Review Body on Doctors' and Dentists' Remuneration

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Forty-Seventh Report 2019

Chair: Professor Sir Paul Curran

CP 148

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

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

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

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

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

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

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

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

The members of the Review Body are:

> Professor Sir Paul Curran *(Chair)*
> David Bingham
> Professor Peter Kopelman
> Professor Kevin Lee
> Professor James Malcomson FBA
> John Matheson CBE
> Nora Nanayakkara[1]
> Jane Williams

The Secretariat is provided by the Office of Manpower Economics.

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[1] Nora Nanayakkara was appointed as a member of the Review Body on Doctors' and Dentists' Remuneration part-way through the pay round on 1 March 2019.

Executive Summary

The DDRB's remit group

1. The Review Body on Doctors' and Dentists' Remuneration provides advice to ministers in the Governments of the UK on the remuneration of doctors and dentists employed by, or providing services to, the National Health Service. It has regard to the considerations spelt out in its terms of reference including, but not limited to, the need to recruit, retain and motivate doctors and dentists, to take account of regional labour markets and their effects on the recruitment and retention of doctors and dentists, the Government's inflation target, the funds available to the Health Departments and the mechanisms to ensure that patients are at the heart of the NHS.

2. The DDRB's remit group is complex. It is made up of over 140,000 Hospital and Community Health Services (HCHS) medical staff (of which there are approximately 60,000 consultants and 65,000 doctors and dentists in training), almost 50,000 General Medical Practitioners (GMPs) and 30,000 General Dental Practitioners (GDPs).

3. During the course of our work this year, a five-year contract was agreed, between the Department for Health and Social Care (DHSC), NHS England, and the General Practitioners Committee of the British Medical Association (BMA), in relation to a new GMP contract in England. The parties to the new contract agreed to ask the DDRB to not make recommendations relating to GMP independent contractor pay over the period of the agreement, and not to make recommendations on salaried GMP pay in England for this round. The expectation however is that, starting with our 2020 report, the DDRB will again make recommendations on salaried GMP pay annually over the period of the agreement.

Context for our report

4. The economic outlook for the UK is uncertain. Commentators such as the Office for Budgetary Responsibility and the Bank of England have revised down forecasts for trade and investment and growth in GDP. However, inflation is expected to remain broadly constant, hovering around 2 per cent. Latest data show average earnings growth across the economy at 3.2 per cent, and for 2018 earnings growth for full-time employees was 2.8 per cent at the median, but reaching 3.2 per cent at the 90th percentile and 4.1 per cent at the 95th percentile, which is where the higher earning members of our remit group are located.

5. Our previous reports described some concerns about capacity in the medical and dental workforce. These mostly remain unresolved, and some appear to be getting more serious. In particular, many medical and dental students, and many substantive NHS doctors and dentists, are EU nationals, and are potentially affected by the continuing uncertainty around the UK's future relationship with the EU. This uncertainty may also affect the recruitment of international students and staff from outside the EU.

6. We have been provided with significant evidence this year about the impact that the pension taxation system may be having on the behaviour of the more highly paid, and most experienced members of our remit group. It appears that some senior staff have been incentivised to change their working patterns by refusing extra shifts, working part-time rather than full-time, retiring early from the NHS, and moving to self-employment rather than remaining as an NHS employee. Pension taxation policy is outside our remit, but there does appear to be a serious problem here, which merits close attention.

7. The challenges of meeting the work-life balance sought by some in our remit group remain. In particular, there are still problems of managing the process of stepping out temporarily from service by doctors in training.

8. Some other workforce issues seem now to be causing rather less concern. For example, efforts have been made, to some extent successfully, to address the scale of payments to locums and to maximise the use of bank arrangements.

9. We were pleased to note that further steps are being taken to address some key issues, notably workforce planning. Wales, Scotland and Northern Ireland are working through the implementation of the plans which had been set in train before we submitted our 2018 report. We also welcome the publication in January 2019 by NHS England of the Long Term Plan (LTP). Although the plan contained little about workforce, it was subsequently clarified that this area was to be the subject of a separate and subsequent exercise, to be carried out under the chair of Baroness Harding of Winscombe. Following this commitment, the Interim NHS People Plan for England, an action plan for 2019-20, setting out a vision of how the NHS workforce will be supported to deliver the LTP, was produced by NHS Improvement shortly before this report was submitted, with a fully costed five-year People Plan expected later this year.

Our remits and our process

10. The Secretary of State for Health and Social Care's initial remit letter (for England) of November 2018 was subsequently adjusted to take account of the signing of the GMPs' contract. The Cabinet Secretary for Health and Sport in the Scottish Government asked us to make recommendations in this pay round for employed doctors and dentists. The Minister for Health and Social Services in the Welsh Government asked for recommendations that would enable him to determine a fair pay award for medical and dental staff in Wales. The Permanent Secretary of the Department of Heath for Northern Ireland wrote to the review body and provided evidence to assist in the task of providing recommendations for Northern Ireland in the 2019-20 pay round.

11. The English remit letter invited the DDRB to consider how resources might be targeted through existing flexible pay premia in the contract for doctors and dentists in training, and as a response to discussions between NHS Employers and the BMA on reform of the consultant contract. The Scottish remit indicated that the Scottish Government would not find it particularly helpful to recommend a different uplift for each pay group in Scotland, and the Welsh Government said it did not support the use of targeted pay for specific specialties within staff groups.

12. We are grateful to the trade unions for meeting the deadlines that had been set and value the balance provided by their continued engagement. We note that of the four Governments, only the Department of Health (Northern Ireland) was able to submit its evidence by our 7 January 2019 deadline. Evidence from the DHSC in England was published on 18 January, the Scottish Government supplied its evidence on 8 February, and the Welsh Government submitted its evidence on 8 March. Government evidence is a key part of the process, and it is difficult, without unduly compressing the timetable, to ensure that the rights of all the parties involved are duly respected and that their participation is valued. If review body reports are to be prepared and delivered in accordance with its remit, governments need to recognise the rights of all the parties involved, and should make every attempt to ensure their own evidence is produced and delivered in a timely manner.

13. All the unions also raised questions about the DDRB's role in the process of pay determination for the medical and dental workforce, and the way that DHSC reacted to our recommendations last year. We have offered in Chapter 1 of our report our observations on the issues raised by the unions. The DDRB exists to provide a service to stakeholders but its ability to provide that service is conditioned by the way in which the parties engage with the process.

The case for a pay award

14. We looked, as we have done in previous years, first at the case for a general pay uplift, and then at the case for making targeted recommendations in relation to any of the groups within our overall remit.

15. Headline workforce figures do not suggest any sudden decline in overall medical or dental workforce numbers. Medicine and dentistry undergraduate courses remain popular. Many junior doctors step out temporarily from service for a year or two during their training period, but most seem likely in due course to return to the NHS, albeit not necessarily full time. It is notable that during the last few years there has been an increase in doctors taking voluntary early retirement.

16. We have some serious concerns about morale, and its impact on the motivation of our remit group. It appears that a long period of real-terms pay decline over the last decade is starting to have a significant negative impact. This emerged strongly from the tone and content of the written evidence we received from the BMA, the British Dental Association (BDA), and the Hospital Consultants and Specialists Association (HCSA). It was visible in the sharp fall in satisfaction in pay as reported in staff surveys (Table 4.2). We also heard it on our visits in England, where several very negative comments were made about the Government's decision to stage and abate the pay recommendations that we made last year for many of our groups, for example reducing the recommended increase for consultants from 2 per cent to 1.5 per cent.

17. This concerns us. The NHS has always relied to a considerable extent on goodwill and vocational commitment. Even though unquantifiable, this discretionary effort makes a significant contribution to NHS productivity. It cannot simply be taken for granted. The government and NHS leadership have ambitious plans for the future, and our remit group will have key roles to play. Discussions need to conclude on the contracts and other issues which affect SAS doctors, the reform of the dentists' contract and the consultant contract, and the junior doctors' contract review process. For all of these, sustainable success requires mutual confidence and reasonable goodwill. In that context, the recent staff survey results, showing declines in almost every measure of engagement and job satisfaction, are worrying.

18. We noted the recently concluded GMP framework agreement for England assumes that salaried GMPs will receive at least a 2 per cent pay uplift for 2019-20, and specifically aims to address other significant problems for contractor GMPs. These include questions of liabilities and responsibilities arising from practice ownership, and the funding of professional medical indemnities. The total financial benefits of these new arrangements for individual contractor GMPs may be considerably more than 2 per cent.

19. We did not hear any specific calls for our recommendations for awards in the different countries to be varied. However, we note that current approaches to public sector pay differ between England and Scotland. In addition, each Government has implemented pay uplifts in ways that produce divergences in pay. We regard the market for the medical and dental workforce as largely a UK-wide one, although also with an international component. In the longer term, diverging basic pay in the four countries will have an impact on the mobility of the workforce within the UK and this should be evaluated more systematically when considering our recommendations.

Pay policy, productivity and affordability

20. As requested, we have set out in Chapter 3 our views on the questions of productivity and affordability. Productivity is an issue we have considered carefully. Measuring it is important but not straightforward. The data we currently receive relates only to the service as a whole and tells us little about the productivity of our remit group. As such, they provide only a broad and imperfect indication of the affordability constraints that might inform pay recommendations.

21. Much of the messaging about productivity from within the NHS stresses that greater productivity is delivered through multi-disciplinary team working. This would imply that productivity measurements based on the work of individual doctors are unlikely to be very helpful. Productivity is a system-wide imperative, and it is likely to be aided, or impeded, by the general levels of commitment, morale and motivation within the NHS, including our remit group, and productivity enhancements would be best addressed through contract negotiations through which specific groups can be rewarded financially for their contributions.

Pay uplift

22. **After considering all the evidence, we recommend a general uplift of 2.5 per cent, to be applied across our remit group, from the start of April 2019.**

23. It is worth noting that, applied to those in our remit in England, this would add £316 million to the paybill in 2019-20, compared with what the DHSC described as an envelope of £250 million for substantive HCHS medical staff. For General Dental Practitioners, it would add around £46 million to the total paybill against the DHSC quoted envelope of £37 million. We have set these figures against other NHS costs, such as the almost £1 billion annually for agency expenditure on medical and dental staff in England, and the overall annual NHS Resource Departmental Expenditure Limit in England of over £110 billion.

24. Complementing the GMP framework agreement, our recommendations aim to offer a background against which discussions on the workforce strategy, contract reform and resolution of issues for many in our remit group, and potential adjustments to the junior doctors' contract, can take place constructively, to the overall benefit of NHS productivity.

Targeting

25. We have also considered the case for more specific recommendations, targeted at particular groups within the workforce. We distinguish between targeting by grade, targeting by specialty and targeting by geographical area.

26. In some respects, we see already divergent pay levels in different parts of the United Kingdom, for example, in England with the London allowance, and arrangements such as 'Golden Hellos'. The different ways in which Governments have implemented our awards, especially in 2018, have produced de facto targeted pay, whether or not that was their intended outcome. The impact of these existing arrangements for differentiated pay should not be overlooked by those considering further initiatives for specialty or geographic supplements.

Targeting by grade

27. Last year we recommended that specialty and associate specialist doctors (SAS) should receive a 3.5 per cent increase in their national salary scales from April 2018. Other than in Wales, this has not been fully implemented. The Westminster Government implemented a 3 per cent increase from October 2018 in England, while the Welsh Government implemented our recommendations in full, including a 3.5 per cent uplift for SAS doctors from April 2018. In Scotland, an award of 3 per cent for SAS doctors, or £1,600 for those already earning £80,000 or more, was implemented from April 2018 and, at the time of submission, in the absence of a fully functioning Northern Ireland Assembly, there had been no implementation of any of our recommendations.

28. We were pleased that the Secretary of State committed to working with the BMA SAS committee to reform the SAS contract in England and agreed, in principle, that this will include reopening the Associate Specialist (AS) grade to extend career development for this group.

29. This represents a good start on the road to reinvigorating this small but important group of senior doctors. This year, we see a value for money justification for going a little further. Many of the staff in the SAS group are highly experienced and are able to carry out specialist procedures efficiently and effectively in a way that helps towards overall productivity and relieves some of the burden on the consultant workforce. Some 40 per cent of the doctors in the group are qualified international doctors, who can be deployed without a long training period. They are also the group whose pay is most susceptible to international recruitment influences, such as the relative strength or weakness of sterling.

30. **We recommend that this group should receive an extra 1 per cent in addition to the 2.5 per cent general increase that we are recommending for all groups.**

31. The extra cost would be £11 million, which we consider would be further cost-effective investment in raising the profile and attractiveness of this important but too often under-valued group of staff.

Targeting by specialty or geographically

32. We were not presented for this round with any specific proposals for specialty or geographic targeting, and were strongly urged by the unions not to take this approach.

33. In previous reports we have noted the use of 'Golden Hellos' to attract more people to train as GMPs in certain geographical areas, and in our last report we signalled support for targeting towards training places in histopathology. For this round, we are content to make no specific recommendations on targeting so as not to undermine the constructive background for future dialogue that our other recommendations are intended to create, although we are clear that it remains important to monitor the effects of existing initiatives. But we continue to believe that targeted pay arrangements can have a part to play in ensuring that available resources are allocated most effectively, and we encourage parties to actively pursue these options further and make specific proposals to us in the future.

Looking ahead

34. We have already indicated that the priority for the NHS in England must be to substantiate the LTP with a credible workforce strategy, which has the support of key stakeholders. We look forward to playing our part in helping the success of such a strategy.

35. We were told that there had been positive progress in implementing and delivering the anticipated benefits of the first phase of the GP Contract in Scotland, and we look forward to the next phase building on that foundation.

36. Our recommendations were informed by evidence provided by all the parties, and we set out in Chapter 11 the areas where we would like to see further, or better quality data. Some of these areas represent data shortages or gaps which are long running, others represent new areas of emphasis. We would highlight in particular, as we did in last year's report, the need for some resolution to the widely differing pictures of dentistry as presented by the parties.