	9
End of Fixed Term Contract - Completion of Training Scheme	674
End of Fixed Term Contract - End of Work Requirement	189
End of Fixed Term Contract - External Rotation	233
End of Fixed Term Contract – Other	651
Initial Pension Ended	1
Mutually Agreed Resignation - Local Scheme with Repayment	18
Mutually Agreed Resignation - Local Scheme without Repayment	259
Mutually Agreed Resignation - National Scheme with Repayment	6
Pregnancy	74
Redundancy – Compulsory	58
Redundancy – Voluntary	73
Retirement – Age	1,555
Retirement - Ill Health	137
Voluntary Early Retirement - No Actuarial Reduction	141
Voluntary Early Retirement - With Actuarial Reduction	65
Voluntary Resignation - Adult Dependents	50
Voluntary Resignation - Better Rewards Package	445
Voluntary Resignation - Child Dependents	126
Voluntary Resignation – Health	192
Voluntary Resignation - Incompatible Working Relationships	117
Voluntary Resignation - Lack of Opportunities	68
Voluntary Resignation - Other/Not Known	2,549
Voluntary Resignation – Promotion	765
Voluntary Resignation – Relocation	1,418
Voluntary Resignation - To undertake further education or training	239
Voluntary Resignation - Work/Life Balance	916
Unknown	5,768
Total	16,918

Note: Leavers data based on information supplied from 5,016 GP practices. Leavers include those moving between GP practices.

The UK Medical Careers Research Group conducts cohort surveys on doctors' career choices and progression. It has surveyed all medical graduates, from all UK medical schools, in 12 year-of-qualification cohorts. The newest cohort survey includes medical graduates who qualified from UK medical schools in 2012. This survey of 5,432 doctors highlights a number of key points of relevance to this review:

- 22.1 per cent of respondents had obtained professional or other post-school qualification before entering medical school.
- Respondents were asked whether they had obtained any non-clinical qualifications during medical school and 39 per cent had gained an intercalated degree (e.g. BSc, BA, BMedSci) during their time at medical school.
- The most popular overall first choice of a long-term career was for general practice (25 per cent across all respondents). The next highest percentage of first choices was for the hospital medical specialties (21 per cent), followed by surgery (14 per cent).
- Respondents were asked to evaluate fourteen factors by how much each factor had influenced their choice of specialty, or non-medical job, on a scale of 'not at all', 'a little', 'a great deal'. Overall, looking at factors affecting 'a great deal', 'enthusiasm/commitment' followed by 'self-appraisal of own skills/aptitudes' had the most influence on career choices, whilst, interestingly for this review, 'the requirement to repay student debt' and 'future financial prospects' had the least influence.
- Respondents were asked a series of questions on their intentions to practise medicine in the UK and the NHS. Some 74 per cent of respondents indicated that they definitely or probably intended to practise medicine in the UK for the foreseeable future; 17 per cent were undecided and 9 per cent definitely or probably did not intend to do so.
- For those who were not definite about practising medicine in the UK, respondents were asked to indicate whether they were considering one or more of the following options: 'practising medicine abroad', 'leaving medicine but remaining in the UK' and 'leaving medicine and leaving the UK'. Practising medicine abroad was selected by 88 per cent overall; 9 per cent of these participants indicated that they were considering leaving medicine but remaining in the UK; 6 per cent indicated that they were considering leaving medicine and leaving the UK (Ellison, 2015).

The 1996 cohort survey (of 3,868 doctors who qualified from UK medical schools in 1996) also highlighted some key findings of relevance to our review. It showed that in 2015:

- The majority of cohort doctors were still working in medicine (92 per cent, with 87 per cent of men and 38 per cent of women having worked continuously full-time in medicine since qualifying). Some 67 per cent of all respondents had worked continuously in the NHS (men 66 per cent, women 69 per cent).

-
- Almost all doctors (93 per cent) intended to continue (definitely/probably) working in medicine in the UK for the foreseeable future. However, the majority (64.3 per cent) of those working abroad did not intend to return to the UK (men 68 per cent; women 60 per cent).
 - Some 85.4 per cent were working in fully NHS funded UK medical occupations; 3.6 per cent were working in UK Medical universities; 0.7 per cent in HM Forces; 1.2 per cent in UK Other public sector; 2.2 per cent in UK Medical private sector; and 5.4 per cent were working in medicine abroad.
 - The majority of cohort doctors worked in general practice (36 per cent; men 28.6 per cent, women 42.4 per cent), or in the hospital medical specialties (15 per cent; men 15.7 per cent, women 14.5 per cent), or as surgeons (12.3 per cent; men 19.8 per cent, women 5.9 per cent).
 - When asked whether respondents viewed their current specialty/employment type as their final choice of career, 85 per cent responded 'Definitely' (88 per cent of men, 83 per cent of women), 9 per cent responded 'probably', and 6 per cent were uncertain (Lachish, 2016)

Among the youngest cohort studied by the UK Medical Careers Research Group (some 4,436 doctors who qualified from UK medical schools in 2002), relevant findings showed that by 2013, almost a third (30.9 per cent) of cohort doctors said that they had unmet needs for advice on future career planning, management or career change (33.2 per cent women, 27.3 per cent men (Birnie and Smith, 2016).

Among an older cohort, (2,347 doctors who qualified from UK medical schools in 1977), the study showed that:

- Only 6.9 per cent of doctors were on a register to practise in any country outside the UK.
- Doctors were asked 'Were you working in clinical practice at the time you retired?' 94.3 per cent of retired doctors replied 'yes' and only 5.7 per cent replied 'no'.
- The doctors were asked to select, from a list of factors, any factor that would encourage them to stay working in medicine for longer. About 22 per cent cited 'career change and development opportunities' (Smith, 2016).

Career websites also provide some indications of the destinations of leavers. The popularity of conferences such as 'Medical Success', an annual event specifically aimed at doctors considering career alternatives inside and outside of medicine, indicates that there is interest in career change within the medical profession. Our research highlights that recent events have included exhibitors or sponsors from, among others: management

consultancies; finance and banking employers and education. Examples include: McKinsey & Company; The Boston Consulting Group; Cancer Research UK; BUPA; Citi Bank; Deloitte; Goldman Sachs; Morgan Stanley; Royal Air Force; Royal Navy; Teach First; VSO (Medical Success; online).

5.3 Chapter Summary and Implications

Although there has been significant growth in the numbers of medical and dentistry students taking breaks from their studies, all of the indications are that these continue, for today's students as much as in the past, to be very largely a 'career for life', decided on at a relatively early stage in people's lives. Retirees, moving from one contract to another, moving role and practice and, in some cases, death in service, far outnumber voluntary leavers and mature entrants.

As such, apart from the numbers going overseas and those moving into clinical academia (where the numbers are almost certainly underestimated as schools are partly staffed by practicing doctors and dentists) which clearly support overseas and UK academic pay comparisons, it is hard to justify the choice of specific occupations to compare earnings with solely on the basis of data on career outflows and inflows. While there is more and more accurate data on these movements now available, the information on the destination occupations of leavers in particular is still frustratingly poor.

Indeed these findings might support arguments for more generic comparisons with managerial/professional and high earning occupational categories rather than specific occupations, although as we have seen, stakeholders and the medical and dental professionals we have consulted have many suggestions. The varied levels and patterns of earnings in these occupations makes their selection almost by definition somewhat controversial, and the exit and entry data we have reviewed unfortunately does little to make that selection process more objective.

6 Career Paths and Anchor Points

6.1 Introduction

The PA pay comparison methodology developed in 2008 identified levels within the hospital doctors' and specialists career paths, referred to as anchor points, designed to represent distinct stages within that career which could be benchmarked against career levels within the comparator professions. In practice since then, this has largely been done by slotting in the doctor benchmarks against the generic Hay responsibility levels and job family descriptors, without reference to the role profiles.

This review has highlighted a consensus that there have been no substantive changes since PA drafted the hospital doctors' career path in 2008, which we support. Therefore the descriptors of the hospital doctors and trainee roles and anchor points remain essentially unchanged and we believe remain valid. The choice of occupational and sector comparisons is much more open to debate and considered in the following chapter.

However, as highlighted by our review, the greater emphasis on external matching has led us to conclude that the role profiles, which are no longer referred to by the DDRB, are an unnecessary duplication and detailing. They are not used in practice and the emphasis in benchmarking needs to be on key differentiating but comparable factors, such as qualifications required. More detail about what a doctor does often doesn't help to compare accurately with an equivalent level of skill or responsibility in the actuarial or legal profession. That is why generic level descriptions of the type used by Hay, underpinned by points factor job evaluation which is designed specifically to compare different jobs on a common and consistent basis, have as we seen in Chapter 5 often superseded detailed role profiles and job descriptions.

So we have produced briefer descriptions of the key levels in the medical career paths, designed to act as a single and more practical support for the external benchmarking. On this basis we have also developed new summary descriptors for GPs and for dentists' career paths, as specified in the requirements for this review, and supported by all the stakeholders we have consulted with, largely due to the different skills and competencies required to operate in practice settings. To date, GPs have been included in DDRB pay comparisons with a simple slotting in of the core GP role at the entry consultant level. The summary descriptions and anchor points in the career paths for GPs and practice dentists

have been identified based on clear differentiation in qualifications, skills/competencies, responsibilities and experience, and again, the levels and rationale for them were relatively straightforward to agree with all our stakeholders. The relativities across and between them is probably more controversial.

In the following sections we give an overview of the now four career paths and recommended anchor points in each, followed by the descriptions of each pathway and supporting justification and explanation for the anchor points chosen. We also include the equivalent descriptions for the career paths in the four occupational/industry comparisons currently utilised, before moving on to consider additional potential comparators in the next chapter.

6.2 Overview of Career Paths

The table below summarises the distinct anchor points we have developed and are recommending within the career paths of GPs and dentists, next to the anchors for hospital and specialist doctors, and also our initial recommendations as to the appropriate job level to match them at within Hay Group's remuneration database. We have discussed these matches with Hay's experts, but they should be regarded as preliminary at this stage, and will need to be confirmed once this methodology has been agreed.

As we comment below, the anchor points within each career path/ladder have been perhaps surprisingly straightforward to specify and define. Probably more controversial is the relativities across these different paths and where the anchor points slot in relative to each other. How does the general assessment and managerial skills of a GP stack up against the more specialist skills and knowledge of a hospital doctor, for example?

Our assessment would be that specific role profiles of the type PA drafted for external comparison do not help to address this area of internal relativities and as we comment in the final chapter, only the application of a points factor job evaluation system, such as Hay or the NHS system, could more definitively address this issue.

Table 6.1: Overview of the Medical and Dental Career Paths and Anchor Points Proposed

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice Doctors	4. General Dental Practice Dentists	Survey match levels
Consultant - experienced		Managing Partner/ Principal GP	Principal/Practice Owner Dentist	Hay level 21
Consultant - newly qualified	Associate Specialist	Partner GP	Partner/Providing-Performer Dentist	Hay level 20
ST3+	Speciality Doctor	Salaried GP	Associate/Performer Specialist Dentist	Hay level 19
			Associate/Performer Dentist	Hay Level 18
		Registrar GP	Hay level 17	
ST 1&2		GP Specialist Trainee		Hay level 16
F2			Foundation Dentist/ Vocational Dental Practitioner	Hay level 15
F1				Hay level 14

6.3 Descriptions of the Medical and Dental Career Paths

The summary descriptors below provide key differentiating information about each level and the anchor points within the two career medical paths formerly profiled and now with the addition of the GP and Dentist career paths and anchor points we are recommending, including differentiating skills, experience and responsibilities and initially suggested matching level in Hay's market databases.

The sources of information for these new descriptors have included the following:

Hospital doctors/specialist doctors:

As in the original PA study (2008), plus:

- GMC (2013), Good Medical Practice

- Discussion with GMC/BMA/AOMC contacts

GPs

- Health Careers
- The RCGP Curriculum (2016)
- Royal College of General Practitioners
- British Medical Association website
- The Foundation Programme
- General Practice (GP) National Recruitment Office
- Discussion with RCGP and BMA contacts

Dentists

- The UK Committee of Postgraduate Dental Deans and Directors (COPDEND)
- British Dental Association: Vocational Training and Dental Foundation Training
- General Dental Council: Preparing for practice, 2015
- UK Dental Core Training Curriculum, 2016 and 2015, COPDEND
- Dental Foundation, Training Curriculum, 2015, COPDEND
- Discussion with BDA contacts.

We have informally discussed these initial drafts with the BDA and GMC but the finalised versions should, we recommend, be confirmed with them and the BMA. We provide more information and justification for the choice of anchor points subsequently.

Table 6.2: Summary Descriptors of Medical and Dental Career Paths Proposed

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
<p>Consultant – experienced Consultants at this level have at least 19 years of experience and are on the maximum of the pay scale. They are more likely to have a level 4 Clinical Excellence Award (or equivalent), but this is not always the case.</p>		<p>Managing Partner/Principal GP The Managing Partner/Principal GP has responsibility for the overall leadership, financial and operational management, clinical governance and compliance for the practice. They have considerable autonomy in how the practice services are delivered, according to the contract with their CCG.</p>	<p>Principal/Practice Owner Dentist A Principal GDP/Practice Owner has lead operational and financial management, clinical governance and leadership responsibility for the practice and its associates and ‘owns’ the practice contract. Responsibility for NHS contract and relationships with the PCT. Typically also is a performing dentist with in excess of five to ten years’ experience. May be a specialist dentist. Dentists at this level generally operate as independent small business owner/operators, some on multiple sites.</p>	Hay level 21

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
<p>Consultant – newly qualified</p> <p>Consultants are determined on the basis of the formal qualification required (Completion of Certificate of Training), and the level of Clinical accountability specified.</p> <p>Will be a recognised internal expert in chosen speciality, leading a team/ department, allocating and overseeing quality of work and managing performance, and likely to have additional NHS responsibilities and external duties e.g. clinical governance, medical education etc.</p>	<p>Associate Specialist</p> <p>This grade was closed to new entrants on 1.4.09.</p> <p>These doctors have:</p> <ul style="list-style-type: none"> • Full registration with the General Medical Council • Completed a minimum of four years in the registrar or staff grade and/or specialty doctor grade and/ or in the clinical and/or senior clinical medical officer grades, at least two of which have been in the appropriate specialty • Have completed 10 years medical work since obtaining a primary medical qualification which is acceptable by the GMC for full, limited or temporary (but not provisional) registration. <p>Although often senior in position, an Associate Specialist has a number of key differences from a Consultant including that most programmed activities will be devoted to Direct Clinical Care and a minimum of one will be allocated for Supporting Professional Activities (a Consultant has an average of 7.5 programmed activities for Direct Clinical Care and 2.5 for Supporting Professional Activities).</p>	<p>Partner GP</p> <p>Continues to develop and deploy clinical and diagnostic expertise. Now also shares responsibility and risk for the survival and growth of the practice, helping to determine the practice strategy and range of services provided, and contributing to the day to day financial and operational management of the practice.</p> <p>Increasingly work involves leading and co-ordinating multi-disciplinary teams to provide integrated care in their community.</p> <p>May also be involved in the training of other practice staff.</p>	<p>Partner/Providing-performer Dentist</p> <p>Typically will have at least 5 years' dental experience (although can occur at any stage post DFT/VT) and will have developed business acumen and management / leadership skills, as well as being an experienced dentist.</p> <p>Shares accountability and risk of the financial and operational management of the practice; including its survival and growth.</p> <p>GDP partner continues to enhance and deliver a wide range of dental care and treatment for their patients; or continues to operate and further develop their expertise within their specialism of choice.</p>	<p>Hay level 20</p>

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
<p>ST3+</p> <p>ST3 is the second competitive entry point for most trainees on uncoupled training programmes. All trainees are required to complete Royal College membership exams between ST3 and ST7. For some Specialties this is at ST3 (e.g. General Surgery) or ST4 (e.g. Paediatrics). Others require exams to be completed after ST4 (but pre-CCT).</p>	<p>Speciality Doctor</p> <p>A doctor can be appointed to this grade if they have:</p> <ul style="list-style-type: none"> • Full registration with the General Medical Council, and • Have completed at least four years full-time postgraduate at least two of which will be in a Specialty Training programme in a relevant specialty or as a fixed term Specialty Trainee in a relevant specialty (or equivalent experience and competencies). <p>Specialty Doctors progress through two pay thresholds by evidencing that they have participated in job planning and appraisal and have developed whilst in the role.</p> <p>In future, the Specialty Doctor grade will provide the opportunity to choose to continue to make a valued contribution to service delivery or to seek to re-enter the Training Grades. Alternatively, either Specialty or Associate Specialist doctors who wish to progress may choose to apply for entry to the Specialist Register via Article14 of the General and Specialist Medical Practise (Education, Training and Qualifications) Order 2003</p>	<p>Salaried GP</p> <p>Core role is as a clinical generalist, the initial point of contact for the patient in primary care and growing their expertise and knowledge through experience. Accountable for the care and outcomes of their patients.</p> <p>Work involves diagnosing and assessing medical need focused on the whole health of the patient in their community, over the short, medium and longer term. Requires a wide range of varied medical skills and knowledge. Treats common conditions.</p> <p>Acts to initiate and co-ordinate urgent and specialist treatment through multi-disciplinary teams from across the healthcare system – secondary and community services. GPs can also focus on developing expertise in a special interest area, such as dementia or dermatology. CPD is vital to keep up with medical developments in a wide range of areas.</p>	<p>Associate/ Performer Specialist Dentist</p> <p>A sub-division of the Associate/ Performer dentist is the Specialist dentist in general practice. This is an advanced dentist role within a practice, responsible for undertaking more complex diagnoses and typically practicing only in their specialist field. Other core skills include organisation and management and patient service and caring skills and competencies. The dentist receives a Certificate of Completion of Specialist Training (CCST) or equivalent and gains entry onto the appropriate GDC, typically after 3-5 years. Specialist training can be pursued immediately following DFT/VT or after gaining experience as an associate within a GDP.</p> <p>Associate/ Performer Dentist</p> <p>Core dentist role in which dentist is a general practitioner, handling unsupervised a variety of dental needs and responsible for the care and outcomes of their patients. Includes patient examination and diagnosis; treatment planning and patient management; health promotion and disease prevention; medical and dental emergencies; anaesthesia, sedation, pain and anxiety control; periodontal therapy &</p>	<p>Hay level 19</p> <p>Hay level 18</p>

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
		<hr/> <p>ST 3 GP Registrar: Final year under the supervision of a GP trainer.</p>	<p>management; hard & soft tissue surgery; non-surgical management of the hard & soft tissues of the head & neck; management of the developing dentition; restoration and replacement of teeth. Dentists at this level need to display professionalism, and clinical, communication, management and leadership skills.</p>	<p>Hay level 17</p>

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
<p>ST 1&2</p> <p>For those specialties that offer run-through training, the early years of training are denoted ST1 and ST2 (ST3 for Paediatrics).</p> <ul style="list-style-type: none"> • The Royal College of Anaesthetists refers to the first two years of Specialty Training as 'basic' • The Royal College of Paediatrics and Child Health refer to the first three years as 'Level 1' or 'basic Specialist Training' • The Royal College of Physicians refers to these two years as Core Medical, and ST3 and above as Specialty Training <p>Alternatively, this is the first stage of uncoupled training (also known as Core Training) which has a duration of 2 years for most specialties.</p>		<p>GP Specialist Trainee</p> <p>Three years of further training, usually consisting of 18 months in hospital posts and 18 months in general practice. Curriculum organised around 5 broad areas of capability: knowing self and others; applying clinical knowledge; managing complex/long term care; working well in organisations and systems; and caring for the whole person and wider community.</p> <p>The specialty training programme includes passing the MRCGP examination. Certificate of Completion of Training secures entry to the GP Register.</p>		Hay level 16
<p>F2</p> <p>The second year Foundation Programme focuses on training in the assessment and management of the acutely ill patients. Training encompasses generic professional skills applicable to all areas of medicine (teamwork, communication, IT skills, etc.)</p> <p>Successful completion of the second year leads to the Foundation Achievement of Competence Document (FACD).</p> <p>At the end of the second year trainees must undergo competitive entry to obtain a place on the Specialty Training run-through (or on the Core Training Programme).</p>			<p>Foundation Dentist (FDs) (E,W, NI) and Vocational Dental Practitioner (VDPs) (Scotland)</p> <p>Dental Foundation Training (DFT) in England, Wales and Northern Ireland and Dental Vocational Training (DVT) in Scotland comprises of a mandatory year in an approved practice (Dental Foundation/DF1). This may be followed by voluntary dental core</p>	Hay level 15

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice	4. General Dental Practice	Survey match levels
<p>FI</p> <p>The Foundation Programme is a two-year training programme that forms the bridge between medical school and Specialty/General Practise Training. All graduates of UK medical schools are required to complete the Foundation Programme before applying for Specialty Training.</p> <p>The first year of the Foundation Programme builds upon the knowledge, skills and competences acquired in undergraduate training, normally involving six different rotations or placements in medical or surgical specialities.</p> <p>Successful completion of the first year will lead to Registration with the General Medical Council (GMC).</p>			<p>training (DCT 1 – 2/3) which varies from 1 – 3 years.</p> <p>DFT builds the knowledge, skills and attributes required to work independently within NHS primary care as a skilled generalist. It combines experiential learning within General Dental Practice, with study days targeting specific areas of the DFT curriculum. Upon entry to DFT, Foundation Dentists are registered with the GDC.</p> <p>During DFT/DVT foundation dentists are employed under a contract of service by an approved training practice to deliver a range of dental care and treatment.</p> <p>Successful completion of foundation training is required to work in primary dental care. FT/VT is necessary for unsupervised entry to the NHS Performers List in England and Wales and Health Boards in Scotland and Northern Ireland.</p>	<p>Hay level 14</p>

6.4 Explanations of anchor points for GPs and dentists

The key anchor and break points in the GP and dental career ladders have been relatively straightforward to agree and define. The rationale for the selection of these anchor points are provided in the tables below.

Table 6.3: Explanation of Anchor Points for GPs

Anchor Point	Explanation
GP Specialist Trainee	This is the first distinct anchor point for GPs, as it represents the completion of foundation training and the undertaking to complete the Certificate of Completion of Training (CCT) Programme to specialise in general practice. This logically aligns to newly qualified entrants with 2 years' experience in comparator professions.
Registrar GP	This provides an anchor point as the registrar operates as a GP delivering day to day clinical care within a practice but remains under the supervision and guidance of a partner in the practice/GP trainer. This is the route followed by the vast majority of GPs and recognised and understood clearly by all parties.
Salaried GP	This is the core GP role recognised by all our stakeholders and by patients themselves. It is a logical anchor point to select on the basis of the completion of the formal qualifications and experience required to operate independently and assess and treat many patient diagnoses and issues, referring onto specialist care when appropriate. The role also carries increased clinical accountability related largely to the appropriate delivery of day to day and on-going care, advice and support to patients.
Partner GP	This is a logical anchor point as it marks the move to self-employment and its associated responsibilities and risks, requiring a skill set in business and management that is becoming increasingly arduous and complex, and a change in the earning structure based on profits of the practice.
Managing Partner/ Principal GP	This anchor point is necessary for adequate benchmarking and differentiation due to the higher level of accountability and autonomy held by the Managing Partner/Principal GP. Almost all stakeholders felt that this was a sensible division in GP management roles and any formal job evaluation would pick up this distinction on the basis of greater managerial responsibility.

Table 6.4: Explanation of Anchor Points for Dentists

Anchor Point	Explanation
Foundation Dentists (FDs) (E,W, NI) and Vocational Dental Practitioners (VDPs) (Scotland)	<p>Foundation Dentists have been identified as an anchor point as it represents the first year of training, post qualification, within the general practice workplace, and aligns clearly with graduate entry across the comparator professions. Dental Foundation Training (DFT) in England, Wales and Northern Ireland and Dental Vocational Training (DVT) in Scotland form the bridge between newly qualified dentists and working independently in NHS primary care.</p> <p>Upon entry to DFT, FDs or VDPs are registered with the GDC. DFT can be followed by voluntary Dental Core Training (DCT1 to DCT2/3 according to stage of training). During which trainees spend time in further training posts in order to clearly demonstrate progress and professional development in multiple areas. There is however no statutory or contractual requirement for any dental graduate to undertake DCT.</p>
Associate/ Performer Dentist	<p>Following completion of Foundation training, dentists can work as independent practitioners in primary care by acquiring a PCT/Health Board Performers List number which enables them to enter primary care through a practice as either a self-employed associate or as an assistant employed directly by a practice on a salary basis (although this entry is now rare).</p> <p>This independence to practice has been identified as a clear anchor point for benchmarking purposes. New entrants to the Associate role following completion of FT/VT are likely to be Hay level 16, rising to Level 18 when acting at the generally fully expected level of competence after an appropriate period of experience at this level.</p>
Associate/Performer Specialist Dentist	<p>Dentists can undertake specialist training (which takes place in hospital departments linked to university dental schools) and then work as a specialist in general practice. Specialist dentists operating in general practice have been identified as an anchor point due to the formal and advanced nature of the qualifications and specialist skills required of this role.</p> <p>This sub-division of an Associate/Performer dentist is required for accurate benchmarking purposes and reflects a more specialist set of skills compared to the widening range of competencies required by the core associate roles.</p>
Partner/Providing Performer Dentist	<p>Partner in general dental practice is a clear anchor point due to the change in earning structure (based on GDP profit) and greater operational leadership and responsibility/accountability level accompanying the partnership buy-in.</p>
Principal/Practice Owner Dentist	<p>Principal GDP or practice owner is a clear anchor point for benchmarking purposes as at this career level earnings are a result of ownership (inclusive of the personal risks this brings) and the role holds the greatest level of accountability and an additional degree of autonomy.</p>

6.5 Summary Descriptions: Other Professions Currently Used Career Paths

For completeness, we also include here the descriptors at each anchor point for the four occupations currently used, which we are not proposing should be changed.

Table 6.5: Anchor Points in Comparator Professions

Medical Anchor Points	Legal	Accounting/Tax	Actuaries	Pharmaceutical
Consultant - experienced	<p>Partner role in the Law career path: would be expected to be an authority in their own field, accountable for their own department in terms of leadership and performance and have complete autonomy in decision making.</p> <p>It should be noted, however, that at the top end of the Law career path, Partners are likely to be owner-managers and as such part of their reward comes as a result of ownership (and the risks that brings).</p> <p>A split could be based on size of organisation or seniority of partner.</p>	<p>The Consultant (min) and (max) broadly align with the Partner/ Finance Director role in the Accountancy career path:</p> <ul style="list-style-type: none"> • This corresponds to at least 10 years PQE for an Accountant. • At this level in both career paths individuals are expected to be expert in their own field. • They are likely to be accountable for their own department in terms of leadership and performance. <p>Split could be based on size of organisation or seniority of Partner may be helpful, if this information is available.</p>	<p>Partner/Business Director role in the Actuarial career path:</p> <ul style="list-style-type: none"> • At this level in both career paths the incumbent is expected to be an authority in their own field. • They are likely to be accountable for their own department in terms of leadership and performance. • They are likely to have complete autonomy in decision making. It is hard to provide separate matches for Consultant (min) and Consultant (max) although size of organisation or seniority of Partner should be considered (if this information is available). 	<p>Aligns well with Director of Medical Affairs/Clinical Research/Drug Safety.</p> <p>In these roles you would expect at least 10 years PQE experience and for the individual to be a subject matter expert. The individual would have direct responsibility for the function and would define the vision and strategy.</p>
Consultant - newly qualified				<p>Aligns well with Head of Medical Affairs/ Clinical Research/Drug Safety.</p> <p>In these roles you would expect at least 7 years PQE experience (with at least 5 years in pharmaceuticals) and a strong level of technical expertise. The individual would be expected to provide strategic direction, leadership and line management and co-ordinate across a number of teams.</p>

Medical Anchor Points	Legal	Accounting/Tax	Actuaries	Pharmaceutical
<p>ST3+</p>	<p>Is an operational specialist but not usually a top legal expert in the organisation. Considerable legal judgement, experience and independent reasoning is required. Usually 5-8 years' experience. Initiates and/or challenges legal policies.</p> <p>Practising attorney with sufficient experience (usually 3-5 years). Follows precedents and works independently on a day to day basis. Unusual situations presented to the superior for review.</p>	<p>The ST3+ anchor point in the Career Path 1 is broader than the Accountancy career path roles and covers both Manager and Senior Manager:</p> <ul style="list-style-type: none"> • This is broadly the 4-10 years post-qualification, although it may be longer. • The individual is recognised as an expert in their own specialist area and is likely to be the first point of client contact. • The individual will operate independently and be responsible for supervising coaching and mentoring others. <p>However, at this level some differences between Career Path 1 and the Accountancy career path emerge. The Senior Manager role is slightly larger, is likely to have more people management responsibilities than ST3+, and is involved in business development. Alignment is better with the Associate Specialist role.</p>	<p>Manager role:</p> <ul style="list-style-type: none"> • This is broadly the 4-10 years post-qualification, although it may be longer. • The individual is recognised as an expert in their own specialist area. • The individual will operate independently, receiving little or no direct supervision. • The individual will be responsible for supervising, coaching and mentoring others. Towards the top of the ST3+ anchor point, and for the Associate Specialist, better alignment is seen with the Senior Manager role, with a broader focus on business and more direct line manager responsibility. 	<p>Aligns with the Medical Affairs/ Clinical Research/Drug Safety Physician and the Senior Physician. At this level technical expertise becomes in depth, they manage teams and have increased accountability.</p>

Medical Anchor Points	Legal	Accounting/Tax	Actuaries	Pharmaceutical
ST 1&2	<p>Qualified Legal Executive with minimum 3 years' experience. Manages, controls and monitors the work of a group of Paralegals/Legal Executives/Clerks (+- 3-8). Controls the department's budget and plan for future development. Newly qualified with 2-3 years' experience. May control 1-5 Law Clerks or Legal Execs.</p>	<p>Leader of small team/provides day to day supervision of a small group of professional accountants and clerical personnel. Technical lead level of professional. Often provides work direction to others. Provides day to day supervision of a small group of professional accountants and clerical personnel.</p>	<p>Immediately post-qualification working through up to 3 years' experience. Provides technical advice, manages won workload, may supervise juniors.</p>	As for medical career path
F2	<p>Newly qualified with 1-2 years' experience. May control 1-3 Law Clerks or Junior Legal Executives.</p>	<p>The Trainee Accountant level in the Accountancy career path is broadly comparable with the F1 anchor point in Medical Career Path 1:</p> <ul style="list-style-type: none"> • In both career paths this is the period prior to qualification. • At this level the individual will receive considerable guidance and supervision and work as part of a team. • At this stage the individual will be expected to demonstrate a basic level of technical knowledge but will escalate any problems or issues. 	<p>Actuarial trainee – developing basic technical knowledge, works under guidance and supervision.</p>	
F1				

6.6 Chapter Summary

Based on our analysis and on developments in pay benchmarking practices over the past 10 years reviewed previously, we have proposed the use of briefer summary descriptors of the anchor points in each medical and dental career path. We have produced these for the existing hospital doctor and dentist career paths, supporting along with all our stakeholders the retention of the current six anchor points used.

We have also produced new descriptors in the same format for the new GP and GDP career paths on account of the different sets of skills and competencies required, and propose five anchor points in each of these.

We also in the Chapter provide more detailed justifications for the choice of anchor points in each career path.

7 Occupations, Markets and Data for the Comparisons

7.1 Introduction

Currently four occupations/sectors are used in the market comparisons, and as we have seen in earlier chapters, these have been widely supported, particularly the pharmaceutical sector and legal profession. PA also recommended that architecture, teaching, pilots and management consultancy were added to the comparisons, although this was not put into practice, largely it appears because of the lack of access to quality market data. Prior to that the methodology originally set out by Towers Perrin (now Willis Towers Watson) in 1997 included six occupations covered on their database, with tax professionals distinguished from accountants and engineers also included.

As we comment in the final chapters, we see conceptual as well as practical problems in extending the list of occupations much beyond the current ones. We tend to prefer wider defined sectors rather than specific occupations given the acknowledged uniqueness of the medical employment market, and for us, after our detailed investigation, only vets for the general practice roles and Higher Education sector comparisons warrant serious consideration for inclusion in the Review Body's future annual reports.

In this section therefore we:

- Profile and critique the occupations that have been suggested to us and might be included in the comparisons;
- For those that might be taken forward give our initial thinking on how these occupations might be benchmarked with the medical career paths outlined in the previous chapter;
- Given the issues with data access, highlight both where we think data sources might add to the range and quality of data considered on the existing occupations, and where new data might be sourced for potentially new occupations and sectors.

7.2 Possible Occupations to Include

Not surprisingly, all of our many stakeholders and interviewees on this project had many different ideas for occupations and sectors to include in the comparisons. The criteria they emphasised in making these comparisons were to some extent at least as interesting as the actual suggestions and, perhaps in keeping with wider social trends:

- Tended to put less emphasis on traditional professional status;
- All emphasised the levels of qualifications and experience required and continuing CPD needs, the investment that they need to make if you like in education and knowledge to be able to practice in their profession and then work and earn to get a return on that investment;
- Emphasised the growing importance in these roles of (often managerial) responsibility and decision making – running a practice, dealing with the CQC, etc. – as well as taking on the risks of being a partner, running a department, co-ordinating a multi-professional team, etc.

In the table below we summarise our analysis of each of the occupations and sector mentioned, considering their merit for inclusion in terms of:

- These comparative job content and responsibility factors, such as similar lengthy education, responsibility for people's lives and for the survival of a practice etc.;
- Stakeholder views on the merits of including them and whether or not the somewhat limited data on entry to and exit from the profession might also support inclusion;
- The very practical consideration of the availability and access to good quality pay and earnings survey data;
- Overall implications and conclusions.

Table 7.1: Determination of additional occupations: summary analysis

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information	Implications
Architects	Professional qualification/ training align well, with architects requiring 4 years post-degree to qualification, and another 5 – 10 years' experience as associates typically to partner level.	Similar progression in terms of technical knowledge (range of generalist and specialist areas involved) and wider client and project management skills.	Partnership structures across all size ranges common, although PLC model has extended. Probably stronger focus on project management and delivery in these roles. Some health and safety dimensions.	Some support.	No data.	RIBA the professional institute carries out a salary survey as part of its wider annual business benchmarking studies, covering 300 employers/ 31,000 staff. Pay levels generally higher in London/South East.	Has been used in the past, was recommended by PA and there are reasonable grounds for including again, if the survey data can be accessed.
Management consultancy	McKinsey and the leading strategy firms employ top calibre graduates and MBAs. The major generalist consulting and accountancy firms e.g. PwC, Deloitte employ specialist health sector teams. And specialists can achieve senior levels/partnership status very largely on the basis of their technical knowledge. But the bulk of learning is on the job/experiential and project and client management and delivery as well as sales are typically stronger requirements.		Some, though by no means all, operate on a partnership basis with regional networks, but increasingly moving to PLC structures and with takeovers e.g. by IT and insurance companies. Risks largely related to project management.	Limited support, largely from doctors consulted.	Much discussed by head-hunters etc. but very limited in practice.	Surprisingly badly covered by surveys, partly like engineering because of the wide diversity of specialisms and suppliers. The Institute of Consulting (now part of CMI) we believe holds some data, as does the AOMC as part of its annual industry survey. The Big 4 accounting firms include consulting in their comparisons. But there appears to be no major, authoritative survey covering the occupation.	Seems little rationale on the basis of qualifications, career path or skills, other than in terms of intellectual demands and as another high earning profession. Market data and access to it will be difficult.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information	Implications
Pilots	Pilots typically are trained in the Armed Forces or gain their own private licence unpaid. Time required/ years of experience probably has broad equivalence at co-pilot/ ST3 level and for commercial Captains at the Consultant level.	Considerable job complexity and knowledge required despite increasing sophistication of computers and lessening reliance on 'flying'/ manual skills. Also six monthly testing of continuing abilities makes CPD demanding.	Doctors we spoke to were very supportive of the comparison on the basis of responsibility for lives, as well as to a lesser degree complexity of the skill sets needed. Some other stakeholders opposed them as example of 'cherry picking' high paying comparisons.	Strong support by some, strong opposition by others. Known to be another high earnings profession. Also comparatively small numbers.	No data but unlikely to be any movement.	Very limited bar an international survey club that the major airlines run for themselves. BALPA apparently also gather earnings data but we have been unable to secure details. Earnings pattern is complex –shift pay, rest periods etc. So difficult to access from outside the industry. Some studies have used Air Traffic Controllers as a proxy with their life/death impact. But this seems to us a fundamentally different role in terms of skills/ job content.	Recommended at senior levels by PA but not carried out. Data seems unavailable and we are less convinced by job/skill comparability arguments. But strongly supported by doctors.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information	Implications
School teaching and leadership roles	Career path typically involves one year Certificate of Education post-graduation, though increasing number of specialities e.g. special needs and growth in mature entry routes. Development and selection of leaders and head teachers now increasingly defined and structured.	Wide range of skills needed – teaching, coaching, communications, interpersonal, organisation etc. Despite 'super teachers' however, career ladder largely involves moves to take on management responsibilities and accountabilities.	Management responsibilities at subject and Head Teacher levels, plus the responsibility in loco parentis for the children, as well as financial and operation performance of the school, makes comparisons more relevant/ possible at senior levels with both hospital and GP workforce.	Very little mention/ support, bar parallels made with medical academic roles.	Odd individual cases in the mature entry data.	Information generally in the public domain and increasing range of pay levels with devolvement, performance pay and spread of free schools. But very different labour market, large numbers recruited but relatively high turnover of staff –1/3 leave within 1 year of qualifying and unlike doctors, most don't return to continue their careers.	Has been used in the past, could be used at the top 2 – 3 levels, but HE roles generally regarded as more comparable by our stakeholders, and us.
Engineering	Engineering roles include Aeronautical, Automotive, Civil, Electrical, Materials, and Mechanical - making it hard to identify a common career path or competencies. As a result, it is difficult to make alignment between the Engineering and Medical career paths, at least beyond the lowest levels. Although represented by a number of professional bodies, there is not usually a need for Engineers to study for a further accreditation / qualifications. Like architects, skills sets developed across broad areas – further technical expertise, project and client management, etc. – and career ladder tends to run into management/senior management posts, with strong emphasis on project delivery.		Again some employed in partnerships and some in public sector and academia, although bulk now work in larger corporates. Management responsibilities more significant with growing experience and health and safety responsibilities/risks too.	Some mentions particularly by the dentists we interviewed, but fewer than the existing comparators used.	Individual examples from mature entry data e.g. software and systems engineers.	Data is available but highly diverse and probably easier to conduct if comparisons are focused on one key area, such as electrical, for more accurate matching. Survey databases such as Hay and Willis Towers Watson cover all levels of job e.g. WTW covers 17 engineering disciplines in its career map framework up to CEO/ Level 25 – their UK general industry survey costs c£2,500 for non-participants.	Has been used in the past, selection and benchmarking of market data in such a varied profession is the key barrier to comparisons.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information	Implications
Veterinary medicine	Strong similarity in academic requirements, length of training and career paths. There are 20,000 vets in the UK and it is a very popular university choice, with similarly high entry requirements. The degree is generally 5 years, in some cases 6. Most then go into practice where they develop their clinical expertise.	Very similar knowledge base and types of skills required – clinical, organisational, caring, service, etc. Many vets study for additional qualifications, such as RCVS. Certificates and Diplomas e.g. in pathology and in specialist clinical practice. The RCVS also requires that all vets keep their skills/knowledge up to date throughout their careers.	Very similar to practice-based GP and GDP roles. Organisation and management responsibilities grow with experience and assumption of risks/responsibilities of the practice at partner level. 24/7 service responsibilities in many cases	Generally supported for practice roles, particularly by those in those roles – the dentists we spoke to saw it as the most relevant - due to similar structures and also similar intellectual demands and length/ type of training.	No moves in-between the professions, but RCVS data suggests other non-practice roles held by vets match quite closely the pattern of medical leavers and alternative employment – government, academia, the pharma sector and working overseas.	Seems reasonably available information and cheap to access (£160), at a limited number of job levels, through the Society of Practicing Veterinary Surgeons and Association of Vets in Industry (see below)	Based on this analysis we regard this as the occupation with the strongest basis for inclusion in the comparisons, largely in relation to the practice-based doctor and dentist roles, where all of the factors listed suggest that it should be given serious consideration for inclusion.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information	Implications
Opticians	Limited alignment with medical career path, closer to dentists. A year of supervised practice, following graduation, before registration with the GOC is required. Length of training is shorter (4 years in total; 5 years in Scotland) and career progression opportunities limited once registered bar into management.	Some similarity in that clinical decision making skills are required and there is a statutory requirement to undertake CPD. Can undertake further training to practise in areas of specialist skill and knowledge, like dentists and GPs.	Professionally accountable role regulated by GOC. In private practice, risks reflective of GP/GDP sole practitioners/ partners linked to business operation/performance. However for many they are operating in a more dynamic retail environment and increasingly employed by large corporates.	Considered partly relevant by some for GDPs and GMPs only.	No data.	Very limited data available and is produced by recruiters e.g. Hunter; less robust than that sourced through professional body. Limited data available through GOC	Some limited justification based on qualification route and career path for comparison with GDP/GP only, although shorter training time. But lack of data is a major barrier.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information
Finance and banking	<p>Hugely diverse sector. More requirements in terms of qualifications since the financial Crash but generally at lower academic levels. Also complex mix of professional associations and industry bodies. Highest quality grads and MBAs do typically work in the higher paying areas such as investment banking and private equity. But still areas where roles with comparatively high pay which has no obvious link to qualifications and experience e.g. trading.</p> <p>Heavy overlap in corporate and middle office roles with accountancy and tax qualification and careers already covered in the DDRB comparisons</p>	<p>Reforms have made key roles more accountable e.g. risk adjusted measures of performance. But specialist risk managers undertake a lot of this work. Top specialists can earn the same as/ more than managers and leaders, but generally a strong emphasis on sales and income performance</p>	<p>Interestingly few mentions, apart from some of the doctors we consulted, and less emphasis than in the last review by PA, where it emerged strongly from the social cohort analysis</p>	<p>Again, much discussed by head-hunters etc. but very limited in practice.</p>	<p>McLagan dominate pay data in the higher paying end of the financial services market. The data is expensive and generally only available to participants, although we believe they have made information available to international bodies e.g. the IMF. Highly specialist roles and multiple industry breakdowns make comparison outside of the sector problematic, while the structure of earnings is totally different – generally much higher variable bonuses but lower value pensions. Large majority of higher paying roles based in London.</p>	<p>As for management consultancy, other than as another high earning group there seems little really to justify direct comparisons, and accessing and making sense of the data would be very difficult. The existing accounting/tax comparisons cover the roles in industry well already and are much more straightforward to benchmark.</p>

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Market remuneration information
University academic and leadership roles	<p>Wide range of roles in universities, with a national pay structure for academics up to professor level. Progression can be on the basis of teaching but generally research skills emphasised. Entry now typically post-doc at lecturer/assistant lecturer and progress on basis of increasing research and publication achievements. Beyond national structure, professors are typically organised in 3 – 4 bands on basis of reputation/ influence and publications, with world class reputation/influence the highest level. Academics may take on 'temporary' discipline/ school management responsibility, but typically now there will be a parallel senior professional/ leadership structures up to Vice Chancellor level.</p>	<p>Increasing performance focus on academics in terms of research publications, research revenues etc. At more senior levels there are roles with major strategic management and leadership accountabilities, particularly in the larger institutions – financial, property, staff and student management.</p>	<p>Strong support generally expressed for a variety of reasons, including the number and knowledge of clinical academic roles</p>	<p>Apart from other healthcare professionals coming into medicine as mature entrants, this seems to be one of the largest destination for 'leavers' from medical and dental schools, as well as practitioners carrying out these roles on a part-time basis. There are according to confidential UCEA data c 2000 clinical academics on the consultant scale, c 200 GPs on the GP clinical educator scale (NHS); and c500 post-CCT doctors and dentists on the clinical lecturer scale, as well as some on individual HEI's own clinical academic scales.</p>	<p>Pay databases have improved significantly over the last decade. National published structure covers most institutions for jobs below c £50k salary. Above that both UCEA for all institutions and Hay for the Russell Group run detailed and well - structured surveys. Initial enquiries suggest access could be negotiated to one/ both at a reasonable price. Clinical academics are paid on a range of university and NHS scales. Levels appear straightforward to benchmark – see UCEA survey levels in the Appendix that could be used.</p>	<p>Strong case for inclusion, particularly for hospital roles, on the basis of all of these criteria, notably similarity of skills and roles. While quality pay data is available and accessible, it could though be questioned as to whether, like the private medical sector, the NHS 'deal' really drives the salary levels in these contiguous occupations.</p>

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data
<p>Large private sector professional and leadership roles</p>	<p>Large UK based PLCs typically now will have clearly defined organisation layers and grading structures, with accountabilities and required skills and competencies defined. Management has become an increasingly professional occupation, with significant growth in the number of business schools and MBAs and chartered management qualifications. In practice, leaders tend to be graduates with an additional professional qualification who have progressed up a functional specialism, most commonly finance, and then broadened into general management.</p>	<p>Supported as reasonable comparison for medical roles with a significant management component e.g. medical director, particularly by more senior doctors we consulted.</p>	<p>Administration and lower level management roles seem to be quite common sources of mature entrants into the medical professions.</p>	<p>Considerable amount of data available. Easy to match into Hay private sector database using the level matches already used for the professional group comparisons. All of the other major survey providers – WTW, Xpert HR etc. have similar matching methodologies and large national survey databases. Growing levels of incentives in the private sector at senior levels makes comparison of the total package more problematic.</p>	<p>Direct match at the more senior medical roles involving significant degree of management responsibility. Selection relates more to choice between trying to get at earnings in very similar occupations and roles, or favouring broader, larger and more generic datasets showing the range of earnings across generic roles with a similar scale of professional skill requirement and management responsibility.</p>
<p>SCS and other public sector senior professional and leadership roles e.g. local authorities</p>	<p>As for private sector management, these roles have become increasingly professionalised in recent years and are now generally organised into grading structures with jobs measured on the basis of reputable point's factor job evaluation systems. Jobs are generally graded on the basis of managerial responsibility and accountability at senior levels, although technical expertise and knowledge is also rated highly for policy and professional roles.</p>	<p>Mentioned by some of the doctors and used as comparators by a number of the other Pay Review Bodies</p>	<p>Medical staff work in other parts of the public sector and there is increasing joint working, particularly with local government in community care.</p>	<p>Pay information widely available with senior pay generally in the public domain, national published pay structures for professional staff and a range of pay surveys available now too where pay has been more devolved. Various public sector data cuts can be drawn down at the different responsibility levels from databases such as Hay. Many public sector employers already use the Hay system, so benchmarking is straightforward – see Appendix.</p>	<p>Relatively straightforward to match with and access pay data. Probably seen as useful by most stakeholders. Again, the question as to its use relates more to the purpose of the comparisons and whether looking at roles also subject to government pay policy is a genuine market pay comparison.</p>

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data	Occupation
Small business leaders/partners	Typically, management structures and roles in small businesses are less professionalised and are as commonly staffed by school leavers as graduates, except in areas such as technology where many founders and entrepreneurs are graduates and/or have prior experience in large employers. Partner/owners would probably be the only level/role that would be an obvious match into the medical and dental career paths.	Growing demands of the managerial and organisational components of the role and the risks of partnership make this appear an increasingly relevant comparator for practice dentists and partner GP roles, which the dentists in particular emphasised.	Seen as relevant for practice roles by those consulted, particularly those in practice roles, who generally saw it as the second most relevant comparator grouping	None/ no data	Generally small business and particularly partnerships are poorly covered by pay databases. In the Xpert HR database for example the smallest size cut is for firms with fewer than 500 employees and £100m turnover. The Federation of Small Business don't appear to run or recommend any pay surveys. The structure of earnings may also be different due to the owner/equity component. Hay however, has 123 employers with a turnover of under £10 million	Difficult to achieve in practice, despite the obvious analogies with practice-owning dentists and doctors, largely due to the lack of decent survey data.

Occupation	Qualifications, training, career path	'Technical' skills/ competencies	Responsibilities and risks	Stakeholder, Doctor and Dentist Views	Entry and Exit Data
Other NHS roles in the Agenda for Change and Very Senior Managers Structures	The NHS job evaluation system underpins the Agenda for Change Pay Bands and the measurement criteria encompass professional qualifications, skills and knowledge as well as measuring managerial responsibilities and accountabilities. The system was originally developed to encompass medical roles. A separate, somewhat simpler classification system operates for Very Senior Manager roles largely differentiating on the basis of the scale of the managerial responsibility. It would therefore be very straightforward to align particularly the hospital doctor and dentist anchor points with the NHS bands.	Not referred to by many stakeholders, but that may partly have been because they did not regard it as a different market within the scope of this review. There are joint career frameworks applying to medical and AFC graded staff endorsed by stakeholders including the BMA and BDA.	Seems to be by some way the largest group of mature entrants into the medical professions.	Pay data generally publicly available and surveys also carried out on actual pay levels within bands by survey houses such as IDR.	Comparisons appear to be straightforward and justified on these criteria. But as for the wider public sector comparison, it would be open to dispute as to whether this would be a fair market comparison, given that the employer is the same and as with medical academics, there is some overlap in existing pay structures.
Overseas Comparisons	Although career paths and roles differ widely between countries e.g. balance of specialist and generalist work, relationships to pharmacy, physiotherapy, etc., clearly in terms of comparing and benchmarking job content and different levels in the respective career structures, these would be the most straightforward comparisons to make. The difficulty with comparisons would be more to do with assessing pay and remuneration on a consistent basis, rather than job level and size comparisons.	Most of the stakeholders consulted felt that while overseas comparisons are difficult, more knowledge about the levels and structures of remuneration for medical staff overseas would be useful.	By far the largest group of 'joiners' and 'leavers' into the medical and dental professions, which has grown over the last decade, as evidenced by the GMC annual survey.	Comparisons are difficult/expensive but perfectly possible. Large multinational firms for example carry them out regularly and there are suppliers who specialise in this aspect of remuneration e.g. ECA. OME has looked at aspects of rewards overseas in the past e.g. comparisons of unsocial hours working arrangements in 2015. See Chapter 5 for more detail.	Justified and possible in terms of all of the selection criteria set out. The major barriers relate to difficulties in comparing packages on a common basis and the costs of doing this.

Summarising across this wide list of occupations and sectors would appear to produce the following groupings in terms of potentially expanding the comparator group of four.

- First, in terms of additional occupations **the strongest case can be made for vets and for architects**. The case for the former is strengthened by the extension of the comparisons in this review to GP and GDP career paths, while the latter has been used and recommended before, and only the lack of quality data appears to have prevented its continuance.
- **Engineers and pilots** are the other occupations with the strongest but more debatable justification. On pilots the debate may be nullified by the apparent continuing lack of access to decent market data on total earnings. Engineers appear a reasonable choice on virtually all of the selection criteria used. But the diversity of employers and specialisms makes for a very diverse employment and pay market which makes accurate anchoring and benchmarking problematic.
- There does not appear to be as strong a case for looking at banking and financial services roles or management consultancy, where there are also more significant difficulties of job matching, earnings comparisons on a consistent basis and data access.
- Second in terms of broader occupational and sector groupings, **Higher Education seems now to have a very strong case for inclusion**, not least because of the numbers in medical education roles who are currently spread across HE and NHS scales. High quality matching and pay data is now available here. The case for comparison here appears stronger than for schools' roles.
- **Wider comparisons with more broadly defined groupings of managerial and professional roles at equivalent levels of skills and responsibility** would also appear to be beneficial, in both larger private sector employers and, if data is available, SMEs for practice-based roles.
- Comparisons with the rest of the public sector and with other NHS staff are also relatively straightforward to conduct and carried out already by some of the other PRBs, but more controversial on the basis of the objectives and principles underpinning this market pay comparison exercise.

7.3 Summary Descriptions at Anchor Points: Other Potential Professions' Career Paths

To include in the future DDRB market pay comparisons, any new occupations or professions need to have both a career structure that can be benchmarked effectively with the medical and dental anchor points we have defined; and accessible remuneration

information. Below in Table 7.2, for the three occupations which appear to have a strong case for inclusion alongside the existing four, we show initial suggestions as to the anchor points which would align with the anchor points developed and used for the medical and dental career paths. These highlight the level and nature of qualifications, particularly at the lower levels, then progress up through years of PQE with growing clinical/technical knowledge and expertise, and then at the higher levels managerial responsibilities become more important criteria to compare and align. Anchoring is also supported by the defined benchmark levels of role and responsibility which surveys in these areas use to gather and categorise their earnings data from participants.

For wider populations of managers and professionals in private and/or public sectors then the existing Hay responsibility levels can be used to ensure accurate benchmarking at each of the six current anchor points, without the need for this type of distinct anchor point descriptor. **The responsibility levels at which the current six anchor points for the two career paths for hospital doctors/dentists should be checked and confirmed with Hay.** Similarly **the suggested new anchor points for GPs and GDPs should be discussed and confirmed with Hay,** either through a Hay point job evaluation exercise and/or by slotting against their generic and job family level descriptors (see Appendix).

Table 7.2: Career Paths and Anchor Points for the Three Additional Occupations

Medical Anchor Points	Higher Education (see UCEA survey levels in Appendix)	Vets	Architects
Consultant experienced	Match likely to be with UCEA Senior Salary Survey level 3 – director/head of a major function/group of functions/department/school	As in general practice, vets progress in terms of their clinical expertise, can specialise in particular areas, and/or often also move to assume managerial responsibilities as a partner within a practice, or increasingly as a director in a larger corporate entity. The highest level of matching role in the SPVS Salaries Survey is for vets with 20 years plus experience and for Senior Director/Managing Partner level. Below that is the head of a department or partner in a practice.	The Consultant grade aligns well with Partner/ Director / Chief Architect: <ul style="list-style-type: none"> • At this level in both career paths individuals are expected to be an authority in their own field • They are likely to be accountable for their own practice or department in terms of leadership and performance • They are likely to have complete autonomy in decision making At the top end of the Architect career path, Partners are likely to be owner-managers and as such part of their reward comes as a result of ownership (and the risks that brings). It is hard to provide separate matches for Consultant (min) and Consultant (max) although size of organisation and seniority of Partner should be considered.
Consultant – newly qualified	New Consultant would likely match in with a level 4 senior function head/head of a subset of an academic area – titles include Associate Dean, Deputy Leader. Professors typically fall at UCEA Levels 4/5 depending on reputation and responsibilities.	The SPVS survey reflects growth in skills and experience as reflected by increasing years of PQE – levels of responsibility, from projects to budgets and the team and line management responsibility, and also areas of specialisation. The median pay for a qualified vet in a mixed practice in 2014 was £41,000 while in industry the median for typically more experienced vets was £59,000.	The ST3+ anchor point aligns broadly with the Associate role: This is approximately the 5-10 years post-qualification for Architects, although it may be longer. The individual will be recognised as an expert in their own specialist area The individual will operate independently, receiving little or no direct supervision. They will be responsible for supervising, coaching others. However, the Associate may have direct reports and may be accountable for complex commissions/projects.
ST3+	Higher ST levels would likely match in with levels I and J in the UCEA Salary Survey, with titles including reader, principal lecturer, junior professor.		

Medical Anchor Points	Higher Education (see UCEA survey levels in Appendix)	Vets	Architects
ST 1&2	Progress on basis of increasing research and publication achievements – Level K is the core lecturer level, operating independently in subject field, co-ordinating a team and with significant responsibility for students.	<p>The RCVS refers to ‘day one competences’ expected of all vets, that is that they expect the (extended) degree programmes to enable students to perform at an expected/acceptable standard from day 1.</p> <p>They cover general professional skills and attributes; practical and clinical competencies, and underpinning knowledge and understanding.</p> <p>The pay for newly qualified vets in 2014 was £31,000</p>	<p>The ST1&2 anchor point aligns with the lower end of Project Architect (the top end of the Project Architect range is more aligned with ST3+):</p> <p>For Architects this is approximately the 3-5 years post qualification (for medics it is the 2-3 years post qualification).</p> <p>Individuals will have solid technical knowledge but may need supervision in complex situations.</p> <p>They may supervise others and will have direct client liaison.</p> <p>Architects with up to 5 years PQE averaged £32,500 in salary in 2016.</p>
F2	Wide range of roles at this level in universities, with a national pay structure for academics up to professor level. Progression can be on the basis of teaching but generally research skills emphasised up through senior lecturer and up to reader/junior professor level.		<p>The F2 anchor point broadly aligns with the Part 3 Assistant/Newly Registered Architect:</p> <ul style="list-style-type: none"> • This is the 1-2 years following qualification for Architects (versus the year following qualification for medics) • The individual is responsible for managing their own workload • The individual will provide technical advice but will need supervision.
F1	Entry is now typically post doctorate at lecturer/assistant lecturer level, which is Level L in the UCEA survey. Professionally qualified, normally with experience in excess of 2 years.		<p>The F1 anchor point aligns well with Part1/2 Assistant:</p> <ul style="list-style-type: none"> • In both career paths this is the period prior to qualification • At this level the individual will receive considerable guidance and • supervision and be responsible only for discrete tasks - any issues will be escalated • At this stage the individual will be expected to demonstrate a basic level of technical knowledge. <p>The median pay in 2016 for Part 2 Architectural Assistants was £26,000</p>

7.4 Pay Data Sources: Other Potential Professions

For the three highlighted occupations, in the table 7.3 below we also present the findings of our research into the best and most accessible sources of market pay information that the OME could use for the comparisons. In the fourth column, we also show possible additional sources of information which could be used to complement and expand on data drawn from Hay's general survey database and similar sources.

Table 7.3: Potential Data Sources for the New Matching Occupations and Markets

Occupation:	Higher Education	Vets	Architects	Senior management and professional roles in various sectors
Potential pay data sources	<p>UCEA runs its own Senior Salary Survey and contracts Xpert HR to run a linked survey covering middle and junior level staff.</p> <p>Jobs are matched in at 11 levels in the Senior Survey from the Vice Chancellor downward and another 8 levels of job in the wider survey (see appendix, where these are shown and we have suggested some initial benchmarking levels with the DDRB career anchor points already)</p> <p>The senior survey holds data from 145 institutions and over 27,000 individuals and the wider survey has data from 101 employers and 212,000 individuals, from Administrator through to Research Fellow/Reader.</p> <p>Jobs are broken down into c70 functions and data is analysed by employer size and location, as well as level and function.</p> <p>Standard access for non-participants is £1700 but we have spoken to UCEA and they would be willing to help with matching of the medical career paths and discuss the costs of providing the data to OME.</p> <p>UCEA also carry out a confidential survey of Clinical Academic Pay.</p>	<p>Society of Practising Veterinary Surgeons Annual Salaries Survey</p> <ul style="list-style-type: none"> - Over 250 practices participate, 1878 incumbents - Covers: salaries; other earnings e.g. overtime, bonus, on call, pensions and main benefits, working hours and contractual arrangements etc. - Covers 5 different roles and analysis by years of pqe, - £31k newly qualified up to £69k at 20 years pqe (2014 data). - Pay analysed by sector, size and region <p>Cost: £160 pa</p>	<p>RIBA includes earnings data in its annual Business Benchmarking survey, covering over 300 employers and 31,000 staff, with more than half working for architectural practices/partnerships.</p> <p>Earnings are benchmarked at 8 levels from Architecture Assistant Part 1 through to Partner/Director/Sole Principal. Salaries are also analysed by years of pqe, region and practice size. Summary results are free to download, detailed access would need to be negotiated, no indicative price given.</p> <p>Pay levels are generally low at the median as there are a lot of small practices covered. So this data might need to be supplemented by information on architects in major firms from one of the major survey providers such as Hay or WTW.</p>	<p>General managers and senior professionals in industry:</p> <p>A number of the other professions use either the Xpert HR or the Hay general industrial database to provide them with a broad multi-sector comparison at equivalent levels of responsibility.</p> <p>Hay's wider UK database covers 70 job families with data from 600+ organisations across 20 industry sectors and some 900,000 incumbents in total. A Total Remuneration value is available to give a basic overview of the value of benefits provided in addition to total cash.</p> <p>The Xpert HR National General Management survey run with the Chartered Management Institute covers 417 employers and 52,000 individuals matched at 10 job levels. The smallest level of analysis for SME roles is for firms with under 500 staff and under £500m turnover.</p> <p>Senior Civil Service. The pay scales for the SCS are public and the Cabinet Office/ CSEP should be able to provide information on the distribution of jobs and individuals within these wide pay bands.</p>

7.5 Pay Data Sources: Current Professions

Our research has also raised some possibilities for improvement in the remuneration data which is used for the current comparisons, primarily in relation to the employers that are included in the comparisons and the number of survey sources used. As we saw in Chapter 5, the market trend has been to include more roles in the comparisons and to use a wider range of survey sources, helping in the process to understand the pay and labour markets being looked at and possibly also making the recognition that there is no single 'market median' number out there. In reality there are a range of labour markets for many occupations and a single employer can set its pay levels taking account of and informed by this market information but not deterministically copying it.

Hay is the sole provider of the current market information. It has one of the largest UK general industry databases and as profiled below, this provides excellent coverage of the occupations/job families which are used for the DDRB comparisons. Indeed, Cabinet Office recommends and sources this database for use by all of the other central government departments. However, the information is very largely for employer organisations with few if any partnerships included.

Particularly the senior doctors we spoke too felt that the large London-based legal partnerships were the more appropriate comparators for them, and probably on the basis of their intellectual abilities that might be where top London hospital consultants would have ended up had they pursued a legal career. In this case though it might be argued that they are not representative of the medical profession as a whole and per partner earnings in the 'Magic Circle' law firms are far from representative of the earnings of senior lawyers and partners in the UK legal profession as a whole. And in this case, access to market data for the biggest partnerships is extremely difficult anyway.

Nonetheless, in the table below we show some possible additional sources of data that could be used to supplement the Hay information for the existing professions.

Table 7.4: Additional Data Sources for the Existing Matching Occupations

Occupations	Sources	
Legal	Current Sources	Hay – corporate legal roles, 343 participants and 11,000 job holders
	Potential Additional sources	<p>The Law Society carries out an annual survey of salaries for solicitors in private practice with c500 participants. The results cover different levels from Associates up to Equity partners and the results are broken down by years of pqe, practice size, specialism and location. The summary results are free to download.</p> <p>Willis Towers Watson carries out a Legal sector survey in the UK annually focusing on law firms and fee earning professionals, covering base and variable pay, benefits and employment terms. Results are broken down by level/years pqe, specialism and location. Cost is £3900 to participants and access would need to be negotiated.</p> <p>Various recruitment firms also carry out annual earnings surveys in the profession, although the quality and level of detail in these is highly variable.</p>
Accounting/Tax	Current Sources	Hay, corporate finance, tax and accounting roles, 654 participating employers and 36,000 job holders
	Potential Additional sources	<p>Willis Towers Watson carries out a large survey for the major accounting firms of accounting and tax professionals up to partner levels. Costs would be broadly equivalent to their legal survey.</p> <p>Recruitment consultants again operate in this area. Stott and May for example carry out a survey of the profession annually for the ICAEW, with more than 5,000 participants. Results cover base pay and bonuses and are analysed by career stage/years pqe, firm size and sector and location. Summary results are free to download, more detailed access would need to be negotiated</p>
Actuaries	Current Sources	Hay – corporate pension roles, 21 participants, 600 job holders
	Potential Additional sources	<p>Xpert HR runs an annual Actuaries and Actuarial Students Salary Survey for the Institute and Faculty of Actuaries, with 11 organisations and 1161 individuals included. Jobs are matched at 9 levels in the profession from actuarial trainee up to director level. Pay is analysed by employer size and location</p> <p>In addition, the survey reports on pay settlements and pay movements for matched groups of employees over the previous 12 months, and provides data on bonus payments, car allowances, and labour turnover.</p>
Pharmaceutical	Current Sources	Hay – a range of corporate managerial and professional roles, 6 participants, 60 job holders
	Potential Additional sources	Radford data covers a wide range of pharma and Life Science technical, scientific and managerial roles. It is purchased by Cabinet Office for use across government, so could be purchased potentially through them or directly negotiated from Radford.

7.6 Chapter Summary

We have carried out a detailed analysis of possible occupations that have been raised and might be considered for use as potential comparator occupations for benchmarking doctor and dentist earnings externally. The selection criteria have focused on job, skill and career comparability; stakeholder and doctor/dentist support; and pay data availability.

This analysis leads to the conclusion that:

- There is a strong case for including architects (used previously in these comparisons) in the comparisons for all of the career paths; and vets for the practice-based roles; engineers and pilots were also rated highly as comparators by some stakeholders;
- Higher education also has a very strong case for inclusion based on the number of academic medical teaching and research roles;

We provide draft anchor point descriptions for these three occupations/careers of architects, vets and higher education, paralleling the medical career path.

- Looking at wider categorisations beyond the occupational level, using the same criteria lends support to the inclusion of overseas medical and dental remuneration comparisons; and
- Large company managers/leaders for the higher anchor points in the hospital-based career paths; along with
- Small company owners/managers for the practice-based roles.

We also suggest pay data sources for the three new areas and for these broad senior management comparisons, as well as suggesting how the data sources for the current four occupations could be enhanced and extended, in line with practice externally.

8 Summary Critique of the Existing Methodology

8.1 Introduction

We have carried out a thorough review and critique of the existing pay comparisons and pay comparison methodology which the DDRB uses to benchmark the remuneration of doctors and dentists with that of other occupations and professions, considering the methodology from a number of different perspectives. In this chapter, in the table below we summarise the features, strengths and weaknesses of that methodology and the implications implied by our analysis, before moving in the final chapter to make suggestions and recommendations for future changes.

As we have stated, our various stakeholders have generally supported the continuance of the current methodology. But there was also support and ideas for updating, extension and improvement and we have recorded, categorised and added to these suggestions to address any issues that have been highlighted.

Table 8.1: Summary Analysis of the Current Methodology

Feature	Strengths	Weaknesses	Implications
Pay comparisons are made at six anchor levels in the medical training and career structures.	<ul style="list-style-type: none"> Anchor levels well defined, justified and supported by stakeholder as providing an effective profile and coverage of the medical career structure. 	<ul style="list-style-type: none"> GPs and GDPs not profiled, despite different skills and competencies required. 	<ul style="list-style-type: none"> No additional levels/anchors required -But GP and GDP descriptors and anchors definitely needed, potentially alongside of some data from some occupations specific to these roles.
Anchor levels are described and supported with detailed role profiles and a tailored competency framework.	<ul style="list-style-type: none"> Detailed back up provided to support matching of the anchor points into survey databases for other occupations. Makes it appear to be a more rigorous methodology. 	<ul style="list-style-type: none"> Detailed role profiles have largely become superfluous: they are used in practice, not specific enough to support matching in to the different medical specialities, nor general enough to support comparisons with other new professions. Most pay surveys now provide their own descriptors and job matching methodologies. No job evaluation is in place to support either internal or external comparisons on a consistent basis e.g. is a GP at the same level as a consultant? 	<ul style="list-style-type: none"> Questionable if the role profiles are actually required going forward given that the anchor points seem relatively clear and accepted.
Four comparator occupations are used: lawyers, accountants, actuaries and pharma industry profs/managers.	<ul style="list-style-type: none"> Strong stakeholder and wider support for the use of these professions, particularly lawyers and pharma sector. The first 3 have very similar training and career profiles, while the pharma sector is another significant employer of medical professionals. - Good market data is available for these occupations. 	<ul style="list-style-type: none"> Additional occupations which could be considered relevant and were originally recommended/used are not included e.g. architects. Occupations which might be seen to be more relevant to general practice roles are not included e.g. vets. 	<ul style="list-style-type: none"> Including GPs and dentist profiles strengthens the case for matching with some additional occupations operating in partnership structures. Varying the matching occupations to suit the different disciplines seems sensible on the basis of comparable skills e.g. leadership and management skills required in practices.

Feature	Strengths	Weaknesses	Implications
<p>Data for these occupations is sourced from the Hay Group UK general industrial survey database, matching in at the appropriate Hay survey responsibility levels.</p>	<ul style="list-style-type: none"> • Utilises one of the best and biggest general UK survey databases, widely used across the public sector • Good sample sizes in the matching groups (except for actuaries). • Hay survey levels are a widely used and accepted means of market matching and benchmarking used widely in public and private sectors. • All data is collected and analysed on a consistent basis. 	<ul style="list-style-type: none"> • Other related markets and survey sources are not accessed e.g. lawyers and accountants in partnerships. • Most large employers today will use multiple data sources and more data is generally available vs. 10 years ago. • Detailed job evaluation and matching using the Hay job evaluation system has not been undertaken and Hay were not involved in making the original matching with the anchor points. • No comparisons are made with medical overseas earnings (although OME have compared aspects of these packages in specific research reports). 	<ul style="list-style-type: none"> • Supplementing Hay's information with some additional survey sources now available seems sensible e.g. for senior roles in Higher Education. • While complex/ expensive to carry out, OME should probably consider carrying out overseas comparisons every few years as this is seen as vital by almost all stakeholders.
<p>Comparisons are made on the basis of cash earnings.</p>	<ul style="list-style-type: none"> • Commonest method of comparing earnings, making for straightforward comparisons e.g. using graphs and calculating comparison ratios. 	<ul style="list-style-type: none"> • No comparison of the pension and benefits package, and no adjustment to reflect this (unlike some of the other PRBs). 	<ul style="list-style-type: none"> • While detailed total reward comparisons are difficult/ expensive, a simple adjustment to reflect different pension values might be implied. • We do not however see any need for an 'X' factor type adjustment, of the type used for military personnel, to reflect the full employment rates of medical professionals. Employment rates for all top graduates are high and unemployment rates in professions such as law low. In addition our experience is that in competitive markets high employment rates drive higher not lower rates of pay.
<p>Additional analyses are carried out comparing with national average earnings currently and since 2010, inflation and also graduate earnings in other disciplines.</p>	<ul style="list-style-type: none"> • Analysis has developed in recent years and this successfully highlights relative position and trends, particularly at the lower levels. 	<ul style="list-style-type: none"> • More detailed analyses and comparisons with national earnings not carried out e.g. highest paying occupations, narrower sector breakdowns etc. 	<ul style="list-style-type: none"> • Continuing the trend to greater use of the national earnings stats and new data sources e.g. LEO would further enrich the comparisons, and avoid/lessen debate over the choice of specific occupations and 'cherry picking'.

9 Conclusions and Recommendations

9.1 Introduction

The detailed work carried out for this review has thoroughly examined the existing methodology which the DDRB employs for making external pay comparisons, from the perspectives of: the various stakeholders involved; doctors and dentists at various stages in their careers themselves; and in the context of trends in the career patterns and employment of medical staff; and wider pay market trends and developments over the last decade in how such comparisons are undertaken. The conclusion is that the current methodology is largely reinforced.

The key questions therefore addressed in this final section of the report are:

- What updating is needed?
- How to profile and anchor GPs and dentists for pay comparisons purposes and what to compare them with (if it needs to be any different to hospital doctors)
- Do we need additional occupations for comparison and if so which?
- Are any other improvements now possible and desirable?

9.2 Clarify the Purpose of the Comparisons

In order to agree on the recommendations and changes it requires that the primary purpose of these pay comparisons is clarified. Almost all employers will say that they use market data to ensure their remuneration is competitive, so as to recruit and retain and motivate staff of the calibre and in the quantities they need. But this disguises some quite different approaches which are used in practice to affect this.

Some employers use market data to very precisely determine the pay rates of their jobs and spend significant amounts of resource in ensuring that they match. They will define their labour markets very narrowly and typically review information from their direct competitors who have exactly the same jobs as they do. For other employers however, market data is used more broadly to inform and influence but not drive the pay levels they set, alongside other important factors such as internal relativities and perceptions of fairness, organisation design, culture and of course affordability.

To an extent the trends we have profiled in Section 5 indicate a general move amongst UK employers from the latter towards a greater emphasis on the former, helping to drive the growth in the quantity and quality of market pay information in sectors such as Higher Education and government since this methodology was established 10 years ago. Yet as all our stakeholders have pointed out to us, probably the key feature of these medical roles and careers is their uniqueness and the difficulty in externally matching with other occupations, however much resource and effort is put into the exercise in terms of describing the roles and buying and matching into external survey data. There has been very little evidence of change over the past decade in the medical resourcing model, of recruiting the brightest graduates and employing them for their whole career, bar a growth in the movement to and from overseas, (although stakeholders did point out the growing pressures on the continuance of this model, even if they are not primarily pay related, from factors such as property price escalation, increased workload and rates of change in the NHS, pricing pressures, etc.).

It is therefore a good example of the situation which Marsden (2002) foresaw with the growing professionalisation of work, of the need to move to an agreed but broad approach to job classification in pay comparability exercises, 'to reduce the natural idiosyncrasy of jobs and help to identify contours of similarity and equivalence', and allowing for considerable scope for personal development and growth in a role.

The prime purpose of these comparisons for doctors and dentists is not to set their exact rate of pay, but appears to be rather to inform these decisions and help to ensure that remuneration is set and seen to be fair and appropriate. Comparing doctor and dentists' earnings with average UK earnings shows them to be high earning and not median paying professions. But almost certainly if the public were asked about this in the same way as IPSA did for MPs, the vast majority would agree with this positioning given the education, demands and life-saving skills and responsibilities of the medical profession. What work is more valuable than saving lives in society?

For doctors and dentists themselves, who in the main still spend their career in the NHS, the information is to some extent making a statement to those starting their studies that this is what you can reasonably expect to earn over the rest of your career. The trend analysis already carried out in the DDRB reports also shows us that in relative terms, many of the medical roles benchmarked have been falling back and it is probably this, rather than the levels at which lawyers or pilots are paid, that will be increasing the pressure on the continuing 1 per cent cap on earnings growth, which has been the main cause of this relative decline.

As such and as outlined below, there are risks in stretching the comparisons to many other specific occupations and roles, or increasing the number of anchor levels. What would comparing a hospital consultant with a pilot really tell us, even if we could access the data?

Accepting that is the primary role which the DDRB sees for these comparisons, then the following areas are recommended in order to update and improve the current approach to comparison.

9.3 Recommendations

1. **Adopt Summary Descriptors for Anchoring Roles in Each Medical/Dental Career Path.** There appears to be no continuing need for detailed role profiles and competencies for the existing hospital career paths, nor the new ones defined as part of this Review for doctors and dentists in general practice. The various medical and dental specialities and professional groups all have these, in different formats and tailored to their own specific needs. These are excellent for determining career progression from one level to another in anaesthetics, psychiatry and all of the other specialities, but add little and in many ways only serve to make cross professional comparisons more difficult to assess.

Comparisons across these medical and dental roles and with other professions will best be facilitated by brief summary descriptions of each anchor level in terms of the common features and factors that will be key to matching, such as level of qualifications, years of required experience and scale of responsibility and risk . Greater and more specific detail just confuses and obscures.

2. **Adopt Five Anchor Points in the New GMP Career Path and Five in the GDP Career Path.** We have set out the career paths for GPs and GDPs on this basis in Chapter 7 and drafted/edited the existing role profiles and anchor points in a similar format. These anchors can then be matched into the equivalent level in the external databases such as Hay which are used. The career paths are summarised in the tables below. While the length of training requirements can be a helpful benchmarking criteria, the introduction of age discrimination legislation means that the use of typical age and length of service as matching criteria need to be treated with caution.

Table 9.1: Overview of the Medical and Dental Career Paths and Anchor Points Proposed

1. Hospital Doctors and Dentists	2. Speciality/ Associate Specialist Doctors	3. General Medical Practice Doctors	4. General Dental Practice Dentists	Survey match levels
Consultant - experienced		Managing Partner/ Principal GP	Principal/Practice Owner Dentist	Hay level 21
Consultant - newly qualified	Associate Specialist	Partner GP	Partner/Providing-Performer Dentist	Hay level 20
ST3+	Speciality Doctor	Salaried GP	Associate/Performer Specialist Dentist	Hay level 19
			Associate/Performer Dentist	Hay Level 18
		Registrar GP		Hay level 17
ST 1&2		GP Specialist Trainee		Hay level 16
F2			Foundation Dentist/ Vocational Dental Practitioner	Hay level 15
F1				Hay level 14

NB: The exact positioning of the roles relative to each other and the Hay survey levels will be confirmed after discussion with Hay Group and possibly also job evaluation.

3. Carry Out More Detailed Job Analysis to Confirm Relativities Across the Career Paths and into the External Database(s). It is recommended that the internal relativities between medical and dental career paths, which have the potential to be a controversial area, are confirmed by a more detailed points factor job evaluation exercise, using either the Hay system or possibly the NHS job evaluation system, to confirm the suggested relativities in the most objective and scientific manner. Using the Hay system, the market-leading methodology in UK job evaluation, would also help with matching into their salary database more accurately, as each survey level has an associated range of job size/job evaluation points. It may be that the size of practice could influence, for example, whether the top anchor point for GPs and GDPs is at Hay level 20 or 21.

The NHS system on the other hand would allow the annual report to focus more on NHS comparisons more generally, which could be seen as desirable from an

occupational/career and employer funding point of view, as NHS Employers have argued.

If this is seen as too expensive and time-consuming an exercise then it is recommended that at least a meeting and discussion should be held with Hay Group consultants to carry out this exercise and ensure that the medical and dental anchors suggested are confirmed as being benchmarked into the Hay survey database at the most appropriate level.

4. **Continue to Focus on and Enhance the Market Data for the Current Four**

Professions. All of our stakeholders supported the existing comparators and in the vast majority of cases saw them as being stronger matching professions than any new ones suggested as additions. Therefore it is recommended that the OME examine and profile these markets in more detail to better understand the range of pay in them, and broaden the sources of data, particularly to cover law partnerships and magic circle firms, and employer models which better fit with roles based in general practice (though pay survey data for SMEs is unfortunately poor).

In particular the quality of surveys carried out by professional institutes and employer associations has improved markedly in recent years, often involving the large survey providers as suppliers, although access and cost of doing so would need to be negotiated. We suggest some additional comparators below and recommend that these are confirmed in meetings with the suggested suppliers, which can also be used to confirm the job matching of the anchor points at the appropriate survey level. Many of these surveys already operate a read-across into the Hay survey and other general industry databases.

Covering partnerships in the professions is particularly important for the practice-based roles, although this could also be seen to be relevant for the hospital roles, either using the same sets of data, or possibly focusing on the larger practices and national firms for hospital posts and smaller regional and local practices for the GP and GDP career paths. It could be argued that only the practice-based data should be used for the GP and GDP comparators, but it is recommended that the Hay professional's data is also used for these roles as providing a wider view of the employment market for these professions.

5. **Selectively Extend the Matching Occupations.** In chapter 7 we analysed many different potential occupational comparisons on the basis of the criteria of job and career comparability and pay data availability. On this basis only two or three areas stood out and it is recommended that the comparisons are extended to include vets for GPs and GDPs, relevant Higher Education roles for hospital-based doctors and dentists, and architects possibly for all four medical and dental career paths, or at least for the practice-based roles.

The case for other occupations is less clear when so few if any people actually move between them, opening up as we have said the risks of confusion of purpose and conflict, and adding very little to the existing information and to what, for example, the ONS high earning occupations' data reveals. The list of occupations and potential survey sources is summarised in the table below. Obviously, this list is provisional and issues of access and costs may change the actual outcomes. Other reputable providers may also be available.

6. Continue to Make More of the Improving National Datasets and Trend Analyses.

Given that with such low levels of movement into and out of the medical professions we can really only select comparable occupations on the basis of where other similar top graduates end up working and their earnings, then it makes sense to continue to use national earnings and graduate information in the DDRB's annual report and it is recommended that the greater use of this data evident in the 2017 report should be continued. The HESA and new LEO degree matching earnings data analysis, more detailed sector, occupational and sector breakdowns in the ONS data can continue to be used to add to the information and understanding provided in the annual report. The analysis of trends over time and changes in relative positioning of medical earnings is a key aspect of this analysis, for example changes in the relative positioning in national average earnings of medical roles over time, and we have profiled how some of the other Review Bodies use this information in Chapter 5 and highlight further ONS earnings data cuts which could be useful for DDRB to include to provide context to its consideration of doctors' and dentists' pay. For example:

- Movement in the earnings of the 'professional occupations' and the 'Managers, directors and senior officials' major occupational groups in SOC 2010.
- Movement in earnings among the Level 4 skill, sub-major groups of SOC 2010 which includes: corporate managers and directors; Science, research, engineering and technology professionals; Health professionals; Teaching and educational professionals; Business, media and public service professionals.
- Movement in earnings levels between the public and private sectors at the 90th, and 95th and 98th percentiles of full-time employees' earnings.

We also recommend use of the more generic samples from the survey provider datasets, such as the Hay general all private sector and public sector employer samples, at the equivalent survey levels. Hay's UK database of over 800 employers for example, breaks down into eight core revenue size categories and 18 sectors including pharmaceuticals, and we recommend using their datasets for larger companies (includes over 200) for hospital roles and smaller companies (123) for the practice roles at the top two anchor points.

Data sources for each recommended anchor point in the four career paths are shown in Tables 9.2, 9.3 and 9.4 below.

7. **Carry Out Overseas Comparator Studies.** Overseas remuneration comparisons in any occupation are not straightforward and generally somewhat expensive to carry out. But on the basis of actual doctor and dentist movements then this is to be recommended, even if there is little evidence that it is primarily the level of earnings overseas that is the main driver of movement. These studies can also be helpful in suggesting alternative options for structuring remuneration and motivating and engaging medical professional, as described in Chapter 5. However, looking at only certain aspects of the reward package risks missing the total reward picture, given the very different methods of remunerating medical professionals globally. Ideally the comparisons would look at the most relevant countries in terms of doctor and dentists movements to/from the UK; the remuneration method and structure, salary levels, additional remuneration and benefits, contractual terms and with adjustments for cost of living/purchasing power and exchange rates. Therefore this type of study might perhaps best be carried out every three to four years to help to allay the costs.
8. **Reflect Total Rewards.** Carry out a simple adjustment where possible on the market total cash data to reflect different pension values, as is already done by some of the other Review Bodies in their comparisons. This appears to be reasonably straightforward to achieve with the Hay market data and they already conduct this type of analysis for public sector clients, and can apply the methodology in international comparisons. As already stated, it is not recommended that any adjustment is made to reflect the high/full employment of doctors.

Table 9.2: The Hospital Doctor/Dentist Career Paths and Recommended Comparators

Anchor Point	Comparators
F1 and F2 • Matched at Hay level 14 and 15 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and/or ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and/or the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Architecture (RIBA)
ST1&2 • Matched at Hay level 16 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay)

Anchor Point	Comparators
ST3+ Specialty Doctor <ul style="list-style-type: none"> Matched at Hay level 17 - 19 and equivalent in additional surveys 	Higher Education (UCEA/Xpert HR or Hay/Russell Group) Architecture (RIBA) Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Higher Education (UCEA/Xpert HR or Hay/Russell Group) Architecture (RIBA)
Consultant (min) Associate Specialist <ul style="list-style-type: none"> Matched at Hay level 20 and equivalent in additional surveys 	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Higher Education (UCEA/Xpert HR or Hay/Russell Group) Architecture (RIBA) Large Private Sector £500m +and possibly Public Sector Senior Managers Level 20 (Hay)
Consultant (max) <ul style="list-style-type: none"> Matched at Hay level 21 and equivalent in additional surveys 	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Higher Education (UCEA/Xpert HR or Hay/Russell Group) Architecture (RIBA) Large Private Sector £500m + and possibly Public Sector Senior Managers Level 21 (Hay)

Table 9.3: The Recommended GP Career Path and Comparators

Anchor Point	Comparators
GP Trainee - Matched at Hay levels 15/16 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay)
Registrar GP - Matched at Hay level 16/17 and equivalent in additional surveys	As above
Salaried GP - Matched at Hay level 18/19 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Architecture (RIBA) Vets (SPVS)
Partner GP - Matched at Hay level 20 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Architecture (RIBA) Hay – level 20 leaders in smaller employers (under £10m) Vets (SPVS)
Managing Partner GP - Matched at Hay level 21 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Architecture (RIBA) Hay – level 21 leaders in smaller employers (under £10m) Vets (SPVS)

Table 9.4: The Recommended General Practice Dentist Career Path and Comparators

Anchor Point	Comparators
Foundation Dentist - Matched at Hay level 14/15 and equivalent in additional surveys	As for FI/F2 Hospital Doctors
Performer Dentist - Matched at Hay level 17/18 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Architecture (RIBA) Vets (SPVS)
Performer Specialist Dentist Matched at Hay level 18/19 and equivalent in additional surveys	As above
Partner Dentist - Matched at Hay level 20 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Pharmaceutical (Hay) Architecture (RIBA) Hay – level 20 leaders in smaller employers (under £10m) Vets (SPVS)
Practice Owner Dentist - Matched at Hay level 21 and equivalent in additional surveys	Accountancy- Corporates (Hay) Accountancy – Practices (Willis Towers Watson and ICAEW) Law - Corporates (Hay) Law – Practices (Willis Towers Watson and the Law Society) Actuarial – Corporates (Hay) Actuarial – Practices (IFA/Xpert HR) Architecture (RIBA) Hay – level 21 leaders in smaller employers (under £10m) Vets (SPVS)

Appendices

Appendix 1: References

Appendix 2: Glossary of Terms

Appendix 3: Dentists and Doctors' Research Questionnaires

Appendix 4: Survey Benchmark Levels

Appendix 1: References

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Appendix 2: Glossary of Terms

AOMRC - Academy of Medical Royal Colleges

ASHE – Annual Survey of Hours and Earnings

BDA - British Dental Association

BMA - British Medical Association

DDRB - Doctors and Dentists’ Remuneration Review Body

GMC - General Medical Council

HESA - Higher Education Statistics Agency

ICAEW - Institute of Chartered Accountants in England and Wales

OME - Office of Manpower Economics

ONS- Office for National Statistics

RCGP – Royal College of General Practitioners

RIBA – Royal Institute of British Architecture

SOC 2010 – Standard Occupational Classification 2010

SPVS - The Society of Practising Veterinary Surgeons

UCAS - Universities and Colleges Admissions Service

UCEA - Universities and Colleges Employers Association

Appendix 3: Research Questionnaires

Dentists' Phone Interview Questionnaire

Questions

Introduction

Thank you for agreeing to take part in this research. Each year the DDRB carries out comparisons in its report of the pay for doctors and dentists at various career levels with other professional careers and occupations. The methodology used was established a decade ago

My name is X and I work for The Institute for Employment Studies, an independent charitable research institute, which is carrying out this review.

An important part of the review is to gather the views of a sample of dentists and doctors themselves on the relevant occupations and careers included in the comparisons and how the comparisons should be done.

We should take no more than 20 minutes. Your individual responses will be held by IES and kept totally confidential, with the information used only in summary fashion in their final report and generally to inform the recommended future methodology.

The current methodology compares 6 career levels with 4 occupations.

This input is a vital part of the research and so we are extremely grateful for your help with the study.

Personal Background

1. What is your level of post-qualification experience (tick one)?

1-2 years

3-7 years

8-10 years

11-20 years

More than 20 years

2. What role do you currently undertake?

Manager of a practice

Practice owner

Dentist employed by a practice

Associate dentist

Hospital dentist

Community dentist

3. What is the setting for your work?

Large/medium/small practice/hospital/community clinic

Urban/rural location

Job and Career

4. Can you briefly describe the dental career path - what are the major levels and breakpoints that we can use to benchmark with other professions, how many and at what levels?

5. Which tasks/responsibilities/accountabilities are the clearest differentiators between your role and those immediately above and below in the career pathway? (In general dental practice there isn't really a career pathway as such, solely an associate and then a practice owner)

6. Which of the skills and competences demanded by your current role are:

The most difficult to perform well?

The most difficult for a new entrant to the role to master?

7. Why did you originally come into dentistry? How important a factor was the reward package?

8. What other occupations or degrees did you originally consider?

9. At present, what are your career intentions for the next 3-5 years?

Continue to develop experience in my current role

Progress in my current area to a more senior role

Move into another speciality/area of dentistry

Move to another practice

Leave the UK to work in dentistry overseas

Leave the NHS to work in the private sector

Leave dentistry to work in a different occupation

Move to part time working

Retire

Other - please describe

10. What jobs are your friends and peers from university doing now? (Gather individual example details if possible)

11. If you were ever to leave dentistry in the UK, what would you do instead?

12. Do you have former peers and colleagues who have done any of the following since they registered: Yes, one or two, yes, more than two (probe on actual examples and details).

Moved into another speciality/area of medicine

Left the UK to work in medicine overseas

Left the NHS to work in the private sector

Left dentistry to work in a different occupation

Other, (please describe)

13. Would you consider moving to practise overseas on a permanent basis? Do you have friends/colleagues who have moved overseas? Where? Why?

External comparisons

14. When considering other occupations and careers to compare dentistry with, what factors do you think need to be taken into account?

Very important/Of some importance/Not important at all

Similar levels of qualifications and experience

Similar skills and competencies

Similar levels of responsibility and decision making

Level of risk

Professional status

Other factors (please describe)

15. If you were to consider leaving the medical profession, how important would the following factors be in influencing you as to another occupation to move into?

Very important/Partly Important/Not important at all

The professional standing and reputation of the occupation

The likely workload and working hours

The earnings and rewards on offer

The skills demanded and challenge of the work

The variety and autonomy in the work

The opportunities to develop and progress

The working environmental

The associated lifestyle

Other factors (please list)

16. Currently there are four occupations that are used in the comparisons. Please indicate how relevant and effective comparators you think that these are to the medical profession (tick one for each occupation)?

Very relevant/Partly relevant/Not relevant at all

Lawyers

Accountants and tax professionals

Actuaries

Pharmaceutical industry managers and professionals

17. From the following list of occupations, please indicate for each how relevant they might be to use as comparator professions. Very relevant/Partly relevant/Not relevant at all

Medical roles overseas

Architects

Management consultancy

Pilots

School teaching and leadership roles

Engineering

Veterinary medicine

Opticians

Finance and banking

IT and technology

The Civil Service professional and leadership roles

Journalism

Surveyors

University academic and leadership roles

Science professionals

Large private sector professional and leadership roles

Small business leaders/partners/owners

Other (please describe)

Summary/conclusions

- Summarise main points made
- Next steps in the project

Thank you for helping with our research.

Doctors' Email Questionnaire

Each year the DDRB carries out comparisons in its report of the pay for doctors at various career levels with other professional careers and occupations. The methodology used was established a decade ago and is currently being reviewed and updated by The Institute for Employment Studies, an independent charitable research institute.

An important part of the review is to gather the views of a sample of doctors themselves on the relevant occupations and careers included in the comparisons and how the comparisons should be done – the skills and competencies to take account of and so on. I would be grateful therefore if you could assist IES by completing their online questionnaire by clicking on the link below

LINK ADDRESS

It should take no more than 10 minutes to complete. Individual responses gathered from the research will be held by IES and kept totally confidential, with the information used only in summary fashion in their final report and generally to inform the recommended future methodology.

This input is a vital part of the research and so we are extremely grateful for your help with the study. Please complete the questionnaire by **Friday June 2nd**

If you have any queries about the questionnaire or study, please contact Duncan Brown, the Study Coordinator, by email via Joe.cunningham@employment-studies.co.uk

Thank you very much for your help.

Yours,

Questions

Introduction

- Please work through the questionnaire providing a response to each question. Mostly the questions ask you to mark a response in the relevant box. In some cases you will be asked to write in your answers.
- Responses will be treated in the strictest confidence and no responses attributable to individuals.
- Thank you for your help.

Job and Career

1. What is your area of work (tick one)?

Hospital practice

General practice

Public health medicine

Community health

Research or academic medicine

Other (please describe)

2. What is your current role (tick one)?

Consultant

Speciality Registrar

Speciality Trainee

Foundation programme 1/2

Speciality Doctor

Associate Specialist

General Practitioner

Other – please describe

3. What is your level of post-graduation experience (tick one)?

Less than 12 months

1-2 years

3-4 years

5-9 years

10-20 years

More than 20 years

4. At present, what are your career intentions for the next 3 – 5 years (please tick any relevant categories)?

Continue to develop my experience in my current role

Progress in my current area to a more senior role

Move into another speciality/area of medicine

Leave the UK to work in medicine overseas

Leave the NHS to work in the private sector

Leave the NHS to work in medicine in HM Forces Move to an academic post

Become a contractor/locum

Move to part time working/reduced hours

Retire

Leave medicine to work in a different occupation

(Which occupation do you plan to move into? Please describe)

Other (please describe)

5. Do you have former peers and colleagues who have done any of the following since they registered: (tick any relevant categories)? Yes, one or two, yes, more than two

Moved into another speciality/area of medicine

Left the UK to work in medicine overseas

Left the NHS to work in the private sector

Left medicine to work in a different occupation

(Which occupation did they move into? – please describe)

External comparisons

6. When considering other occupations and careers to compare medicine with, what factors do you think need to be taken into account (tick the relevant category for each factor)?

Very important/Of some importance/Not important at all

Similar levels of qualifications and experience

Similar skills and competencies

Similar levels of responsibility and decision making

Level of risk

Professional status

Other factors (please list)

7. If you were to consider leaving the medical profession, how important would the following factors be in influencing you as to another occupation to move into?

Very important/Partly Important/Not important at all

The professional standing and reputation of the occupation

The likely workload and working hours

The earnings and rewards on offer

The skills demanded and challenge of the work

The variety and autonomy in the work

The opportunities to develop and progress

The working environment

The associated lifestyle

Other factors (please list)

8. Currently there are four occupations that are used in the comparisons. Please indicate how relevant and effective comparators you think that these are to the medical profession (tick one for each occupation)

Very relevant/Partly relevant/Not relevant at all

Lawyers

Accountants and tax professionals

Actuaries

Pharmaceutical industry managers and professionals

9. From the following list of occupations, please indicate for each how relevant they might be to use as comparator professions

Very relevant/Partly relevant/Not relevant at all

Medical roles overseas

Architects

Management consultancy

Pilots

School teaching and leadership roles

Engineering

Veterinary medicine

Opticians

Finance and banking

IT and technology

The Civil Service professional and leadership roles

Journalism

Surveyors

University academic and leadership roles

Science professionals

Large private sector professional and leadership roles

Small business leaders/partners/owners

Other (please list)

Thank you for helping with our research.

Appendix 4: Survey Benchmark Levels

The Hay UK Generic Capsule Level Descriptors

Level

20

Descriptor

Considerable proficiency in a specialist field or discipline gained through deep and broad experience built on concepts and principles. Typically manages broadly similar sub-functions and integrates and coordinates relationships with other parts of the organisation over a one year horizon, with a significant impact on tactical results. Interaction with others requires highly developed skills to motivate, inspire and persuade. Decision-making involves the use of creative thinking and significant judgement to create functional policy with long term scope. The focus is on the delivery of medium term results within functional policy and precedent and outputs are subject to periodic review against targets. Jobs typically have a direct and controlling impact on the results of a significant area of a large organisation or on a key aspect of performance of a medium sized organisation.

Examples: Report to board director in a major UK company; Police Force Area Commander; some University Professors; Army Lt Colonel

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Proficiency in a specialist field or discipline gained through deep and broad experience built on concepts and principles. Typically manages broadly similar sub-functions and integrates and coordinates relationships with other parts of the organisation over a one year horizon, with a significant impact on tactical results. Interaction with others requires highly developed skills to motivate, inspire and persuade. Decision-making involves the use of judgement and there is an emphasis on the development of new/improved procedures and on the translation of policy into operational plans. The focus is on the delivery of medium term results within functional policy and precedent and outputs are subject to periodic review against targets. Jobs typically have a direct and controlling

impact on a key aspect of performance of a small organisation or a contributory impact on a large organisation.

Examples: Line manager responsible for major part of a function in a large UK company; Head of Major service in a District Council; Head of Large Primary School

18

Extensive professional knowledge about theoretical concepts and principles in a specialist field normally associated with a professional or academic qualification or considerable experience. Typically manages broadly similar sub-functions and integrates and coordinates relationships with other parts of the organisation over a one year horizon. Interaction with others requires highly developed skills to motivate, inspire and persuade. Decision-making involves the use of judgement and there is an emphasis on the development of new/improved procedures and on the translation of policy into operational plans. The focus is on the delivery of medium term results within functional policy and precedent and outputs are subject to periodic review against targets. Jobs typically have a direct and controlling impact on a key aspect of performance of a very small/small organisation. OR

Proficiency in a specialist field or discipline gained through deep and broad experience built on concepts and principles. Performance or supervision of moderately diverse activities that is precise as to content and objective and requiring awareness of related activities in order to operate within a short/medium time frame. Interaction with others requires highly developed skills to motivate, inspire and persuade. Decision-making involves the use of judgement and there is an emphasis on the development of new/improved procedures and on the translation of policy into operational plans. The focus is on the delivery of medium term results within functional policy and precedent and outputs are subject to periodic review against targets. Jobs typically have a contributory impact on a medium sized organisation through the determination of resource utilisation in the medium term and through the provision of advisory or facilitative services upon which others take action.

Examples: Key functional expert in charge of corporate service team in a PLC; Senior Lecturer, Squadron Leader

17

Professional knowledge about theoretical concepts and principles in a specialist field normally associated with a professional or academic qualification or significant experience. Performance or supervision of moderately diverse activities that is precise as to content and objective and requiring awareness of related activities in order to operate within a short/medium time frame. Interaction with others requires highly developed skills to motivate, inspire and persuade. Decision-making involves the use of judgement

and there is an emphasis on the development of new/improved procedures and on the translation of policy into operational plans. The focus is on the delivery of medium term results within functional policy and precedent and outputs are subject to periodic review against targets. Jobs typically have a contributory impact on a medium sized organisation through the determination of resource utilisation in the medium term and through the provision of advisory or facilitative services upon which others take action.

Examples: Production manager and lawyer/accountant with c3 years PQE in the private sector; Army Captain, Advanced Skills Teacher, Experienced Lecturer top university.

16

Professional knowledge about theoretical concepts and principles in a specialist field normally associated with a professional or academic qualification or significant experience. Performance or supervision of related activities that is precise as to content and objective and requiring awareness of related activities. Interaction with others requires highly developed skills to motivate, inspire and persuade. Work requires the consideration of future implications beyond the immediate problem and may involve the creation of new approaches and procedures to solve the problem. The level of discretion is governed by established practices, procedures and policies. Outputs are subject to managerial review and jobs typically have a contributory impact on a medium sized organisation through the determination of resource utilisation in the medium term and through the provision of advisory or facilitative services upon which others take action.

Examples: Qualified accountant in the private sector; Nurse Manager; Police Sergeant

15

Practical, applied and highly authoritative but non-theoretical knowledge of specialised methods and processes gained by on the job experience or part professional qualification. Performance or supervision of related activities that is precise as to content and objective and requiring awareness of related activities. Interaction with others requires highly developed skills to motivate, inspire and persuade. Work requires the consideration of future implications beyond the immediate problem and the level of discretion is governed by established practices, procedures and policies. Outputs are subject to managerial review and jobs typically have a contributory impact on a small organisation through the determination of resource utilisation in the medium term and through the provision of advisory or facilitative services upon which others take action.

Examples: Computer Services Co-ordinator; Nursing Team Leader, Teacher

14

Practical, applied and highly authoritative but non-theoretical knowledge of specialised methods and processes gained by on the job experience or part professional qualification.

Performance or supervision of related activities that is precise as to content and objective and requiring awareness of related activities. Interaction with others requires social skills and the ability to understand and influence. Work requires the consideration of future implications beyond the immediate problem and is not closely supervised. It is governed by standardised work routines that permit the use of initiative and jobs typically have an impact through the provision of specialised advisory, diagnostic or operational services.

Examples: Part qualified accountant; qualified nurse.

Appendix Table 1: The UCEA Senior Salary Survey and Salary Survey in HEIs Job Levels

Title	Description	Purpose	Reports To	Staff	Budget	Experience
1	Head of Institution - Vice-Chancellor/Principal/ equivalent	The most senior manager within the institution. Typical job titles: Vice-Chancellor, Principal, Chief Executive Officer.	Governing body			
2	Deputy Vice-Chancellor/ Pro Vice-Chancellor/ Chief Operating Officer/Registrar/ Secretary	<p>The highest level of appointment reporting directly to the Head of Institution with primary responsibility for the organisation's performance and strategic development.</p> <p>Deputy Vice-Chancellor Responsible for a major part of the institution's academic life. May have Pro Vice-Chancellors reporting into this role and Dean responsibilities for a specific faculty in addition to Deputy Vice-Chancellor responsibilities. Likely to deputise the Head of Institution. Applies to a handful of positions in the institution. Reports to level 1. Typical job titles: Deputy Vice-Chancellor, Vice Principal, Provost.</p> <p>Pro Vice-Chancellor Responsible for a significant part of the institution's academic life and unlike level 3 has responsibility across the institution. May have Dean responsibilities for a specific faculty in addition to Pro Vice-Chancellor responsibilities. Likely to deputise the Head of Institution. Applies to a handful of positions in the institution. Reports to level 1. Typical job titles: Pro Vice-Chancellor, Provost</p> <p>Chief Operating Officer Responsible for or has oversight for all or most of the institution's internal professional services or administrative services functions at a strategic rather than an operational level. Usually applies</p>	Level 1			

Title	Description	Purpose	Reports To	Staff	Budget	Experience
		<p>to one or two positions in the institution. This role has a larger scope than a Registrar/Secretary. Reports to level 1. Typical job titles: Chief Operating Officer, Chief Financial Officer.</p> <p>Registrar/Secretary Responsible for more than one functional area at a strategic rather than operational level. May have oversight for several internal professional or administrative services of the institution. Usually applies to one or sometimes two positions in the institution. Reports to level 1. Typical job titles: University Secretary and Registrar. Although academic registrars without a university secretary function are occasionally found here, they are more commonly recorded under level 3B with job function SA (Student Support and Administration).</p>				
3A	Head/Director of major academic area	<p>Heads a major academic area where a number of schools/departments/divisions are combined into a small number of larger groupings. Has significant management and resource responsibility and will be part of the university's senior management team (although level 2 roles may meet separately as the ultimate executive decision-makers). Reports to either level 1 or 2. Probably applies to a very small number of positions in the institution and likely to be a Dean, director of a faculty or a head of an academic division. Typical job titles: Executive Dean, Dean, Head of College, Head of School.</p>	Level 1 or 2			

Title	Description	Purpose	Reports To	Staff	Budget	Experience
3B	Director of major function/group of functions e.g. finance, corporate services, HR	Overall responsibility for matters across a major function or group of functions or defined activity. Will be part of the HEI's senior management team (although level 2 roles may meet separately as the ultimate executive decision-makers). Responsible for staff within the function or activity at a strategic rather than operational level. Has major strategic input into financial matters related to the area of activity and has influence across the institution. Reports to level 1 or 2. Typical job titles: Director of Human Resources, Director of Finance, Chief Information Officer, Director of Marketing and Corporate Communications, Director of Estates and Facilities, Academic Registrar, Director of Student Operations and Support, Director of Research and Enterprise.	Level 1 or 2	Will have responsibility for staff within the function or activity at a strategic rather than operational level.	Have major strategic input into financial matters related to the area of activity and have influence across the institution.	
3/4A1	Head of a distinct area of academic responsibility centre size 1, e.g. head of school/division/department	Heads a distinct area of academic responsibility, probably at a school or department. Manages a large unit of more than 100 staff including academic and support staff but excluding atypical staff. Have a clearly defined resource management/budgetary responsibility for an academic area. Responsible for all staff within a school/department. Unlikely to be on the senior management team, unless it is the first level of function head below the role of level 2. Reports to level 2 or 3. Typical job titles: Head of Department, Head of School, Associate Dean, Deputy Dean, (with oversight for over 100 staff).	Level 2 or 3	Will have responsibility for all staff within the school/department (department Size 1 Large 100+ staff including all academic and support staff but excluding atypical staff)	Has clearly defined resource management/budgetary responsibility for the academic area	

Title	Description	Purpose	Reports To	Staff	Budget	Experience
3/4A2	Head of a distinct area of academic responsibility centre size 2, e.g. head of school/division/department	Heads a distinct area of academic responsibility, probably at a school or department. Manages a medium-sized unit of between 51 and 100 staff including academic and support staff but excluding atypical staff. Have a clearly defined resource management/budgetary responsibility for the academic area. Responsible for all staff within the school/department. Unlikely to be on the senior management team, unless it is the first level of function head below the role of level 2. Reports to level 2 or 3. Typical job titles: Head of Department, Head of School, Director, Associate Dean (with oversight for 51 to 100 staff).	Level 2 or 3	Will have responsibility for all staff within the school/department (department Size 2 Medium 51 to 100 staff including all academic and support staff but excluding atypical staff)	Has clearly defined resource management/budgetary responsibility for the academic area	
3/4A3	Head of a distinct area of academic responsibility centre size 3, e.g. head of school/division/department	Heads a distinct area of academic responsibility, probably at a school or department. Manages a small unit of between 1 and 50 staff including academic and support staff but excluding atypical staff. Have a clearly defined resource management/budgetary responsibility for the academic area. Responsible for all staff within the school/department. Unlikely to be on the senior management team, unless it is the first level of function head below the role of level 2. Reports to level 2 or 3. Typical job titles: Head of Department, Head of School, Director, Associate Dean (with oversight for 1 to 50 staff).	Level 2 or 3	Will have responsibility for all staff within the school/department (department Size 3 Small 1-50 staff including all academic and support staff but excluding atypical staff)	Has clearly defined resource management/budgetary responsibility for the academic area	

Title	Description	Purpose	Reports To	Staff	Budget	Experience
4A	Head of a subset of an academic area/director of a small centre	Heads a subset of a division/department/school (e.g. subject discipline group) or research group. Alternatively could have cross school/departmental responsibilities. Line manages staff within the area of activity and may have delegated responsibility for budget setting and management within the area of activity. Reports to level 3 or 3/4. Such posts may include professors who head departments/research centres. Typical job titles: Director, Divisional Leader, Deputy Head, Associate Dean.	Level 3 or 3/4	Will be responsible for staff within the area of activity	May have delegated responsibility for budget setting and management within the area of activity	
4B	Senior function head	Responsible for a complete function or activity below Senior Management Team level but will be part of the management team for the overall function. Has responsibility for budget setting and management within the function and has responsibility for staff within the function or activity. Reports to level 2 or 3. Typical job titles: Deputy Director of Human Resources, Head of Faculty Finance, Head of Infrastructure Management, Head of Marketing, Assistant Director of Estates, Head of Research Support.	Level 2 or 3		Have responsibility for budget setting and management within the function and has responsibility for staff within the function or activity.	
5A	Professor	Senior Academic appointments which may carry the title of Professor but which do not have departmental line management responsibilities.				
5B	Function head	Full managerial responsibility for one or more activities and provides input into policy formation for those activities. Responsible for staff within the area of activity. Has delegated responsibility for budget setting and management within an area of activity. Reports to level 3 or 4. Typical job titles: Human Resources Manager (Reward), Finance and Planning Manager, Head of Networks, Head of Market Insights.	Level 3 or 4		Have delegated responsibility for budget setting and management within an area of activity.	

Title	Description	Purpose	Reports To	Staff	Budget	Experience
Level I	Non-Academic Staff Section Manager Senior Lecturer (pre 92) Principal Lecturer (post 92) Reader Principal Research fellow	To be responsible for the day-to-day management of a significant professional service unit, activity, department or project, with specifically identified responsibilities. Includes academic subject specialists, academic programme coordinators and/or academic staff with high level expertise/knowledge.	Function Head	May have responsibility for one or more Team Leaders (Level J). May conduct appraisals and objective setting.	Has responsibility for day-to-day management of section/project. May have responsibility for department budgets.	Provides expert/specialist advice. Fully experienced in the day-to-day management of a section, department or project.
Level J	Section/Team Leader (Professional, Technical, Administrative) Lecturer B(pre- 92) Senior Lecturer (post 92) Senior Research Fellow	To be responsible for the day-to-day management of a team of staff. Specialists with experience or seniority but limited management responsibility may be found at this level. In the case of academic staff there may be no responsibility for staff or budgets but substantial responsibility for students.	Section Manager (level I), Function Head (5B)	Has supervisory responsibility for a team of experienced staff (level K or below). Mentor, may be responsible for appraisals.	May have day-to-day responsibility for the team budget.	Specialists with experience but limited mgmt responsibility may be found at this level.
Level K	Senior Professional/ Technical/Staff Lecturer A (pre-92) Lecturer (post-92) Research fellow Researcher/senior research assistant Teaching fellow	To operate at an experienced, professional level in a single area of work without supervision. Likely to be responsible for less experienced staff at level L and below and may co-ordinate the activities of a team. In the case of academic staff there may be no responsibility for staff or budgets but significant responsibility for students.	Section Manager (level I) or Section/ Team Leader (level J)	Likely to have responsibility for staff who are first-line managers or supervisors, maybe a 'mentor'.	May have day-to-day responsibility for the team budget.	Fully qualified, or with equivalent experience, likely to have operated at a lower level for some time prior to promotion to this level.
Level L	Professional/ Technical/ Senior Administrative Staff Research Assistant Teaching Assistant	To operate as a fully competent professional within a single area of work with minimal supervision. This is a standard 'Officer' level. For academic jobs this is an assistant or instructor role. In some professional areas this would be the expected entry level.	Senior Professional Staff (K) or Team Leader (Level J)	May lead a small team or offer advice and guidance to less experienced or trainee staff.	None	Professionally qualified with experience usually in excess of 2 years.

Title	Description	Purpose	Reports To	Staff	Budget	Experience
Level M	Assistant Professional Staff Administrative Staff	Typically an entry level professional, working under instruction from others within a defined area of work. May be part-qualified in an appropriate professional discipline. May supervise/assist/guide less experienced administrative staff.	Senior Professional Staff (Level K) or Team Leader (Level J) Normally works under direct supervision of more experienced staff within well-defined limits.	None	None	Relevant experience, usually more than 12 months.
Level N	Junior Administrative Staff Clerical Staff Technician/Craftsmen Operative	Normally working under closer supervision than level M staff but experienced in specific areas of job role. Responsibility mainly for performing a range of simple, routine tasks within basic procedures and under regular supervision. May be a school leaver, trainee or modern apprentice. Would not cover academic roles	Professional Staff (Level L) or Senior Professional Staff (Level K)	None	None	Entry level, usually less than 12 months experience.
Level O	Routine Task Provider	Carrying out a range of simple tasks within a defined routine and where guidance is readily available/ under regular supervision. Some planning and organising of own workload will typically be required (largely around the timing and sequencing of assigned tasks to make sure deadlines are met).	Supervisory staff at a more senior level.	None	None	Unnecessary
Level P	Simple Task provider	Carrying out simple and/or repetitive tasks under close supervision, typically supporting students and staff often as part of a team engaged in the same tasks. These tasks and routines are generally simple and repetitive and are closely supervised.	Supervisory staff at a more senior level.	None	None	Unnecessary